SURVIVORS OF CHILD SEXUAL ABUSE: A CLINICAL EVALUATION BEFORE AND AFTER ATTENDING COUNSELLING

Lynnette Emily Briggs

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ABSTRACT

The long-term effects of childhood sexual abuse (CSA) are well documented in the clinical literature. Studies show that many survivors experience long term sequelae in terms of their overall social, psychological and sexual functioning in adult life. Thus it is likely that many survivors will seek assistance such as counselling at some stage of their lives in order to deal with the problems related to CSA. Given the range of psychological sequelae to sexual abuse experiences, it is important to determine women’s psychological and social functioning before and after attending counselling.

This study had two main aims. The first was to determine, on assessment of clients for intake into the sexual abuse programme of a Family Health Counselling Service (FHCS) the range and extent of symptomatology, including symptoms of post-traumatic stress disorder, dissociative symptoms, symptoms of anxiety and eating disorders, depression, substance abuse and impaired social functioning.

The contribution of post-traumatic stress disorder symptomatology (PTSD) to the therapeutic domain of sexual abuse counselling is an important one. That is, it provides an observational framework for studying the effects of the abuse and any change following regular attendance at counselling. From a social and political perspective PTSD symptomatology provides a model for understanding the mental health needs of a specific population—adults with problems related to child sexual abuse. This allows for the emergence of much needed data that have not previously existed about the effects of CSA.

The second aim was to determine the number of women in the study who experienced a decrease in symptoms of PTSD, dissociative symptoms, symptoms of anxiety, depression
and substance abuse, and who experienced an improvement in their overall social functioning following counselling.

Measurement occurred at initial assessment and at three and six months intervals after counselling had commenced. As this was a clinical study of women clients attending the FHCS for counselling there was no control group.

The results of the study confirmed the general impression that the impact of child sexual abuse is serious and can manifest itself in a wide variety of symptomatic and pathological behaviours. Generally, where the women reported multiple abusive episodes which involved sexual intercourse, the likelihood of their having symptoms of PTSD was significantly increased.
PREFACE

Hurt children often grow up to become distressed and unhappy adults. Unfortunately, despite the widespread incidence of child abuse in this country, it is often ignored. With the feminist revolution in the late 1960s and 1970s this picture started to change. Women began to speak out about their experiences and attention was turned to the previously unrecognised suffering of survivors of child sexual abuse. As a social work clinician working with women clients attending mental health services, it became increasingly evident to me that child sexual abuse had been a common experience for many of them. The sad fact is although 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, abusive experiences in childhood were seldom discussed or detected.

Though most clinicians would agree that exposure to extreme stress or trauma (such as child sexual abuse) can cause psychological damage, there is considerable controversy about whether post-traumatic stress disorder (PTSD) is an appropriate diagnosis for survivors of child sexual abuse. In this study it became evident that many of the women did have full, or partial, symptoms of PTSD. This was a very important finding as a major advance in the field of trauma and post-traumatic stress has been the identification of a distinct set of biological alterations that correlate with the concept of PTSD.

This finding has implications for treatment of all trauma survivors regardless of whether the PTSD is the result of CSA or any other kind of traumatic event such as war or torture. My hope is that such developments may assist people to recover from the effects of psychological trauma.
ACKNOWLEDGMENTS

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PUBLICATIONS

Publications and papers associated with this thesis, which have either been, or are in the process of being published, are listed below.


# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>Preface</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgment</td>
<td>v</td>
</tr>
<tr>
<td>Publications</td>
<td>vii</td>
</tr>
<tr>
<td>List of Tables</td>
<td>xii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>xv</td>
</tr>
<tr>
<td><strong>Chapter 1. Introduction</strong></td>
<td>1</td>
</tr>
<tr>
<td>Social Analysis of Sexual Abuse</td>
<td>2</td>
</tr>
<tr>
<td>The Incidence of CSA in New Zealand</td>
<td>4</td>
</tr>
<tr>
<td>Overview of the Clinical Literature</td>
<td>5</td>
</tr>
<tr>
<td>Definition of Child Sexual Abuse</td>
<td>7</td>
</tr>
<tr>
<td>Terminology</td>
<td>8</td>
</tr>
<tr>
<td>Overview of the Thesis</td>
<td>8</td>
</tr>
<tr>
<td><strong>Chapter 2. What is Child Sexual Abuse</strong></td>
<td>10</td>
</tr>
<tr>
<td>How Common is Child Sexual Abuse ?</td>
<td>11</td>
</tr>
<tr>
<td>The Social Context in which Sexual Abuse Occurs</td>
<td>16</td>
</tr>
<tr>
<td>The Sequelae of Sexual Abuse</td>
<td>20</td>
</tr>
<tr>
<td>Summary</td>
<td>32</td>
</tr>
<tr>
<td><strong>Chapter 3. Therapy for Survivors of Child Sexual Abuse</strong></td>
<td>33</td>
</tr>
<tr>
<td>Therapeutic Approaches</td>
<td>34</td>
</tr>
<tr>
<td>Specific Treatments for Survivors of Child Sexual Abuse</td>
<td>39</td>
</tr>
<tr>
<td>Therapy for the Survivor with PTSD and Dissociative Symptoms</td>
<td>42</td>
</tr>
<tr>
<td>Medication and Therapy</td>
<td>50</td>
</tr>
</tbody>
</table>
Chapter 4. Methodology 56

Overview of study design 56
Ethical Issues 59
Aims of the Study 60
Study Hypotheses 61
Selection and Recruitment 61
Inclusion and Exclusion Criteria 62
Baseline assessment 63
Three Months Follow-up Interviews 67
Six Months Follow-up Interviews 68
Counsellor Report 68
Data Handling and Data Checking 69
Statistical Analysis 69

Chapter 5. Baseline Results 70

The Sample 71
The Nature and Extent of CSA 73
Other Abuse and Neglect 76
Mental Health History 79
Current Symptomatology and Social Functioning 84
Analysis of Symptomatology 89
Correlations Between Measures 92
Relationship of Antecedent Events to Symptomatology 94
Associations Between CSA and Symptomatology 96
Predictors of PTSD Symptomatology-Multiple Regression Analysis 97
Associations of Conduct and Eating Disorders with PTSD 102
Effects of General Psychopathology and CSA Experience on PTSD 104
Chapter 6 Outcome of Counselling

Referrals to Counselling
Characteristics of Study Dropouts
Changes in Symptomatology
Defining Outcome At Six Months
Therapeutic Intervention
Client Self Report
Counsellor Report
Other Factors Affecting Symptom Change
Childhood Effects on Outcome
Do Other Factors Impact on the Overall Outcome of Counselling?
Comparisons with the Christchurch Outcome of Depression Study
Overall Summary of Results

Chapter 7. Discussion of Results

Summary of Results
The Nature and Extent of Sexual Abuse
Current Symptomatology
Associations between CSA and PTSD Symptomatology
Predictors of PTSD Symptomatology
Outcomes after Counselling
Description of Treatment
Other Difficulties
Comparison between the CSA Study and the Outcome of Depression Study
Significant Differences in Outcome
Overall Conclusion
### Chapter 8 Methodological Considerations and Conclusions 157

Methodological Considerations 157
Ethical and Logistic Factors 159
Risk Factors for PTSD 159
Concluding Comments 160
Directions for Future Research 162

### Bibliography 164

### Appendices 185

1. Initial Referral Form and Sexual Abuse History
2. Survey Information Pamphlet
3. Study Consent Form
4. Self-report Questionnaires
5. Three months follow-up general questions
6. Six months follow-up general questions
7. Counsellor Report Form
8. DSM-IV Diagnostic Criteria for PTSD
<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>28</td>
</tr>
<tr>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>5</td>
<td>71</td>
</tr>
<tr>
<td>6</td>
<td>72</td>
</tr>
<tr>
<td>7</td>
<td>72</td>
</tr>
<tr>
<td>8</td>
<td>73</td>
</tr>
<tr>
<td>9</td>
<td>74</td>
</tr>
<tr>
<td>10</td>
<td>75</td>
</tr>
<tr>
<td>11</td>
<td>75</td>
</tr>
<tr>
<td>12</td>
<td>76</td>
</tr>
<tr>
<td>13</td>
<td>77</td>
</tr>
<tr>
<td>14</td>
<td>78</td>
</tr>
<tr>
<td>15</td>
<td>81</td>
</tr>
<tr>
<td>16</td>
<td>82</td>
</tr>
<tr>
<td>17</td>
<td>83</td>
</tr>
<tr>
<td>18</td>
<td></td>
</tr>
</tbody>
</table>

LIST OF TABLES

1. Studies showing characteristics of childhood sexual abuse reported from adult retrospective non-clinical samples
2. Long-term effects of sexual abuse noted in each study
3. Studies of the effects noted in specific populations and mental health clients
4. Summary of factors contributing to symptom severity
5. Cross tabulation of ethnicity with relationship status
6. Derivation of income for total sample
7. Referral sources for sexual abuse counselling
8. Additional reasons given for seeking counselling now
9. Frequency and type of sexual abuse experienced before 16 years of age
10. Relationship between the perpetrator and the child for CSA before 16 years of age
11. The number of women who first reported each type of sexual abuse experience by age of first occurrence
12. Frequency and type of ASA reported
13. Relationship between the perpetrator and the woman for sexual abuse after 16 years of age
14. Relationships with and between parents before 16 years of age
15. Frequency distribution of responses to conduct disorder criterion related questions
16. Percentage of criteria related symptoms
17. Frequency of responses to DSM-IV eating disorder questions
18. Other psychopathology measured by the SCL-90 at baseline
<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Social functioning measured by the SAS at baseline in a sample of sexually abused women</td>
</tr>
<tr>
<td>20</td>
<td>Factor analysis</td>
</tr>
<tr>
<td>21</td>
<td>Pearson correlations between SCL-90 subscales and PTSD total score at baseline</td>
</tr>
<tr>
<td>22</td>
<td>Correlations between SCL-90, SAS total scores and PTSD derived factors</td>
</tr>
<tr>
<td>23</td>
<td>Pearson correlation matrix of PTSD, SCL-90, SAS, and AUDIT total scores</td>
</tr>
<tr>
<td>24</td>
<td>Pearson correlations between PTSD, SAS, SCL-90 and AUDIT total scores and antecedent factors</td>
</tr>
<tr>
<td>25</td>
<td>Comparison of the mean PTSD total score with incidence of sexual intercourse in CSA</td>
</tr>
<tr>
<td>26</td>
<td>Stepwise multiple regression analysis of variables found to predict PTSD in a sample of sexually abused women</td>
</tr>
<tr>
<td>27</td>
<td>Comparison between age of first occurrence of CSA by sexual intercourse and mean PTSD total score at baseline</td>
</tr>
<tr>
<td>28</td>
<td>Comparison of first instance and duration of sexual intercourse with mean PTSD total score at baseline</td>
</tr>
<tr>
<td>29</td>
<td>Comparison of the relationship between the perpetrator and the child for CSA before 16 years of age and the mean PTSD total score at baseline</td>
</tr>
<tr>
<td>30</td>
<td>Comparison of mean baseline PTSD total score by whether or not sexual intercourse was involved in the CSA and/or ASA experience</td>
</tr>
<tr>
<td>31</td>
<td>Mean PTSD score at baseline by conduct disorder and CSA by sexual intercourse</td>
</tr>
<tr>
<td>32</td>
<td>Mean PTSD score at baseline by eating disorder and CSA by sexual intercourse</td>
</tr>
<tr>
<td>Page</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>33</td>
<td>The effect of SCL-90 and being threatened with abuse on PTSD symptomatology</td>
</tr>
<tr>
<td>34</td>
<td>A comparison of characteristics between study dropouts and study completers</td>
</tr>
<tr>
<td>35</td>
<td>A comparison of mean PTSD, SCL-90, and SAS total baseline scores between study dropouts and study completers</td>
</tr>
<tr>
<td>36</td>
<td>Comparisons between baseline, three and six months mean PTSD, SCL-90 and SAS total scores among a sample of sexually abused women</td>
</tr>
<tr>
<td>37</td>
<td>Multiple regression analysis of predictability of six months PTSD score by baseline PTSD score</td>
</tr>
<tr>
<td>38</td>
<td>Comparison of mean baseline and six months PTSD total score by whether CSA experience involved sexual intercourse or not</td>
</tr>
<tr>
<td>39</td>
<td>Pearson correlations of percentage change in PTSD, SCL-90 and SAS total scores between baseline and six months</td>
</tr>
<tr>
<td>40</td>
<td>Summary of factors affecting baseline, six months, and percentage change in PTSD scores</td>
</tr>
<tr>
<td>41</td>
<td>Summary of factors affecting baseline, six months, and percentage change in PTSD scores</td>
</tr>
<tr>
<td>42</td>
<td>Summary of childhood effects on the baseline and six months PTSD score and percentage change in PTSD score</td>
</tr>
<tr>
<td>43</td>
<td>Summary of other factors affecting outcome of counselling as measured by percentage change in PTSD score</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Distribution of AUDIT total scores at baseline among a sample of sexually abused women</td>
<td>89</td>
</tr>
<tr>
<td>2</td>
<td>Factor scree plot</td>
<td>90</td>
</tr>
<tr>
<td>3</td>
<td>Flow diagram of referrals for counselling</td>
<td>108</td>
</tr>
<tr>
<td>4</td>
<td>Scatterplot of baseline and six months PTSD total scores</td>
<td>112</td>
</tr>
<tr>
<td>5</td>
<td>A two study comparison of SCL-90 scores over a six months period grouped by type of CSA</td>
<td>133</td>
</tr>
<tr>
<td>6</td>
<td>A two study comparison of SAS scores over a six months period grouped by type of CSA</td>
<td>134</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION

Adult problems in self perception and self acceptance, relationship to others, and worldview can often be understood as the logical consequences of child maltreatment. This is the central message in John Briere’s (1992) book, Child Abuse and Trauma. Briere (1992) makes the case for recognising that much of what mental health professionals see as adult psychopathology actually reflects long-term reactions to child abuse. Though the type of abuse experienced, be it sexual, physical or psychological, may make a difference, it is being abused as a child that seems to matter most. As Briere (1992:17) points out, child abuse occurs during the most critical period of life, that is, when assumptions about self, others and the world are being formed; when their relations to their own internal states are being established; and when coping and affiliative skills are first acquired.

Professionals working in mental health services and the therapeutic community need to be aware of this as, in the absence of appropriate intervention, hurt children often grow to become distressed and symptomatic adults. Although the research on several forms of child abuse is still limited, it seems clear that untreated trauma arising from abuse during childhood constitutes a major risk problem for a variety of mental health and social problems later in life (Briere, 1992:77).

While this may be true for all forms of child abuse, this research deals specifically with the problems related to child sexual abuse (CSA). Furthermore, though 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.
Social Analysis of Sexual Abuse

In order to understand the dynamics of CSA in society, propositions about gender relations in the family and the context in which sexual abuse occurs need some exploration.

Though no explicit family policy exists in New Zealand, there is an abundance of policies that affect the family, all of which reflect and embody assumptions about the definition and nature of family life. These assumptions include the belief that in a "normal" family the adult male's role is primarily in the paid workforce. Familial ideology, therefore, constructs and reinforces specific ideas about the most desirable form of gender and family relations. The construction of the family in this way has resulted in women being socially defined as mothers and wives responsible for the bearing and rearing of children, the care of husbands, and the maintenance of the domestic sphere (Ballock and Cass, 1988).

The economic dependency of women, which is a consequence of this division of labour, is also a major source of men's power within households. For women, this, the structural root of power, is the crucial issue. When evaluating the differing explanations that have been offered by various theorists who have examined the sexual abuse of children, this imbalance of power in male-female relationships needs to be taken in to account. This approach is favoured, rather than the customary one of drawing on historical, anthropological and psychoanalytic perspectives, as it is more helpful in understanding the nature and incidence of sexual abuse in contemporary western society.

Put briefly, through most of this century CSA was either simply ignored or elaborately reconstructed. It was supposed that either it did not really happen and all children tended to imagine it, or occasional miscreant kids followed their wishful thinking in seductive conquest (Summit, 1995). The feminist revolution of the 1960s and 1970s abruptly reframed this picture and was instrumental in bringing to public attention the unrecognised suffering of survivors of both rape and child sexual abuse. Recently much more attention has been paid to
the social context in which sexual abuse occurs and in the last few years publications about sexual abuse in New Zealand have become available.

Previously, most explanations about sexual abuse were American and reported in psychiatric and psychological journals. Freudian concepts dominated earlier thinking on the subject while later theories focused on the characteristics of the individual offender, subcultural patterns and interactional processes within the family. Such explanations are frequently based on extrapolations from a small number of cases, the findings of which have been uncritically incorporated into subsequent writings (Bender and Blau, 1937; Lustig, et al., 1966).

Furthermore, 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, coupled with society's prevalent but erroneous attitude that children are predominantly sexually abused by strangers and not family members, led to the development of several myths about sexual abuse.

The greatest explanatory power in dispelling these myths 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 is that 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 further examined by feminist theorists.

In doing so Blake-White and Kline (1985) defined the distinguishing characteristics of an abusing male as a tendency to be introverted, mistrustful and suspicious; to have few friends or contacts outside the home; and often to 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".

Over the years feminists (Forward and Buck, 1978; Blake-White and Kline, 1985) have also drawn 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, they 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.

When considering some of the processes that operated in structuring the organisational arrangements of contemporary New Zealand society, it can be seen that it is in the home that the economic relationship, and therefore the power relationship, between men and women becomes clear, as it is here that redistribution between wage-earners and their economic dependents takes place. In return for her subsistence the wife-mother exchanges housework, childcare and sexual servicing with the male wage-earner.

Feminist theorists have clearly linked issues of sexual abuse to overall structural dynamics, such as power and familial dependency. That is, by making explicit how the siting of women in the private sphere, in the family, and in personal relationships, social control has been largely left to men inside the family unit. It is in such a context 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.

In sociological terms then, the problem of sexual abuse can be related to an imbalance of power in gender relations. A greater understanding of the way in which power is distributed unequally according to gender in the context of contemporary New Zealand society provides an appreciation of the social context in which sexual abuse can occur.
The Incidence of Child Sexual Abuse in New Zealand

Members of the helping professions, clinical advisors to Government, and the New Zealand community in general, have become increasingly aware of the widespread incidence of sexual abuse in this country. Although increased publicity surrounding the incidence of sexual abuse has focused public attention on the issue and prompted greater emphasis on identifying the prevalence of abuse, the secrecy surrounding it still makes research in the area difficult. Until recently, most of the studies carried out were in clinical settings with little work being undertaken on general population samples of sexual abuse victims.

To date, the most definitive, community-based study of childhood sexual abuse (which continues to provide a benchmark against which other data may be compared) is that undertaken in America by Russell (1983, 1986). Using this study as a guideline, estimates show that one in four female children and one in 10 male children are sexually abused in New Zealand.

In New Zealand a Dunedin-based general population study, looking at the impact of sexual and physical abuse on women’s mental health, supported these findings (Mullen et al., 1988). They found one in three women in their study reported having had one or more unwanted sexual experiences before the age of 16 years. Another community-based New Zealand study (Bushnell et al., 1992) estimated a 13 percent prevalence rate for intra-familial abuse. These figures highlight the importance of the issue in present-day New Zealand society and suggest that any individual girl is at high risk of some form of sexual abuse.

Overview of the Clinical Literature

The clinical literature was reviewed for this thesis with the following two questions in mind. What is CSA and what are the effects on adult functioning?

Long-term effects
The long-term effects of childhood sexual abuse have been well documented in the clinical literature. They include 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 (Meiselman, 1978; Courtois, 1979; Herman, 1981; Gelines, 1983; Briere, 1984; Mullen et al, 1988). Given the psychological sequelae to sexual abuse experiences, it is important to determine the effectiveness of counselling.

**Effect on severity**

Several factors are identified in the literature as influencing the impact, and therefore the severity, of child sexual abuse. Such factors 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 of sexual abuse on a child will be a function of the developmental stage of the child (Lewis and Sarrel, 1969; Browne and Finkelhor, 1986; Moscarello, 1990).

**Post-traumatic stress disorder**

The term *post-traumatic stress* refers to certain enduring psychological symptoms that reliably occur in reaction to a highly distressing psychically disruptive event. In 1980 the American Psychiatric Association recognised 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* (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III,1980; DSM-III-R,1987). The American Psychiatric Association also noted that the most severe and long-lasting symptoms occurred when the stressor was human, as in sexual assault.
The psychological reaction to sexual assault was first described in 1974 by Burgess and Holmstrom as the rape trauma syndrome. A strong case was made by Lindberg and Distad (1985) for viewing post-traumatic stress as an appropriate diagnosis for some adults who suffered sexual abuse during childhood. Others (McLeer et al., 1988; Kiser et al., 1988; Dahl, 1989) also found symptoms of post-traumatic stress among survivors of sexual abuse. Symptoms include the classic triad of haunting intrusive recollections (flashbacks); numbing or constriction of feelings and focus; and lowered threshold of anxious arousal. These occur after experiencing intense fear, terror, and loss of control (American Psychiatric Association, 1987).

While post-traumatic stress can occur immediately, often the full effect of the trauma of sexual abuse is not noticeable for many years (Moscarello, 1990).

Dissociative symptoms are also included in the criteria set for PTSD and an additional dissociative disorder diagnosis would not be given if the symptoms occur exclusively during the course of PTSD. Probably the simplest and most common form of dissociation involves a cognitive separation of the individual from their environment at times of stress or trauma.

In traumatic circumstances dissociation may occur either temporarily or permanently (Spiegel et al., 1988). For example, in sexual abuse amnesia for the actual abuse and other events related to the abuse serves the purpose of removing from the individual’s awareness parts of the event or the event in total. In this sense dissociation is a defence mechanism which can be mobilised as a means to escape mentally from a situation from which there is no physical escape route (Spiegel et al., 1988). “Flashbacks” signal the return of memories previously forgotten. However, not all agree. In their Dunedin general population study Mullen et al., (1988) reported no evidence was found to support symptoms described as “the post sexual abuse syndrome”.
Definitions of Child Sexual Abuse

Definitions of childhood sexual abuse are unclear, and no standard definition exists. The use of the word “abuse” in itself presupposes a value judgment that the involvement of children in sexual gratification by adults is wrong. Children and adolescents are emotionally and materially dependent on adults and are unlikely to understand adult meanings of sexuality. This means they unable to exercise real choice if approached by an adult. Usually the age difference between the abuser and the abused has been defined as needing to be of five years or more (Browne and Finkelhor, 1986:66). However, with 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. 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). This includes incest which, as Fairtlough (1983) points out, is seen as a particularly damaging aspect of the spectrum of child sexual abuse. Dolan (1991:1) defined incest as “sexual contact with anyone considered to an be an inappropriate sexual partner because of blood, or social ties, to the individual and her family”.

Terminology

Throughout the literature the terms “victim” and “survivor” are used interchangeably. In this study the term “survivor” will be used because it implies, as Dolan (1991) suggests, that all clients have what it takes to survive. That is they have persistence, strengths, skills and personal resources. Other terms 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 verbally reveals a history of sexual abuse. This is a significant event in counselling sexual abuse survivors, and it is important that professionals can respond appropriately when disclosures of previous sexual abuse occur. The term “intervention methods” embraces a wide variety of specific counselling techniques which have a theoretical base and therapeutic aims.
Overview of the Thesis

Currently no basic data exists in New Zealand which indicate the effectiveness of sexual abuse counselling. The purpose of this study was to clinically evaluate women’s psychological and social functioning before and after attending sexual abuse counselling. There were two main aims. The first was to ascertain the symptomatology and current social functioning of a sample of women presenting for intake into a Family Health Counselling Service's Sexual Abuse Programme. The second aim was to determine the number of women in the study who had experienced a decrease in symptomatology and who had made an improvement in their overall social functioning following counselling. Measurement occurred at initial assessment and at three and six months after counselling had commenced.

Two hypotheses were explored in this study. The first was that women with the worst CSA histories would be more symptomatic and more socially impaired at assessment. The second was related to the outcome of sexual abuse counselling. It was expected that unless the women had been further sexually abused as an adult and providing they had attended counselling regularly, an improvement would be noticeable in their symptomatology and social functioning at the six months follow-up interview.

Every woman client entering the Family Health Counselling Service’s Sexual Abuse Survivors Programme between August 1993 and June 1996 who met the inclusion criteria was invited to participate in the study. Following an initial assessment clients were referred out to Accident Rehabilitation and Compensation Insurance Corporation (ACC) accredited counsellors in the private sector for sexual abuse counselling. If, for a variety of reasons a referral out was not possible, then the women were offered counselling through the Family Health Counselling Service.

Chapter Two addresses the question of how common childhood sexual abuse is, the social context in which it occurs and the long-term effects in adult life. Chapter Three discusses therapeutic theories about sexual abuse and looks at treatment for adult survivors.
Included in that chapter is a discussion about the use of appropriate intervention methods and the ongoing debate about the relative merits of long and short-term therapies. Chapter Four focuses on the methodology used in the study, the selection of study participants, the initial assessments, the follow-up assessments and data analysis. Chapter Five gives a description of the abused women and looks at baseline symptomatology and overall social functioning before attending counselling. Chapter Six looks at the psychological and social functioning of the women following counselling. In doing so attempts are made to look at predictors of improvement from counselling. Chapter Seven summarises the research and discusses the overall results of the study. Chapter Eight makes recommendations for future studies.
CHAPTER TWO

WHAT IS CHILD SEXUAL ABUSE?

Recognition that child sexual abuse is a widespread social problem is a recent phenomenon in New Zealand. Internationally it is generally accepted that the problem is far greater than estimates from reported cases would indicate. Attempts to address the issue have been slow. This makes it difficult to gain an accurate understanding of incidence and prevalence, as most of the information about sexual abuse has been discussed in the clinical literature with very little information available from non-clinical populations. This situation is reflected throughout the clinical literature. Even in international studies much of the relevant research in the area of child sexual abuse is fraught with methodological problems. For example, no standard definition of child sexual abuse appears to exist. Most researchers have created an operational definition for the purposes of their own study. The main variables in contention seem to be sample populations, 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 whether the child views the abusive experience as negative.

The chapter is divided into three parts. The first looks at how common child sexual abuse is from a national and international perspective. Clinical retrospective studies are considered first. The focus then moves to the data arising from more empirically based studies. Researchers undertaking such studies have attempted to address the methodological problems mentioned above by applying more stringent definitional criteria to community-based samples. However, perceptions of any social phenomenon—its relevance, effects and causes—are largely determined by the belief systems of the perceivers. Part two reviews theoretical explanations of sexual abuse, and then explores propositions about gender relations in the family and the context in which sexual abuse occurs. In doing so, it takes into account
the imbalance of power in male-female relationships. Part three looks at the sequelae to child sexual abuse in adult life.

How Common is Child Sexual Abuse?

The focus of this study is on the experiences of girls and women. It is not the intention of the author to convey the impression that sexual abuse of boys and men is not important or to minimise it in any way. However, prevalence and incidence reports of sexual abuse of males is minimal and largely based on child protection agencies. From what is known it seems the characteristics of child sexual abuse differ significantly for boys and girls. For example, while the majority of boys are abused outside the home by a non-relative, girls are more likely to be abused within the home by an adult relative (Fisher, 1991:3).

Many of the earlier sexual abuse studies are based on international clinical samples and are reported in psychiatric and psychological journals. As the available literature on sexual abuse in New Zealand is sparse, it is essential that these studies are canvassed and the central themes highlighted. One of the main themes to emanate from the literature is that the majority of sexually abused children are female. This was first demonstrated by De Francis (1969) who found that 90 percent of the sexual abuse victims were female, and later by Beezley et al. (1981) and Conte and Berliner (1981) who found that 86 percent of victims were girls.

It tends to be generally accepted that, apart from the relationship between wife and husband, a prohibition exists on sex within the family. This belief is challenged by the literature, which shows that a significant number of studies suggest that the incidence of sexual abuse is most prevalent within families. When looking at who does the abusing it was found 93 to 97 percent of the offenders were male, with the most statistically numerous configuration reported being father or step-father and daughter incest (De Francis, 1969; Finkelhor, 1979; Conte and Berliner, 1981). Finkelhor (1979) found no cases of mother-son incest and concluded that father-daughter incest was the most traumatic. While not specifying the sex of the offender, Beezley et al., (1981) noted that in two percent of the cases studied
the abuse was committed by the mother. Though a common image of the dynamics of incest is that of a teenage girl giving out signals of sexual readiness to her father, many of the studies demonstrated that the abuse starts before puberty (Conte and Berliner, 1981). The mean age for the start of abuse was identified by Lukianowicz (1972) as eight and a half years and by Finkelhor (1979) as ten years.

The findings of a clinical study in New Zealand (Briggs, 1992) were congruent with the above studies. This study found 51 percent of the 105 women in the sample considered they had been sexually abused. The degree of intra-familial child sexual abuse in this study was probably under-estimated, as step-fathers and foster-fathers were not separated out from the “known to the child category”. This meant that while 13 percent reported being abused by father or adoptive father and 7 percent reported being abused by someone they knew, the data are skewed in comparison to other studies where categories of intra-familial abusers are a distinct category on their own. Stranger abuse accounted for 22 percent, with 98 percent reporting being abused by a male and two percent by a woman. Eight percent were abused before they were five years of age, 30 percent between the ages of six and ten years, 45 percent between 11 and 15 years, and for 17 percent the abuse first happened between 16 and 20 years of age.

Most of the above studies have tended to focus on incest, with less restrictive definitions of what constitutes sexual abuse. A review of the more empirically-based research, which considers both intra-familial and extra-familial child sexual abuse, provides a different as well as a convergent perspective.

**International research**

Several studies have been conducted in an attempt to ascertain the incidence and prevalence of child sexual abuse in general populations. Kinsey *et al.*, (1953) and Landis (1956) were among the first to attempt to document the incidence of sexual abuse in America. Later Finkelhor (1979) conducted the first large-scale and the most widely quoted study ever
to be undertaken in the United States. Age difference between the abused and the abuser was the determining factor in defining sexual abuse in this study.

When reporting on their student study, Briere & Runz (1985) made the point that dysfunctional victims are less likely to attend college and thus these samples may not accurately reflect the incidence of sexual abuse among the general population. In a Canadian study, Bagley & Ramsey (1986), sexual abuse was defined as genital contact between a child and someone at least three years older, or where force had been used. All participants in this study were women under forty years of age. Goldman and Goldman (1986) adapted Finkelhor’s questionnaire for an Australian sample. Sexual abuse was defined by age discrepancy between the abused and the abuser. Their findings were similar to Finkelhor’s, the exception being an increased incidence rate for girls.

To date the most definitive community-based study of child sexual abuse (which continues to provide a benchmark against which other data may be compared) is that undertaken in America by Russell (1983, 1986). In this study specifically trained interviewers spent time with each participant, allowing rapport to be established before asking questions designed to trigger memories of sexual abuse, whereas other studies asked a smaller number of questions about abusive experiences. Russell’s definition included non-contact sexual abuse. While the incidence of child sexual abuse in Russell’s study is higher than the incidence found in any other American study, Russell (1983) believed her rates were still low given the proportion of women who were either unable or unwilling to disclose.

**New Zealand research**

As public awareness, community education, social service workers’ abilities to intervene, and the development of services for sexual abuse have all increased over the past two decades, so too has the estimated prevalence in New Zealand. Whether this is due to increased sensitivity to the issue with a corresponding willingness to report incidences, or whether there has been a significant increase in the overall rates of child sexual abuse, it is
difficult to say. Russell’s (1983, 1986) American community study of adult women survivors of child sexual abuse still provides the best estimate of past reporting rates. Using this study as a guideline, 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.

Findings from a community based study (Mullen et al., 1988) adds support to Russell’s study. This first New Zealand general population study was based in Dunedin and looked at the impact of sexual and physical abuse on women’s mental health. A sample of two thousand women, randomly selected from the electoral roles of five contiguous New Zealand Parliamentary constituencies, were sent a questionnaire. A sub-sample of 314 women who had high scores on the General Health Questionnaire (GHQ) were invited to participate in a further interview. Questions on child or adult sexual abuse experiences were included in the subsequent interview schedule. Those who reported sexual abuse were questioned further in a semi-structured interview to elucidate the details of the abuse.

A “child” was defined in this study as a person twelve years of age or younger. Of the women interviewed, 13 percent reported genital contact child sexual abuse. Men were reported to be the perpetrator in 98 percent of the abusive episodes. When weighted back to the original random sample (to allow for the over-representation of women with high initial GHQ scores), this study gave a rate of reported child sexual abuse of nearly ten percent for the population as a whole.

The Christchurch Psychiatric Epidemiology Study (CPES) was a large New Zealand community survey of mental disorders. Taking a sub-sample from that study, Bushnell et al., (1992) re-interviewed 301 women aged between 18 and 44 years to determine the influence of child sexual abuse on adult depression. Sexual abuse was defined by an affirmative response to a question about sexual contact by a family member before the age of 15 years. Non-genital contact was excluded. Estimates of the prevalence of sexual abuse were achieved by adjusting weights to compensate for the fact that only a proportion of those eligible were interviewed.
Forty-nine women reported incestuous abuse, giving a back-weighted prevalence estimate of 13 percent for intra-familial abuse in this study.

