

THE LONG TERM EFFECTS OF INCEST: CLINICIANS' PERCEPTIONS

by

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## ABSTRACT

Clinical intervention for incest's immediate and long-term impact has traditionally been accompanied by disbelief or minimization of victims' disclosures. The present study examined clinicians' current perceptions in order to illuminate the effects which increasing public and professional awareness may have had on intervention strategies. Questionnaires were mailed to all clinical psychologists and psychiatrists in Vancouver. Questionnaires were received from 45% of those contacted.

The data were analyzed for effects of gender, profession, experience, and training in sexual abuse intervention on perceptions of incest survivors. Clinicians' perceptions of incest case incidence, relationship of incest participants, duration, types of coercion, frequency of effects associated with incest among their cases, assessment, diagnostic and intervention practices were elicited.

Gender accounted for the most differences on cross tabulations. Relative to male clinicians, female clinicians more frequently estimated a high incidence of incest cases in their practices; reported seeing more victims during the past year; reported an earlier onset of incest; and endorsed more long-term effects. Relative to male clinicians, female clinicians were more likely to endorse the importance of long-term psychotherapy, skills training and incest group therapy and were less likely to endorse the importance of family therapy.

Interactions among gender, profession, training and experience were found on estimates of incidence.

Affective disorder was most frequently diagnosed. Fewer psychiatrists than psychologists diagnosed borderline personality disorder.

Trained clinicians were more likely than untrained clinicians to estimate a high incest incidence; see more victims; endorse some long-term effects and the importance of long-term psychotherapy. Trained clinicians were more willing to ask about incest when clients presented non-sexual problems.

Training, or working with many incest victims, both more frequently reported by female clinicians, appears to sensitize clinicians to a possible incest history and a range of long-term effects among their clients.

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- to Candice, Rose and Kim, who persist in keeping me on track.
- to the women and men who risk breaking the conspiracy of

silence, who teach us all about the impact of incest.

## DEDICATION

To Vera, for her strength



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# CHAPTER I

## REVIEW OF THE LITERATURE

### Introduction

Incest has been a controversial topic for many years. Since Freud postulated and then recanted the childhood trauma theory of adult neurosis, the prevalence, reality, potential harm, and treatment of incest victims have been at issue. In 1896 Freud proposed his childhood seduction theory of adult neurosis on the basis of his female patients' accounts of childhood sexual abuse. In The Aetiology of Hysteria (1896/1959) Freud concluded,

I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experiences, occurrences which belong to the earliest years of childhood (p. 203).

As a result of his self-analysis, a year later Freud abandoned the theory. He commented,

Almost all of my women patients told me that they had been seduced by their fathers. I was driven to recognize in the end that these reports were untrue and so came to understand that the hysterical symptoms are derived from phantasies and not from real occurrences (1933/1966, p. 584).

Freud's retraction of the trauma theory had a profound impact on clinicians' beliefs regarding disclosures of sexual abuse. Cultural and social factors during Freud's time no doubt played a role in clinicians' enthusiastic relegation of sexual victimization to the realm of their patients' fantasies and oedipal wishes. Rush (1980) provides a vivid account of the sexually repressive society in which Freud lived. Sexual slavery

and child prostitution were forbidden yet quietly thrived. Given the existing social context, the "Freudian coverup" was enthusiastically embraced. Ferenczi (1949), one of Freud's associates, was an exception. He believed that his patients' accounts of incest were true, and that incest had traumatic consequences.

The degree to which Freud is held solely responsible for the resulting resistance of therapists to accepting the reality of childhood incest varies. Masson (1984) contends that Freud recanted his seduction theory to protect a friend and that this constituted a major turning point in the treatment of sexual abuse victims. Peters (1976) agrees that Freud and his followers "oversubscribed to the theory of childhood fantasy and overlooked incidents of the actual sexual victimization in childhood" (p. 401). Peters does not contend, however, that allegiance to Freud was the primary motive for attributions of fantasy to disclosures. Rather, it is his belief that such an attitude relieved the guilt of adults (i.e., clinicians). Miller (1984) offers several additional reasons for analysts' rigorous efforts to recast childrens' disclosures of abuse as oedipal wishes and fantasies rather than acknowledging the reality of their victimization. These reasons include: unresolved idealizations of the analysts' own parents; a fear of confronting their own childhood trauma; and a faithful adherence to Freudian dogma.

It is perhaps to Freud's credit that he did not abandon the seduction theory entirely when he advanced his notions of childhood sexuality and incestuous oedipal strivings. In his autobiographical study (1925/1959) he reiterated his belief that incest plays a role in the etiology of neurosis, albeit "a humbler one" (p. 34).

Clinicians have not attended to Freud's later comment to a great degree. "The legacy of Freud's inquiry into the subject of incest was a tenacious prejudice, still shared by professionals and laymen alike, that children lie about sexual abuse" (Herman, 1981, p. 11). Freud's comments pertained to adult recollections of childhood events. The notion of seduction fantasies has nevertheless provided a convenient rationale for professionals to relegate children's reports of *current* sexual abuse to the realm of fantasy and desire. A recent study by Attias and Goodwin (1985) revealed that 40% of psychiatrists in their survey believed that one quarter of children's disclosures are fantasies.

Two issues within the literature on incest have crystallized out of Freud's writings. First, debate regarding the prevalence of incest has encouraged investigations of prevalence in numerous and varied populations. Second, there is much debate in the literature (and among clinicians) as to the degree of harm (if any) that incest might have on its participants immediately and over a longer period of time.

## Problems in Researching the Effects of Incest

Attempts to delineate the prevalence and long-term effects of incest are subject to several problems. The majority of studies are based on self-selected samples that obtain retrospective, self-report data (e.g., Briere, 1984; VanBuskirk & Cole, 1983). Victims' reports may be distorted by the passage of time following termination of incest. When incest has been disclosed during childhood, the possibility that reactions to the disclosure have been traumatizing and may contribute to incest's long-term impact cannot be separated from the incest itself (e.g., Tsai, Feldman-Summers & Edgar, 1979). Some would suggest that reports of incest and its consequent impact may be fantasized, or at least exaggerated. The opposite situation is also possible. Incest victims may deny their victimization. At least one study exists that supports this possibility. In their follow-up study of the effects of incest and maternal separation, Bagley and McDonald (1984) found 3 out of 20 women who denied childhood victimization despite the fact that the incest had been verified. In a study of incest among mothers of abused children, Goodwin, McCarthy and DiVasto (1981) found 2 mothers who initially denied childhood victimization but later disclosed to their therapists.

Studies reported in the psychological literature have been based on individual case studies (Rascovsky & Rascovsky, 1951), therapy cases (Courtois & Watts, 1982; Herman, 1981), and



community and college surveys (Bagley & Ramsay, in press; Briere, 1984; Finkelhor, 1979; Russell, 1983) and national population surveys (e.g., Canadian Commission on Sexual Offenses Against Children and Youths, 1984). The majority of these studies suffer from methodological problems of selected samples, lack of control group comparisons and objective measures. The subjects of clinical studies of sexual abuse often come from disorganized homes; the effects of childhood incest and other family problems such as alcoholism are confounded (Bess & Janssen, 1982).

In addition to methodological problems, basic issues regarding the operational definition of incest (and sexual abuse in general) impede comparisons between studies. Sexual activities that have been included in research range from an isolated victimization by unwanted exposure to another person's genitals or having received an obscene phone call (e.g., Nash & West, 1985) to repeated victimizations involving intercourse (e.g., Yorukoglu & Kempf, 1966).

The relationship between participants which is considered incestuous also varies among studies. Some studies include only blood relatives, in accordance with the legal definition of incest (e.g., Bagley & McDonald, 1984). Other studies include persons involved in familial-type relationships, such as step or adoptive parents (e.g., Russell, 1983). The inclusion of such a broad range of sexual abuse experiences makes the detection and identification of harmful consequences experienced by incest

victims very difficult. Finkelhor (1979, 1984) and Briere (1984) have conducted large intensive investigations of the long-term effects of sexual abuse and have provided much of the current knowledge on this issue. These researchers do not distinguish between intrafamilial and extrafamilial sexual abuse (terms used by Russell, 1983) in assessing adult adjustment, although they do provide data on the relationships between victims and abusers. Finkelhor and Hotaling (1984) argue that to restrict research to incest is to disregard one third of the data on the occurrence of sexual abuse and that to do so is to prejudge what is considered abusive. Finkelhor (1984) did not find the distinction between abuse within or outside of the family an important one in determining the impact of abuse on children. Bagley & Ramsay (in press) support this position. In earlier work Bagley and his colleagues identified two variables which were associated with serious sexual abuse: the age difference between victim and abuser; and the use of coercion by the abuser. (Sorrenti-Little, Bagley & Robertson, 1984). Both Finkelhor and Bagley operationalize incest as sexual activity between people too closely related to marry, a definition which is quite narrow given the current increase in families where remarriage or common-law marriage exists.

The findings from studies of the long-term effects of incest and sexual abuse suggest that incest can and does have a significant impact on adult functioning, especially if the perpetrator is a father or stepfather (Browne & Finkelhor,

1986). Thus some distinctions among participants and sexual activities are warranted in conducting research on the effects of incest.

In addition to distinguishing between intrafamilial and extrafamilial abuse there is evidence to suggest that the victimization of boys differs from that of girls (Nasjleti, 1980; Pierce & Pierce, 1985). The long-term impact of sexual abuse may also differ for men and women, especially in terms of sexual adjustment (Finkelhor, 1984). For this reason most studies are confined to an examination of women's experiences as they are most often the victims of abuse. The majority of the studies which will be reviewed in the present study suffer from the operational and sampling problems described. Nevertheless findings on the prevalence and long-term impact of incest and sexual abuse do converge and provide an outline, albeit a sketchy one, of the pervasive occurrence and potential negative consequences of sexual and incestuous abuse.

### The Prevalence of Incest and Sexual Abuse

Studies of child sexual abuse suggest that a substantial proportion involves incestuous assault by family members such as biological, step, or adoptive relatives, or by partners of family members (e.g., mothers' boyfriends). DeFrancis (1969) estimated that between 50,000 and 100,000 cases of child sexual abuse occur in the United States each year. This number is twice

as high as estimates of battered children (DeFrancis, 1972). In his study of cases referred to courts, DeFrancis (1969) found that 38% of the abusers were related to the child. Burgess, Holstrom and McCausland (1980) reported that half of the abusers in cases reported to a hospital were fathers or father surrogates.

While the proportion of fathers who incestuously abuse their children varies depending on the population studied, it is generally agreed that incest is more prevalent than was once thought. Early studies of incest asserted that incest was a relatively rare phenomenon. Weinberg (1955) concluded that incest (defined as intercourse between blood relatives) occurred at the rate of one case per million in English speaking countries. Ferracuti (1972, cited in Russell, 1983) estimated that there are between 1 and 5 cases per million persons every year throughout the world. The strict definition of these studies prevents the inclusion of other forms of sexual activity within nuclear families that other researchers consider to be abusive and exploitive (e.g., Butler, 1978).

Recently, large general population surveys have also found high rates of sexual abuse and incest. The Commission on Sexual Offenses Against Children and Youths (1984) concluded that one in four girls in Canada will be sexually assaulted before the age of 18. This conclusion was based on information garnered from four national surveys undertaken by the Commission. Differences between surveys highlight the fact that estimates of

incest vary according to which group is surveyed. The results of the National Population Survey and the National Police Survey indicated that between one fifth and one quarter of sexual assaults on children were committed by family members. The findings of the National Hospital Survey and the National Child Protection Survey indicated that almost half of the assaults seen in hospitals are committed by family members and almost 90% of cases reported to child protection agencies involve family members.

In contrast, the National Study of the Incidence and Severity of Child Abuse and Neglect (1981) estimated that 7% of cases known to professionals in the United States involve sexual abuse. Since few cases of sexual abuse are reported in general this criterion may result in underestimates (Finkelhor & Hotaling, 1984). Furthermore, the Canadian Commission's data indicates that incestuous abuse is not uniformly reported among organizations. Thus the American National Study's figure is uninformative.

Russell (1983) conducted a study of 930 women in San Francisco using a probability sampling procedure. Thirty one percent reported at least one experience of extrafamilial sexual abuse prior to the age of 18. Twenty percent reported at least one incident prior to the age of 14. Intrafamilial sexual abuse was reported less often but the prevalence was much higher than Weinberg's (1955) estimate. Sixteen per cent of Russell's subjects experienced intrafamilial abuse prior to the age of 18.

For 12% the experience occurred before the age of 14. Of the 152 women reporting intrafamilial abuse, 42 (27.6%) had been sexually abused by fathers (biological, step, foster or adoptive). This represents 4.5% of the total random sample of women. Uncles were reported with a slightly higher frequency (4.9% of the sample).

Russell (1983) noted that only 2% of intrafamilial and 6% of extrafamilial abuse were reported to the police. This figure provides some support for Finkelhor and Hotaling's (1984) caution that an incidence study based on cases known to professionals is highly likely to underrepresent the occurrence of sexual abuse. Similarly, Gagnon (1965) found that only 6% of 400 offenses had been reported to police; 21% disclosed the incident for the first time to the interviewer. It is quite likely that studies will not elucidate the extent of incest accurately, by virtue of the social taboo surrounding incest and attitudes toward disclosures of abuse. As Louise Armstrong (1978) has suggested, incest is not taboo but talking about it is. Many occurrences of incest are probably not reported to anyone, including interviewers.

