" WOMEN SURVIVORS OF SEXUAL ABUSE:
Identification and Disclosure"

A thesis presented in partial fulfilment of the requirements
for the degree of Master of Social Work
at Massey University

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1992

ABSTRACT

The long-term effects experienced by women survivors of childhood sexual abuse are now acknowledged and well documented in the clinical literature. Women attending social service agencies rarely reveal a history of sexual abuse unless they are prompted in some way. This thesis is concerned with finding the most effective ways of identifying women who have been sexually abused as children. The study was undertaken to test the validity of a predictive theory devised by Ellenson (1985,1986) who claimed that survivors of childhood sexual abuse displayed clearly identifiable symptoms known as the *Post-Traumatic Stress Syndrome*. (PTSS).

The first phase of this study disproved Ellenson's theory. His set of predictive indicators could not be used to accurately identify whether or not a woman had been sexually abused. The second phase of the research was drawn from a series of indepth interviews with social workers and other health professionals involved in counselling women. The purpose of these interviews was to discover how practitioners identify women clients with a history of sexual abuse.

As a consequence of these two inquiries, the author then constructed an "*Index of Sexual Abuse Indicators*" which could have validity for social workers in the practice setting.

ACKNOWLEDGEMENTS

I would particularly like to acknowledge the assistance of the women who participated in the 1986 evaluation and the practitioners involved in the field research during 1990 and 1991. Without their help this research could not have been undertaken.

My thanks are also extended to: Professor Ian Shirley, Dr Celia Briar and Dr Robyn Munford, Thesis Supervisors, Massey University; Professor Peter Joyce, Department of Psychological Medicine, Christchurch Clinical School, for his statistical assistance with the second analysis of the data; Dr Dugald McDonald, University of Canterbury, for his encouragement over the years and assistance in editing this thesis; Margaret (Porter) Smith, Social Work Student/Research Assistant during 1986 and Elizabeth Chesterman, Social Work Student/Research Officer during 1990.

Of special mention must be the support, encouragement and practical assistance given to me by my husband Gary. I also extend my thanks to my women friends and colleagues, and in particular to Daryle Deering, for the encouragement given to complete this thesis.

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CHAPTER 1

INTRODUCTION

As a clinician working with women clients attending counselling centres, it has become increasingly evident to me that sexual abuse is a common experience for many of them. I have also found that women attending social service agencies rarely reveal a history of sexual abuse unless they are prompted in some way. This has meant that while some of them may have already spent a considerable amount of time in treatment centres of one kind or another in order to deal with their "psychological problems", sexual abuse experiences had never been discussed or detected.

I believe–and this belief has been reinforced during my sixteen years of clinical practice–that recovery is more likely to occur once the abuse is disclosed. My own clinical experience has shown me that the decision to disclose–particularly to a woman's personal circle rather than in a clinical situation–may be related to several factors which prevent a clear indication as to the effects of telling or not telling about the experience. While silence about an experience may cause individual suffering, social reactions and consequences may not be so harsh if the event is reported later. Disclosure about sexual abuse is currently more openly encouraged and women are more likely to be believed now than in the past.

It is important, therefore, that social workers are able to identify clients with sexual abuse histories and that they precipitate disclosure of the abuse during the counselling process. However, the possibility that previous sexual abuse experience is a contributing factor in their need for counselling is not always considered by the professionals referring the women, or by the women themselves. This knowledge has continued to concern me and provided the impetus for this research.

Setting The Context Of The Study

Over recent years members of the helping professions, clinical advisors to Government, and the New Zealand community in general, have become increasely aware of the widespread prevalence of sexual abuse. During the 1980's, publicity surrounding the incidence of sexual abuse focussed public attention on the issue and prompted greater emphasis on identifying the prevalence of abuse. While there are no conclusive figures on the extent of sexual abuse in New Zealand, Russell (1983) estimates that one in four women have been sexually abused as children. While it is not intended to minimise the problem of sexual abuse to boys and men, the focus of this study is on the experiences of girls and women.

In sociological terms the problem of sexual abuse is related to an imbalance of power in gender relations. State policy in New Zealand consistently identifies women's role as that of an economically dependent wife and mother. In other words the "normal" family is constantly portrayed as a nuclear unit consisting of a male breadwinner, economically dependent housewife and children. Despite the increasing participation of women in paid work, most women earn an insufficient income to maintain themselves and their children independently of a male breadwinner (Briar, 1992).

It is in the home that this economic relationship, and therefore the power relationship, between men and women becomes apparent. Within the home the redistribution between wage-earners and their economic dependants takes place. In return for her subsistence, the male wage-earner exchanges housework, childcare and sexual servicing with the wife-mother. Although the state has introduced regulations which give some protection against abuses to paid workers, the "private" arena of the unpaid workforce and the family is exempt. Indeed the state is often slow to intervene when serious abuse has taken place.

Clear links can, therefore, be drawn between issues of sexual abuse and the structural dynamics of womens' economic dependency. It is within the context of the home that men, on whom others are economically dependent, may choose to exercise sexual coercion in an attempt to assert or regain a sense of power within the family. However, not all abusers are "breadwinners". Some feminists would argue that sexual abuse is, in itself, a means by which some men gain and maintain power over women and girls (Brownmiller, 1977; Saphira 1979).

Feminist explanations of sexual abuse are powerful in that they address both economic and social relations, and they link private and public worlds. For women the structural roots of power relations are at the centre of household and familial relationships. These relationships are crucial to an understanding of womens' sexual abuse as the "home", which is frequently referred to as a source of stability in society, a haven in a heartless world (Barrett, 1980) is also the context in which most sexual abuse occurs. This occurs despite the serious effects of sexual abuse upon women being made more public as a result of recent research.

At a personal level sexual assault can induce a life crisis which may inflict major psychological and physiological trauma upon the survivor. A strong case was made by Lindberg and Distad (1985) for viewing the *Post-Traumatic Stress Syndrome* (PTSS) as an appropriate diagnosis for some adults who suffered sexual abuse during childhood. While PTSS can occur immediately, often the trauma of sexual abuse is not integrated for many years (Moscarello,1990).

Other researchers (McLeer *et al.*, 1988; Kiser *et al.*, 1988; Dahl, 1989) have also found symptoms of PTSS amongst survivors of sexual abuse. Symptoms include the classic triad of haunting intrusive recollections; numbing or constriction of feelings and focus; and lowered threshold of anxious arousal. These come after experiencing intense fear, terror, and loss of control (American Psychiatric Association 1987).

The psychological reaction to sexual assault was first described in 1974 by Burgess and Holmstrom as the *Rape Trauma Syndrome.* In 1980, the American Psychiatric Association recognized the characteristic common symptoms which follow a psychological traumatic event (natural and man-made disasters, war, political terrorism, hostage-taking, and crimes of violence) with the inclusion of the diagnosis of Post-traumatic Stress Disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III and DSM-III-R). It also noted that the most severe and long-lasting symptoms occured when the stressor was human, as in sexual assault.

Several factors influence the impact of abuse on a child. These include: the age of the child (Price and Valdiserri,1981); the nature of the relationship between the child and the perpetrator(s); the gender (Schultz and Jones,1983); the frequency and duration of the abuse (Tsai *et al.*,1979); the nature of the incident(s), particularly the use of force and/or violence (Elwell, 1979; Schultz and Jones,1983). It is generally assumed that the impact of trauma or sexual abuse on a child will be a function of the developmental stage of the child (Lewis & Sarrel,1969; Browne & Finkelhor,1986; Moscarello, 1990).

The long-term effects experienced by women survivors of childhood sexual abuse have been well documented in the clinical literature (Meiselman,1978; Courtois,1979; Herman,1981; Gelinas,1983; Briere,1984). Social workers are aware that survivors experience a wide variety of symptoms, such as low self esteem, depression, suicide attempts, alienation, distrust, sexual acting

out, difficulties in relationships, fear of parenting, problems with sex and men in general, and abuse of alcohol and other drugs.

In counselling women who exhibit such behaviours, the right questions at the right time can often elicit a response that confirms a worker's suspicion that the woman has been sexually abused. To aid sexual abuse survivors to achieve a full emotional recovery, it is important that social workers can identify clients with sexual abuse histories and precipitate disclosure of the abuse during the counselling process. This raises important questions about how social workers identify sexual abuse survivors and how they precipitate client disclosure of that abuse in practice settings. These are the questions which this thesis sets out to address.

The Incidence of Sexual Abuse In New Zealand

One of the main problems confronting research on sexual abuse concerns the secrecy which surrounds the subject. This makes it difficult to gauge the extent of the problem in New Zealand. Prevalence figures based on reported cases must be questioned, as the findings are reliant on a person's memory of events Moreover, as Finkelhor (1979: 46) found, even in confidential self-report studies there may be a degree of under-reporting if respondents are asked about threatening experiences.

Taking these reservations into account, studies do show that on the basis of cases reported in New Zealand, one in four female children are sexually abused and one in ten male children. Further estimates show that of the one in four females who are abused, 89% are abused by a trusted person, and one in three are under the age of sixteen years (Russell, 1983). These figures suggest that any individual girl is at high risk for some form of sexual abuse and they highlight the importance of the issue in present-day New Zealand society.

In New Zealand, little work has been undertaken on general population samples of sexual abuse victims, thus making reliable inferences about the prevalence of sexual abuse in the community difficult. It is probable, therefore, that the extent of sexual abuse in New Zealand is greatly underestimated when relying solely on reported cases.

Terminology and Methodology

Throughout the literature the terms "victim" and "survivor" are used interchangeably. Some authors (Courtois and Watts, 1982; Finklehor,1979) believe that a child who is involved with an adult cannot give informed consent and is therefore "victimised" by the adult for the latter's own gratification or needs. Others, however, prefer to use the term "survivor" for a variety of individual reasons (Armstrong,1978). In this study any reference to the literature will include the term used by the author being cited.

Definitions of childhood sexual abuse are unclear, and no standard definition appears to exist. Most researchers have created an operational definition for the purposes of their own study. The use of the word "abuse" in itself presupposes a value judgement that the involvement of children for sexual gratification by adults is wrong. Children and adolescents are emotionally and materially dependent on adults. They are unlikely to understand adult meanings of sexuality, and are, therefore, unable to exercise real choice if approached by an adult.

Kempe offers the clearest definition and defines sexual abuse as "the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not fully comprehend, or that violate the social taboos of the family" (1977:382). Child sexual abuse (as defined by Browne and Finklehor,1986: 66) consists of two overlapping, but distinctive, types of interaction. The first is forced or coerced sexual behaviour imposed upon a child. The second is sexual activity between a

child and a person five years or older, regardless of whether or not obvious coercion is involved. Both definitions include infra-familial and extra-familial sexual abuse, and are similar to the one utilised in this study.

Usually the age difference between abuser and the abused has been defined as needing to be of five years or more. However, with the recent concern about younger perpetrators, Johnson (1988,1989) advocates (along with other criteria) a two-year age difference in defining sexual activities which are clearly abusive. Cantwell (1988) focuses entirely on behaviour and advances a definition which by passes the issue of age. Thus, oral-genital contact or penetration of the vaginal/anal opening with fingers or objects would be regarded as abnormal. Such descriptions of children as abusers complete the spectrum of abusive behaviour first described between adults and children, then adolescents and children, and finally children with other children.

The majority of studies reviewed in this thesis define sexual abuse as involving physical contact. These definitions range from touching to sexual intercourse, but they exclude experiences such as obscene telephone calls and indecent exposure. For this study, sexual abuse is defined as any physical contact of a sexual nature between an adult who has violated a position of trust, authority, or the caretaking role (regardless of kinship) and a child, as well as unwilling sexual contact between a child and an adult who is a stranger. This includes incest, which, as Fairtlough (1983) points out, is seen as a particularly damaging aspect of the spectrum of child sexual abuse.

Other terms commonly used throughout this study are "client," "disclosure" and "intervention methods". A woman attending a social service agency is referred to as a "client". "Disclosure" refers to a particular point in time when a client orally reveals a history of sexual abuse to a social worker, or another professional and it is, therefore, a significant event in diagnosis and counselling. The term "intervention methods" embraces a wide variety of

specific counselling techniques which have a theoretical base and therapeutic aims.

Methodology

In examining the research process two major categories can be defined. These are identified as "quantitative" and "qualitative" research methodologies. Both are used in this study. Generally the first (the quantitative or logical-positivist approach) is reflective of an empirical-analytical view of science. While this is not the only approach, there is some consensus about what constitutes mainstream empirical social science. Rosenman and Ruckdeschel (1981: 37) advance four propositions:

(i) scientific knowledge must be definable, measurable and testable;
(ii) there is a basic logical unity between natural and social sciences;
(iii) empirical knowledge must be separated from the pursuit of moral aims;
(iv) the observer must be objective or neutral about what he or she is observing.

In this approach, the first stage in research is involvement with theoretical concerns. These may involve general "problems" for a particular discipline, or the theoretical interests of a researcher. This leads to the formulation of hypotheses which express the nature of the problem or interest to be investigated. The second stage involves the use of a set of technical procedures to collect information or data from the chosen research population (which may be people or documentary sources of various kinds). The third stage is one in which the results of this data collection are analysed and interpreted.

With this approach, as Field and Morse suggest, " . . . observations are reduced to numerical form with the goal of testing existing theory via the

process of deduction, ie: by drawing from previous knowledge in order to deduce potential relationships" (1985: 4). From an examination of the data, patterns and relationships are discerned, propositions developed and hypotheses tested, in order to generate theory or use developed theories to explain the data.

In contrast to quantitative procedures the aim of the qualitative or naturalist approach (reflective of the interpretive paradigm) is to develop theory inductively from the data as it arises. This approach suggests that one of the ways in which research can proceed is for the researcher to enter a natural setting for a period of time, either as a member of the group under study, or as someone with a recognized research role. Feminist researchers often utilize qualitative methods to provide alternative sources of data that are unable to be produced by quantative methods. Ideally feminist research should, as James (1986) and Craig (1991) observed, be useful for women, and the knowledge gained should contribute to political changes that improve their lives. While this study was not undertaken to bring about direct change in policy, it is hoped that it has the potential to make life better for women clients presenting at social service agencies.

One question which does need to be addressed concerns feminist research. What is it, and how does it differ from the more traditional research methods discussed? The search for a feminist methodology entails finding appropriate techniques which match the process of inquiry.

Throughout the feminist research literature there is an ongoing debate about the use of quantitative and qualitative research methods. Some feminists (Stanley and Wise, 1983; Wood Wetzel,1986) have argued that quantitative research methods are inconsistent with feminist principles. That is, they believe quantitative research has an over-reliance on the scientific methods which, while emphazing rationality and control, also de-emphasize intuition, subjectivity, feeling, complexity and integration.

Wood Wetzel argues that data attained through the use of quantitative research methods has " . . . abstracted women's experiences and silenced their voices rather than being used to confirm the high risk associated with women and their concerns" (1986: 171). She equates feminist research with qualitative research, and maintains silence can be broken by means of research that informs policy by documenting the reality of individual experience. Viewed this way, qualitative research is thus a method of action for change, and not just an end in itself, as such action is inherently therapeutic and leads to personal change.

Jayaratne (1983) argues for the use of both quantitative and qualitative research methods. She believes that while qualitative research can convey the complexities of human situations, quantitative research can provide the data from which to make generalised statements. These statements are important, both for influencing and advising policy makers on public policy, and devising strategies for bringing about social change.

Others, notably Smith and Noble-Spruell (1986) disagree with that point of view. They state that " . . . while the results of surveys using quantitative research tools have the appearance of objectivity, they tend to provide only limited and superficial knowledge; the questions asked often only reflect the values of the researcher; the gap between research knowledge and action is often vast, and it is political expediency that usually dictates what actually gets done" (1986: 140).

They do agree, however, with Jayaratne's process of enquiry. Her process emphasizes the balance between experiential approaches to research and illustrates that women can reclaim and reconstruct traditional methodologies for their own purposes. Jayaratne's work also reminds researchers not to reject, out of hand, those components of existing knowledge which are useful. To purge women's research of "male" methods on principle is both problematic and simplistic.

As McRobbie (1982) argues, if research has to change the way in which people look at things and challenge the structures which determine the conditions in which they live, then it has to be convincing. It has to display all the qualities typically linked with "official" research; that is it has to have rigour, scholarliness, precision and lucidity. According to McRobbie, " . . . these features continue to have great relevance for those modes of operation linked with feminist research and cannot be simply jettisoned as being part of male practice; nor can they be mechanically replaced by more feminine qualities" (1982: 54).

The belief that loss of such techniques could be a loss for women is also supported by other authors (Coyner,1983: 63; du Bois,1983: 109). Whether a different political orientation inevitably leads to a different methodology, and whether methods themselves could be sexist, or whether there is something absolute about the logic of enquiry, inference and analysis, are all questions that are being addressed. The answers are proffered from a range of ideological positions and, although it may be possible to agree on the questions to ask and the purpose of research itself, there is still controversy about whether this amounts to a distinctive methodology or not.

From this brief review of the literature it can be seen that all the writers mentioned so far advance feminist research as an appropriate methodology for women. At the same time there are some common themes and cross-over points between feminist and traditional research methods. In analysing feminist research *Fausa Newsletter* (1984) espouses the main concerns of most feminist researchers, and reflects the beliefs and values found throughout the literature: namely, *"that research related to women must be defined and conducted by women and governed by a feminist perspective".*

In order to develop, support and explicate theory, Jayaratne (1981,1983) advocates the use of qualitative research methods in conjunction with quantitative research methods. Her approach in fusing these methodologies

is political. She believes the appropriate use of both quantitative and qualitative methods in the social sciences could help the feminist community in achieving its goal more effectively than the use of either quantitative or qualitative methods alone.

The current study is in line with feminist tradition in that it is based on a commitment to bring about change in accordance with women's identified needs; change, that is both predictable and feasible for women. It is hoped that the knowledge gained will contribute to changes in the counselling process, thus improving the chances for women survivors of sexual abuse in making a full recovery.

Ethical Considerations

The initial survey was carried out as part of an evaluation of a community counselling centre aimed at identifying the target population attending the centre. It was also designed to determine whether the service offered was in keeping with the needs of the clients. A key element in the evaluation was to determine the number of women attending with histories of sexual abuse. Approval to conduct the survey was sought from the Medical Superintendent of Community Health Services and from the women attending the service.

The twelve practitioners invited to participate in the analysis of clinical practice did so on the understanding that the inquiry was part of a larger study being presented to Massey University. Their cooperation was given on the basis of informed consent.

As no clients were directly involved, it was not necessary to seek approval from an Ethics Committee. The cases reviewed in testing the usefulness of the index of sexual abuse indicators were carried out by the eight practitioners working with the clients, and not by the researcher. No further approval was required.

After the first interviews, each participant received a letter summarising the initial findings, along with a request for participation in another interview, and an invitation to comment on the process to date. One practitioner asked for clarification on the analysis of the question of practitioner gender. After the findings were clarified that participant was satisified with the reporting of the results. Each participant has received a copy of the findings of the second interviews. A summary of the final results will be sent to all the practitioners who participated.

In 1986, with the assistance of a student on placement at a community counselling centre, I carried out a survey to determine whether women presenting for counselling had been sexually abused at some stage of their childhood or young adult years, and whether that abuse continued to have an ongoing effect on their adult relationships (Appendix1). A self-report questionnaire was sent to every woman who had attended the centre between February and August in 1986. We also attempted to look at the long-term effects of childhood sexual abuse using a cluster of symptoms from the *Post-traumatic Stress Syndrome* (Briggs & Porter,1986).

The survey has drawn extensively on the work of Ellenson (1985), who described a set of symptoms which he claimed were unique to incest survivors and clincially predictive of a history of childhood sexual abuse in adult women. He believed it was possible, through the identification of these symptoms, to predict sexual abuse histories even in women who denied any abusive experiences or who repressed the abusive experience(s). The symptoms appear to be independent of age, ethnicity, educational attainment, socio-economic status, and reason for referral. These symptoms are divided into two main categories; thought content disturbances and perceptual disturbances.

Ellenson (1985,1986) found that the best way of gaining this type of information from clients was through the expanded use of a mental status examination (M.S.E.). By this method the symptoms contained in the predictive syndrome could be identified in women clients, thereby making it possible to detect unrevealed histories of sexual abuse. The predictive syndrome also revealed a history of nightmares (bad dreams), phobic or anxiety reactions to situations, and the presence of auditory or visual hallucinations.

Questions relating to Ellenson's predictive syndrome were included in the postal questionnaire used in this study. Chi-square tests were carried out on items in the questionnaire considered to be predictive of a history of sexual abuse, in an attempt to identify the number of sexually abused women in the survey who had also experienced symptoms of PTSS.

While the findings of the survey showed some differences in prediction levels between the abused and the non-abused women in the survey, they were inconclusive. The numbers in the chi-square cells were small and it was determined that the data needed to be analysed in another way to be more accurate. A second analysis of prediction levels was undertaken during 1991.

Aims of the Research

This research involves two major, but distinctively different, inquiries about how women clients with histories of sexual abuse are identified in practice. Part one aims to test the validity of Ellenson's (1985,1986) predictive syndrome. Part two attempts to understand how social workers and other health professionals precipitate clients to disclose a history of sexual abuse during the counselling process.

Structure and Organisation of the Thesis

This study looks at the use of Ellenson's predictive syndrome as a way of identifying women survivors of childhood sexual abuse. It also undertakes an analysis of the empirical work on sexual abuse and looks at how practitioners in the field facilitate women clients to disclose histories of sexual abuse. Discussion of these issues will be pursued in distinct chapters. The content of each is outlined below.

Chapter 2 reviews the literature on sexual abuse and Chapter 3 discusses the findings of the various studies examined. Chapter 4 looks at Ellenson's theory and discusses the findings of the survey. The first analysis of the data collected in the survey estimates the number of women with histories of sexual abuse and it examines whether or not there is a significant difference between the number of abused and non-abused women who experienced symptoms of the *Post-traumatic Stress Syndrome* (PTSS). A second analysis of the data is undertaken in order to assess whether the use of Ellenson's predictive syndrome makes it possible to detect histories of sexual abuse in women who may also have experienced symptoms of PTSS.

The focus of Chapter 5 is the analysis of clinical practice carried out in 1990 and 1991. That is, the way in which practitioners in the field identify and precipitate clients to disclose experiences of sexual abuse. Chapter 6 is concerned with the development of practice guidelines. It also summarises the research and discusses how the results may assist social workers to identify women survivors of sexual abuse.

PART ONE

CHAPTER 2

EXPLANATIONS OF SEXUAL ABUSE

This chapter reviews the literature on sexual abuse and attempts to evaluate the differing explanations that have been offered by various theorists who have examined sexual abuse of girls. In doing so, it takes into account the imbalance of power in male-female relationships. This approach is favoured, rather than the customary one of drawing on historical, anthropological and psychoanalytic perspectives, as I consider it more helpful in understanding the nature and incidence of sexual abuse in contemporary New Zealand society. It should be noted that the literature on sexual abuse in New Zealand is sparse. In examining explanations of sexual abuse therefore, it is essential that the international studies are canvassed and the central themes are highlighted.

One of the main themes to emanate from the international research is that the majority of children sexually abused are female. This is demonstrated in a 1969 study by De Francis, which found that 90% of the sexual abuse victims were female, and in later studies by Beezley*et al.,* (1981) and Conte and Berliner (1981) who found that 86% of victims were girls. Comments in the literature which mention boys being sexually abused are few and therefore exceptional (Renvoize,1982). It may be, however, that sexual abuse of boys is less frequently reported than that of girls, thereby concealing the true prevalence of sexual abuse amongst male children.

Finkelhor (1979) found no cases of mother-son incest. Studies carried out by Beezley*et al.,* (1981) did not specify the sex of the perpetrator, but did note that in 2% of the cases studied the abuse was committed by the mother. While it may be argued that women are unable to rape and therefore would be unlikely to sexually abuse their children as Fairtlough asserts, " . . . much sexual abuse is not intercourse but masturbation, exhibitionism and oral sex, all of which are acts which could be committed by women" (1983: 6).

Most writers accept that a general prohibition on sex exists within the family, apart from the relationship between wife and husband. However, a significant number of studies suggest that the incidence of sexual abuse is most prevelant within families. Frequently the offenders are male, with the most statistically numerous configuration reported being father, or step-father and daughter incest. De Francis (1969), Finkelhor (1979), and Conte and Berliner (1981) all found that 93-97% of the offenders were male.

A common image of the dynamics of incest portrays a teenage girl giving out the magical vibrations of sexual readiness to her father, who is aware of his passing youth and regrets he is growing older (Hart ,1979). In contrast to this view, many studies demonstrate that the abuse starts earlier, usually before puberty (Conte and Berliner, 1981). Lukianowicz (1972) identified the mean age for the start of abuse to be eight and a half years. Finkelhor (1979) found it to be ten years and that father-daughter incest was felt to be the most traumatic. It seems that for girls who experience incest as a child, it is often the beginning of a history of abuse which continues throughout their lives. Many survivors who report experiences of violence as a daughter or a wife, also report being raped or coerced into sex as an adolescent or child (Armstrong, 1978).

There have been a number of references to, and explanations about, sexual abuse. Such references have been mainly American, and reported in psychiatric and psychological journals. Explanations are frequently based on extrapolations from a small number of cases (Bender and Blau, 1937; Lustig,1966), and these "findings" become uncritically incorporated into subsequent writings. Freudian concepts dominate earlier thinking on the subject; later theories focus on the characteristics of the individual offender, subcultural patterns and interactional processes within the family.

Over the past few years, feminists have developed theories about sexual abuse (Forward and Buck, 1978; Blake-White and Kline, 1985), and found it possible to draw a parallel between ideas about sexual abuse and theories about family

violence. In challenging the focus of individual, interactional and subcultural factors about familial violence, feminists have developed an analysis of the structural nature of violence against women. This analysis can also be related to the status of women within the family and in the wider society.

Most of the earlier prevalence studies were carried out by men. The question here is whether men investigating male behaviours are able to filter the facts through their own socialisation bias. Spender's (1981a) analysis of how male versions of reality have tended to be reflected in sociological theories is useful in this context. This fact, coupled with society's prevalent, but erroneous, attitude that children are predominantly sexually abused by strangers and not family members, has led to the development of what I shall refer to as *mythical theories* about sexual abuse. Discussion of these and other theories are the focus of the next section.