The Anderson et al., (1993) study, designed to ascertain the prevalence and nature of child sexual abuse, selected a sample of women from 3000 who had previously been sent a postal questionnaire by the Otago Women’s Health Study (Mullen et al., 1988). From the group identified (on the postal questionnaire) as having poor mental health as adults and an increased prevalence of child sexual abuse, 298 were invited for a semi-structured interview. Of the women who had reported no abusive experiences, either as children or adults, 320 were randomly selected for a control group. The findings from this study were similar to that of Russell’s (1983) study. It was found that nearly one women in three reported having had one or more unwanted sexual experiences before the age of 16 years. Overall, this study found a high prevalence rate (32 percent) of reported child sexual abuse experiences before 16 years in a community sample of women.

The definition of sexual abuse included non-genital contact, which would account for the difference in prevalence rates from the Mullen et al., (1988) findings where a definition that excluded non-genital contact abuse was used. Although the interview sample did not include rural women, comparisons between urban and rural women were available from the postal questionnaire data. No systematic differences were found for overall prevalence rates and type of abuse experience between the urban and rural women, nor between the ten percent of women in the sample who grew up outside of New Zealand and the New Zealand women.

This is consistent with international studies (Baker and Duncan, 1985; Goldman and Goldman, 1986) where wide variations between regions showed until the data were analysed according to the region in which the person grew up in. The immigrant women mostly came from Australia and Great Britain.

The Canterbury Suicide Study also included in their interview schedule questions in regard to previous child sexual abuse (Beautrais et al., 1994). The data collected included a
description of the sexual behaviour, the age at which it occurred, the relationship between the abused and the abuser and the reactions of the abused at the time. Questions were also asked about any disclosure of the abuse to another person, and whether any counselling had been received to assist to deal with the sexually abusive experience. Sexual abuse was defined as experiencing physical or psychological force to participate in genital touching or sexual intercourse before 16 years of age. From the initial sample of 85 medically serious attempted suicides, 35 percent reported a history of child sexual abuse. Of the 90 control subjects it was found four percent reported a history of child sexual abuse.

Using a retrospective data set, gathered cross-sectionally from the Otago Women’s Health Survey, Romans et al.,(1995) assessed factors associated with good and poor psychological outcomes in a subset of women who reported significant prepubertal sexual abuse. The subset of 320 included abused women and a comparison group of non-abused women. A total of 138 of the women interviewed reported significant child sexual abuse that had involved genital contact.

The Christchurch Child Health and Development Study began with a birth cohort of 1265 children born in the Christchurch urban region. These children have been studied at birth, four months, one year, and then annually. The 18 years old interview schedule included questions about sexual abuse. Of the 516 young women interviewed, 17 percent reported experiences of child sexual abuse (Fergusson et al.,1995).

All the studies were retrospective and consequently refer to abuse which happened to the respondents during their child years. This means that all estimates of prevalence are based on adult populations, and this leaves unanswered the question of whether or not the current generation of children are having the same experiences. Taking these factors into account, these non-clinical studies do indicate that between 10 and 54 percent of the participants in the studies experienced child sexual abuse.
In a review of incidence rates across surveys Finkelhor and Baron (1986:45) noted that the higher rates tend to come from the more meticulous studies with the more carefully designed questionnaires, those with clearer definitions of CSA, with better trained interviewers, and the more intensive attempts to achieve candour. This suggests under-reporting is a serious problem.

The Social Context in which Sexual Abuse Occurs

In order to gain an understanding about the dynamics of sexual abuse it is necessary to understand the context in which it occurs. The intention of this section is to construct a picture of the interior of the social unit which is the arena of major sexual dramas and abuses. A prevalent but erroneous attitude in society is that children who are sexually abused are usually adolescents who, whether consciously or unconsciously, are the seducers of adults, and that abusers are predominantly strangers. This view has led to the development of several myths about the context in which child sexual abuse occurs. Such myths are exposed by the studies reviewed in the previous section. These studies show that, for most children, the abuse starts before puberty, they experience the abuse in their own homes, the abusers are known to the child, and in most cases it is men who do the abusing. Many experiences of child sexual abuse are also accompanied by threats of force or violence.

Several theorists (Finkelhor, 1979; Herman & Hirschman, 1977; Forward & Buck, 1978; Blake-White & Kline et al., 1985) found abusing males were often an excessively controlling and dominating force within the family. These males frequently used physical violence to assert their power. Lusting et al., (1966) found incestuous fathers felt the need to be patriarchs, held rigidly to segregated behaviour patterns in the home when compared with a group of wife-beaters, were more rigid in sex-role divisions when allocating household tasks and held a clear expectation that female children would carry out these chores. Scheurell and Rinder (1973) confirmed these findings in a study of social networks in incestuous families.
Such findings were reinforced later by Herman and Hirschman (1977), who speculated that these families become socially isolated by 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 (thus, sexual abuse has more to do with controlling or possessing a child than with sexual feelings).

The age of abuse, the sexual acts involved and the relationship of the abuser to the child reported in the New Zealand studies were all similar to those factors in other studies. Mullen et al., (1988) reported 15 percent of the abusers were father-figures and 24 percent were other male relatives; thus for 39 percent of the women in this study the abuse was intra-familial. One difference was the large number (49 percent) who reported being abused by a stranger. This difference could be a reflection of the methodological approaches used and the questions asked at the time of data collection. When looking at the age at which the sexual abuse occurred, it was found that the majority of children were abused between eight and 12 years of age with one percent reporting being sexually abused between 12 and 16 years and almost five percent after they had attained 16 years of age. The study also showed that experiences involving repeated abuse were more common when the abuser was a relative. The sexually abusive incidents involved sexual penetration and genital contact. The sexually abused women did not differ from the population as a whole in terms of social class and educational background.

For 10 of the 49 women reporting incest in the follow-up study by Bushnell et al., (1992) the experience involved physical violence. For 25 of those abused, the incest had involved sexual intercourse or attempted sexual intercourse. Another 10 women reported being sexually abused by someone outside the family, and 28 reported experiencing long-term effects as a result of the abuse. Intra-familial sexual abuse was reported by more than one in eight women. This rate was three times higher than estimated in the Mullen et al., (1988) study, which had comparable methodology, definition of abuse and sample population.
In the Anderson et al., (1993) study the abusers were normally known to the child, with 38 percent being abused by family members. Intra-familial abuse, particularly by fathers and stepfathers, accounted for approximately 12 percent of the total sample, with stepfathers being ten times more likely to abuse than biological fathers. Stranger abuse accounted for 15 percent of all abusive experiences. The abuse reported in this study was largely in the prepubertal age group, ten to twelve years of age, with eleven year olds being the most vulnerable. The data indicated that 42 percent experienced multiple episodes of abuse, with 30 percent of the sample experiencing abuse over a three year period. The abusive experiences involved were: non-contact abuse 13 percent; non-genital contact 15 percent; genital touching 27 percent; genital touching of the abuser 20 percent; attempted sexual intercourse 12 percent; sexual intercourse 12 percent. As each episode was counted separately, women who had multiple experiences of abuse appear in more than one category of abuse. No differences were found in the social-economic status of the families of origin between the abused women and the women in the control group.

The researchers in the Canterbury Suicide Study (Beautrais et al., 1994) found that suicide attempters with a history of child sexual abuse were significantly younger than those suicide attempters not reporting abuse. They also found that those attempters reporting abuse also tended to report higher rates of family problems.

In the overall sample, from which the Romans et al., (1995) sub-sample was selected, the relationship of the abuser to the child was reported as being the following: father nine percent, stepfather four percent, brother 11 percent, other male relative 27 percent, family friend nine percent, neighbour 24 percent, boarder two percent, stranger seven percent and other eight percent. Multiple experiences of abuse occurred for 22 percent of the women. The abusive experiences involved were: sexual intercourse 11 percent; attempted sexual intercourse 17 percent; genital touching 41 percent; genital touching of the abuser 31 percent. For most the abuse occurred during their prepubertal years.
In the Christchurch Health and Development Study (Fergusson et al., 1995) the relationship of the abuser to the child was reported in percentages as follows: 23 percent family members (seven percent natural or step parents and seven percent, sibling or step-sibling; other relatives ten percent; family friends 18 percent; stranger abuse 29 percent; other acquaintances 29 percent. Multiple experiences of abuse occurred for 37 percent. The abusive experiences involved were: six percent; attempted or completed sexual intercourse, genital touching 13 percent; non-contact abuse 12 percent. For 58 percent the abuse occurred between 11 and 15 years; 41 percent were prepubertal; 30 percent were abused between six and ten years and 11 percent between birth and five years of age.

Some findings from the New Zealand studies reviewed are noted in Table 1 below. From the studies reviewed it can be seen that the context in which sexual abuse occurs in New Zealand is no different from that in other countries (Finkelhor, 1979; Russell, 1983; Goldman and Goldman, 1986). The majority of children abused were aged between 8 and 12 years. In most cases the abusers were male and were known to the child, thus weakening the myth that children are sexually abused by strangers. Furthermore, much of the abuse was intra-familial. Of specific note is the similarity between the Australian and New Zealand studies.

<table>
<thead>
<tr>
<th>Country</th>
<th>Study</th>
<th>Date</th>
<th>N</th>
<th>Peak age</th>
<th>% Intra-familial abuse</th>
<th>% Known to the child</th>
<th>% Stranger abuse</th>
<th>% Multiple abuse</th>
<th>% Violence or Force</th>
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<tr>
<td>USA</td>
<td>Finkelhor</td>
<td>1979</td>
<td>796</td>
<td>10</td>
<td>43</td>
<td>33</td>
<td>24</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Russell</td>
<td>1986</td>
<td>930</td>
<td>11.5</td>
<td>22</td>
<td>60</td>
<td>11</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>Australia.</td>
<td>Goldman &amp; Goldman</td>
<td>1986</td>
<td>991</td>
<td>10-12</td>
<td>13</td>
<td>76</td>
<td>24</td>
<td>36</td>
<td>58</td>
</tr>
<tr>
<td>NZ</td>
<td>Mullen et al.,</td>
<td>1988</td>
<td>314</td>
<td>8-12</td>
<td>15</td>
<td>24</td>
<td>49</td>
<td>42</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Anderson et al.,</td>
<td>1993</td>
<td>497</td>
<td>10-12</td>
<td>12</td>
<td>47</td>
<td>15</td>
<td>42</td>
<td>-</td>
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<tr>
<td></td>
<td>Romans et al.,</td>
<td>1995</td>
<td>320</td>
<td>10-12</td>
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<td>7</td>
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<td></td>
<td>Fergusson et</td>
<td>1995</td>
<td>516</td>
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The Sequelae to Child Sexual Abuse

This section discusses the links between a history of child sexual abuse and a wide range of clinical sequelae. The long-term effects of child sexual abuse have been well documented in the clinical literature. The studies reviewed reveal that the majority of women sexually abused as children demonstrate very disturbing problems in adult life. In this section seven major areas of individual functioning that give cause for concern are identified. Specifically they are: emotional effects, behavioural effects, cognitive effects, interpersonal effects, overall social functioning, special populations and finally factors associated with severity. Each aspect will be discussed in turn.

Emotional effects

The symptom most often reported from women with histories of abuse is depression (Meiselman, 1978; Herman, 1981). These findings were confirmed by other researchers (Peters, 1984; Bagley and Ramsey, 1985), who found that sexual abuse as a child was associated with a higher incidence of depression and a greater number of depressive episodes over time. Peters (1984) also found that even in a multiple regression analysis which took into account other factors such as a poor relationship with a mother, the variable “child sexual abuse” made an independent contribution to depression. A later study (Sedney and Brooks, 1984) also confirmed the link between child sexual abuse and later depression in non-clinical samples. In a review of the literature on the impact of child sexual abuse Browne and Finkelhor (1986) make reference to a 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 non-abused subjects. Browne and Finkelhor (1986) also found that while the studies reviewed used an overly inclusive definition of sexual abuse, the results were consistent with those from carefully controlled
studies. While the studies quoted above were all with clinical populations, and no comparisons were made with women in the general population, a separate community study carried out by Bagley and Ramsay (1985) supported these findings.

Anxiety, tension, fear and phobias are other reactions that have long been observed in survivors of child sexual abuse (Herman, 1981; Gelinas, 1983; Briere, 1984; Sedney & Brooks, 1984). Others found that students who were sexually abused as children were more likely to exhibit significantly more acute and chronic anxiety, somatisation and obsessive compulsive traits (Bagley & Ramsay, 1985; Briere & Runtz, 1988b) than those not abused. A community-based study (Burnam et al., 1988) found sexual abuse victims reported nearly four times the number of experiences of panic attacks, phobias and obsessive compulsive disorders reported by the non-abused group.

**Behavioural effects**

Studies based on both clinical and non-clinical samples also show that victims of child sexual abuse were more self-destructive (Yellowless & Kaushik, 1990, Briere, 1984). In a college student sample Sedney and Brooks (1984) found that 39 percent with child sexual abuse experiences reported having had thoughts of self-harm, compared with 16 percent 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 child sexual abuse and suicidal ideation, or deliberate attempts at self-harm.

Vulnerability to re-victimisation is also common. Some studies found between 33 and 68 percent of the sexual abuse victims (depending on the seriousness of the abuse) being raped at a later time (Yellowless & Kaushik, 1990; Fromuth, 1983; Millar et al., 1978). For example, Russell (1986), found that between 40 and 62 percent of the abused women were later sexually assaulted by their husbands, as against 21 percent for non-victims. Briere (1984) reported that 49 percent of his clinical sexual abuse sample confirmed being battered in adult relationships, compared with 18 percent of the non-abused group. Wyatt et al., (1992)
found in their study that women abused as children were 2.4 times more likely than those in controls to be sexually abused as adults.

**Cognitive effects**

In reviewing both the clinical and non-clinical literature, support can be seen for the idea that survivors of child sexual abuse continue to feel isolated and stigmatised in adult life. When compared with non-abused women, considerably higher numbers of sexual abuse survivors report feelings of stigmatisation, isolation, and feelings of alienation (Briere, 1992; Herman, 1981; Courtois, 1979). Women who were sexually abused as children tend to have self-esteem problems. Studies (Bagley & Ramsay, 1985; Courtois, 1979; Herman, 1981) show that compared to non-abused women sexual abuse survivors have a predominantly negative self-image. Other perceptual distortions include: distrust of others, guilt, perceived helplessness and hopelessness about the future (Dolan, 1991).

**Interpersonal effects**

The long-term effects of child sexual abuse on adult sexual functioning has received a lot of attention. Both clinical and non-clinical studies (Meiselman, 1978; Courtois, 1979; Finkelhor, 1979; Herman, 1981; Briere, 1984; Jehu, 1988) report finding sexual problems among adult survivors. Becker and Skinner (1984) argued specifically that many survivors of sexual abuse develop sexual problems as a result of their assaults and that these problems did not appear to have dissipated with the passage of time.

**Effect on overall social functioning**

Women who were sexually abused as children often report making poor adult relationships and having a greater incidence of divorce (Finkelhor et al., 1989). Women survivors also often report difficulty with the parenting role. A study by Goodwin et al., (1981) concluded that 24 percent of the mothers with parenting problems in their programme
had histories of sexual abuse themselves, compared with three percent of the non-abused 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.

In terms of symptomatology, many sexual abuse survivors meet the diagnostic criteria for a borderline personality disorder (BPD). In looking at the overlap between BPD and child sexual abuse, Fisher (1991) found that between 67 and 86 percent of BPD patients reported having histories of child sexual abuse. Individuals with Borderline Personality Disorder have a pattern of unstable and intense relationships (*The Diagnostic and Statistical Manual of Mental Disorders*, 1994). Prevalence is estimated to be two percent of the general population, 10 percent of outpatients in mental health clinics, and 20 percent of psychiatric inpatients. Consequently the poor treatment prognosis associated with a BPD diagnosis presents serious concerns when applied to survivors of child sexual abuse (Gelinas, 1983; Briere, 1984, 1989).

**Effect on special populations**

Several authors (Herman 1981; Peters, 1984; Briere, 1984; Yellowless & Kaushik, 1990) writing about special populations drew attention to the link between child sexual abuse and later substance problems. In the area of eating disorders studies suggest that around 30 percent of eating disordered patients have histories of previous child sexual abuse (Bulik *et al.*, 1989; Connors & Morse, 1993). It seems that sexually abused adolescents, particularly girls, often use eating as a way of feeling in control of themselves (MacDonald *et al.*, 1995). However, while sexual abuse may play a role in the development and maintenance of eating disorders in general, it is best considered as a risk factor in overall psychopathology, rather than being seen as a specific cause.
Post-traumatic stress disorder

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 recognised the characteristic common symptoms which follow a psychologically traumatic event (natural and man-made disasters, war, political terrorism, hostage-taking, and crimes of violence) and included a diagnosis of post-traumatic stress disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM III). In 1985 a strong case was made by Lindberg and Distad for viewing post-traumatic stress as an appropriate diagnosis for some adults who suffered sexual abuse during child. Others (McLeer et al., 1988; Kiser et al., 1988; Dahl, 1989) have also found symptoms of post-traumatic stress amongst survivors of sexual abuse.

The essential features of post-traumatic stress disorder (PTSD) are the development of characteristic symptoms following exposure to an extremely traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about the unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Diagnostic and Statistical Manual of Mental Disorders, 1994).

The person’s response to the event must involve intense fear, helplessness, or horror. In children, the response must involve disorganised or agitated behaviour. The characteristic symptoms resulting from exposure to the extreme trauma include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness, and persistent symptoms of increased arousal. The full symptom picture must be present for more than one month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging),
being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or man-made disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. It also noted that the disorder may be especially severe or long-lasting when the stressor is of human design (e.g., torture or rape).

Community-based studies reveal a lifetime prevalence for PTSD ranging from one to 14 percent, with the variability related to methods of ascertainment and the population sampled. Studies of at-risk individuals (e.g., combat veterans, victims of volcanic eruptions or criminal violence) have yielded prevalence rates ranging from three to 58 percent. While PTSD can occur immediately, often the trauma of sexual abuse is not integrated for many years (Moscarello, 1990). Specifiers are used to specify onset and duration of the symptoms of PTSD. “Acute” is used when the duration of the symptoms has been for less than three months. “Chronic” is applied to situations where the symptoms exceed three months’ duration. “Delayed” indicates that at least six months have passed between the traumatic event and the onset of symptoms. (Appendix 8 contains DSM-IV diagnostic criteria for PTSD 309.81).

**Dissociative disorder**

Dissociative symptoms are also included in the criteria set for PTSD, and an additional Dissociative Disorder diagnosis would not be given if the symptoms occurred exclusively during the course of PTSD. However, as (Spiegel et al., 1988) suggest, in traumatic circumstances dissociation may be a means of resolving psychological conflicts away and may occur either temporarily or permanently. In survivors of prolonged child abuse, dissociative capacities may be developed to extreme levels (Briere, 1989; Herman, 1992). A similar association between child abuse and the extent of dissociative symptomatology has been documented in subjects with borderline personality disorder (Herman et al., 1989) and multiple personality disorder (Putnam et al., 1986; Ross et al., 1990).
The essential feature of the dissociative disorders are outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (1994) as a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient, or chronic.

*Dissociative amnesia* is characterised by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness. This disorder involves a reversible memory impairment in which memories of personal experience cannot be retrieved in a verbal form (or if temporarily retrieved cannot be wholly retained in consciousness). The disturbance is not due to the direct physiological effects of a substance or a neurological or other general medical condition. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Dissociative amnesia most commonly presents as a retrospectively reported gap or series of gaps in recall for aspects of the individual’s life history. Increased reporting in the number of cases of dissociative amnesia (particularly in the United States) has sparked a debate over what has now been labelled as ‘recovered memory syndrome’.

*Dissociative Disorder Not Otherwise Specified* is included for coding disorders in which the predominant feature is a dissociative symptom, but that does not meet the criteria for any specific Dissociative Disorder. In sexual abuse, amnesia (dissociative) for the actual abuse and other events related to the abuse serves the purpose of removing from the individual’s awareness parts of the event or the event in total. In this sense, dissociation is a defence mechanism which can be mobilised as a means to escape mentally from a situation from which there is no physical escape route (Spiegel *et al*, 1988).

Dissociative symptoms are also included in the criteria set for PTSD, and flashbacks signal the return of memories previously forgotten. Flashbacks are sudden, intrusive sensory
memories which include visual images of the abuser’s face or aspects of the actual sexual abuse taking place (Briere, 1992).

**Somatoform disorders**

The clinical literature also suggests an association between somatisation disorders and child trauma (Herman, 1992). The diagnosis of somatisation disorder was developed from the earlier concept of Briquet’s syndrome, and recent studies show concordance between the two disorders (Cloninger et al., 1986; De Souza & Othmer, 1984). It was first noted in the clinical literature by Meiselman (1978) and later by Sitley (1988), both of whom found that approximately that 52 percent of women evaluated in physical pain programmes revealed histories of child sexual abuse. In a controlled study of 60 women with somatisation disorder Morrison (1989) found that 55 percent of the women had been sexually abused as children.

The essential feature of the somatisation disorder is a pattern of recurring, multiple, clinically significant complaints. A complaint is considered somatic if it occurs over a period of several years and cannot be explained by any known general medical condition or the direct effects of a substance and causes significant impairment in social, occupational, or other important areas of functioning, which results in a need for medical treatment (Diagnostic and Statistical Manual of Mental Disorders, 1994).

Studies report widely variable lifetime prevalence for rates of somatisation disorder, ranging from 0.2-2 percent for women and .02 percent for men. Differences may be explained by different clinicians undertaking assessment and by the demographic variables in the samples studied. Table 2 below summarises the studies which attempt to note the long-term effects of child sexual abuse. The effect noted column refers to the effect reported for each study.
Table 2
Long-term effects of sexual abuse noted in each study

<table>
<thead>
<tr>
<th>Study</th>
<th>Date</th>
<th>Effect noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meiselman</td>
<td>1978</td>
<td>Depression</td>
</tr>
<tr>
<td>Herman</td>
<td>1981</td>
<td>Depression</td>
</tr>
<tr>
<td>Gelinas</td>
<td>1983</td>
<td>Anxiety &amp; phobias</td>
</tr>
<tr>
<td>Peters</td>
<td>1984</td>
<td>Depression</td>
</tr>
<tr>
<td>Sedney &amp; Brooks</td>
<td>1984</td>
<td>Depression</td>
</tr>
<tr>
<td>Bagley &amp; Ramsey</td>
<td>1985</td>
<td>Depression</td>
</tr>
<tr>
<td>Briere &amp; Runtz</td>
<td>1985</td>
<td>Depression</td>
</tr>
<tr>
<td>Browne &amp; Finkelhor</td>
<td>1986</td>
<td>Depression</td>
</tr>
<tr>
<td>Briere &amp; Runtz</td>
<td>1988b</td>
<td>Anxiety/somatisation</td>
</tr>
<tr>
<td>Burnam et al.,</td>
<td>1988</td>
<td>Anxiety/phobias</td>
</tr>
<tr>
<td>Millar et al.,</td>
<td>1978</td>
<td>Revictimisation</td>
</tr>
<tr>
<td>Herman</td>
<td>1981</td>
<td>Self-harm</td>
</tr>
<tr>
<td>Fromuth</td>
<td>1983</td>
<td>Revictimisation</td>
</tr>
<tr>
<td>Briere</td>
<td>1984</td>
<td>Self-destructive/revictimisation</td>
</tr>
<tr>
<td>Harrison et al.,</td>
<td>1984</td>
<td>Self-harm</td>
</tr>
<tr>
<td>Sedney &amp; Brooks</td>
<td>1984</td>
<td>Self-harm</td>
</tr>
<tr>
<td>Bagley &amp; Ramsey</td>
<td>1985</td>
<td>Suicidal ideation</td>
</tr>
<tr>
<td>Russell</td>
<td>1986</td>
<td>Revictimisation</td>
</tr>
<tr>
<td>Yellowless &amp; Kaushik</td>
<td>1990</td>
<td>Self-destructive/revictimisation</td>
</tr>
<tr>
<td>Curtois</td>
<td>1979</td>
<td>Stigmatisation/isolation</td>
</tr>
<tr>
<td>Herman</td>
<td>1981</td>
<td>Stigmatisation/isolation</td>
</tr>
<tr>
<td>Briere</td>
<td>1984</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Bagley &amp; Ramsey</td>
<td>1985</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Dolan</td>
<td>1991</td>
<td>Low self-esteem/powerlessness</td>
</tr>
<tr>
<td>Meiselman</td>
<td>1978</td>
<td>Adult sexual functioning</td>
</tr>
<tr>
<td>Curtois</td>
<td>1979</td>
<td>Adult sexual functioning</td>
</tr>
<tr>
<td>Finkelhor</td>
<td>1979</td>
<td>Adult sexual functioning</td>
</tr>
<tr>
<td>Herman</td>
<td>1981</td>
<td>Adult sexual functioning</td>
</tr>
<tr>
<td>Becker &amp; Skinner</td>
<td>1984</td>
<td>Sexual problems</td>
</tr>
<tr>
<td>Briere</td>
<td>1984</td>
<td>Adult sexual Functioning</td>
</tr>
<tr>
<td>Jehu</td>
<td>1988</td>
<td>Adult sexual Functioning</td>
</tr>
<tr>
<td>Goodwin et al.,</td>
<td>1981</td>
<td>Parenting problems</td>
</tr>
<tr>
<td>Gelinas</td>
<td>1983</td>
<td>Borderline Personality symptoms</td>
</tr>
<tr>
<td>Briere</td>
<td>1984</td>
<td>Borderline Personality symptoms</td>
</tr>
<tr>
<td>Finkelhor et al.,</td>
<td>1990</td>
<td>Relationship &amp; divorce problems</td>
</tr>
</tbody>
</table>

Table 3 below is a summary of studies which attempt to quantify the extent to which the sequel of sexual abuse appears in populations of substance abusers and clients attending either outpatient or inpatient mental health services. The effect noted column refers to the effect reported for each study.
Table 3

Studies looking at the effects noted in specific populations and mental health clients

<table>
<thead>
<tr>
<th>Study</th>
<th>Date</th>
<th>Effect Noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herman</td>
<td>1981</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Peters</td>
<td>1984</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Briere</td>
<td>1984</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Bulik et al.,</td>
<td>1989</td>
<td>Eating disorders</td>
</tr>
<tr>
<td>Yellowless &amp; Kaushik</td>
<td>1990</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Kaushik</td>
<td>1993</td>
<td>Eating disorders</td>
</tr>
<tr>
<td>Connors &amp; Morse</td>
<td>1995</td>
<td>Eating disorders</td>
</tr>
<tr>
<td>MacDonald</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meiselman</td>
<td>1978</td>
<td>Somatisation symptoms</td>
</tr>
<tr>
<td>De Souza &amp; Othmer</td>
<td>1984</td>
<td>Somatisation symptoms</td>
</tr>
<tr>
<td>Lindberg &amp; Distad</td>
<td>1985</td>
<td>PTSD symptoms</td>
</tr>
<tr>
<td>Cloninger et al.,</td>
<td>1986</td>
<td>Somatisation symptoms</td>
</tr>
<tr>
<td>Sitley</td>
<td>1988</td>
<td>Somatisation symptoms</td>
</tr>
<tr>
<td>McLeer et al.,</td>
<td>1988</td>
<td>PTSD symptoms</td>
</tr>
<tr>
<td>Kiser et al.,</td>
<td>1988</td>
<td>PTSD symptoms</td>
</tr>
<tr>
<td>Spiegel</td>
<td>1988</td>
<td>Dissociative symptoms</td>
</tr>
<tr>
<td>Morrison</td>
<td>1989</td>
<td>Somatisation symptoms</td>
</tr>
<tr>
<td>Dahl</td>
<td>1989</td>
<td>PTSD symptoms</td>
</tr>
<tr>
<td>Briere</td>
<td>1989</td>
<td>Dissociative symptoms</td>
</tr>
<tr>
<td>Herman</td>
<td>1992</td>
<td>Dissociative/somatisation symptoms</td>
</tr>
</tbody>
</table>

Effect on severity

Several factors influence the impact and therefore, the severity of child sexual abuse. They include: the age of the child at the time of the abuse (Price & Valdiserri, 1981; Browne & Finkelhor, 1986; Sirles et al., 1989; Wyatt & Newcombe, 1990) the nature of the relationship between the child and the perpetrator(s) and the gender (Schultz and Jones, 1983; Mitchell, 1988; Sirles, Smith et al., 1989; Wyatt & Newcombe, 1990) the frequency and duration of the abuse (Tsai et al., 1979; Sirles, Smith et al., 1989; Furniss et al., 1988) and the nature of the incident(s), particularly the use of force and/or violence (Elwell, 1979; Schultz and Jones, 1983; Carter, 1987). Thus, the effects of child sexual abuse are most extreme when there is an early onset of abuse, when the abuse occurs over a long period of time, when a family member is involved and, in particular, when the perpetrator is a violent father.
It is generally assumed that the effect of trauma of sexual abuse of a child will be a function of the developmental stage of the child (Lewis & Sarrel, 1969; Browne & Finkelhor, 1986; Moscarello, 1990). Table 4 below summarises the studies looking at factors which contribute most to symptom severity. The right-hand column lists the factors in each study.

Table 4
Summary of factors contributing to symptom severity

<table>
<thead>
<tr>
<th>Study</th>
<th>Date</th>
<th>Factors Noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elwell</td>
<td>1979</td>
<td>Use for force/violence</td>
</tr>
<tr>
<td>Price &amp; Valdiserri</td>
<td>1981</td>
<td>Age of child</td>
</tr>
<tr>
<td>Schultz and Jones</td>
<td>1983</td>
<td>Relationship/gender/force/violence</td>
</tr>
<tr>
<td>Browne &amp; Finkelhor</td>
<td>1986</td>
<td>Age of child</td>
</tr>
<tr>
<td>Tsai et al.,</td>
<td>1987</td>
<td>Frequency/duration</td>
</tr>
<tr>
<td>Carter</td>
<td>1987</td>
<td>Force/violence</td>
</tr>
<tr>
<td>Furniss et al.,</td>
<td>1988</td>
<td>Frequency/duration</td>
</tr>
<tr>
<td>Mitchell</td>
<td>1988</td>
<td>Relationship/gender</td>
</tr>
<tr>
<td>Furniss et al.,</td>
<td>1988</td>
<td>Relationship/gender</td>
</tr>
<tr>
<td>Sirles, Smith et al.,</td>
<td>1989</td>
<td>Relationship/gender</td>
</tr>
<tr>
<td>Sirles, Smith et al.,</td>
<td>1989</td>
<td>Age of child/frequency/duration</td>
</tr>
<tr>
<td>Wyatt &amp; Newcombe</td>
<td>1990</td>
<td>Age of child/relationship/gender</td>
</tr>
</tbody>
</table>

Many of the respondents in the above studies reporting child sexual abuse also reported experiencing psychological difficulties as adults. In that respect the findings from the New Zealand studies are consistent with other non-clinical studies and indicate that those abused as children may experience long-term sequelae. 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. In this study the women reporting child sexual abuse had higher diagnostic scores for depression, anxiety, and phobic disorders.

The Epidemiology follow-up study (Bushnell et al., 1992) considered a number of possible routes whereby child experiences may have increased the risk for adult depression. With reference to sexual abuse in particular, it seems clear that the quality of the intra-familial environment was most important when considering risk for adult depression in women. When the influence of intra-familial child sexual abuse was examined it was found to approximately
double the rates of depression in adulthood and to increase the total number of psychiatric symptoms women were likely to experience, thereby overall increasing the severity of adult psychopathology.

Anderson *et al.*, (1993) indicated that child sexual abuse had been a substantial problem for the abused women resulting in adverse consequences in adult life. They found that many of the risk factors for child sexual abuse are also the same for psychiatric disorders. The findings also indicated that if the sexual abuse was not disclosed within the first year following the episode then it was likely it might not be disclosed for up to ten or more years later. This means that survivors may be young adults before disclosing the abuse, thus prolonging treatment.

A preliminary analysis of the data from the Canterbury Suicide Study clearly provides a case for the view that sexual abuse during childhood may act as a risk factor for suicidal behaviour as an adult (Beautrais *et al.*, 1994:143). The researchers found that suicide attempters with a history of child sexual abuse were significantly younger, had significantly lower maternal and paternal care and higher maternal and paternal protection scores. They also reported higher rates of family problems, thus making apparent the relationship between the effects of dysfunctional family environments, sexual abuse and suicidal behaviours.

The abused sample of women in the Romans *et al.*, (1995) follow-up study reported a range of negative effects which could be attributed to their abuse. Sexual dysfunction, fear of men, and a lack of trust in interpersonal relationships especially with men was reported by 37 percent. A further 10 percent reported low self esteem. Five to 10 percent reported hatred of the abuser and problems with relationships. Promiscuity, depression, substance abuse, specific fears and a strong commitment to protecting their own children were also seen as consequences of their abuse. Specifically 23 percent of the women in this study were found to have significant morbidity.
In the Fergusson et al., (1995) study, reactions to the abusive experiences varied widely according to the nature of the abuse. Generally, those reporting non-contact sexual abuse had not sought treatment for the effects of the abuse at the time of the interviews. This differed, however, where the abuse had involved sexual intercourse. Of those reporting abuse in this category, 40 percent had sought treatment or counselling for themselves by the time they were 18 years of age. As indicated, the results in this study clearly suggest that the severity of the abuse and the effects varied with the relationship between the abuser and the child.