As noted earlier the inconsistency of definitions found among studies further complicates attempts to document sexual abuse and incest. To obtain an accurate estimate of the prevalence of incest and sexual abuse definitions of the activities which constitute abuse must be clearly stated. This is especially important in order to distinguish abusive

activities within the family from consensual sexual exploration (e.g., between siblings of similar age) that is not considered harmful by the participants and would likely not be reported. Butler (1978) employs the term "incestuous assault" to refer to any physical sexual contact or other explicit sexual behaviour that an adult family member imposes on a child, who is unable to alter or understand the adult's behaviour because of his or her powerlessness in the family and early stage of psychological development.

A Canadian community survey conducted by Bagley and Ramsay (in press) employed an operational definition similar to that suggested by Butler, but which also includes abuse by family members who are not necessarily adults themselves. This definition is in keeping with a recent direction in the professional literature that suggests that harmless sibling incest is also a myth (Cole, 1982). The criteria used by Bagley and Ramsay included "*at least* a manual assault on the child's genital area by someone at least three years older than the victim, or by someone (regardless of age) using direct force or threat" (p. 8). Twenty one percent of the women interviewed by Bagley and Ramsay reported experiencing sexual abuse of this nature prior to the age of 16.

The prevalence of child sexual abuse in Great Britain was investigated using a nationally representative sample (Baker & Duncan, 1985). Twelve per cent of women and 8% of men reported at least one sexual abuse experience before age 16. Subjects who

were 15 years or older at the time were interviewed, in their homes. This arrangement may have prevented some victims from reporting ongoing abuse and may account for the slightly lower rate than some other studies have reported. Utilizing data collected by Kinsey, Pomeroy, Martin and Gebhard (1953), Gagnon (1965) found that 28% of 1200 women reported a sexual experience with an adult before the age of 13.

The prevalence of childhood sexual abuse has also been studied among college and university populations. The majority of these studies have not distinguished incestuous from non-incestuous experiences but it is likely that a large proportion of the victims included in these studies are incest victims.

Finkelhor (1979) reported that 26% of his college undergraduate sample had experienced at least one sexual contact with a relative. This figure includes contacts with siblings. Since no distinction was made regarding the age of participants non-abusive experiences may have been included. Where siblings differ in age by several years, a power imbalance (physical or psychological) would exist which could render the experience abusive and exploitive as Butler (1978) suggested. Sixteen per cent of Finkelhor's subjects reported at least one childhood experience involving an adult, but the frequency of experiences involving adults within the family is unknown. It is interesting to note that Finkelhor's definition of sexual contact included an invitation to do something sexual. This criterion is not



commonly found in studies, except those which have used Finkelhor's criteria. Together with the lack of age criterion, this broad definition may account for the substantial reporting rate he obtained.

Using Finkelhor's criteria with an age difference criterion, Briere (1984) reported that 15% of female university undergraduates had experienced sexual contact at or before the age of 14 with a person at least five years older than themselves. In their study of college women, Sedney and Brooks (1984) found that 16% of the women reported a childhood sexual experience; 13% reported an experience involving a family member. Family members most often cited were brothers, cousins, uncles, sisters and grandfathers. Only one case of father-daughter incest was reported. Fromuth (1986) also studied the prevalence of childhood sexual abuse among female college students. Twenty two per cent reported at least one sexually abusive relationship during childhood.

The prevalence of incest and sexual abuse has also been studied in clinical populations. Here too the reported rates vary but the range is similar to that found in nonclinical samples.

In a sample of children referred by courts, clinics and psychiatric hospitals, Lukianowicz (1972) found that father-daughter incest was reported by 4% and other forms of incest were reported by 4% of the sample. Among adolescent girls

in a psychiatric hospital, Husain and Chapel (1983) found that 13.9% had been incestuously abused. This low figure probably reflects their narrow definition of incest which included only overt sexual intercourse between people not permitted to marry. Emslie and Rosenfeld (1983) found a history of incest in 37.5% of nonpsychotic girls, 10% of psychotic girls and 8% of all boys in a psychiatric hospital.

The prevalence of sexual abuse is even higher. Landis (1940, cited in Gelinas, 1983) reported a rate of 33% among psychiatric patients. In a recent study of adolescents in a psychiatric hospital, Sansonnet-Haydon, Haley, Marriage and Fine (1985) found that 60% of adolescents with a psychotic major depression had a history of sexual abuse. Seventeen per cent with nonpsychotic depression and 24% with other diagnoses also reported prior sexual abuse. Prior sexual abuse was the only significant factor discriminating between groups. There were no differences between the groups on factors such as age, sex, or number of previous hospitalizations. Sansonnet-Haydon et al. concluded that psychosocial factors such as sexual abuse experiences may predispose adolescents to psychotic illnesses. Their view stands in contrast to current research that focusses on the biological antecedents of adolescent psychotic illness.

Studies of incest in adult clinical populations have also been conducted. Bess and Janssen (1982) found that 30% of adult 'walk-in' patients in a hospital psychiatric clinic reported a history of incest. Among psychotherapy clients, Rosenfeld (1978)

found that 6 of 18 new psychotherapy patients in a one year period had a history of incest.

Incest and sexual abuse experiences are commonly reported among specific troubled populations. In a study of prostitutes, James and Meyerding (1977) reported that 36.6% of 136 women had a history of prior incest. Almost two thirds (61%) of 200 female street prostitutes in San Francisco had been victims of childhood incest or sexual abuse (Silbert, 1982). Two thirds of these victimized women were assaulted by natural, foster or stepfathers. Almost half (44%) of the women in a residential drug treatment program had experienced childhood incest (Benward & Densen-Gerber, 1975). For one quarter of the women, incestuous assault had involved sexual intercourse.

Sexual abuse has been reported in conjunction with adolescent running away. Sixty three per cent of incestuously abused adolescents in a treatment program had run away (Lindberg & Distad, 1985b). In another study of sexually abused adolescents, Fischer (1983) found that 81% had a history of running away.

The overlap in prevalence which exists between clinical and non-clinical populations may reflect the fact that incest victims may frequently utilize clinical services but may also be able to function fairly well in day to day life. When studies have explored the issue of psychological or psychiatric treatment histories among non-clinical populations, subjects

reporting a history of sexual abuse are more likely than non-abused subjects to report visiting health centres (Pennebaker, 1985); consulting a physician or having been hospitalized for depression (Sedney & Brooks, 1984). In a study of clients at a crisis centre, Briere (1984) found that women with a history of sexual abuse were more likely to be taking psychoactive medication than were non-abused clinic clients. Thus the long-term effects of incest may be such that adult functioning is affected but is not sufficiently impaired to prevent pursuing activities such as post-secondary education.

Higher rates of sexual abuse and incest among some groups, for example among prostitutes, may reflect one form of chronic disordered social functioning to which some victims will be prone. The larger social context, however, must not be overlooked. The relationship between childhood incest and prostitution may have at least social (i.e., economic) and psychological (e.g., low self-worth) components. Adolescents who run away from home have few financial options available to them. Prostitution may become one of their economic choices.

It is simplistic to assume that the impact of childhood incest will be unidimensional or linearly related to adult functioning. Future research should investigate in greater detail the variables of abuse and the family context within which abuse occurs to elucidate the relationship between childhood abuse and adult social maladjustment. Clearly prospective studies of sexually abused children and adolescents

would provide useful data in this regard.

In summary, large studies of students and community samples indicate that approximately one quarter of women have been sexually abused before the age of 18. Approximately half of the assaults were committed by family members or trusted family friends (Bagley & Ramsay, in press). The prevalence of sexual abuse and incest tends to be higher in clinical samples and among particular dysfunctional groups such as prostitutes.

### The Issue of Harm

When cases of incest are reported in the literature there has been a tendency, especially in psychiatric reports, to assert that victims are not harmed by their experiences. For example, Bender & Blau (1937) concluded that the children in their study suffered no ill effects from their sexual experiences. Since the children were observed to be "unusually charming and attractive in their outward personalities", Bender and Blau speculated that the children were not innocently seduced but were the active seducers (p. 514). The authors noted that

these children undoubtedly do not deserve completely the cloak of innocence with which they have been endowed by moralists, social reformers and legislators (p. 514).

Yates (1982) counters such logic with the comment that

all children undergo eroticization; we can never consider children truly innocent if we equate innocence with erotic unresponsiveness (p. 484).

Thus the issue of harm has been interwoven with the issue of blame. The argument that abuse must not be harmful since victims

do not avail themselves of opportunities to stop it ignores the reality of children's powerlessness in relation to adults, especially when the adults are their relatives. Neither is failure to stop incest synonymous with initiating incest although the conclusion that incest must be harmless is common to both positions. The child who is blamed for incest's occurrence is assigned a great deal of power and responsibility which is probably developmentally inappropriate. At the same time power and responsibility is abrogated from the adult.

If the child initiates the sexual relationship, so the argument goes, then it must not be harmful. Yates (1982) believes that the eroticization process of children exposed to incest is independent of the harmfulness of the experience. Speculation on seductive, active participation in incestuous activity because opportunities to report or terminate the incest are not utilized by children (e.g, Bender and Blau, 1937; Justice & Justice, 1979) is too simplistic. In addition to a power imbalance between children and adults which prevents children from terminating incest, and the responsibility of adults to control incestuous impulses, this attitude overlooks other dynamics of the the incest relationship which prevent children from trying to stop it. It is a myth to assume that all incest occurs by force and is characterized by terror. Incest may be the only source of affection offered by the adult to the child (DeYoung, 1982c). Children may split the love and affection they receive from the physical sexual contact that

accompanies it (Stein, 1973). Thus seductiveness may be a learned response to acquire non-sexual affection (Simari & Baskin, 1980). Participation may also provide protection from punishment or cruelty directed at other members of the family (Herman, 1981). Regardless of the 'rewards' which may cause a child to initiate or maintain an incest relationship the responsibility for avoiding incest belongs to the adult who is capable of informed decision-making (Butler, 1978; Yates, 1982).

Reports of incest that purport to demonstrate a lack of harmful consequences for victims often involve siblings (see for example, Constantine, 1980 cited in Herman, 1981) or incest that occurs in late adolescence (e.g., Koch, 1980). Rascovsky and Rascovsky (1950) reported a case of consummated incest between a 21 year old woman and her father. The authors concluded that consummation prevented the likelihood of psychotic illness in the woman, and enhanced her adjustment. Another study which is frequently cited in support of the inconsequential impact of incest was based on only two cases, one of mother-son incest and one of father-daughter incest (Yorukoglu & Kempf, 1966). Recent reports indicate that incest usually begins around the age of nine (Finkelhor, 1979; Herman, 1981). Therefore, reports involving older adolescents may not be representative of the trauma experienced by children. In support of this possibility Koch (1980) suggests that less trauma occurs if the child's ego is sufficiently developed.

Speculation regarding the degree to which victims actively seduce their abusers as suggested by Bender and Blau (1937) is a recurrent theme in research. (Nabakov's *Lolita* is often cited as an example of this theme in popular literature.) Such an attribution may be couched within psychodynamic formulations. For example, Gross, Doerr, Caldirola, Guzinski and Ripley (1980) account for the occurrence of incest as a result of early levels of fixations in the child's psychosexual development.

These patients have tried to overcome their emotional deprivations in childhood and need for closeness and to solve their problems about dependency relatedness and trust by getting involved in incestuous relationships and, in adolescence, entering into other premature and impulsive plunges into genital activity. These activities proved disappointing, traumatic and destructive (p. 93).

The authors fail to consider the possibility that dependency relatedness and trust problems may be the result of, rather than the precursor of, incestuous relationships. Bagley and Ramsay (in press) support the notion that lack of parental warmth and support may make the child vulnerable to incestuous experiences but their view does not suggest that the child actively seeks sexually abusive relationships as does Gross et al.'s view.

An active role has been attributed to incest victims by others (Maisch, 1972; Weinberg, 1955). Henderson (1975) states that "in father-daughter incest, the father is aided and abetted in his liaison by conscious or unconscious seduction by his daughter....The daughters collude in the incest relationship and play active and even initiating roles in establishing the pattern" (p. 1533). Lukianowicz (1972) also concluded that "the



children were far from being innocent victims; on the contrary, they were willing partners and often provocative seductresses" (p. 309). Finally, some have attempted to blame the reactions of society or parents, rather than the experience of incest, for the trauma that victims can suffer (Kinsey et al., 1953; Gundlach, 1977). According to Maisch (1977)

it is a well-tried and proven discovery of psychological and psychiatric research that the harmful effects finally brought about by the official discovery of the offense and the punishment of it are more serious than those that might arise during the course of the incest (p. 208).

While other research indicates that negative parental response can contribute to the trauma (Browne & Finkelhor, 1986; Sorrenti-Little et al., 1984; Tsai et al., 1979) it is not considered more traumatizing than the incest itself.