Feminist Explanations

The greatest explanatory power lies in feminist theories which are a variant of family dynamics theory. However, there is a difference between the two perspectives. The principal feature of feminist theory stems from the way in which it exposes the misogynist attitudes that are implicitly (and in some cases explicitly) contained in other theoretical traditions. These attitudes, together with the question of male power within the family and society (including aspects of normal male sexual socialisation) have been examined by feminist theorists.

Several theorists, (Finkelhor,1979; Herman & Hirschman,1977; Forward & Buck,1978; Blake-White & Kline,1985) found abusive males were often family tyrants who were excessively controlling and a dominating force within the family. These males frequently used physical violence to assert their power. Forward & Buck (1978) maintain that the father all too often perceived his daughter to be his sexual property, to exploit as he saw fit.

Lustig's (1966) study highlighted the way in which incest offenders felt the need to be patriarchs, yet were uncertain of their masculine identity. These findings were reinforced by Herman and Hirschman (1977) who speculated that the social isolation noted by Finkelhor (1979) and others arises from the father's attempt to rule their families with a minimum of outside interference. That is, they create a situation where they can reconstruct by means of violence, threats of violence or sexual coercion, the patriarchal family wherein a man is obeyed and serviced by his wife and children.

In their study of social networks in incestuous families, Scheurell and Rinder (1973), found some evidence which provided support for the claims by Lustig (1966) that incest offenders felt the need to be patriarchs, yet were uncertain of their masculine identity. They found incestuous families, when compared with a group of wife-beaters, were more rigid in sex-role divisions when allocating household tasks, and there was a clear expectation that female children would carry out these chores. Moreover, such fathers held rigidly to segregated behaviour patterns in the home.

Fairtlough (1983: 22) argues that " . . . the abuse of girls by men is in many ways the logical extension of stereotyped masculine and feminine sexuality". Male sexuality is generally constructed in such a way that men are seen and are expected to be powerful, active and experienced. On the other hand, women are seen as powerless, passive and innocent, thus making girls the ideal sexual partners for men to ensure the playing out of stereotypes. This means, therefore, that while "female" and "male" refer to biological differences, the concept of "gender" is more a social construct and a result of the socialisation process.

The claim made by fathers that sexual frustration led to loss of control of their overwhelming sexual urges needs to be critically examined. If physical release is necessary there are other ways of achieving it, for example, by masturbation.

However, as Brady points out, " . . . some men consider masturbation unmanly and a homosexual act, and male gender identity appears to be dependent on their sexual success (1979: 75)".

Finkelhor's (1981) research considers how the use of a child as a sexual partner may bolster the ego of a man uncertain of his adequacy as a male. Some survivors were of the opinion that their fathers felt more sexually secure with them because their compliance was easily secured and they did not criticise his performance (Armstrong 1978). In general, most men expect their appropriate sexual partners to be smaller and younger. Therefore, sexual attraction to a girl is a step further on the same gradient. As Hite reported, one man, in writing about pornography, stated, " . . . that the younger a model and the more brazen the behaviour then the more tantalising he found her to be" (1981: 376).

The role of pornography has also been examined by feminists in regard to incest and the sexual abuse of children. There has been much controversy over the precise relationship between the use of pornography and the acting out of sexual behaviour. As Finkelhor's (1981) findings showed, child pornography is consumed almost entirely by men. If men find child pornography exciting, then this indicates that for some men at least, sex which involves the sexual abuse of children is a source of erotic pleasure. This further indicates that there is some connection between child pornography and child sexual abuse.

When reporting on work undertaken on pornography in the United States, Fairtlough (1983) reveals that in 1977 there were two hundred and sixty four different magazines available depiciting sexual acts between children and adults, one of which instructed a father on methods of achieving intercourse with a pre-pubertal daughter.

An investigation of sixty-four films found that sixteen involved incestuous behaviour and some police officers believed that child molesters frequently used pornography to build up to the event. This assertion is borne out by a

study in New Hampshire which found that in all twenty-seven cases of incest brought before the courts the perpetrator had used child pornography before and during the abuse (Fairtlough,1983). It needs to be mentioned here that according to a model developed by Finkelhor (1981), sexual abuse will only take place if the man already has sexual feelings about the child (Appendix 2). However, male sex-role socialization, exposure to child pornography and previous sexual experience with children are all factors which encourage the development of such feelings.

While I have argued that sexual abuse is not primarily motivated by sexual feelings but rather by a desire to control or possess a child, it is still true that a perpetrator expresses this sexually, and hence must be able to fantasize a sexual interaction. Overcoming internal and external inhibitors are other factors contingent on this premise.

Stress, the use of alcohol, or social and personal frustration may lessen internal inhibitors, while an absent or sick mother and social or geographical family isolation may weaken external inhibitors. Finally, resistance by the child must be overcome and in some cases force, or threats of it, are sufficient to ensure compliance. The child may, however, be emotionally vulnerable, ignorant of what is happening, or feel powerless to prevent it occuring, and thus offer little resistance.

Finkelhor's (1981) multi-causal explanation has the advantage of acknowledging men's behaviour, as it makes no distinction between intra and extra-familial abuse. In this way it can account for father-daughter incest, sexual abuse by other relatives and sexual abuse by friends or strangers. As suggested earlier, such patterns are likely to occur in families where the father chooses to assert or regain a sense of power within the family.

Popular myths about sexual abuse are exploded by feminist explanations as evidenced by the studies discussed. One of the most important myths is that children are the seducers of adults, whether consciously or unconsciously. As shown, this belief cannot be supported by the studies discussed simply because so many experiences of childhood sexual abuse are accompanied by threats of force or violence. Feminist explanations also make it clear that while sexual abuse is about controlling or possessing a child it has little to do with sexual feelings.

Freudian Theories

Freud, perhaps the first writer to deal with the subject of sexual abuse, initially theorized that the trauma resulting from the experience of sexual abuse during the critically formative period of childhood caused subsequent adult psychopathology. At that stage Freud concluded that incest was pivotal in the formation of neuroses. To aid recovery of amnesiacally-dissociated memories he used hypnosis to treat survivors of previous sexual abuse experiences.

Later, however, finding that the widespread prevalence of incest was "hardly credible," Freud attempted to recant his earlier writing by replacing it with the Oedipal theory, and relegated incest to the realm of fantasies created by the women he saw. Rush (1980: 82), in her analysis of Freud's personal and intellectual conflicts asserted, " . . . that while he knew that the sexual abuse of children existed he could not reconcile the implications of such abuse with other men of his class and thus he altered his telling of reality".

His new theory attributed adult symptoms to early and arrested pyschosexual development. Symptoms were seen as the pathological sequelæ of frustrated internal sexual and aggressive drives. Situational events were de-emphasized, and treatment focused on helping clients to recognize and understand their maladaptive distortions. For over half a century Freudian theory and technical precepts evolved, prevailed, and continued to influence generations of

clinicians. Though the introduction of ego psychological concepts and their emphasis on adaption in the environment moderated the older views, the drive-determined substrate and technical precepts derived from it remained.

Even when psychiatrists first began to accept that in some cases the apparent fantasies may have been real, Freudian concepts continued to have an effect on interpretations of writers in the area of sexual abuse and writers still frequently perceived sexual abuse as the child's, or the woman's, fault. This belief can be seen in the writings of Bender and Blau (1937: 517) where they refer to the conspicuously charming and attractive personalities of the victims. The implicit assumption here is that the girls themselves, and not the men, were the initiators of the act.

Other writers, such as Howard (1959), viewed incest as being the expression of hostile and castrating feelings towards the father. Weiss (1955) assumed that if the incest continued, then the survivor must have colluded in the abuse. The victim's submissive behaviour towards the therapist and a tendency towards promiscuity in adolescence were given as evidence for making such a claim.

This does not deny that children do have sexual feelings and that they may act in a way that appears to adults to be sexual. It merely restates that such behaviour does not mean that children are able to consent to a sexual relationship. An analogy highlights this: the contention that children playing at parenting dolls are ready to take on the role of parenting would be considered preposterous. Similarly, attention-seeking behaviour in emotionally deprived children is an expression of their need for physical and emotional affection, not of their need for sexual attention.

While traditional psychoanalytical theories have greatly contributed to therapeutic knowledge and skills, their preoccupation with internal events have had negative and destructive consequences for the detection, assessment and treatment of adult survivors of childhood sexual abuse. Furthermore, Freudian

and Neo-Freudian theories were based on the belief that sexual abuse was not psychologically harmful. Such theories are, therefore, good examples of what is meant by *mythical theories* about sexual abuse.

Theories of Family Dynamics

The principal features characterising these modern theories seem to be a shift in emphasis away from a victim-perpetrator model towards an analysis of family history and interaction. This shift began during the nineteen sixties and seventies. The problems associated with childhood sexual abuse started to be seen as an expression of family dynamics when a number of writers (Maisch,1973; Rosenfield,1979; Justice and Justice,1979), began to suggest that sexual abuse within the family was a response to an imbalance of power in relationships. The emphasis shifted to focus on the interactional behaviour of the family. At the same time, it was also argued that incest was more commonly a symptom in inward-looking families, and that it was more likely to occur when the wife did not fulfil the nurturing role expected of her (Cormier,1962; Lustig et al,1966).

Central to these studies is the role of the mother. It is suggested that in abusive families the mother appears to have implicitly colluded with the abuse. Three common assumptions have been made of the mother's role in abusive families. The first, according to Rist is, " . . . that she is committed to pursuing her own desires and wishes, rather than caring for her daughters and husband" (1979: 687). This assumption implies that the mother "escaped", either through frigidity, through mental illness, or through having interests outside of the home.

Secondly, the literature suggests that most mothers consciously, and unconsciously, know that the abuse is going on, but if confronted with the truth will deny it, blame the daughter, or take no action to prevent the abuse from occurring (Kempe 1977). Implicit in the third assumption is ". . . the belief that the mother colluded with the abuse because she was relieved of the burden of

having sex with her husband" (Justice and Justice, 1979: 97-99). Hence, from a family dynamics perspective, the literature on childhood sexual abuse (while seeing it as a family interactional problem) persistently views the mother as collusive, and often as the guilty party when her partner abused the children. Such views have the potential to influence family therapists working with abusive families. Three criticisms may be made about working with families from this perspective.

The first criticism is that a family dynamics approach views family therapy as an appropriate way to work when sexual abuse has occurred within a family. In reality, however, this often leads to mother-blaming. At the same time there is evidence to the contrary which shows that mothers do respond and do take action when they discover abuse. Beezley et al (1981) found that in 73% of the cases they studied, the abuse was reported by the mother. Conte and Berliner (1981) found that in 60% of cases reported to a sexual assault centre in one year, involving 583 children, the mother had taken immediate action to prevent reoccurrence of the abuse.

The second criticism is that family dynamics theorists tend to unconditionally accept the structure of the traditional family. The mother is expected to provide for the emotional and sexual needs of her husband, and to be the source of all affection and protection for her children. Some therapists (Forward & Buck,1978; Giaretto,1977), have acknowledged the fathers', or males', responsibility in sexual abuse, but they tend to minimise the act of abuse irrespective of the mother's personality or role in the family.

A family dynamics perspective fails to see that even if some daughters do feel betrayed by their mothers, it is often intertwined with protective and sympathetic emotions. It is important, therefore, to locate this sense of betrayal in a more general context. Traditionally, mothers provide most of the nurturing care for children in Western society. In response to this nurturing role children may invest in them an almost magical sense of power. Given this sense of power,

children would expect that their mother, and not their father, should protect them. When she cannot do this their sense of betrayal by her, rather than by their father, is felt more acutely.

The third criticism is that family dynamics theories fall short of explaining why some men believe that they have a right to satisfy their sexual urges with their children. Nowhere do these theories acknowledge the needs and feelings of the mother or the children, nor do they make any attempt to understand why a woman may not wish to have sex with her husband. Finally, family dynamics, as a theoretical explanation about the occurrence of childhood sexual abuse can not be seen as a sole causative factor. At best, they can only be considered as accompanying variables.

Sub-cultural Theories

Some theorists (De Francis,1969; Beezley *et al.*,1981) found a relationship between the incidence of sexual abuse and financial hardship, stress and unemployment. Others (Lukianowicz,1972; Reimer,1940) suggests that incest occurrs in families of low socio-economic status, and that in these homes it is a culturally acceptable form of behaviour. However, these studies are usually based on groups who, because of their low economic status, were easy to label. They are relatively powerless, have very little control over their lives and are under greater surveillance by the authorities. There is, of course, a greater possibility of concealment of abuse of any kind in middle-class households. Unlike lower socio-economic families, they are less likely to come to the attention of social service agencies.

While supporting the above findings (where factors such as unemployment and financial stress have a part to play in the dynamics of abuse) Finkelhor (1979) does not accept that such dynamics cause the abuse, but rather that they may reduce the male's ability to rationalise his behaviour towards the girl or women he is abusing. In an attempt to draw together data about abusing families,

Finkelhor (1981) has developed a multi-causal model which identifies four factors that appear to be relevant in precipitating sexual abuse (Appendix 2). According to this model, sexual abuse only takes place if the man has sexual feelings about the child. Factors which encourage the development of such feelings are male sex-role socialization. These patterns of sexual behaviour are more likely to occur in families where the father wishes to assert his dominance. The child's resistance to the abuse may be overcome by force, or threats of force, which are sufficient to ensure compliance.

Finklehor's model takes a multi-causal approach, but diverges from others because it acknowledges the responsibility of the man for his behaviour. It does not see children as merely passive participants. Furthermore, as it makes no distinction between intra and extra-familial sexual abuse and sexual abuse by friends or strangers, such a model dissipates myths about who sexually abuses children.

The Relationship between Alcohol Consumption and Sexual Abuse

Early research into the area of sexual abuse identified alcoholism, or drunken episodes, as a primary variable in incestuous families (Marcuse 1923). As Lustig *et al.,* (1966) observes, " . . . if a behaviour pattern such as incest reduces family tension and thus contributes to the equilibrium of the family, it tends to become a part of that family which, once established, can be self-perpetuating". While this is certainly true of incest as a regulator of a family's state of equilibrium, the same is true of alcohol.

More recent writers (Finkelhor,1981; Herman,1981; Justice & Justice 1979; Barnard,1984) link alcohol abuse to the incidence of sexual abuse. Drawing on his own clinical experience Barnard claimed that, " . . . these two behaviours co-exist more frequently than would be expected by chance alone" (1984: 22).

He found a number of similarities between alcohol-abusing families and incestuous families. Although such links seemed obvious, it was usually only one, rather than both of the symptoms that was treated.

Others, (Stanton &Todd,1982; Wegscheider,1981) also firmly established this link. While it would be unrealistic to assert that all families with an adult who has an alcohol problem will be incestuous, or, conversely that in all incestuous families an alcohol problem will also exist, there is growing evidence that these two behaviours co-exist to a greater extent than previously recognized.

The explanation of the relationship between alcohol use and sexual abuse most often given is the *disinhibition paradigm*. This paradigm is based on the premise that alcohol has an anaesthetizing effect on the inhibition centres in the brain. The function of the inhibition centres includes the control of socially acceptable behaviours. When alcohol is consumed the disinhibition paradigm causes changes in thinking and input processing by the drinker. Consequently, a drinker's control sytem can become dysfunctional as a result of these changes.

However, despite the occurrence of neurophysical changes in an individual using alcohol, a clear cause and effect relationship between alcohol and sexual abuse has not, as yet, been established. Several criticisms can be levelled at the disinhibition paradigm. The first is a societal tendency to see the consumption of alcohol as blameworthy whenever it accompanies problematic behaviour. For example, there is an expectation of *disinhibition* and *losing control* over one's behaviour when drunk. Such a belief takes away the need for self responsibility.

Secondly, drunken men are legally and socially held less responsible for their actions. The attribution of the responsibility for the sexual abuse to drunk behaviour has consequences. That is, drunkenness, while allowing for admission of the occurrence of deviant behaviour, also maintains the definition

of the family as normal by focussing the blame on alcohol as the *cause* of the deviant act. A third criticism of the disinhibition paradigm (as a theoretical explanation for the ocurrence of sexual abuse) is that it suggests the abuse occurs as the result of loss of control over one's sexual urges.

Graham described the disinhibition paradigm as " . . . an intense involvement in the present situation, along with a lack of forethought and concern about future consequences of one's actions" (1980: 146). It is, however, acknowledged that sexual abuse has nothing to do with love and sex, but is an act of violence and social control. It is pertinent, therefore, to look at the relationship between alcohol and child sexual abuse as one facet of alcohol abuse and violence in general.

Furthermore, as Finkelhor's multi-causal model has already explained, sexual abuse could only take place if a man had sexual feelings about the child. Sexual abuse is more likely to occur in a family where the father wishes to assert his dominance. Covington emphasizes this point when she asserts that, " . . . some abusers use alcohol deliberately in order to act out their aggression, this is particularly evident in cases of sexual abuse" (1986: 11).

It seems, therefore, that although the consumption of alcohol may well have certain effects on perception, thinking, emotions and physiology, it is a myth that drunkenness alone can be inferred as a *cause* of child sexual abuse. I believe that while the the alcohol may be an *accompanying factor,* the sexual abuse event itself is mediated by an increase in power concerns of the male drinker.

Personality Characteristics of the Offender

Personality characteristics have been offered as a theoretical explantion as to why some men sexually abuse children. These characteristics, which are interpreted as "causing" the sexual abuse, include deviant patterns of arousal, feelings of personal and social inadequacy, sexual repression and arrest of

psychological development at a juvenile level. The search for these specific personality characteristics, which differentiate the child sexual abuser from other men, has received a lot of attention.

The literature contains conflicting views about the personality characteristics of sexual abuse offenders. Contrary to common belief, incestuous fathers may come from any socio-economic class and are not usually intellectually impaired (Cavallin 1966). Another writer, Renvoize (1982), estimates that 80% of incest offenders have never been involved with the police before. Maisch (1973) compiled a heterogeneous profile of the offender and Cavallin (1966) and Lukianowicz (1972) maintain that men who abuse rarely suffer from a recognisable mental illness. In arguing that alcoholism is a problem common to many incestuous fathers, Virkkunen (1974) suggests that (as shown above) the use of alcohol serves to reduce internal inhibitions about the act, rather than creating sexual feelings about a child.

Blake-White and Kline (1985) define the distinguishing characteristics of an abusing male as a tendency to be introverted, mistrustful and suspicious; have few friends or contacts outside the home; and often have a pre-occupation with sex. They also maintain that he presents to the outside world as an "all together" person, a solid family man and a good provider. Forward and Buck (1978: 31) reinforce this view stating that the male who commits sexual abuse is rarely a freak, a dangerous criminal or a psychotic, " . . . he is often an otherwise law-abiding guy next door".

In defining the sexual traits of men who commit sexual abuse the findings are also contradictory. Fairtlough (1983: 21) comments" . . . some men were found to be undersexed, others oversexed." Similarily Nelson, (1982: 63) claims " . . . men are unconscious homosexuals while others are uninhibited heterosexuals".

Some experiments which attempt to measure sexual response indicate that incest offenders are more aroused by pictures depiciting sex with an eight-year-old than by similar pictures of adult women. Similar results are apparent amongst heterosexual paedophiles (Renvoize, 1982: 94).

It seems evident, therefore, that most of the findings in regard to personality characteristics of male sexual abusers have been inconclusive. As a theoretical explanation for occurrence of sexual abuse, the personality characteristics of offenders have little to offer. Although the abuser may tend to be introverted, mistrustful and suspicious with few friends or contacts outside the home, the offender usually presents as a solid family man and good provider. The most that can be said is that although a sex offender is very rarely a dangerous criminal or a psychotic person, he often has a pre-occupation with sex.

Summary

In order to gain a theoretical understanding about the dynamics of sexual abuse, a range of theories have been critically reviewed. Freud saw women presenting with problems of sexual abuse as fantasizing. If believed, counsellors working from this perspective and basing their intervention on such beliefs would be less than helpful to their clients.

Similarly, a family dynamics approach would consider family therapy as an appropriate way to work with a family within which sexual abuse has occurred. This study has shown how a family dynamics model of child sexual abuse persistently views the mother as collusive and often as the guilty party when her partner abuses a child. There is evidence to the contrary indicating that most mothers do respond and take action when they discover the abuse. The earlier suggestion that sexual abuse within a family was a response to an imbalance of power in gender relationships is more in keeping with the view that this study takes.

Feminist studies have been instrumental in bringing to public attention the unrecognised suffering of survivors of both rape and child sexual abuse. These studies illustrate how the trauma of sexual abuse is often exacerbated by social stigmas and by social taboos surrounding discussion of such experiences. It is evident that sexually abusing families are more traditional in their sexual division of labour. As women are generally situated in the private spheres of the family and personal relationships, social control is largely left to men. It is in such a context that men may choose to exercise sexual coercion, in an attempt to assert, or to regain, a sense of power within the family, thus predetermining the context in which sexual abuse of children can occur.

CHAPTER 3

RESEARCH ON SEXUAL ABUSE

Although the need for the counselling of women who have been sexually abused in childhood is now acknowledged by Government advisors and the helping professions in general, empirical evidence about the actual effects of the abuse is sparse. In the literature depression is identified as the long-term effect most commonly reported by women survivors. At the same time significant numbers of women also report serious problems with sexual adjustment, interpersonal relationships, continuing education, and other pyschological disorders.

This chapter reviews the literature which deals with the impact of child sexual abuse on later life. The review shows that writers on the topic are divided into two major schools of thought. Firstly, there are those who can be classified as "*minimalists*". They tend to downplay the long-term effects of childhood sexual abuse (Weiner,1962; Henderson,1975,1983; Nelson,1979) and claim that it is possible that the long-term effects observed in survivors of childhood sexual abuse are not necessarily a function of sexual abuse, but of other pathological elements, such as psychological abuse, parental neglect, or family disorganization.

Secondly, there is a much larger school which can be described as the "*maximists* ". This group claims that the majority of child victims are adversely affected in some way by sexual abuse. They believe that they have convincingly demonstrated that childhood sexual abuse is a major source of serious stress in adult women (Meiselman,1978; Courtois,1979; Finkelhor,1979,1982,1984; Herman,1981; Conte & Berliner,1981; Gelinas,1983; Briere,1984; Fromuth,1983; Blake-White & Kline,1985; Ellenson,1985,1986; Gorcey*et al.,* 1986; Mullen *et al.,* 1988).

The divergence of views between the two schools rests upon the claim by the *minimalists* that most of the studies to date have involved clinical samples. By this they mean that the sample of survivors of childhood sexual abuse involved in the studies have been identified during therapeutic interventions.

Their argument is that such samples are skewed and misleading, and as such are not representative of the vast majority of children who have been sexually abused. They suggest that comparative studies between abused and non-abused children, controlled for various background factors, need to be carried out before the sexual abuse experience can be directly connected in a cause-and-effect way to any specific kind of psychopathology (Cohen, 1983).

While we learn from this group to view the literature about childhood sexual abuse with caution (because of the predictive value and the effects on diagnosis for intervention and therapy of survivors of sexual abuse) it is important to establish and resolve the competing claims of the two schools of thought. In an attempt to resolve this dispute this chapter initially looks at prevalence of sexual abuse and then reviews the international and New Zealand studies undertaken with respect to childhood sexual abuse. The second task entails looking at factors such as the profiles of the abusers, the nature of abuse, and the long-term consequences. These factors are explored to determine the predictors about the likely sequelæ of abuse, both in general and in specific cases.

Thirdly, methodolgical problems and the reliability and validity of the studies reviewed are considered and assessed in order to determine their significance for this study. The findings from the studies are presented in tabular form as this was considered to be the most effective and concise way of presenting the results. It also impressed as being a useful technique in identifying those elements which needed to be taken into account in designing the research strategy for the fieldwork of this study.

International Research

The two studies by Kinsey et al (1953) and Landis (1956), were among the first to attempt to document the incidence of sexual abuse among the general population in America. Finkelhor (1979) conducted the first large-scale and the most widely quoted study ever to be undertaken. An Australian study, undertaken by Goldman and Goldman (1986), using college students as a sample, was a replication of Finkelhor's study. Both of the latter studies used the age difference between the abused and the abuser as the determining factor in defining sexual abuse.

The most extensive study to determine the incidence of sexual abuse was carried out in San Francisco by Russell (1978) who used specially trained market research interviewers to conduct the interviews. A number of questions were asked to elicit information as to whether or not the respondents had experienced sexual abuse as a child. The incidence of childhood sexual abuse in Russell's study is higher than the incidence found in any other American study. As suggested by Finkelhor (1984), this could have been because Russell asked thirteen separate questions designed to trigger memories of sexual abuse, whereas the other studies asked a smaller number of questions about abusive experiences.

Nash and West's (1985) study in Britain used a randomly selected sample of women from a general practitioner's patient list and female graduate medical students. They used a definition that excluded verbal suggestions, obscene phone-calls and exhibitionism. Futhermore, this study looked only at abuse between adults and children, and excluded abuse by peers.

The definition used by Baker and Duncan in the United Kingdom study considered a child to have been abused if, " . . . some-one who was sexually mature had involved the child in any activity which led to the other person's sexual arousal" (1985: 457). This included touching, exposure of sexual

organs, the showing of pornographic material or talking about sexual activities in an erotic way. In contrast to this, the definition used in a Canadian study conducted by Bagley and Ramsey (1986), was solely concerned with genital contact between a child and someone at least three years older, or where force had been used.

Throughout the literature sexual abuse was limited to experiences with physical contact between the abuser and the abused. The definitions of sexual abuse used, the sampling procedures, and the questions asked have not been consistent throughout the studies reviewed. This has made valid comparisons within and across countries difficult. All the studies are retrospective and consequently refer to abuse which happened to the respondents during their childhood years. For some this could have been some considerable time ago. This means that all estimates of prevalence are based on adult populations and we do not know whether or not the current generation of children are having the same experiences. However, the findings reported in Table 3.01 are from studies of non-clinical samples from countries similar to New Zealand and these studies show that, in general, females experienced sexual abuse more frequently than males.

The ten international studies reviewed are listed in Table 3.01 which shows the country, the author, the total sample size, and the numbers reporting sexual abuse. Where possible, comparisons between the number of females reporting sexual abuse experiences to that of males are also made. "Type" refers to the population of people involved in the sample.