**Summary**

The present review confirms the general impression that the impact of child sexual abuse is serious and can manifest itself in a wide variety of symptomatic and pathological behaviours. There is virtually no general domain of symptomatology that has not been associated with a history of sexual abuse. In the absence of more precise research, these studies do demonstrate that for many women, sexual abuse in child has long-term effects which interfere in several critical areas of adult functioning. All the studies seem to be consistent in one aspect: namely that counsellors are likely to find the presence of long-term sequelae in many adult survivors of child sexual abuse. This means that many sexual abuse survivors will require therapy to assist them in overcoming the devastating effects of their sexual abuse experiences. Therapy for sexual abuse survivors is discussed in the next chapter.
CHAPTER THREE

THERAPY FOR SURVIVORS OF CHILD SEXUAL ABUSE

Chapter Two reviewed a range of national and international studies and highlighted the long-term sequelae evident in adult survivors of childhood sexual abuse. These sequelae mean that it is highly probable that many survivors will seek therapeutic assistance at some stage of their lives in relation to the traumatic effects of that sexual abuse.

Traditionally, therapy was oriented primarily to the past and has its roots in several different disciplines all of which typically concern themselves with explaining, diagnosing, and understanding human nature. With the emergence of behaviour therapy in the 1960s this changed; the focus shifted to more short-term interventions, and past-oriented therapy was dismissed by adherents of these new approaches as time-wasting and too speculative (O'Hanlon & Weiner-Davis, 1989). Since then therapy has emerged as a separate and distinct discipline practiced by psychiatrists, psychologists, social workers, family therapists, ministers, nurses, counsellors and others. Several new interventions, many short-term (e.g., cognitive and interpersonal therapies) have been expressively designed, or adapted from the more traditional psychoanalytic or dynamic therapies. The focus of these new approaches are more concerned with seeking change and solutions, rather than understanding and explanations about how the problems arose.

While therapeutic theory and techniques are important components of therapy for a successful outcome, so too is the therapist's general orientation to working with abuse survivors. As Briere (1992:96) makes clear, the optimal therapy for survivors of sexual abuse requires unwavering attention to the inner experience of the survivor, understanding of the social context in which the abuse occurs, and a treatment perspective that views symptomatic behaviours as logical responses to post-traumatic learning, cognition’s and affects.
Though the growing awareness of the impact of sexual abuse has led to the development of a number of therapeutic approaches for the treatment of sexual abuse related problems in children, there is a distinct lack of outcome studies in the specific area of sexual abuse therapy for adult survivors of child sexual abuse.

Despite the lack of outcome studies, various treatment approaches have proved helpful in dealing with related problems. This chapter reviews cognitive therapies that assist with situationally related depression, behavioural interventions that have proved to be effective for anxiety, and psychodynamic therapies that seek to address the sequelae of early developmental disruption, loss or abandonment. Therapies more specifically used when working with adult survivors of child sexual abuse will then be considered. In doing so the process and content of each approach and the therapist issues are considered. The ongoing debate about the relative merits of long and short-term therapies is also transversed.

**Therapeutic Approaches**

When looking at therapeutic approaches for working with survivors it is helpful to consider the content of the three major therapeutic approaches—dynamic, cognitive and interpersonal—used today. To this end, Karasu (1990) has provided a useful comparison of the three approaches which shows how each approach appears to be different from the others (at least overtly) in terms of its theoretical orientation, major goals, mechanisms of change, and techniques. For example, the core concepts of pathology and etiology within a psychodynamic framework are rooted in Freudian personality and infantile sexuality theories (Freud, 1905). Freud attributed adult symptoms to early and arrested psychosexual development, whereas from a cognitive perspective, effective psychotherapy teaches the client to recognise and alter distorted thoughts, beliefs, and perceptions through cognitive change (Beck, et al., 1979). The interpersonal approach generally deals with current, rather than past interpersonal relationships and enduring aspects of personality (Weissman & Markowitz, 1994).
The psychodynamic approach

Freud theorised that sexual trauma during the critically formative period of childhood caused subsequent adult psychopathology. While initially he saw incest as being pivotal in the formation of neuroses, later he attempted to deny his earlier writing by offering the Oedipal theory. Incest was then relegated to the realm of fantasies created by the women he saw (Rush, 1980:82). His new theory attributed adult symptoms to early and arrested psychosexual development. Symptoms were seen as the pathological sequelae of frustrated internal sexual and aggressive drives.

Changes in modern psychodynamic treatment theory and practice since Freud's time now portray an approach which has a spectrum of expressive and supportive techniques. The major change tends to be a shorter treatment time, with the therapist taking a more active role in the therapeutic process and employing an approach which involves more confronting and clarifying of present problems, rather than the interpretation of core conflicts. However, as Karasu (1990) notes, the psychodynamic approach, whether long or short-term, aims to modify the structural substrate of a disorder, not merely its immediate manifestations. Resolving intrapsychic conflict related to significant others in the client's present and past effects a re-organisation of ego and superego structures, not simply symptomatic relief.

More specifically, the psychodynamic approach may be regarded as having several successive treatment goals which are, in part, contingent on length of treatment. They are: the provision of symptom relief through cathartic expression of suppressed aggressive feelings; the lowering of superego demands and perfectionist standards so as to reduce feelings of guilt and inadequacy and thus allow self-esteem to be raised; the clarification of how current narcissistic wishes for love and excessive expectations in significant relationships are unrealistic and misdirected, i.e., how they are unwittingly repeated in actions toward others and aggressively turned against the self; and finally, the uncovering and recreation of the earlier conflicts from which the current disorder derives (Jacobson, 1971).
It seems, then, as Karasu (1990:135) states, "... modern psychodynamic theory combines aspects of such psychoanalytic formulations as early childhood disappointment and loss, damaged self-esteem, persistent unresolved rage beneath an unloved and punished self, a sense of helplessness and hopelessness and difficulties in autonomy and intimacy due to reactivation of conflicts unresolved in infancy. Such assumptions continue to underlie current dynamic treatment despite the technical differences between long and short-term modalities".

**The cognitive behavioural approach**

Several theorists contributed to the cognitive-behavioural framework and its application to psychopathology. The major guidelines for a cognitive approach were developed for the treatment of depression (Beck *et al.*, 1979). In essence, Beck's cognitive theory of depression posits that negatively distorted thinking patterns are the basis for depressed behaviour and symptoms; in short dysphoria is a disturbance of cognition, not of mood (Karusu, 1990:137). Cognitive therapy consists of standardised interviews consisting of approximately 45 minutes, and it is characterised by highly specific learning experiences. The major cognitive aims or processes of change have three successive components: recognition of faulty thinking through self-monitoring; modification of thinking patterns through systematic evaluation and empirical testing of the validity of automatic thoughts and silent assumptions; and self-mastery by means of homework and everyday practice on one's own (Jarrett & Rush, 1985).

Initially, treatment aims at symptom reduction and emphasises the recognition of self-destructive thoughts. Subsequent phases, which aim at prophylaxis, concentrate on the modification of specific erroneous assumptions within and outside the treatment sessions. To isolate, control and change illogical thinking, treatment is organised to elicit and subject to rational examination the actual mental contents of conscious depressive ideation and to trace their impact on dysphoric feelings and behaviours in current concrete situations. The ultimate purpose is self-control and self-mastery. Clients explicitly rehearse and train themselves to recognise and restructure their own faulty cognition's so they can cope better in the future (Karusu, 1990: 139).
Cognitive approaches to treatment came to the attention of most clinicians through the treatment of depression. There is now general acceptance of its usefulness for other conditions. Wider applications relate to conditions which often cannot be treated easily and effectively in other ways. These conditions include anxiety, obsessional disorders, eating disorders, some somatic disorders and sexual and marital problems.

**The interpersonal approach**

Interpersonal therapy (IPT), as a time-limited treatment for major depression, was developed, defined in a manual, and tested in randomised clinical trials by Klerman *et al.*, 1984). IPT makes no assumptions about origin but uses the connection between onset of depressive symptoms and current interpersonal problems as the treatment focus. More specifically, it focuses on the individual's social circle, the most intimate family and love relationships, friendship, work, and community impact. Thus, IPT generally deals with current rather than past interpersonal relationships, focusing on the client’s immediate social context, and attempts to intervene in symptom formation and social dysfunction associated with depression rather than in enduring aspects of personality (Weissman & Markowitz, 1994). The emphasis is on the solving of interpersonal problems. It entails supportive and behavioural strategies as well as both directive and non-directive exploratory methods information, guidance, reassurance, clarification, communication skills education, behavioural modification and environmental management (Karasu, 1990: 140).

The first treatment phase of IPT focuses on information gathering and includes an assessment of symptoms. A structured interview that focuses on current life events and family history may be used. Findings are confirmed with explicit diagnostic queries to the client (Karasu, 1990: 140). The setting up of an explicit therapeutic contract, clearly outlining the roles and expectations of both the therapist and client, completes the first phase. Phase two, the crux of treatment, addresses the identified primary problem areas. Each problem has its own therapeutic tasks and strategies in the here-and-now. For example, in dealing with abnormal grief reactions, a major technique is facilitation of the mourning process to allow
expression and exploration of affects surrounding the loss (both positive and negative), sadness, guilt, and remorse, as well as good feelings, courage, and hope for new beginnings. In the final phase IPT involves consolidation of therapeutic gains and ways of identifying and counteracting symptoms should they arise again.

The therapeutic relationship in IPT is explicitly not the primary focus of treatment, and the role of the therapist and use of the therapeutic relationship have been delineated according to specific guidelines. This means the IPT therapist advocates for the client, takes a deliberately directive stance and ensures that the therapeutic relationship is not interpreted as transference (Klerman et al., 1984). The fundamental goals of IPT relate to the need to maintain good interpersonal relations and social adaptability. As such, they include reconstruction of present maladaptive relationships and where possible, restoration of past losses. This entails both coping with the immediate stressful interactions and forming better or new relationships by developing problem-solving strategies and mastery in social skills. IPT has subsequently been modified for different age groups and types of mood and non-mood disorders.

Interpersonal Counselling (IPC), which is based on IPT, may be helpful for survivors of CSA who have symptoms that do not meet the full criteria for psychiatric disorder. IPC was specifically designed to work with clients who are distressed but who do not have serious concurrent psychiatric disorders. IPC has a maximum of six sessions within which the therapist assesses the client’s current functioning, recent life events, occupational and familial stress and changes in interpersonal relationships. The assumption is that such events may provide the context in which emotional and bodily symptoms occur. Results from trials using a control group showed that clients receiving IPC had significantly greater symptom relief than those who were not, and of particular interest was an improvement in depressed mood. It was also noted that IPC led to greater, rather than less, use of mental health services by clients newly attuned to the psychological source of their symptoms (Klerman & Weissman, 1993).
**Evaluation of the three approaches**

It seems then that while the major elements involved in these three therapeutic approaches are different from each other in terms of their theoretical orientation, major goals, mechanisms of change, and technique, they all share some important common elements. Nonetheless, all three approaches are dedicated to a particular point of view and have a certain preferred theses or content areas which make them different from the others in other ways. Examples are: childhood conflicts-disappointment in parents, excessive guilt and unexpressed rage (psychodynamic); marital disputes, environmental stresses, gender or role problems (interpersonal); and preconceptions about self and future and illogical expectations of others (cognitive). The psychodynamic approach emphasises unconscious processes and the primacy of affect and cognitive therapy focuses on the role of thinking, whereas the interpersonal approach foregoes the internal mechanisms of disturbances and concentrates on the socio-environmental context in which it occurs.

Thus, important common elements in all three approaches include attempts to help clients gain a sense of self mastery, to combat social isolation, to restore a sense of group belonging, and to find meaning in their lives. All these elements form the bases for therapeutic intervention with adults who have problems related to childhood sexual abuse. This chapter will now look more specifically at therapy for this client population.

**Specific Treatments For Survivors of Child Sexual Abuse**

This section reviews the literature regarding treatment for adult survivors of child sexual abuse. Given the range and complexity of problems related to childhood sexual abuse, intervention requires a correspondingly diverse set of therapeutic approaches. As shown in the previous chapter, the long-term effects of child sexual abuse range from cognitive distortions and impaired self reference to symptoms of post traumatic stress, dissociative and somatoform disorders. Post Traumatic Stress refers to certain enduring psychological symptoms that occur in reaction to a highly distressing psychologically disruptive event.
Somatisation relates to the interface between psychological distress and physical health. Physical problems that have been associated with histories of child abuse include: headaches, stomach pain, nausea, sleep disturbances, anorexia and asthma, to name but a few.

With respect to dissociation, Putnam (1991:145) states that it "... is a process that produces a discernible alteration in a person's thoughts, feelings or actions so that for a period of time certain information is not associated or integrated with other information as it normally or logically would be. This process, which is manifest along a continuum of severity, produces a range of clinical and behavioural phenomena involving alterations in memory and identity that play important roles in normal and pathological mental processes".

In terms of dissociation as an intrapsychic defence, Spiegel (1988:22) writes: "... dissociation has recently been understood as a defence not simply against memories of warded-off unconscious wishes, but rather as a defence against the traumatic experience itself". Kluft (1992:143) adds "... dissociation is pragmatically understood as a defence in which an overwhelmed individual cannot escape what assails them by taking meaningful action or successful flight, and escapes by altering instead their internal organisation; ie, the individual flees inwardly". It is a defense of those who suffer an intolerable sense of helplessness and have had the experience of becoming an object, the victim of someone's willful mistreatment, the indifference of nature, or of one's own limitations. It is a feeling or a realisation that one's own will and wishes have become irrelevant to the course of events.

Briere (1989) has found dissociative symptoms are quite frequent in sexual abuse survivors. In addition, the existing data support the clinical impression that more severe dissociative symptoms are associated with more severe trauma: that is, an earlier onset of abuse and repeated abusive experiences. For example, Briere and Conte (1989) describe a sample of 468 male and female clinical subjects with a reported history of childhood sexual abuse. They report that 60 percent (n=279) of their subjects described an inability to remember that the abuse had occurred at some time during their lives. Those with amnesia
were more likely to have had more severe, earlier onset, repetitive, and physically injurious abuse with multiple perpetrators and direct prohibitions of harm for disclosure.

Most systematic reviews of PTSD and dissociation note a robust relationship between symptomatology and traumatic circumstances such as wartime combat, natural disaster, concentration camp experiences, and interpersonal violence, including sexual and physical abuse (Gelinas, 1983; Goodwin, 1989; Kluft, 1988; Loewenstein, 1991a; Putnam, 1985, 1989; Ross, 1989; Spiegel, 1990, 1991b). Spiegel (1990) delineates the overlap of dissociative symptoms and those of post-traumatic stress disorder (PTSD). Indeed, psychogenic amnesia is among the DSM-IV diagnostic criteria for PTSD.

**Diagnosis of PTSD and dissociation in survivors of CSA**

Dissociative symptoms can be grouped into several categories, including amnesia, autohypnotic, and "process" symptoms. PTSD, somatoform, and affective symptoms are also commonly found in clients with dissociative disorders (Loewenstein et al., 1988; Loewenstein & Putnam, 1990; Loewenstein, 1991b). For example, in a study at Sheppard Pratt Hospital, about 80 percent of the dissociative disorder patients met criteria for PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders* (Armstrong & Loewenstein, 1990). With few exceptions, the remaining clients had some PTSD symptoms short of the full list of criteria, or had a lifetime history of PTSD that was in remission at the time of the interview. Virtually all of these patients gave histories of sexual and/or physical abuse in childhood.

Amnesia symptoms include: blackouts or time loss; fugues; reports of disremembered behaviour; unexplained possessions; inexplicable changes in relationships; chronic mistaken identity experiences; childhood amnesia and/or fragmentary recall of the entire life history; and brief amnesias during conversations or other interactions with people. Autohypnotic symptoms include spontaneous trances, enthrallment, spontaneous age-regression, voluntary analgesia, negative hallucinations, depersonalisation and out-of-body experiences.
Dissociative process symptoms include: complex dissociative multimodal hallucinations; pseudohallucinations; passive-influence experiences; presence of distinct personalities or personality states; switching phenomena (ie, transitions between these states); and linguistic changes, such as referring to the self in the first person plural or third person singular (Loewenstein 1991b; Putnam, 1989). While not meeting the full criteria for multiple personality disorder, dissociative sexual abuse survivors often have a mixture of autohypnotic symptoms, amnesia for at least some parts of childhood, somatoform symptoms, and PTSD symptoms. Often anxiety and phobias are present as well. Such symptoms are best conceptualised as part of the PTSD syndrome.

Thus, all clients with a history of childhood trauma should be fully evaluated for chronic complex dissociative symptoms. Conversely, all clients with a history of dissociative symptoms should be assessed for a history of childhood abuse or trauma as well as for PTSD. However, therapists need to be aware that unless they are asked direct questions, clients commonly conceal the presence of such symptoms even from therapists they know well. This means that therapists of sexual abuse survivors should routinely perform a systematic assessment of PTSD and dissociative symptoms.

**Therapy for the Survivor with PTSD and Dissociative Symptoms**

Basically, therapy for sexual abuse survivors with PTSD and/or, dissociative symptoms is the same as that for survivors in general. Common issues with this client population are about acceptance of a diagnosis, trust, boundaries, limits, dangerousness to self and/or others, and the establishment and maintenance of a workable therapeutic relationship (Kluft, 1991). When working with such clients the therapist needs to be active, flexible, and "human" while maintaining appropriate boundaries and a clear sense of his or her role with the client (Kluft, 1991; Spiegel, 1991b). That is, the therapist’s role is that of a therapist and not as a public advocate, surrogate parent or detached detective in search of the "truth" (Kluft, 1991). It is essential to establish limits on behaviours that can undermine therapy, such as ongoing enmeshment with abusive individuals, severe eating disorders, substance abuse,
intractable self-destructiveness or dangerousness toward others, and abuse of the survivor's own children. Resolution of these sorts of difficulties is needed before any trauma related therapy can be undertaken.

The transference and counter-transference responses that may occur in the treatment of abuse survivors are usually dominated by post-traumatic themes (Loewenstein, 1993:83). For example, the highly dissociative client commonly experiences the world as a place where abuse is inevitable and the only freedom one has is to attempt to attenuate and/or manage the inescapable abuse. Thus, all people, including the therapist, are perceived as potentially or actually exploitative and may be expected to violate boundaries with which they are entrusted, no matter what their official role description or reputation (Briere, 1989; Spiegel, 1986).

Sometimes, a flashback transference occurs in which the therapist is literally seen as a past abuser or other important past figure (Briere, 1989; Spiegel, 1986). Alternatively, the therapist may be experienced in the transference as a co-abuser who is detached from and/or promoting of the abuse; as a failed past helper or even as the client, with the actual client taking the role of the abuser or the therapist. In the latter case, the therapist often shares with the client a profound sense of helplessness or impotence about the possibility of achieving any change or growth. The therapist must recognise this as a projective identification from the client and interpret it as such. This sort of intervention may be successful in resolving stalemates in therapy resulting from such a transference/counter-transference process (Peebles-Kleiger, 1989).

A related process is that of the unconscious flashback. This is where the individual has a sudden, discrete experience that leads to an action that recreates or repeats a traumatic event, but the subject does not have any awareness at the time or later of the connection between this action and the past trauma (Putnam, 1989:237). Unconscious flashbacks are very common in clients with a history of childhood sexual abuse. At some level, many of these clients may seem to be living in flashbacks much of the time. The therapist and the client may unconsciously recreate old interactions between the client and important past figures, abusive
or not. This often painful process is related to the client's psychogenic amnesia. For example, the memories that make such difficulties comprehensible are dissociated. Usually the therapeutic predicament comes first, with the solution to the problem emerging only as the amnesia abates. This usually happens by uncovering additional traumatic material or by coming to a new understanding of previous material. In addition, some severe suicidal and self-destructive crises that occur with the repression of abuse memories in abuse survivors are actually partly related to the resurfacing of earlier suicidal or hopeless feelings that were dissociated at the time of the abuse (Paddison, 1993).

The sexual abuse survivor with a dissociative disorder often describes a family characterised not only by abusiveness but also by a particularly malignant blend of severe sexual abuse, reversal of roles, loss of boundaries, and enmeshment in intense, confusing, complex abusive relationships, characterised by a double-binding mixture of torment and nurturance (Braun and Sachs, 1985; Fine, 1991). Rather than risk the destruction of the client's inner survival system and skills, in the beginning of treatment the therapist must acknowledge that the survivor needs encouragement to recognise, use, and modify dissociative defences and coping capacities to help shape a more satisfactory contemporary adaptation.

Clients need to be assisted in understanding that they adapted to a crazy childhood situation, rather than accepting that they were crazy. Thus, actively working with dissociation, rather than attempting to abate or suppress it, empowers the survivor to move from a stance of feeling helpless, overwhelmed, trapped, and victimised (Spiegel 1991b). Utilisation of the dissociativity of the survivor can help her reconstruct the past history to understand how she survived the trauma at the time of its occurrence. This allows the survivor to move from living in a perpetual flashback reality into a world characterised by greater freedom and continuity of thought, feeling, and action. Similarly, if a diagnosis of PTSD is made by the therapist, it can be a relief to the client to receive education about the disorder. Frequently, the client expresses surprise that the symptoms of nightmares, flashbacks, intrusive imagery, amnesia, triggered panic reactions, and psychic numbing actually are part of a comprehensible clinical entity for which there is a clear method of treatment.
As well as giving information about dissociation and PTSD, it is also helpful to inform the client about the likely difficulties in attempting to treat such conditions. These difficulties include the certainty that therapy can be painful and that the client may experience substantially more symptoms for periods of time, even as therapeutic gains are made. The uncovering of hidden traumatic memories and their implications for the client's life, as well as the relinquishing of dissociative amnesia, make intervention exceptionally uncomfortable and distressing at times for both the client and the therapist (Kluft, 1991). Nonetheless, the client who successfully completes a treatment for a complex dissociative disorder is rewarded with a sense of mastery and freedom, coherence of sense of self, cessation of dissociative and PTSD symptoms, and real clarity about the meaning of her life history (Paddison, 1993). It is not difficult to see the relevance of understanding these formulations about dissociation to the sexual abuse survivor.

**The systemic approach**

The systemic approach is based on a general method developed for dealing with all possible presenting difficulties in therapy. As described by Sanders (1992) it has four major dimensions—pattern, system, time and gender—through which any difficulty is explored. No one of these dimensions is seen as having priority over the others; rather they are all regarded as being primary. Questioning occurs both within any one dimension and across the dimensions, and the four lock into each other in such a way that they are inseparable. This directs the therapist to explore regularities of patterns of behaviour, affect, meaning and belief, across time and within all relevant systems. It recognises that gender differences are fundamental to the way difficulties arise and are perpetuated. The therapist becomes an integral part of the change process (Sanders, 1992).

A major feature of the approach is the emphasis placed on the need for the therapist to undertake a full and thorough enquiry about the client’s problem. As shown in the preceding discussion, it is not uncommon for people who have experienced abuse to deal with the pain and confusion by shutting the experiences away and almost totally forgetting, or colluding
with the abuser's view, that it was useful, normal or harmless (Gil, 1988; Courtois, 1988; Ellenson, 1986). A full enquiry protects the therapist from either pathologising the client or being too readily assured that the abuse is of no real concern.

Once the therapist has developed a full understanding, ideas or suggestions may be drawn from other major schools of therapy. For example, strategic therapy has much to offer in terms of managing difficult symptoms, particularly when the person feels overwhelmed and distraught by the unfolding of memories. Gil (1988) reports using tasks to make the process of dissociation a survival skill, used during abuse, that persists into adulthood and is one within the client's control. Clients are set tasks of practising dissociating, increasing or decreasing its intensity. Other useful strategies are described by Bass and Davis (1988), Courtois (1988), Dolan (1989), Gilligan and Kennedy (1989) and Gil (1988).

A major contribution from the systemic school is the circular question (Palazzoli et al., 1978) which provides new information in the form of previously unrecognised connections between behaviours, feelings, beliefs, attitudes and values. Such questions can be used to help the person understand more about the family system within which abuse occurred and help them more accurately locate a child's place and responsibility in such an arrangement. Questioning that connects behaviours, meanings, affect and belief across a number of levels of system can make sense of symptoms that, until this point, have been disturbing mysteries.

Recognition and labelling of affect and its connection to past events can be a first step to healing for the sexual abuse survivor. Patterns of meaning are those that directly relate to the abuse experience and its subsequent legacy. One of the tasks of therapy is to reclaim the original meaning of abuse such that it is labelled for what it is - the responsibility of an adult and not a child, a violation and not an act of love. Understanding the meaning attributed by the client to subsequent symptoms is also important, as people often label memory flashback of the abuse experience, fears and suicidal urges, as evidence of madness. It can, therefore, be extremely helpful for a person to understand that these apparent signs of insanity are in fact quite sane responses to earlier “crazy” experiences.
The time dimension can be conceptualised as past, present and future, and the therapist aims to connect the patterns, as described earlier, to different times in the person’s life. Attention is paid to the time the abuse began and attempts are made to locate this within arrangements in the family or wider familial or social systems. The goal of this is to lift the burden of responsibility for causing and perpetuating abuse from the shoulders of the child. The value of future time questions has also been explored. As Penn (1985: 301) found, questions about the future promote the rehearsal of new solutions and suggest alternative actions. She reports that in many respects, working with abuse survivors is similar to working with families with a chronic illness whose concept of the future is frozen in time. That is, abuse survivors often find it difficult to recall a time before the abuse began and to believe that they will ever move to a point beyond it.

A systemic approach, as argued by Walters (1990:13), is congruent with a feminist perspective in family therapy. She believes many of the techniques of family therapy demonstrate a tunnel vision that sees only what is immediately apparent and never explores that which lies below the surface, and that "meaning" is relegated to the margins or conferred within the formulae of systems theory. In contrast to this, the systemic approach is a therapy that is committed to explaining and describing the context and the process in the formation and transformation of any human experience. This is particularly important when working with sexual abuse, where the widest level of the system, the social and cultural milieu in which one is raised, must be considered if the problem is to be adequately understood at both the individual and the system level.

Beliefs are the bedrock on which people build their lives. The experience of abuse can shape beliefs in ways that are self-limiting, destructive and isolating. The way in which the systemic approach looks beyond the individual and their beliefs and takes into account the context in which the abuse occurred makes it an appropriate way to intervene when working with survivors of childhood sexual abuse.
Solution-focused therapy

Solution-focused techniques (de Shazer, 1985, 1988; de Shazer et al., 1986) provide a realistic map of recovery while implicitly offering hope to any client. Basic to this approach is the concept of co-creation of solutions by client and therapist (O'Hanlon & Weiner-Davis, 1989). This is based on the respectful assumption that clients have the inner resources to construct highly individualised and uniquely effective solutions to the problems that bring them to therapy. Solution-focused therapy assumes that the construction of a solution is a joint process between client and therapist, with the therapist taking responsibility for empowering the client to create and experience her own uniquely meaningful and effective therapeutic changes.

In order to feel somewhat "in control" before undertaking therapy focused specifically on the resolution of the past trauma, the client needs to acquire some physical and emotional stability (Dolan, 1991:30). Solution-oriented techniques are offered as an effective means to provide some realistic hope and stability for the client during the therapy process and to enable her to replace negative, self-destructive expectations with a healthy and positive, yet realistic, vision of the future. These techniques can be used throughout therapy. They provide a useful way for the client to acknowledge her progress and set goals for the future even when she is no longer actively in treatment.

Shifting from the present not only to the past but also to a hopeful future makes dealing with the trauma less overwhelming for the sexually abused client and makes the treatment process more manageable for the therapist. Once the therapist has learned the facts of the client's abuse, treatment planning should begin. Solution-focused therapy has five important tools: pretreatment changes (O'Hanlon & Weiner-Davis, 1989); the Solution-Focused Recovery Scale; the miracle question (de Shazer, 1988); the first session formula task (de Shazer, 1985); and constructive individual and systemic questions (Lipchik, 1988).
"Pretreatment change" refers to an improvement in the situation for which the client is seeking therapy that occurs between scheduling the appointment and coming to the first session (O'Hanlon & Weiner-Davis, 1989). The client is asked if she is aware of any such changes and whether she would like them to continue. This question leads easily into the Solution-Focused Recovery Scale (de Shazer, 1988). The purpose of the Solution-Focused Recovery Scale is to provide a context of hope and to shift the focus toward healing. The scale is designed to be read aloud to the client, with the client responding verbally, although it could easily be adapted and adjusted for the purpose of having clients fill it out themselves in group or individual settings. The therapist can then show the client what areas she marked as already existing signs of healing and/or pretreatment changes and ask the client to speculate about what she thinks will be the signs of healing she (and, in some cases, significant others) will notice next.

The miracle question, developed by de Shazer (1988) at the Milwaukee Brief Family Therapy Centre, is particularly useful in empowering very demoralised clients to imagine a solved version of their seemingly hopeless problems. The client is asked: "If a miracle happened in the middle of the night and you had overcome the effects of your childhood abuse to the extent that you no longer needed therapy and felt quite satisfied with your daily life, what would be different?"

The first session formula task relates to the questions asked by the therapist during the first session (de Shazer, 1985). The client is asked to think about the things in their life that they would like to have continue and to make a written list of those things between now and their next therapy session. Having the list to hold on to is particularly important in the intense early stages of treatment when focusing on the past trauma may tend to eclipse the client's awareness of the safety, comfort, and support available in her everyday life in the here and now. The list, which can be as long as the client wishes to make, serves as a tangible reminder to the client that she has comfort and security available in her present life. This is particularly helpful when long dissociated memories of sexual abuse are just coming into the client’s conscious awareness (Dolan, 1991:36).
Constructive systemic questions (Lipchik, & de Shazer, 1986) are a specific form of solution-focused intervention that can be employed both individually and systematically. Individual questions help the clients identify the specifics of their own solutions, while systemic questions evoke and utilise the resources of family, friends and significant others. For example, constructive individual questions include asking the client to consider what would be the first (smallest) sign that things are getting better for her and that the sexual abuse is having less of an impact on her current life. Clients are also asked what they will be doing differently when the sexual abuse trauma is less of a problem in their life and what they will be doing differently with their time. Constructive systemic questions include asking the client to identify what her family, friends and significant others would say are the first (smallest) sign that things are getting better for her and what positive differences that these changes may be making in their relationships with each other.

A major aspect of solution focused therapy is the focus on the client’s strengths and abilities. This is particularly helpful in empowering survivors of sexual abuse to participate in their own treatment. Given their history of victimisation, the posture of respect, pragmatism, and hopefulness is uniquely suited to the survivor of sexual abuse who may be unable to respond to other more intrusive and less personalised therapy approaches. Overall, as a therapeutic approach, solution focused therapy assists people to change rather than focus on old deficits.

A group therapy approach

Group therapy programmes, as an approach to working with survivors of CSA, have developed as more time limited interventions than individual therapy. This can, however, as Goodman & Nowak-Scibell (1985) argue, provide a therapeutic contrast with the lack of boundaries found in sexually abusing families. The issue of time limitations is similar to that of open membership versus closed group membership groups. Both have advantages: for example, while a group programme may not be appropriate for addressing the more complex symptomatology resulting from an abuse history, it may be helpful in stabilising survivors and
preparing them for individual therapy. Alternatively, it has been found that closed groups seem more comfortable for survivors and better able to facilitate trustful bonding, which would be threatened by membership turnover (Bergart, 1986).

Overall, as a treatment modality, group therapy is seen more as a helpful adjunct than as a treatment modality in its own right for working with survivors (Courtois, 1988; Briere, 1989). As Fisher (1991: 118) points out, there is agreement among the helping professions that a group format is particularly effective for accessing the interpersonal issues facing survivors and effectively counteracting family denial of the problem. Group therapy is also effective in alleviating feelings of stigma and decreasing the sense of isolation so often experienced by survivors.

**Medication and Therapy**

While therapy, whether individual or group, is an essential role in the treatment of trauma related to childhood sexual abuse, it is sometimes not enough on its own. For example, adult survivors are vulnerable to a number of other psychiatric difficulties that may also require pharmacological intervention. As Saporta & Case (1993:104) explain, coexisting related symptoms such as uncontrolled physiologic reactions can undermine the client's emotional well-being and impair her capacity to engage in therapy. They also argue that a decrease in the baseline level of arousal can restore the client's control over bodily responses and improve cognitive function, thus enhancing the effectiveness of therapy.

The goal of pharmacotherapy is to improve the client’s capacity to utilise therapy, while improving functioning and reducing suffering in other areas of her life. However, effective pharmacotherapy requires careful identification and monitoring of target symptoms. The few controlled trials that have looked at treatment for PTSD include a few medication trials together with a mixture of behavioural, cognitive behavioural, and behavioural-psychodynamic approaches (Putnam, 1996). Some authors (Davidson *et al.*, 1990; van der Kolk *et al.*, 1994) indicate that tricyclic antidepressants in conjunction with therapy and
serotonin re-uptake blockers can assist with intrusive and hyperarousal symptoms. Others (Smith et al., 1989; Yehuda et al., 1991, 1993; De Bellis et al., 1994a) point out the specific treatment needs for PTSD as opposed to those associated with depression. As Saporta & Case (1993) make clear the type of medication indicated is determined by the most prominent target symptoms and may vary from client to client.