As recently as 1983 Henderson maintained that research regarding the psychological harmfulness of incest remains inconclusive. Perhaps of more concern is the recent increase in literature which posits that incest can be a neutral, or even a positive experience for the child. Referred to as the "pro-incest lobby" (p. 11), DeMott (1980) critically reviewed the academic literature which adopts such a conclusion. Herman (1981) discusses the pro-incest literature found in pornographic publications. Some groups in the United States lobby for the abolition of age of consent laws contending that such laws deprive children of their right to experience positive sexual activities with adults. Despite the position of this small group of researchers an increasing body of literature converges on the

conclusion that a history of incest is associated with a wide range of negative cosequences (e.g., Herman, 1981; Tsai et al., 1979). Damaging effects may be seen immediately following the assault or may emerge many years later (Peters, 1976).

### The Long-Term Effects of Childhood Sexual Abuse and Incest

Studies which have investigated the impact of sexual abuse and incest have often been based on clinical observation and may be quite subjective. The immediate impact of incest in particular has been documented in this way. Browne and Finkelhor (1986) distinguished between initial effects that may occur within two years of the termination of the abuse and long-term effects. Although they considered the existing research to have methodolgical flaws (lack of standardized outcome measures and comparisn groups) Browne and Finkelhor concluded that at least some victims experience initial effects of fear, anxiety, depression, anger and hostility.

Peters (1976) suggested that children may be unable to express their emotional reaction to sexual abuse and may "retreat into emotional withdrawal" (p. 417). Such withdrawal may be manifested as outward adjustment to adult authority and hospital routine, as noted by Bender and Blau (1937). Finally, in the case of Bender and Blau's report, response to hospital life may not be an appropriate measure of trauma (or lack of it). For the non-abused child separated from supportive parents

and a safe home, shyness and anxiety in a hospital are likely. For the sexually abused child, the hospital and its personnel might, quite reasonably, be considered a safer and more supportive environment than the child's home. Anxiety might be less expected from these children and its absence should not be interpreted as evidence that the incest was harmless.

The long-term effects of incest may not be manifested as a linear progression from childhood manifestations of trauma to adult symptoms of dysfunction or maladjustment. Some children show no apparent negative effects at the time of initial assessment, but may manifest a delayed response days or years later (Lindberg & Distad, 1985a). Others will demonstrate longstanding difficulties which persist into adulthood. The conclusion that incest is not traumatizing, based on the observation of child victims, does not consider the developmental tasks of acquiring self-esteem and identity, or of forming trusting and intimate relationships. Therefore follow-up studies, especially longitudinal studies, are important. Bender and Grugett (1952) reported such a study. However, since their subjects had received psychiatric treatment and were hospitalized or institutionalized for variable periods of time, the generalizability of their conclusions are questionable.

The recent increase in research of the long-term impact of incest appears to reflect the heightened awareness among the public and clinicians of incest's prevalence. Although studies of incest and sexual abuse are appearing with greater frequency,

the majority suffer from methodological problems involving selected samples, and a lack of control group comparisons and objective measures. Nevertheless, agreement among these empirical studies is consistent with the notion that sexual abuse and incest can result in multifaceted, long term harm.

A review of the extant literature in greater detail will allow comparisons which may account for variations in outcome.

In the following literature review, long-term effects that are consistently reported will be grouped as "Frequently Reported Effects". Effects that are less consistently reported will be grouped as "Commonly Reported Effects". Finally, effects that have been equivocally supported by empirical research will be grouped as "Infrequently Reported Effects". The division between groups is not conclusive or discrete, rather it is utilized for organizational purposes.<sup>1</sup>

### *1. Frequently Reported Effects*

This group is extensive. Effects which will be examined include chronic depression, low self-esteem, suicide attempts (or self-destructive behaviour), difficulties with relationships, sexual dysfunction, a tendency to be revictimized, somatic complaints, isolation and stigma, and substance abuse.

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<sup>1</sup>The three groups correspond to three symptom groups which were analyzed in the present study (see Appendix G).

## *1.1 Depression*

The most common symptom reported in studies of sexual abuse and incest is depression. A prospective study by Bagley and McDonald (1984) examined the impact of incest, physical abuse, and maternal separation on later adult functioning. A prospective study of women who had been physically abused or incestuously assaulted during childhood was conducted. Only those girls who had been removed from their homes between 1965 and 1970 were included in the study. A random selection of cases from a social service department was conducted. The authors were able to locate and interview 20 of 32 incest survivors and 37 of 59 women who had been physically abused as children. The participants ranged in age from 18 to 24 years at the time of the follow-up interviews. A comparison group of 30 nursing students who had not been removed from their homes during childhood was also interviewed.

The authors defined incest to include only those cases of sexual activity occurring between biological relatives for a duration of three months or more. Furthermore, the victims were less than 14 years old while the perpetrator was more than 18 at the time of the incest. The incest was verified at the time of the child's removal from the home, by both the child and another adult "familiar with the household". This is an important criterion since the chance of fabricating the abuse is reduced. Retrospective studies often include self-identified incest or sexual abuse victims, without obtaining objective verification

of the abuse. Some critics doubt the legitimacy of associating current maladjustment with past trauma because of the retrospective and subjective nature of these reports. It is usually assumed that without verification of the abuse fabrication or exaggeration of incest will occur in some reports. It is seldom considered a possibility that incest will be denied. Thus it is important to note that in this study 3 of the 20 women who were known to have been incestuously abused as children denied that any abuse had occurred when asked by the interviewer. Retrospective data may be inaccurate either because incest that has not occurred will be reported, or because incest that has occurred will fail to be reported.

The Middlesex Hospital Questionnaire, a short version of the Coopersmith Self-Esteem Inventory, and a measure of psychosexual adjustment were administered. Through interviews the authors found that none of the women had ever been offered any help regarding the incest despite the awareness of the social service department that it had occurred.

The results indicated that the incest group as a whole had poorer outcomes on measures of depression, self-esteem and sexual adjustment than did the physically abused or neglected group and the control group. In a stepwise multiple regression analysis, sexual abuse was the only significant predictor of poor outcome on these measures.

Depression in clinical populations has also been frequently reported. All of the 27 adolescents (aged 12 to 18) in a treatment program for apprehended incest victims experienced anxiety, depression and feelings of helplessness (Lindberg & Distad, 1985b). Depression was also commonly observed among adolescents by Molnar and Cameron (1975) in a hospital setting and by Fischer (1983).

Herman (1981) found that 60% of the therapy clients with a history of incest she interviewed had experienced depression. Fifty five per cent of the comparison group also reported depression. This finding is not surprising given that Herman's comparison group consisted of 20 women who were victims of "covert incest", defined as

seductiveness on the part of fathers...behaviour that was clearly sexually motivated, but which did not involve physical contact or a requirement for secrecy (p. 107).

Behaviours included in this definition involved exhibition, voyeurism and sexual stimulation of the daughter by discussing the father's or daughter's sexual activity in detail, or leaving pornography conspicuously for daughters to find. Herman's definition of overt incest included only physical contact between an adult in a position of paternal authority and a child that had to be kept secret (p. 70). Some researchers would consider the two groups to be similar. Although Herman was interested in the differential impact, if any, between overt and covert incest, she considers overt incest to be one extreme on a continuum of a family pattern involving paternal authority

within the family.

Meiselman (1978) found depressive symptoms among incestuously assaulted (35%) and non-assaulted (23%) therapy patients. Depression was reported by all 17 women who entered therapy and who had been incestuously assaulted (Lindberg & Distad, 1985a). Thirteen of the women (77%) in their study had been victimized by fathers (biological, adoptive or stepfathers). Depression was common in Westermeyer's (1978) sample of 32 therapy patients.

Depression has been reported by women with a history of sexual abuse in a community mental health study conducted by Bagley and Ramsay (in press). Significant differences in depression between sexually abused and non-abused groups were found on the total score of the Middlesex Hospital Questionnaire and on the depression and anxiety subscales. Similarly, all subjects with current depression, as measured by the Centre for Environmental Studies Depression Scale (CES-D) had a history of sexual abuse.

Among college women, more sexually abused women than non-abused women reported depression (Sedney & Brooks, 1984). Depression and anxiety were also more severe among the sexually abused women compared to the non-abused women, as indicated by frequency of physician consultations and hospitalizations for depression. When those women with a history of non-familial sexual experiences were excluded from the analyses, comparisons



of depression between incest victims and non-abused women were not significant. The definition of abuse used by Sedney and Brooks may have influenced this finding. It is possible that women reporting familial sexual experiences were reporting sexual activity with siblings since the most frequent family member was reported to be a brother, cousin or uncle. Familial experience alone would not constitute serious sexual abuse. It is unclear to what extent these experiences were included in their study.

Fromuth (1986) used the Beck Depression Inventory (BDI) short form to assess depression among college women with and without a history of sexual abuse. Her definition was similar to Finkelhor's (1979) definition, including sexual invitations, exhibitionism and various physical sexual contacts. An age criterion was used to exclude sexual exploration between siblings and peers. No differences in depression scores on the BDI were found. Differences between Fromuth's findings and those of other researchers may be due to the recruiting procedure she employed. During a recruitment speech in classes, students were informed that the study would explore the effects of childhood sexual experiences on current psychological and sexual adjustment. Women who had never disclosed their abuse, or who felt poorly adjusted may have avoided participating in the study.

Utilizing the Hopkins Symptom Checklist (SCL-90), Briere and Runtz (1983) found that college women with a history of sexual

abuse were more likely to report depression than were non-abused college women. Their definition, like Fromuth's, was adapted from Finkelhor (1979).

### *1.2 Suicide Attempts and Self Destructive Behaviours*

Suicide attempts and self-mutilation are also frequent. Suicidal ideation, suicide attempts and self-mutilation are regularly reported among adolescents (Fischer, 1983; Lindberg & Distad, 1985b; Molnar & Cameron, 1975; Sansonnet-Hayden et al., 1985).

Gelinas (personal communication, 1985) noted that the best single indicator of prior incest victimization in a general adult psychiatric population is adolescent suicide attempts or gestures. Self-injurious behaviour (e.g., slashing, bruising, burning, self-poisoning) has also been reported (DeYoung, 1982b). It is likely that such activity serves several purposes. It may be a reaction to feelings of low self-esteem, or a form of escape - either through death or through drawing attention to one's situation in the hope of being removed from it. Among adolescents still in an abusive situation, self-mutilation may be a strategy to avoid further victimization (DeYoung, 1982c; Halliday, 1978). When the abuse has ended, the continuation of such behaviour may be characterized as a survival strategy which is no longer adaptive (Lindberg & Distad, 1985b).

Briere, Runtz and Lightfoot (1985) studied 191 female clients at a community mental health centre in Winnipeg,

Manitoba. One hundred and twenty nine of the clients were sexual abuse victims, which the authors suggest is likely due to the centre's community profile as a service for sexual abuse victims. The comparison group of non-abused clients included 62 women. Of 14 women who first attempted suicide before the age of 13, 92.9%, or 13, of them were sexual abuse victims. Similarly, of 39 who attempted suicide during adolescence, 87.2%, or 34, of them were sexually abused. The authors found no significant differences between abused and non-abused women in terms of suicide attempts in adulthood. This pattern of adolescent suicide attempts differentiating abused and non-abused women supports Gelinas' finding.

Bagley & McDonald (1984) reported that 25% of the women in their study who had been incestuously abused had attempted suicide compared to 5% of the women who had been physically abused.

A higher rate of pre-admission suicidal behaviour has been found in a sample of adult psychiatric inpatients who had been abused (physically, sexually, or both) than among those who had not been abused (Carmen, Rieker & Mills, 1984). Among the female patients, 24% of abused women compared to 9% of non-abused women were actively self-destructive while hospitalized.

### *1.3 Low Self-Esteem*

As Browne and Finkelhor (1986) noted, low self-esteem is not always evident among children who have been sexually abused. For example, Mannarino and Cohen (1986) found little evidence that children "felt inferior" (only 4% of 45 children reported this). At the time of clinical evaluation, however, half of the children in the study were not yet 5 years old. Young children may not have developed a sufficient sense of self to determine whether they have a positive or negative self-image. Conversely, low self-esteem is reported among the majority of incest victims in studies of adolescents (Fischer, 1983; Lindberg & Distad, 1985b).

Low self-esteem is consistently reported in studies of adult sexual and incest victims. Bagley and McDonald (1984) found that incestuously assaulted women suffered poorer self-esteem than physically abused women. The impact of incest was significant beyond the effects of maternal separation experienced by both groups of women.

Sixty per cent of the women in Herman's (1981) study who experienced overt incest had a predominantly poor self-image compared to 10% of the comparison group of women who had experienced covert incest. As one incest survivor stated, "It left me feeling bad and unworthy to live a normal life" (p. 97).

Impaired self-esteem has been noted among abused psychiatric patients (Carmen, Rieker & Mills, 1984) as well as in community

samples (Courtois, 1979). In Bagley and Ramsay's (in press) community study, women with a history of sexual abuse reported very poor self-esteem nearly four times more often than non-abused women.