TABLE 3.01

International Studies of Childhood Sexual Abuse

Country	Study	Date	N	No.Reported Abuse	Males	Females	Type
USA	Kinsey	1953	4,441	24%	0	24%	General Population
	Landis	1956	1,800	65%	30%	35%	College Students
	Russell	1978	933	54%	0	54%	Random Sample
	Finkelhor	1979	796	28%	9%	19%	College Students
	Finkelhor	1982	521	20%	5%	15%	Parents
	Kercher	1984	2,000	7.4%	18%	82%	Random Sample
U.K.	Nash & West	1985	315	46%	0	46%	G.P. Patients Medical Students
	Baker & Duncan	1985	2,019	20%	8%	12%	National Sample
Canada	Bagley & Ramsey	1986	377	22%	0	22%	Health Survey
Australia	Goldman & Goldman	1986	991	37%	9%	28%	College Students

New Zealand Research

The estimated prevalence of sexual abuse in New Zealand has increased considerably over the past few years. From the results of overseas studies (Russell, 1983) and on the basis of cases reported in New Zealand, estimates suggest that one-in-four female children, and one-in-ten male children are sexually abused in this country.

The first general population based study was Saphira's (1979) survey. She placed a self-report retrospective questionnaire in the *New Zealand Women's Weekly,* a popular women's magazine. Three hundred and fifteen women

responded to the survey. It was found that of those who reported having been sexually abused, 71% were under eleven years of age when the abuse began, and 12% were under six. All the abusers were male, with 50% being the father-figure. Sexual intercourse occurred in 26% of the cases. While Saphira's study provided useful information on the nature of sexual abuse, it was not possible to estimate in a reliable way the incidence of abuse occuring in the general population as her sample was the self-selected group who responded to the survey.

A study by von Dadelszen (1987) began in 1984 with the aim of ascertaining the extent and nature of histories of sexual abuse among girls in the care of the Department of Social Welfare. Two hundred and thirty-nine 15 and 16 year-old girl residents living in Social Welfare care in five main urban centres were selected for the sample. The data was collated in 1985 from the one hundred and thirty-six girls (57% of the sample) who agreed to be interviewed by a woman interviewer of their choice. The interviewing team consisted of one Pakeha, one Samoan, and four Maori women.

Of the girls interviewed 71% had experienced some form of sexual abuse. A further 4% reported experiences which did not involve genital contact, but which were sexual in nature and were viewed negatively by the girl. The ages of the girls when they were first abused ranged from 2 to 15 years, with an average age of 10 years. Nearly all (96%) of the abusers were male. In 18% of the cases the abuser was a father, or father substitute. Maori and Pakeha girls were equally likely to have been abused.

Sexual abuse within the girl's immediate, or extended, family accounted for 51% of the experiences. About one-third of the abuse reported in the interviews was previously known to the Department. However, if the abuse was familial, and if the abuser had ongoing access to the child, then discovery of the abuse would be more likely to result in a girl being taken into state care. While the reported incidence of sexual abuse by family members

was high, it has to be noted that the sample was selected from a specific population and cannot be seen as representative of the New Zealand population as a whole.

Taylor and Foster (1986) carried out a study of complaints made to the New Zealand Police involving sexual offences against children and young persons aged 16 years and younger. The data was collated in 1986 during May in Christchurch, and July in Auckland. Of the one hundred and two complaints, eighty-three were followed up. It was found that 26 cases involved intra-familial sexual abuse and in 27 cases the alleged offender was known to the survivor. In 28 cases the offender was a stranger, and in two instances the perpetrator was unknown.

The alleged offenders were all males. Twenty-one offenders were fathers, or father substitutes and ten others were family members. Thirteen of the abused children were aged between 3-5 years, and twenty-four between 6-10 years, with the largest number (63) between 11-16 years of age. The study gives a clear picture of the types of sexual offences against children being brought to the attention of an enforcement agency. It is not however, an epidemiological study of child sexual abuse in New Zealand. Furthermore, it is probable that the results under-estimate intra-familial child sexual abuse, since parents and victims are more likely to involve the police if the alleged offender is a stranger or non-family member (Taylor and Foster 1986).

Mullen *et al.* (1988) conducted a large study based on the general population of Dunedin, and looked at the impact of sexual and physical abuse on women's mental health. A sample of two thousand women was randomly selected from the electoral roles of five contiguous New Zealand Parlimentary constituencies. The women were sent a questionnaire in which items on social, educational, and medical status were included, as well as a twenty-eight item General Health Questionnaire (GHQ).

Interviews were carried out with a sub-sample of 314 randomly selected from those women with high GHQ scores. The interviews were conducted in their own homes. Their psychiatric status was assessed with the short *Present State Examination* (PSE). Questions on child or adult sexual abuse experiences were included in the subsequent interview schedule. Respondents who had been abused were questioned further in a semi-structured interview to elucidate the details of the abuse. A "child" was defined in this study as twelve years of age or younger.

Of the women interviewed 13% reported childhood sexual abuse. When weighted back to the original random sample (to allow for the over-represention of women with high initial GHQ scores), this study gave a rate of reported childhood sexual abuse of 9.9% for the population as a whole. A further 0.9% of the women in the sample reported being sexually abused between twelve and sixteen years of age and 4.6% of them reported being sexually abused after they had attained sixteen years of age.

Of those who identifed themselves as having been sexually abused as a child, 49% reported that they were abused by a stranger, 15% by father-figures, and 24% by other male relatives. Five (12%) found it too distressing to give any details other than to confirm they had been sexually abused. Mullen *et al.* (1988) made the point that, at the time both the GHQ and PSE measures were administered, the women knew only that they were participating in a health survey; therefore the scores were obtained before the exploration of any abuse. The sexually abused women did not differ from the population as a whole in terms of social class, educational background, number of children or frequency of marriage.

Table 3.02, below lists all known New Zealand studies. It shows that little work has been undertaken on general population samples of sexual abuse survivors in this country. This makes reliable inferences about the incidence of sexual abuse in the community difficult.

TABLE 3.02.

New Zealand Childhood Sexual Abuse Studies

Study	Date	N	No. Reported Abuse	Male	Females	Type
Saphira	1979	-	315	0	100%	General Population
von Dadelszen	1987	136	96	0	75%	Department Social Welfare Files
Taylor & Foster	1986	102	86	17%	83%	Department Social Welfare Files Police Files
Mullen *et al.,*	1988	314	41	0	13%	Electoral roll sub sample

The Nature and Extent of Sexual Abuse

In the New Zealand studies reviewed it was found that almost all sexual abusers tended to be male within an age range of 29-35 years, and the majority were known to the child. There was no significant ethnic difference in the incidence of sexual abuse. In the two clinical studies, intra-familial sexual abuse accounted for nearly a quarter of the abuse. The findings from the two general population studies were similar to the clinical studies. In the self-report survey, 50% identified fathers, or father-susbsitutes, as the abusers. The Dunedin-based study found that 15% were abused by father-figures and 24% by other male relatives; thus for 39% of the women in this study the abuse was intra-familial.

When looking at the age at which reported sexual abuse occurs, the studies show that it can happen from a few months of age onwards. The average age of girls being abused was 10-15 years, and of boys (from the studies that

included them) 12-13 years. The Dunedin-based study was again the exception. However, as the author sugests the explanation for this low rate could " . . . lie in the construction of the questionnaire and must be accepted as a failure to identify cases in this age group" (Mullen *et al,* 1988: 844).

Nearly half of the girls identified in von Dadelszen's (1987) study as having been sexually abused had experienced two, or more, often unrelated incidents of abuse. The girls experienced abuse both before and after they came into Social Welfare care. In most cases, however, when the abuse occurred in residential or foster care, the abusers were not the care-givers.

In the Taylor and Foster (1986) study, a small number of the referrals concerned long-standing sexual abuse, with some complaints of intra-familial abuse by more than one family member. More than one offender was involved in 5% of the complaints. The Mullen *et al* (1988) study also showed that most of the women sexually abused in childhood recounted incidents of gross abuse. Experiences involving repeated abuse were more common when the abuser was a relative. However, when the data relating to women subjected to repeated abuse was separated out from those abused by relatives no consistent pattern with regard to long-term effects emerged.

The findings on the incidence of sexual abuse in New Zealand are consistent with the results from general population studies in other countries. These results are shown in Table 3.03 below. This table identifies the abuser and the relationship between the child and the abuser. It includes four New Zealand studies and two major American studies. To date, these are the most extensive general population studies undertaken in both countries. This allows for some general comparisons to be made between New Zealand and America in identifying the abuser and in defining the relationship between the abuser and the child.

Table 3.03 shows that the findings of the New Zealand studies are consistent with the American studies. In most cases the abusers were male and known to the child, thus disproving the myth that children are sexually abused by strangers. The Dunedin-based study is an exception here, with 49% reporting stranger abuse. The variations in the stated relationships could, however, be a reflection of the methodological approaches used, and the questions asked at the time of data collection.

TABLE 3.03.

Reported Relationship between the Abuser and Child

expressed as percentages

Study	Date	Male offender	Father-figure or Relative	Known to the child	Stranger
Saphira	1979				
(Girls)		100	45	44	12
von Dadelszen	1987				
(Girls)		95	51	36	9
Taylor &Foster	1986				
(Girls)		100	28	31	20
(Boys)		100	5	1	10
Mullen *et al,*	1988				
(Girls)		100	15	24	49
Finkelhor	1979				
(Girls)		94	43	33	24
(Boys)		84	17	53	30
Russell	1983				
(Girls)		96	29	60	11

The Effects of Sexual Abuse Noted In The New Zealand Studies

In New Zealand, Saphira (1979) reported that the effects of sexual abuse included loss of self confidence, inability to trust people, feelings of

worthlessness, fear of men and nightmares. Most respondents in her survey reported having experienced sexual difficulties in adult relationships.

Von Dadelszen (1987) found that the most common feelings the girls expressed were fear, anger and shame. Furthermore, girls who had been sexually abused were more likely than those who had not been abused to have run away from home, have experienced problems at school, truanted regularly, had problems with alcohol and other drugs, and to have been sexually active with peers. They were also more likely to have been involved in crimes against persons (assaults) and property (thefts and damage).

Although the police study (Taylor and Foster,1986) did not make specific reference to the effects of sexual abuse, it did discuss the fact that in some cases withdrawal of court proceedings occurred because of the traumatized state of the children. The Mullen *et al* (1988) study confirmed the relative importance of the contribution of past abusive experience to the general level of psychiatric morbidity experienced by women in the community. The women reporting childhood sexual abuse had higher diagnostic scores for depression, anxiety and phobic disorders.

Accurate knowledge about the true incidence of childhood sexual abuse in the general population is lacking. However, the literature did report a common finding. That is, that there are long term emotional or affective sequelæ to childhood sexual abuse. This issue is the focus of the next section.

Long Term Effects On Emotional Functioning

The symptom most often reported in the clinical literature from women with histories of childhood sexual abuse was depression (Meiselman,1978; Herman, 1981). Empirical studies by Peters (1984) and Bagley and Ramsey (1985) confirm those findings. These latter studies found that sexual abuse

as children was associated with a higher incidence of depression and a greater number of depressive episodes over time. Peters (1984) found that even in a multi-regression analysis which took into account other factors such as a poor relationship with a mother, the variable "childhood sexual abuse" made an independent contribution to depression.

Sedney and Brook's (1984) study also confirmed the link between child sexual abuse and later depression in nonclinical samples. They found subjects with childhood sexual abuse experiences were more likely to have reported symptoms of depression, and to have been hospitalized as a result of that depression. In a review of the research on the impact of childhood sexual abuse Browne and Finkelhor (1986) found that while the studies used an overly-inclusive definition of sexual abuse, their results were consistent with those from carefully controlled studies. They referred to the survey of 278 undergraduate college students carried out by Briere and Runtz (1985), who found that sexual abuse victims reported more depressive symptoms during the 12 months prior to the study than did the nonabused subjects.

Anxiety, tension, fear and phobias are other reactions observed in survivors of childhood sexual abuse (Gelinas, 1983). Briere (1984) found that 54% of the women sexually abused in childhood experienced anxiety attacks, and nightmares and had difficulties sleeping. Sedney and Brooks (1984) compared sexually abused and nonabused subjects and found the sexually abused victims had experienced more anxiety attacks, were more nervous, and had more sleeping difficulties when compared with a control group.

The studies quoted above were all with clinical populations. No comparisons were made with women in the general population. Bagley and Ramsay's (1985) community study also supported these findings. Other studies based on both clinical and nonclinical samples showed that victims of childhood sexual abuse were more self-destructive. Yellowless and Kaushik (1990) found childhood sexual abuse to be a significant predictor for suicide

attempts. In their case-control study of the sequelæ of childhood sexual assault in adult psychiatric patients they reported suicide attempts had been made by 34% of the sexual abuse survivors in the study compared to 11% of nonabused women. Briere (1984) also reported that 51% of sexually abused clients had a history of suicide attempts compared with 34% of nonabused clients. A further 31% of sexually abused clients had a desire to hurt themselves against 19% of nonabused clients.

Sedney and Brooks (1984) found that 39% of their college student sample with childhood sexual abuse experiences reported having had thoughts of self-harm, compared with 16% of the control group. Others (Harrison *et al.* 1984; Herman,1981), also reported such findings. In a later study, Bagley and Ramsay (1985) demonstrated that an association existed between childhood sexual abuse and suicide ideation, or deliberate attempts at self-harm.

In reviewing the literature, which included findings from clinical samples, support was found for the idea that survivors of childhood sexual abuse continue to feel isolated and stigmatized in adult life. Briere (1984), Herman (1981) and Courtois (1979) all found considerably higher numbers of sexual abuse survivors reported feelings of stigmatization, isolation, and feelings of alienation, when compared with nonabused women.

Women who had been sexually abused as children tended to have self-esteem problems. Bagley and Ramsay (1985) found women with very poor self esteem were nearly four times as likely to have experienced a history of childhood sexual abuse when compared with other subjects. Courtois (1979) reported that 87% of a community sample reported their sense of self had been affected negatively by the sexual abuse experience. Herman (1981) also reported that 60% of her sample of incest victims had a predominantly negative self-image.

Problems with sex and difficulties in relationships with men were reported by survivors of childhood sexual abuse (Briere,1984; Meiselman,1978; Jehu,1988). Re-victimization in adult relationships was also common (Yellowless and Kaushik,1990; Fromuth,1983; Millar *et al,* 1978). Russell (in press) found that between 33% and 68% of the sexual abuse victims, (depending on the seriousness of the abuse), were raped later on, compared with 17% of nonabused women. In this same study, Russell found that between 40% and 62% of the abused women were later sexually assaulted by their husbands. The comparative figure for nonvictims was 21%. Briere (1984) reported that 49% of his clinical sexual abuse sample confirmed being battered in adult relationships, compared with 18% of the nonabused group.

Adult sexual functioning received a lot of attention with regard to the long-term effects of childhood sexual abuse in the literature (Meiselman,1978; Courtois,1979; Herman, 1981; Briere,1984; Jehu,1988) and most of the studies reported finding later sexual problems among survivors. Becker and Skinner (1984) argued that many survivors of sexual assault developed sexual problems as a result of their assaults, and these problems did not appear to have dissipated with the passage of time.

Non-clinical studies showed effects on sexual functioning as well. Courtois (1979) noted that 80% of incest victims in her sample reported an inability to relax and enjoy sexual activity, avoidance of, or abstention from sex, or, conversely, a compulsive desire for sex. In Finkelhor's (1979) study of college students a significantly higher rate of sexual adjustment problems was reported by the women sexually abused in childhood. Fromuth (1983), on the other hand, when comparing abused and nonabused students, found no correlation. This discrepancy could, however, be related to the fact that all of Fromuth's subjects were unmarried with an average age of 19 years. It may have been that some of the long-term effects had not yet been evidenced in this younger population.

Women who had been sexually abused as children often experienced difficulty with the parenting role. The study by Goodwin *et al* (1981) concluded that 24% of the mothers with parenting problems in their programme had histories of sexual abuse themselves, compared with 3% of the nonabused group. They suggested that the difficulty in parenting resulted when closeness and affection were endowed with .a sexual meaning and observed that these mothers maintained an emotional and physical distance from their children, thus potentially setting the stage for abuse.

Several authors writing about special populations drew attention to the link between childhood sexual abuse and later substance abuse. Yellowless and Kaushik (1990) found 45% of the abused women in their case-control study had substance abuse problems compared with 16% of nonabused women. Peters (1984), in a carefully controlled community study, found that 17% of the sexually abused women had symptoms of alcohol abuse, compared with 4% of nonabused women. A further 27% had abused at least one type of drug, whereas the rate among the nonabused women was 12%. Herman (1981) noted that 35% of the women with histories of incest in her clincial sample had abused drugs and alcohol, and Briere (1984) found this to be so for 27% of the subjects in his study.

While the majority of studies reviewed concluded that the effects of childhood sexual abuse are long-term and psychologically disturbing, there is variability and confusion about the effects described in the literature. It is here that the divergent views of the two schools of thought, the *minimalists* and the *maximists,* becomes clear. The minimalists do not believe the long-term effects seen in survivors of childhood sexual abuse are necessarily a function of sexual abuse. They suggest instead that these effects may be the result of other pathological elements such as parental neglect, family disorganization, or psychological abuse.

The minimalists base their claim on the belief that most of the studies to date have involved vague and unclear definitions of child sexual abuse, are retrospective, are generally based on clinical, or small, samples of survivors, and there is a lack of clarity in findings as to which forms of abuse are being discussed. Their argument is that such studies cannot be seen as representative of the vast majority of children who have been sexually abused. The maximists, on the other hand, claim that the majority of children sexually abused in childhood are adversely affected in some way by the abuse and that this abuse continues to have a major emotional effect throughout their adult lives.

The findings from the studies, based on both clinical and nonclinical samples, show that women survivors of childhood sexual abuse are more likely to manifest depression, self-destructive behaviour, anxiety, feelings of isolation and stigma, low self esteem, a tendency toward revictimization, and substance abuse. They are also more likely to have experienced difficulties with parenting, personal relationships and sexual functioning.

Table 3.04 below summarises those studies which attempt to quantify the extent to which the psychosocial sequelæ of sexual abuse appears in a specific population. In the "Effect Noted" column "link" refers to the studies that found a non-significant trend occurring. The number refers to the percentage of the total sample where the effect was observed.

TABLE 3.04

Studies of Noted Long Term Effects of Sexual Abuse
expressed as percentages

Effect	Study	Date	Type of Sample	N	Effect Noted
Depression	Bagley & Ramsey	1985	Random	387	link
	Briere & Runtz	1985	Students	278	link
	Herman	1981	Clinical	60	60
	Meiselman	1978	Clinical	108	35
	Mullen	1988	Electoral roll	314	link
	Peters	1984	Random	119	link
	Sedney & Brooks	1984	Students	301	link
Suicidial Ideation	Yellowless & Kaushik	1990	Clinical	44	34
	Bagley & Ramsey	1985	Random	387	link
	Briere	1984	Com.Health Centre	153	51
	Harrison *et al.*,	1984	Clinical	62	link
	Sedney & Brooks	1984	Students	301	39
Lowered Self-esteem	Bagley & Ramsey	1985	Random	387	link
	Curtois	1979	Media & Clinicial	31	87
	Herman	1981	Clinical	60	60
Anxiety fear & phobias	Bagley & Ramsey	1985	Random	387	19
	Briere	1984	Health Centre	153	54
	Gelinas	1983	Clinical	-	link
	Gorcey *et al.*,	1986	Media & Clincial	92	link
	Mullen *et al.*,	1988	Electoral roll	314	link
	Sedney & Brooks	1984	Students	301	59
Sexual functioning & relationship problems	Bagley & Ramsey	1985	Random	387	link
	Briere	1984	Health Centre	153	45
	Curtois	1979	Media & Clincial	31	80
	Finkelhor	1979	Students	796	link
	Gorcey *et al.*,	1986	Media & Clincial	92	85
	Herman	1981	Clinical	60	55
	Jehu	1988	Clinical	51	94
	Langmade	1983	Clinical	68	link
	Meiselman	1978	Clinical	108	87

These empirical studies of the long-term effects of childhood sexual abuse demonstrate that childhood sexual abuse is a major source of distress in

adult women. These studies also identify a series of other factors that influence the impact of childhood sexual abuse and, therefore, the degree of long-term psychological disturbance. Eight factors have been identified and each of these will be discussed in turn.

(1) *Impact of Age of Onset.* Throughout the literature there is an ongoing debate about how the age of a child might affect her or his reaction to a sexually abusive experience. While young children are very impressionable–which may make them more vulnerable to trauma–they are also very naive. This naivety in turn may protect them from some of the negative effects, especially if they are ignorant of the social stigma surrounding the kind of victimization they have suffered. Findings from the available studies were contradictory and inconclusive on this point.

Meiselman (1978) reviewed adults in treatment and suggested that younger children were somewhat more vulnerable to trauma. She found that 37% of those abused prior to puberty were more seriously disturbed, compared with 17% of those who were abused after puberty. Curtois (1979) also found more effects from prepubertal experiences when assessing the impact of child sexual abuse on long-term relationships. Other studies, while identifying a trend or tendency for younger age to be associated with trauma, concluded that the trend was insignificant. Two such studies were conducted by Finkelhor (1979), using a multivariate analysis, and Russell (in press). Langmade (1983)went even further concluding that there was no association between sexual anxiety, sexual guilt, or sexual dissatisfaction in adults and the age at which they were sexually abused.

By contrast Bagley and Ramsey (1985) found an association between younger age and trauma but this association dropped out on multivariate analysis, especially when controlling for acts involving penetration. The Tuft's Centre (1984) which set out to identify reactions at different ages to sexual abuse, concluded that age bore no systematic relation to the degree of

disturbance. They saw the stages of development through which the abuse persists as being more important.

The studies reviewed did not resolve the disputes as a clear relationship between age of onset of the abuse and trauma was not found. The most that can be said is that there may be a trend showing that the younger the age of onset of the abuse the more traumatic it appears to be.

(2) *Impact of Gender of the Offender.* Table 3.03 showed that, in both New Zealand and other countries, the majority of abusers were male and known to the child. This may be the reason that very few studies have looked at the impact of abuse according to the sex of the offender. Finkelhor (1984) and Russell (in press) were the only studies in the literature that explored this factor at all. They both found that adults sexually abused as children by male perpetrators rated their experiences as being much more traumatic than those who were abused by females. The paucity of literature and the high percentage of male abusers made any further comparisons of the impact of gender difficult.

(3) *Impact of Relationship to the Offender.* Sexual abuse by a close relative involves a betrayal of the trust between a child and a caregiver. Generally, it is considered to be more traumatic than abuse by someone outside the family. This view was supported in the literature, at least for some types of family abuse: by Landis (1956) in an early study asking students about how they recovered; by Anderson *et al* (1981), in a chart review of adolescents in a hospital treatment setting; and by Friedrich *et al* (in press), in their evaluation of young victims and associated trauma.

Other researchers (Finkelhor, 1979; Russell in press; Seidner & Calhoun, 1984; Tufts,1984) found no difference in the impact of abuse by family members versus abuse by others. It is important to remember, however, as Browne and Finkelhor (1986:73) pointed out, that " . . . how closely related a

victim is to the offender does not necessarily reflect how much betrayal is involved in the abuse". These researchers make the point that while abuse from a trusted person may involve betrayal, abuse from a distant relative may also involve fear, and thus be rated more negatively. However, abuse by a trusted person, i.e., friend or neighbour, may be more traumatic than abuse by a distant relative because of the closer emotional involvement the child would have with the trusted person. Such explanations make it easier to understand why the relative-nonrelative distinction is not necessarily a consistent predictor of trauma.

The picture changed though when fathers, or father figures, were specifically separated out from other family members. Both Finkelhor (1979) and Russell (in press) found that abuse by fathers, or father figures, was significantly more traumatic for survivors than abuse by other people. Bagley and Ramsey (1985) also found a small, but insignificant, amount of impairment in women abused by father figures. The Tufts (1984) study had similar results for abuse by stepfathers, but not for abuse by natural fathers.

While some authors suggest that abuse from a trusted person may involve feeling betrayed (in contrast to abuse from a distant relative which often involves fear and betrayal) the literature consistently reports that familial abuse is more traumatic when compared with abuse by other perpetrators.

(4) *Impact of Child, Sibling, Cousin, and Adolescent Child Abuse.* Recent research has begun to focus on the need to recognise both the signficance and the effects of sibling and cousin incest, of child-child and adolescent-child sexual abuse. Some authors (Cantwell,1988; De Jong, 1989; Smith and Israel, 1987) found an overlap between these various forms of abuse, and challenged the acceptance of sibling abuse as not being harmful. De Jong (1989) believes sibling incest to be the commonest form of incest.

Friedrich (1988) believes that it is essential to employ a developmental paradigm when looking at the effects of childhood sexual abuse. A younger child will construe abuse quite differently from an older child. The effect of the abuse will depend on the cognitive level at which each child is functioning. For example, a younger child will be far more concrete about the abuse and may only perceive it to be abuse if there is pain. An older child, however, will be able to conceptualize it in more abstract terms. The immaturity of a younger child also increases the likelihood of regressive responses, while the older child may exhibit behavioural responses such as running away or drug taking. In addition, the response to the abuse from the family of a younger child may be quite different from that of the family of an older child.

A second paradigm which Friedrich (1988) presents as requiring consideration centres around the process of adaption in response to abuse. Obviously, what is being adapted also needs to be taken into account. He suggests that greater initial symptomatology is associated with greater severity of abuse.

(5) *Impact of Type of Sexual Act.* Several studies confirm that the type of sexual abuse is related to the degree of trauma experienced. In a study of the long- term effects of sexual abuse on adult women, Russell (in press) found that the 59% of cases where intercourse, or attempted intercourse, had occurred were far more traumatic in comparison to the other 36% where unwanted genital touching had been the main experience. Bagley and Ramsey's (1985) community study confirmed these findings. In a multivariate analysis, using a composite of standarized instruments, they found penetration to be the single most powerful variable explaining severity of mental health impairment. Other researchers, however (Landis,1956: Peters,1984: Seidner & Calhoun,1984: Tufts,1984), while confirming the relationship between the type of sexual contact and subsequent effects, did not find the clear differentiation that Russell (in press) and Bagley and Ramsey (1985) did between intercourse and genital touching.

The Tufts' (1984) study measured children's anxiety, and found children who had been fondled without penetration to be more anxious than those who had actually suffered penetration. Other studies (Finkelhor,1979; Anderson *et al* 1981; Fromuth,1983) do not show any consistent relationship between type of sexual activity and effect. Therefore, while a number of studies do show that molestation involving more intimate contact is more traumatic than less intimate contact, there is some disagreement about whether intercourse and penetration are demonstrably more serious than hand-genital contact.