**Issues in Therapy**

The three main issues that tend to arise in relation to therapy for survivors of CSA are: the gender of the therapist, the therapeutic process (Blake-White & Kline, 1985), and the mental health of the therapist. For example, factors such as the gender of a therapist can influence the therapeutic process and play a part in the eventual outcome of therapy. However, the literature contains controversial and contradictory opinions on the question of who works with whom. Some authors (Silverman, 1977; Herman, 1981, Briere, 1989) believe a woman survivor may experience additional trauma as a result of an interaction with males subsequent to sexual assault and suggest that same-gender therapists are important and fundamental for effective therapy. Others see it differently. Jehu (1988) argues that if problems such as mistrust of men or the oversexualisation of relationships are replicated in the treatment situation, then a male therapist can provide an appropriate corrective experience, and Deighton and McPeek (1985) consider it essential that abused women explore their feelings with a competent male therapist during the treatment process.

In looking at group programmes Hildebrand and Forbes (1987) suggest that a male-female leadership pair allows 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 (1987:293) also 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.
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 therapists working with survivors of sexual abuse must constantly be aware of possible reactions clients can experience to the therapist's gender, and must be able to interpret the reaction with the client when appropriate.

As already discussed in this chapter, the goals of therapy are generally framed according to the orientation of the therapist. However, given the differences in each approach, when working with survivors of sexual abuse there is general agreement regarding the phases of the therapeutic process. The first involves the issue of safety where an alliance between the therapist and client is formed. It is here that the client needs guidance to see her reactions and adjustments as valid responses to trauma. A range of self-destructive behaviours such as suicidality; substance abuse, eating disorders; passive failures of self protection and repetitive involvement in exploitative relationships can occur. All need to be taken seriously and managed appropriately. For example, it may be necessary to refer the client to a mental health service or detoxification centre (Herman, 1992).

The second phase of the therapeutic process involves more in-depth abuse-focused therapy. At this stage there is a need to balance two agendas: the survivor’s need for safety, support and stability, and therapeutic processes that inherently stretch the survivor’s capacities and admit threatening material into awareness. It is important that interventions do not focus too much either on the former, and thus not allow the survivor to progress in therapy, or on the latter, which runs the risk of overstressing the client and may cause her to withdraw and take fewer healthier therapeutic risks (Briere (1992:111).

The third phase involves the client actively pursuing social re-connection with former relationships. Where these relationships have been abusive, new boundaries, limits and issues of secrecy need to have been addressed before therapy can end (Herman, 1992). The end of therapy may evolve intrinsically out of the treatment process; however, when working with sexual abuse survivors the cessation of the therapeutic relationship assumes greater
proportions for the client and, in fact, may restimulate major abuse-related issues. Thus, while a relatively separate issue, termination needs to be prepared for and re-addressed before therapy can be considered complete.

The mental health needs of therapists working with sexual abuse survivors have been addressed by a number of writers (Briere, 1989; Dolan, 1991; MacDonald et al., 1995). The main issues identified seem to be isolation, dealing with the internal impact of the ongoing horror stories and the development of secondary post-traumatic stress. Briere (1989: 164) comments that therapy with abuse survivors is a relatively autistic process; a closed system where the therapist absorbs the client’s pain and is often unable to fully unburden it to others. Both Dolan (1991) and Briere (1989) describe how the impact of constantly dealing with abuse can produce secondary symptoms of post-traumatic stress in the therapist. These may include sleeplessness, mental replaying of client’s descriptions of abuse after the session similar to flashbacks, lack of interest in own personal relationships, numbing and generalised anxiety similar to that found in actual survivors of sexual abuse. There may also be a tendency to see every client as a potential sexual abuse survivor.

In order to take care of clients, therapists need to take care of themselves. There are a number of ways in which this can done: maintaining a balance between work and personal life (i.e, leaving work at work), acknowledging the stress of the job and obtaining support through good supervision, and working in a team or networking with other abuse workers. Finally, a more balanced perspective is gained by working with different client populations. This has the effect of reassuring the therapist that not everyone on their caseload are as psychologically damaged as CSA survivors may be.

Summary

The psychodynamic approach arose from Freud’s personality and infantile sexuality theories, and he attributed adult symptoms to early and arrested psychosexual development. Freud saw women who presented with problems of sexual abuse as fantasizing. Therapists
working from this perspective and basing their intervention on such beliefs would be less than helpful to their clients. The suggestion in the previous chapter that sexual abuse within a family is a response to an imbalance of power in gender relationships is more in keeping with the view that this study takes. Some of the flaws associated with psychodynamic theory are currently being corrected by significant revisions in therapy format, strategy and research. Examples are shorter duration for therapy with a combination of expressive and supportive techniques and the development of standardised manuals. However, despite these modifications, Freudian concepts continue to underlie current modern psychodynamic theory and practice.

From a cognitive perspective, effective therapy of abuse trauma must include interventions that help the survivor to update their victimisation-related assumptions. The client is taught to recognise and alter abuse-distorted thoughts, beliefs and perceptions, through what is referred to as cognitive restructuring. Such activities help survivors to become aware of their beliefs, as well as recognising any distortions they contain and to substitute more accurate alternative beliefs.

Evidence from controlled clinical trials has demonstrated efficacy for the use of IPT as a reasonable alternative or adjunct to medication for working with depressed clients and other clinical populations. However, because not all survivors meet criteria for psychiatric disorder, IPC, which was specifically designed to work with distressed rather than psychiatrically disturbed clients, may be helpful to some clients. It seems though, that while symptom relief and an increase in depressed mood was experienced with the participants in the trials, IPC may have alerted them to the need to further address the source of their symptoms.

The systematic approach directs the therapist to explore regularities of pattern behaviour, affect meaning and beliefs across time and within all relevant systems. It is only recently that systems therapists have begun to explore how their view of the generation and resolution of human difficulties can be applied to working with survivors of sexual abuse. Solution-focused therapy is based on brief therapy techniques. Where it differs from brief
therapy is that the solution-focused therapist works for as long as it takes for the client to experience symptom relief, resolution of the intrusive memories about the CSA and acquisition of a hopeful orientation toward the future.

Some of the more frequently encountered problems for adult survivors of childhood sexual abuse include symptoms of PTSD and dissociation. Sometimes pharmacological interventions for clients who experience symptoms of PTSD are helpful, whereas the use of medication for dissociative symptoms is limited.

It needs to be noted that while distressful for the client, and at times the therapist, the contribution of PTSD and dissociation symptomatology to the therapeutic domain of sexual abuse counselling is useful. That is, PTSD symptomatology provides an observational framework for studying the effects of the abuse and the effectiveness of counselling.

In summary, there are a number of therapeutic approaches that may be helpful for treating problems related to sexual abuse. Unfortunately, because attention to the treatment needs of CSA survivors is very recent, to date, much that is known is anecdotal. Very limited systematic research comparing different types of treatment has occurred and no controlled trials with adult survivors have been undertaken. The few studies that have been undertaken have involved the treatment of children rather than adults. Furthermore, as Lanktree and Briere (1995:1146) note, the lack of an equivalent untreated comparison group poses a threat to internal validity to these studies. Such a threat raises the question as to whether any improvement in symptomatology achieved is a result of the treatment received, or merely the passage of time associated with the completion of a treatment programme.

Given the preliminary state of research on treatment outcomes for survivors of CSA it is clear that much is needed in this area. That is the purpose of this study.
CHAPTER FOUR

METHODOLOGY

Overview of Study Design

The aim of this study was to evaluate the efficacy of counselling for survivors of childhood sexual abuse. This entailed making some comparisons about individual well-being before and after attending counselling. After various designs were considered, the most feasible option appeared to be a naturalistic one.

The two main approaches to research are the use of either experimental or quasi-experimental methods. The experimental approach makes use of randomised experiments—experiments that are characterised by the use of initial random assignment for inferring treatment-caused change. In contrast to this the naturalistic approach places a special emphasis on quasi-experiments—experiments that have treatments, outcome measures and experimental units, but do not use random assignment to create the comparisons from which treatment-caused change is inferred (Cook and Campbell, 1979:6).

Quasi-experimental designs can include a naturally occurring event; thus comparisons are based on “real world” experiences. Such experiences are not created, sustained, or discontinued solely for the research purposes. Although experimental designs may provide the best way to test cause-and-effect relationships, there are times where true experiments may not be possible. For example, when denial of treatment for a mental health issue is thought to be unethical. At such times quasi-experimental designs are a preferred approximation (Dane, 1990: 117).
Issues for all treatment studies

There has been growing recognition that traditional methods used to evaluate treatment efficacy are problematic (Mechanic, 1996; Andrews et al., 1994; Jacobson and Traux, 1991). The main issues are two-fold. First, there is a lack of standardised treatment-outcome measures and thus comparisons across studies are difficult if not impossible. Second, treatment effects are typically inferred solely on the basis of statistical comparisons between mean changes resulting from treatments under study.

Of particular importance to this study is the fact that psychotherapies are composed of many intricate components featuring changing dialectical interactions between client and therapist, and that they are not reproducible technologies (Glass, 1984). Thus, treatment studies evaluating therapeutic intervention involve client, therapist, therapy and interactive factors, all of which need to be taken into account.

Mechanic (1996) identified a number of issues relating to mental health research which have relevance for the measurement of treatment outcome studies. They include: broadening the context of outcome evaluation beyond simple symptom changes to include a variety of clinical and social outcomes; recognition that the “real world environment” in which mental health services operate can affect clinical outcomes; the lack of extensively used practice guidelines (outside the USA) and the frequently non-standardised treatment interventions that comprise mental health treatments (referring to the “blackbox” of treatment and programme variation); and funding, ethical and methodological difficulties, such as selective attrition. All of these issues make randomised controlled trials and large-scale studies difficult to implement and often present problems of interpretation.

Although basic design options may differ between naturalistic and controlled studies, in both cases addressing the issues raised by Mechanic (1996) can assist in reducing potentially contaminating and confounding influences. Though these are general guidelines for mental
health treatment studies, they would also apply to the treatment of problems specifically related to sexual abuse.

**Issues with quasi-experimental designs**

Two major criticisms of quasi-experimental designs are the lack of random assignment and, as for all treatment studies in general, the lack of standardised treatment outcome measures. Compounding this problem further is the fact that of the varying measures of treatment outcome that have been used, the domains or criteria for determining positive or negative outcomes within these domains, have also differed. Researchers undertaking treatment outcome studies have nevertheless achieved consensus on a number of principles and methods as standards for assessing the internal and external validity of treatment research. In brief, as Beutler and Hill (1992) note, these principles include the following seven criteria:

- That client samples are representative of those about whom generalised conclusions are to be made.

- That measurement is based on instruments which have already established independent evidence of reliability and validity.

- That methodological attention is given to the potentially negative effects of low statistical power and redundant data.

- That samples of therapists are large enough to distinguish between therapist and therapy effects.

- That manuals spanning a variety of theoretical orientations are used to increase the reliability and skilfulness of the therapy be assessed.

- That results should be protected against investigator bias.
• That clinical meaningfulness is assessed in order to supplement estimates of statistical significance.

With regard to treatment studies of adult survivors of CSA, though many counsellors are able to state a particular mode of intervention, the lack of specificity about the intervention used presents a major difficulty when attempting to evaluate effectiveness (Krupnik and Pincus, 1992). Manuals that span a variety of theoretical orientations allow for the reliability and skillfulness of therapy to be assessed. Modification of treatment manuals making them more applicable for sexual abuse therapy would allow for conceptual linkages and theories of treatment, thus allowing for a more accurate evaluation of clinical practice in this area.

**Summary of treatment studies**

Treatment studies in general still have a number of challenges to overcome in developing good outcome measures. A major one is to take into account the real-life settings within which mental health services operate. Treatment studies of adult survivors of CSA have not as yet taken full advantage of some of the methodological strategies that have become a virtual requirement in other mental health areas. In order to achieve scientific credibility and to develop useful knowledge about the treatment of problems related to sexual abuse it is necessary to adopt such strategies.

This study has attempted to conform to Beutler and Hill’s (1992) principles. Where possible, standardised instruments have been used and the selection of clinically relevant measures, the intervals between measures and the choice of the number of measurement points were all designed in accordance with these principles. This study involved many therapists, some from the private sector, of which the majority worked in the same centre, and some, one of which was the author, were in the FHC Service. The main therapeutic task of the author involved the assessment of clients and recruitment into the study, but it also included therapy with a small number of the clients who could not be referred elsewhere.
Ethical Issues

Random assignment is an important procedure in the evaluation of cause-effect relationships. If benefits are withheld from participants, however, the evaluation of treatment approaches involves serious ethical questions. It is only ethical to assign patients to treatments in a trial if there is a genuine uncertainty about which treatment (or absence of treatment) is better. This is sometimes referred to as the “window of uncertainty” (Dane, 1990). Other issues involve the level of informed consent, confidentiality and control over participants’ experiences.

Quasi-experimental designs lack random assignment and include settings that are normally frequented for purposes other than participating in research. They are, however, bound by the same ethical considerations as noted above for randomised experimental designs. Those considerations are that the research practice should be conducted in an ethical manner which meets codes of ethical practices adopted by professional organisations and the appropriate ethical committees.

Castor-Lewis (1988) provides a provocative examination of the ethical issues involved in research with child sexual abuse survivors. Two major problems were discussed, both of which cast the research enterprise experienced by the survivor as a recapitulation of her abuse. As Castor-Lewis (1988:74) argues “. . . .the gaining of information could constitute a boundary violation for a person whose boundaries were flagrantly, aggressively, often repeatedly, and sometimes violently violated in the context of early trauma”.

Another issue lies in the inherent power differential between the researcher and the survivor. For example, researchers are often affluent professionals compared with victims who are often poor and non-professional. Thus, cautions Castor-Lewis (1988), research with this population of people must be carried out with great sensitivity and established protocols. This requires that researchers are fully aware of the issues regarding abuse and have themselves dealt with any abuse issues of their own.
Aims of the Study

The purpose of this study was to evaluate how women were functioning before and after attending sexual abuse counselling. There were two main aims. One was to determine on assessment of clients for intake into a Family Health Counselling Service's Sexual Abuse Programme, the number of women in the study who had current symptoms of PTSD, dissociation, anxiety and depression. Baseline symptom scores of conduct and eating disorders were also obtained, as was information in regard to current alcohol use, early relationships with and between parents, and current social functioning.

The second aim was to determine the number of women in the study who had experienced a decrease in symptoms of PTSD, dissociation, anxiety, depression, and who had made an improvement in their overall social functioning following counselling. Measurement occurred at initial assessment and at three and six months after counselling had commenced. This study had the approval of the Southern Regional Health Authority’s Ethics Committee.

Study Hypotheses

There were two hypotheses for this study:

1. The women with the worst CSA histories would be most symptomatic and most socially impaired at assessment.

2. Following counselling an improvement would be noticeable in the womens’ overall symptomatology and social functioning provided that they had (a) attended regularly and (b) that they had not been sexually abused as adults.
Selection and Recruitment

Subjects were recruited through the Family Health Counselling Service’s (FHC) Sexual Abuse Survivors Programme. Every woman entering the programme between August 1993 and June 1996 who met the inclusion criteria was invited to participate in the study. The final sample contained 100 women.

Inclusion Criteria:

1. Aged 16 years or more
2. Has a history of child sexual abuse
3. Has signed a consent form

Exclusion Criteria:

1. Currently being treated by another agency/professional
2. Intellectually handicapped
3. More than six months pregnant
4. History of treatment for schizophrenia and or/manic depression
5. Recently started on anti-depressants
6. Currently suicidal
7. Currently in a violent relationship where further abuse is likely to occur
Following an initial assessment, clients on the FHC Service's Sexual Abuse Programme were either referred out to counsellors in the private sector for counselling, or if, for a variety of reasons, referral out was not possible, they were offered counselling through the FHC Service. After treatment options had been decided, the study was discussed with those women who met the inclusion criteria and they were invited to participate.

Once written consent was obtained, the counsellor undertaking the initial assessment gave the women the self-report baseline questionnaires to complete before leaving the counselling service. When making contact for the three and six monthly follow-up interviews the participants were given three options: to attend the centre for interview; to have someone from the study visit them at home; or to have the questionnaires posted out with a self-addressed envelope for returning the material to the researcher. Data collection from the sexual abuse counsellors was by post. Each counsellor was sent a letter with the counsellor questionnaire, a self-addressed envelope and a copy of the study’s consent form signed by the woman. Section 4 of the consent form states that the woman understands that the counsellor will be contacted with regard to progress made in counselling.

The follow-up contacts during 1993 and 1994 were undertaken either by the researcher or by other FHCS staff during counselling sessions. Most of the participants with private counsellors opted to complete and return the follow-up questionnaires by post. Between October 1995 and January 1997 the majority of the follow-up interviews were, following training, carried out by post-graduate social work students undertaking research placements at the Family Health Counselling Service. The students received ongoing supervision during the period of their involvement with the study interviews. Ten percent of the clients interviewed by the students were recontacted to ensure research protocols had been adhered to.

Baseline Assessment

Data was collected using a set of questionnaires (Appendix 3). The accurate assessment of a history of child sexual abuse presents major challenges to researchers, as no standard
definition exists. In this study the participants defined sexual abuse themselves either by making a self-referral, or by allowing someone else to refer them to the sexual abuse counselling programme. Section A of the questionnaires were completed by the Family Health counsellors undertaking the initial assessment. It consisted of questions relating to referral details, demographic information, psychiatric history and whether participants had made any suicide attempts in the past six months. Sections B-G were self-report questionnaires that were completed by the clients involved in the study.

**Sexual abuse experiences**

Included in Section A were 23 questions about the respondent’s sexual abuse experiences both before and after 16 years of age. These concerned the frequency, the nature, the extent, the perpetrator and the age at which the CSA occurred, reactions and disclosure about the abuse and whether the respondent had ever received any counselling prior to her presentation to Family Health Counselling.

**Post-traumatic stress disorder**

The presence of symptoms of Post-traumatic stress disorder and dissociation was assessed using a slightly modified version of the questionnaire developed by Coons *et al.*, (1990). Originally they designed a questionnaire to assess the incidence of PTSD symptoms among women attending the Julian Centre (a women’s counselling clinic) in the United States. The questionnaire was administered to 46 women patients attending the clinic and 20 female bulimic outpatients attending a state clinic for eating disorders. The bulimic group were chosen as a control group because they had similar socioeconomic backgrounds to those of the patients from the Julian Centre. The results showed that while the women’s clinic patients suffered from a significantly higher incidence of traumatisation than the bulimic patients, overall there was a high incidence of dissociative and PTSD symptomatology in both groups. The instrument has validity in a form of criteria-related validity. That is, the scores are
compared with established criterion as described in the DSM IV (Diagnostic and Statistical Manual of Mental Disorders, 1994) for PTSD and dissociation.

**Psychiatric symptomatology**

Psychiatric symptomatology was assessed by use of the SCL-90 (Hopkins Symptom Check List, Derogatis, 1983). The SCL-90 was originally developed to measure clinical improvement during the course of treatment. The revised SCL-90 is a 90-item questionnaire of current psychiatric symptoms from which nine sub-scale scores are derived: somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism.

Subjects are asked to complete the questionnaire according to how frequently they have experienced each item in the previous week on a five-point scale. Each question is scored: not at all=0; a little bit=1; moderately=2; quite a bit=3; extremely=4. The final score on each subscale is achieved by adding up the scores of all the items in the subscale, and dividing them by the number of items. Thus, all final scores must be in the range of 0-4. A global score can be obtained by adding up the sub-scales to make a total sample score. The SCL-90 has been well researched psychometrically. Each of the sub-scales has shown good internal consistency (coefficient alpha from 0.77 to 0.90) and high concurrent validity with the MMPI (Derogatis et al., 1976). In an early concurrent validity study of the SCL-90 Derogatis et al., (1976) found that scores in “symptomatic volunteers” ranged from 0.82 to 1.87, indicating <0.05 would be a normal population score.

More recently, a bulimia nervosa study (Peveler and Fairburn,1990) showed that the optimum cut-off for a mean total sub-scale score of the SCL-90 was 1.05 (giving a sensitivity of 76 percent and specificity of 92 percent) for caseness of psychiatric disorder according to the Present State Examination (Wing et al., 1974). Thus, the SCL-90 mean total score for their sample would be 9.4.
**Social functioning**

Overall social functioning was assessed by use of a self-report social adjustment scale (SAS). The methodological issues and history of development of the SAS have been reviewed (Weissman and Bothwell, 1976; Weissman et al., 1981). The SAS is a standardised questionnaire with demonstrated reliability and validity. Empirical validity was evidenced by the efficacy of the instrument in statistically differentiating a non-clinical community sample from three psychiatric populations (alcoholic, depressed and schizophrenic persons). The scale also distinguished acutely depressed from recovered patients (Weissman and Bothwell, 1976).

In a recent study Oakley-Browne (1993) also found a difference in SAS scores between women aged 18-44 years with a current major depressive episode (total mean score=2.3, sd=0.5) and women who had never been depressed (total mean score=1.9, sd=0.4).

The SAS contains 45 items about social functioning over the past two weeks. Eleven sub-scale scores and a total are derived by computing mean scores for each of the sub-scales and averaging all responses to yield a global estimate of social functioning. As some questions do not apply to some people on the basis of the questions answered the scores are pro-rated.

In addition to yielding a global measure of social functioning, the SAS also assesses role performance in six social contexts: relevant occupation performance (work either inside or outside the home), social and leisure functioning, relations with extended family, marital role, parental role, and membership in a family unit. The six sub-scales fall into four descriptive categories: performance at expected tasks, feelings and satisfaction derived from the role, interpersonal friction and arguments, and interpersonal behaviours and skills.

Each question is scored on a 1-5 basis, but for some questions, “not at all=1” while for others “all the time=1”. The questionnaire is set out so that scoring ranges between 1-5 from left to right. Each sub-scale final score is achieved by adding up the scores of all items in the
sub-scale, and by dividing the number of items. All the final scores must be in the range of 1-5, ranging from appropriate to impaired social functioning, with the highest scores reflecting greater impairment.

**Alcohol use**

Alcohol abuse was assessed by the use of the Alcohol Use Disorder Identification Test (AUDIT), a ten item screening instrument which was specifically developed by Barbor *et al.*, (1989) to identify people with alcohol problems rather than alcohol dependence. This standardised questionnaire contains questions relating to amount and frequency of the drinking, alcohol dependence and problems caused by alcohol including adverse psychological reactions. This instrument has good psychometric properties and has demonstrated reliability and validity. A score of 0-7 indicates no problem, while a score of eight and over indicates hazardous alcohol use.

The original AUDIT recommended a cut-off score of 11. Thus a person scoring 11 or more is classified as a positive case (Saunders and Aasland, 1987). On the basis of the validation study (Barbor *et al.*, 1989), a lower cut-off score of 8 or more qualifies as a positive case. In this study, eight was used as a cut-off score in order to determine the number drinking at unsafe levels among the total sample. The participants completed the AUDIT at initial interviews (baseline) then again at the three and six months follow-up interviews.

**Eating disorders**

Section E was included as a way of determining eating patterns in a sample of sexually abused women. As no suitable validated questionnaires were available 21 items about past and current eating habits relevant to the diagnosis of anorexia nervosa and bulimia nervosa, as defined in the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, 1994) for eating disorders, were constructed specifically for this study. Responses to the criterion-
related questions about height and weight allow body mass index (BMI) scores to be calculated for the women.

Antecedent events in childhood

Three specific questions were designed to gain information about antecedent events in childhood. These questions asked about relationships with and between parents. The questions related to how the respondents’ parents got on together, and how the respondents, when between the ages of 0-15 years, got on with each of their parents. A further 12 criterion-related questions for childhood conduct disorder, as defined in the DSM IV (Diagnostic and Statistical Manual of Mental Disorders, 1994), were also constructed for this study.

Three Months Follow-up Interviews

At the three-month follow-up interviews, the first page of each questionnaire was completed by the interviewer. It contained seven items, especially constructed for the current study. After stating the number of counselling sessions attended, respondents were asked to indicate on a four-point scale how happy they were with their progress to date (very unhappy=1; unhappy=2; happy=3; very happy=4). Using a five-point scale respondents were also asked to indicate how they felt now and whether anything changed (worse=1; same=2; a little better=3; better=4; much better=5). A yes or no response determined whether respondents attributed any changes to counselling or other circumstances. A general question asked whether there was anything else they wanted to report. Although the instrument is not scored and has not been subjected to any reliability tests, the questions assess a general satisfaction factor which, as suggested by Ruggeri (1994), should be not be overlooked.
Six months Follow-up Interviews

At the six month follow-up interviews the first page of each questionnaire was again completed by the interviewer, with some additional items. A yes or no response to these items ascertained whether the respondent was still attending counselling and whether her memories about her abuse experiences had changed at all during the counselling process. If changes in memories had occurred respondents were asked to describe the change. They were then asked to repeat the same self-report questionnaires completed at the three month follow-up. By repeating these questionnaires at three month and six month follow-up interviews, an individual’s progress in treatment was able to be monitored.

Counsellor Report

At six months the clients counsellors were also asked to complete a questionnaire. This instrument was constructed for the current study and consisted of 12 items relating to: total number of counselling sessions attended; total number of cancellations; number of times the client failed to arrive for her appointment; whether the client was still in counselling; and if not, how termination had occurred. A seven-point scale was used to ascertain how satisfied the counsellors were with the client’s progress during counselling and how satisfied they were with their intervention overall (dissatisified=1; satisfied=7). They were also asked to note the main intervention method used and to indicate whether the client had exhibited any suicidal ideation during the time she was engaged in counselling.

Data Handling and Data Checking

Every client in the study was given a study identification number which was separate from her clinical file number. Initially, all the data were entered into PARADOX, a relational data base, (Borland International, 1992), by data entry personnel. After data entry was completed, one in every ten cases was selected and checked for data errors. A small number of errors were identified and the codes corrected. At that stage some of the low-frequency codes
within some of the variables were collapsed into one code, or the variable was recoded into a new variable that was more appropriate for statistical analysis.

The data were then converted from PARADOX files to SPSS for statistical analysis. Before undertaking any statistical analysis, the data were scanned on the data editor to identify any coding errors. Frequency tables were also run to ensure the numbers in each data set were complete.

Exploratory statistics were initially used to look at the data. Probability plots were used to check that the data approximated a normal distribution throughout the sample. All original data files, both Paradox and SPSS, have been kept.

**Statistical Analysis**

Statistical analysis was undertaken using the Statistical Package for the Social Sciences, SPSS Version 7.0 for Windows on Microsoft Windows 95 and NT (SPSS Inc., 1995). As statistical analysis progressed, some of the data were transformed and new variables created from the data file. Where the data were not normally distributed, recoding and transformation of the data were undertaken to make the best approximation to normality.

Statistical methods included: descriptive statistics; means and standard deviations; cross tabulations; graphs; t-tests; factor analysis with varimax rotation; Pearson correlations; analysis of variance; and multiple linear regression. Two-tailed tests of significance were used throughout.
CHAPTER FIVE

BASELINE RESULTS

General Comment

Over the three year study period 168 referrals were received specifically for the Family Health Counselling Service’s Sexual Abuse Programme. The age limit and gender requirements restricted participation in the study for some clients. For example, three referrals to the programme were for children and five were for men. Furthermore, during the first year of the study the entry age was 18-50 years. This meant that four women aged 16 and 17 years who had been referred for sexual abuse counselling were unable to be included in the study. However, following approval from the local ethics committee in 1994, and providing there had been a twelve months abuse-free period, the bottom age limit was dropped to include 16 and 17 year olds in the study.

Unfortunately, following assessment some of the women were not invited to participate in the study. The main reason for this was that some clinicians forgot to invite the women to participate following the initial assessment or, as happened in the Rangiora base for the first year, the clinician failed to tell the women presenting there about the study.

While the main route for entry to the study was through the FHC Service’s Sexual Abuse Programme, some women, referred for other reasons to the service, were identified at assessment with problems related to CSA. In such cases, if the women were referred for sexual abuse counselling, then they were also invited to participate in the study.
The Sample

The final sample consisted of the 100 women aged between 16 and 50 years with histories of CSA who met the inclusion criteria and accepted the invitation to participate in the research. The overall ethnic distribution was: 88 percent Pakeha; 11 percent Maori and one percent Pacific Island. Just over a third attended four or more years of secondary school (mean=3.5 years). Of the eight who received tertiary education, six attended university.

Over half (63%) of the women were responsible for child care and six percent were caring for parents in the home. Table 5 shows 52 percent of the women were either married or in a relationship.

**Table 5**

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NZ Maori</td>
</tr>
<tr>
<td>In a relationship</td>
<td>2</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Separated</td>
<td>5</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td>Remarried</td>
<td>2</td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

As can be seen in Table 6, half the women received a benefit or a training allowance, a small number were self-employed and the rest had either their own or their partner’s income. Where income was derived from more than one source the main source of income was recorded.
Table 6

Derivation of income for total sample

<table>
<thead>
<tr>
<th>Income</th>
<th>Number of times reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self employed</td>
<td>2</td>
</tr>
<tr>
<td>Benefit or a training allowance</td>
<td>50</td>
</tr>
<tr>
<td>Own or partner’s income</td>
<td>48</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 7 shows that 38 percent of the referrals to the programme were self referrals and 30 percent were referred by a general practitioner, with a further 28 percent being referred by mental health services or another health professional.

Table 7

Referral sources for sexual abuse counselling

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Number of times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>38</td>
</tr>
<tr>
<td>Family/friend</td>
<td>2</td>
</tr>
<tr>
<td>Mental health service</td>
<td>13</td>
</tr>
<tr>
<td>Other health profession</td>
<td>15</td>
</tr>
<tr>
<td>General practitioner</td>
<td>30</td>
</tr>
<tr>
<td>Legal system</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

While 31 percent of the women stated CSA was the sole reason for seeking counselling now, 69 percent gave further additional reasons as well as CSA. These reasons are shown in Table 8. The number exceeds 69 percent because some women reported more than one reason.

Table 8
Additional reasons given for seeking counselling now (N=100)

<table>
<thead>
<tr>
<th>Reason</th>
<th>% Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse</td>
<td>1</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>3</td>
</tr>
<tr>
<td>Depression</td>
<td>19</td>
</tr>
<tr>
<td>PTSD symptoms</td>
<td>6</td>
</tr>
<tr>
<td>Anxiety</td>
<td>7</td>
</tr>
<tr>
<td>Relationship problems with family</td>
<td>4</td>
</tr>
<tr>
<td>Relationship problems with partner</td>
<td>24</td>
</tr>
<tr>
<td>Child behaviour/parenting problems</td>
<td>8</td>
</tr>
<tr>
<td>Unresolved grief</td>
<td>6</td>
</tr>
</tbody>
</table>

Nature and Extent of CSA

The sexually abusive activities reported included: exposing sex organs, touching, wanting or attempting sexual intercourse, actual sexual intercourse, rape, inappropriate viewing of sexual activity, invasion of sexual privacy, or other unwanted sexual activity. Data collection and analysis for sexual abuse incidents that occurred before 16 years of age and for sexual abuse experienced after 16 years were treated separately.

For analysis of sexual abuse before 16 years of age, responses to questions about whether rape or sexual intercourse had occurred were collapsed into one category and called “sexual intercourse”.

Table 9 shows many of the women experienced a range of abusive incidents involving both non-genital and genital contact, and thus the number of times of abuse exceeds one hundred. As shown in the table, the incidence of attempted intercourse was 55 percent while 58 percent reported CSA involving actual sexual intercourse.

Table 9
Frequency and type of sexual abuse experienced before 16 years of age (N=100)

<table>
<thead>
<tr>
<th>sexual activity</th>
<th>1-3 times</th>
<th>Multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure of ‘sex parts’</td>
<td>14</td>
<td>42</td>
</tr>
<tr>
<td>Someone wanting sex with you</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Sexual touching</td>
<td>19</td>
<td>62</td>
</tr>
<tr>
<td>Attempting intercourse</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>22</td>
<td>36</td>
</tr>
<tr>
<td>Inappropriate viewing of sexual activity</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Invasion of sexual privacy</td>
<td>7</td>
<td>39</td>
</tr>
<tr>
<td>Other unwanted sexual activities</td>
<td>7</td>
<td>17</td>
</tr>
</tbody>
</table>

When looking at who the perpetrators were, 98 percent of the women reported abuse by a male. Of the two percent of CSA by women abusers, one woman reported being abused by her mother and another by an aunt. For purposes of analysis the perpetrators were assigned to the following categories: extra-familial, relatives, siblings, step or foster father, natural father, husband/partner and stranger.