#### *1.4 Feelings of Isolation and Stigma*

In addition to feelings of isolation, incest victims may actively isolate themselves (Fischer, 1983). Lindberg and Distad (1985b) found that 19 of 27 incestuously abused adolescents in a treatment program "routinely isolated themselves from others by locking themselves in their rooms, sleeping in closets or ceasing all verbal contact" (p. 523). These behaviours typically occurred in response to recollections of the trauma brought out in therapy. Active isolation may be utilized as a defense against feelings of being overwhelmed by memories of the incest experience. Feelings of isolation may serve to distance the incest survivor from others to prevent the development of relationships, which may also feel overwhelming and may lead to memories of the trauma. Feelings of isolation may also be linked to feelings of stigma and alienation from others which many victims report (Jehu & Gazan, 1983). Fearing disbelief, punishment or blame, isolation may also arise from the victim's perception that there was nobody to whom the incest secret could be revealed (Benward & Densen-Gerber, 1975). Many women in Herman's (1981) study considered themselves evil and responsible for not stopping the incest and all of them felt stigmatized by the experience. Seventy three per cent of incest victims in

Courtois' (1979) community study reported moderate to severe feelings of isolation and alienation.

Briere (1984) found that feelings of isolation were reported by 64% of sexually abused women at a community clinic compared to 49% of non-abused women.

### *1.5 Relationship Difficulties*

Incestuously assaulted women frequently have difficulties in establishing and maintaining relationships, both with women and with men (Briere, 1984; Courtois & Watts, 1982; VanBuskirk & Cole, 1983). Difficulties reported include the inability to trust, fear, hostility and a sense of betrayal (Brown & Finkelhor, 1986; Courtois, 1979). This is not surprising since incest is "*relationally-based sexual abuse*" (Gelinas, 1983, p. 319).

Two studies of incest victims suggest that they are particularly likely to have difficulty in establishing close relationships. Thirty one per cent of the incest group in Meiselman's (1978) study had never married. Sixty four per cent of the incest group reported conflict with or fear of their partners compared to 40% in the non-abused comparison group. Courtois (1979) reported that 40% of incest survivors in her study had never married and seventy nine per cent indicated moderate or severe problems relating to men. Sexually abused women in Bagley and Ramsay's community study (in press) reported prior divorce more often and rated current marriages more

adversely than did non-abused women.

### *1.6 Sexual Dysfunction*

Sexual adjustment has been studied extensively among sexual abuse and incest victims. Reports of sexual dysfunction are especially prominent among incest victims (Browne & Finkelhor, 1986). The nature and extent of these are reviewed by Jehu and Gazan (1983). Clinical studies reveal significant sexual maladjustment among incest victims compared to non-abused therapy patients (Meiselman, 1978) and compared to physically abused women (Bagley & McDonald, 1984). The majority of incest survivors in Lindberg and Distad's (1985a) study reported sexual dysfunction as did the women in VanBuskirk and Cole's (1983) study.

In a study of patients at a hospital walk-in psychiatric unit, adult sexual impairments were reported by seventy per cent of those with a history of incest compared to 18% of those without such a history (Bess & Janssen, 1982). Similarly, Courtois (1979) found that sexual impairment was reported by 80% of incest survivors in her community study. Sexual impairment and decreased sex drive were noted by Briere (1984) more frequently among sexually abused women than among non-abused women. Tsai et al. (1979) found sexual impairment and dissatisfaction more frequently among sexually abused women who perceived themselves to be poorly adjusted and seeking psychotherapy compared to sexual abuse victims who perceived

themselves to be well adjusted and a non-abused control group.

In a study of college students, Finkelhor (1984) found lower sexual self-esteem among those with a history of sexual abuse than among those without such a history. Utilizing Finkelhor's sexual self-esteem scale, Fromuth (1986) found no differences between groups of abused and non-abused women. Participants in her study were cognizant of the study's purpose - to investigate the effect of childhood sexual experiences on current sexual and psychological adjustment. Participants' responses may have been influenced by this knowledge. A possible indication of response bias is the fact that Fromuth found differences in frequencies of various adult sexual activities, but no difference on the subjective measure of sexual self-esteem.

### *1.7 Repeated Victimization*

Sexually abused and incestuously assaulted women are prone to repeated victimization in adulthood (Wooley & Vigilanti, 1984; Fromuth, 1986). Although not studied empirically, repeated victimization may occur in foster homes and institutions in which the child is placed after removal from an incestuous home (Yates, 1982). Of 341 sexual assault victims seen in a hospital emergency room, 82 (24%) had previously been victims of sexual assault. For almost one fifth of the victims prior assaults had included incest (Miller, Moeller, Kaufman, DiVasto, Pathak & Christy, 1978). Among college students Fromuth (1986) found a significant relationship between a history of sexual abuse and



later being raped, or being the victim of coercive sex.

Physical assault is common also. More than half (55%) of the incest survivors in Bagley and McDonald's (1984) study reported being battered more than once by a husband, boyfriend or pimp compared to 8% of the physically abused victims. Battering was reported by eleven (27.5%) incest victims in Herman's (1981) study, while none of the comparison group reported this. Similarly the majority of incest victims in VanBuskirk and Cole's (1983) study was unassertive and "co-operative, eager to please and acquiescent" in relationships (p. 508). Almost half (49.9%) of the sexually abused women in Briere's study of clinic clients had been battered compared to less than one fifth (19%) of non-abused clients.

### *1.8 Somatic Complaints*

Somatic complaints have been observed frequently among sexually abused and incestuously abused women. Such reports have been observed among adolescent incest victims in treatment programs (Kaufman, Peck & Tagiuri, 1954) and in hospital psychiatric wards (Sansonnet-Hayden et al., 1985).

There have also been reports in the literature of hysterical seizures and the occurrence of incest (see Goodwin, Simms & Bergman, 1979 for a discussion of this). Gross (1979) reviewed four cases in which adolescent girls who experienced hysterical seizures (e.g., fainting, convulsions, amnestic episodes) also had been raped by their fathers. Goodwin et al. (1979) describe

six cases of hysterical epilepsy in which incest was reported. Independent verification of the incest was also obtained, although the authors did not state how this was done. Standage (1975) suggested that at least 10% of hysterical seizures are associated with prior incest.

Physical complaints such as headaches, backaches, gastrointestinal and genitourinary problems are frequently reported (Carper, 1979; Courtois & Watts, 1982; Kaufman et al., 1954).

Among college women, Briere and Runtz (1985) found a positive relationship between sexual abuse history and reports of bodily complaints (measured by the Hopkins Symptom Checklist [SCL-90]). In a study of psychosomatic disease, Pennebaker (1985) found that subjects who had experienced a childhood sexual trauma were more likely to report "virtually every disease, symptom or negative mood" (p. 86) compared to subjects who had experienced non-sexual traumas or no traumas.

The high incidence of somatic complaints among sexual abuse victims requires further investigation for two reasons. First, somatic complaints may mask sexual abuse or incest and may be victims' means of seeking help from medical personnel (Hunter, Kilstrom & Loda, 1985). Second, somatic complaints may serve as clues to the specific nature of the incest trauma (Hyde, 1984).

The body is the repository of the incest memories and experiences both in women who remember their abuse and in women who have repressed the incest experience (Hyde, 1984, p.448).

For example she notes that chronic sore throat, earache and chest pain with a sensation of suffocation are often associated with forced fellatio in childhood.

### *1.9 Substance Abuse*

Abuse of alcohol and drugs has been reported in studies of adolescent incest victims (Fischer, 1983; Lindberg & Distad, 1985b). Herman (1981) reported that 35% of women who had been incestuously assaulted had abused drugs or alcohol compared to 5% of the women in the comparison group. In a residential treatment program, 44% of the women were incest victims (Benward & Densen-Gerber, 1975). A large proportion of prostitutes who are incest victims also reported using drugs (Silbert & Pines, 1981).

Briere (1984) found that sexual abuse victims were more likely to have a history of alcoholism or drug addiction than non-abused women utilizing a community clinic. A community study by Peters (1984, cited in Browne & Finkelhor, 1986) found that 17% of sexually abused women had symptoms of alcohol abuse (compared to 4% of non-abused women) and 27% abused at least one type of drug (compared to 12% of non-abused women).

### *1.10 Summary of Findings*

In summary, women who have been sexually abused (including incestuous abuse) frequently report feelings of depression, isolation and stigmatization, and low self-esteem. Incest

victims also exhibit self-destructive behaviour and attempt suicide, both as adolescents and as adults. Somatic complaints, difficulty in relationships, sexual dysfunction, a tendency to revictimization, and substance abuse are frequently found in studies of incest victims.

## *2. Commonly Reported Effects*

The symptoms included in this group include feelings of depersonalization or dissociative experiences, feelings of guilt or shame, anger, sleep disorders and eating disorders. None of these effects has received researchers' attention equivalent to empirical investigations of symptoms discussed in the previous section. Typically the behaviours reported are based on researchers' observations of small clinical samples, with the exception of dissociative experiences.

### *2.1 Dissociative Experiences*

Psychological distancing from the traumatizing experience is often utilized by victims and consists of feelings of derealization, depersonalization, dissociation, feeling numbness in parts of the body (which Gelinas, [1983] referred to as self-hypnotic anaesthesia experiences), or seeing the self from outside the body. Gelinas (1983) reported that victims consciously induced a dissociative defense such as "becoming part of the wall" (p. 316). These experiences may become nonvolitional and may be experienced as "confusion". As one woman in Herman's (1981) study described,

my head just died then...It's like it never happened.  
Every time I try to talk about it, my mind goes blank.  
It's like everything in my head explodes (p. 86).

Symptoms and description such as this may be attributed to "psychosis" (Bagley & Ramsay, in press) and may lead survivors to seek treatment.

Dissociation is reported in clinical samples of sexual abuse and incest victims (Briere, 1984; Lindberg & Distad, 1985a); among college women (Briere & Runtz, 1985); and in a community sample (Bagley & Ramsay, in press) of sexually abused women. While frequently reported, this symptom is not exclusive to sexual trauma. Its occurrence is frequently observed after non-sexual trauma also (e.g., among Vietnam veterans) (Norman, 1984). As a result, dissociative experiences are included as a criterion for the psychiatric diagnosis of Post-Traumatic Stress Disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 3rd Edition, 1980), a diagnosis which has been applied to incest survivors' symptoms (Hyde & Kaufman, 1985; Linberg & Distad, 1985a).

Dissociative states, amnesias, the ability to spontaneously block out pain, and a history of childhood sexual or physical abuse are frequently observed in people who receive the diagnosis of Multiple Personality Disorder (DSM III) (Bliss, 1984). Rosenbaum and Weaver (1980) reported that violent or brutal, rather than "tender" incest, was often found in the histories of those with multiple personalities. Saltman and Solomon (1982) consider multiple personality to be "one moment

along the continuum of dissociation, which is a universal mechanism" (p. 1130).

## *2.2 Eating Disorders*

Meiselman (1978) reported that incestuously abused women were more obese than non-abused women in her study. Hyde and Kaufman (1985) suggested that obesity, anorexia and uncontrollable eating disorders may indicate incest victims' struggles with sexuality. Overeating and a tendency toward obesity has been reported among adolescents (Fischer, 1983). In a study of college women, Runtz and Briere (1985) found that sexually abused women were more likely to report undereating during adolescence.

## *2.3 Feelings of Guilt and Shame*

Guilt experienced by incest victims has been described as massive (Hyde & Kaufman, 1985) or intense (Sloane & Karpinski, 1942). Tsai and Wagner (1978) consider guilt to be universal among incest victims. These feelings arise from several situations. Women report feeling guilty for having participated in the incest and for failing to stop it or prevent siblings from being abused (Lindberg & Distad, 1985a). Victims may experience guilt or shame that they enjoyed the affection or attention that accompanied the abuse (Herman, 1981). Once incest has been disclosed, victims may feel guilty for having gotten the abuser in trouble (Gelinas, 1983).

#### 2.4 Anger

Anger and hostility, like guilt, are often reported. Such feelings are directed at the abuser, as well as at the parent (often the mother) who failed to protect the child, or failed to stop the abuse once it was disclosed (Herman, 1981; Meiselman, 1978). Other family members (Courtois & Watts, 1982) or authority figures are also targets of hostility (Fischer, 1983). Briere (1984) found that sexually abused women were more likely to report problems with anger than non-abused women.

#### 2.5 Sleep Disorders

Difficulties with sleep (Lindberg & Distad, 1985a) and chronic nightmares in which the trauma is relived (Hyde & Kaufman, 1985) have been reported. Nightmares and restless sleep were reported by more sexually abused than non-abused women in Briere's (1984) study.

#### 2.6 Summary of Findings

Effects that have been reported in some studies include experiences of depersonalization and dissociation, and eating disorders. Feelings of guilt and anger, and sleep disorders are also common. These effects have not been investigated empirically.

### *3. Infrequently Reported Effects*

Several behaviours have been associated with a history of incest or sexual abuse but investigations are inconclusive as to the strength of association. These behaviours include abuse of one's own children, homosexuality and phobias.

#### *3.1 Abuse of One's Children*

Incest survivors have a tendency to repeated victimization that may be perpetrated by their spouses or partners (Herman, 1981). Abusiveness in relationships may be committed against children as well as spouses. A lack of assertiveness and a tendency to repeat their mother's pattern of marrying demanding, authoritarian husbands may contribute to incest survivors' inability to protect their children from abusive partners (Gelinas, 1983). A history of incest was disclosed by 24% of mothers of abused children compared to 3% among a control group (Goodwin et al., 1981). Their study, however, referred to "abusive mothers" as those who had contributed to the development of a family situation where child abuse occurred (p. 89). This definition does not distinguish between mothers who contributed to abuse by failing to prevent or stop it, and mothers who actively abused their children. While there may be a relationship between prior incest and abuse of survivors' children, Goodwin et al.'s finding cannot be interpreted as an indication that abused mothers abuse their children.