Wyatt and Powell (1988) were more specific, and reached the general conclusion that the most negative consequences for children were associated with abuse by fathers, genital contact, and the use of force. They saw genital contact and the use of force as being the two factors that determined the severity of the trauma experienced. Sirles, Smith and Kusama (1989) reported severity to be related to older survivors, a closer relationship of the offender to the child, greater frequency and longer duration of abuse.

(6)*Impact of the frequency and duration of the abuse*. "Duration" refers to the period of time over which the abuse occurred, and "frequency" is the number of times the abuse occurred. Throughout the literature these factors have been discussed together and the findings are therefore reported under the same heading.

Most clinicians working with sexual abuse survivors tend to believe that the duration of the abuse is associated with the degree of trauma. However, this belief is not clearly supported in the studies reviewed, only four out of nine studies associated duration with greater trauma. Three studies found no relation between frequency, duration and the degree of trauma experienced, and two studies even found some evidence to the contary.

Russell (in press) found that 73% of the women in her study had self-rated abuse that had lasted more than five years as extremely traumatic, compared

with 62% where the abuse lasted 1 week to 5 years and 46% where it occurred only once. Tsai *et al* (1979) found duration and frequency associated with greater negative effects when compared on other standardized tests. Bagley and Ramsey (1985), used a composite of indicators concerning depression, psychoneurosis, suicidal ideation, psychiatric consultation and self concept to look at the general mental health status of adult victims. They found women with longer-lasting experiences were more traumatized than those whose experiences had been briefer.

In studying children, Friedrich et al (in press) found that the frequency and duration of abuse predicted disturbances. Finkelhor (1979), however, in a survey of college students, used a self-rating scale of how negative the experience was in retrospect and found no association between degree of trauma and duration. Langmade (1983) found no difference on measures of sexual anxiety, sexual guilt, or sexual dissatisfaction between women seeking treatment who had been abused over a long or short duration.

The Tuft's (1984) study of children did not find an association between short or long duration of abuse and measures of distress. Two other studies showed an inverse relationship. Courtois (1979) found that adult women with histories of abuse over a long duration reported the least trauma. Seidner and Calhoun (1984) also reported that a high frequency of abuse was associated with a higher level of self-acceptance but a lower level of social maturity.

(7) *The Impact of Telling or not Telling.* Finkelhor (1979), in a multivariate analysis, found that telling or not telling was essentially unrelated on a self-rating sense of trauma scale. The Tuft's researchers (1984) found, when evaluating abused children, that the longer the duration before telling about the abuse, the less anxiety and hostility they exhibited. These studies were supported by Bagley and Ramsey (1985). While finding a simple zero correlation between telling and not telling on a composite measure of

impairment based on depression, suicidial ideation, psychiactric consultation and self esteem, they also found that the association became nonsignificant when controlled for other factors.

(8) *The impact of the use of force and/or violence*. Using a multivariate analysis, Finkelhor (1979) identified the use of force by an abuser as the variable causing the most trauma in survivors. Fromuth's (1983) findings from a replication of Finkelhor's study supported these results. Russell (in press) found 71% of the victims of force rated themselves as extremely or considerably traumatized, compared with 47% of the other victims. Friedrich *et al* (in press) also found the use of force to be strongly correlated with trauma. Researchers from the Tuft's centre (1984) selected force as one of the few variables associated with children's initial reactions. They reported that in such cases the children showed greater fear of aggresssive behaviour in others.

Other studies, however, report findings to the contrary. Anderson *et al,* in studying initial effects, concluded that, " . . . the degree of force or coercion used did not appear to be related to the presence or absence of psychosocial sequelæ" in the adolescents they evaluated (1981: 7). Seidner and Calhoun (1984) found that force was related to higher self acceptance but with lower social maturity, which in effect is not really strongly in favour either way. In Bagley and Ramsey's (1985) study, force was associated with greater impairment, but in a multivariate analysis this association dropped to just below the level of significance.

Summary of Impact Factors

The literature reviewed clearly supports the beliefs of the maximists as the studies show that women survivors of childhood sexual abuse demonstrate very disturbing problems in adult life. Research from related fields has suggested that several factors influence the impact of sexual abuse on a

child. They include the age of the child (Price and Valdiserri,1981), and the nature of the relationship between the child and the perpetrator(s) as well as the gender (Schultz and Jones, 1983).

Furthermore, the frequency and duration of the abuse (Tsai *et al.,* 1979), and other specific details of the incident(s), particularly the use of force and/or violence are all important factors in understanding the long-term consequences of childhood sexual abuse in later life. There is also a general assumption that secrecy about the abuse has an impact on the degree of trauma experienced.

From the studies reviewed it is evident that sexual abuse by fathers, or father substitutes, does have a more negative and longer-term impact than abuse by strangers. Sexual approaches by siblings of a similar age does not appear to be quite so traumatic although this can depend on the age of abuser. Any coercion, by the use of force and/or violence has an immediate impact on the degree of trauma experienced and is more likely to result in long-term psychological disturbance.

Young children are more likely to be drawn into activities that they do not fully comprehend and it is only in retrospect that they may feel guilty, unhappy, resentful and/or frightened about the abuse. The effect of the duration of abuse is an area in which there is the least consensus in the studies reviewed. The impact of secrecy about the abuse is also difficult to assess. The studies reviewed could not confirm that disclosing the abuse had any impact on the overall degree of trauma experienced. However, it is difficult to isolate any specific factors that could be said to consistently contribute to the impact of sexual abuse on a child.

The minimalists base their disclaimer about the long term-effects of childhood sexual abuse on the belief that most of the studies to date have involved vague and unclear definitions of child sexual abuse, are retrospective, are

generally based on clinical, or small samples of survivors, and that there is a lack of clarity in findings as to which forms of abuse are being discussed. Their argument is that such studies cannot be seen as representative of the vast majority of children who have been sexually abused.

Taking this point into account, O'Reilly and Timm (1981) documented many of the previously described clinical observations in a comparative survey of women who had been sexually abused as children with women who had not. Their results indicated that the survivors of childhood sexual abuse did have more negative self-concepts, greater feelings of powerlessness and worthlessness, and more intense suicidal ideation than the non-abused women thus adding support for the maximist school of thought. They found that the abused women also had more difficulty forming and maintaining interpersonal relationships, experienced less sexual satisfaction, had more difficulty establishing a sense of trust, and more frequently assumed responsiblity for their "relationship failures" than the non-abused women.

As the research indicates that the presence of psychosocial disorders in adulthood is not unusual for those sexually abused in childhood it would be reasonable to expect that a high number of women in the general population have a pyschiatric disorder. In the few community studies of psychiatric disorders that have been undertaken only current depression, or depressive symptoms in women have been looked at. Mullen *et al* (1988) reported overall morbidity levels but not specific diagnosis. The only other source of data on psychiatric disorders in New Zealand is the *New Zealand Psychiatric Register,* which does not include data on the prevalence of psychiatric disorders in the general population.

A New Zealand community-based epidemiological survey of pyschiatric disorders (Wells *et al,* 1986) is of particular interest to this study. Using a wide variety of pyschiatric disorders as its parameters, this study aimed to determine the prevalence of a number of disorders, in the community.

A probability sample of 1498 adults aged 18-64 years was drawn from the Christchurch urban area of approximately 300,000. There was a 70% response rate to the survey. The *Diagnostic Interview Schedule* (DIS) was chosen for determining psychiatric disorder (Appendix 3). The DIS is specifically designed for large-scale community surveys employing lay interviewers, and enabling an adequately large sample to be taken without resorting to screening instruments. Diagnoses were made using the international psychiatric classification DSM-III (*Diagnostic and Statistical Manual,* (Appendix 3).

Wells *et al* (1986) identified a relationship between heavy drinking and other psychiatric disorders. One of the major predictors of heavy drinking was the number of *Child Conduct Disorder* symptoms. This is of particular interest to this study as the *Post-Truamatic Stress Syndrome*, (PTSS) has some symptoms in common with *Childhood Conduct Disorder.* This disorder is an indicator of childhood sexual abuse (Appendix 3).

While it was not a total population investigation, there is no reason to suspect that Christchurch is greatly different from other parts of New Zealand and the findings are probably a reasonable estimate of psychiatric disorder for demographically similar groups throughout the remainder of the country. This first study has begun to produce findings which will permit comparisons to be made with a growing body of literature in other countries.

Reliability and Validity of the Studies Reviewed. The minimalists argue that much of the relevant research in the area of childhood sexual abuse is fraught with methodological problems. The major problems tend to be the definition of terms and the sampling methods. Sexual abuse is defined differently by different researchers and a number of variables are adopted before operational definitions are arrived at.

The main variables in contention seem to be the age of the child, the age of the abuser, the relationship between the child and the abuser, the sexual act performed, whether it is voluntary or involves force, and how the child feels about the abuse.

Clearly, not all abusive behaviour combines all possible variables, and most interact with each other in a variety of ways. For example, children of a similar age playing together and touching each other's genitals openly would not normally be considered abuse, as it is the inequality in the sexual attention of the older person that makes the behaviour abusive (Saphira,1985). The different mix of factors has, however, led to confusion in defining sexual abuse *per se*. Most of the overseas studies reviewed earlier used either age discrepancy or the relationship between the child and the abuser as the main variables in defining behaviour as abusive.

In New Zealand the Department of Social Welfare study considered experiences were abusive if the girls expressed negative feelings about them (von Dadelszen, 1987). The Dunedin-based study defined anyone twelve years or younger as a child. The use of this definition resulted in their failure to identify the number of women abused as adolescents, a group which accounted for a large number of survivors in most of the other studies (Mullen *et al,* 1988). No specific definition of sexual abuse was used in the police study. The major hypothesis explored was that concern for the welfare of the child in the criminal justice system could be a crucial factor in determining whether or not a case would result in a criminal prosecution. Files relating to all types of sexual offences against persons aged 16 years and under were retrieved and the actual existence of a file was the deciding factor for inclusion in this study.

Most of the reported findings were drawn from clinical samples, which meant they represented only particular sub-groups of the population. As a case in point, the Department of Social Welfare study was limited by the fact that it

was only concerned with girls under guardianship of the State. In addition, some of the studies had a geographical bias. The Department of Social Welfare study was carried out in five main urban areas of the country, and the sample for the police study was drawn from two major cities in New Zealand.

One general population study was limited to those readers of a popular magazine. This cannot be seen as representative of the general population in New Zealand. Clearly, the wide variety of understandings used in defining what constitutes sexual abuse make comparisons across countries and between studies extremely difficult. It also makes it difficult to gain an accurate understanding of the prevalence of sexual abuse in New Zealand.

Conclusion

Despite the problems associated with the New Zealand studies reviewed, the findings are generally consistent with research in other countries and demonstrate that social workers are likely to find the presence of long-term psychosocial sequelæ in adult survivors of childhod sexual abuse. In the absence of more concise research the studies can be used in determining who does the abusing and the relationship between the child and the abuser. The studies show that in most cases the abusers were male, and known to the child.

Furthermore, the studies confirm that for approximately a quarter of the children the sexual abuse is intrafamilial. A number of theories relating to the sexual abuse of girls have been discussed and the studies support the argument that while the home is portrayed as the only really valid place for childrearing and for individual emotional security, most children experience abuse in their own families.

The minimalists claim that sexual abuse cannot be directly connected in a cause-and-effect way to any kind of psychopathology. However, there is

evidence to the contrary from which, regardless of the variation, two firm generalisations can be made. The first is that, while the minimalists may cast doubt on the conclusions of others in regard to the long-term psychological effects of sexual abuse, all the studies in this literature review appeared to be consistent in one respect; namely that for many women, sexual abuse in childhood has long-term effects which may create interference in several critical areas of functioning in adult life.

The second generalisation stems from the Dunedin study (Mullen *et al*, 1988), and the Western American study (Gorcey *et al*, 1986). These studies were conducted over the general population (not clinical studies) and they tell us that those who experience sexual abuse as children are more likely to experience psychiatric disorders in adulthood. The findings from these two studies clearly support the view of the maximists. As Mullen *et al*, remarked, " . . . one of the abiding observations in psychiatric epidemiology is that women are over-represented among those with depressive and anxiety disorders " (1988: 845) .

This poses specific problems for social work practice as women presenting at social service agencies rarely reveal a history of sexual abuse on initial contact with the agency. To aid the chances of a survivor making a psychological recovery from the long term effects of sexual abuse social workers need to be able to identify them at the beginning of the counselling process. If the abuse is not revealed spontaneously then social workers need to be able to precipatate further disclosure of this information during the counselling process.

An area in which even less research and theorisation has occurred is the association between women's experiences of childhood sexual abuse and the development of symptoms of *Post-Traumatic Stress Syndrome* in later life. These issues are a major focus of this research and are pursued in Chapter 4.

CHAPTER 4

ELLENSON'S THEORY: A PREDICTIVE SYNDROME

Chapter three reviewed a range of national and international studies and highlighted the long-term psychosocial sequelæ evident in adult survivors of childhod sexual abuse. It is, therefore, highly probable that survivors of sexual abuse will need to seek counselling at some stage of their lives. The focus of this chapter is aimed at testing Ellenson's (1985,1986) *Predictive Syndrome* .

Ellenson (1985) decribed a *predictive syndrome* as an indicator in detecting histories of sexual abuse. He identifies a set of indicators (on which his theory is based) from symptoms contained in the Post Traumatic Stress Syndrome. The Post Traumatic Stress Syndrome (Diagnostic and Statistical Manual of Mental Disorders,1980) is characterised by nightmares, intrusive recollections of the event, acting as if or feeling that the event is recurring in response to a situational cue, memory lapses, anxiety, problems with relationships, and a feeling of detachment from others. Recent researchers (Ellenson,1985; Blake-White and Kline,1985; McLeer *et al.*, 1988; Kiser *et al.*,1988; Dahl,1989; Moscarello,1990) have found symptoms of PTSS among women survivors of sexual abuse.

TESTING ELLENSON'S THEORY

Ellenson (1985) identified a set of symptoms he considered to be clinically predictive of a history of childhood sexual abuse in adult women, regardless of whether or not the women themselves reveal a history of abuse experiences. He described (1985,1986) specific thought content and perceptual disturbances found to be unique to, and shared by, adult women incest survivors, which, he claimed, would have to be seriously considered.

Ellenson based his theory on interviews that he conducted with over sixty adult women incest survivors. He found " . . . all the women had experienced certain recurring hallucinations which were astonishingly similar and so common that they were considered to constitute part of a syndrome that could be predictive of a history of sexual abuse. Such hallucinations may be psychosensorial or psychic" (1986: 152). Moreover, he defined psychic hallucinations as " . . . the result of the imagination without the interposition of a sensory stimulus" and psychosensorial hallucinations as " . . . the result of the combined action of the imagination and of the organs of sense" (1986: 151). Such hallucinations, he believed, are experienced as being perceived through specific sensory organs; that is, the women would imagine that they could see, hear, feel or smell things which did not in fact exist.

This distinction between "sensed" hallucinations and "perceived" hallucinations is not offered in the DSM III (1980). Ellenson argued, however, that the significance of the distinction has not been previously demonstrated. This is because of the failure to assess the involvement of sensory organs in hallucinations when doing routine mental status examinations. He reported the content of the hallucinations (ranging from brief and ill defined, to prolonged and highly detailed prognoses) experienced by the sixty-plus women interviewed, regardless of individual differences in age, ethnic background, and socioeconomic status, were more similar than would be expected by chance alone.

Vague, unelaborated hallucinations are termed "elementary" (Hinsie and Campbell 1976: 334). As such, they were the kind reported by the vast majority of the women interviewed by Ellenson (1985,1986). While the elaborateness of a given hallucination may differ, it is an important factor in diagnosis. For instance, the DSM III requires that the auditory hallucinations that support a diagnosis of schizophrenia involve a running commentary on the behaviour of a person experiencing two or more voices conversing, or frequent hallucinations having a content of more than one or two words.

In Ellenson's study, the factors that increased the elaborateness of the women's recurring psychosensorial hallucinations were secondary drug abuse, sexual abuse and particularly prolonged or vicious sexual abuse that began in early childhood.

The psychic auditory hallucinations tended to be vocal sounds, more elaborate than their psychosensorial counterparts, and could be divided into three main groups (Ellenson,1986: 153). Firstly, "persecutory" voices sometimes railled a survivor in her head condemning her in sexual terms, and sometimes threatening harm or death. Secondly, at other times "directive" voices were reported, which goaded survivors towards physical self harm, suicide or acts of violence towards herself or others. Finally, "inner helper" voices attempted to soothe a few survivors.

More frequent and elaborate hallucinations of this kind have been associated with particularly prolonged and perverse, sadistic, and painful sexual abuse, and with abuse initiated before school age. Ellenson (1986: 154) pointed out that in the DSM III (1980) the only reference made about such experiences is under the diagnostic criteria for schizophrenia and for schizotypal personality disorder. Although considered perceptual disturbances, they are called recurring *illusions* in that reference.

On completion of the interviews Ellenson (1986: 155) stressed that the women did not just fear something that *might be present;* they experienced it as something *definitely there.* Further reality testing efforts seldom satisfied them that *something* was not present. They did not misperceive a *real stimulus;* they perceived an object that did not exist in *current reality.* He believed that the hallucinations reported by the women during the interviews amounted to intrusive recollections that took the form of sensory phenomena.

These hallucinations, Ellenson (1986: 152) claimed, " . . . have been called *memory* or *retroactive* hallucinations. That is, they are pieces of incestual

events, or related affects, or both, experienced in childhood and as such, they can be found to constitute reliable evidence of a history of childhood sexual abuse". Ellenson's predictive syndrome therefore fell into two main categories, one was concerned with thought content disturbances, and the other perceptual disturbances. Ellenson's theory was influential in the overall research design of part one of this study.

METHODOLOGY

As part of an overall evaluation about referrals to a community Counselling Centre, a self-report questionnaire, based on Ellenson's predictive syndrome, was used to identify the number of women presenting at the counselling centre between February and August in 1986 who had been sexually abused. Of those who had been sexually abused the study sought to ascertain the age at which the abuse occurred and the effect of the abuse on their ongoing relationships. It was also designed to ascertain whether the women had ever experienced any symptoms of PTSS. The following hypotheses were proposed.

Hypothesis 1. That there would be a statistically high probability that any of the women presenting for counselling, and involved in the study, would have a history of sexual abuse.

Hypothesis 2. That there would be a significant variation between the abused and the non-abused women in their ability to form satisfactory ongoing relationships.

Hypothesis 3. That there would be a statistical difference between the abused and the non-abused women in regard to their ever having experienced symptoms of PTSS.

The Questionnaire

The questionnaire was administred as a pilot test to sixteen women staff members from an outpatient Alcohol and Drug Centre, two community-based Counselling Centres, and a hospital-based Crisis Team. None of the women involved in the pilot test were included in the survey. There was a one hundred percent response rate to the pilot test.

Pre-test validity of the questionnaire was inferred from two areas; responses and reactions to the test questionnaire in the pilot trial and general understanding of the wording of the questionnaires. The results of the pilot showed that nearly three quarters of the sixteen women had been sexually abused. The respondents' ages ranged from 29 years to 51 years, with a mean of 34 years. Three of the respondents reported difficulty with the parenting role, three quarters had been depressed at some stage of their lives, and over a third of those who had been sexually abused had experienced difficulties in their sexual relationships. The pilot trial confirmed the theoretical belief that a statistically high number of women would have experienced sexual abuse at some stage of their lives, and that the abuse would have had a significant impact on the ability of those women to form satisfactory ongoing relationships.

After the pilot trial of the questionnaire was completed, the women involved were given the opportunity to discuss the questionnaire in terms of content validity. While it was apparent that some questions needed to be changed in order to remove ambiguities, the women were satisfied that the questions were representative of the area under study.

Symptoms of Ellenson's (1985,1986) predictive syndrome fall into two main categories; thought content disturbances and perceptual disturbances. Variables relating to the symptoms were included in section five of the questionnaire which enabled the researcher to look at both of these areas.

The questions in the first section were used to obtain demographic data about the womens' current social situation; the second section specifically asked women about their families of origin and canvassed relationships within the family; the third section asked about childhood happiness and school achievements; and the questions in the fourth section enabled the researchers to determine the number of women in the study who had been sexually abused during childhood, adolescence or young adulthood.

Section five of the questionnaire, drawing on Ellenson's theory, focused on more recent events and contained questions which specifically sought to identify thought disturbances. The main emphasis centred around recurring nightmares which perceived harm coming to the individual herself, or others. Items in this section also reflected the presence of any phobias by asking about recurring and unsettling intrusive obsessions. Perceptual disturbance questions looked for recurring auditory and/or visual hallucinations. The questions in the sixth section focused on the respondents adult relationships and ability to trust others along with feelings of guilt, sexuality, self esteem and self confidence.

It was not possible to specify exact numbers of symptoms or combinations of symptoms that predict a history of sexual abuse. As a rule of thumb, Ellenson (1985) suggested a symptom was significant if it occurred two or more times a month or had occurred at least that often in the past. He believed that any combination of seven symptoms or more was predictive of sexual abuse; a combination of five symptoms, including one perceptual disturbance symptom, was considered highly predictive. Two perceptual disturbance symptoms were also considered highly predictive.

Other researchers have found that the best way of gaining access to this type of information is through unstructured interviewing techniques. This is because it has been found that clients rarely volunteer such information early in treatment unless it is presented in such a way as to be non-threatening.

The women involved in the survey under review were already clients of the centre and it seemed inappropriate to ask them to attend for further interviews. Hence the decision to construct a self-report questionnaire as a way of collecting data from the women about any sexual abuse experiences.

Construction of the questionnaire for the survey was the responsibility of the author of this study. The format followed the suggestions for questionnaire construction as outlined in Grinnell (1985). The questions were *fixed alternative* questions so that the responses were relevant to the inquiry and did not require any subjective intrepretation. After consideration was given to a range of psychological inventories and other surveys, the questions were prepared specifically for this survey. Each section began with instructions on how responses were to be recorded. The questionnaire is set out in Appendix 5.

The Sample: The Participants

The amended questionnaires were posted to the women in the sample who had attended the community based Counselling Centre between February and August 1986 (Appendix 5). Many of the women were still attending for counselling, or were involved in ongoing support groups which had originated from the Centre. The majority of the women invited to respond to the questionnaire had already discussed with staff members their possible participation.

There was no pre-selected control group but the non-abused women, while still part of the clinical sample, were in effect the control group for the survey. When looking for the presence of PTSS, the histories of the abused women were compared with those of non-abused women.

Data Collection

The questionnaires were posted to 170 women, with a covering letter inviting them to participate in the survey (Appendix 4). Of the 170 questionnaires sent out, 93 were returned completed and 8 unanswered by the return date specified. A further 16 arrived too late to be included in the analysis, 12 of which had been answered, giving therefore an overall response of 118 in total. Another 6 that were unable to be delivered were returned by the Post Office. All the women were asked to complete the same type of survey questionnaire. It was a self-report questionnaire consisting of six sections which, in total, contained one hundred and thirty eight variables.

Procedures Used In Processing the Data.

The questionnaires were designed so that they could be coded in numerical form directly on the sheets, punched onto cards, then entered into a Burroughs Large System, Version H. The SPSS programme was used for computer analysis and produced frequency distribution, cross tabulations and Chi squares for analysis of 93 of the completed questionnaires. However, as the numbers in the Chi-square cells were too small to be of any real statistical value, variables that appeared to be significant in predicting symptoms of PTSS in this study were analysed again.

In conducting the second analysis an alternative computer programme, *MYSTAT*, was used. This programme is a personal computer version of *SYSTAT*. This programme enabled a multivariate analysis of the data to be undertaken which allowed for the construction of multiple regression tables of significant variables. This type of analysis seemed better suited to the re-evaluation than the cross tabulations used previously. The twelve completed questionnaires that were too late for the first analysis were included in the second run, thus raising the overall response to 105 in total.

Items that were related to Ellenson's (1985) predictive syndrome, and those which appeared to have some predictive potential in the first analysis, were identified on the questionnaire. Other items such as parenting, fear, guilt, anxiety, relationship difficulties, sexual behaviour, substance abuse, school problems and truancy, all stated clearly in the literature as observable consequences of sexual abuse, were also identified. As depression was so common (98%) among the women in the total sample this item was not included in the second run. The variables identified were then entered into the MYSTAT programme from which sets of tables were generated for further analysis.

Data Analysis and Intrepretation

Analysis of the demographic data indicated that the age range of the women in the sample was 15 - 65 years with a mean of 34 years, and a median and mode of 32 years. The population of the city where the survey was undertaken is predominately Pakeha, with 3% being Maori and 1% Pacific Island polynesians (N.Z. Year Book, 1986-87). The ethnic composition of this survey had a slightly higher Maori population than would be expected as 95% of the women were Pakeha, 4% Maori and 1% Maori-Pakeha.

In stating sexual preference, 93% of the women saw themselves as heterosexual, 4% bi-sexual and 1% lesbian. Two percent of the sample did not respond to this question. Many of the women were in relationships: 53% were married with another 4% living in defacto situations. A further 25% were divorced or separated, 3% were widowed and 16% were single. The majority (86%) had children. The demographic composition of the sample data is shown in Table 4.01 below.

TABLE 4.01

Frequency distribution showing characteristics of respondents

Variable	Categories	Adjusted Frequency % (N = 93)
Ethnicity	Pakeha	95
	Maori-Pakeha	1
	N.Z. Maori	4
Marital Status	Single	16
	Married	53
	De facto	4
	Divorced/separated	24
	Widowed	3
Sexual Preference	Heterosexual	93
	Lesbian	1
	Bisexual	4
Children	No children	14
	Children	86
	Child management problems	39
Alcohol	Caused problems in home	31
	Problems for self	27
	Treated alcohol/drug problems	7
School	Problems at school	28
	Truancy	27
	Expelled from school	9
Run away from Home	< 1 week	14
	> 1 week	3
	Never Runaway	76

The last four items in Table 4.01 show responses to questions about child management, running away, substance abuse, and problems at school, all of which formed questions in section one of the questionnaire. Of the 86% who had children 39% had child management problems. Alcohol caused problems in the home life of their family of origin for 31% of respondents. Substance abuse was a problem for 27%, with 7% having been in treatment

at some stage. School days were not uneventful as 28% had problems at school, 27% truanted and 9% were expelled. A small number (14%) had run away from home for less than one week with 3% having absconded for more than a week.