Natural fathers accounted for 18 percent of the CSA, stepfathers and foster fathers 11 percent; thus overall, 29 percent of the women were abused by their fathers or father figures. Abuse by a male sibling accounted for another 20 percent. Other relatives, such as uncles, cousins, brothers-in-law, were responsible for 27 percent. Overall 76 percent of the women reported CSA involving intra-familial perpetrators.

Of the 56 percent extra-familial abuse reported, the main perpetrators included family friends 26 percent, own friends and boyfriends six percent, neighbours 10 percent, and 14 percent by sundry others including an employer and a teacher. A further 16 percent reported stranger abuse.
Some women reported both extra and intra-familial abuse, and thus overall the number of perpetrators exceeds one hundred. Using the above categories, Table 10 depicts the relationship between the perpetrator and the child for CSA before 16 years of age.

**Table 10**

**Relationship between the perpetrator and the child for CSA before 16 years of age (N=100)**

<table>
<thead>
<tr>
<th>Perpetrator Type</th>
<th>Number of women reporting each type of perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra-familial known perpetrator</td>
<td>56</td>
</tr>
<tr>
<td>Relatives as perpetrator</td>
<td>27</td>
</tr>
<tr>
<td>Male sibling as perpetrator</td>
<td>20</td>
</tr>
<tr>
<td>Stranger as perpetrator</td>
<td>16</td>
</tr>
<tr>
<td>Step/foster father as perpetrator</td>
<td>11</td>
</tr>
<tr>
<td>Father as perpetrator</td>
<td>18</td>
</tr>
</tbody>
</table>

As shown in Table 11, in this sample the majority of the CSA first occurred before the women were 10 years of age. Furthermore, of the 58 who reported CSA by sexual intercourse, 28 reported the first instance occurred between 0 and 9 years, 11 between 10 and 12 years and 19 between 13 and 15 years.

**Table 11**

**The number of women who first reported each type of sexual abuse experience by age of first occurrence (N=100)**

<table>
<thead>
<tr>
<th>Type of Sexual Experience</th>
<th>0-9 Years</th>
<th>10-12 Years</th>
<th>13-15 Years</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure</td>
<td>29</td>
<td>14</td>
<td>5</td>
<td>48</td>
</tr>
<tr>
<td>Threatened intercourse</td>
<td>33</td>
<td>10</td>
<td>8</td>
<td>51</td>
</tr>
<tr>
<td>Touching</td>
<td>53</td>
<td>19</td>
<td>8</td>
<td>80</td>
</tr>
<tr>
<td>Intercourse</td>
<td>28</td>
<td>11</td>
<td>19</td>
<td>58</td>
</tr>
<tr>
<td>Other unwanted activity</td>
<td>15</td>
<td>5</td>
<td>3</td>
<td>23</td>
</tr>
</tbody>
</table>
Other Abuse and Neglect

The women were asked questions in regard to further sexual abuse as an adult and other childhood experiences of trauma or abuse. This included asking some questions about their relationship with their parents and the quality of the relationship between their parents.

Adult sexual abuse

Forty-one women reported adult sexual abuse (ASA) as well as CSA. Given that rape involves sexual intercourse, for purposes of analysis, the ASA responses to questions where rape or non-consensual sexual intercourse had occurred were collapsed into one category and called “rape”. The main activities involved for ASA are shown in the table below. As some of the women reported more than one experience of ASA the number of incidences recorded exceeds 41. As can be seen the majority of the abuse involved rape multiple times.

<table>
<thead>
<tr>
<th>Activity</th>
<th>1-3 times</th>
<th>Multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure of ‘sex parts’ &gt;16 yrs</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Someone wanting sex with you &gt;16 yrs</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Sexual touching &gt;16 years</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Attempting intercourse &gt;16 years</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Rape &gt;16 yrs</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Inappropriate viewing of sexual activity &gt;16 yrs</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Invasion of sexual privacy &gt;16 yrs</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Other unwanted sexual activities &gt;16 yrs</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

The relationship of the women to the perpetrator was recorded for all episodes of abuse and is shown in Table 13. As can be seen, the majority of the abusers were known to the women. In total 32 percent of the abusive episodes involved intra-familial perpetrators.
When the same perpetrator categories as noted for CSA were used, it was found 17 percent of the abusers were fathers, or father figures, and five percent were male siblings, with a further 10 percent being another relative. The 53 percent extra-familial category of abusers included employers, teachers, mother’s partners, family friends and boyfriends. Husbands or partners accounted for another 22 percent. Only 17 percent of the women reported stranger abuse. Again the number exceeds 100 as some women were abused by more than one perpetrator.

Table 13

<table>
<thead>
<tr>
<th>Relationship between the perpetrator and the women for sexual abuse after 16 years of age (N=41)</th>
<th>Number of women reporting each type of perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra-familial perpetrators</td>
<td>22</td>
</tr>
<tr>
<td>Relatives as perpetrator</td>
<td>4</td>
</tr>
<tr>
<td>Male sibling as perpetrator</td>
<td>2</td>
</tr>
<tr>
<td>Step/foster father as perpetrator</td>
<td>4</td>
</tr>
<tr>
<td>Father as perpetrator</td>
<td>3</td>
</tr>
<tr>
<td>Husband/partner as perpetrator</td>
<td>9</td>
</tr>
<tr>
<td>Stranger as perpetrator &gt;16 years</td>
<td>7</td>
</tr>
</tbody>
</table>

Other childhood experiences of trauma or abuse

Question 6 asked about traumatic events before the age of 16 years. Eleven women reported having witnessed or having been a victim of a disaster, accident or war, which may have affected their ability to live their lives as before the traumatic event had occurred.

Question 7 asked about childhood experiences other than sexual abuse. Sixty-nine reported emotional or psychological abuse and two reported other abuse. Fifty-two women reported feeling threatened with abuse, 22 were beaten so badly they required medical attention and five reported being physically abused.
Being beaten and physically abused were listed separately, as some of the women did not consider they had been beaten so badly they had to see a doctor but reported physical abuse in the “other abuse” category. Thus, responses that indicated physical abuse had occurred were recoded into a different category and named “physical abuse.” Other abuse relates to verbal abuse and to being left alone as a child.

**Quality of parental relationships**

Relationships with and between parents in respondents’ childhood were determined by asking three questions constructed for this study relating to how their parents got on together, and how the respondents, when between the ages of 0 and 15 years got on with each of their parents. Scores range from 1 to 4. A score of one would indicate a good relationship and a score of four would indicate a poor relationship. The numbers do not add up to 100 in every category due to missing parents. Table 14 shows the quality of the relationships with, and between, the women and their parents.

**Table 14**

Percentage ratings of relationships with and between parents before 16 years of age (N=100)

<table>
<thead>
<tr>
<th>Relationships with Parents</th>
<th>1 Very Good</th>
<th>2 Good</th>
<th>3 Okay</th>
<th>4 Poor</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>With mother 0-9 yrs</td>
<td>27</td>
<td>14</td>
<td>32</td>
<td>22</td>
<td>2.5</td>
<td>1.14</td>
</tr>
<tr>
<td>With mother 10-12 yrs</td>
<td>16</td>
<td>14</td>
<td>35</td>
<td>31</td>
<td>2.9</td>
<td>1.05</td>
</tr>
<tr>
<td>With mother 13-15 yrs</td>
<td>11</td>
<td>30</td>
<td>47</td>
<td>1</td>
<td>3.2</td>
<td>0.96</td>
</tr>
<tr>
<td>With father 0-9 yrs</td>
<td>22</td>
<td>12</td>
<td>31</td>
<td>23</td>
<td>2.6</td>
<td>1.13</td>
</tr>
<tr>
<td>With father 10-12 yrs</td>
<td>18</td>
<td>8</td>
<td>34</td>
<td>29</td>
<td>2.8</td>
<td>1.10</td>
</tr>
<tr>
<td>With father 13-15 yrs</td>
<td>11</td>
<td>6</td>
<td>30</td>
<td>37</td>
<td>3.1</td>
<td>1.02</td>
</tr>
<tr>
<td>Relationship with parents (averaged)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.9</td>
<td>1.02</td>
</tr>
<tr>
<td>Relationships between parents</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>1.14</td>
</tr>
<tr>
<td>Parental relationship-child aged 0-9 yrs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.7</td>
<td>1.11</td>
</tr>
<tr>
<td>Parental relationship-child aged 10-12 yrs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.00</td>
<td>2.9</td>
</tr>
<tr>
<td>Parental relationship-child aged 13-15 yrs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.9</td>
<td>1.00</td>
</tr>
</tbody>
</table>

3.0
Mental Health History

At assessment the women were specifically asked if they had ever been treated for psychiatric problems. The women were also asked questions relating to specific childhood disorders.

Previous psychiatric treatment

Twenty-four percent of the women in the sample reported having received previous psychiatric treatment, with the majority giving depression as the main reason for doing so. For this referral, 21 of these 24 women had been referred for treatment for depression.

The women were also asked whether they had ever attempted suicide. Ten of the women reported having done so, and three had been referred to the Family Health Counselling programme following the attempt, thus leading to entry to the study. Further examination of the data revealed five of these 10 women had reported receiving previous psychiatric treatment and having made suicide attempts in the six months preceding entry to the study.

Of the women with no previous treatment history, five percent had attempted suicide in the six months prior to entering the study, whereas of those with previous treatment 50 percent had made a suicide attempt. As expected, when these two variables were cross-tabulated a significant relationship was found ($\chi^2 = 4.12$, df=1, $p<0.05$). This suggests that the women who had received previous psychiatric treatment were more likely to attempt suicide.
**Conduct Disorder**

The DSM-IV, the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) describes the essential feature of conduct disorder as a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviours fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals (criteria A1-A7); nonaggressive conduct that causes property loss or damage (criteria A8-A9); deceitfulness or theft (criteria A10-A12); and serious violations of rules (criteria A13-A15). Three behaviours are needed for a diagnosis of conduct disorder over the same 12 month period.

The two sub-types of conduct disorder are childhood and adolescent with the main difference being the age of onset. The DSM-IV (1994) defines childhood-onset as the onset of at least one criterion characteristic before the age of 10 years. Adolescent-onset is defined by the absence of any criteria characteristic prior to 10 years.

For many individuals conduct disorder remits by adulthood. However, earlier onset of conduct disorder predicts a worse prognosis and an increased risk in adult life for a personality disorder. The DSM-IV (1994) groups the personality disorders into three clusters based on descriptive similarities. Cluster B includes the antisocial, borderline, histrionic and narcissistic personality Disorders. Conduct disorder is a precursor to antisocial personality disorder.

Gender differences are also found in specific types of conduct problems. Generally, females display nonaggressive behaviours such as lying, truancy, running away, substance abuse, and prostitution. Males, on the other hand, are more likely be aggressive and frequently exhibit fighting, stealing and vandalism. The prevalence of conduct disorder varies widely depending on the nature of the population sampled and methods of ascertainment. For females under the age of 18 years the rates range from two to nine percent (DSM-IV, 1994).
Physical or child sexual abuse are included in the DSM-IV (1994) as predisposing factors for conduct disorder. However, the DSM-IV also notes that runaway episodes occurring as a direct consequence of physical or sexual abuse do not typically qualify as a symptom of conduct disorder.

Table 15 shows a frequency distribution of responses to questions about specific behaviours before the age of 15 years. As shown in the table, even if criterion questions related to staying out at night, running away and truanting from school are excluded from the analysis, a substantial number of the women would still meet the criteria (three or more symptoms) for Conduct Disorder. For example, it is unusual to find such a high number of women reporting conduct causing, or threatening, physical harm to other people or animals, starting fist fights, using weapons when fighting, or mugging or robbing someone.

<table>
<thead>
<tr>
<th>Question</th>
<th>% Positive Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you ever skip school?</td>
<td>58</td>
</tr>
<tr>
<td>Did you ever run away from home and stay out overnight?</td>
<td>42</td>
</tr>
<tr>
<td>Did you start fist fights?</td>
<td>32</td>
</tr>
<tr>
<td>Did you ever use a weapon in a fight?</td>
<td>10</td>
</tr>
<tr>
<td>Did you ever force someone to have sex with you?</td>
<td>3</td>
</tr>
<tr>
<td>Did you ever hurt an animal on purpose?</td>
<td>11</td>
</tr>
<tr>
<td>Did you ever hurt another person on purpose (other than in a fight?)</td>
<td>23</td>
</tr>
<tr>
<td>Did you deliberately damage things that were not yours?</td>
<td>21</td>
</tr>
<tr>
<td>Did you set fires?</td>
<td>7</td>
</tr>
<tr>
<td>Did you lie a lot?</td>
<td>36</td>
</tr>
<tr>
<td>Did you steal things?</td>
<td>49</td>
</tr>
<tr>
<td>Did you ever rob or mug someone?</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 16 shows the proportions reporting the number of symptoms for conduct disorder. Employing a criterion level of three or more criterion for probable “caseness,” 52 percent of the total sample were identified as “probable cases”.

<table>
<thead>
<tr>
<th>Number with</th>
<th>Frequency of reporting</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 criteria</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>1 criterion</td>
<td>22</td>
<td>35</td>
</tr>
<tr>
<td>2 criteria</td>
<td>13</td>
<td>48</td>
</tr>
<tr>
<td>3 criteria</td>
<td>16</td>
<td>65</td>
</tr>
<tr>
<td>4 criteria</td>
<td>10</td>
<td>75</td>
</tr>
<tr>
<td>5 criteria</td>
<td>8</td>
<td>83</td>
</tr>
<tr>
<td>6 criteria</td>
<td>9</td>
<td>92</td>
</tr>
<tr>
<td>7 criteria</td>
<td>2</td>
<td>94</td>
</tr>
<tr>
<td>8 criteria</td>
<td>4</td>
<td>98</td>
</tr>
<tr>
<td>9 criteria</td>
<td>2</td>
<td>100</td>
</tr>
</tbody>
</table>

**Eating disorders**

Eating disorders are characterised by severe disturbance in eating behaviour. The two specific diagnoses are anorexia nervosa and bulimia nervosa. The requirements for a diagnosis of anorexia nervosa as defined in the DSM-IV (1994) are: refusal to maintain a minimally normal body weight for age and height (e.g., weight loss leading to maintenance of body weight is less than 85 percent of that expected, or failure to make expected weight gain during a period of growth); intense fear of gaining weight or becoming fat, even though underweight;
disturbance in the way that body weight, size or shape is experienced; and denial of the seriousness of current body weight; and amenorrhea in females.

There are two specific types of anorexia nervosa. One is the restricting type where weight loss is achieved by rigidly restricting food intake, and the second is where strict attempts to limit intake are punctuated by episodes of binge eating followed by purging through self induced vomiting, and the use of laxatives and diuretics.

According to the DSM-IV (1994), the essential features of bulimia nervosa are recurrent episodes of binge eating at least twice a week during a three-month period; feeling a lack of control over eating behaviour during these binges; self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain; and persistent concern with body weight and shape. Again, there are two types. One is the purging type where the individual engages in self-induced vomiting or the misuse of laxatives, diuretics or enemas during the current episode. The second is the non-purging type where the person has used inappropriate compensatory behaviours such as fasting or excessive exercise, but does not regularly engage in self-induced vomiting or the misuse of laxatives, diuretics or enemas during the current episode.

Disturbances in eating behaviours were assessed by responses to questions relevant to the diagnosis of anorexia nervosa and bulimia nervosa according to the criteria in the DSM-IV (1994). Ninety-nine of the women completed or partially completed this section. The responses to the criterion related questions are shown in Table 17. As can be seen many of the women responded yes to several of the questions.

**Table 17**

<table>
<thead>
<tr>
<th></th>
<th>Number reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoccupation with weight</td>
<td>73</td>
</tr>
<tr>
<td>Fear of becoming fat</td>
<td>62</td>
</tr>
</tbody>
</table>
It is generally accepted that a body mass index (BMI) score over 20 is desirable in a healthy female. The women were asked to record their lowest ever body weight, with corresponding height and age. As some of the women were reluctant to answer questions in respect to their eating behaviour, lowest ever BMI scores could only be calculated 37 of the women. These scores ranged from 14 to 25 (mean score=18.9). Thus, 65 percent of the 37 women had, at some stage of their life, had a BMI score of less than 20, with 30 percent having had a BMI score of less than 18.

At assessment the women were also asked to record their current age, body weight, and height. Current BMI scores were able to be determined for 36 of the women. These scores ranged from 18-36 (mean score=24.7). Of the 36 women, only five percent had a BMI score of less than 20. Thus, although some of the women may have previously had symptoms of eating disturbance at the time of the study this had changed, and the majority had BMI scores at or above the desirable level.

In this study then, probable cases of anorexia and bulimia nervosa were determined by the number of positive responses to the DSM-IV (1994) criterion-related questions for eating disorders.

**Current Symptomatology and Social Functioning**

After completing general FHC service intake procedures for assessment current symptomatology and social functioning was further assessed using a series of self-report questionnaires.
Post-traumatic stress disorder and dissociation

One of the long-term effects associated with child sexual abuse is post-traumatic stress disorder (PTSD). However, there is a disagreement about how often PTSD symptoms are actually found among survivors of CSA. Some authors contend that symptoms of PTSD are nearly universal in adult survivors of CSA (Lindberg and Distad, 1985; Goodwin, 1990; Herman, 1992). Others, such as (McLeer et al., 1988; Resnick et al., 1993), conclude that only a minority of survivors of CSA exhibit PTSD symptoms.

As described in the DSM-IV (1994), the essential features of PTSD are that the person must have experienced an event outside the range of normal human experience and have had symptoms lasting for longer than one month in each of the following categories: intrusive re-experiencing of the trauma; persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness; and persistent autonomic signs of anxiety.

In this study the presence of symptoms of post-traumatic stress disorder and dissociation was assessed using a slightly altered version of a screening device developed by Coons et al., (1990). The instrument was basically a symptom checklist containing questions about the frequency of different experiences of amnesia, depersonalisation and derealisation, along with some specific questions about symptoms which follow the pattern of a post-traumatic stress reaction.

The questionnaire was modified for this study to ascertain the number of times the women had experienced any of the symptoms over the past month. Respondents were asked to indicate how often over the past month they had experienced 45 symptoms. Each question was scored: never=0; rarely=1; sometimes=2; often=3; lots of times=4. The instrument has criterion-related validity. That is, the items on the questionnaire can be compared with established criteria as described in the DSM-IV (1994).
A maximum score of 180 on the PTSD questionnaire can be obtained by summing an individual’s item scores. In this study the individual PTSD scores ranged from 11 to 152 with a mean score of 86 (sd=29). This suggests that many women had frequently been displaying these symptoms for the past month. Two of the questionnaires were excluded from the total sample as the participants had missed several questions.

**Psychiatric symptomatology**

Psychiatric symptomatology was assessed by use of the SCL-90 (Hopkins Symptom Check List, Derogatis, 1983). A sub-scale score on the SCL-90 was achieved by summing all the sub-scale scores and dividing them by the number of items. Thus scores can range from 0 to 4.

In this study the SCL-90 mean sub-scale scores ranged between 1.5 and 2.0. A mean total score for the sample was obtained by summing the mean scores for each sub-scale. The SCL-90 mean total score was 14.1 (sd=6.3) which is considerable higher than that found in the Peveler and Fairburn (1990) study.

While there have been no specific studies of the SCL-90 with sexual abuse survivors, in terms of severity of psychopathology the women are comparable to scores for psychiatric populations (Derogatis et al., 1976; Friedman et al., 1995). Table 18 shows the nine SCL-90 sub-scale scores at initial interview and the mean total score for the sample.

<table>
<thead>
<tr>
<th>Sub-scale</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger/hostility</td>
<td>1.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Anxiety score</td>
<td>1.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Depression</td>
<td>2.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>1.7</td>
<td>0.9</td>
</tr>
<tr>
<td>Paranoid ideation</td>
<td>1.7</td>
<td>0.9</td>
</tr>
</tbody>
</table>
Social functioning

Overall social functioning was assessed by use of the SAS self-report questionnaire developed by Weissman and Bothwell (1976). The efficacy of the SAS for clinical study and research is enhanced by the availability of substantial normative data for both clinical and non-clinical populations (Weissman and Bothwell, 1976).

The most consistent findings across studies applying the SAS to survivors of sexual abuse appear to be impaired leisure functioning and relationships with extended family (Amick and Kilpatrick, 1988). While the SAS is widely used with a variety of populations, its demonstrable use with survivors of sexual abuse is still being further defined.

As noted in the methodology chapter, in answering each question the respondents select a point along a 5-point continuum with the highest scores reflecting greatest impairment. The sub-scale scores for behavioural performance, feelings and satisfaction, interpersonal friction and arguments, and interpersonal behaviours and skills for the women in this study are shown in Table 19. As not all the sections contained in the questionnaire apply to everyone, the overall scores have been calculated on the basis of the questions answered.

As shown in the table the total mean score for the study was 2.51 (sd= 0.44). Of note, in terms of severity of impaired social functioning, the mean scores of the women in this study are higher than the mean scores of women with a major depressive disorder interviewed as part of a community epidemiology study (Oakley-Brown, 1993).
Table 19
Social functioning measured by the SAS at baseline in a sample of sexually abused women (N=100)

<table>
<thead>
<tr>
<th>SAS sub-scales</th>
<th>Mean Scores</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance</td>
<td>2.71</td>
<td>0.60</td>
</tr>
<tr>
<td>Feelings &amp; satisfaction</td>
<td>2.47</td>
<td>0.61</td>
</tr>
<tr>
<td>Friction</td>
<td>1.75</td>
<td>0.52</td>
</tr>
<tr>
<td>Interpersonal behaviour</td>
<td>2.85</td>
<td>0.55</td>
</tr>
<tr>
<td><strong>Total Mean Score</strong></td>
<td><strong>2.51</strong></td>
<td><strong>0.43</strong></td>
</tr>
</tbody>
</table>

*Alcohol use*

The 10-item AUDIT (Barbor *et al.*, 1989) was used to gain information about alcohol use over the past twelve months (the AUDIT is a screening instrument only and should not be used as a diagnostic tool). The highest possible score for all ten items is 41. Generally, high scores for the first three items, in the absence of elevated scores on the remaining items, indicate hazardous alcohol use. Elevated scores on items from 4-6 imply the presence or emergence of alcohol dependence. High scores on the remaining four items suggest harmful alcohol use.

A score of 0 to 7 indicates no problem, while a score of eight and over indicates hazardous alcohol use. One woman in the study did not answer this section at all. An analysis of the data revealed that at baseline 31 percent of the subjects scored eight or more on AUDIT which indicates hazardous or harmful alcohol consumption. The total number of women with scores of 8 or more is shown in Figure 1.
Figure 1
Distribution of AUDIT total scores at baseline among a sample of sexually abused women; a score more than seven qualifies as a probable positive case (N=99)

![Histogram showing distribution of AUDIT scores]

<table>
<thead>
<tr>
<th>AUDIT Score</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>18</td>
</tr>
<tr>
<td>8-14</td>
<td>12</td>
</tr>
<tr>
<td>15-21</td>
<td>6</td>
</tr>
<tr>
<td>22-28</td>
<td>1</td>
</tr>
</tbody>
</table>

Std. Dev = 6.10  
Mean = 5.9  
N = 99

Analysis of Symptomatology

A reliability scale analysis showed good internal consistency between all the items contained in the PTSD questionnaire (coefficient Alpha = 0.94). Given this high item correlation, the data was entered into a factor analysis to see if the total score could be used for an analysis of the data.
**PTSD and dissociation-factor analysis**

A principal components extraction method with a varimax rotation was used to explore this possibility. As shown in Figure 2 an examination of the factor analysis showed one large factor (eigenvalue=12) and three other factors with eigenvalues over two. Thus, the most parsimonious solution was the retention of these four factors with item loadings of >0.5. These identified factors appeared to be similar to the diagnostic clusters of symptoms described in the DSM-IV (1994) for PTSD.

**Figure 2**

Factor Scree Plot

```
14
12
10
8
6
4
2
0
```

Further examination of the items in the four factors suggested the following names: affective state, intrusive thoughts, dissociative symptoms, and memory. As the PTSD score was derived from summing all the items in the four factors, or a score from counting all the questions in the PTSD questionnaire correlated >0.94, the PTSD total score will be used for further analyses.
Table 20
FACTOR ANALYSIS (N=98)
PC extracted 4 factors. VARIMAX rotation 1 for extraction 1 in analysis.
1- Kaiser Normalisation. VARIMAX converged in 20 iterations. Rotated Factor Matrix

<table>
<thead>
<tr>
<th>Questions (Loadings =&gt;.5)</th>
<th>Factor 1 Affective</th>
<th>Factor 2 Intrusive</th>
<th>Factor 3 Dissociative</th>
<th>Factor 4 Memory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often it seems as if I am in a dream or fog</td>
<td>0.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I experience sudden and unexpected mood changes</td>
<td>0.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have feelings of detachment</td>
<td>0.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I am split into different parts</td>
<td>0.59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have unexplained irritability or outbursts of anger</td>
<td>0.58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel outside my body watching myself do things</td>
<td>0.52</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes I feel controlled by some force</td>
<td>0.51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have the uncanny ability to predict the future</td>
<td>0.51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often feel as if I want to run away or escape</td>
<td>0.51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have blank spells</td>
<td>0.51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I try to avoid thoughts or feelings that remind me of the abuse</td>
<td>0.73</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certain events remind me of abuse or trauma</td>
<td>0.73</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I avoid activities that remind me of abuse or trauma</td>
<td>0.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have flashbacks of previous abuse or trauma</td>
<td>0.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have unwanted intrusive thoughts about abuse or trauma</td>
<td>0.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I try to forget or ignore abuse or trauma</td>
<td>0.58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have bad dreams or nightmares about abuse or trauma</td>
<td>0.57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My memory for some things is better than for most people</td>
<td>0.54</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am always on guard or fearful harm will occur</td>
<td>0.52</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I find things I do not remember purchasing</td>
<td>0.79</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have found drawings which I do not remember doing</td>
<td>0.74</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I cannot recall doing or saying things others tell me about me</td>
<td>0.68</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People call me by unfamiliar names</td>
<td>0.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have been told I do things I do not remember</td>
<td>0.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes I find myself in strange places away from where I live or work</td>
<td>0.56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I cannot remember events in school or childhood</td>
<td>0.70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am unable to talk about traumatic events</td>
<td></td>
<td></td>
<td></td>
<td>0.56</td>
</tr>
<tr>
<td>I have trouble with memory even when I am not taking alcohol or drugs</td>
<td></td>
<td></td>
<td></td>
<td>0.56</td>
</tr>
<tr>
<td>I have decreased concentration</td>
<td></td>
<td></td>
<td></td>
<td>0.54</td>
</tr>
<tr>
<td><strong>Total Mean Score</strong></td>
<td><strong>86 (s=29)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>11-152</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Correlations Between Measures

In this section Pearson correlations were used to assess the relationships between PTSD, SCL-90, SAS and AUDIT total score. As both PTSD and SCL-90 are concerned with psychopathology, the relationship between these two measures was examined first. The results are shown in Table 21. As expected, the PTSD total score and the SCL-90 sub-scales were found to be significantly correlated at the p<0.01 level.

Table 21
Pearson correlations between SCL-90 sub-scales and PTSD total score at baseline (N=98)

<table>
<thead>
<tr>
<th>SCL-90 sub-scales</th>
<th>PTSD total score at baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatisation</td>
<td>0.62</td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>0.74</td>
</tr>
<tr>
<td>Interpersonal score</td>
<td>0.45</td>
</tr>
<tr>
<td>Depression score</td>
<td>0.67</td>
</tr>
<tr>
<td>Anxiety score</td>
<td>0.68</td>
</tr>
<tr>
<td>Anger/hostility</td>
<td>0.56</td>
</tr>
<tr>
<td>Phobic</td>
<td>0.54</td>
</tr>
<tr>
<td>Paranoid ideation</td>
<td>0.56</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>0.59</td>
</tr>
</tbody>
</table>

All correlations are significant at the 0.01 level (2-tailed)

As shown in Table 22, significant correlations were also found between the PTSD derived factors, SCL-90 and SAS total scores at the p<0.01 level. As the factors were derived from the PTSD total score, this result was also expected.
Table 22
Pearson correlations between SCL-90, SAS total scores and PTSD derived factors (N=98)

<table>
<thead>
<tr>
<th></th>
<th>Factor 1 Affective State</th>
<th>Factor 2 Intrusive Thoughts</th>
<th>Factor 3 Dissociative symptoms</th>
<th>Factor 4 Memory</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCL-90 total score at baseline</td>
<td>0.66</td>
<td>0.49</td>
<td>0.57</td>
<td>0.45</td>
</tr>
<tr>
<td>SAS total score at baseline</td>
<td>0.49</td>
<td>0.42</td>
<td>0.41</td>
<td>0.34</td>
</tr>
</tbody>
</table>

All correlations are significant at the 0.01 level (2-tailed).

Pearson correlations were then used to explore associations between PTSD, SCL-90, SAS total scores and the AUDIT total score. As shown in the following table, although the PTSD, SCL-90 and SAS total scores remain positively correlated (p<0.01), the associations with AUDIT are not statistically significant.

Table 23
Pearson correlation matrix of PTSD, SCL-90, SAS, and AUDIT total scores at baseline (N=98)

<table>
<thead>
<tr>
<th></th>
<th>AUDIT total score</th>
<th>SAS total score</th>
<th>SCL-90 total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAS total score</td>
<td>0.09</td>
<td>0.61**</td>
<td></td>
</tr>
<tr>
<td>SCL-90 total score</td>
<td>0.12</td>
<td>0.56**</td>
<td>0.74**</td>
</tr>
<tr>
<td>PTSD total score</td>
<td>0.12</td>
<td>0.56**</td>
<td>0.74**</td>
</tr>
</tbody>
</table>

**correlations are significant at the 0.01 level (2-tailed)

As shown in the above tables, scores on the PTSD, SCL-90 and SAS are all positively correlated with each other. Therefore, it would be expected that if a woman’s scores are high on one measure she is likely to score highly on all these three measures. Given this degree of correlation between the measures, the total PTSD, SCL-90 and SAS total scores were used for the remaining data analysis.
Relationships of antecedent factors to symptomatology in this clinical sample

In order to determine any associations between CSA and later mental health problems, antecedent factors that may impact on overall symptomatology need to be taken into account. In this study possible associations between factors such as other childhood experiences, including probable case for conduct disorder, eating disorder, all sexual abuse experiences and overall symptomatology were examined. Pearson correlations allowed for an estimation of the independent impact any of these factors may have had on overall symptomatology. The results are presented in Table 24.

It appears that in this clinical sample the variables identified as being most significantly associated with overall symptomatology, particularly with the PTSD total score, are: probable case of conduct disorder; being threatened with abuse other than sexual; invasion of sexual privacy; and attempted or actual sexual intercourse as a child. Although slightly less significant, being beaten as a child and exposure of sexual parts also emerged as two factors that may contribute to overall symptomatology. The high degree of correlation between probable case of conduct disorder and PTSD total score was unexpected and is further analysed later.

Thus, it seems, that when the full range of CSA and ASA experiences reported in this study are considered, other factors, such as relationship with and between parents, physical abuse, psychological abuse, victim or witness to a disaster, accident or war, were non-significant. This could have occurred because there is no effect or because not enough people had experienced that variable. Of interest to this study is that the strongest correlations were with the PTSD total score.
In summary, given the high degree of correlation \((p<0.01)\) between general psychopathology, as measured by the SCL-90, SAS and PTSD questionnaires, the PTSD total score will be mostly used to further investigate associations between CSA and symptomatology. The next section addresses this issue.
Associations between CSA and Symptomatology

As with most studies of CSA this research included all instances of contact and non-contact sexually abusive experiences. Table 24 highlighted the high correlation between the PTSD total score and attempted or actual sexual intercourse. Thus, in order to ascertain if some CSA experiences are more likely to impact on the degree of symptomatology, sexual intercourse was used as the main variable for differentiating between the CSA experiences reported and the impact on the PTSD score.

*CSA experiences and PTSD symptomatology*

Table 25 compares the mean PTSD scores of the women reporting CSA that had not involved sexual intercourse with those that had 1-3 or multiple experiences of CSA involving sexual intercourse. As shown, if CSA by sexual intercourse occurred multiple times then there is a high likelihood that the PTSD score will be correspondingly higher. This result is notable, as it indicates that it is the actual occurrence of CSA involving intercourse that has the most impact on PTSD symptomatology. Moreover, it is clear that if the CSA involved multiple experiences of sexual intercourse (i.e, more than 1-3 times) then the impact on PTSD symptomatology will be correspondingly higher.

<table>
<thead>
<tr>
<th>Number of times CSA involved sexual intercourse</th>
<th>N</th>
<th>PTSD total score</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>41</td>
<td>75</td>
<td>26</td>
</tr>
<tr>
<td>1-3 times</td>
<td>21</td>
<td>93</td>
<td>24</td>
</tr>
<tr>
<td>Multiple times</td>
<td>36</td>
<td>102</td>
<td>27</td>
</tr>
</tbody>
</table>
Table 24 showed which variables significantly correlated with symptoms of PTSD and overall symptomatology in this study. As shown in Table 25 the number of experiences of CSA involving sexual intercourse had a further impact on PTSD symptomatology. However, throughout the literature the independent effect of CSA on PTSD symptomatology has remained suggestive rather than conclusive. The argument seems to be centred around the role of other relevant variables, known for their traumatic effects, such as family disruption, poor parental relationships, physical abuse, emotional abuse and adult trauma. A multiple regression analysis was employed in an attempt to further identify which variables were unique predictors of PTSD in this study.