### 3.2 *Homosexuality*

Due to the predominance of males among the perpetrators of sexual assaults, including incest, the question of the impact of sexual abuse and incest on adult women's sexual preference has been investigated. For example Fromuth (1986) found a significant relationship between a history of sexual abuse and having a homosexual experience. Two thirds of the incest survivors in VanBuskirk and Cole's (1983) study had engaged in a sexual relationship with a woman; sexual satisfaction was rated as poor to satisfactory. Nevertheless the majority of women in the study preferred sexual and emotional relationships with men. Thus the finding of homosexual experiences must not be interpreted as an expression of sexual preference. Finkelhor (1984) found no relationship between childhood sexual abuse and current homosexuality among female college students.

One study did report a positive relationship between childhood molestation and adult lesbianism. Gundlach (1977) reported that 16 of 17 women who had been molested by a relative or close family friend became lesbians. (Of 458 women who were studied only 7.6% reported being raped or molested by an adult before the age of 16.) In comparing the respondents' descriptions of molestation, Gundlach commented that the experiences were characterized by threats or coercion. Overt threats and coercion to which Gundlach referred may represent one type of serious abuse, but other less overtly threatening situations may also constitute serious abuse. As discussed

earlier, Sorrenti-Little et al. (1984) found that serious sexual abuse (measured by low self-esteem on the Tennessee Self-Concept Scale) included abuse committed by use of force or by a person at least 3 years older than the victim, regardless of whether force or threat was used. This finding suggests that Gundlach's notion of sexual molestation is quite narrow. As an indication of this, he commented that

a number of heterosexual women have told me of their sex play...with an adult male. But the situation was always one in which the girl was not threatened or coerced (p. 378).

Had these reports of "sex play" been considered abusive, and had they been included in the study, Gundlach might not have obtained such a positive relationship between childhood abuse and adult lesbianism.

Meiselman (1978) reported that 30% of incest victims in her study were lesbians or had significant homosexual experiences. Herman (1981) found that only 5% of incest victims were lesbians and 7.5% considered themselves to be bisexual. The difference between the reported frequencies is quite large. Pending further investigation, conclusions regarding the relationship between childhood sexual abuse and adult homosexuality should remain tentative.

### *3.3 Phobias*

Phobic reactions in response to traumatic aspects of the incest experience have been described by several researchers (Courtois & Watts, 1982; Gelinas, 1983; Hyde & Kaufman, 1985).

Only one empirical study (Fromuth, 1986) that examined phobias was found. Among college women who completed the SCL-90 a significant correlation was found between the phobic anxiety scale score and a history of childhood sexual abuse. Clinical observations suggest that phobias are common among incest victims but empirical support is lacking at the present time.

### *3.4 Summary of Findings*

The findings of homosexuality, and a cycle of violence in which sexually abused girls grow up to abuse their children have not been empirically substantiated or are inconclusive at the present time. It appears that phobias are common but this finding requires replication.

### *4. Conclusions Regarding Long-Term Effects*

In conclusion a review of the literature on the long-term effects of incest and sexual abuse indicates that both types of abuse may have negative consequences for victims, both as adolescents and as adults. Studies differ as to the aspects of functioning that are assessed, assessment methods used, and the sample studied. Perhaps the most important difference between incest and sexual abuse survivors is the relatively greater difficulty experienced by the former group in interpersonal relations (Browne & Finkelhor, 1986). This finding will require further empirical investigation, however, the difference in interpersonal functioning seems theoretically logical.

## The Importance of Familial Relationship to Long-Term Effects

An argument can be made that sexual abuse by a person known to the child is more devastating than abuse by a stranger. People in positions of trust in relation to the child, such as teachers, physicians, babysitters and family friends, bear a responsibility to the child. This responsibility is one of protection from harm. When abuse occurs the trust is betrayed. A breach of the special safety and protection expected to exist in the home, among family members, will undoubtedly have some consequences, especially on the developing child.

Betrayal may have a major impact on the child's ability to develop trusting relationships in the future. A similar argument can be made for incestuous assault in which the trust between the adult (or older sibling) and the child is betrayed. It is likely that familial abuse perpetrated by a father or father-figure is especially harmful. A neutral or punitive response to disclosure by a mother is also a betrayal of trust.

There is some empirical support for this position. Among victims admitted to a rape crisis centre, child incest victims were more traumatized than adult or child rape victims (Ruch & Chandler, 1982). This finding must be considered with caution though. Trauma was operationalized by assessment of emotions, behaviours and cognitions, including the ability to make decisions about the situation. Such decisions will likely be more difficult and more complex for the incest victim. A recent

review of research on the long-term effects of sexual abuse (including incest) by Browne and Finkelhor (1986) is consistent with the hypothesis that father-figure incest is particularly harmful. According to these authors the "relative-nonrelative distinction is not necessarily a consistent predictor of trauma" (p. 73) but greater trauma is evidenced when the offender is a father or stepfather. Russell (1984) reported that more serious forms of sexual abuse were perpetrated against daughters by stepfathers than by biological fathers.

In addition to the betrayal of trust that accompanies incest, a betrayal of love occurs. The issue of love is seldom discussed in the literature, or is mentioned only briefly. Robert Stein (1973), a Jungian analyst, conceptualized the incest wound to describe the splitting of eros and sexuality.

It is not uncommon that open sexual provocation by the adult occurs and that the child then cannot repress sexuality. In these cases the spiritual feelings of warmth and tenderness are repressed (p. 134).

This split between love and genital sexuality has been discussed in reference to seductive behaviour exhibited by children who have recently or repeatedly been incestuously abused. Sexual activity and affection become confused because children have experienced sexual activity with parents which the children understand to be affection (DeYoung, 1982a). In some instances children are told by the abuser that the sexual activity is an expression of love and affection. Passive acceptance of victimization in order to obtain affection has been used to support the argument that seductive children may have solicited

the abuse (e.g., Bender & Blau, 1937; Henderson, 1975; Justice & Justice, 1980). Women who have experienced this passivity describe enduring the sexual activity in order to receive cuddling, attention, affection, or love that *only* occurred in conjunction with the abuse (Herman, 1981). They often experience guilt for not having stopped the incestuous assaults.

When abuse occurs within the family, the child often has nowhere to turn for help. The child must resort to other means of escape from the traumatic situation. Psychological escape may take the form of dissociation, repression or denial. Physical escape may be effected by suicide attempts, or running away. Thus the misuse of trust by the abuser and the confusion of love and sexuality may have profound consequences for the child's later ability to trust others and form intimate relationships.

In defending the notion that seemingly inconsequential incidents of sexual abuse may have long-term effects, Nash and West (1985) state,

Stable families with loving relationships and a healthy open attitude towards sexuality probably afford some protection but ultimately it is the individual child's assessment of any sexual contact with an adult...which determines whether or not the event will affect her adversely (p. 90).

Stable families with loving relationships are precisely what incest victims lack. Studies suggest that a negative response from parents to incest disclosures negatively impacts on the child. Browne & Finkelhor (1986) cited two studies of incest's immediate effects in which greater behavioural disturbances were

manifested by children whose parents reacted with anger or punishment. Tsai et al. (1979) found that supportive family members or friends contributed to the sense of adult adjustment achieved by adults who were molested as children.

Incest is therefore hypothesized to have specific negative consequences because the perpetrator and victim are involved in a familial relationship. This is consistent with the notion that the betrayal of love and trust has negative consequences for the child. The failure of a parent to believe, protect or support a child victim also constitutes a betrayal of trust. Thus many women express anger at their mothers who did not believe them or stop the abuse (Herman, 1981). It cannot be assumed, however, that this betrayal equals the magnitude or quality of betrayal evinced by the perpetrator of incest.

One study contradicts the hypothesis that relationship to the perpetrator is an important variable in predicting poor adjustment among adult survivors. Sorrenti-Little et al. (1984) found that the use of threats or force, an age difference of 4 to 5 years between victim and perpetrator plus physical sexual contact predicted the poorest outcomes. Sexual experiences involving these variables were considered to constitute serious sexual abuse. Relationship between participants was not reported to be a contributing factor to this equation.

The authors noted that the study was based on outcomes of self-concept among college students and might not be

representative of the range of serious forms of sexual abuse (i.e., where victims' poor self-concept prevents achievements such as entering university). Most importantly the researchers were investigating the impact of peer sexual experiences on adult self-concept. Prediction of poor adult self-concept among those who had experienced adult-child sexual experiences may have found different factors. The factors that were investigated (but which were not included in their final prediction equation) included: the number of incidents (more incidents had poorer outcomes); the longer the period of abuse (longer periods had poorer outcomes); having told someone about the abuse (poorer outcome, perhaps because it did not stop the abuse from continuing); negative feelings about the experience at the time (poorer outcome); negative feelings about the experience now (poorer outcome); and relationship to offender (worst outcome if offender was a stranger, less poor if offender was a relative). Family relationships tended to develop into long-term abuse that led to intercourse (and had poorer outcomes of adult self-concept). To the extent that these relationships began with a naive child, less threat or force would be required to coerce the child. An extension of Sorrenti-Little et al.'s (1984) study to predict serious sexual abuse from adult-child relationships would be valuable. To generalize the parameters of serious sexual abuse from peer sexual relationships may not be appropriate.



Further research is required to elucidate the impact of the betrayal of love and trust on incest victims. Rather than investigating discrete variables of the incest experience (e.g., duration, use of force), a closer examination of the incestuous relationship between adult and child, and between adult and child within a family system, is essential. Russell's (1984) work on the prevalence of abuse by biological and step fathers is a first step in this direction. She examined the length of time the father had spent with the daughter prior to age 14, to assess the relative impact of abuse by a primary father figure (defined by number of years spent). More stepfathers than biological fathers committed serious forms of sexual abuse (in terms of force used and act committed) than did biological fathers. As the prevalence of remarried families increases this direction of research will become more important (Perlmutter, Engel & Sager, 1982).

#### Diagnostic Issues and Models of Psychopathology

The recognition that long-term harm may be a consequence of incest has spurred clinical investigations of psychopathology among incest survivors. The Minnesota Multiphasic Personality Inventory (MMPI) has been used to objectify the study of psychopathology among incest survivors. The nature of psychopathology which may uniquely characterize incest survivors, demonstrated by MMPI profiles, has also been investigated.

Meiselman (1980) found a 48 MMPI profile among therapy patients reporting incest (as did Tsai et al., 1978) but the same profile was obtained from a matched control group of non-abused therapy patients. When further examined, Meiselman found that the incest survivors endorsed more items associated with sexual maladjustment than did the non-abused women. The finding of an elevated MMPI 48 profile in these two groups suggests that the MMPI is measuring poor social adjustment among therapy patients that may not be due to prior incest.

Tsai et al. (1979) examined the level of adjustment achieved by women who had been sexually molested in childhood. Their results suggested that situational variables, such as frequency and duration of molestation, were correlated with adult adjustment as measured by self-report and the MMPI. An elevated 48 MMPI profile was obtained from half of the poorly adjusted group. The concomitants of this profile included: a history of poor familial relationships; problems stemming from early establishment of an attitude of distrust toward the world; poor social intelligence and difficulty in becoming emotionally involved with others; sexuality seen as a hostile act through which anger is released; low self-concept; and a characteristic pattern of choosing men inferior to themselves in their relationships (p. 414).

Findings of an elevated 48 MMPI profile among incest survivors have been reported by other researchers among adolescent and adult daughters in treatment programs who were

incestuously assaulted by natural, adoptive or stepfathers (Scott & Stone, 1986a; Scott & Stone, 1986b). Feelings of isolation and alienation which are commonly reported by incest victims probably contribute to the elevated 8 (Schizophrenia) scale. According to Maloney and Ward (1976) an elevated 4 scale is common in other diagnostic groups and in the normal population. For example, women diagnosed as having multiple personality disorder show elevations on these two scales, as well as on others (Bliss, 1984). It is interesting to note that multiple personality is considered by some to be a borderline diagnosis (e.g., Benner & Joscelyne, 1984). A history of sexual abuse in childhood and an elevated 48 profile may be considered only two factors in a highly complex clinical picture of symptoms, psychopathology and diagnosis.

While the research may appear to suggest that incest victims suffer unique psychopathology, this conclusion requires substantiation not found among the current studies of MMPI profiles. All of the elevated profiles were obtained from incest survivors in psychotherapy. Their profiles did not differ from the profiles of non-abused psychotherapy patients. MMPI profiles from incest survivors in treatment have been shown to differ from those of matched controls who were not abused and who were not in treatment. It might be tempting to conclude that all incest victims will evidence clinical levels of psychopathology. Given the findings of Tsai et al. (1979) this conclusion would be unjustified. Women in their study who considered themselves

to be well adjusted despite childhood sexual abuse had nonsignificant MMPI profiles. Only half of the molested women who reported poor adjustment had elevated scale scores on the MMPI. The distribution of incest survivors in these two groups is unknown and the possibility that incest victims were overrepresented in the 'poor adjustment' group cannot be ruled out. Despite the harmful consequences of incest, the current research suggests that clinical levels of psychopathology are possible but not inevitable (Tufts, 1984 cited in Browne & Finkelhor, 1986) as Scott and Stone (1986b) speculated.