Item 46 of the questionnaire asked the women about any attempts to engage them in sexual activities before they were aged 16 years. Item 47 asked them if any sexual activities had actually occurred before they were 16 years of age. Item 48 asked if any sexual acts had occurred without their consent when they were aged between 16 - 20 years. Item 49 asked the women whether they considered any of the above activities to be sexual abuse. Table 4.02 shows forty seven women (51% of the total sample) answered yes to this question. Table 4.02 sets out the responses recorded regarding the experiences of the women who considered that they had been sexually abused.

Of the forty-seven women abused; 8% were aged less than 5 years when the abuse first occurred; 30% were aged 6 - 10 years; 45% were between 11 - 15 years; and 17% were abused between 16 - 20 years of age. When looking at who did the abusing it can be seen that 73% of abusers had been known to the child, with 22% being strangers. The father was the abuser in 13% of the cases. Rates of disclosure of the abuse varied, with 66% having told some-one; 20% reported the abuse immediately; 4% reported one week later and 4% reported some months later. For 42% it took years to disclose the abuse and 30% had never told anyone before responding to the questionnaire. Shame was recorded as the main reason for not doing so.

TABLE 4.02

Frequency distribution of sexual experiences

Variable	Categories	Adjusted Frequency % (N = 47)
Sexually Abused		
	Attempted abuse <16 years	53
	Attempted abuse >16years	33
	Abused aged 0 -16 years	45
	Abused aged 16 -20 years	33
	Total considered abused	80
Age first occurred in years	0 - 5	8
	6 - 10	30
	11 -15	45
	16 - 20	17
Gender of Abuser	Male	98
	Female	2
Relationship abuser/survivor	Father	13
	Known person	73
	Stranger	22
Told of Experience	Told anyone	66
	Told straight away	20
	Weeks later	4
	Months later	4
	Years later	42
	Never told	30
Reason for not Telling	Shame	33
	No one to tell	22
	Afraid of disbelief	6

Table 4.03 looks at the nature of the sexual abuse experience and the duration. While other sexual acts were reported, sexual intercourse was the main experience. For 2% of the women two or more offenders were involved. Of the women who had been abused as children 32% had been sexually abused more than once. Although the number of Maori women in the sample was small, no ethnic differences in the rate of sexual abuse were reported.

At the end of the questionnaire the women were asked if there were any other sexual abuse experiences they wanted to record. The answers were in text and not easily able to be coded and included in the computer analysis. A manual analysis of the answers showed that of the abused women who answered this question, 48% indicated that subsequent abuse experiences had occurred when they were aged between 16-20 years, or in adulthood.

TABLE 4.03

Frequency distribution of the nature of the sexual abuse experiences

Variable	Categories	Adjusted Frequency % (N = 47)
Abuse Experience	Fondling	43
	Intercourse	51
	Involvement > 2 people	6
Main Abuse Experience	Fondling	40
	Intercourse	59
	Involvement > 2 people	2
Duration of Abuse	< 1 month	65
	< 1 year	13
	1 - 2 years	4
	2 - 5 years	8
	> 10 years	10
Number of Times Abused	Once	26
	Twice	8
	Three -six	6
	Ten or more	18

While depression is the symptom most commonly reported by survivors of sexual abuse, nearly all of the women, abused and non-abused, had been depressed. The findings confirmed the existence of depression in 98% of the total sample. Of the 69% who received treatment for depression, 25% were on medication, 10% were hospitalized and 21% attended counselling. For 56% of the women the depression lasted longer than three months, just three months for 3%, two months for 2%, and for 42% less than one month.

In analysing relationships, 60% were not in a satisfactory relationship and 26% had never had a satisfactory sexual relationship. Furthermore, 39% reported that it was safer to trust no-one and 29% did not trust their partner. Questions about self esteem revealed that 69% of the women had low self esteem, 29% did not believe in themselves, 44% believed people were only nice to them when they had a hidden reason, and 68% felt guilty without knowing why. These results are presented in Table 4.04 on the next page.

In reviewing those items relating to Ellenson's (1985) predictive syndrome the findings reveal that from the total sample of the women some had experienced several items; 80% of the women had bad dreams, 51% had dreams involving threats to their families, 25% reported dreams in which children were being harmed, 50% dreamed about death and 36% had a recurring dream. Anxiety and phobic reactions were also high. A large number (68%) reported fear of dogs, cats and spiders, and 46% had difficulties relating to people socially. Security worried 58% of the women; 13% had a fear of the dark, and 32% worried about being at home alone.

The presence of auditory or visual hallucinations when at home alone was reported by 26% of the women; 17% reported seeing shadows moving outside their house; 28% reported seeing unusual shadows around their bed and 12% saw shadowy figures in the house. Another 44% heard sounds at night, and 15% experienced feeling an evil presence in their home at times. The results are presented in Table 4.05 on page 79.

TABLE 4.04

Frequency distribution of observable consequences of sexual abuse

Variable	Categories	Adjusted Frequency % (N = 93)
Depression	Number depressed	98
	No. treated for depression	69
	No. medicated	25
	Hospitalised	10
	Counselling	21
	No treatment	26
Length of Depression	< 1 month	42
	2 months	2
	3 months	3
	> 3 months	56
Trust/Relationships	Safer to trust no one	39
	Does not trust partner	29
	No current satisfactory relationship	60
	No satisfactory sexual relationship	26
Self Esteem	Do not care about self	69
	Disbelief in self	30
	Hidden reason to be nice	44
	Feel guilty for no reason	68

TABLE 4.05

Frequency distribution of the number who had experienced symptoms of PTSS

Variable	Categories	Adjusted Frequency % (N = 93)
Dreams	Bad dreams	80
	Dreams threatening family	51
	Dreams of children being harmed	25
	Dreams of death	50
	Same dream	36
Anxiety and Phobic Reactions	Particular fears	68
	Social behaviour	46
	Worry of security	58
	Afraid of the dark	13
	Afraid of being alone	32
Presence of Auditory/Visual Hallucinations	Hear strange things when alone	26
	Shadows moving	17
	Sounds	44
	Unusual shadows around bed	28
	Shadowy figures in house	12
	Felt an evil presence in home	15

In an attempt to identify the number of women who had experienced symptoms of the Post-traumatic stress syndrome and to assess the influence of the sexual abuse on their interpersonal relationships, Chi-square tests were carried out with those items on the questionnaire which were considered to be predictive. Table 4.06 below presents these results. The classification "high", "medium" and "low" relate to the predictive potential of each variable.

As shown, when the variable "sexually abused before 16 years" is cross-tabulated with prediction items, it is not significant in predicting symptoms of PTSS. However, an affirmative response to the questions asking about attempted, or actual, sexual contact without giving consent between the ages of 16 -20 years, did show significant differences (Chi-square = 6.8 df=2, p.< 0.03) as did the presence of guilt (Chi-square = 9.8, df2, p.<0.007). Small differences were also noted with other questions where an affirmative response was given. These responses were concerned with school problems (Chi-square = 5.7 df=2, p.<0.05), and the abuse of alcohol (Chi-square = 6.5 df=2, p.<0.03).

TABLE 4.06
Prediction levels associated with symptoms of PTSS
and sexual abuse experience

Prediction & PTSS Variable	Abused (N=93)	Non-abused	df=	P
Sexually abused less 16 yrs			2	0.80
High	13	16		
Medium	20	21		
Low	8	12		
Sexually abused 16 -20 yrs			2	0.03
High	15	14		
Medium	11	30		
Low	4	16		
School Problems			2	0.05
High	12	17		
Medium	12	29		
Low	2	18		
Feels Guilty			2	0.007
High	23	5		
Medium	29	12		
Low	8	12		
Abused Alcohol			2	0.03
High	13	16		
Medium	7	34		
Low	5	14		

Table 4.07 shows that significant differences were found in the type of sexual abuse experienced (Chi-square = 13.4, df=4, p.<0.009). Where the main experience was sexual intercourse, significant differences were also found in the prediction level (Chi-square = 10.9, df=4, p.< 0.027). "High", "medium" and "low" relate to the predictive potential of each variable.

TABLE 4.07

Prediction levels associated with the nature of the sexual abuse experiences

Prediction & PTSS	Fondling	Sex-Intercourse (N = 93)	More I person	df=	P
	Type of Experience			4	0.009
High	3	12	3		
Medium	11	13	0		
Low	7	2	0		
	Main Experience			4	0.027
High	3	14	1		
Medium	9	15	0		
Low	7	2	0		

Where women indicated that sexual intercourse had mainly occurred during the abuse experience (Chi-square = 10.2, df=1, p.<0.03), a significant difference was found in the prediction of the effects of the abuse on the women's relationships. If fondling was the main experience, however, (Chi-square = 5.5, df=2, p.<0.06) it was not significant in predicting effects of the abuse on the women's relationships.

An analysis of the findings also showed that there is an association between sexual abuse, school problems and the ability to form satisfactory relationships (Chi-square =5.7 df=2, p.<0.05). The results of these chi-square

tests are shown in Table 4.08 below. "High", "medium" and "low" relate to the predictive potential of each variable.

TABLE 4.08

Prediction levels associated with an ability to form satisfactory relationships

Prediction & PTSS	Yes (N = 93)	No	df=	P
Main Experience Fondling, Sex-Intercourse, More I person			1	0.03
High	0	5	1	
Medium	5	4	0	
Low	13	11	0	
Type of Experience Fondling, Sex-Intercourse, More I person			4	0.06
High	0	6		
Medium	5	4		
Low	12	12		
School Problems			2	0.05
High	4	4		
Medium	5	7		
Low	8	39		

Hypothesis 1 suggested that there was a statistically high probability that many of the women involved in this study would have a history of sexual abuse. Table 4.02 gives a breakdown of responses to questions relating to any sexual activities the women had been involved with before they were 16 years of age and when they were aged between 16-20 years. When asked

whether they considered the sexual experiences they had reported constituted sexual abuse, 51% of them said yes. Thus, the hypothesis was confirmed.

Hypothesis 2 stated that there would be a significant variation between abused and non-abused women in their ability to form satisfactory ongoing relationships. Chi-square tests were carried out to see if there was an association between prediction levels and the variables relating to relationships contained in the questionnaire. This hypothesis was unable to be supported.

As shown in Table 4.08 there were clear differences in the nature of the sexual abuse experience for the women who had been abused. When the abused and non-abused women were compared, however, no significant differences were found in the prediction of the effects of the abuse on the women's relationships. In order to clarify the situation, further Chi-square tests were carried out, but the questionnaire design did not take into account within-subject variation. Therefore no conclusion could be drawn about which questions were the best predictors for relationship difficulties.

Hypothesis 3 claimed that there would be a statistical difference between the abused and non-abused women in regard to their ever having experienced symptoms of PTSS. Although no significant differences were found in the *sexually abused before 16 years of age* group, there were *significant differences in the group abused between 16-20 years* as shown in Table 4.06. It was important, and interesting, to note that the type of sexual experience that happened during the abuse, and feeling guilty without reason, were the only two items that reached statistical significance.

While the findings showed some differences in prediction levels between the abused and the non-abused women, they were inconclusive. The numbers in the Chi-squares cells were too small to have any real statistical value and

the hypothesis could only be partially supported. In order to be more conclusive, it was decided to analyse those variables which seemed to be significant in predicting symptoms of PTSS. These variables were then entered into the MYSTAT programme for re-analysis.

It was expected that this second analysis of the data (using a multivariate analysis) would support Hypothesis 3. Forty-two of the women in the total sample had been sexually abused before aged 16 years. Sexual abuse by 16 years therefore became one of the main variables.

Table 4.09 and Table 4.10 below were generated from the MYSTAT Stats Rainfall. This analysis of the data produced total observations for each item, the number of cases, the mean, the standard deviation and the range for those sexually abused by age 16 years. Levels of significance were then able to be calculated.

As shown on Table 4.09 and Table 4.10 school problems and feeling guilty were still the only two items that were significant when compared with the variable *sexual abuse before sixteen years of age.* As Table 4.10 shows the items contained in Ellenson's (1985) predictive syndrome were then compared with the variable *sexual abuse before 16 years of age.* No real significant differences between the abused and the non-abused women were found.

TABLE 4.09.

Potentially predictive variables for those sexually abused by 16 years of age

No of times Abused		0	1-2	3+	
N = 105		63	19	23	
Marital status	Never	10	2	3	
	Married	32	13	10	
	Previously	21	4	10	
Child Management Problems	Yes	20	7	13	
	No	32	10	8	
	N/A	11	2	2	
Relationship with Mother	Good	46	12	10	
	Not good	9	7	7	
	N/A	8	0	6	
Relationship with Father	Good	35	10	11	
	Not Good	10	6	3	
	N/A	18	3	9	
Parents Happy	Yes	38	10	10	
	No	21	9	13	
	N/A	4	0	0	
Alcohol Problem in family home	Yes	18	8	9	
	No	45	11	14	
Own Alcohol Abuse	Yes	13	7	7	X2 = 2.35
	No	50	12	16	p = .31
Own Drug Abuse	Yes	13	5	3	X2 =1.19
	No	50	14	20	
School Problems	Yes	18	1	10	X2 = 7.67
	No	45	18	13	df = 2
					p =.022
Truancy	Yes	15	6	7	X2 =.62
	No	48	13	16	df =2
					p =.21
Qualifications	Yes	41	12	13	
	None	22	7	10	

Table 4.10

Observable consequences of sexual abuse by16 years of age

No of times Abused		0	1-2	3+	
N = 105		63	19	23	
Bad Dreams	Yes	48	14	22	X2=4.567
	No	15	5	1	df = 2
					p =.10
Dreams Children Harmed	Yes	13	4	7	
	No	49	14	16	
		N/A	1	1	
Same Dream	Yes	19	6	10	
	No	43	12	13	
	N/A	2	1		
Nervous	Yes	23	6	9	
	No	40	13	14	
Afraid of the Dark	Yes	38	13	18	
	No	25	6	5	
Evil presence felt	Yes	38	13	18	
	No	55	17	16	
	N/A	1			
Trust no-one	Yes	23	11	10	X2 = 2.77
	No	40	8	13	df = 2
					p =.25
Feels Guilty without reason	Yes	37	11	18	X2 = 3.00
	No	26	8	23	df = 2
					p= .2
Trouble Sexual Behaviour	Yes	7	4	5	X2 = 2.08
	No	56	15	18	df =2
					p =.35
Relationship Broken because of Sexual Problem	Yes	16	4	9	
	No	44	14	14	
	N/A	3	1		
Life Worth-while	Yes	54	17	19	
	No	8	2	4	
	N/A	1			

MYSTAT allowed for data manipulation and the next two tables show variables that appeared to be significant in predicting symptoms of PTSS. The items relating to symptoms of PTSS were then correlated with the variable *sexual abuse before aged 16 years*.. Table 4.11 is a breakdown of the number of PTSS symptoms experienced by the sixty-three non-abused women, the nineteen who had been abused on one or two occasions, and the twenty three who had been abused three or more times. A comparison of the three groups showed that 48% of the women who were abused three or more times experienced seven or more symptoms of PTSS. This was the only real difference found.

TABLE 4.11

Total PTSS symptoms experienced by those sexually abused before 16 years of age

No of times Abused		0	1-2	3+
N = 105		63	19	23
Total PTSS Symptoms Experienced	0-2	13 (21%)	5 (26%)	2 (9%)
	3-6	35 (55%)	10 (53%)	10 (43%)
	7 +	15 (24%)	4 (21%)	11 (48%)

Of the twenty-three women abused more than three times, seven had previously disclosed the abuse and sixteen had not. Rates of disclosure and non-disclosure of sexual abuse were then correlated against the number of PTSS symptoms experienced by the women. The findings are presented in Table 4.12 and show that 57% of the women who had disclosed the abuse had experienced seven or more symptoms of PTSS compared to 44% of those who had not disclosed. However, 50% of those who had not disclosed had experienced three to six symptoms of PTSS compared with 29% from the disclosed group.

TABLE 4.12

Disclosure of Sexual Abuse and experience of symptoms of PTSS

		Disclosed	No Disclosure
N = 23		7	16
Total PTSS Symptoms Experienced	0-2	1 (14%)	1 (6%)
	3-6	2 (29%)	8 (50%)
	7+	4 (57%)	7 (44%)

Given the above findings the second analysis could not confirm Hypothesis 3. Nor could it confirm the use of Ellenson's predictive syndrome.

If looked at in another way, however, then some significant variables emerge. For example, what is it that predicts the number of PTSS symptoms? Is it sexual abuse at all, or is it something else?

Seven items considered to be predictive of PTSS were collated and compared with other apparently significant items. These items are listed in Tables 4.13 and 4.14. These tables are a multiple regression analysis of various predictive items which, as shown, are significant in predicting levels of PTSS.

TABLE 4.13

Association between Prediction Variables and Total symptoms of the PTSS in the whole sample

Variable	r	t	p
N = 105			
Parents happiness	0.29	3.01	0.003
School problems	0.20	2.02	0.041
Sexual contact >16yrs	0.27	2.88	0.005
Feels guilty	0.44	4.95	0.005
Relationship breakdown	0.40	4.29	0.005
Life worthwhile	0.20	2.03	0.045

TABLE 4.14

Duration of Sexual Abuse and experience of symptoms of PTSS

Variable	r	t	p
N = 52			
Duration of abuse	0.28	2.07	0.004

For analysis of prediction levels, items relating to PTSS were collated and re-named as Total PTSS, those relating to sexual abuse before 16 years of age were re-named as "No. abuse1", and those relating to sexual abuse between 16-20 years were re-named as "Abuse 16". These items then

became the dependent variable for the purposes of analysis. They were collated and compared with other apparently significant variables. Table 4.15 shows the results of this analysis.

TABLE 4.15

Multiple Regression of Prediction Variables with Symptoms PTSS Variables

1. N = 52

Multi R = .55 R squared = .30 df= 4.92 F=9.88 p=0.000

Variable	Co-eff	t	p
Relationship breakdown	-0.28	3.06	0.003
Parents happiness	0.15	1.66	0.101
Feels guilty	0.27	2.84	0.006
Sexual contact >16 yrs	-0.16	-1.73	0.087

2. N = 52

Multi R = .49 R squared = .24 df= 3.93 F=9.75 p=0.000

Variable	Co-eff	t	p
Relationship breakdown	-0.35	-3.82	0.000
Parents happiness	0.21	2.25	0.027
Sexual contact >16 yrs	-0.17	-1.79	0.077

3. N = 52

Multi R = .36 R squared = .13 df= 3.97 F=4.81 p=0.004

Variable	Co-eff	t	p
Parents happiness	0.25	2.56	0.012
Sexual abuse <16 yrs	0.05	0.45	0.651
Sexual contact >16 yrs	-0.20	-1.99	0.050

The expression of feeling guilty is highly correlated with the variable *parental happiness*. It is questionable however whether "feeling guilty" is a "symptom" of PTSS. If the variable "feels guilty," is removed, as noted in multi-regression analysis 2, the other items are still significant in predicting symptoms of PTSS. When comparing "parental happiness", "No. abuse1", and "sexual contact between 16-20 years", the "No. abuse1" variable alters the level of significance.

Parental happiness, school problems, unwanted sexual contact between 16-20 years, and length of time before disclosure of sexual abuse are all significant in predicting symptoms of PTSS but not necessarily accurate in predicting sexual abuse.

Discussion of the Research Results

The studies reviewed in Chapter 3 suggested several factors influence the impact of sexual abuse on a child. In this section the results from the survey are interpreted and compared with the findings of the studies reported in the literature. The factors are discussed separately. Generally the survey findings are congruent with the literature.

Impact of Age of Onset. Table 4.02 gave a breakdown of age when the women in this survey were first abused. Later, when looking at prediction levels for PTSS, a multivariate analysis of the data showed that while there was a nonsignificant trend for women sexually abused before sixteen years of age to experience some symptoms of PTSS, this decreased when controlled for other factors. The findings showed that symptoms of PTSS were much more evident among the women abused between 16-20 years ($p < 0.005$).

The findings are consistent with the literature in that they do not show a clear relationship between age of onset of the abuse and trauma, especially when controlled for other factors. Age at onset, however, relates to other factors,

such as relationship to the offender and duration of the abuse. Until more comprehensive studies are undertaken it is not possible to say whether age has any independent effect or is simply masked in complexity.

Impact of Gender of the Offender. Of the 51% of women sexually abused in this survey, 98% of them were abused by males. Such a high percentage of male abusers makes any comparison of the impact of gender difficult, and therefore no further analysis of this factor was undertaken.

It also showed that sexual abuse in New Zealand appears no different from other countries, as in most cases the abusers were male and known to the child (Table 3.03). Little work has been undertaken looking at the impact of abuse according to the sex of the offender. In the two studies that did take this factor into account sexual abuse experiences with male perpetrators were rated as being much more traumatic than those with female perpetrators.

Impact of Relationship to the Offender. As shown in Table 4.02 in this study nearly 13% of the women identified in this study were abused by their natural or adoptive father, and 73% by a person known to them. Only 22% were abused by strangers. Unfortunately, stepfathers and foster/fathers were not separated out from the 73% of abusers in the "known to the child category" thus the low figure recorded for "father" would skew the data, thereby making further comparisons unreliable.

Sexual abuse by a close relative or a trusted person has been considered to be more traumatic than abuse by a distant relative or unknown person. This is because of the betrayal of trust involved, even though abuse by a more distant person may elicit more fear. The literature consistently reported, however, that compared with abuse by other perpetrators, the abuse was found to be more traumatic when fathers, or father figures, were separated out from other family members.

Impact of Child, Sibling, Cousin, and Adolescent Child abuse. In looking at the relationship of the abuser in this study there was a category for brother or sister, or other relative. Children, adolescents or young relatives were not separated out from grandfathers, uncles, or older cousins. Thus, analysis of this question to determine impact of the abuse by a member of this population of abusers was not possible, as any comparisons made would be unreliable. All that can be said is that the findings from the data showed that four of the women were abused by brothers, and ten by other male relatives, giving an overall 13% as being abused by a male relative or sibling.

Recent attention to the signficance and effects of sibling and cousin incest has begun to challenge the acceptance of sibling abuse as not being harmful. It seems that younger children construe abusive experiences differently from an older child and the resulting trauma depends on the cognitive level at which a child is functioning. Furthermore, family response to the abuse of a younger child may be different to family response to the abuse of an older child.

Impact of Type of Sexual Act. The survey findings were generally consistent with the literature. A variety of sexual acts were involved. Fondling occurred in 40% of cases. Attempted, or actual sexual intercourse occurred for 59% of the women and was one of the few findings that were significant at the $p<0.009$ level as shown in Table 4.07. Nearly 2% reported the involvement of two or more offenders. As shown in Table 4.07 this study found that the association between the type of experience and later symptoms of PTSS was significant at the $p>0.027$ level.

The literature showed that there was some disagreement about whether sexual intercourse and penetration are demonstrably more serious than hand-genital contact. While some studies showed that molestation involving more intimate contact was more traumatic than less intimate contact, others did not find a clear differentiation between the two. Generally the conclusions

reached were that the most negative consequences for children were associated with abuse by fathers, genital contact, a closer relationship of the offender to the child, greater frequency and longer duration of abuse.

Impact of the frequency and duration of the abuse. Table 4.03 shows the duration and frequency of the abuse for women in the survey. Table 4.14 showed that duration of abuse was significant at the $p<0.004$ level when looking at the prediction potential of the variable with symptoms of PTSS. The studies reviewed in the literature reached contradictory conclusions about any relationship between duration and frequency of sexual abuse and associated trauma.

The Impact of Telling or Not Telling. Table 4.02 shows the length of time between the occurrence of the abuse and the time before disclosure by the women in the survey. As Table 4.12 shows, the second analysis of the data found that of the seven who had experienced multi-abuse and who had disclosed the abuse, one reported having experienced 0-2 symptoms of PTSS, two experienced 3-6 symptoms and four experienced 7+ symptoms. Of those who had never disclosed the abuse before answering the questionnaire, one had experienced 0-2 symptoms, eight experienced 3-6 symptoms and seven experienced 7+ symptoms. On a multivariate analysis, however, this factor became insignificant, which again is consistent with the literature.

The decision to disclose, however, may be related to several other factors which prevent a clear indication as to the effects of telling or not telling about the experience. While silence about an experience may cause individual suffering, social reactions and consequences may not be so harsh if the event is reported later. Disclosure about sexual abuse is currently more openly encouraged. Women are more likely to be believed now than in the past.

Furthermore, the studies did not support the view that recovery from the negative effects of sexual abuse can occur until the abuse has been disclosed and dealt with appropriately. While initially finding a correlation between trauma, and disclosure and non-disclosure of sexual abuse experiences, most studies found the association became insignificant when controlled for other factors.

The impact of the use of force and/or violence. In both the first and second analyses of data from the survey, the numbers reporting the use of force or coercion were too small to be significant. Whether the degree of force or coercion is related to the presence or absence of psychosocial sequelæ in survivors of sexual abuse is debated throughout the literature. Some studies maintain that the use of force is strongly correlated with trauma, while some reported findings to the contrary. Yet another group report that while force is associated with greater impairment, in a multivariate analysis this association drops to below the level of significance .

Impact on Social Functioning. Table 4.08. which summarises the findings from this study, reveals that 28% of the abused women had experienced problems at school, with significant differences ($p.<0.05$) in prediction levels of PTSS. Nearly 27% had truanted, and 9% were expelled from school, with 17% running away from home for varying lengths of time. These findings were confirmed (Table 4.13) in the second analysis, which, using a multivariate analysis, was controlled for other factors ($p<0.041$). Throughout the literature reference is made to sexually abused children having problems at school, truanting and running away from home.

Results show that in this study 39% of the women who had children had child management problems. Table 4.09 which summarises the second analysis of data confirmed 57% of the women who had been sexually abused more than once had child management problems compared with 31% of those who reported no abusive experiences. When compared with the total PTSS

factors on a multivariate analysis, child management problems became insignificant as a predictor of childhood sexual abuse. This is consistent with the literature which suggests that women who have been sexually abused as children often experience difficulty with the parenting role.

Several studies discussed in the literature review reported that a significant number of childhood sexual abuse survivors experience later difficulties in relationships, problems with sex and relating to men, as well as having a fear of men in general. Revictimization was also reported in the literature and several researchers found that survivors of childhood sexual abuse develop substance abuse problems more frequently than would be expected by chance alone.

In an attempt to identify the number of women who had experienced symptoms of post-traumatic stress syndrome, and to assess the influence of sexual abuse on their interpersonal relationships, Chi-square tests were carried out in the initial analysis with those items on the questionnaire which were considered to be predictive. Tables 4.07 and 4.08 show that on Chi-square tests no significant differences were found between the abused and the non-abused women.