Predictors of PTSD Symptomatology-Multiple Regression Analysis

Regardless of whether the “enter, forward or stepwise” method was used, the $R^2$ remained much the same. Therefore, for this regression analysis, a stepwise method was used. Every variable that had a significant association with the PTSD total score was entered into the regression model. Of these variables, CSA by sexual intercourse was the most significant ($p<0.001$) in predicting PTSD. The variable “threatened with abuse” was retained in the regression model but it was less significant ($p<0.01$) and contributed very little independent information overall. The other variables failed to reach significance for inclusion in the model.

Thus, as can be seen in Table 26, of the observed variability in PTSD total score, 18 percent is explained by the independent variable CSA by sexual intercourse. The variable threatened with abuse accounted for a further six percent of the variance. Combined, these variables account for 24 percent of the observed variability in PTSD total score.
Table 26

Stepwise multiple regression analysis of variables found to predict PTSD in a sample of sexually abused women (N=98) a, b

\[ R=0.49, R^2=0.24, \text{Adjusted } R^2=0.22 \]

<table>
<thead>
<tr>
<th>Variables</th>
<th>Unstandardized Coefficients</th>
<th>Std. Error</th>
<th>t</th>
<th>p</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA by sexual intercourse</td>
<td>11.65</td>
<td>3.03</td>
<td>3.85</td>
<td>&lt;0.001</td>
<td>0.36</td>
</tr>
<tr>
<td>Threatened with abuse</td>
<td>7.53</td>
<td>2.79</td>
<td>2.70</td>
<td>&lt;0.01</td>
<td>0.25</td>
</tr>
</tbody>
</table>

a. Dependent variable: PTSD total score at baseline
c. Independent variables: (Constant), CSA by Sexual Intercourse

As shown, a stepwise multiple regression analysis was employed to test the strength of an association between a history of CSA and symptoms of PTSD. The results showed that if CSA by sexual intercourse was involved then other variables become non-significant in predicting PTSD. Therefore, in this study the variable CSA involving sexual intercourse has emerged as the key variable in predicting PTSD symptomatology.

Chapter Two discussed the literature examining the relationship between abuse-specific variables and later mental health problems. Certain aspects appear to especially affect the degree of trauma likely to be sustained following experiences of CSA. As shown above, such aspects include the involvement of penetration or sexual intercourse in the abuse experience. Other aspects include abuse-specific variables such as the age of onset of the CSA and the relationship of the perpetrator to the child. The relationship between these abuse-specific variables and the impact on the PTSD score are examined next.

Post-traumatic effects and age of onset of CSA

Table 27 shows the age when sexual intercourse was first reported to have happened for the women in this study, the number of times they were abused and the mean PTSD score for each age group.
As can be seen, the majority were abused by intercourse before the age of nine years. Indeed, the mean PTSD score for the women reporting CSA involving sexual intercourse in this age group is higher than those abused after nine years of age. Of note is the decrease in the PTSD mean score between 10 and 12 years of age and the slight increase again in the 13 to 15 years age group.

However, in a one-way ANOVA no significant main effect was found between the variables age of onset of CSA by sexual intercourse and the PTSD score (F=1.41, df=2, p=0.25).

<table>
<thead>
<tr>
<th>Table 27</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comparison between age of first occurrence of CSA by sexual intercourse and mean PTSD Score at baseline (N=57)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Range</th>
<th>PTSD total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st instance of reported sexual intercourse</td>
<td>Mean</td>
</tr>
<tr>
<td>0-9 yrs</td>
<td>103</td>
</tr>
<tr>
<td>10-12 yrs</td>
<td>88</td>
</tr>
<tr>
<td>13-15 yrs</td>
<td>94</td>
</tr>
</tbody>
</table>

**Post-traumatic effects and duration of CSA**

A re-coding of the data relating to the number of age categories in which the CSA involving sexual intercourse occurred was undertaken to allow for an assessment of duration effects. This re-code involved creating three new age groups, 0-9 years, 10-12 years and 13-15 years. Group 1 refers to CSA occurring in any one of the three age groups. Group 2, refers to CSA occurring across two age groups, that is between 0-12 years of age. Group 3 includes 13 women for whom CSA started between 0-9 years of age and continued across all ages groups. The score for the one woman where the CSA occurred in two non-consecutive age groups is included in Group 3.
Tables 28 shows a comparison of the mean PTSD total scores for these groups. As illustrated below, generally the longer the duration of the CSA the higher the PTSD score is likely to be. For example, the mean PTSD score for Group 3 is considerably higher than the mean PTSD score for Group 1. Thus, it appears that the duration of the abuse may impact on the PTSD total score. However, the way the data were collected makes it difficult to determine the effects between onset of abuse and the duration of the abuse on the mean PTSD scores.

**Table 28**

**Comparison of 1st instance and duration of sexual intercourse with mean PTSD Score at baseline (N=57)**

<table>
<thead>
<tr>
<th>Duration of sexual intercourse through age groups</th>
<th>N</th>
<th>Mean PTSD total score</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>35</td>
<td>96</td>
<td>23</td>
</tr>
<tr>
<td>Group 2</td>
<td>8</td>
<td>89</td>
<td>25</td>
</tr>
<tr>
<td>Group 3</td>
<td>14</td>
<td>104</td>
<td>32</td>
</tr>
</tbody>
</table>

* 1 woman had CSA by intercourse between 0-9 yrs & 13-15 yrs but not at 10-12 yrs

**Post-traumatic effects and the relationship of the perpetrator to the child**

The family dynamics surrounding CSA potentially affect the degree of post-traumatic effects experienced by an abused child. The trauma can result from the meaning of the abusive act as much as the physical danger. Moreover, it may be less of an “event” than a “relationship” or a “situation” that goes on for a long period and may change in meaning over time. Thus, the trauma may well come more from betrayal in the relationship and from being trapped in a situation, rather than resulting from an overwhelming event.

Of the women reporting CSA involving sexual intercourse, 22 were abused by an intra-familial perpetrator, 27 by an extra-familial perpetrator and nine reported being abused by both intra and extra-familial perpetrators. As shown in Table 29 the women in this study
with the highest mean PTSD score were those who had experienced both intra and extra-
familial abuse.

Table 29

Comparison of the relationship between the perpetrator and the child for CSA before 16 years of age and the mean PTSD score at baseline (n=58)

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>Number reporting</th>
<th>Mean PTSD score</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra-familial</td>
<td>27</td>
<td>92</td>
<td>29</td>
</tr>
<tr>
<td>Intra-familial</td>
<td>22</td>
<td>96</td>
<td>21</td>
</tr>
<tr>
<td>Both</td>
<td>9</td>
<td>109</td>
<td>24</td>
</tr>
</tbody>
</table>

Initially, in a one-way ANOVA the kind of perpetrator did have a significant effect on
the mean PTSD score (F=6.66, df=3,94, p<0.01). However, in a two way ANOVA
comparing the impact of both the type of perpetrator and CSA by intercourse on the PTSD
score, no significant effect was found (F=1.39, df=1,92, p=0.24).

Post-traumatic effects of CSA and ASA

Research suggests that individuals sexually abused as children have an elevated risk of
being sexually abused as adults. This raises the question as to how much of the post-
traumatic effects of sexual abuse are explained by CSA and how much are from ASA.

To explore possible differences between post-traumatic effects of CSA and ASA the
mean PTSD baseline scores for both types of abuse were compared and are presented in Table
30. As can be seen, the women who were not abused by intercourse, either as children or as
adults, had the lowest PTSD scores overall. Of interest is that those abused by CSA involving
sexual intercourse, but not ASA involving sexual intercourse, had the highest PTSD score
overall. Even those women who were abused by intercourse both as children and as adults had
a lower score than those with CSA by intercourse alone.
A two-way ANOVA compared CSA by sexual intercourse and ASA by sexual intercourse with the PTSD total score. Although a significant main effect was found with CSA by intercourse (F=3.49, df=2, p<0.05), no significant main effect was found between ASA involving sexual intercourse and PTSD total score (F=.49, df=2, p=0.99), nor were there any interactive effects (F=1.06, df=4, p=0.38).

Table 30

Comparison of mean baseline PTSD total scores by whether or not sexual intercourse was involved in the CSA and/or ASA experience (n=100)

<table>
<thead>
<tr>
<th>CSA by sexual intercourse</th>
<th>ASA by sexual intercourse</th>
<th>N</th>
<th>Mean PTSD score</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>30</td>
<td>69</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>11</td>
<td>80</td>
<td>34</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>35</td>
<td>100</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>22</td>
<td>93</td>
<td>27</td>
</tr>
</tbody>
</table>

Association of Conduct and Eating Disorders with PTSD

A high correlation was found between having a probable case of conduct disorder and the PTSD total score (see Table 24). Furthermore, of the 28 women who reported features of anorexia or bulimia nervosa, 57 percent had been abused by sexual intercourse as a child. Thus, the association between conduct and eating disorders and the PTSD score required further investigation.

Conduct disorder

A comparison of the mean PTSD scores of the women who met criteria for classification as probable cases of conduct disorder and who were abused by intercourse is presented in Table 31. As shown the women with the highest PTSD score were those with symptoms of conduct disorder and who had been abused by sexual intercourse. Furthermore, a chi square
test showed that the women who had conduct disorder were more likely to have been abused by sexual intercourse ($\chi^2=8.08$, df=2, $p<0.05$).

<table>
<thead>
<tr>
<th>Table 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean PTSD score at baseline by conduct disorder and CSA by sexual intercourse (N=98)</td>
</tr>
</tbody>
</table>

| Conduct disorder | CSA by Sexual Intercourse | Total sample mean |
| --- | --- | --- | --- |
|  | None | 1-3 times | Multiple times | PTSD Score | Std. Deviation | PTSD Score | Std. Deviation | PTSD Score | Std. Deviation |
| No (49) | 67 | 26 | 91 | 30 | 92 | 25 | 78 | 29 |
| Yes (49) | 82 | 29 | 95 | 20 | 103 | 28 | 95 | 28 |

As it had already been shown that CSA by intercourse contributed to PTSD symptomatology, it was important to see whether conduct disorder made a further independent or interactive effect on the extent of PTSD symptoms. In a two-way ANOVA conduct disorder just failed to show an independent main effect on PTSD total score (F=3.00, df=1, $p=0.08$), and there was no evidence for an interactive effect (F=0.21, df=2, $p=0.81$).

However, the underlying strength of this association was shown when CSA by sexual intercourse was just coded as a yes or no response rather than the usual, none, 1-3 times or multiple times. When that ANOVA was calculated, conduct disorder did show a significant main effect (F=4.16, df=1, $p<0.05$).

**Eating disorder**

A comparison of the mean PTSD scores of the women who met criteria for classification as probable cases of eating disorder and who were also abused by intercourse. is presented in
Table 32  As can be seen, those women who met criteria as probable cases of eating disorder and were also abused by sexual intercourse had the highest PTSD scores. This was particularly so for those abused multiple times. However, a chi square test showed the relationship between these two variables ($\chi^2= 0.12$, df=1, $p=0.91$) was not statistically significant. Furthermore, when a two-way ANOVA compared the effect of both CSA by sexual intercourse and probable case of eating disorder on the PTSD score no main effect was found ($F=0.74$, df=1, $p=0.39$).

Table 32  
Mean PTSD Score at baseline by eating disorder and CSA by sexual intercourse  
(N=98)

<table>
<thead>
<tr>
<th>Eating Disorder</th>
<th>None</th>
<th>1-3 times</th>
<th>Multiple times</th>
<th>Total sample mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Score</td>
<td>Std. Deviation</td>
<td>PTSD Score</td>
<td>Std. Deviation</td>
<td>PTSD Score</td>
</tr>
<tr>
<td>No (70)</td>
<td>68</td>
<td>30</td>
<td>93</td>
<td>28</td>
</tr>
<tr>
<td>Yes (28)</td>
<td>82</td>
<td>19</td>
<td>93</td>
<td>19</td>
</tr>
</tbody>
</table>

Thus, although at first significant associations were found between PTSD total scores and some specific variables, such as the relationship of the perpetrator to the child, ASA, and conduct disorder, when compared with CSA involving sexual intercourse the contributions of these variables to the PTSD total score became non-significant.

Effects of General Psychopathology and CSA Experience on PTSD Score

Finally, as general symptoms (SCL-90) and PTSD symptoms are correlated, it was important to see whether the effects of CSA by intercourse and being threatened with abuse exerted independent main effects on PTSD symptoms when the level of general symptoms were allowed for.
A stepwise method was used for this multiple regression. While CSA by intercourse and general symptoms (SCL-90) both exerted an independent main effect on PTSD symptoms, in this analysis the independent effect of threatened with abuse was no longer significant. The results are shown in Table 33.

Table 33

The effect of SCL-90 and being threatened with abuse on PTSD symptomatology (N=98) a, b

<table>
<thead>
<tr>
<th>Variables</th>
<th>Unstandardized Coefficients</th>
<th>Std. Error</th>
<th>t</th>
<th>p</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCL-90 total score at baseline c</td>
<td>3.15</td>
<td>0.30</td>
<td>10.57</td>
<td>&lt;0.001</td>
<td>0.68</td>
</tr>
<tr>
<td>CSA by sexual intercourse</td>
<td>8.70</td>
<td>2.11</td>
<td>4.11</td>
<td>&lt;0.001</td>
<td>0.27</td>
</tr>
</tbody>
</table>

R=0.79, R²=0.62, Adjusted R²=0.61

a Dependent variable: PTSD total score at baseline
c Independent variables: (Constant), SCL-90 total score at baseline

Most of the effects of “being threatened with abuse” reflect an increase across a broad range of symptoms, but CSA by intercourse still has additional specific effects on PTSD symptomatology.

Summary

One of the aims of this study was to determine on assessment of clients for intake into a Family Health Counselling Service's Sexual Abuse Programme, the number of women in the study who had current symptoms of PTSD, dissociation, anxiety and depression. In addition baseline symptom scores of conduct and eating disorders were also obtained, as was information in regard to current alcohol use, early relationships with parents and between parents, and current social functioning.
An analysis of the baseline data has revealed several very important findings. The first is that many of the women were exhibiting symptoms of PTSD at the time of entry to the study. The degree of PTSD symptomatology among the sample was determined by the use of a questionnaire designed specifically to detect such symptoms. The responses to the questionnaire were then run through a factor analysis which revealed four main factors that closely relate to the criteria outlined in the DSM-IV (1994) for PTSD.

The second is that the overall psychopathology of the women in this study, as measured by the SCL-90 and SAS total scores, was also considerable and is comparable to psychiatric outpatients. These results are consistent with the findings found in the studies discussed in Chapter Two containing both clinical and non-clinical samples.

The third important finding is that in this clinical sample the results of the study do not support the notion that there may be a link between the type of CSA experienced and alcohol consumption. That is, although an analysis of responses to the AUDIT questionnaire revealed 31 percent of the women in the study were reporting hazardous or harmful alcohol consumption, no significant associations between alcohol consumption, the CSA experienced and the psychopathology of the women were detected.

The fourth, and perhaps the most important finding overall, is that the severity of PTSD symptomatology was specifically associated with multiple episodes of CSA which involved actual sexual intercourse. This finding was consistent throughout data analysis regardless of the age the CSA began, the relationship of the perpetrator to the child, later ASA involving sexual intercourse, current alcohol use and other antecedent factors such as symptoms of conduct disorder and relationships with and between parents.

Finally, using a multiple regression analysis, it was found that though the variable “threatened with abuse” added very little independent variance to PTSD symptomatology overall, it was retained in the model. Thus, it needs to be noted that abuse, broader than CSA,
played a role in determining what predicted the PTSD total scores for the women in this study.

However, when the effects of general symptomatology (SCL-90) were allowed for, the variable “threatened with abuse was excluded from the model”. This suggests CSA by intercourse has additional specific effects on PTSD symptomatology.

A hypothesis explored in these analyses was that, in a clinical sample, the women with the worst CSA histories will be more symptomatic and socially impaired at assessment. Given the above findings, this hypothesis is confirmed.
CHAPTER SIX

OUTCOMES AFTER COUNSELLING

The second hypothesis postulated in this study was that the women who had attended counselling regularly, and who did not have a history of sexual abuse as an adult, would have made the most improvement in their overall symptomatology and social functioning. The aim of this chapter is to evaluate the psychological and social functioning of the women before and after sexual abuse counselling.

Following assessment at the FHC Service, counselling was recommended for all the women. Three women declined any further therapeutic intervention but chose to stay in the study and participate in the follow-up interviews. Two-thirds of the sample were eligible for ACC funded counselling with a counsellor in the private sector. The remaining one-third were offered counselling with a FHC counsellor.

The women were followed up at three and six months after assessment at the FHC Service. However, the six months time frame was considered to be more useful for exploring the overall outcome of counselling than the shorter period.

Referrals to Counselling

Initially 67 women were referred to a private counsellor and 30 remained in the FHC Service. At the three months follow-up it was found that this situation had changed considerably. Figure 3 shows that, of the 67 women referred for counselling in the private sector, 16 never made it to their first counselling session (one had died in a car accident prior to attending counselling) and nine had either voluntarily returned to FHC or been referred back there by the private practitioner. The reasons for returning to FHC related either to a change
in the women’s mental health status or because they were unable to engage with the counsellor they were seeing. Thus, at the three months follow-up, 42 women had attended counselling with a private counsellor and 39 with an FHC counsellor. At six months 36 women had received counselling with a private counsellor and 38 had attended FHC. In total 23 of the initial participants dropped out, and 74 completed the study.

**Figure 3**

*Flow diagram of referrals for counselling*

100 women Assessed  
(98 Completed all Questionnaires)

97 Referred for Counselling  
(3 declined counselling)

67 Private Counsellor  
30 FHC Counsellor

1 died before attending counselling  
15 never attended counselling

3 months Private Counsellor = 42  
3 months FHC Counsellor = 39

6 months Private Counsellor = 36  
6 months FHC Counsellor = 38

74 Women completed counselling & 6 months follow-up

**Characteristics of Study Dropouts**

A comparison of the characteristics of the study participants revealed very few differences between the 23 women who dropped out of the study and the 74 study completers. No differences were detected in terms of number of years at secondary school
Adult relationships were also similar. Twenty-six percent of the dropouts were separated or divorced; 48 percent were either married or in a relationship and had dependent children. In comparison with this, 30 percent of the completers were separated or divorced; 54 percent were either married or in a relationship and 70 percent had dependent children. Two-thirds of the dropouts received a benefit compared with half of the completers. The only variable which differed significantly (p<0.05) between the two groups was age (study dropouts, mean=27 years; sd=6 and study completers, mean=32 years; sd=8).

The abuse histories of the two groups provided some useful insights. While both groups reported similar levels of CSA by sexual intercourse (dropouts 65 percent and completers 54 percent), the dropout group had greater levels of revictimisation (dropouts 52 percent and completers 37 percent). While the differences were not statistically significant, those that had been most abused tended not to stay in counselling.

As Table 34 shows, no significant differences were found between the two groups in terms of ethnicity, the reporting of previous psychiatric problems, any suicide attempts in the six months prior to participating in the study, or probable case of conduct or eating disorder.

**Table 34**

A comparison of characteristics between study dropouts (n=23) and study completers (n=74)

<table>
<thead>
<tr>
<th></th>
<th>Dropped out</th>
<th>Completed</th>
<th>χ²  (df)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pakeha</td>
<td>21</td>
<td>68</td>
<td>0.41 (2)</td>
<td>0.81</td>
</tr>
<tr>
<td>- Maori</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric history</td>
<td>6</td>
<td>18</td>
<td>0.03 (1)</td>
<td>0.86</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>3</td>
<td>7</td>
<td>0.24 (1)</td>
<td>0.62</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>8</td>
<td>41</td>
<td>2.98 (1)</td>
<td>0.08</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>6</td>
<td>22</td>
<td>0.11 (1)</td>
<td>0.74</td>
</tr>
</tbody>
</table>
Likewise, as shown in Table 35, no significant differences were found in the mean baseline PTSD, SCL-90 and SAS total scores between the two groups.

### Table 35

A comparison of mean (± Std.Dev.) PTSD, SCL-90, and SAS total baseline scores between study dropouts (n=23) and study completers (n=74)

<table>
<thead>
<tr>
<th></th>
<th>Dropped out</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD total score</td>
<td>87 (32)</td>
<td>86 (29)</td>
</tr>
<tr>
<td>SCL-90 total score</td>
<td>14.5 (6.6)</td>
<td>14.1 (6.1)</td>
</tr>
<tr>
<td>SAS total score</td>
<td>2.53 (0.48)</td>
<td>2.50 (0.41)</td>
</tr>
</tbody>
</table>

Changes in Symptomatology

Before examining the actual results it is helpful to review the context within which the data were obtained. The PTSD, SCL-90, SAS and AUDIT questionnaires were completed by clients after the initial assessment, and again at three and six months. These measurement points were chosen as meaningful in terms of the therapeutic process. Table 36 compares the PTSD, SCL-90 and SAS total scores at baseline, at three months and at six months. It can be seen that the mean scores on all three measures decreased over the duration of the study.

### Table 36

Comparisons between baseline, three and six months mean (± Std. Dev.) PTSD, SCL-90 and SAS total scores among a sample of sexually abused women (N=74)

<table>
<thead>
<tr>
<th></th>
<th>Baseline (Std. Dev.)</th>
<th>3 months (Std.Dev.)</th>
<th>6 months (Std.Dev.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD total score</td>
<td>86</td>
<td>29</td>
<td>74</td>
</tr>
<tr>
<td>SCL-90 total score</td>
<td>14.1</td>
<td>6.3</td>
<td>11.8</td>
</tr>
<tr>
<td>SAS total score</td>
<td>2.50</td>
<td>0.42</td>
<td>2.37</td>
</tr>
</tbody>
</table>
Paired sample t-tests showed statistically significant changes had occurred between the baseline and the three months PTSD total score (p<0.01), the three months and the six months PTSD total score (p<0.01), and between the baseline and the six months PTSD total scores (p<0.01). Statistically significant changes were also found between the baseline and the three months SCL-90 total scores (p<0.01), the three months and the six months SCL-90 total scores (p<0.05) and between the baseline and the six months SCL-90 total scores (p<0.01).

Slightly less significant changes were found between the baseline and the three months SAS total scores (p<0.05) and the three and the six months SAS total scores (p<0.05). Changes between the baseline and the six months SAS total scores were significant (p<0.01).

As expected, most of the change occurred within the first three months of counselling. Given that one of the aims of this study is about outcome following counselling, it is important to bear this finding in mind when evaluating changes in symptomatology after counselling.

However, changes over time in one group tell very little about the efficacy of therapy. For example, community surveys consistently show that when standardised measures of mental health are repeated, the repeat scores reflect, on average, better mental health. Such studies are conducted on persons who have not usually sought professional help (Henderson and Jorm, 1990:721). Thus, while the findings in Table 36 are statistically significant, two further questions need to be addressed with regard to clinically significant change. One is whether the degree of improvement over the six months is clinically significant; the second is whether the change is due to therapeutic intervention.

**Defining Outcome At Six Months**

This study has already established that PTSD, SCL-90 and SAS scores are all positively correlated with each other at baseline (see Table 23) and, as shown in Table 36, that changes in symptomatology had occurred over the six months duration of the study. However, the
definition of significant change following therapeutic intervention is problematic. Two options were considered for defining change.

Option one was to use the actual six months PTSD total. This option raised the question as to whether the baseline PTSD total score correlated with PTSD total score at six months. In order to address this question a multiple regression analysis and scatter plot was used to determine whether the baseline PTSD score may predict the PTSD score at six months.

The scatter plot score presented in Figure 4 shows the linearity between the baseline and the six months PTSD score. As can be seen, although some scores fall on either side of the regression line the six months PTSD score can be predicted by the baseline PTSD score.

**Figure 4**

*Scatterplot of Baseline and Six Months PTSD Total Scores*

PTSD Total Score at Baseline
The result of the multiple regression analysis is shown Table 37. As shown, 40 percent of the observed variability in the six months PTSD score is accounted for by the baseline PTSD score. Thus the relationship between the two scores is highly significant.

Table 37

Multiple regression analysis of predictability of six months PTSD score by baseline PTSD score (N=74) a,b

R=0.64, R²=0.40, Adjusted R²=0.39

<table>
<thead>
<tr>
<th>Variables</th>
<th>Unstandardized Coefficients</th>
<th>Std. Error</th>
<th>t</th>
<th>p</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Total Score at baseline c,d</td>
<td>0.69</td>
<td>0.99</td>
<td>6.97</td>
<td>&lt;0.001</td>
<td>0.63</td>
</tr>
</tbody>
</table>

a  Dependent variable: PTSD total score at 6 months
b  Method: Enter (Criterion: Probability-of-F-to-enter <= .050)
c  Independent variables; (Constant), PTSD total score at baseline
d  Probability-of-F-to-remove >=.050 limits reached.

The dilemma of using option one is that the women who were least disturbed at the baseline appeared to be doing the best, even though they may not have improved very much over the duration of the study. This dilemma is highlighted by examining CSA by involving sexual intercourse and the mean PTSD total scores.

As already shown, the severity of PTSD symptomatology is specifically associated with multiple episodes of CSA involving sexual intercourse. A comparison of the mean baseline and six months PTSD scores showing whether the CSA involved no sexual intercourse, one to three times or multiple times is presented in Table 38.

As expected, the PTSD scores for those abused multiple times were higher than the others at baseline, and at the six months follow-up these women were still more symptomatic than those who had been abused less often. Of importance here is that while the PTSD scores of the women abused by CSA involving sexual intercourse were higher at both baseline and six
months, the differences achieved by each group in the percentage change in PTSD score is not as great.
Table 38
Comparison of mean (± St. Dev.) baseline and six months PTSD score by whether CSA experience involved sexual intercourse or not (74)

<table>
<thead>
<tr>
<th></th>
<th>Baseline (Std. Dev.)</th>
<th>6 months (Std. Dev.)</th>
<th>% Change (Std. Dev.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>73 (27)</td>
<td>54 (27)</td>
<td>25 (32)</td>
</tr>
<tr>
<td>1-3 times</td>
<td>95 (20)</td>
<td>74 (30)</td>
<td>20 (28)</td>
</tr>
<tr>
<td>Multiple</td>
<td>100 (27)</td>
<td>81 (30)</td>
<td>17 (29)</td>
</tr>
</tbody>
</table>

Thus, the second option considered was the use of the percentage change in PTSD total score over the six months. This option would adjust for severity at baseline. Before doing so how the percentage change in PTSD total score related to percentage change in the SCL-90 and SAS total scores was examined. As can be seen in Table 39 the percentage change in each measure between baseline and six months was positively correlated.

Table 39
Pearson correlations of percentage change in PTSD, SCL-90 and SAS total scores between baseline and six months (N=74)

<table>
<thead>
<tr>
<th></th>
<th>% Change in PTSD score at six months</th>
<th>% Change in SCL-90 score at six months</th>
<th>% Change in SAS score at six months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage change in SCL-90 Score</td>
<td>0.68**</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Percentage change in SAS Score</td>
<td>0.47**</td>
<td>0.55**</td>
<td>-</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed)

After considering both options it was decided that the key outcome measure for this study was the percentage change achieved in the PTSD total score over the duration of the study. This means that “improvement” is defined by the percentage change achieved by the six months follow-up. Thus, regardless of the PTSD total score at baseline and at the six
months follow-up, a percentage improvement in PTSD score can be determined for each woman.

**Therapeutic Intervention**

Questions regarding the efficacy of therapeutic intervention usually refer to the benefits derived from it, its potency, its impact on clients, or its ability to make a difference in people’s lives (Jacobson and Truax, 1991). In order to address the above questions, various aspects of the treatment received needed to be considered, such as how many sessions the women had attended, their level of satisfaction with the counselling they received, the method of termination and whether the counselling contribute to positive life changes. Other factors such as who the women saw for counselling, whether they were still attending, how satisfied the counsellors were with the client’s progress and how termination of counselling occurred have also been taken into account. The results of these investigations are shown in Table 40 and Table 41 below.

**Client Self Report**

A comparison of the mean number of sessions attended showed very little difference in recall by both the counsellors (mean=12, sd=10) and the clients (clients mean=13, sd=9). Pearson correlations showed a significant positive relationship between these two variables (p<0.001).

**Number of sessions attended**

As Table 40 shows, despite the expectation that increased time in counselling would relate to greater improvement, a one-way ANOVA revealed no relationship between the number of sessions attended and the overall percentage change in PTSD total score.
As can be seen the women who attended fewer sessions had achieved more change between their baseline and six months follow-up PTSD scores and had made greater percentage improvement overall than the women who had attended more sessions.

**Women’s satisfaction with counselling**

The efforts of others working in this field to define and measure client satisfaction have varied widely in method and systematic knowledge. Recent findings have correlated levels of patients’ satisfaction to the nature of the intervention and the quality of some skills used by practitioners (Ruggeri, 1994: 213). In this study “satisfaction” is inferred from an increase in general happiness, more positive feelings, and the making of positive life changes.

At the six months follow-up the women were asked to rate their responses to some general questions about how happy they were with their progress in counselling. As might be expected, the women who were happy or very happy with their progress made greater improvement in their mean PTSD scores over the six months than those who were unhappy with their counselling.

As can be seen in Table 40, a one-way ANOVA revealed significant main effect differences between client happiness with counselling and the women’s overall percentage change in PTSD score. Tukey post hoc pairwise comparisons indicated these differences between unhappy and happy with progress in counselling were significant at the p<0.01 level. That is, the more satisfied the women were with their progress, the more percentage change they had achieved in their PTSD score.

At the six month follow-up the women were also asked how they felt now. Their responses to this question were then compared with their mean baseline, six months PTSD scores and overall percentage improvement in PTSD score at six months. Table 40 shows that the women who reported feeling a little better, better, or much better, made greater improvement in their PTSD score than those who felt worse following counselling.
A one-way ANOVA revealed a significant main effect between how the client felt now and the overall percentage change in PTSD score. A Tukey post hoc test indicated a significant interactive effect between feeling the same and much better at six months and between feeling worse and much better with the overall percentage improvement in the PTSD total score (p<0.05).

**The contribution of counselling to positive life changes**

The women were asked whether they attributed the life changes they had made to counselling, other circumstances, or a combination of both. As shown in Table 40, the 21 women who attributed the changes to both counselling and other circumstances made the most change in their overall percentage improvement in PTSD score. However, this was closely followed by the 43 women who attributed the changes made to counselling alone. Conversely, the 10 women who attributed all the changes to circumstances other than counselling made the least percentage change in their PTSD score overall.

A one-way ANOVA followed by a Tukey post hoc test compared the overall percentage change in PTSD score with the variable attribution of change. As can be seen in Table 40, a significant main effect was found between attribution of change and the overall percentage change in PTSD score. The post hoc test indicated a significant difference (p<0.05) between the attribution of positive change to both counselling and other circumstances, in contrast to just other circumstances alone.

**How termination occurred**

Completion of therapy and the way in which termination occurs is an important dimension in the therapeutic process. The differing ways in which termination of counselling occurred in this study, and mean changes in the PTSD score at baseline and six months, are presented in Table 40. Due to the low numbers, the “counsellor terminated” and “referred out” categories were combined. The “referred out” related to two women who were referred
from FHC to the Anxiety Disorders Unit because that was considered to be a more appropriate treatment option for each of them at this stage. One counsellor terminated therapy with a client because she did not believe the client was ready to engage in sexual abuse counselling at that particular stage of her life. As failure to keep appointments effectively meant that the client had ended the counselling sessions, the “client terminated” and “client failed to arrive (FTA)” categories were also combined.

As can be seen, changes in the PTSD score between baseline and six months indicate that the women who had completed counselling had the lowest mean PTSD scores overall. As Table 40 clearly shows, the women still in counselling had made the least percentage change in their overall PTSD scores. However, an examination of all the scores indicates that the rest of the women achieved a similar percentage improvement in their PTSD scores regardless of how termination occurred in each case.

A one-way ANOVA followed by a Tukey post hoc test compared how termination occurred and the percentage change in PTSD scores. Table 40 shows, significant main effects were found between the method of termination and the overall percentage change in PTSD score. The post hoc test indicated a significant difference between the variables “still in counselling” and “finished counselling” in the overall percentage change in PTSD score at the p<0.001 level.

Counsellor Report at Six Months

At the six months follow-up the counsellors completed a questionnaire containing some general questions about their intervention. They were asked about their satisfaction with the client’s progress in counselling, the degree of their satisfaction with the termination process, and the main model of intervention.
Satisfaction with client progress and outcome of counselling

On a scale of one to seven points, 85 percent of the counsellors responded that they were satisfied (mean=5) with the client’s progress in counselling. Given that high degree of counsellor satisfaction, it was expected that there would be a significant association between the variables “counsellor satisfaction” with client’s progress in counselling and “client happiness with progress in counselling,” and the overall percentage change in the PTSD scores.