Manifestations of psychopathology that are unique to incest survivors may be difficult to determine due to the variation of contacts which incest survivors make with the mental health system. The research on incest suggests that victims may seek help from a variety of sources, usually when they enter adolescence (Herman, 1981). Conversely, many victims will not disclose incest or will seek treatment years after the victimization has ended. As adults they often seek help for the consequences of incest, such as relationship problems, sexual dysfunction or depression, without revealing the potential origin of their difficulties. The seventeen women in Lindberg and Distad's (1985a) study entered therapy for a variety of reasons, none of which were perceived as incest-related by the women. Nevertheless, all of them considered the incest to have been the most psychologically traumatic event of their lives.

Delayed disclosures may also contribute to the difficulty of assessing incest's impact on adult maladjustment. Disclosure of childhood incest may be delayed until several months or years into treatment (Westermeyer, 1978). Some clients may terminate therapy only to return later to discuss what is 'really' bothering them. This may be one reason why adult incest survivors who enter the mental health system receive a variety of diagnoses: diagnoses are typically based on presenting symptoms rather than on historical factors. There appear to be differences between diagnoses commonly applied to sexually abused women and non-abused women. Wooley (1981, cited in Wooley & Vigilanti, 1984) found DSM-III (1980) diagnoses of Anxiety Disorders, and Avoidant or Dependent Personality Disorder more frequently among sexually abused women than among non-abused women who utilized a community mental health clinic.

Wooley and Vigilanti (1984) have found that the presenting symptoms of sexually abused women are often confusing or appear to be contradictory.

They include: a lack of trust, coupled with extreme dependency; fear of being alone, yet an equally strong fear of becoming intimate; profound feelings of inadequacy in conjunction with a malignant sense of power and control (especially over men); and ambivalence toward the person who abused them (p. 347).

This pattern of polarized and intense needs and affects is suggestive of the Borderline Personality Disorder (BPD) diagnosis in DSM-III (1980).

The diagnoses of Borderline and Hysterical Personality Disorder are frequently found in the literature on chronic pelvic pain and psychopathology (Benson, Hanson & Matarazzo, 1959; Castelnuovo-Tedesco & Krout, 1970; Gidro-Frank, Gordon & Taylor, 1960). Given the evolution of hysteria as a psychosomatic illness involving the uterus this connection may not be surprising. Nevertheless, all of the studies mentioned found concomitant occurrences of chronic pelvic pain (with no evident organic etiology), Hysterical or Borderline Personality Disorders, and traumatic childhood events or previous stressors. In a study of 25 women with chronic pelvic pain, Gross et al. (1980) found a high incidence of psychopathology and a history of incest among 36% of them. Of nine women with a history of incest, six (66%) received the diagnosis of Borderline Syndrome. The Syndrome definition utilized in this study differs from that of DSM-III. Nevertheless, the criteria are similar to DSM-III criteria and include: hostile and/or depressed feeling; a history of impulsive behaviour; poor social adaptiveness; and intensely dependent and manipulative relationships with others (Gunderson & Singer, 1975). The remaining three women with a history of incest were diagnosed as having severe Hysterical Character Disorder. The criteria for this diagnosis included: self-centered behaviour which is often seductive and dramatic; volatile and shallow feelings; frequently dependent and demanding behaviour; liberal use of fantasy and the use of denial to cope with strong feelings (Chodoff, 1974).

The diagnosis of BPD has frequently been associated with chronic pelvic pain, Multiple Personality Disorder and a history of childhood sexual abuse. Despite this, Briere (1984) suggested that many sexual abuse victims may inappropriately receive the diagnosis of BPD and proposed a Post-Sexual-Abuse Syndrome diagnostic category for such cases. The notion of a separate category underscores Briere's contention that attention to, and working through, incest issues will result in better therapeutic outcomes than occur at present. Briere's hypothesis is as yet untested. However, Gelinas (1983) has also noted that incest survivors may inappropriately receive the diagnosis of BPD. Like Briere, she suggested that the influence of the BPD diagnosis' poor treatment prognosis may result unnecessarily in a poor therapeutic outcome for incest survivors.

The contribution that childhood incest makes to adult dysfunction is reflected in several researchers' explanatory models of psychopathology. Gelinas outlined a constellation of symptoms and behaviours that she considered to be common among untreated adult incest survivors. This characteristic picture is "composed of the secondary elaborations of the untreated negative effects" (p. 326). Gelinas postulated that the trauma of incest results in a traumatic neurosis, similar to the post traumatic stress response described by Horowitz and Kaltreider (1979). As long as the negative effects remain untreated they may be elaborated and become increasingly intrusive in victims' lives.

There is an involuntary compulsive tendency toward repetition of some aspects of the traumatic experiences despite pronounced conscious efforts at avoidance and suppression (p. 317).

If untreated, secondary elaborations of the traumatic neurosis may develop such as chronic depression, guilt, and low self-esteem. "Developmental triggers" often precipitate symptoms of the traumatic neurosis which may have been hidden for years after the cessation of the incest. Defined as "any normal developmental occurrence that calls into play a new area of functioning that apparently has been impaired or disordered because of the incest" (Gelinas, 1983, p. 317) these developmental triggers account for the initial onset or exacerbation of psychiatric symptoms which may occur after a period of normal functioning.

It has been noted that incest victims cannot be distinguished from non-victims in a psychiatric practice on the basis of demographic variables (Westermeyer, 1978). Gelinas (1983) developed an Incest Recognition Profile (IRP), based on the secondary elaborations of the traumatic neurosis, to facilitate identification of women who may have been incestuously assaulted. The main elements of the IRP are: chronic depression with complications of a chronic mood disorder (e.g., substance abuse, suicidal behaviour, sexual dysfunctions, poor relations); dissociative and impulsive elements; and a personal history of 'parentification'. This last category is defined as "premature and heavy financial, housekeeping or



child-care responsibilities as a child or adolescent, pseudomaturity" (p. 327).

In contrast to Gelinas' dynamic formulation, Tsai et al. (1979) postulated a learning model to account for the development of symptoms after the incest has ended. According to these authors, any aspect of the molestation event which is traumatic may become generalized.

The pairing of the negative emotional responses with the stimulus array constituting the molestation experience(s) may produce a conditioned emotional response that is subjectively quite negative for the child. Then, through a process of stimulus generalization, these conditioned negative responses may later be elicited by activities carried out even in a nonmolestation situation and/or by other men with whom the women are intimately involved in their lives. (p. 415)

Wooley and Vigilanti (1984) conceptualized incestuous families as engaging in double binds wherein the victim receives conflictual messages. The result of the double bind pattern is a failure by the victim to achieve separation of identity from the parents and a continuation of the "no-win cycle of love/hate and fear/dependency" (p. 348). Over time, symptoms that result from a paradoxical situation (e.g., low self-esteem, depression) can be triggered by one component of the system rather than the entire process. Wooley and Vigilanti further suggested that the no-win situation experienced by incest victim is consonant with Seligman's (1975) model of learned helplessness.

A link between initial traumatic events and later triggers or situations that elicit negative feelings for incest victims

is posited in each of the models. Given this link, a separate diagnostic category such as that postulated by Briere (1984) may not be necessary. The diagnosis of Post Traumatic Stress Disorder (PTSD) may be an appropriate diagnosis (Hyde & Kaufman, 1985). In their study of 17 women entering therapy who experienced childhood incest, Lindberg and Distad found that the symptoms and symptom onset fit the diagnostic criteria for PTSD (DSM-III). These symptoms included: anxiety, recurrent nightmares or intrusive daytime imagery related to the trauma, insomnia, depression, anger, guilt and mistrust. Additional long-term destructive patterns described by Lindberg and Distad include substance abuse, feelings of worthlessness, suicide or suicide attempts, isolation and/or emotional numbing.

The diagnosis of PTSD is seldom suggested in the diagnosis of symptoms presented by incest survivors. A closer look at the diagnostic criteria provides a possible reason for this omission. The first criteria for PTSD is the "existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone" (DSM-III, 1980). The women in Lindberg and Distad's study all considered incest to have been the most traumatic experience of their lives. If adult survivors are unable to make a cognitive connection (e.g., due to denial or repression) between their current symptoms and their prior victimization it is unlikely that PTSD will be considered a relevant diagnosis. If the clinician does not consider incest a sufficiently universal stressor PTSD is again unlikely. Rather,

diagnoses which are less dependent on stressors or prior events such as Hysterical or Borderline Personality Disorder, Anxiety or Depressive Disorders are more likely to be utilized.

(According to DSM-III, Anxiety and Depressive disorders may be diagnosed in conjunction with PTSD if symptoms are sufficient to warrant it.)

### Treating the Long-Term Effects of Incest

The importance of clinicians' awareness that childhood incest may contribute to adult dysfunction has been stressed by several researchers (e.g., Carper, 1979; Miller, 1984). A failure to recognize and work through incest issues with victims may cause them to become repetitive treatment seekers (Gelinas, 1983). Psychosomatic disorders may mask distress due to incest or sexual abuse (Hunter et al., 1985). In his study of the relationship between health, childhood trauma and confiding, Pennebaker (1985) found that sexually traumatized persons reported more physical problems than non-traumatized or non-sexually traumatized persons. The former group was also less likely to have confided in others about the trauma than were the latter groups. The finding that women who had at least one person in whom they could confide were more likely to have found some meaning for their sexual victimization (Silver, Boon & Stones, 1983) lends support to the notion that discussion of the incest experience is beneficial. As Gelinas (1983) points out, however, "victims very rarely disclose spontaneously and

therapists don't ask" (p. 326). For example, Fletcher (1979, cited in Bess & Jenssen, 1982) found that only fifteen per cent of 1000 persons reported in a poll that their physicians asked about their sexual activity. It is conceivable that asking about victimization may be intrusive and coercive in a therapeutic relationship (Brickman, personal communication, 1985). Awareness on the part of the therapist that incest may have occurred and may be indicated by a disguised presentation, however, could facilitate victims' disclosures of past incest experiences. If the patient senses that the therapist is uncomfortable, or does not believe incest to be real or important, the patient will not disclose prior incest (Rosenfeld, Nadelson & Krieger, 1979).

Westermeyer (1978) described 32 cases involving incest in his private psychiatric practice. Six of these cases were not disclosed until 2 to 12 months after treatment began. Three disclosures were made after one year of treatment. Similarly, Rosenfeld (1979) found that 6 of the 18 female psychiatric patients (33%) he evaluated in a one year period had a history of incest. One patient reported incest spontaneously; two reported it during evaluation; two reported it later in therapy when asked; and one young child told her grandmother later during therapy.

The prevalence of incest reported in community surveys and in psychiatric settings suggests that clinicians have or will have contact at some point in their careers with adults who have experienced childhood incest. Some of their patients or clients

may not disclose it unless they are asked. In order to develop and implement efficacious intervention strategies, the current practices of clinicians regarding evaluation of new patients and therapy for identified incest survivors in their practices require examination.

### The Current Study

The purpose of the present study is to examine mental health professionals' experiences treating incest survivors. The extent to which they identify incest survivors in their practices may reflect their willingness to acknowledge incest cues or to provide an environment in which victims feel able to disclose the abuse. Data will be collected from two groups - psychiatrists and clinical psychologists. Distinctive information regarding the long-term effects of incest may be found that reflect differences in client populations between the two professions may be found. Possible re. in fee structures associated with the two professions (e.g., third party medical coverage versus private payment) and work settings (e.g., hospital clinics and wards versus private practices). The clients may vary in level of psychosocial functioning reflected by their socioeconomic status (and ability to pay for private therapy).

Gender differences in relation to clinicians' experiences will also be examined. It is possible that incest survivors seek

out female therapists more often than male therapists. In addition to more experience, female therapists are likely to have been exposed to more information regarding violence against women (e.g., through women's therapy journals, women's caucuses of professional organizations). The result of such sensitization may be a heightened awareness of prevalence and an increased willingness to explore incest histories with their patients or clients.

The long-term effects that mental health professionals associate with incest may be related to their attitudes regarding incest. Only one study has been found that assessed psychiatrists' views of father-daughter incest based on their experiences with victims. LaBarbera, Martin and Dozier (1980) conducted a survey of 200 child psychiatrists in the United States. There was little agreement regarding the immediate or long-term effects of incest. Seventy two percent did expect victims to experience heterosexual deficits as a long-term consequence. "A significant finding was that the degree of harmfulness attributed to incest declined with the number of daughters treated by the psychiatrist. This effect...did not reflect years of psychiatric experience." (p. 150). The authors did not provide any possible explanation for this finding.

The present study differs from the LaBarbera et al. study in several ways. The present study does not focus on clinicians' hypotheses about the long-term effects of incest. Rather, experiences of clinicians working with adult survivors of incest

will be assessed. Differences between immediate and long-term effects (e.g., later feelings of guilt and low self-esteem) suggest that the effect of the number of adults seen by clinicians may affect attributions of harmfulness differently than the number of child victims seen by clinicians. Finally, media coverage of incest has increased dramatically in the past five years making comparisons to LaBarbera et al.'s study problematic. It is expected that clinicians will be more sensitized to the political and ideological issues surrounding sexual abuse of children and will attribute greater significance to women's experiences of distress than was suggested by LaBarbera et al.'s study.