In the second analysis, Table 4.13 found relationship breakdown because of sex to be one of the variables predictive of PTSS at the $p<0.005$ level. It could not be said however, that earlier sexual abuse was the reason for the relationship to break down in the first place. Therefore, while it was a predictor of PTSS, it was not necessarily a predictor of previous sexual abuse.

Of the women abused as children in the survey, 48% had been subsequently abused either as teenagers, or between 16 - 20 years of age, or as adults. These experiences, listed on the questionnaires, showed that half of the 48% indicated that rape, or attempted rape, had occurred.

Several of the women in the survey who reported sexual abuse also reported having had substance abuse problems. The initial Chi-square tests using prediction variables were significant at p= <0.03 (Table 4.06). The second analysis showed an association between sexual abuse before age 16 years and alcohol problems at the p= <0.022 level (Table 4.09). However, when controlled for other factors, alcohol abuse, while being a significant problem in this sample of women, was not a predictor of sexual abuse.

Studies show depression to be the symptom most often reported among adults with histories of childhood sexual abuse. However, evidence is split about the effects of sexual abuse and the severity of the associated trauma experienced in later life. In this study it was found that 98% of the respondents experienced depression at some stage. For 56% the depression had lasted for longer than 3 months. However, the data did not allow for comparisons between non-abused and abused women for predictive symptoms. As depression was so common amongst the total sample further comparisons were not possible.

Conclusion

The study leads to the conclusion that sexual abuse is a common experience for many of the women presenting at counselling centres. However, the possibility of any sexual abuse experiences being a contributing factor in a woman's need for counselling is not always considered by the professionals referring the woman, or by the woman herself.

Some of the women in the survey had already spent a considerable amount of time in treatment centres of one kind or another in order to deal with their "psychological problems". However, sexual abuse experiences had never previously been discussed or detected. Women survivors rarely reveal a history of sexual abuse on initial contact with the agency, yet the findings from this survey confirmed that 51% of the women attending for counselling had

been sexually abused. Only one had been referred specifically for sexual abuse counselling. The balance had presented themselves, or been referred, for a variety of reasons.

Therefore, in order to elicit a response that confirms a workers' suspicion that a woman may have been sexually abused, the right questions need to be asked at the right time. Ellenson (1985, 1986) claimed that even if sexual abuse is denied by the client, if the symptoms are present, then a counsellor's index of suspicion should be high. The items in the questionnnaire were based on Ellenson's theory.

In analyzing the results from the questionnaire this study cannot support the use of Ellenson's (1985,1986) predictive syndrome as an aid to the prediction of histories of sexual abuse. The findings were more supportive of the beliefs of the minimalists' group than the maximists'. The minimalists maintain that the long-term effects seen in cases of sexual abuse survivors are not necessarily a function of sexual abuse, but could be related to other pathological elements such as psychological abuse, parental neglect, or family disorganisation.

It is important to note, that while the findings of this study are congruent with the claims of authors that parental unhappiness is just as likely to contribute to symptoms of PTSS in adult life as is childhood sexual abuse, it is the use of Ellenson's predictive syndrome which this study cannot support, and not the symptoms experienced by survivors.

The results do show that clinical depression, fear, guilt, anxiety and relationship difficulties are all observable consequences of sexual abuse, a pattern which Ellenson also confirms. Furthermore is seems evident that women sexually abused between 16 and 20 years of age are more likely to experience symptoms of PTSS as a result of that abuse than those abused before sixteen years of age.

PART TWO

The preceding chapter looked at the use of Ellenson's predictive syndrome as a means of identifying women with sexual abuse histories. Ellenson's predictive syndrome was not able to be supported. Given that the estimated prevalence rate of sexual abuse in the general population is high (Russell,1983), important questions need to be asked about how practitioners in the field precipitate disclosure of sexual abuse among women clients. Part two addresses this question. During 1990 and 1991 the practice of twelve practitioners was examined from five different counselling services. The research methods used and the results of that inquiry are discussed in the following chapter.

CHAPTER 5

PRECIPITATING DISCLOSURE OF SEXUAL ABUSE IN PRACTICE

Women attending counselling services rarely reveal sexual abuse experiences upon initial contact with the agency. Access to counselling services occurs in a variety of ways. Whereas some clients are referred for psychological problems in general, others attend because of a particular "disability". The access route includes community-based counselling centres, alcohol and drug services, medical, or psychiatric services, and practitioners working in private practice. The clients are normally referred for "counselling".

One of the aims of counselling is to relieve the emotional and psychological distress of another person. In order to carry this out, it is necessary for the practitioner to create a safe and supportive space in which the client can explore and express personal feelings and thoughts in an atmosphere of respect and trust (Goldstein,1980). It is also assumed that the practitioner and the client will explore alternative ways of behaving. The counselling process starts with "intake." This is the chronological point at which a referral is accepted into an agency. Once accepted, an "assessment" of the presenting problem the person presents with is made.

Assessment involves an evaluation of a client's problem and planning of the appropriate intervention method to deal with it effectively. It also involves "contracting" to work with the client for a given time after which, if the problem is resolved, the counselling relationship is terminated. Both intake and assessment procedures are determined by "agency philosophy".

Agency philosophy, within the context of counselling, can be defined as the "human action, or conduct, that happens in a particular agency". Intake,

assessment, evaluation, intervention planning, contracting and termination are the core concepts of any counselling process.

Other factors such as the gender of a practitioner, can also influence the counselling process and play a part in the eventual outcome of counselling. In most counselling agencies today there is agreement in principle that any preference indicated by the sexual abuse survivor regarding the gender of a counsellor should be given consideration. However, the literature also contains controversial and contradictory opinions on the question of who works with whom. Different people have different reactions, depending on their unique situations, but over-identification of the counsellor with the survivor, anger towards the abuser by the counsellor, transference of negative feelings to the counsellor, and whether co-therapists of both sexes should be involved in counselling survivors, are all issues that have yet to be resolved.

Some authors (Herman & Hirschman,1977; Silverman,1977; Herman,1981), when considering the additional trauma a woman survivor may experience as a result of an interaction with males subsequent to sexual assault, have suggested that it may be easier for a survivor to talk to a woman counsellor. These same authors also suggest, however, that a female counsellor may tend to over-identify with the victim, and/or become so angry with the abuser that she avoids the topic and does not recognise the survivor's ambivalent feelings towards him, thus limiting the effectiveness of treatment.

Bergart (1986) made similar comments about the possibility of a female group leader over-identifying with the victim, or becoming angry with the woman's passivity towards the abuser. She also comments that, " . . . . a male counsellor may identify with the abuser and blame the victim" (1987: 273). Others (Jehu,1988) argue that, where male therapists are concerned, if problems such as mistrust of men or the oversexualization of relationships are replicated in the treatment situation, then a male therapist can provide an

appropriate corrective experience. Becker and Skinner (1984: 229) summarise these issues when they state, " . . . . that in working with survivors of sexual abuse one of the issues that has never been addressed adequately is the use of male therapists".

The avantages and disadvantages of co-therapy was also discussed in the literature. Deighton and McPeek (1985) consider it essential that abused women explore their feelings with a competent male counsellor during the treatment process. Hildebrand and Forbes (1987) agree that a male-female leadership pair allow group members who are fearful of males to see female therapists as lending a certain amount of credibility and safety to the therapy team. However, while co-therapy can be useful in providing role models, Hildebrand and Forbes suggest that, " . . . it may prove to be an initial barrier for women who are still at a stage where they are unable to relate to any male, in other than a negative way" (1987: 293).

All these suggestions and other unresolved issues concerning the influence of the gender of the therapist with female survivors, need to be systematically investigated. The important message is that practitioners working with survivors of sexual abuses must constantly be aware of possible reactions clients can experience to the counsellor's gender, and must be able to interpret the reaction with the client when appropriate. Given this brief overview and explanation of counselling and some of the issues involved, this inquiry looked at what actually happens in the practice setting. In order to do so certain questions needed to addressed. Questions such as, what are the main influences on the counselling process? Where in the process do they occur? For example, is it at the point of entry, during the assessment, or the intervention phase? Are they related to the extent of the intervention? Is the gender of a practitioner an issue? Is one model of practice more effective than another?

METHODOLOGY

Grounded theory, or "qualitative comparative analysis" as developed by Glaser and Strauss (1967), provides a useful framework for attempting to gain an understanding of what happens in the counselling process. This approach (a form of field methodology) aims to generate theoretical constructs which explain actions in the social context under study. It is, therefore, helpful in attempting to study complex areas (such as the emotional and social effects of sexual abuse) where salient variables have not been identified.

Such an approach consists of a series of hypotheses linked together in such a way as to explain the phenomenon. As described by Glaser and Strauss it is a systematic process of data collection, organization and analysis, which puts " . . . a high emphasis on (developing) theory as a process, as an ever developing entity . . . not a finished product" (1967: 32).

It is a strategy which enables social workers to develop practice theories relative to the phenomena they are observing. It encourages the capturing of context and meaning. Used in this way, grounded theory is more a strategy for the construction of a *practice theory* than a methodology. This is why this approach has been utilised in examining how practitioners precipitate women clients to disclose histories of sexual abuse.

Because (as shown in chapter 1) there is no generally accepted definitive description of childhood sexual abuse, most researchers construct an operating definition for the purposes of their own study. However, in this inquiry it was the client who decided if a sexual experience had been a negative one or not. Therefore it was the client, and not the practitioner or the researcher, who defined sexual abuse. The task of the practitioner is to precipitate client disclosure of previous experiences of sexual abuse.

The aim of grounded theory is to discover the dominant process in the particular social setting under observation leading to the generation of hypotheses that may have a generalized applicability (Field and Morse,1985). It is a combination of inductive and deductive approaches, and like all methods, the investigator focuses the research according to a conscious selective process.

The outcome of grounded theory is that of building middle-range theory, either substantive or formal. In this situation it was *substantive* in that the investigation was restricted to a single area of inquiry, that is, the counselling process. It was *formal* in that it was developed for a conceptual area of inquiry i.e., the identification of women who have experienced childhood sexual abuse. Both substantive and formal theory are grounded in empirical data and represent the outcome of a blurred and intertwined process of data collection, coding and analysis (Glaser & Straus,1967: 43).

The advantages for social work research of this form of theory development is to provide frameworks which are rich in meaning, as well as information about counselling activities previously undocumented. The steps involved in theory building, as outlined by Glaser and Strauss (1967), are utilised as a "description" of the research process.

In using a qualitative approach to research, this inquiry set out to link a series of hypotheses together in order to address two elements of the counselling process. The first was to identify and analyse the process that occurs in practice when counselling women, and thereby generate theory which is applicable to identifying women who may have experienced childhood sexual abuse. The second was to gain an understanding of how social workers/practitioners precipitate women clients to disclose a history of sexual abuse during counselling.

Sample: The Participants

There are several entry points through which survivors of sexual abuse seeking to deal with their psychological problems can gain access to the helping services. In order to gain a comprehensive overview of the counselling process twelve social workers/practitioners from five different counselling services were invited to participate in a series of in-depth interviews.

The sample for the first interviews included social workers/practitioners from a community based Counselling Service, an Acute Psychiatric service, an Alcohol and Drug outpatient service, a Sexual Abuse Counselling Centre, and practitioners in private practice. Nine of the participants involved in the first interviews, two male, and seven female practitioners, took part in the second interviews.

The age range of the participants was 25 to 58 years. Eight participants were women and four were men. All of the participants were trained in a health-related discipline and regularly attended in-service training, workshops and seminars related to their work. It was expected that the knowledge base, skills and practice abilities of all the participants would be of a similar level.

The Interviews

Individual focused interviews were undertaken with twelve participants during 1990 and 1991. Appendix 6 shows the open ended questions that were used in the first set of interviews. Each interview lasted approximately one hour. The form of the interview opening was considered crucial and it was decided that an introductory statement aimed at increasing the participant's motivation to co-operate in the first few minutes of the interview be used. This statement led quite naturally into the questions which were designed to encourage the

respondent to freely discuss the ways in which she or he worked with clients. They were invited to comment on the following: what they considered influenced the counselling process; gender issues; currrent effects of the abuse; models of practice; whether one model of practice seemed more effective than another.

The second set of interviews attempted to look more specifically at what precipitates a situation in which clients will disclose their sexual abuse experiences. In these interviews the questions were aimed at determining the various ways in which a client behaves that alerts a practitioner to the possibility that she may be a sexual abuse survivor (Appendix7). Questions about what the practitioners did with the information, and questions as to how they told a client about their thoughts, were also asked.

Given the questions to be considered in the second interviews, it seemed inappropriate to re-interview the sole sexual abuse counsellor. The reason for this decision was that as sexual abuse was the reason clients attended the sexual abuse centre, "disclosure" of the abuse was not an issue. As the male practitioner from the Psychiatric Service had made it clear in the first interview that he did not work with survivors of sexual abuse, he also was excluded from the second interviews. One of the other male practitioners was away on leave for several weeks and was unable to be contacted for another interview.

Interviewing in this way moved away from more formal methods, but still gave the interviews a standard form. It ensured that all the relevant topics were discussed with all the participants, as well as ensuring they had the opportunity to fully develop their own views. This format also enabled the interviewer to choose how to phrase questions and whether to explore or probe, while at the same time keeping within the framework imposed by the topics to be covered. In areas such as this inquiry, where the subject matter is highly complex or emotional, the flexibility of the informal approach is more

likely to succeed in getting the respondent's true perception (Moser and Kalton, 1981).

Elizabeth Chesterman, a social work student on placement in her final year from Canterbury University, was interested in carrying out the interviews as a learning experience in field research and design, as well as fulfilling the requirements of a research paper for herself. While having the necessary skills to carry out the interviews successfully, Elizabeth Chesterman (hereafter referred to as the research officer) was also experienced and interested in working with sexually abused women.

It seemed important that the research officer feel free to acknowledge her own beliefs and values if asked, yet at the same time encourage respondents to talk about their beliefs and values pertaining to the questions. Both researchers were aware that most of the participants were known to one or other of them, and acknowledged that this could affect the interaction that occurs during the interview process.

Ongoing supervision, training and briefing of the research officer was essential throughout the fieldwork for several reasons. These mechanisms were designed to ensure that there was no difficulty in setting up the interviews, and that the interviews were in accordance with the research design. It was also important to ensure that the research officer was comfortable with the interview process, and that her interest was maintained. Because most of the participants were known to both researchers, unsolicitated feedback about how the practitioners experienced the interviews was given. All comments were very positive in regard to Elizabeth's performance as an interviewer and to the possibilities of the final outcome of the research itself.

Data Collection

Responses were obtained during one-hour individual interviews with the participants. All the responses to the questions asked were recorded. After considering all the possibilities it was agreed that for the first interviews the best method for recording the data was the use of an audio-recording device. Following each interview the research officer would play back the recording and summarise the interview. This method would have the advantage of leaving her free to concentrate on the interviews, as well as providing the researcher with a record of how the interviews were being conducted, and a test of the accurracy of her summarising.

During the second interviews to speed data analysis the participants' responses were recorded in writing during each interview. The format allowed the research officer to choose how to phrase her questions while at the same time keeping within the framework imposed by the topics to be covered.

Procedures Used In Processing The Data

Analysis of grounded theory data differs from that of more traditional methods. It is an ongoing systematic process of data collection, organisation and analysis. The researcher begins with some general subject awareness, then as the data becomes available collects, codes, and analyses the information in order to identify the next category, subject, object to be sampled (Glaser and Strauss, 1967). In this study the data were collected, coded and then collated depending on the number of times each item was used.

The findings are presented mainly in tabular form. On completion of the interviews, all the data collected was coded and analysed. Each item of data was analysed for content and recorded on data coding sheets. These were then sorted according to general focii (agency philosophy etc).

Data Analysis and Intrepretation

The questions asked in the first interviews seemed to provide natural categories for coding and comparing the data. "Categories" and "properties" are concepts indicated by the data. Glaser and Strauss (1967) define a "category" as a conceptual element of the theory, and a "property" as a conceptual aspect or element of a category. From the analysis it became apparent that some collapsing of the categories was also required. For example, answers to questions about the practice model used in questions four and five tended to be very similar. The following is a summary of the findings.

The main Influences on the counselling process were identified as follows: *Agency Philosophy.* The practitioners were asked whether they considered agency philosophy had an influence on the counselling process. All responded that the philosophy of an agency is often reflected in the name of the agency which suggests the sort of service offered. For example, the names Alcohol and Drug Centre, Counselling Centre, Psychiatric Services and the Sexual Abuse Counselling Centre, all specifically state their main function and the reason for attendance tends to be reflected in the type of agency attended. Even though some clients are seen privately, rather than in State-funded agencies, because referrals from the Family Courts or Accident Compensation Corporation (ACC) state the reason for the referral, in the first instance the name determines the reason for being seen.

Intake Procedures. While related to agency philosophy, intake was considered by all of the practitioners to be one of the main influences on the counselling process. Issues such as waiting lists at this stage were seen as having a major influence on the counselling process.

Usually there is a precipitating factor which encourages a client to seek counselling at a particular time. With the exception of the psychiatric services,

intake was seen as an ideal time for disclosure of sexual abuse to occur. However, all the practitioners said that in order to get disclosure you needed to ask the right questions at the right time and delayed appointments impacted on this process.

Practitioners pointed out that generally, client attendance at all of the above services is voluntary, with the exceptions being where a client is admitted under the *Mental Health Act* to the Psychiatric Services, or the Court has requested a client attends for treatment at an Alcohol and Drug Service. This means clients attend the services because they, or their families, perceive they need help with a specific problem, and that in the main, they are ready to do something about the problem now.

In regard to the influence intake procedures may have on the counselling process, all the practitioners mentioned the clients' first impression of the agency as being important. For example, the environment of the waiting room at one of the services was not seen as benefical because of overcrowding, and the mixing of clients in differing stages of drug withdrawal. Both intake and enviromental factors were felt to be demoralising for the prospective client.

Other factors, such as practitioners being on time, personally greeting their clients, the counselling room itself, ensuring that the client feels comfortable, and assuring the client of the confidentiality of the interview were considered important.

Assessment Procedures. It became clear from the interviews that the type of agency seems to influence what happens in the assessment interview. For example, if a person seeks help at an Alcohol and Drug Service, then it is important to get a full history of the substance abuse problem. In the Psychiatric Service, at least initially, treating the psychiatric symptoms is of utmost importance. While no specific inventories have to be used for

assessment at the community Counselling Centre, there was still an expectation that somehow "psychological problems" would be the focus of the assessment interview.

Formal inventories of any kind looking for specific information were seen as an influence on the counselling process by six of the practitioners, as time constraints for the assessment process often determined whether or not any other problem was looked. While all the practitioners felt it was important to ask questions about negative sexual experiences in the initial interview, it was also acknowledged that the most important aspect was to engage the client. Two of the four Alcohol and Drug practitioners felt it was crucial to go for disclosure in the first interview, particularly for the Drug Clinic clients, as they believe the worker has only one chance to ask the right questions in that service.

As a way of precipitating disclosure of negative sexual experiences, the Private Practitioners, the Psychiatric Social Workers and the Social Workers in the Counselling Centres all felt it was important to include questions about negative sexual experiences in initial assessment interviews. They believed, however, that while the answer at that stage might be negative it did not mean sexual abuse could be ruled out. The practitioner working in the Sexual Abuse Counselling Centre also saw environmental factors as being important. As the agency's function was specifically sexual abuse counselling, however, the other issues mentioned were not apparent in this service.

Models of Practice. In the previous section the practitioners stated they saw one of the main influences on practice as being the primary function of their agency. For example, if a practitioner worked in the Alcohol and Drug centre, then this tended to influence his or her counselling practice because it determined the practice model being used. When asked about the practice model they considered to be the most effective for working with survivors of

sexual abuse, the practitioners responded by giving a list of the "intervention methods" they used. No full explanation of these methods is given here, as to do so would be a long and complicated process far beyond the brief of this study.

With the exception of the sexual abuse counselling service, all the agencies are so-called short term, or crisis intervention agencies. Most of the practitioners, however, saw the length of the intervention period being determined by the need of the client, rather than by strict agency policy. If sexual abuse was the presenting problem, then options for counselling, including the possibility of referral out of the agency, were discussed at the initial interview.

Table 5.01 below is a summary of the methods used. Generally all the practitioners work eclectically (EC), using what method seems to be appropriate at the time, with both male and female practitioners using gestalt (GE), action methods (AM), empowerment (EM), and life stories (LS). Women practitioners specifically used a Feminist Perspective (FP), a Human Development Model (HD), FamilyTherapy (FT), Visualisation (VP), Social Learning theory (SL), and a Client Centred Approach (CC), in assessment. Male practitioners included the use of Rational Emotive Therapy (RE), Transactional Analysis (TA) and Relaxation Training (RT) as practice methods during the process of assessment.

TABLE 5.01

Practice Methods and Times Used

Male Practitioners	RE	GE	TA	AM	FP	HD	EM	RT	FT	VP	LS	SL	CC	EC	Total Methods Used
1.	X	X	0	0	0	0	0	0	0	0	0	0	0	X	3
2.	0	0	X	X	0	0	0	X	0	0	0	0	0	X	4
3.	0	0	0	0	0	0	X	0	X	0	X	0	0	X	4
4.	0	0	0	0	0	0	0	0	0	0	0	0	0	X	1
Totals for Males	1	1	1	1	0	0	1	1	1	0	1	0	0	4	12
Female Practitioners															
5.	0	0	0	0	X	0	X	0	0	0	X	X	0	X	5
6.	0	0	0	0	X	0	0	0	0	0	X	X	0	X	4
7.	0	0	0	X	0	X	0	0	X	0	0	0	0	X	4
8.	0	0	0	0	0	0	0	0	0	0	X	0	0	X	2
9.	0	X	0	0	0	X	X	0	X	0	0	0	0	X	5
10.	0	0	0	0	X	0	0	0	0	0	0	0	0	X	2
11.	0	0	0	0	0	0	X	0	0	0	0	0	X	0	2
12.	0	0	0	0	0	0	0	0	0	X	0	0	0	X	2
Totals for Females	0	1	0	1	3	2	3	0	2	1	3	2	1	7	26
TOTALS BOTH	1	2	1	2	3	2	4	1	3	1	4	2	1	11	38

[a] Note: X= this method used
0= this method not used

Gender Issues. All the women counsellors saw the gender of the practitioner as an issue, and four stated their belief that men should never work with sexually abused women. The other four women all believed it should be women working with women, but it must be the client's own choice, and not the counsellor's, that determines who works with whom. Three of the women counsellors stated that at times, after resolution of the effects of the abuse itself, it may be appropriate for a male counsellor to be involved as a co-worker.

Three of the male practitioners, while believing it to be the women's choice, had worked with women sexual abuse survivors at some stage. For two of them their gender was not an issue, and one of these two considered it as perhaps more therapeutic to have a male rather than a female counsellor. The third male practitioner stated that he had a policy of not working with women survivors of sexual abuse unless a women specifically asked for him to do so. The fourth male practitioner considered that expertise and a woman's choice, but not gender, should determine who works with whom. He also reported that he did not work with survivors as he did not have any expertise in this area of practice.

Effects of the Abuse Now. Most of the practitioners mentioned that women rarely reveal a history of sexual abuse on initial contact with the agency, unless of course sexual abuse is given as the presenting problem. From the literature it can be seen that women clients present with a number of different problems including depression, suicide attempts, anxiety, low self esteem, difficulties in relationships, problems with sex and men in general, drug and alcohol abuse and difficulty with the parenting role. Given this large range of symptoms experienced by survivors, how then are problems related to sexual abuse identified without the women seeking help revealing a history of sexual abuse? A question relating to this issue was included in the practitioner interviews. Table 5.02 below is a summary of symptoms reported by the clients, or observed by the practitioners, during counselling.

TABLE 5.02

Reported Existing Effects of Abuse for Clients in Practitioner Study

Effect Noted	Practitioners 1	2	3	4	5	6	7	8	9	10	11	12	Total Times
Alcohol & Drug Dependence	X	X	0	0	X	X	X	0	0	0	0	0	5
Anger/difficulty relating to men	0	0	0	0	0	0	0	X	0	0	0	0	1
Lack of trust in people	0	0	0	0	X	X	0	X	0	0	0	0	3
Dysfunctional Sexual relationships	0	0	X	0	X	X	0	0	X	0	0	X	5
Dysfunctional Partner relationships	0	X	0	0	X	X	0	0	X	0	0	X	5
Dysfunctional Parental relationships	0	X	0	0	X	0	0	0	X	0	0	X	4
Victimizing relationships	0	X	X	X	0	X	0	0	X	0	0	0	5
Eating disorders	X	0	0	0	0	X	0	0	X	0	0	0	3
Sexual Orientation	X	0	0	0	0	0	0	0	0	0	0	0	1
Prostitution	0	0	0	0	X	X	X	0	0	0	0	0	3
Depression	0	X	X	X	X	X	X	X	0	X	0	0	8
Parenting Difficulties	0	X	0	0	0	X	0	0	X	X	0	0	4
Sexual Promiscuity	X	0	0	0	0	0	X	0	0	0	X	0	3
Over Achieving	0	0	0	0	0	0	X	0	0	0	0	0	1
Low self esteem	0	X	0	0	0	X	0	0	X	X	X	0	5
Unresolved grief	0	0	0	0	0	0	0	X	0	0	0	0	1
Self harm	0	0	0	0	0	0	0	0	0	X	0	0	1
Own children abused	0	0	0	0	0	0	0	0	X	0	0	0	1
Anxiety	0	0	0	0	0	0	0	0	0	X	0	X	2
Phobias	0	0	0	0	0	X	0	0	0	0	0	X	2
Symtoms PTSS	0	X	0	0	0	0	0	0	0	0	0	0	1
TOTALS	4	8	3	2	7	11	5	4	8	5	2	5	64

[a]Note: X= this method used
0=this method not used

The practitioners reported that while all the symptoms/problems listed in Table 5.02 were experienced to a greater or lesser extent by their clients, depression was the most commonly reported symptom. The findings were consistent with the literature and the survey in this study, in regard to the long-term effects of childhood sexual abuse.

Models of Practice and the Effectiveness of Each. The answers pertaining to questions four and five were so similar that the data has been collapsed and presented as one table. On comparison, the interviews showed that while there was little difference in the overall way the practitioners worked, there were some minor differences. The male practitioners tended to look for clues and then, with awareness, followed them up. The women practitioners found it harder to say what came first. For example, did "the knowing" come first, then the discussion, or did the discussion come first thereby precipitating "the knowing"?