As Table 40 shows, this was not the case. The overall percentage change achieved in PTSD score was similar, regardless of whether the counsellor was satisfied with the client’s progress in counselling or not. While a one-way ANOVA found a significant main effect between client happiness with progress and counsellor satisfaction with client progress in counselling (F=4.50, df=2,71 p<0.05), as Table 40 shows counsellor satisfaction with client progress was unrelated to the percentage change in PTSD score.

Satisfaction with termination of counselling

The majority of the counsellors indicated they were satisfied with the way in which termination had occurred. As already noted, the women who were still in counselling at the six months follow-up had higher PTSD scores, and had made less overall percentage change in their scores, than those who were not. This may of course reflect the tendency for more distressed clients to require greater amounts of time in treatment.

A one-way ANOVA and Tukey post hoc test compared counsellor satisfaction with termination of counselling and change in PTSD scores. As Table 40 shows, though a significant main effect was found between counsellor satisfaction with termination of counselling and the overall percentage change in PTSD score, the post hoc test indicated the relationship between the two variables was a negative one (p<0.05).
Main intervention strategy reported

Intervention strategies for counselling sexual abuse survivors range from long-term psychotherapy to shorter-term interpersonal and cognitive behavioural therapies. In this study 32 counsellors reported using cognitive behavioural therapy as the main strategy for intervention and 21 reported using supportive counselling. The other 21 reported using a range of therapies including: solution focused; systematic; psychodynamic; narrative; and a trauma model. The way in which the data were collected precludes any further analysis of how any specific intervention strategies may relate to outcome.
Table 40

Summary of factors effecting baseline six months and percentage change in PTSD scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Level (n)</th>
<th>PTSD Means</th>
<th></th>
<th>F**</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Baseline</td>
<td>6 Months</td>
<td>% Change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sessions attended</td>
<td>1-4 (10)</td>
<td>102 (29)</td>
<td>66 (31)</td>
<td>28 (42)</td>
<td>0.93</td>
<td>3.70</td>
</tr>
<tr>
<td></td>
<td>5-10 (33)</td>
<td>80 (24)</td>
<td>60 (30)</td>
<td>25 (30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11-20 (22)</td>
<td>88 (29)</td>
<td>72 (30)</td>
<td>18 (26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; 20 (9)</td>
<td>89 (38)</td>
<td>82 (37)</td>
<td>9 (23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Happiness with counselling</td>
<td>Unhappy (8)</td>
<td>62 (17)</td>
<td>65 (26)</td>
<td>-6 (40)</td>
<td>7.07</td>
<td>2.71</td>
</tr>
<tr>
<td></td>
<td>Happy (45)</td>
<td>92 (28)</td>
<td>74 (32)</td>
<td>20 (27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very happy (21)</td>
<td>84 (29)</td>
<td>54 (28)</td>
<td>36 (24)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How clients felt</td>
<td>Worse (5)</td>
<td>86 (32)</td>
<td>83 (29)</td>
<td>-5 (34)</td>
<td>4.81</td>
<td>3.70</td>
</tr>
<tr>
<td></td>
<td>Same/ a little better (22)</td>
<td>95 (27)</td>
<td>84 (32)</td>
<td>11 (30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Better (18)</td>
<td>84 (31)</td>
<td>66 (28)</td>
<td>20 (26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Much better (29)</td>
<td>81 (28)</td>
<td>52 (25)</td>
<td>35 (27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client attribution of change</td>
<td>Counselling (43)</td>
<td>91 (28)</td>
<td>70 (31)</td>
<td>23 (27)</td>
<td>3.23</td>
<td>2.71</td>
</tr>
<tr>
<td></td>
<td>Other circumstances (10)</td>
<td>88 (33)</td>
<td>80 (30)</td>
<td>0 (38)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Both (21)</td>
<td>76 (26)</td>
<td>55 (31)</td>
<td>28 (29)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How termination occurred</td>
<td>Completed (28)</td>
<td>76 (27)</td>
<td>49 (23)</td>
<td>31 (34)</td>
<td>2.87</td>
<td>3.70</td>
</tr>
<tr>
<td></td>
<td>Client terminated/ FTA (10)</td>
<td>102 (22)</td>
<td>73 (31)</td>
<td>29 (25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Still in counselling (33)</td>
<td>90 (30)</td>
<td>81 (31)</td>
<td>11 (25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counsellor terminated / Referred out (3)</td>
<td>93 (19)</td>
<td>64 (28)</td>
<td>30 (29)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsellor Report</td>
<td>Dissatisfied (11)</td>
<td>107 (19)</td>
<td>81 (25)</td>
<td>23 (23)</td>
<td>0.02</td>
<td>1.72</td>
</tr>
<tr>
<td></td>
<td>Satisfied (63)</td>
<td>83 (29)</td>
<td>65 (32)</td>
<td>21 (31)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with client termination</td>
<td>Yes (31)</td>
<td>77 (26)</td>
<td>53 (24)</td>
<td>28 (32)</td>
<td>4.76</td>
<td>2.71</td>
</tr>
<tr>
<td></td>
<td>No (10)</td>
<td>103 (23)</td>
<td>67 (35)</td>
<td>37 (29)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Still attending (33)</td>
<td>90 (30)</td>
<td>81 (31)</td>
<td>11 (25)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Percentage change was quoted for each individual, therefore, the mean percentage change does not necessarily equal the difference in the mean between baseline and six months PTSD score

** The F quoted is for the main effect for the variable of interest
Other Factors Affecting Symptom Change

It is important in comparative efficacy studies that the issue of therapist effects and the statistical implications for the analysis of therapeutic outcomes be given due consideration. In this study the FHC Service clinicians were selected, trained and supervised in treatment modalities thought suitable for working with adult survivors of CSA. Referrals to the private sector were made to selected therapists likely to be similar in skill and competence level to those in the FHC Service. Thus, as much as possible, the study was designed to minimise the effects of individual therapists on outcome.

*Therapist effects and changes in PTSD scores*

Table 41 shows that while the women seen by a Family Health counsellor had made a slightly higher percentage improvement in their PTSD score than those seen by a private counsellor, there was very little difference overall. A one-way ANOVA compared the PTSD scores and found who the client saw did not affect the percentage change in PTSD score.

*Still attending counselling at six months*

The results to date have shown there was a tendency for those women who were still in counselling at the six months follow-up to have higher PTSD scores than those who were not. Though it would be expected that those who were less symptomatic were more likely to complete counselling sooner, this was an interesting finding; thus this variable was further investigated. As shown in Table 41, a one-way ANOVA revealed a significant main effect between still being in counselling and the overall percentage change achieved in the PTSD score.
Suicidal ideation

Counselling provides an opportunity to confront issues related to the abuse. As Briere (1992:61) reports, for some clients the ultimate strategy for avoiding overwhelming painful memories may be suicide. In this study the counsellors reported 30 percent of the women had exhibited suicidal ideation during the time they were engaged in counselling. However, in this study, as Table 41 shows in a one-way ANOVA, no significant main effects were found between suicidal ideation and the overall percentage change in PTSD score.

Table 41
Summary of factors affecting baseline six months and percentage change in PTSD scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Level (n)</th>
<th>PTSD Means</th>
<th>F**</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Baseline</td>
<td>6 Months</td>
<td>% Change</td>
<td></td>
</tr>
<tr>
<td>Therapist effects</td>
<td>Private counsellor (36)</td>
<td>83 (30)</td>
<td>69 (31)</td>
<td>20 (28)</td>
<td>0.23</td>
</tr>
<tr>
<td></td>
<td>FHCS (38)</td>
<td>86 (28)</td>
<td>65 (32)</td>
<td>23 (32)</td>
<td></td>
</tr>
<tr>
<td>Still in counselling</td>
<td>No (41)</td>
<td>83 (27)</td>
<td>56 (27)</td>
<td>30 (31)</td>
<td>8.82</td>
</tr>
<tr>
<td></td>
<td>Yes (33)</td>
<td>90 (30)</td>
<td>81 (31)</td>
<td>11 (25)</td>
<td></td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>No (52)</td>
<td>80 (28)</td>
<td>62 (31)</td>
<td>21 (33)</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>Yes (22)</td>
<td>102 (23)</td>
<td>79 (29)</td>
<td>22 (23)</td>
<td></td>
</tr>
</tbody>
</table>

* Percentage change was quoted for each individual, therefore, the mean percentage change does not necessarily equal the difference in the mean between baseline and six months PTSD score

** The F quoted is for the main effect for the variable of interest

Childhood Effects on Outcome

A number of other relevant variables, such as feeling threatened with abuse (other than CSA), physical or psychological abuse as a child, and poor parental relationships are all known to affect adult psychopathology. This raises the question as to whether any of these variables may also affect the final outcome of counselling. A one-way ANOVA was used to investigate the effect of each variable on the percentage change in PTSD score. Table 42 presents a
summary of these comparisons. No significant main effects between the variable of interest and the percentage change in PTSD score were found. Likewise, there were no interaction effects.

Table 42
Summary of childhood effects on the baseline and six months PTSD score and percentage change in PTSD score

<table>
<thead>
<tr>
<th>Variable</th>
<th>Level (n)</th>
<th>PTSD Mean (sd)</th>
<th>F*</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Baseline</td>
<td>6 Months</td>
<td>%Change</td>
<td></td>
</tr>
<tr>
<td>Threatened with abuse</td>
<td>Never (34)</td>
<td>76 (30)</td>
<td>56 (31)</td>
<td>25 (33)</td>
<td>0.57</td>
</tr>
<tr>
<td></td>
<td>1-2 times (6)</td>
<td>89 (27)</td>
<td>81 (33)</td>
<td>12 (14)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiple (34)</td>
<td>96 (25)</td>
<td>76(30)</td>
<td>20 (28)</td>
<td></td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>Never (23)</td>
<td>81 (28)</td>
<td>57 (29)</td>
<td>30 (28)</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>1-2 times (4)</td>
<td>75 (28)</td>
<td>74 (31)</td>
<td>34 (31)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiple (47)</td>
<td>90 (29)</td>
<td>71 (32)</td>
<td>19 (30)</td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td>Never (71)</td>
<td>86 (29)</td>
<td>67 (31)</td>
<td>21 (31)</td>
<td>0.18</td>
</tr>
<tr>
<td></td>
<td>1-2 times (3)</td>
<td>88 (36)</td>
<td>64 (33)</td>
<td>29 (8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiple (0)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Parental relationships</td>
<td>Okay (37)</td>
<td>89 (30)</td>
<td>64 (30)</td>
<td>26 (28)</td>
<td>0.82</td>
</tr>
<tr>
<td></td>
<td>Not okay (33)</td>
<td>83 (26)</td>
<td>67 (32)</td>
<td>19 (33)</td>
<td></td>
</tr>
</tbody>
</table>

* F quoted is from a one-way ANOVA with the variable of interest and the percent change in PTSD score as the dependent variable. No interactions were significant so the F quoted is for the main effect for the variable of interest.

Do Other Factors Impact on the Overall Outcome of Counselling?

Effective counselling assists a client to return to normal functioning by the end of therapy and there are many different approaches that are helpful in counselling sexual abuse survivors. As discussed in Chapter Three, some of these approaches may involve a combination of both therapy and medication.
An examination of the data relating to the women who had attended the FHC Service for counselling revealed some of them had been medicated with antidepressants. This raised the question about whether the use of medication contributed to the overall outcome of counselling. Other relevant variables that may influence overall symptomatology include alcohol consumption, probable case of conduct or eating disorder and adult sexual abuse experiences. Thus, these variables also need to be taken into account when considering the outcome of counselling. All these issues are examined as follows.

**Therapy and medication**

Evaluation of the impact of antidepressant medication on outcome of counselling was not an aim of this study. The information about the use of medication could only be obtained retrospectively from the clinical files for the women who had either stayed, or had returned to FHC for counselling, and not for those who attended counselling in the private sector. Nevertheless, given that over 50 percent of the sample were counselled at FHC, such an investigation was worthwhile.

Further examination of the data showed that of the 38 women who were counselled at the FHC service, nine of the women who had returned from the private sector along with twelve others were prescribed antidepressant medication. This meant that at some stage after counselling had started 21 in total were prescribed antidepressants.

As shown in Table 43, despite differences in the baseline and six months PTSD scores between the women who required medication and those who did not, the percentage change in PTSD score achieved was similar. Using a one-way ANOVA, no significant main effect nor an interactive effect was found between antidepressant medication and percentage change in PTSD score. This means, in this clinical study, the use of antidepressant medication together with counselling, did not influence the outcome at six months.
Alcohol consumption

Some studies (Briere, 1992) show that self-medication, or excessive use of alcohol and drugs, can dramatically impede therapy, thus it was necessary to determine the impact of alcohol consumption on PTSD symptoms at six months. In keeping with the AUDIT scoring system the AUDIT total six months scores were recoded into a new variable called “alcohol”. This variable contained three categories: safe, moderate and hazardous levels of drinking. This recode allowed for an assessment of the effect of alcohol consumption on the percentage change PTSD score at six months.

As can be seen in Table 43 there was very little difference in the mean baseline and six months PTSD total scores between the three groups. The moderate drinkers had the lowest baseline and six months scores and had achieved more overall percentage change in their PTSD scores in comparison to the safe and hazardous drinkers.

A one-way ANOVA compared the variable “alcohol” with the percentage change in PTSD score. No main effect was found between alcohol consumption and the overall percentage change in PTSD score, nor were there any interactive effects.

Conduct Disorder

Fifty-five percent of the women involved in the six months follow-up would have met criteria for probable case of conduct disorder. A significant relationship (p<0.05) was initially detected earlier in this study between CSA by sexual intercourse, symptoms of conduct disorder and the baseline PTSD score. Thus, it was important to ascertain if probable case of conduct disorder affected the outcome of counselling.

A comparison of the mean baseline, six months and percentage change PTSD scores is shown Table 43. As can be seen the mean baseline, six months and percentage change in
PTSD score was similar for all the women regardless of whether they met criteria for probable case of conduct disorder or not.

In a one-way ANOVA no main effect were found between probable case of conduct disorder and the percentage change in PTSD score.

**Eating disorder**

In this study, inquiry into both anorexic and bulimic types of eating disorders revealed 28 probable cases. It was of interest to note that the women who met criteria for probable case of eating disorder had a higher PTSD score at baseline and a lower score at six months. They also achieved almost twice as much improvement in their PTSD score overall. It is difficult to ascertain why this should have occurred. One possible reason may have been that the women who had met criteria for probable case of eating disorder were more likely to have received previous counselling and thus may dealt with some issues related the CSA.

Attendance at any previous counselling was a question asked in this study. Of the women who completed the six months questionnaires 21 reported they had attended previous counselling, eight of which would have met criteria for probable case of eating disorder. However, a chi square found no relationship between these two variables ($\chi^2=0.75$, df=1, p=0.81).

Using a one-way ANOVA the variable “probable case of eating disorder” just failed to reach significance as a main effect on the percentage change in PTSD score at six months (p=0.07).

**Previous psychiatric history**

Twenty-five percent of the women in the six months follow-up had reported a previous psychiatric history before entry to the study. The mean baseline, six months and percentage
change in PTSD scores of the women with a previous psychiatric history were compared with the scores of the women with no previous history. There was very little difference in baseline, six months and overall percentage change in PTSD score between the two groups.

A one-way ANOVA was then used to investigate the effect of a previous psychiatric history on the percentage change in PTSD score. No main effect was found. The results are shown in Table 43.

**Adult sexual abuse**

The second hypothesis of this study asserted that the women who attended counselling regularly, and who did not have a history of sexual abuse as an adult, would have made the most improvement in their overall symptomatology and social functioning. This means it was expected that ASA would be related to the overall outcome of counselling. A comparison of the mean baseline, six months and percentage change in PTSD scores are shown in Table 43.

As can be seen, while there was a slight difference in the baseline PTSD scores, there was no difference at all in the six months PTSD scores regardless of whether the women had been sexually abused as an adult or not. The women with ASA made more improvement in their percentage change in PTSD score overall. One explanation for this unexpected finding could be that women experiencing ASA are more likely to tell someone and to engage in counselling earlier rather than later. Earlier disclosure means they are more able to deal with the trauma before it becomes chronic in nature.

A one-way ANOVA investigated the effect of ASA on the percentage change in PTSD score. No significant main effect was found. Thus, in this study there was no evidence that ASA significantly influenced the six months PTSD total scores, nor did it affect the percentage change following counselling.
Table 43

Summary of other factors affecting outcome of counselling as measured by percent change in PTSD score

<table>
<thead>
<tr>
<th>Variable</th>
<th>Level (n)</th>
<th>PTSD Mean (sd)</th>
<th>F*</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Baseline 6 Months % Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication (FHC only)</td>
<td>No medication (17)</td>
<td>77 (28) 58 (31) 25 (36)</td>
<td>0.05</td>
<td>1.36</td>
<td>0.82</td>
</tr>
<tr>
<td></td>
<td>Medication (21)</td>
<td>92 (26) 71 (33) 22 (30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>Safe (39)</td>
<td>85 (27) 67 (30) 21 (29)</td>
<td>1.23</td>
<td>2.71</td>
<td>0.30</td>
</tr>
<tr>
<td></td>
<td>Moderate (14)</td>
<td>83 (29) 58 (34) 31 (32)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hazardous (21)</td>
<td>91 (32) 73 (32) 15 (30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>No (33)</td>
<td>85 (33) 66 (32) 22 (28)</td>
<td>0.01</td>
<td>1.72</td>
<td>0.92</td>
</tr>
<tr>
<td></td>
<td>Yes (41)</td>
<td>88 (35) 68 (31) 21 (32)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>No (52)</td>
<td>84 (28) 69 (30) 17 (28)</td>
<td>3.28</td>
<td>1.72</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>Yes (22)</td>
<td>93 (31) 63 (35) 31 (33)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous Psych. History</td>
<td>No (56)</td>
<td>87 (30) 69 (30) 17 (28)</td>
<td>1.34</td>
<td>1.72</td>
<td>0.47</td>
</tr>
<tr>
<td></td>
<td>Yes (18)</td>
<td>84 (26) 63 (35) 29 (21)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASA</td>
<td>No (47)</td>
<td>83 (31) 67 (31) 19 (30)</td>
<td>0.97</td>
<td>1.72</td>
<td>0.33</td>
</tr>
<tr>
<td></td>
<td>Yes (27)</td>
<td>92 (24) 67 (32) 26 (31)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* F quoted is from a one-way ANOVA with the variable of interest and the percent change in PTSD as the dependent variable. No interactions were significant so the F quoted is for the main effect for the variable of interest.

Summary

Hypothesis two asserted that the women who attended counselling regularly, and who did not have a history of sexual abuse as an adult, would have made the most improvement in their overall symptomatology and social functioning.

In regard to the latter issue, it was found that ASA did not affect the overall outcome following counselling. It seems that the women who had experienced ASA made more improvement in their percentage change in PTSD score than those who did not experience ASA. This may be because women experiencing ASA are more likely to tell someone and to engage in therapy earlier rather than later. Earlier disclosure means they are more able to deal with the trauma before it becomes more chronic in nature.
From the findings presented it can be seen that overall, though the PTSD scores of some of the women improved, the majority appeared to have made limited change following counselling. Thus, in this study, regardless of regular attendance at counselling for sexual abuse the outcome was very disappointing.

Nevertheless, though hypothesis two is rejected, several major findings that are relevant to sexual abuse counselling did emerge. The first is that in this study CSA involving sexual intercourse were associated with higher levels of psychopathology at both baseline and at the six months follow-up.

The second finding relates to how satisfied the women were with their progress in counselling. This study has shown the degree of percentage improvement achieved in the PTSD scores was positively associated with how satisfied the women were with their progress in counselling. This finding adds support to the few studies reported in the literature (Ruggeri, 1994) that have found a significant association between the level of client satisfaction and treatment outcome.

As expected, a positive association was found between client and counsellor satisfaction with client progress in therapy. It was somewhat disconcerting to note that no significant associations were found between counsellor satisfaction with client progress and percentage change in PTSD score. From a clinical perspective this is unusual, as generally speaking, therapists would have an idea of how their clients were progressing in treatment.

The third finding was that the number of sessions attended was, if anything, inversely related to the progress actually made in counselling. For example, although the women who attended fewer counselling sessions had higher symptom levels at baseline than those who attended more sessions, they had made greater percentage change in their PTSD score overall. This may of course reflect the need for the more symptomatic to require a greater amount of time in counselling (i.e., longer than six months).
The fourth finding is that while CSA involving sexual intercourse affected both the baseline and six months PTSD score, it did not appear to significantly affect the overall percentage change in PTSD score. Thus, it could not be demonstrated that the CSA experience also affected the overall outcome of counselling.

The fifth finding relates to associations with other mental health problems. It has been suggested that there is a link between alcohol consumption and CSA. In this study no associations were found between alcohol consumption and the PTSD score at the six months follow-up, nor with the percentage change in PTSD score. In fact, very little change in drinking behaviour had occurred over the duration of the study.

Likewise, no significant relationships were found between probable case of conduct disorders and percentage change in PTSD score. Nor were any significant associations found between eating disorders and percentage change in PTSD score. Nevertheless, the women who met criteria for a probable case of eating disorder had made considerably more percentage change in their PTSD score. One suggestion for this could be that the occurrence of an eating disorder is more likely to have brought the woman into contact with a helping professional. This may have provided the opportunity for resolution of some of the long-term effects associated with CSA.

The sixth finding relates to the impact of other childhood factors on the percentage change in PTSD score. The clinical literature suggests that adverse childhood factors such as poor parental relationships, being threatened with abuse, physical and psychological abuse, may predispose some individuals to adult psychopathology. In this study no significant main effects were found between such factors and the percentage change in the PTSD score.

The seventh finding relates to the use of medication alongside therapy. The literature reported in Chapter Three suggests that, though essential as therapy may be in the treatment of trauma, it is sometimes not enough on its own. For example, survivors of trauma are vulnerable to a number of other psychiatric difficulties that may also require pharmacological
intervention. A decrease in mental health status resulted in 12 of the women being seen by a FHC counsellor and the nine women who returned to the FHC service being prescribed antidepressant medication. Though small in number, in this clinical study the use of antidepressant medication together with counselling did not appear to influence the percentage change in PTSD score nor the outcome of counselling at six months.

Finally, this study has shown that the overall psychopathology of the women, as measured by the SCL-90 and SAS total scores, is considerable, and comparable to that of psychiatric outpatients (Derogatis et al., 1976; Friedman et al., 1995; Nierenberg et al., 1995). While some of the women had made some positive changes following counselling, overall the majority made little significant change. The next section compares the findings from this study with another study of women who are comparable in terms of age. This comparison gives an indication as to what change could be expected in general psychopathology following a similar period of treatment.

**Comparisons with the Christchurch Outcome of Depression Study**

A sub-sample of 70 women (mean age=29 years) from the Christchurch Outcome of Depression study have been selected for this comparison with 71 of the women from this study. In comparing these two studies, the current study will be referred to as the CSA Study and the Christchurch Outcome of Depression Study as the Depression Study. The Depression Study was a drug trial study. Twenty-one of the seventy women selected for the sub-sample had a history of CSA. For eight of these women the abuse experience had involved sexual intercourse. Following a full psychiatric assessment, participants were randomly assigned one of two specific antidepressants used in the treatment of depression. While specific therapy as such was not part of the Depression Study, the participants were regularly followed-up for six months by a clinician.

Both studies used SCL-90 and SAS as standardised measures across the same three time periods. Figure 5 below compares the women from the CSA Study with the Depression
Study women in terms of their SCL-90 total scores. Figure 6 compares the SAS total scores at baseline, three and six months and the corresponding percentage change in SCL-90 at six months. The graphs also show whether the women had been sexually abused at all and whether the CSA experienced had involved sexual intercourse.

As can be seen, there is a noticeable difference between the baseline scores of the abused women for both studies in comparison to the scores of the women with no abuse at all. As would be expected, the scores of the latter group are lower at six months than the others in the two studies. The women reporting CSA by sexual intercourse had higher scores on all three measures across the three time periods for both studies.

Compared with the Depression Study the women in the CSA Study made considerably less improvement in their SCL-90 and SAS total scores during the six months period under study. This is particularly so for the women abused by sexual intercourse.
A two-way ANOVA compared the SCL-90 percentage improvement score in the two studies with the variable CSA by sexual intercourse. The result showed a significant main effect between study group and the percentage improvement in the SCL-90 score ($F=13.57$,
df=1,136, p<0.001). There was no evidence of an interactive effect between the Study Group, CSA by intercourse, and percentage change in SCL-90 score.

**Figure 6**

*A Two Study Comparison of SAS Scores Over A Six Month Period Grouped By CSA Type (N = 141)*

<table>
<thead>
<tr>
<th>Measurement Periods</th>
<th>Depression Study</th>
<th>CSA Study</th>
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<tbody>
<tr>
<td>Baseline</td>
<td>CSA - Intercourse</td>
<td>CSA - No Intercourse</td>
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<tr>
<td>3 month followup</td>
<td>CSA - No Intercourse</td>
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<tr>
<td>6 month followup</td>
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A two-way ANOVA also compared the percentage improvement in the SAS total scores between the two studies with the variable CSA by sexual intercourse. The result showed a significant main effect between the study group and the percentage improvement in the SAS total score ($F=13.33$, $df=1,136$, $p<0.001$). There was no evidence of an interactive effect between the Study Group, CSA by intercourse, and percentage change in SAS total score.

In summary, this section has compared two studies that used the same instruments over the same time period to assess general psychopathology with a group of women matched in age. As shown, the women in the Depression Study achieved more change in their SCL-90 and SAS total scores than the women in the CSA Study. While is difficult to know precisely why one study had a far better outcome in terms of general psychopathology at six months than the other, it is possible to offer a tentative explanation.

The majority of the counsellors in the CSA Study reported using cognitive behavioural therapy as the main treatment approach. The efficacy of cognitive therapy has been demonstrated in a large number of clinical trials (Hollon et al., 1991). In general, there is significant empirical support for the application of cognitive therapy to a variety of clinical populations. There have also been a number of studies that have compared cognitive therapy with pharmacotherapy for depression (Blackburn et al., 1981; Elkin et al., 1989; Hollon et al., 1992) and found the two treatments to be equally effective, with little evidence favouring combined treatment over the delivery of each modality singularly.

Davidson and Foa (1991) note the comorbidity of other psychiatric disorders with PTSD is found in virtually all research studies, irrespective of whether clinical or community samples are used. One of most common comorbid conditions is depression (Davidson et al., 1991). Due to a decrease in mental health status, 21 of the women in the CSA Study were prescribed antidepressant medication after counselling had commenced. However, antidepressant medication did not appear to affect their percentage change in PTSD score. As Putnam (1996:460) notes, however, some medications may be effective in treating PTSD as
well as comorbid conditions such as depression and anxiety. Thus, in the CSA study while antidepressant medication may have assisted in decreasing symptoms of general psychopathology for the women it did not significantly affect the PTSD symptomatology. This could account for the lack of a significant relationship between percentage change in PTSD score. Perhaps this means that treatment for PTSD requires something different from that for treatment of depression.

**Overall Summary of Results**

Hypothesis one asserted that the women with the worst CSA histories would be more symptomatic and socially impaired overall. Hypothesis one was confirmed. The findings from this study clearly indicated that incidents involving a variety of sexual activities may account for the degree of interpersonal trauma experienced by an individual from CSA. As shown when correlating the PTSD total score with abuse experience, where sexual intercourse was involved there was a high likelihood that the PTSD score would be correspondingly high. Taken both individually and in interaction, other CSA experiences were not significant factors in the determination of PTSD scores. Thus, having sexual intercourse was the single biggest contributing factor as a predictor of PTSD symptomatology.

Hypothesis two asserted that the women who attended counselling regularly and who did not have a history of sexual abuse as an adult would make the most improvement in their overall symptomatology and social functioning. In this study, ASA did not affect the final outcome of counselling. In fact, the women abused both as adults and children had a better outcome following counselling than those only abused as children.

Overall, the results show that although some of the women in the CSA study had made some improvement in their PTSD scores following counselling, for the majority little significant change was evident. This means that hypothesis two could not be supported.
In an attempt to better understand what change could be expected following six months of treatment the SCL-90 and SAS total scores of the women in the CSA Study were compared with a sub-sample of women from the Depression Study. The scores of the women in the Depression Study had decreased considerably more over the same period of time. One explanation for this difference could be the treatment approach used. For example, as Marmar et al., (1994a) points out, there is consensus among clinicians treating adults with PTSD that the best overall approach involves an integration of cognitive, behavioral, psychodynamic and pharmacological interventions. Pharmacological interventions are generally viewed as an adjunctive treatment aimed at reducing overwhelming intrusive and hyper-arousal symptoms. However, medication may also be effective in treating comorbid conditions such as depression. Thus, for the women in the CSA Study although the depression may have been treated, the PTSD was not treated or, at best, only partially so. Given the lack of outcome studies available, further research is needed to advance understanding and treatment for PTSD disorders among adults survivors of CSA.
CHAPTER SEVEN

DISCUSSION OF RESULTS

The purpose of this thesis was to clinically evaluate the psychological and social functioning of 100 women before and after their attendance at sexual abuse counselling. It was hypothesised that the women with the worst CSA histories would be the most symptomatic and more socially impaired at assessment. Secondly, it was hypothesised that, providing the women had not been sexually abused as adults and had attended counselling regularly, an improvement would be noticeable in their overall symptomatology and social functioning at the six months follow-up interview.

The first section of this chapter will discuss the overall results of the study. The second section will discuss more specifically the functioning of the women at assessment and then after counselling.

Summary of Results

One hundred women survivors of child sexual abuse who attended a Family Health Counselling Service’s sexual abuse programme were recruited for this study. Of these women, 74 attended counselling and completed the six months follow-up questionnaires.

Thirty-five different counsellors were also involved in the study. Seven of these counsellors, including the author, worked in the FHC Service. The private counsellors mainly worked in the same therapy centre in the inner city. The few that worked independently were well known to the FHC Service.
Effectiveness of counselling was determined by the number of women in the study who had experienced a decrease in PTSD and SCL-90 symptoms, and who had achieved an improvement in their overall social functioning following counselling.

Though measurement occurred at the initial assessment, three and six months after counselling had commenced, the longer time frame of six months was mainly used for exploring the overall outcome of counselling. The counsellors involved in the study also completed some general questions in regard to the overall outcome of their counselling at the six months follow-up.

Hypothesis one was confirmed. That is, in this study the women with the worst CSA histories were more symptomatic and more socially impaired at assessment. However, hypothesis two could not be supported, as though the women had attended counselling regularly, the change they had achieved in their scores was minimal overall. This lack of significant change was further highlighted when their SCL-90 and SAS scores were compared with the scores of a sub-sample of women participating in the Christchurch Outcome of Depression Study. Finally, though expected, ASA did not appear to influence the percentage change in PTSD score at six months. Thus, overall the results of the study were somewhat inconclusive and therefore, disappointing. However, several significant findings came to light. These findings will now be discussed and compared with the findings from the studies discussed in Chapter Two and Chapter Three.

The Nature and Extent of Sexual Abuse

In accordance with the studies discussed in Chapter Two, almost all of the women in this study (98%) reported abuse by a male. As some of the women reported both intra and extra-familial abuse, the number of perpetrators exceeded 100. For example, 76 percent of the women reported intra-familial abuse and 56 percent reported abuse by an extra-familial perpetrator.
The CSA reported included a range of sexually abusive experiences: exhibitionism; inappropriate viewing of sexual activity; genital touching; through to penetration of the vagina or anus with objects, or by sexual intercourse. Other authors (Courtois, 1988; Dolan, 1991), have noted that the level of intrusion implied in the above range of abusive activities does not necessarily correspond to the degree of psychological trauma experienced. In this study the severity of the abuse was related to the degree of impairment in symptomatology. The women who reported CSA by sexual intercourse were generally more symptomatic and more socially impaired at assessment than the women whose sexual abusive experiences did not involve penile penetration.

Forty women in this study were sexually abused again as an adult. One of the few studies to directly compare symptomatology of child and adult survivors of sexual abuse was under taken by Murphy et al., (1998). They found higher rates of somatisation, obsessive compulsive behaviours, depression, anxiety and hostility among women abused as children and as adults.

In this study it was expected that the women abused again as adults would make less overall improvement in symptomatology following counselling. Surprisingly, this was not the case: the women who experienced sexual intercourse as adults but not as children had the lowest PTSD score at six months and made the best percentage improvement overall. It could be speculated that this was because adults are more likely to seek assistance following an abusive experience than children and thus deal with the post-traumatic effects before they become chronic in nature.

Current Symptomatology

Overall symptomatology was measured by responses to a series of self-report questionnaires relating to symptoms of PTSD, general psychopathology (SCL-90) and social functioning (SAS). In accordance with the studies reviewed in Chapter Two, this study found that the impact of CSA is serious and that the women reported a wide variety of symptomatic
and pathological behaviours. Indeed, the overall psychopathology of the women (as measured by the SCL-90 and SAS total scores) was comparable to scores found among psychiatric populations (Derogatis, et al., 1976; Friedman et al., 1995; et al., Nierenberg., et al., 1995).