Clinicians' experiences will be compared to the research findings based on victims' reports of the consequences of incest. Similarity between consequences described by victims and by clinicians will add to the growing body of literature on the long-term effects of incest. Disparity between victims' reports and clinicians' reports has implications for the education of mental health professionals regarding incest and masked presentations of incest survivors in clinical settings.

The following hypotheses will be tested:

1. Female clinicians will have seen more incest victims in the past year, will estimate that incest survivors comprise a greater percentage of their practices, and will endorse a broader definition of incest than will male clinicians.
2. Psychiatrists will report more violent forms of coercion

used than will psychologists.

This difference may be due to differences in client/patient populations.

3. Non-physical coercion (such as emotional appeals) or the bestowing of special favours by perpetrators of incest will be the types of coercion most frequently reported by clinicians.

4. Psychiatrists will report that physical abuse occurs concurrently with incest to a greater extent among their patients than will psychologists.

The difference may be due to a difference in client/patient populations.

5. Father-daughter incest will be the most frequent pattern of incest seen in clinical practices.

6. A presentation of incest as the secondary problem will be more commonly seen than will a presentation of incest as the primary (presenting) problem.

7. Clinicians who have training in working with incest or sexual abuse victims will be more likely to ask new patients about prior incest.

8. The more incest victims seen by a clinician during the past year the more willing she or he will be to ask new patients about prior incest.

9. Clinicians will be more willing to ask a general sexual history than specifically about prior incest in cases presenting with non-sexual difficulties.

10. Female clinicians will be more accurate in their report of



effects associated with incest than will male clinicians, reporting more often that they see effects and behaviours frequently seen among incest survivors (as indicated by research on victims).

11. The more patients with a history of incest seen by a clinician, the more variables the clinician will endorse as occurring often or always with a history of incest, particularly those effects most commonly associated with incest.
12. Psychiatrists will be more likely than psychologists to report seeing women who have histories of prostitution, running away, substance abuse, repeated victimization, and who abuse their children.  
Thess differences may be due to differences in client/patient populations.
13. The most frequent diagnosis will be that of borderline personality disorder.
14. Female clinicians will consider skills training and group therapy for incest survivors as often or always important more than will male clinicians.
15. Female clinicians will utilize diagnoses which acknowledge the impact of a previous trauma on current functioning (e.g., Post-Traumatic Stress Disorder) more than will male clinicians.

## CHAPTER II

### METHOD

#### Subjects

Psychologists who were members of the British Columbia Psychological Association in 1985 and who indicated that they specialized in clinical psychology were sent a survey package. The current study was limited to those who practiced in the Greater Vancouver area. Psychiatrists' names were obtained from the 1985 Membership Registry of the British Columbia College of Physicians and Surgeons. All those who listed at least one mailing address in the Greater Vancouver area received surveys at that address. If a survey package was returned, attempts to locate the person's new address, or mailing the package to their second office, was done. If an alternate mailing address could not be obtained, the person's name was removed from the mailing list. The final number of psychologists who received questionnaires was 217, and the number of psychiatrists was 204.

#### Measures

The "Experience Working with Incest Victims" questionnaire was developed for use in the current study (Appendix A). Several areas of clinical practice were assessed by the questionnaire. The prevalence of female and male incest victims in the clinician's practice, the incidence of victims treated in the

past year; the clinician's perception of the incest experience (relationship between victims and offenders, duration, types of coercion involved, co-occurrence of physical abuse with incest) and clinicians' perceptions of the long-term effects experienced by incest survivors were examined. The clinician's definition of incest was surveyed by providing a number of variables from which to choose those that constituted incest in the clinician's opinion. Assessment procedures, and intervention goals and strategies for working with those adults who have experienced childhood incest were explored, using 5-point ordered scales with end points of "Never Important" to "Always Important".

### Procedure

Pilot testing of the questionnaire was done before the study commenced. The questionnaire was reviewed by a six clinicians with a variety of professional experiences. Reviewers included a physician from a Sexual Assault Assessment Team, two psychiatrists (one who worked with adults and one who worked with children, both in hospitals and private practice) and three clinical psychologists (two in private practice, one employed in a hospital). One of the psychiatrists and one of the psychologists specialized in assessment and treatment of sexual abuse victims. After approximately six revisions an acceptable questionnaire format and length was obtained.

Letters of endorsement were solicited from the professional associations of clinical psychologists and psychiatrists in British Columbia. The President or Chairperson of the Board of Directors was contacted by telephone to describe the research and request that the Board consider endorsing the study and encouraging their members to participate. A copy of the questionnaire and a research proposal (Appendix B) was then sent to the Board of Directors. Both boards agreed to support the study. Letters of support were thus obtained from the British Columbia Psychological Association (Appendix C) and the British Columbia Medical Association Section of Psychiatry (Appendix D).

In addition to the letter of support and questionnaire, an introductory letter was included in the survey package (Appendix E). Clinicians who conducted therapy with adults were requested to complete and return the questionnaire. Clinician who did not do therapy with adults were requested to complete and return the section on demographic data only. Two envelopes, one plain and one printed with the researcher's address, were included in the package. A 3 digit code number was assigned to each clinician who was mailed a survey package. This number appeared on a master list of subjects and on the back of the printed envelope in the appropriate subject's survey package.

Participants were requested to complete the questionnaire in approximately 20 minutes. They were requested to seal the completed questionnaire inside the plain envelope and to seal this one inside the addressed and coded envelope.

Upon receipt, the plain sealed envelope containing the completed questionnaire was separated from the numbered envelope by the author's senior supervisor in order to ensure respondents' anonymity. The plain envelopes were opened by the author and questionnaires were coded with identification numbers based on order of receipt.

A second survey package containing the endorsement letter, a reminder letter (see Appendix F) and another questionnaire was mailed five weeks after the first mailing. The packages were sent only to those who had not returned the first questionnaire as indicated by the senior supervisor's master list.

Copies of the survey package were also mailed to the Chairperson and President of the professional associations in case their members requested information from them. These two clinicians were not included in the survey since they had seen the questionnaires and the research proposal (outlining some of the purposes of the research). Clinicians who had reviewed earlier drafts of the questionnaire were included as subjects in the study. They had not seen final copies of the questionnaire, as had the Chairperson and President, nor were they aware of the study's purpose. It was believed that their experiences working with sexual abuse and incest victims would be a valuable contribution to this exploratory study.

The questionnaire was changed slightly during the data collection. After several questionnaires were received it was

noted that one question was vague (see Appendix A, question 5) and several respondents complained that the checklist of symptoms was difficult to follow. Thus, the first category of question 5 was changed from "0-10" (Form 1 of the questionnaire) to "0" and "1-10" (Form 2 of the questionnaire).<sup>1</sup> Symptoms in the checklist were spaced further apart and lines separated each symptom, but no changes in wording were made. All of the psychiatrists in the study received Form 2 of the questionnaire, on first and second mailings. All psychologists who received a second questionnaire received Form 2. However, questionnaires received from 54 psychologists were Form 1 questionnaires.

#### Statistical Analyses Used

Most of the data in the present study was analyzed utilizing cross tabulations of categorical data (2 x 2 contingency tables). This method limits analyses to comparisons of marginal totals for two variables.

Statistical analysis of categorical data using log-linear models allows an examination of more than 2 variables at a time. The possibility that three factor and higher-order interactions exist among the variables can be examined (Feinberg, 1980).

The logarithm of the expected cell frequency can be written as an additive function of main effects and interactions similar

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<sup>1</sup>Category 1 responses on Form 1 were coded as category 2 (as in Form 2) unless clinicians specifically noted that they had seen "0" victims.

to an analysis of variance model (Brown, 1985). The analysis involves fitting a nested sequence of log-linear models to the cell frequencies. The goodness-of-fit of the model is tested using the likelihood ratio statistic ( $G^2$ ) which is asymptotically distributed as chi-square with  $n - p$  degrees of freedom (where  $n$  = number of cells and  $p$  = number of independent parameters estimated).

The difference in  $G^2$  between 2 models,  $M_1$  and  $M_2$ , is a test of the additional effects of  $M_2$  conditional on the effects in  $M_1$  (since  $M_1$  is nested within  $M_2$ ). This difference has a chi-square distribution with  $df$  equal to the difference in the  $df$  of the number of parameters fitted to the two models. A difference in  $G^2$  which exceeds a descriptive level of significance of .05 when referred to a table of chi-square distribution (on the corresponding difference  $df$ ) indicates that the additional effects of the more complex model ( $M_2$ ) do not fit the data any better than the simpler model ( $M_1$ ) and the simpler model should be chosen as the best model to account for the data.

It is possible that 2 models of similar complexity will fit the data well (e.g., second order models including different interaction terms). In this case a method of determining the best model has not been agreed upon at the present time.

Analyses of variance for repeated measures were performed to test differences on types of presenting problems, assessment strategies, patterns of incest and methods of consent used by

perpetrators, for four factors (gender, experience, training and profession). Differences between means were assessed using the Studentized range statistic.



## CHAPTER III

### RESULTS

Although several a priori hypotheses were generated, the study was primarily exploratory in nature. The possible effects and the direction of the effects for several independent variables could not be anticipated since prior research had not investigated them. In order to examine the effects of factors that differ among clinicians, all variables in the present study were analyzed for effects due to gender, profession, years in practice (experience) or specialized training. Where specific hypotheses about these variables were generated a priori they will be tested and reported. However, effects of each of the four factors on each variable were tested whether specific hypotheses existed or not. These analyses were conducted in order to point to interesting possibilities for future research and to assess the relative importance of the four factors on each variable.

The large number of tests that were performed raise the possibility that some analyses will be significant by chance. Rather than focussing on specific differences between factors on variables, an overview of the results will be examined for patterns of differences which might be examined in greater depth in future investigations.

## Response Rate

Of the survey packages mailed out, 217 psychologists and 204 psychiatrists were contacted. Sixty four psychologists (30%) and 63 psychiatrists (31%) returned questionnaires in the first mailing. A second mailing resulted in the receipt of questionnaires from 34 psychologists (21%) and 28 psychiatrists (20%). Overall, a response rate of almost fifty percent was obtained for psychologists (45%) and psychiatrists (45%).

This response rate represents returned questionnaires from both those who do therapy with adults and those who do not do therapy with adults. The study was directed to the former group. The latter group was requested to complete and return the demographic data section of the questionnaire. Demographic information was returned by 35 psychologists (36% of returned questionnaires) and 17 psychiatrists (19% of returned questionnaires).

Completed questionnaires returned by two psychologists and three psychiatrists were not included in the study as they were missing substantial data (e.g., an entire page was left blank).

The data obtained from 61 psychologists and 71 psychiatrists were utilized in this study. These figures represent 28% and 35% respectively of the psychologists and psychiatrists contacted in this study. The number of cases included in some of the analyses vary slightly due to missing data.

### Representativeness of Study Sample to Population

There was a significant gender difference between the two professions ( $\chi^2(1, N=127)=6.46$ ;  $p<.05$ ). Over 40% (42%) of the psychologists whose returned questionnaires were included in the study were female whereas less than 20% (19%) of the psychiatrists were female (see Table 1).

The distribution of women within the professions found in this study appears to be similar to the distribution in the population. An examination of the British Columbia Psychological Association's 1985 membership directory reveals that 5% of the members' gender could not be determined by name. Of the remaining members, 59% are males and 41% are females.

It was not possible to determine the gender ratio of psychiatrists using this method because the British Columbia College of Physicians and Surgeons Directory lists its members' first initials rather than names. However, of the 57 psychiatrists who are listed in the 1985 Vancouver Telephone Directory and who list a first name 75% are male and 25% are female.

### Demographic Variables

Five percent of the participants in the study did not disclose their gender. Of those who did, 70% of the subjects were male and 30% were female.

Table 1. Distribution of Professions by Gender

Gender	Profession		Total
	Psychologist	Psychiatrist	
female	25	13	38
male	35	54	89
unknown	1	4	5
total	61	71	132

The mean age of the sample was 44 years. Psychiatrists were significantly older than psychologists ( $\bar{X}=47$  years and  $\bar{X}=41$  years respectively) ( $\chi^2(4, N=124)=22.98$ ;  $p<.001$ ). Overall, male respondents were significantly older ( $\bar{X}=45$  years) than female respondents ( $\bar{X}=41$  years) ( $\chi^2(4, N=124)=16.99$ ;  $p<.01$ ).

A nested sequence of log-linear models that included all interactions among the independent variables of profession and gender (and excluding those models which did not include these two variables) was fitted to the data (Table 2). As indicated in Table 2 the log-linear model which included three 2-way interactions, between gender and profession, gender and age, and profession and age, was sufficient to account for the data. Thus pattern differences which existed between gender and age, and profession and age were 'true' pattern differences. The data were not sufficiently accounted for by only one of the independent variables. Male psychiatrists were older than other groups and female psychiatrists were younger than other groups.