All the practitioners mentioned that clues were given out by the client. By this they meant that somehow the way the woman looked or spoke, acted as an indicator that alerted them to the possibility that this client may have been sexually abused. Seventeen models of practice were identified by the practitioners as being effective in working through the sexual abuse experience with survivors.

These models are shown on Table 5.03 on the following page as Eclectic (EC), Gestalt (GE), Psychodrama (PY), Transactional Analysis (TA), Action Methods (AM), Cognitive Strategies(CS), Empowerment (EM), Life Stories (LS), Feminist Perspective (FP), Human Development Model (HD), Family Therapy (FT), Social Learning Theory (SL), Client Centred Approach (CC), Relaxation Training (RT), Grief Work (GW), Behavioural Modification (BM), and Cybernetic Theory (CB).

TABLE 5.03

Practice Models Identified by the Practitioners as Effective for Working With Sexual Abuse Survivors

Male Practitioner	GE	PY	TA	AM	CS	FP	HD	EM	RT	FT	CB	LS	SL	CC	EC	GW	BM	Total Used
1.	0	0	0	X	0	0	0	X	0	0	0	0	0	0	X	X	0	4
2.	0	0	0	0	X	0	0	X	0	X	0	0	X	0	X	0	0	5
3.	0	0	0	0	0	0	0	X	0	0	0	X	0	0	X	0	0	3
4.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	X	0	0	1
Totals for Males	0	0	0	1	1	0	0	3	0	1	0	1	1	0	4	1	0	13
Female Practitioner																		
5.	0	0	0	0	0	X	0	0	X	0	0	X	0	0	0	0	X	4
6.	0	0	0	0	X	X	0	0	0	0	0	0	X	0	0	0	X	4
7.	0	X	0	X	0	0	X	0	0	0	X	0	0	0	0	0	0	4
8.	0	0	0	X	0	0	0	0	0	0	0	0	0	0	X	X	0	3
9.	X	0	0	0	0	X	0	0	0	X	0	0	0	0	X	0	X	5
10.	0	0	0	0	0	0	0	0	0	0	0	0	0	X	X	0	0	2
11.	0	0	0	0	0	0	0	X	0	0	X	0	0	X	X	0	0	4
12.	0	0	X	0	0	X	0	0	X	0	X	0	0	0	0	X	0	5
Totals for Females	1	1	1	2	1	4	1	1	2	1	3	1	1	2	4	2	3	31
TOTALS BOTH	1	1	1	3	2	4	1	4	2	2	3	2	2	2	8	3	3	44

[a] Note: X= this method used
0= this method not used

While the methods are not listed in order of priority of use, it seems, as Table 5.03 shows, that all of the practitioners work mainly eclectically (EC), with empowerment (EM), or a feminist perspective (FP), being the most preferred models. Working eclectically simply means using what seems to be appropriate at the time, regardless of the practice model. Empowerment seeks to empower the client, and entails the recognition that people may be oppressed by virtue of their gender, race or age. An empowerment approach therefore is intended to convey a commitment to the restoration of power and control to the client.

The use of a feminist perspective in counselling clearly reflects a feminist ideology. It seeks to establish a philosophy of counselling that incorporates the female value system in defining human nature. As in the use of empowerment, a feminist perspective has a political commitment to raise the level of power and control of the client. It goes further than empowering individual women, however, as it establishes women, rather than men, as the criterion reference group defining mental health for women.

Clarification Interviews

The next step in the process was to obtain further responses for clarification of what specifically alerted the practitioners to the possibility that a client may have a history of sexual abuse. This entailed asking the practitioners to be involved in a second interview. These interviews aimed to determine how the practitioners precipate client disclosure about sexual abuse experiences. On completion of all the second interviews the data collected from each interview was compared, categorised and assigned to a group.

In response to the first question asked in the second interviews all the practitioners had offered a list of symptoms/behaviours which alerted them to the possibility of a client having a history of sexual abuse. Table 5.04 below is a summary of the symptoms/behaviours reported.

TABLE 5.04

Reported Alerting Symptoms/Behaviours for Clients in Practitioner Study

Behaviour Noted	Practitoners												Total Times
	1	2	3	4	5	6	7	8	9	10	11	12	
Dysfunctional Partner Relationship	0	X	0	0	0	0	0	0	0	0	0	0	1
Dysfunctional Sexual Relationship	0	0	0	0	0	X	0	0	0	0	0	0	1
Dysfunctional Family Relationship	0	0	0	0	0	0	0	0	X	0	0	0	1
Victim/Violent Relationship	0	0	X	0	X	X	0	0	0	0	0	0	3
Lesbian Relationship *	X	0	0	0	0	0	0	0	0	0	0	0	1
Alcohol/Drug Problem	X	X	0	0	X	X	X	0	0	0	0	0	5
Eating Disorder	0	0	0	0	0	0	0	0	X	0	0	0	1
Inappropriate Behaviours	0	X	0	X	X	X	X	0	0	0	0	0	5
Client Appearance/Manner	0	0	0	0	0	X	X	0	0	X	X	0	4
Strong Religious Beliefs	X	0	0	0	0	0	0	0	0	0	0	0	1
Poor Communication Skills	0	0	0	0	0	0	0	0	0	X	0	X	2
Low Self Esteem	0	0	0	0	X	X	0	0	X	0	X	0	4
Lack of Self Confidence	0	0	0	0	0	0	0	0	0	X	0	X	2
Prostitution	0	0	0	0	0	0	X	X	0	0	0	0	2
Depression	0	0	0	0	0	X	X	0	0	X	0	X	4
TOTALS	3	3	1	1	4	7	5	1	3	4	2	3	37

* This is not to suggest that lesbian relationships are necessarily pathological. However, there is some support in the literature that it may be one indicator of childhood sexual abuse (Meiselman,1978; Fromuth, 1986).

[a] Note: X= this method used
0= this method not used

The presentation of the findings from this set of interviews was more difficult than the previous ones, as the answers could not be collated into a table. Therefore the assigning of responses to a group rather than a table seemed the best way to present the practitioner responses to questions two, three, and four. The responses to these questions are as follows:

The second question asked practitioners to consider what they did with the information gained from interviews that indicated a client may have been sexually abused. All the practitioners considered it was important to tell clients what they thought at some stage of the counselling process but that a good rapport needed to be developed first. Three of the practitioners said they took note of any of the clues given out by the woman and when it felt right they then shared their thoughts with the client. This was done regardless of whether the client acknowledged the abuse or not as they believed it important to record any suspicions or experiences which might have an impact on the outcome of the counselling process.

The third question looked at how practitioners tell their clients about their suspicions of sexual abuse. There was commonality in the way practitioners answered this question. All stated that they introduced the issue by checking out the accuracy of their assessment by using non-threatening questions about possible abuse experiences. One said she always included a question about sexual abuse experiences as part of the assessment so that it now was a routine question she asked all clients. Three of the practitioners said that they feed back the messages the clients give them.

The fourth question asked the practitioners how they personally coped with the stories they hear and highlighted the need for regular supervision and a supportive network. All the practitioners commented that you need to be able to share it with someone and stated a need for good support networks. Nine of them were able to use supervision. Two of them said they knew their own threshold and played sport to help to keep a balance between their personal

and professional lives. The responses from the three practitioners who did not have formal supervision indicated that they had more difficulty in dealing with the stories than those with good supporting network.

Discussion of the Research Results

After coding, comparing and analysing the data gained during the first interviews, it can be seen that agency philsophy, intake, and assessment procedures do have an influence on the counselling process. All the practitioners involved emphasised the importance of the physical environment of the work place. They identified the need to ensure their clients were comfortable, and that in order to work effectively a trusting relationship was essential from the onset of counselling.

Constraints to counselling were seen as the need to use formal inventories, waiting lists, and the name of the agency as it tended to suggest the kind of intervention offered to people. Even the private practitioners found that if the referral came from the Family Courts or ACC, there was already an expectation as to the reason the client was attending counselling.

In looking at who works with whom in regard to sexual abuse, the women practitioners all saw the gender of the practitioner as an issue. The male counsellors had all worked to some degree with sexual abuse survivors. However, they believed that women clients should be able to choose whether or not they saw a male counsellor.

There was very little difference in the models of practice used by the practitioners. All made reference to there being something about the clients themselves giving clues about the possibility of them being a sexual abuse survivor. From the first interviews, it was not possible to say what these clues were exactly, and a set of questions tended to flow out of the data. The second interviews were carried out in order to address these questions.

It was intended that the findings from the second interviews would provide the means of generating a theory for use in identifying and working with women who have experienced childhood sexual abuse. Through the process of comparing the practitioner responses, lists of symptoms/behaviours emerged from the data. These could be regarded as clues as to the possibility that a woman client may have been sexually abused.

Each clue can be seen as a property which relates to a conceptual category. Links between the categories can also be discerned, which in turn link to the central theme or core process–the need to identify woman with sexual abuse histories when they present at counselling services. These lists could lead to the development of theory, as some core concepts were identified and eight general propositions were induced from the data collected. These are listed below.

The Propositions

1. The name of an agency, its philosophy, intake, and assement procedures influence the counselling process.

2. The essential factor in the counselling process is the establishment of a trusting relationship between practitioner and client.

3. The gender of a practitioner in counselling survivors of sexual abuse is an ongoing controversial and contradictory issue in the practice setting.

4. Empowerment or a feminist perspective is the preferred way of working with sexual abuse survivors.

5. The way a woman acts can alert a practitioner to the possibility that there may be a history of sexual abuse.

6. Practitioners use their own feelings as an indicator of knowing when the time is right to ask women clients non-threatening questions about sexual abuse experiences.

7. Practitioners check out the accuracy of their assessment by using non-threatening questions about possible sexual abuse experiences.

8. Practitioners who do not have formal supervision have more difficulty in dealing with client stories than those who have good supportive networks.

Each of the propositions has concepts that fit with the counselling process, and can be easily understood by practitioners working in the area. They are also sufficiently general to be applicable to a multitude of daily situations within the field of practice. Finally, keeping these core concepts in mind, a practitioner can to a certain extent predict and control, within the counselling process, some of the consequences of precipating women clients to disclose histories of sexual abuse.

The next step in the process was testing the grounded theory by applying it to an instance of the phenomenon under study. A summary of the work to date was sent to the practitioners. This left open the question of whether the core concepts and the propositions generated could be developed further as specific guidelines aimed at assisting social workers/practitioners in the field, to identify women with histories of sexual abuse. The next chapter addresses this issue.

PART THREE

CHAPTER 6

DEVELOPING PRACTICE GUIDELINES

The field work reported in this study had its beginnings in efforts to identify women clients with histories of sexual abuse attending social service agencies. The research began with a survey which was part of an evaluation of a community counselling centre. As Ellenson's theory, which formed the basis of the theoretical framework for survey, could not be supported the study then looked at how sexual abuse is identified in the practice setting and, based on the clinical work of a variety of health professionals, reported on the findings from a set of in-depth interviews.

Through the process of constant comparative analysis of the practitioner responses collected during these interviews lists of symptoms/behaviours emerged from the data which can be seen as clues that a client may be a sexual abuse survivor. The third aim of this study was to develop practice guidelines which would help social workers/practitioners to identify women survivors of sexual abuse.

Methodology

Two groups of practitioners were involved in this, the third stage of the field work. In February 1991 the practitioners who had been involved in the previous interviews were contacted again with the request for another interview. During this stage of the research these practitioners are referred to as Group A. As the research officer had completed her placement the author carried out these interviews personally. During these interviews the practitioners were asked two main questions which had been identified in the letter they had been sent, a copy of which is shown as Appendix 8.

In addition, a second, fresh group of practitioners, who had not been involved previously, were identified and approached. These practitioners are referred to as Group B. This group were invited to undertake the task of "testing out" a trial "Index of Sexual Abuse Indicators".

Sample: Participants

Group A consisted of nine people, eight of whom had taken part in the second interviews, and one who had taken part in the first, but not the second interview. Of the nine practitioners involved three were male and six were female.

Group B consisted of a different sample of eight female practitioners. All worked in a variety of different social service agencies where women present for counselling. Seventeen practitioners in total, three male and fourteen female, participated in the final stage of this inquiry.

The Interviews

The third set of interviews were carried out face-to-face with seven of the nine participants from Group A. Two more from this group were interviewed at an arranged time over the telephone. The interviews lasted approximately half an hour. The questions, as identified in Appendix 8, were aimed at determining how practitioners precipitate survivors to disclose sexual abuse experiences and how often their suspicions that a woman may be a survivor were confirmed. Questions about how they defined sexual abuse were also asked. While sexual abuse had not been defined previously in the interviews, it seemed important at this stage to ensure that the participants were all talking about the same kind of behaviours.

Data Collection

The participants' responses in seven of the interviews were recorded by a secretary in shorthand during each interview. A tape recording of the interviews was also made as a backup for the secretary. Two telephone interviews were recorded in long-hand and they were not taped, but one participant wrote her responses down at the time and sent them in later, which provided an additional check on validity.

Responses were also obtained from Group B. These participants reviewed thirty-nine client cases where a history of sexual abuse had been identified using a trial 22 item *Index of Sexual abuse Indicators* which was constructed following the stage three interviews with Group A.

Procedures Used in Processing the Data

Responses from the stage three interviews were collated, coded, categorised and sorted into a table. This table was then compared with Table 5.02 and Table 5.04 presented in the previous chapter. The most commonly reported symptoms/behaviours of the three tables were collated together to form the trial *Index of Sexual abuse Indicators* (Appendix 9). This Index was then tested in practice to determine validity .

Data Analysis and Development of Practice Guidelines

All the practitioners defined sexual abuse as involving dependent, developmentally immature children or adolescents in extra or intra-familial sexual activities they did not fully comprehend, or which they felt uncomfortable about. They all mentioned powerlessness, force, or coercion as being included in any definition, and made some reference to the age of a child being important. Their definitions support the definitions given by Kempe and Kempe (1978) and Browne and Finklehor (1986).

Three of the practitioners reported that where they had suspected that a woman had a history of sexual abuse and when they asked the client their suspicions were confirmed 90% of the time. One reported an 80% confirmation rate, two reported a 75% confirmation rate and another two had 50% confirm abuse. One, while giving no estimates, reported that most of women she counselled had been sexually abused. Eight of the practitioners believed that at least 10% of women who denied having been sexually abused were actually abuse survivors.

Table 6.01 below shows the responses to the stage three interviews revealed sixteen symptoms/behaviours which the practitioners identifed as possible symptoms of sexual abuse. As they were very much the same as the alerting symptoms/behaviours listed in Chapter 5 the aim then was to use the knowledge gained so far to:

1. construct an index of sexual abuse indicators which could be used to predict histories of sexual abuse in women presenting for counselling:

2. test the grounded theory by applying it to an instance of the phenomenon under study:

3. evaluate the usefulness of the indicators as a routine screening tool for social workers/practitioners working in the field.

In order to achieve these aims the most commonly reported symptoms/behaviours were collated from Table 5.02 and Table 5.04 with those in Table 6.01 and a twenty-two item trial *Index of Sexual abuse Indicators* was constructed. Table 6.01 is shown below.

TABLE 6.01

Reported Symptoms/Behaviours exhibited by Clients in Practitioner Study

Behaviour Noted	Practitioners 1	2	3	4	5	6	7	8	9	Total Times
Alcohol & Drug Dependence	X	X	X	0	X	X	X	X	X	8
Anger/difficulty relating to men	X	0	X	X	0	X	0	0	0	4
Dysfunctional Sexual relationships	0	0	X	X	0	0	0	0	0	2
Dysfunctional Partner relationships	0	0	0	0	X	X	0	X	X	4
Dysfunctional Parental relationships	0	0	0	0	0	0	0	X	0	1
Eating disorders	X	X	X	X	0	0	0	X	X	6
Prostitution	X	X	0	0	0	X	0	0	0	3
Depression	X	X	X	X	0	0	0	X	X	6
Parenting Difficulties	0	0	0	0	0	0	X	0	0	1
Sexual Promiscuity	X	X	0	0	0	0	0	X	X	4
Asexuality	X	X	0	0	0	0	0	0	0	2
Lack of Self Confidence	0	0	X	0	X	0	0	0	0	2
Low self esteem	X	0	X	0	X	0	0	0	X	4
Self harm	X	0	0	0	0	0	X	0	0	2
Incongruence Appearance/Manner	0	0	0	0	0	0	X	0	0	1
Symptoms PTSS	0	X	0	0	0	X	0	X	X	4
Total	9	7	7	4	4	5	4	7	8	54

[a]Note: X= this effect observed. 0= this effect not observed

To validate this Index the second sample of practitioners, Group B, were invited to "test" the grounded theory by applying it to an instance of the phenomenon under study. The researcher met with six of the participants to give them a letter with instructions on how to use the index (Appendix 10). The other two practitioners involved received the same letter by mail. The outcome of their review of thirty-nine cases is shown in Table 6.02 below.

TABLE 6.02

Symptoms/behaviours identified in thirty-nine case histories of sexually abused women reviewed in the Practitioner Study

Indicator Noted	Practitoners 1	2	3	4	5	6	7	8	Total Times
Alcohol & Drug Dependence	1	1	2	2	2	1	3	1	13
Anger/difficulty relating to men	1	5	2	5	3	2	6	4	28
Lack of trust in people	0	5	3	4	4	2	2	4	24
Dysfunctional Sexual relationships	4	5	4	4	3	1	3	2	26
Dysfunctional Partner relationships	2	6	4	5	5	2	1	3	28
Dysfunctional Parental relationships	5	6	1	5	3	3	2	4	29
Unresolved grief	1	6	5	4	2	4	2	4	28
Eating disorders	0	1	1	3	2	2	1	2	12
Prostitution	1	0	0	0	2	0	1	0	4
Depression	4	5	3	5	5	3	2	4	31
Parenting Difficulties	2	6	1	0	4	1	0	3	17
Own Children abused	0	2	2	0	1	0	0	1	6
Sexual Promiscuity	0	0	0	1	3	1	2	2	9
Asexuality	0	0	2	0	0	0	0	0	2
Overachieving	1	1	1	3	1	1	1	1	10
Lack of Self Confidence	1	3	5	5	5	4	4	5	32
Low self esteem	2	3	5	5	5	4	4	5	33
Self harm	0	1	3	2	3	0	2	3	14
Phobias	0	2	0	0	0	0	1	0	3
Lesbian Relationship	0	0	0	2	0	0	1	0	3
Anxiety	0	3	0	2	4	4	1	4	18
Incongruent Appearance/Manner	0	2	0	2	3	1	0	0	8
Total	25	63	44	59	60	36	39	52	378

Data Analysis and Development of Practice Guidelines

At this stage it is not possible to specify the exact numbers of indicators or combinations necessary to identify a history of sexual abuse. Low self esteem, depression and lack of self confidence scored highest on the list. These factors were observed in over thirty of the cases reviewed. Six more indicators were observed between twenty and thirty times, with another six between ten and twenty. Items on the list that were observed less than ten times were then removed. The data yielded fifteen indicators which could be seen as predictive of sexual abuse from the original twenty-two items listed. This left a simple check list of symptoms/behaviours which can be seen as indicators of sexual abuse. This checklist appears to have face validity for practitioners in practice settings. The Index is shown on the following page as Table 6.03.

Further evaluation of the Index could lead to the assignment of predictive levels by the number of indicators contained both in the Index and in the history of the woman presenting. To do so is beyond the brief of this study. It would involve another study carried out over a longer period of time with the use of statistical analysis to establish the sensitivity and specificity of the Index in predicting sexual abuse histories in women clients. To date, the Index is still in the developmental stage. However, the aim at this point was to develop guidelines which could assist in the early identification of women with histories of sexual abuse presenting for counselling. This has been achieved and the Index, as it stands, is a very simple tool which can be used in the field to assist practitioners to identify women clients with histories of sexual abuse.

TABLE 6.03

Fifteen-item checklist of Indicators of Sexual Abuse

Indicator	Present
Alcohol/Drug problem	
Anger/difficulty relating to men generally	
Lack of trust in people	
Dysfunctional sexual relationships	
Dysfunctional Relationships with partner/friends	
Dysfunctional Parental Relationships	
Eating disorders	
Depression	
Difficulties with parenting	
Over achieving	
Lack of Self Confidence	
Low self esteem	
Unresolved grief	
Self harm	
Anxiety	

[1] Note: indicator present in case history =√
indicator not present in case history =0
not applicable = n/a

Practice Theory

The previous chapter showed how grounded theory was used to collect data, and to organise and analyse it throughout the research process. The aim of grounded theory is to discover the dominant process in the particular social setting under observation leading to the formation of hypotheses that may have a generalized applicability. Through the use of a grounded theory strategy, tentative core concepts regarding a list of symptoms/behaviours that are consistent among clients with sexual abuse histories were identified by field practitioners. The literature reviewed in this study supports their findings.

The outcome of grounded theory is that of middle range theory, either substantive or formal. The symptoms/behaviours identified by the practitioners could lead eventually to the development of theory. Should the field work have continued, then the next step would have been to test out the usefulness of the Index more widely. This would allow for clarification of the items listed. Used in this way, the Index could provide the necessary bridge between practitioners concerned with counselling survivors of sexual abuse and more formal theory.

It is to be hoped that social workers might use the Index shown as Table 6.03 and evaluate the usefulness of it for themselves. At the same time it is essential that practitioners understand the core concepts of the index as this is likely to engender a readiness to use them. It also sharpens practitioners' sensitivity to the problems they face, as well as giving them an image of how they can potentially make matters better for their clients.

In the first interviews, questions about the models of practice employed during counselling seemed to provoke anxiety for some of the practitioners. During the second interviews this changed. It became obvious that as awareness levels and understanding of some of the core concepts about problems associated with sexual abuse increased, so did the practitioners' ability to

theorise and be more critical of their own practice. By providing new information about counselling practices for women survivors of sexual abuse, this study has helped practitioners understand women's experiences, and has contributed towards precipitating change in the practice setting. This change was reflected in the third interviews, as the practitioners were very quickly able to identify what they saw as indicators that alerted them to the possibility that the client had been sexually abused at some stage.

Several of the practitioners also stated that they now felt more able to encourage their clients to disclose the abuse. For most, the process appeared to have alerted them to the devasting effects of sexual abuse. It had given them confidence in dealing with sexual abuse survivors, thus increasing the woman's chance of making a full recovery.

CONCLUSION OF THE STUDY

Over recent times Government, members of the helping professions and the community in general, have become more aware than ever before of the widespread prevalence of sexual abuse and the degree of non-accidental injury. However, the extent of victimisation and the trauma produced by sexual abuse has been insufficiently studied. While both statutory and voluntary agencies may be more aware of the need for staff to respond appropriately when presented with cases of sexual abuse, few New Zealand studies have set out to address the means by which practitioners might more effectively intervene in the counseling process.

This unmet need has been recognised by some women's groups, and these groups in turn have stimulated women health professionals to research the area. The research reported in this study had its beginnings in efforts to identify women clients with histories of sexual abuse attending social service agencies. Although women survivors remained at the centre of this study, the

focus throughout has been on the "practitioner" and the way in which she or he precipitates identification and disclosure of sexual abuse. Practitioners plan their interventions according to their understanding of the situation they are confronted with. This understanding is dependent on the values, attitudes and beliefs a practitioner has about women in general, and about sexual abuse in particular. Given the high prevalence rates of childhood sexual abuse, together with the fact that survivors of sexual abuse enter the helping services through a variety of agencies, practitioners need to be able to precipitate disclosure of sexual abuse when working with women.

While the use of the predictive syndrome, as postulated by Ellenson (1985,1986) was unable to be confirmed, the survey results did support the long-term effects experienced by sexual abuse survivors reported in the literature. The linking of symptoms to a history of sexual abuse paves the way for the client's exploration of the impact of abuse on her life, and cuts through the common defence of denial.

As Chesterman (1990: 39) suggests, however, " . . . sexual abuse disclosure rates are likely to be related to a practitioner's index of suspicion". If practitioners are unable to identify clients with histories of sexual abuse, then they will have difficulty implementing effective intervention strategies. Such findings are consistent with the literature reviewed and from the data and propositions generated from this study. In Part Two of the study core concepts at the centre of the counselling process were identified leading to a clarification of the way in which clients disclose of sexual abuse experiences.

From these results an *Index of Sexual Abuse Indicators* was developed and then subsequently "tested out" by a group of practitioners/social workers working with survivors of sexual abuse. As it stands at present, this index has face validity for practitioners in the field. What is needed now, however, is for the Index to be used widely, with a view to evaluating the usefulness of the indicators for social workers/practitioners working in the field.

Thus, the study concludes with a question as to whether or not the *Index of Sexual Abuse Indicators* could fruitfully be developed further as a guideline for identifying women with sexual abuse histories. Given the promise shown so far, this line of inquiry has much to recommend it.

APPENDIX 1 Covering letter to 1986 Survey

141 Weston Road
Christchurch 5
May 1991

Department of Social Policy and Social Work
Massey University
Private Bag
Palmerston North

TO WHOM IT MAY CONCERN

I was a Social Work student on placement at the Bishopdale Family Health Counselling Centre in 1986.

One of the papers in my course required that I gain experience in research. While I was on placement I was involved as research assistance on a survey carried out by my fieldwork teacher, Lynne Briggs, on the incidence of sexual abuse among women presenting at the Centre over a six month period. The research design, design of the questionnaire, literature review and statistical analysis were carried out by Lynne Briggs.

Margaret A Smith

Margaret Smith (Porter).

APPENDIX 2. Four Preconditions of Sexual Abuse: Finkelhor's Model

According to Finkelhor, four preconditions need to be fulfilled in order for sexual abuse to occur. Each of the preconditions is listed below together with some major factors which commonly facilitate the attainment of each one respectively.

1. An adult must have sexual feelings about a child (or children in general. Facilitating factors:
Male sex-role socialization
Exposure to child pornography
Exposure to advertisements which sexualize children
Childhood sexual experiences
Sexual experiences with other children

2.The adult must overcome internal inhibitors. Facilitating factors :
Socialization in cultural values which do not inhibit sexual interest in children
Low impulse control
Alcohol
Setback to ego
Stress
Frustration in other marital/sexual relationship

3.The Adult must overcome External Inhibitors. Facilitating factors:
Mother who is absent, sick, or powerless
Poor protection by mother
Domineering father
Crowding or sleeping together
Opportunities to be alone together
Social isolation
Geographical isolation

4. An adult needs to overcome any resistance or avoidance attempts by the child. Facilitating factors:
Child is emotionally deprived
Child is socially isolated
Child knows the adult
Child has special fondness for the adult
Child is vulnerable to incentives offered by the adult
Child feels helpless and powerless
Child is ignorant of what is happening
Child is sexually repressed and has sexual curiosity
Coercion

APPENDIX 3 Diagnostic Interview Schedule - DIS

Extract from : Persson & Magnusson, 1988.