A modified version of a questionnaire developed by Coons et al., (1990) was used in this study to assess the presence PTSD symptomatology. Responses to the questionnaire showed that the scores ranged between 11 and 152 with a mean score of 86 (sd=29). This suggested that many of the women had experienced PTSD symptoms over the months preceding entry to the study. A factor analysis was then used to determine the degree of PTSD symptoms among the total sample. The results of that analysis showed four factors that appeared to relate to DSM-IV criteria for PTSD.

Sexual abuse has been linked to later substance abuse, including alcoholism, in a variety of studies. Illustrations of the strength of this potential association are the findings reported by Briere and Runtz (1987). They found that female crisis-centre clients who had also been abused as children were 10 times more likely to have a history of drug abuse and twice as likely to have a history of alcoholism compared to those clients who had not experienced child abuse.

The use of the AUDIT 10-item questionnaire allowed for an assessment of the alcohol consumption by the women in this study. A score of more than seven on the AUDIT indicates hazardous or harmful levels of consumption. Although 31 percent of the women were drinking at hazardous levels at baseline, no associations were found between current symptomatology and AUDIT total score.

In terms of general psychopathology, the total scores on the PTSD, SCL-90 and SAS were all positively correlated. It was, therefore, expected that if a woman scored high on one measure then she was likely to score high on all three measures. Given this high correlation the PTSD total score was used for most of the data analysis.
Associations between CSA and PTSD Symptomatology

One of the long-term effects associated with CSA is PTSD. The studies reported in the literature vary considerably regarding the precise number of times PTSD is associated with CSA (Lindberg and Distad, 1985; Goodwin, 1990; Herman, 1992; McLeer et al., 1988; Resnick et al., 1993). This makes it difficult to ascribe PTSD as a principal sequela of abuse.

The debate about this issue seems to centre on the role of other relevant variables known for their traumatic effects, such as family disruption, poor parental relationships, physical abuse, emotional abuse, and adult trauma—all of which are likely to be correlated with symptoms of PTSD. This means that the independent effect of CSA on symptoms of PTSD has remained suggestive rather than conclusive, as inferences about the relation between variables can only be certain when other variables are appropriately controlled. Furthermore, few studies have been carried out to determine which abuse experiences are associated with PTSD symptomatology.

In this study, initially Pearson correlations were used to ascertain significant associations between all the CSA experiences reported: poor parental relationships, physical abuse as a child, probable case of conduct or eating disorders, further sexual abuse and overall symptomatology (as measured by PTSD, SCL-90 and SAS total scores). From this analysis, the following variables—probable case of conduct disorder, being threatened with abuse other than sexual, being beaten as a child, invasion of sexual privacy, exposure of body sex parts and attempted or actual sexual intercourse—emerged as those variables most likely to contribute to overall symptomatology, and in particular to PTSD symptoms. Of importance here is that the strongest correlations were with the PTSD total score.

The age of onset of CSA, the duration of CSA and the relationship between the perpetrator and the child have also been consistently associated with higher levels of psychopathology. For the majority of the women in this study the CSA began before the age
of nine years. Although no significant differences were found, the mean PTSD score for these women was higher than for those for whom the abuse began later. Likewise, an assessment of duration effects on PTSD score showed that where CSA occurred across more than one age range, the PTSD score was higher.

Although initially a significant association was found between the type of perpetrator and PTSD symptomatology, further investigation showed the severity of the abuse was the most important factor in determining PTSD symptoms.

Briere and Runtz (1986, 1987) found in studies looking at abuse-related suicidal behaviours that there was a 51 to 79 percent likelihood of at least one suicide attempt. These statistics were for unsuccessful attempts. That is, from individuals who lived to make such reports. As Briere (1992:62) comments, the extent of suicide among child abuse victims remains unknown.

In this study the women were only asked about suicide attempts during the six months preceding entry to the study. Though only 10 percent had attempted suicide before entry to the study, another 28 percent had expressed suicidal ideation at some stage while engaged in counselling. Although this is a lower percentage than the studies reviewed by Briere and Runtz (1986, 1987), this finding lends support to the literature in regard to abuse-related suicidal tendencies.

Consequences of CSA have included various forms of maladjustment, such as conduct disorder (Friedrich and Luecke, 1988) and antisocial personality disorder (Luntz and Widom, 1994). Inquires about behaviours in childhood in this study indicated that 52 percent of the women met criteria for probable case of conduct disorder. Probable case of conduct disorder was positively correlated with the PTSD total score at baseline but later, when entered into a multiple regression analysis as a factor in predicting PTSD, it was excluded from the model.
It seems that sexually abused adolescents, particularly girls, often use eating as a way of feeling in control of themselves (MacDonald et al., 1995). Studies also suggest that around 30 percent of eating disordered patients have histories of previous sexual abuse as a child, a figure that is relatively comparable to rates found in the normal population (Bulik et al., 1989; Connors and Morse, 1993).

The findings from this study are consistent with the literature. That is, 28 percent of the women probably would have met criteria for an eating disorder at some stage of their lives. Also consistent with the literature, no significant associations were found between CSA and disturbance in eating behaviours with the baseline PTSD score.

**Predictors of PTSD Symptomatology**

Given the strength of the association between CSA and PTSD symptomatology, a stepwise multiple regression analysis was employed to determine whether variables concerned with other childhood experiences or abuse-specific variables made the strongest contribution to PTSD symptomatology. All the significant variables were entered into the analysis. CSA by sexual intercourse emerged from this analysis as the key independent variable in predicting PTSD symptomatology (see Table 26).

Even when the effects of general symptomatology (SCL-90) were allowed for, the variable “being threatened with abuse” was excluded from the model if CSA by sexual intercourse was included in the analysis. This highlights the specific effect that CSA by intercourse had on PTSD symptomatology.

**Outcomes after Counselling**

Psychotherapy research has been criticised for relying on good prognosis or YAVIS-type (young, attractive, verbal, intelligent, and successful) clients (Rachman and Wilson 1986).
Clearly therapy outcomes based on such clients seriously compromise any ability to
generalise to more representative populations.

With regard to the current study, of the women seeking treatment at the Family Health
Counselling Service nearly half were beneficiaries; a small number were self employed and the
rest had either their own, or their partner’s, income. Just over a third had spent four or more
years at a secondary school. Six women had attended university. Therefore, rather than only
consisting of YAVIS-type clients the sample represented a cross-section of the community.

Comparisons between study dropouts and study completers

All the women completing an assessment for intake into the sexual abuse programme
were referred for counselling. Three women declined any further therapeutic intervention,
stating the assessment interview had validated their story and, at that stage, they felt that was
all they needed. Two-thirds of the sample were eligible for ACC funded counselling with a
counsellor in the private sector. The remaining one-third were offered counselling with a FHC
counsellor.

When comparing the characteristics of the study dropouts and study completers, age
was the only significant difference between the women (study dropouts, mean=27 years and
study completers, mean=32 years, p<0.05).

While the two groups reported similar CSA histories, the dropout group had greater
levels of revictimisation as an adult. Although no significant differences in symptomatology
were found between the two groups, the most abused tended not to stay in counselling.

Changes in symptomatology

An examination of the data showed that significant changes in symptomatology had
occurred across all three measures between assessment and the three and six months follow-
up. As shown though, when some measures of mental health were administered to a community sample on two occasions (from a few days to several months apart), the scores on the second occasion reflected on average, better mental health (Henderson and Jorm, 1990:721). Thus, although finding a change within the first three months was not unexpected, it did mean it was necessary to organise the study in such a way as to determine whether these changes were clinically significant and whether they were due to therapeutic intervention.

After considering two options it was decided that improvement would be measured by the percentage decrease in the PTSD score over the duration of the study. This meant that regardless of the PTSD score at assessment and at six months, the degree of improvement in the PTSD total score could be determined. The percentage change in the PTSD total score was compared with a range of items contained in the questionnaires. One-way ANOVAs were used to determine the effect any of these items may have had on the percentage change in PTSD score at six months.

In terms of the outcome of counselling, an important finding was that the women with histories of CSA involving sexual intercourse had higher PTSD scores at both assessment and the six months follow-up interview than the women whose CSA experiences did not include sexual intercourse.

It was also interesting to note that the women who had made the most improvement in their PTSD score at the six months follow-up were those that had met criteria for having had a probable case of eating disorder. However, in an ANOVA having a probable case of eating disorder just failed to show a significant main effect on the percentage change in PTSD score.

Thus, it seems that in this study, although CSA may have played a role in the development and maintenance of eating disorders, in general it is best considered as a risk factor in overall psychopathology.
Other variables such as probable case of conduct disorder, suicidal ideation or drinking behaviour during the course of the study did not have a significant effect on the percentage change in PTSD score at six months.

**Description of Treatment**

Clients, clinicians and researchers all expect therapy to accomplish particular goals. It is the extent to which these goals have been accomplished that determines whether or not the therapy has been effective or beneficial. The clinical significance of treatment refers to its ability to meet standards of effectiveness set by all the parties concerned. There is little consensus in the field regarding what these standards should be. As Jacobson and Truax (1991:12) noted, criteria should include: an elimination of the presenting problem or changes that significantly reduce one’s risk for various health problems; a recognisable level of positive change and an improvement in client functioning by the end of therapy.

Important aspects that are highly related to the outcome of counselling include: therapist effects; the client’s experience of therapy, and the client’s ability to recognise changes made during the course of counselling. These factors, though not always taken into account when evaluating client progress, all affect progress and the eventual outcome of therapy. Each one will be discussed separately.

**Therapist effects**

As Crits-Christoph and Mintz (1991) point out, therapist variables such as competence or skill have been shown to relate to outcome and variability, which may explain the presence of therapist effects to some extent. Additionally, the processes used to select, train, and supervise therapists in a given study may be responsible for differences in the quality of therapists within a study. Thus, it is important that therapist effects and the implications for the statistical analysis of therapeutic outcomes be given due consideration and treated as random factors in comparative efficacy studies of therapies used.
Throughout this study the FHC Service clinicians were selected, trained and supervised in treatment modalities suitable for working with adult survivors of CSA. Referrals out of the FHC Service were, in the main, only made to one private therapy centre in the city, or to a few selected therapists in the private sector that used similar treatment modalities to the FHC Service. In this way the study was designed to use as many therapists as possible that were likely to have a similar level of clinical skills. This also means that, as much as possible, similar treatment modalities were used. The results showed that there was very little difference in percentage change in PTSD score overall, regardless of whether the clients engaged in counselling with a Family Health Counsellor or a private counsellor.

**Type of intervention**

There are many different therapeutic approaches that may be helpful in counselling sexual abuse survivors, ranging from long-term psychotherapy to shorter-term interpersonal and cognitive behavioural therapies. Clinical prescriptions on how to treat adult survivors of CSA have been written and provide useful guidelines for therapists. However, such prescriptions are subjective judgments only about what works in treatment. What may work for one therapist may not for another (Beutler and Hill, 1992:204).

This study attempted to determine whether some strategies were more effective than others. In doing so the number of counselling sessions attended, client satisfaction with counselling, counsellor satisfaction with client progress in counselling, the mode of termination of counselling and the use of antidepressant medication were examined. All these factors had to be considered when evaluating the effectiveness of counselling.

**Number of sessions attended over study duration**

Despite the seeming likelihood that increased time in counselling would relate to greater percentage improvement in PTSD overall, a comparison of the mean number of sessions attended showed this was not the case. For example, the women who attended fewer sessions
had made greater percentage improvement in their overall score than the women attending more sessions.

There could be two possible reasons for this finding. The first is that this may merely reflect the tendency that the more symptomatic someone is, the longer the period of time (i.e., more than six months) she require in counselling. The second reason, as other researchers have noted about sexually abused children (e.g., Gomes-Schwartz, Horowitz and Cardarelli, et al., 1990), could be that some adult survivors of CSA demonstrate spontaneous non-treated symptom reduction.

This point has been further investigated by Lanktree and Briere (1995:1153). They suggest there are two general types of childhood response to sexual abuse. The first type is where sexually abused children either fail to exhibit overt symptomatology on generic psychological tests, or their symptoms may seemingly resolve as a function of the passage of time. In contrast to this, the second type may be those for whom sexual abuse in childhood has overt symptomatic impacts that do not, in fact, resolve over time. Such children presenting for counselling at a later stage, for example in adulthood are, therefore, more likely to appear in studies such as this one.

Given the age range of the women in the study, it could be argued that the outcome of the women who experienced a relatively longer period of time between the offset of CSA to the onset of intervention may differ from those who received intervention more quickly. For example, a longer period of time between the CSA and the start of counselling might be reflected in a greater degree of symptomatology and, therefore, the need for more time in counselling. Unfortunately, though a valid issue, the test of “time from CSA to counselling” was not examined in this study.

Nevertheless, it remains that in this study the greater the number of sessions attended, the higher the PTSD scores. This means that the women who were still in counselling at the six months follow-up had higher PTSD scores than those who had finished counselling.
Women’s satisfaction with counselling

Although a number of investigators have criticised satisfaction research for relying on few theory-based variables, various findings in the recent literature point to client’s satisfaction with psychiatric services as a particularly salient and appropriate measure of outcome and quality. While clear definitions are rare and conflicting results have been obtained in regard to client satisfaction surveys, the value of measuring satisfaction should not be overlooked (Ruggeri, 1994). The broad definition of satisfaction offered by Lebrow (1983a) is consistent with this study: sensing an increase in general happiness, feeling more positive, and making positive changes in life.

At the six months follow-up interviews the women were asked to rate their responses to some general questions about how happy they were with their progress in counselling. The women who were happiest with their progress, who felt better and who believed that either counselling, or both counselling and other circumstances had assisted them to make positive life changes, achieved greater percentage change in their PTSD scores.

Counsellor report at six months

At the six months follow-up the counsellors were also asked if they were satisfied with their client’s progress in counselling and the way in which termination had occurred. Though most of the counsellors indicated they were satisfied with the client’s progress in counselling, no significant associations were found between counsellor satisfaction with clients’ progress in counselling and their overall percentage change achieved in PTSD score.

The majority of the counsellors indicated they were satisfied with the termination process. The percentage change in PTSD scores of the women no longer in counselling were compared with the women still attending. It was found that the women who were no longer in counselling had made a greater statistically significant percentage improvement in their PTSD score than those still in counselling. It could be that this reflects the tendency for more
distressed clients and those exhibiting more symptoms to require greater amounts of time in treatment.

*Therapy and medication*

Further investigation of the women who had attended between one and 10 sessions revealed that over half of them had attended the FHC Service for counselling. Of particular importance for this study is the fact that 21 of these women were medicated with antidepressants. The question of whether the use of medication contributed to the overall outcome of counselling needed to be investigated.

The results of this investigation showed that despite differences in the baseline and six months follow-up PTSD scores in an ANOVA no significant main effects were found between the use of antidepressant medication and percentage change in PTSD score.

*Other Difficulties*

A number of other relevant variables, such as previous psychiatric history, feeling threatened with abuse, physical or psychological abuse and poor parental relationships, are all known to affect adult psychopathology. This raised the question as to whether any of these factors may have affected the final outcome of counselling. In order to address this question, all these factors were compared with the baseline and six months follow-up PTSD scores. No significant effects were determined between these variables and the percentage change in PTSD score.

*Comparison between the CSA Study and the Depression Study*

Though some of the women in this study had made positive changes following counselling, the majority had achieved little significant change overall. In order to gain an indication as to what may be expected in percentage change in general psychopathology
following a similar period of treatment, the results of this study were compared with another study of women who were comparable in terms of age.

A sub-sample of 70 from the Christchurch Outcome of Depression Study were selected for this comparison. Twenty-one of these women had a history of CSA and for eight, the abuse had involved sexual intercourse. Both studies used the SCL-90 and SAS as standardised measures across the same three time periods. A comparison of the SCL-90 and SAS total scores at baseline, three and six months and the corresponding percentage change at six months was undertaken. The results showed a noticeable difference between the baseline scores of the abused women for both studies in comparison to the scores of the women with no abuse at all.

When comparing the SCL-90 and SAS scores during the six months period under study the women in the Depression Study had achieved significantly more percentage improvement in their scores than the women in the CSA study. This was particularly so for the women abused by sexual intercourse.

In terms of the outcome of counselling, an important finding was that the women with histories of CSA involving sexual intercourse had higher SCL-90 scores and poorer social adjustment than the women whose CSA experiences did not include sexual intercourse at both assessment and the six months follow-up.

**Significant Differences in Outcome**

One explanation for such poor results from CSA counselling could be that a difference in outcome between CSA survivors and depressed patients could be expected as, at this stage, there is very limited data available about efficacy of treatment for PTSD. This is especially so for adult survivors of CSA. In contrast to this, controlled studies investigating treatments for depression have demonstrated the efficacy of cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT).
As Hollon et al. (1991) point out, the efficacy of CBT has been evaluated in an impressive number of trials which give significant empirical support for the application of cognitive therapy to a variety of clinical populations. Authors such as Blackburn et al., (1981); Elkin et al., (1989) and Hollon et al., (1992) all point to the studies that have compared cognitive therapy with pharmacotherapy for depression and found the two treatments to be equally effective. Furthermore, there has been little evidence favouring the delivery of each modality singularly over combined treatment.

In terms of IPT, therapists’ awareness of the need to learn and use empirically validated forms of therapy has increased. This has contributed to the expansion of IPT from research protocols to more general clinical settings. Increasing numbers of protocols have been developed in which IPT has been modified and applied to a variety of patient populations and clinical syndromes. Evidence from controlled clinical trials suggests that IPT is a reasonable alternative or adjunct to medication as an acute, continuation, and/or maintenance treatment for patients with major depression (Weissman and Markowitz, 1994).

A second explanation may be that CSA counselling, as it is currently offered, is not effective. There are two possible reasons for this. The first is that routine counselling in clinical practice gets poorer results than research studies which may have more heterogeneous samples. The second is that even in research studies CSA counselling gets poorer results. This is not to say that CSA survivors do not benefit at all from counselling but that some interventions may be better suited to their problems than others.

As discussed in Chapter Two, community-based studies reveal a lifetime prevalence for PTSD ranging from one to 14 percent. This thesis has already shown that many of the women in the CSA study were experiencing symptoms of PTSD over the month preceding entry to the study. Unfortunately, very few empirical studies exist to define efficacy of different treatment approaches for working specifically with PTSD. Those that do include a few medication trials together with a mixture of behavioural, cognitive-behavioural, and behavioural-psychodynamic approaches (Putnam, 1996).
Chapter Three provided an overview of therapeutic approaches that have shown to be effective with other clinical populations. Though all such approaches can be used for counselling survivors of CSA the outcome of these interventions with this clinical population is unknown. Chapter Three also discussed the use of medication for reducing symptoms of PTSD in conjunction with therapy. As Saporta and Case (1993:104) argued, a decrease in the baseline level of arousal can restore the client's control over bodily responses and improve cognitive function. This in turn serves to enhance the effectiveness of therapy.

Controlled trials indicate that tricyclic antidepressants (Davidson et al., 1990) and serotonin inhibitors (van der Kolk et al., 1994) provide significant improvement in intrusive and hyperarousal symptoms. Studies of combat victims (Smith et al., 1989; Yehuda et al., 1991, 1993) and sexually abused girls (De Bellis et al., 1994a) suggest that trauma-associated hypothalamic-pituitary-adrenal (HPA) axis abnormalities differ from those associated with depression.

Yehuda and colleagues (1991) hypothesised that a central suppressive-inhibitory mechanism involving supersensitivity to cortisol is operating in PTSD, as opposed to the sustained hypercortisolism of melancholic depression. This suggests effective treatment for PTSD requires something different to treatment for depression. Though there may be some common elements occurring in all treatment approaches that may aid both disorders, there may also be some significantly different approaches required to bring about changes. Exactly what these different treatment components may be is as yet, not known. This may suggest a possible and plausible explanation for the difference in outcome between the Depression and CSA studies.

Overall Conclusion

The results from this study suggest that, within a sample of sexually abused women attending an outpatient mental health counselling service’s sexual abuse programme, many of the participants had experienced symptoms of PTSD over the month preceding entry to the
study. It was also found that “having sexual intercourse” was significantly associated with the PTSD total score.

Overall social functioning was assessed by the use of the SAS scale. As evidenced, the mean SCL-90 and SAS scores of the women were comparable to scores of psychiatric populations. These findings parallel those reported in other studies regarding symptoms of PTSD exhibited by women survivors of CSA (Goodwin, 1990; Herman, 1992).

In this study it was found that when variables such as the relationship with and between parents were correlated with SCL-90 and SAS total scores, parental relationships became non-significant if the abuse resulted in having sexual intercourse. No significant differences were found between CSA and ASA.

A stepwise multiple regression analysis was performed to determine the contribution the type of sexual abuse experience had on overall psychopathology. Where the women reported multiple abusive episodes which involved sexual intercourse, the likelihood of their showing symptoms of PTSD was significantly higher. Thus, a “dose response relationship” seemed to exist between the type and extent of the CSA experienced and the likelihood of the presence of PTSD symptoms.

The study also looked at the outcome of counselling. While it was expected that any reduction in symptomatology and increased social functioning would have occurred as a result of counselling, this could not be clearly demonstrated. This means it could be not determined whether the changes in symptomatology that did occur over the course of the study were due to treatment effects, or the passing of time.

An important finding was the tendency for the women who remained in counselling, at least until after the six months follow-up interviews, to have higher symptom levels than the women who had completed counselling. This suggests that some of the women responded to
counselling more quickly than others. That is, they appeared to have got better faster and, therefore, left counselling at an earlier point in time.

In order to gain a better understanding of what change might be expected following six months of intervention the SCL-90 and SAS total scores of the women this study were compared with a sub-sample of the women in the Christchurch Outcome of Depression Study. This showed that the women in this study had achieved minimal change in comparison with the women in the Depression Study. This was particularly apparent where the CSA involved sexual intercourse.

One explanation offered for this difference in outcome was the treatment approach used. That is, at this stage, there is very limited data available about efficacy of treatment for PTSD. In contrast to this, a number of controlled studies investigating efficacy of treatments have already demonstrated that CBT and IPT have good outcomes for the treatment of depression for a variety of clinical populations (Hollon et al., 1992). Thus, a difference in outcome between patients with PTSD symptomatology and depressed patients could be expected. This is especially so for adult survivors of CSA. Such a finding gives support to the notion of “targeted intervention”.

As yet, despite the large numbers of adults receiving state funded counselling in New Zealand to assist with problems related to CSA, virtually nothing is known about the effectiveness of that counselling. Prospective, longitudinal studies to determine the outcome of PTSD interventions among adult survivors of CSA have yet to be undertaken. Such studies are urgently needed to enable both clinicians and funders of services to better understand the treatment needs of adult survivors of CSA.
CHAPTER EIGHT

METHODOLOGICAL CONSIDERATIONS AND CONCLUSIONS

In this chapter some methodological aspects of the design of the study, attrition of sample size, investigator bias and the number of therapists involved, ethical aspects and risk factors for PTSD are considered in appraising the results. Some overall comments on the findings of the study and recommendations for future research conclude the thesis.

Methodological Considerations

The merits of different methodologies were fully discussed in Chapter Four. Clearly the decision to use one approach to research over another is an important consideration. However, given the naturalistic nature of this study the design chosen was quasi-experimental.

Study design

One of the limitations of quasi-experimental studies is that they usually occur in a setting that is not set up specifically for research purposes. That was certainly true for this New Zealand study. The results were, therefore, reliant on self-report data from women attending an existing Family Health Counselling Service’s sexual abuse programme.

This has the potential to limit the external validity of the study, as all the women in the sample came into counselling because they had overt symptoms that had not reduced spontaneously over time. Such women are more likely to seek treatment. Thus, they are also more likely to appear in studies such as this. Given this likelihood, the findings from this study can only be generalised to women who either seek, or are referred for treatment.
Nevertheless, comparisons showed that the women involved in the study were typical clients who are either referred, or who refer themselves, to services for assistance with problems related to child sexual abuse. Therefore, the findings do have clinical relevance. As such the findings are valuable and useful both for clinicians working in the area of sexual abuse and for clinical researchers involved in treatment outcome studies.

**Attrition**

While attrition is an important issue in all quasi-experimental studies it is more so in studies of CSA. The reason for this is that, as shown in earlier chapters, there is still considerable debate about overall symptomatology of this population. Thus, assurances of sample size are essential. However, given the subject matter under study, some reduction in follow-up numbers is to be expected. It is maintained that a 74 percent follow-up rate is sufficient to allow some useful findings to emerge.

**Investigator bias**

Clinical research is fraught with methodological problems, one of which is unintentional investigator bias. The field of child sexual abuse research is very complex and remains vulnerable to many methodological pitfalls. Investigator bias is more likely to be found in studies using a smaller number of therapists, using the same therapists, or where the major investigators also serve as therapists. This study involved many therapists, both counsellors in private practice and in the Family Health Counselling Service, one of whom was the author. The total number of other therapists involved, alongside the fact that only those clients that could not be referred elsewhere were engaged in therapy with a Family Health Counsellor, and, to a lesser extent, with the author, helps to negate unintentional investigator bias.
Ethical and Logistic Factors

Experimentation in the area of human trauma is ethically unacceptable and thus prevents studying the impact of traumatic events in a scientifically pure way. This means studies have to take into account real life events with all the ensuing methodological problems of sampling and controlling for confounding variables.

This problem is highlighted throughout the international literature where the limitations of studies of clinical samples are well recognised. As clinical samples only comprise of selected fractions of populations with PTSD they say little about the risk factors for the disorder or its natural history, including age of onset, duration of symptoms, or comorbidity with other disorders (Breslau, 1998).

Risk Factors for PTSD

The establishment of the diagnosis of PTSD provides an observable framework for a more systematic study of the effects of stress and trauma. Nearly 20 years ago PTSD made its first appearance in the DSM-III (American Psychiatric Association, 1980). Since then information has been gathered about the effects of trauma. However, as Yehuda (1998) points out, the information that has accrued presents some important challenges to mental health professionals. For example, although it is now clear that PTSD is a very serious public health problem, not every trauma victim develops PTSD.

Although this may suggest that if PTSD is not present in all trauma survivors then the importance of traumatic events as etiological agents is diminished, as Yehuda (1998) reminds us, trauma can also result in the development of other anxiety disorders, mood disorders and a whole range of other psychiatric disorders.

Breslau (1998) summarises the few studies of PTSD that have been undertaken in the general population in recent years looking at the prevalence of trauma and PTSD across
subgroups of the population, and identifies risk factors and the types of traumas that are most likely to lead to PTSD. In doing so Breslau (1998:25) notes that compared with males, females are twice as likely to develop PTSD following exposure to a traumatic event. The primary reason given for this difference is that females have a greater vulnerability to PTSD-inducing effects of assaultive violence. Sexual abuse is the type of event that would fit into the assaultive violence category. Breslau (1998:25) also argues that these studies add support to the notion that the nature of the stressor influences the risk of PTSD and suggests the severity of the event has been singled out as a critical factor in the development of PTSD.

Other authors (Davidson et al., 1991) also point out that early history of adversity and exposure to traumatic events has been found to increase the risk of PTSD. Specifically, childhood separation from parents and childhood abuse or sexual assault are particularly associated with increased risk of PTSD. Other factors that seem to be implicated in the development of chronic PTSD include: pre-trauma factors, trauma-related factors and post-trauma factors. Examples of these factors are: individual characteristics, individual experiences during and after the trauma, and environmental aspects (Foa and Meadows, 1998).

Concluding Comments

To date there have been no controlled studies in New Zealand in regard to the psychological and social functioning of women before and after attending counselling for problems related to child sexual abuse. The empirical study of adult survivors of CSA is a new and emerging field which, as yet, has not taken full advantage of some of the methodological strategies that have become a virtual requirement in other mental health research studies. This study has confirmed for New Zealand women, phenomena reported in several other countries. That is, the clinical sequelae associated with CSA are serious with long-term consequences.

This study, using a quasi-experimental methodology, was designed to extend knowledge about the psychological and social functioning of women before and after attending counselling
for problems related to sexual abuse. Where possible, the study used standardised and clinically relevant measures. The intervals between the measures and the choice of the number of measurement points were all designed in order to achieved credibility and to advance knowledge that will be useful for both clinicians working with survivors of CSA and future research.

Two major and important findings emerged from the study. The first is that the study provided an understanding of the number of women with histories of CSA and symptoms of PTSD presenting for counselling at a community Family Health Counselling Centre. Risk factors for development of PTSD appear to involve the severity of the CSA experienced. The study showed that where the women reported multiple abusive episodes of CSA involving sexual intercourse, the likelihood of their having symptoms of PTSD was significantly increased. This finding is supported by the clinical literature.

The contribution of PTSD symptomatology to the therapeutic domain of sexual abuse counselling provides an observational framework for studying the effects of the abuse and the efficacy of treatment for CSA survivors. As discussed, there are many different therapeutic approaches that are helpful in the treatment of other clinical disorders, such as depression, some of which may also assist sexual abuse survivors. For example, treatment may include long term psychotherapy or one of the shorter term therapies such as interpersonal, cognitive behavioural, systemic or problem solving approaches. Any one of these approaches may be offered with, or without, the use of pharmacology.

This study also found that, though the women achieved a decrease in their overall symptomatology, when their percentage change in scores were compared with the women in the Depression Study they were still considerably more symptomatic at the end of the six months. This highlighted the second major finding of the study. It was shown that the women with high levels of PTSD are more likely to have a poor outcome following treatment than those treated for depression. This means there is a need to look closely at the treatment offered for this clinical population.
It may be that the common elements found in all forms of therapy are the strongest factors in determining clinical change and that they play an important role in contributing to positive outcome. However, this study has shown that while the therapy offered decreased symptoms of general psychopathology, the PTSD scores of the women remained high. This suggests that the treatment of PTSD requires something else over and above that what is required for treatment of general psychopathology. As such, this supports the notion of targeted interventions to meet the needs of specific populations. In order to do so the identification and development of suitable treatment modalities for survivors of CSA is urgently needed. Such a move would enable the reliability and skillfulness of therapy to be assessed more accurately and lead to better evaluation of clinical practice in this area.

From a social and political perspective social workers and other health professionals continue to struggle with a system that often denies the extent or importance of CSA as a social problem. Despite this denial, as shown in this study many of the women abused as children developed full or partial forms of PTSD. Thus, though CSA may very well be a social problem the resulting sequelae associated with the abuse makes it a clinical one.

In New Zealand the majority of CSA counselling is undertaken by accredited counsellors in the private sector. Funding is made available through ACC (Accident Rehabilitation and Compensation Insurance Corporation). The Corporation’s annual report shows that during the last fiscal year ACC accepted and funded counselling costs for 8,656 sensitive (sexual abuse) claims (ACC, 1998). This means the government spends millions of dollars for the treatment of problems related to sexual abuse. The dilemma is the efficacy of that treatment is undetermined.

**Directions for Future Research**

The identification and development of suitable outcome measures for the routine monitoring of in-treatment outcomes for problems related to CSA needs to be established.
To date only a limited number of controlled trials have evaluated treatment for CSA. A large treatment outcome study is urgently required to identify intervention strategies that are both beneficial to survivors of child sexual abuse and are useful for the treating clinicians and funders of services. Such a study should include the following:

1. Clearly defined target symptoms (i.e., PTSD or major depressive disorder)
2. Reliable valid measures (i.e., use of standardised questionnaires)
3. Interviewer training (for initial assessment and all ongoing interviews)
4. Specific treatment approaches that can be defined in a manual
5. Unbiased assignment to treatment (i.e., random assignment to a specific treatment approach)
6. Adherence to specific treatment programme (supervision to ensure treatment manuals are followed correctly).

Finally, the fact that exposure to trauma, such as CSA, might have specific biological concomitants provides an important rationale for psychopharmacological intervention. While little is known about the use of medication for reducing symptoms of PTSD in conjunction with therapy, the place of pharmacology would also need to be considered in any future study.

♦♦♦♦♦♦♦♦♦♦
ACC (1998) Accident Rehabilitation and Compensation Insurance Corporation


Borland International (1992) *Paradox Relational Database (release 4.0)* USA.


*Archives of General Psychiatry*, 33:1111-1115


*Archives of General Psychiatry*, 51:599-606


**APPENDICES**

### Appendices

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initial Referral Form and Sexual Abuse History</td>
</tr>
<tr>
<td>2</td>
<td>Survey Information Pamphlet</td>
</tr>
<tr>
<td>3</td>
<td>Study Consent Form</td>
</tr>
<tr>
<td>4</td>
<td>Self-report Questionnaires</td>
</tr>
<tr>
<td>5</td>
<td>Three months follow-up general questions</td>
</tr>
<tr>
<td>6</td>
<td>Six months follow-up general questions</td>
</tr>
<tr>
<td>7</td>
<td>Counsellor Report Form</td>
</tr>
<tr>
<td>8</td>
<td>DSM-IV Diagnostic Criteria for PTSD</td>
</tr>
</tbody>
</table>
Appendix 8  DSM-IV DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person’s response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganised or agitated behaviour

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognisable content

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on
awakening or when intoxicated). Note: In young children, trauma-specific enactment may occur

(4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

(5) physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant areas

(5) feeling detachment or estrangement from others

(6) restricted range of affect (e.g. unable to have loving feelings)

(7) sense of foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

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