The DIS includes a section on alcohol sufficient to yield DSM III diagnoses of alcohol abuse and/or dependence. In the DIS the diagnosis of alcohol disorder, as with other disorders, is made by asking "Have you ever" questions, leading to a lifetime diagnosis which is supplemented by questions about when the first symptoms occurred. This provides some information about when problems began and when they ceased.

Diagnostic and Statistical Manual - DSM III.

305.0x Alcohol Abuse.

Differential Diagnosis.

Non-pathological recreational use of a substance, episodes of intoxication without a pattern of pathological use.

303.9x Alcohol Dependence

Diagnostic Criteria

A. Either a pattern of pathological use or impairment in social or occupational functioning due to alcohol use.

B. Either tolerance or withdrawal:

(1) Tolerance: need for markedly increased amounts of alcohol to achieve desired effect, or markedly diminished effect with regular use of same amount.

(2) Withdrawal: development of Alcohol withdrawal (eg morning "shakes" and malaise relieved by drinking after cessation of, or reduction in drinking).

Childhood Conduct Disorder:

Differential Diagnosis. Isolated acts of antisocial behaviour (Childhood or adolescent Antisocial Behaviour- V codes), Oppositional Disorder.

312.00 Conduct disorder, Undersocialized, Aggressive.
321.10 Conduct disorder, Undersocialized, Non aggressive.
312.23 Conduct disorder, Socialized, Aggressive.

312.21 Conduct disorder, Socialized, Non aggressive.
312.90 Atypical Conduct disorder, residual category.

Post-traumatic Stress Disorder

Differential Diagnosis. Adjustment Disorder with Anxious Mood.

Diagnostic criteria.

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost anyone.

B. Re-experiencing of the trauma as evidenced by at least one of the following.
(1) recurrent and intrusive recollections of the event
(2) recurrent dreams of the event
(3) sudden acting or feeling as if the traumatic event were reoccuring, because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

(1) markedly diminished interest in one or more significant activities
(2) feeling of detachment or enstrangement from others
(3) constricted effect

D. At least two of the following symptoms that were not present before the trauma:
(1) hyper-alertness or exaggerated startle response
(2) sleep disturbance
(3) guilt about surviving when others have not, or about behaviour required for survival
(4) memory impairment or trouble concentrating
(5) avoidance of activities that arouse recollection of the traumatic event
(6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

APPENDIX 4 Letter to Women Survey Participants

Family Health Counselling Centre
3 September 1986

Dear Friend,

I am a Social Worker at the above centre, and with the help of Margaret Porter, a post graduate student on placement at this centre from the University of Canterbury, am attempting to determine the ongoing effects of sexual abuse in female children and young adults.

Women are referred to the helping professions for a variety of reasons and often sexual abuse is never acknowledged during the time they are seen. We are asking every woman who has attended this centre between February and August 1986 to complete the enclosed questionnaire, regardless of the reason for the referral.

I can assure you of complete anonymity, as once the questionnnaire is sent out I have no way of knowing who has returned it, that is unless you actually want to put your name and address on it. Whether you intend to participate or not, I would be grateful if you would return the questionnaire to me in the envelope provided.

Thank you for your co-operation.

Yours sincerely,

Lynne Briggs,
Senior Social Worker.

(R.S.V.P. 10.9.86).

APPENDIX 5 Questionnaire For 1986 Survey

SECTION 1 Demographic Data: This section is to enable us to learn a little about your current situation. Please circle the appropriate number or answer the question in the space provided.

1. What is your present marital status?

1. Single
2. Separated
3. Married
4. Divorced
5. De facto
6. Remarried
7. Widowed
8. Never married

2. What was your age last birthday? _____ years.

3. Age Group:

1. 15 - 20 years
2. 21 - 25 years
3. 26 - 30
4. 31 - 35
5. 36 - 40
6. 41 - 45
7. 46 - 50
8. 51 - 55
9. 56 - 60 years

4. What is your sexual preference?

1. Heterosexual
2. Lesbian
3. Bi-sexual

5. To which of the following ethnic groups do you consider you belong?

1. Pakeha/European
2. Maori - Pakeha
3. New Zealand Maori
4. Other Polynesian
5. If other please indicate which ethnic group: _____

6. How many children do you have? _____

7. How many stepchildren do you have? _____

8. Do you have, or have you had any child management problems?

1. Yes 2. No 9. N/A

Please state: _____

SECTION 2 This section is to gain a little knowledge about you and your own family of origin. Please circle appropriate number or answer the question in the space provided.

9. Were you raised by:

1. Natural parents
2. Adoptive parents
3. Foster parents
4. Step parent (which one)
5. Relatives
6. State Ward
7. Other (please state): _____

10. Is your mother still alive?

1. Yes
2. No

11. Is your father still alive?

1. Yes
2. No

12. Are your parents still married to each other?

1. Yes
2. Separated
3. Widowed
4. Divorced
5. Deceased

13. How old were you when they separated/became widowed?

1. 0 - 5 years
2. 6 - 10
3. 11 - 15
4. 16 - 20
5. 20+ _____
9. N/A

14. How many brothers do you have? _____

15. How many sisters do you have? _____

16. How many stepbrothers do you have? _____

17. How many stepsisters do you have? _____

18. What place do you occupy in the family?

1. Oldest
2. Middle
3. Youngest
4. Second oldest
5. Second Youngest
6. Only child
7. Other (Please state): _____

19. Do you still have contact with your mother/stepmother?

    1. Yes 2. No. 9. N/A

20. Is the contact:

    1. Regular
    2. Irregular
    3. Spasmodic (i.e., regular than irregular)
    4. Infrequent due to specific reason (not in same town etc.)
    5. No contact through your own choice
    6. No contact through their choice
    9. N/A

21. How would you describe your relationship with her?

    1. Good
    2. Tense
    3. Stressful
    4. Close
    5. Difficult (say why)
    6. Hateful
    9. N/A

22. Do you still have contact with your father/stepfather?

    1. Yes 2. No 9. N/A

23. Is that contact:

    1. Regular
    2. Irregular
    3. Spasmodic (i.e: regular than irregular)
    4. Infrequent due to specific reason (not in same town)
    5. No contact through your own choice
    6. No contact through their choice
    9. N/A

24. How would you describe your relationship with him?

    1. Good
    2. Tense
    3. Stressful
    4. Close
    5. Difficult (Why?)
    9. N/A
    6. Hateful

SECTION 3 This section is to determine how you saw your childhood, whether you would define it as happy or unhappy. Please circle correct answer or write in space provided.

25. Do you consider your parents were happy together?

    1. Yes 2. No 9. N/A

26. If not brought up by your parents, do you think on the whole, the people you lived with were happy?

    1. Yes 2. No 9. N/A

27. Were there a lot of arguments in the home?

    1. Yes 2. No

28. Was alcohol (or other drugs) ever consumed?

    1. Yes 2. No

29. Would you consider that alcohol or other drugs caused problems in your family life?

    1. Yes 2. No

30. Who made the decisions in your family or home?

    1. Mother 2. Father
    3. Shared

31. What was your father's employment?

    1. Labourer 2. Clerical
    3. Managerial 4. Sales
    5. Professional 6. Self-employed
    7. Beneficiary 9. N/A

32. What was your mother's employment?

    1. Labourer 2. Clerical
    3. Managerial 4. Sales
    5. Professional 6. Self-employed
    7. Beneficiary 9. N/A

33. Who were you able to state your views to without fear of consequences?

    1. Mother/female carer
    2. Father/male carer
    3. Both
    4. Neither

34. Who were you able to disagree with without endangering yourself?

    1. Mother/female carer
    2. Father/male carer
    3. Both
    4. Neither

35. How would you describe your school days?

    1. Happy
    2. O.K.
    3. Sometimes O.K.
    4. Unhappy

36. Were you successful at school, for example, pass exams, cope with school work?

    1. Yes
    2. No

37. Did you have any problems at school, for example, conflict with teachers in the classroom?

    1. Yes
    2. No

38. What is your highest qualification?

    1. School Certificate
    2. University Entrance
    3. University Degree
    4. Teaching Certificate
    5. Tertiary Certificate
    6. Professional qualification
    7. Other i.e., Nursing
    9. N/A

39. Were you ever suspended or expelled from school?

    1. Yes (what class _____)
    2. No

40. Did you ever play truant from school?

    1. Yes
    2. No

41. How often did you run away from home?

    Approx. No. of days: _____

42. Did you ever get in trouble with the law?

    1. Yes 2. No

43. What offences were you charged with, if any?

    _____

    How old were you? _____

SECTION 4 This section is designed to enable us to determine the extent of sexual abuse, if any, that occurred in child/adolescent/young adult years. Please try to answer as honestly as possible. Please circle the correct answer or write in the space provided.

44. Do you know of anyone who has been sexually abused?

    1. Relative 2. Friend
    3. Neighbour 9. N/A

45. If a relative has been sexually abused who?

    1. Sister 2. Mother
    3. Cousin 4. Stepsister
    5. Brother 6. Stepbrother
    7. Aunt 9. N/A

46. Before you were aged 16 years were any attempts made to do sexual things to you by another person(s)?

    1. Yes 2. No

47. Before you were aged 16 years were any sexual things done to you, or with you, by another person?

    1. Yes 2. No

48. Between the ages of 16 and 20 years did anyone attempt to have sexual contact with you without your consent?

    1. Yes 2. No

49. Do you consider any of these experiences to have been sexual abuse?

    1. Yes 2. No

50. What age were you when the abuse first occurred?

    1. 0 - 5 years 2. 6 - 10
    3. 11 - 15 4. 16 - 20

51. What sex was this person?

    1. Male 2. Female

52. To the best of your knowledge what age was this person? Approximately: _____

53. What was the relationship of this person to you?

    1. Mother/Father
    2. Brother/sister
    3. Other relative, (cousin, grandfather): _____
    4. Neighbour
    5. Friend of family
    6. Family member of friend
    7. Boyfriend
    8. Stranger
    9. Other: _____

54. What type of sexual experience was this?

    1. Fondling
    2. Intercourse or attempted intercourse
    3. Involvement of more than 2 people
    9. N/A

55. Indicate which applied:

    1. Person insisted even though you objected strenuously
    2. Agreed to it or asked the person to do it
    3. Threatened to harm you or tell someone if you refused
    9. N/A

56. State number of occasions this happened. _____

57. By how many people have you been sexually abused?_____

58. Please state what mainly occurred:

1. Fondling
2. Intercourse or attempted intercourse
3. Involvement of more than 2 people
9. N/A

59. Have you ever told anyone about these experiences?

1. Yes 2. No 9. N/A

60. If the answer to the previous question was "No", what prevented you from doing so?

1. Shame
2. No one to tell
3. Afraid of disbelief
4. Other
9. N/A

61. If "Yes", how much time had passed since the experience?

1. Told straight away
2. Weeks later
3. Months later
4. A year later
5. Years later
6. Never told anyone
9. N/A

62. Who did you tell?

1. Mother
2. Father
3. Both parents
4. Sibling
5. School Counsellor/Teacher/Priest
6. Relative
7. Friend/Friend's family member
8. Police
9. N/A

63. What was their response?

1. None
2. Told someone else, i..e, counsellor/parent
3. Initiated action against offender
4. Disbelief
5. Other: _____
9. N/A

64. How long did the sexual abuse go on for?

1. Less than 1 month
2. 1 - 6 months
3. 6 - 12 months
4. 1 - 2 years
5. 2 - 5 years
6. 5 - 10 years
7. 10+ years
9. N/A

65. Why did it stop?

1. No chance to continue
2. You refused
3. Never saw person again
9. N/A

66. Is there any other sexual experience(s) that happened to you that this questionnaire has not asked for yet and you are prepared to tell us about?

1. Yes 2. No 9. N/A

If "Yes", please record details as briefly and as clearly as possible below. Thank you.

_____

_____

_____

_____

SECTION 5 This section will focus on what has happened to you in more recent years. Please circle the correct response or write in the space provided.

67. What type of employment did you enter on leaving school?

1. Clerical
2. Sales
3. Professional
4. Labourer
5. Teaching
6. Trade
7. Self-employed
8. Beneficiary
9. N/A

68. Did you continue in this line of work?

1. Yes 2. No

69. How many jobs have you had on average since leaving school?

1. Less than 5 2. More than 5
3. Less than 10 4. More than 10
5. N/A

70. Were they all of a similar type of work?

1. Yes 2. No

71. Do you find it hard to keep your mind on a job or task, either at home or at work?

1. Yes 2. No

72. What is your current source of income?

1. Wages/salary 2. Self-employed
3. Beneficiary 4. Spouse's salary

73. During the past few years have you been well most of the time?

1. Yes 2. No

74. How would you describe your illness?

1. Physical 2. Emotional
3. Both 9. N/A

75. Do you dream frequently?

1. Yes 2. No.

76. Do you go to sleep most nights without thoughts or ideas?

1. Yes 2. No

77. Do you, or have you ever had bad dreams or nightmares?

1. Yes 2. No

78. In these nightmares are you or your family being threatened by terrible events?

1. Yes 2. No

79. Do you have bad dreams in which children are being harmed?

1. Yes 2. No

80. Do you have nightmares about being chased?

1. Yes 2. No

81. Do you have dreams about death?

1. Yes 2. No

82. Do you ever have the same dream over and over?

1. Yes 2. No

Please explain: _____

83. Almost never dream?

1. Yes 2. No

84. Have you any particular fears, i.e., scared of dogs, spiders, water, fire, etc.?

1. Yes 2. No

Explain: _____

85. Do you find it hard to talk to people you've just met?

1. Yes 2. No

86. Do you believe you are more nervous than other people?

1. Yes 2. No

87. Do you feel unable to tell people about yourself?

1. Yes 2. No

88. When in a group of people do you have trouble thinking of the right things to talk about?

    1. Yes 2. No

89. Do you think you have very few fears compared to your friends?

    1. Yes 2. No

90. On leaving your home do you worry about whether the door is locked and the windows closed?

    1. Yes 2. No

91. Are you afraid of the dark?

    1. Yes 2. No 3. Sometimes

92. When you are alone do you ever hear strange things?

    1. Yes 2. No 3. Sometimes

93. Have you ever felt afraid of being home on your own?

    1. Yes 2. No 3. Sometimes

94. Have you ever seen shadows moving in or around your home?

    1. Yes 2. No

    Please explain: _____

    _____

95. In bed at night, especially when you are alone, have you ever been troubled by sounds like those of an intruder?

    1. Yes 2. No

96. When in bed have you ever experienced hearing booming sounds?

    1. Yes 2. No

    Please explain: _____

97. Have you ever seen unusual shadows while you were in bed?

    1. Yes 2. No

98. Have you ever seen shadowy figures anywhere in your house?

    1. Yes 2. No

99. Have you ever had the experience of feeling an evil presence has entered your home, especially when you are alone?

    1. Yes 2. No

    Please explain: _____

100. Do you feel happy most of the time?

    1. Yes 2. No

101. Do you feel blue a lot of the time?

    1. Yes 2. No

102. Do you, or have you ever felt you do not care what happens to you?

    1. Yes 2. No

103. Do you cry easily?

    1. Yes 2. No

104. Have you ever been depressed?

    1. Yes 2. No

105. Have you ever been treated for depression?

    1. Yes 2. No

106. In what way were you treated?

1. Own doctor
2. Medication
3. Outpatient treatment at hospital
4. Inpatient treatment
5. Counselling only
6. Counselling with medic
7. No treatment (got through it on own)
9. N/A

107. How many days did your depression last? _____

108. Have you ever felt guilty without really knowing why?

1. Yes 2. No

SECTION 6 This section will now ask some brief questions about you and your life. Please circle the correct response or write in the space provided.

109. Do you believe you are an important person?

1. Yes 2. No

110. Have you ever been sorry that you are a female?

1. Yes 2. No

Please explain: _____

111. Should children be taught all the main facts about sex?

1. Yes 2. No

112. Do you believe women should have as much sexual freedom as men?

1. Yes 2. No

113. Have you always been worried about sexual matters?

1. Yes 2. No

Please explain: _____

114. Do you commonly wonder what hidden reason another person may have for saying or doing something nice for you?

1. Yes 2. No

115. Do you like to flirt?

1. Yes 2. No

116. Do you feel strongly attracted to people the same sex as yourself?

1. Yes 2. No

117. Have you ever been in trouble for your sexual behaviour?

1. Yes 2. No

118. Do you feel strongly attracted to people of the opposite sex?

1. Yes 2. No

119. Have you been disappointed in love?

1. Yes 2. No

120. Do you dream frequently about things that are best kept to yourself?

1. Yes 2. No

Please explain: _____

121. Is it safer to trust no-one?

1. Yes 2. No

122. Do you trust your partner?

1. Yes 2. No. 9. N/A

123. Have you been able to have a satisfactory sexual relationship?

1. Yes 2. No

124. Do you find your sex life satisfactory now?

1. Yes 2. No 9. Not applicable

125. Have important relationships in your life broken down because of how you feel about sex?

1. Yes 2. No

126. Have you ever attempted to find help for yourself (and your partner) in regard to your sexual relationship?

1. Yes 2. No

Please explain: _____

127. Do you or have you ever consumed alcohol?

1. Yes 2. No

128. Have you ever abused alcohol?

1. Yes 2. No

129. Have you ever used drugs in a manner which was not prescribed for you?

1. Yes 2. No

Please explain: _____

_____

130. Have you ever been treated for alcohol or other drug abuse either as an inpatient or outpatient?

1. Yes 2. No

Please explain: _____

131. Do you feel life is passing you by?

1. Yes 2. No

Please explain: _____

132. If you are not happy with your life, would you seek help?

1. Yes 2. No

133. Are you currently in a relationship which you feel is both sexually and emotionally satisfying?

1. Yes 2. No

134. Do you feel your homelife is as pleasant as that of most people you know?

1. Yes 2. No

135. Do you usually feel that life is worthwhile?

1. Yes 2. No

136. Have you ever felt better in life than you do right now?

1. Yes 2. No

137. Do you enjoy several play and recreational activities?

1. Yes 2. No

138. If this questionnaire has raised issues for you, is there someone you can discuss it with?

1. Yes 2. No 9. N/A

Thank you for your participation

APPENDIX 6 Introductory Statement and Discussion Questions in Practitioner Study.

Introductory Statement (to be read out to participants)

Women attending social service agencies rarely reveal a history of sexual abuse on initial contact with the agency. They are seldom consciously aware that their presenting problems may be in any way connected with past abusive experiences. They tend to believe that their problems are related to current stressful events in their lives. In order to be of assistance to survivors of sexual abuse, workers must be able to identify women who have been abused, regardless of whether they reveal the abuse or not. Given this statement please respond to the following questions.

1. What do you consider are the Main Influences on the Counselling Process?

- Agency Philosophy?
- Intake Procedures; referral systems?
- The point of entry, intake: what happens?
- Assessment, intervention: what practice model?

ie: What do you look for? Any hunches (intuition) that you work from?

- extent of intervention: how long for?
- Training (Your own, your supervisors?)
- Gender Issues–Interactional model–who works with whom?

2. Effects of Abuse Now?

What effects of the abuse do you see as exhibited in the clients current life (as opposed to their family of origin)?

3. Models of Practice

What models appear to be the most effective in working with survivors of sexual abuse?

4. Is One Model of Practice More Effective Than Another? (If so state why)

APPENDIX 7 First Letter to Participants in Practitioner Study.

34 Glenstrae Road
Christchurch 8
Phone 842-655
18 July 1990

Dear Colleague,

Thank you for taking the time to participate in our inquiry into the counselling process for women presenting at counselling services. The following is a summary of the conclusions drawn from those interviews. We would be happy to discuss any of the findings with you.

After comparing and analysing the interviews it can be seen that agency philosophy, intake, and assessment procedures do have an influence on the counselling process. All the practitioners involved emphasized the importance of the physical environment of the work place, the need to ensure their clients were comfortable, and that in order to work effectively a trusting relationship was essential from the onset of counselling.

Constraints to counselling were seen as the need to use formal inventories, waiting lists, and the name of the agency as it tended to suggest the kind of intervention offered to people. Even the private practitioners found that if the referral came from the family courts or ACC, there was already an expectation as to the reason the client was attending counselling for.

In looking at who works with whom in regard to sexual abuse, the women practitioners all saw the gender of the practitioner as an issue. Four were emphatic that men should never work with sexually abused women. The other four women all believed it should be women working with women, but

that the client's own choice was the important issue, and not the counsellor's. All four of the male practitioners, while seeing it as the women's choice, had worked with sexual abuse survivors at some stage. For two of them this had presented no difficulty, a third saw expertize and a woman's choice as being the determining factor. The fourth, while stating he had a policy of not working with women survivors of sexual abuse, gave an example of an occasion where a woman survivor had specifically chosen to work through her sexual abuse experience with him, and he had done so.

There was very little difference in the model of practice used by the practitioners. All made reference to something about the clients themselves giving clues in regard to the possibility of being a sexual abuse survivor. From the interviews, it was not possible to say what these clues were exactly, but a set of questions tended to flow out of the data. Questions about the way a client presents that alerts you to the possibility that they may be a sexual abuse survivor. Questions in regard as to what you do with that information, and questions in regard as to how you tell your client about your thoughts. In other words, how do you precipitate disclosure in clients about their sexual abuse experiences.

Elizabeth will telephone you to see if you are prepared to be involved in a second (and final) interview and make a time to see you. We realise this does take time but your participation would be greatly appreciated. It is intended that the results of this analysis will lead to the establishment of a set of guidelines for practitioners to use when counselling women. We will send you a copy of the finished analysis. Once again thank you for your co-operation and taking the time to be involved.

Yours sincerely

Lynne Briggs Elizabeth Chesterman

APPENDIX 8 Second letter to participants in Practitioner Study

34 Glenstrae Road
Christchurch 8
Phone 842-655
10 February 1991

Dear Colleague,

I hope you received, and enjoyed reading, the copy of the final outcome of the "Analysis of Practice" inquiry I carried out, with your help, last year. This year I am completing a thesis titled "Precipitating the Disclosure of Childhood Sexual Abuse" .

The field work for the study was originally undertaken in 1986 as part of an evaluation of a community based counselling centre. The main aim of that evaluation was to determine from the women attending for counselling the number who had histories of childhood sexual abuse. From the 105 responses to a self report questionnaire, we found that 51% of the women had been sexually abused at some stage of their childhood or young adult lives.

During the evaluation, attempts were also made using a predictive syndrome postulated by Ellenson (1985), to determine prevalence among the women sexually abused as children and those presenting with symptoms of *Post Tramautic Stress Disorder* (PTSS). The results were inconclusive, and as at that stage the main aim of the evaluation had been achieved, no further analysis of the data was carried out.

It seems, however, that now more people in the helping profession are asking questions about the relationship, if any, between childhood sexual abuse and later development of symptoms of PTSS (Christchurch Press January 1991). I have re-worked the data from the 1986 survey in regard to the use the predictive syndrome and again find that I cannot suppport Ellenson's theory. This leaves unresolved questions about how practitioners predict histories of sexual abuse in women clients. *What are the indicators?* In addressing this question, what appears to be most helpful in looking at predicting histories of childhood sexual abuse in this country is the responses you gave during the interviews you were involved in last year.

This is really important and I would very much like to come back and ask you, as a follow up to last year's work, two more very specific questions. They are:

1. How do you predict sexual abuse in a client?

2. How often are you right ?

I will telephone you over the next few days to see if you are prepared to be involved in a third interview, and if it is possible make a time to see you. This really will be the last request as I realise this does take your time, but your participation would be greatly appreciated. It is intended that the results of this study will be published. However, every endeavour will be made to ensure your identity will remain confidential. Once again I would like to thank you for your co-operation and taking the time to be involved, as, without your participation, the research could not be completed. I will send you a copy of the findings when the study is completed.

Yours Sincerely

Lynne Briggs

APPENDIX 9 Trial Index of Indicators of Sexual Abuse

Name..... No of Cases Reviewed.....

Indicators of Sexual Abuse	Observed
Alcohol/Drug problem	
Anger/difficulty relating to men generally	
Lack of trust in people	
Dysfunctional sexual relationships	
Dysfunctional relationships with partner/friends	
Dysfunctional parental relationships	
Eating disorders	
Prostitution	
Depression	
Difficulties with parenting	
Sexual promiscuity	
Asexuality	
Over-achieving	
Lack of self-confidence	
Low self esteem	
Unresolved grief	
Self harm	
Own children abused	
Phobias	
Lesbian relationship	
Anxiety	
Incongruence (appearance/manner) of client	

APPENDIX 10 Letter to Group B participants in Practitioners Study

34 Glenstrae Road
Christchurch 8
Phone 842-655
12 April 1991

Dear Colleague,

As discussed with you over the telephone I am hoping to complete a thesis titled "Precipitating Disclosure of Childhood Sexual Abuse" during this year. Part of the field work for the study was undertaken in 1986 as part of an evaluation of a community based counselling centre. The main aim of that evaluation was to determine from the women attending for counselling the number who had histories of childhood sexual abuse.

From responses to a self report questionnaire, it was found that 51% of the women had been sexually abused at some stage of their childhood or young adult lives. Furthermore, only one of the women had been referred specifically for sexual abuse counselling even though, for most anyway, the abuse had continued to have an effect on their lives in one way or another .

This left unresolved questions about how practitioners precipitate disclosure of previous sexual abuse experiences if it is not voluntarily revealed by the woman presenting for counselling. This is the second part of the study. During the past twelve months I have undertaken a series of in-depth interviews with a variety of practitioners in social service agencies specifically aimed at determining how they identify clients with previous sexual abuse experiences.

From the responses they gave during the interviews I have constructed a trial "index of sexual abuse indicators," which is the third aim of the study. Your task is the "testing out" of the index to see if it has any face validity for practitioners in the field. In order to do so I am asking that you review five cases where sexual abuse has been identified as a problem, then using the index of sexual abuse indicators as a check list, identify the number of indicators on the list present in each case.

I realise this does take your time but your participation is greatly appreciated, as, without your participation, the research could not be completed. Once again thank you for your co-operation and I will send you a copy of the findings when the thesis is completed.

Yours Sincerely

Lynne Briggs

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