Respondents had been in practice an average of 13 years, with psychiatrists ( $\bar{X}=15$  years) having practiced longer than psychologists ( $\bar{X}=11$  years) ( $\chi^2(3, N=123)=10.67$ ;  $p<.05$ ). Male respondents ( $\bar{X}=15$  years) had also been practicing significantly longer than had their female colleagues ( $\bar{X}=10$  years) ( $\chi^2(3, N=123)=14.28$ ;  $p<.01$ ).

A nested sequence of log-linear models which included all interactions among the independent variables was fitted to the

Table 2. Contingency Table and Summary of Log-Linear Analysis of Models of Gender, Profession and Age

Profession(p)	Gender(g)	Age(a)					Total
		25-35	36-40	41-44	45-50	>50	
Psychologist	male	10	6	7	12	0	45
		(29)	(17)	(20)	(34)	(0)	(100%)
	female	4	10	4	4	2	24
		(17)	(41)	(17)	(17)	(8)	(100%)
Psychiatrist	male	6	4	11	9	23	53
		(11)	(8)	(21)	(17)	(43)	(100%)
	female	3	5	2	1	1	12
		(25)	(42)	(17)	(8)	(8)	(100%)

Summary Table of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
p,g,pg	16	48.35	.0000
p,g,pg,a	12	48.07	.0000
p,g,pg,a,pa	8	21.77	.0054
p,g,pg,a,ga	8	31.63	.0001
p,g,pg,a,pa,ga	4	9.32	.0536

data. The likelihood ratio chi-square statistics ( $G^2$ ) of each of the models containing two 2-way interaction terms and the higher-order model containing three 2-way interaction terms were examined. The difference in  $G^2$  between the model containing interaction terms of gender and experience and gender and profession, and the higher-order model was not significant. As indicated in Table 3 this model, which included interaction terms of gender and profession and gender and experience, was sufficient to account for the data. The analysis suggests that gender is a more 'powerful' variable than profession in accounting for the distribution of clinicians in categories of experience. Female psychiatrists tended to have worked fewer years and male psychiatrists tended to have worked more years than either male or female psychologists.

More female than male respondents reported that they had acquired special training for working with sexual assault or incest victims ( $\chi^2(1, N=127)=5.36$ ;  $p<.05$ ). Significantly more psychologists than psychiatrists indicated that they had acquired such training ( $\chi^2(1, N=127)=3.86$ ;  $p=.05$ ).

A nested sequence of log-linear models was fitted to the data (excluding those models without an interaction term for gender and profession). As indicated in Table 4, the model which includes 2-way interactions between gender and profession, and profession and training was sufficient to account for the data. Male psychiatrists were represented most in the group without special training whereas female psychologists were represented

Table 3. Contingency Table and Summary of Log-Linear Analysis of Gender, Profession and Experience

Profession(p)	Gender(g)	Experience(e)		Total
		0-11	>11	
Psychologist	male	18	17	35
		(51)	(49)	(100%)
	female	17	7	35
		(71)	(29)	(100%)
Psychiatrist	male	16	35	51
		(31)	(69)	(100%)
	female	9	4	13
		(69)	(31)	(100%)

#### Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
p,g,pg	4	13.55	.0089
p,g,pg,e	3	13.48	.0037
p,g,pg,e,ge	2	3.50	.1742
p,g,pg,e,pe	2	8.40	.0150
p,g,pg,e,ge,pe	1	0.77	.3809



Table 4. Contingency Table and Summary of Log-Linear  
Analysis of Profession, Gender and Training

Profession(p)	Gender(g)	Training(t)		Total
		No	Yes	
Psychologist	male	24	11	35
		(69)	(31)	(100%)
	female	13	12	25
		(52)	(48)	(100%)
Psychiatrist	male	45	9	54
		(83)	(17)	(100%)
	female	8	5	13
		(62)	(38)	(100%)

Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
g,p,gp	4	31.88	.0000
g,p,gp,t	3	9.07	.0283
g,p,gp,t,pt	2	4.39	.1114
g,p,gp,t,gt	2	2.92	.2319
g,p,gp,t,pt,gt	1	0.26	.6132

most in the group with special training.

### Perceptions of Incidence of Incest in Clinical Practice

Overall, the majority of clinicians (58%) estimated that 10% or less of their patients or clients had been victims of incest.

Significant gender and profession differences were found on the estimate of incidence. Women (36%) were more likely than men (9%) to estimate that their cases involving incest exceeded 20% (high estimate) ( $\chi^2(3, N=124)=15.63$ ;  $p<.01$ ). Conversely, this cross tabulation also demonstrated that men were more likely to estimate that 5% or less (low estimate) of their cases had experienced incest.

A similar pattern was demonstrated between professions. Psychologists (31%) were more likely than psychiatrists (6%) to estimate an incidence of incest in more than 20% of their cases; psychiatrists were more likely than psychologists to estimate an incidence of incest in 5% or fewer of their cases ( $\chi^2(3, N=129)=16.55$ ;  $p<.001$ ).

Since a significant relationship between gender and profession was found in the study it is possible that the effects of gender were confounded with the effects of profession on this variable. A nested sequence of all log-linear models which included interactions among the independent variables was fitted to the data which are shown in Table 5. The model

Table 5. Contingency Table and Summary of Log-Linear Analysis of Profession, Gender and Incidence Estimates

Profession(p)	Gender(g)	Incidence Estimate(i)				Total
		0-5	6-10	11-20	>20	
Psychologist	male	7	12	6	7	32
		(22)	(37)	(19)	(22)	(100%)
	female	6	2	6	11	25
		(24)	(8)	(24)	(44)	(100%)
Psychiatrist	male	27	12	14	1	54
		(50)	(22)	(26)	(2)	(100%)
	female	2	4	4	3	13
		(15)	(31)	(31)	(23)	(100%)

#### Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
p,g,pg	12	40.76	.0001
p,g,pg,i	9	34.27	.0001
p,g,pg,i,gi	6	19.40	.0035
p,g,pg,i,pi	6	17.85	.0066
p,g,pg,i,gi,pi	3	8.10	.0439

including three 2-way interactions was insufficient to account for the data. The  $p$  value of .0439 indicated that a "significant" amount of error remained after partitioning of the likelihood ratio chisquare statistic ( $G^2$ ) by the model containing three 2-way interaction terms. A model that contained a 3-way interaction term in addition to the three 2-way interaction terms would be required to account for the data. Thus the finding of gender differences on incidence estimates included some profession effects (and vice versa). The distribution of male psychiatrists' estimates showed the most variation; female psychiatrists' estimates showed the least. Whereas male psychiatrists were more likely than other groups to estimate a low incidence, female psychologists were more likely than the other groups to estimate a high incidence.

Trained clinicians were more likely to estimate an incidence of incest greater than 20% than were untrained clinicians ( $\chi^2(3, N=124)=21.72$ ;  $p<.001$ ). A nested sequence of all log-linear models which included an interaction term of gender and training was fitted to the data which are shown in Table 6. The model that includes three 2-way interaction terms of training and gender, gender and estimate, and training and estimate was sufficient to account for the data. Female clinicians with training were more likely than male or female clinicians without training to make high estimates.

The longer a clinician had worked, the smaller was the estimated percentage of incest victims in his or her practice

Table 6. Contingency Table and Summary of Log-Linear Analysis of Training, Gender and Incidence Estimates

Training(t)	Gender(g)	Incidence Estimates(i)				Total
		0-5	6-10	11-20	>20	
Not Trained	male	27	20	16	4	67
		(40)	(30)	(24)	(6)	(100%)
	female	8	5	5	3	21
		(38)	(24)	(24)	(14)	(100%)
Trained	male	7	4	4	4	19
		(37)	(21)	(21)	(21)	(100%)
	female	0	1	5	11	17
		(0)	(6)	(29)	(65)	(100%)

Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
t,g,tg	12	43.32	.0000
t,g,tg,i	9	36.83	.0000
t,g,tg,i,gi	6	21.96	.0012
t,g,tg,i,ti	6	16.48	.0114
t,g,tg,i,gi,ti	3	6.86	.0765

( $\chi^2(3, N=120)=15.77$ ;  $p<.01$ ). Almost one third of clinicians (29%) who had worked 11 years or less estimated an incidence that exceeded 20% whereas less than one tenth of clinicians (18%) with more experience estimated an incidence greater than 20%. A nested sequence of all log-linear models which included an interaction term of experience and training was fitted to the data (shown in Table 7). The model that includes three 2-way interactions between training and experience, training and estimate and experience and estimate was sufficient to account for the data. More trained clinicians made high estimates than did untrained clinicians regardless of experience and more inexperienced clinicians made high estimates than did experienced clinicians. Thus more inexperienced trained clinicians made high estimates than the other groups. The fewest high estimates were made by experienced untrained clinicians.

It should be noted that differences were demonstrated on all four factors when they were cross tabulated pair-wise with incidence estimate. Only log-linear models for three dimensional contingency tables (2 factors and incidence estimate) have been analyzed. The small sample size prevented analysis of log-linear models which contained more than three variables.

Most clinicians (82%) reported assessing or treating no more than 20 incest victims in the past year. A significant gender difference was found on this estimate. Female clinicians (32%) were more likely than male clinicians (13%) to report seeing more than 20 victims ( $\chi^2(1, N=124)=4.99$ ;  $p<.05$ ).

Table 7. Contingency Table and Summary of Log-Linear Analysis of Training, Experience and Incidence Estimates

Training(t)	Experience(e)	Incidence Estimate(i)				Total
	(yrs.)	0-5	6-10	11-20	>20	
Not Trained	11 or less	11	7	14	5	37
		(30)	(19)	(38)	(13)	(100%)
	over 11	20	18	7	2	47
		(43)	(38)	(15)	(4)	(100%)
Trained	11 or less	2	3	5	12	22
		(9)	(14)	(23)	(54)	(100%)
	over 11	5	2	4	3	14
		(36)	(14)	(29)	(21)	(100%)

#### Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
t,e,te	12	39.22	.0001
t,e,te,i	9	34.90	.0001
t,e,te,i,ei	6	18.60	.0049
t,e,te,i,ti	6	15.80	.0148
t,e,te,i,ei,ti	3	2.37	.4993

The number of victims seen in the past year by psychologists and psychiatrists did not differ. Nor did the number of years of experience result in significant differences in the number of victims seen. Exactly one third of trained clinicians reported seeing more than 20 victims in the past year compared to approximately one eighth of untrained clinicians (12%) ( $\chi^2(1, N=124)=6.025$ ;  $p<.05$ ). It is interesting to note that all of the trained clinicians reported seeing at least one victim in the past year whereas 5% of the non-trained clinicians reported seeing no victims in the past year ( $\chi^2(2, N=124)=7.34$ ;  $p<.05$ ). A nested sequence of all log-linear models including an interaction term of gender and training was fitted to the data which are shown in Table 8. The model which included interaction terms of gender and training and training and victims was sufficient to account for the data. The analysis suggests that training is a more 'powerful' variable than gender in accounting for the distribution of clinicians in categories of victims seen (when gender and training are included in the same analysis).

A significant gender difference was demonstrated for estimates of the percentage of male incest victims in their practices. Over one third (37%) of male clinicians estimated that more than 10% of their incest cases are male. Less than one fifth (17%) estimated that none of their incest cases were male victims. Female respondents showed a reverse pattern. Fewer female clinicians (17%) than male clinicians estimated that males comprised more than 10% of their incest cases. Almost 40%



Table 8. Contingency Table and Summary of Log-Linear  
Analysis of Training, Gender and Victims Seen  
During Past Year

Training(t)	Gender(g)	Victims Seen(v)		Total
		0-20	>20	
Not Trained	male	59	8	67
		(88)	(12)	(100%)
	female	18	3	21
		(86)	(14)	(100%)
Trained	male	16	3	19
		(84)	(16)	(100%)
	female	8	9	17
		(47)	(53)	(100%)

Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
t,g,tg	4	65.58	.0000
t,g,tg,v	3	12.63	.0055
t,g,tg,v,gv	2	6.85	.0325
t,g,tg,v,tv	2	5.82	.0543
t,g,tg,v,gv,tv	1	2.32	.1281

of female clinicians estimated that none of their incest cases involved male victims ( $\chi^2(2, N=113)=7.73$ ;  $p<.05$ ).

It had been hypothesized that female clinicians would report seeing more incest victims in the past year and would estimate a greater incidence of incest in their practices than would male clinicians (Hypothesis 1). This hypothesis was confirmed.

### Perceptions of Incest

The situations which comprise clinicians' definitions of incest were explored (see Appendix A, question 1). The small sample size prohibited analyses other than a descriptive analysis of the data. Almost half of the respondents (44%) considered all 16 of the situations to constitute incest. (Some clinicians added extra variables as well, such as "violation of trust".)

Clinicians were requested to estimate, based on their experience, the average age of the victim at which incest begins and the average age at which it ends. Some respondents provided ranges of ages. For the age of onset, the youngest age given was used in analyses. For the age of cessation, the oldest age given was used.

Female clinicians reported that their clients or patients experienced incest at an earlier age than did male clinicians. In particular, more women (39%) than men (15%) reported incest

beginning before the age of five ( $\chi^2(3, N=117)=11.22$ ;  $p<.05$ ). Similarly over 70% of female clinicians reported incest beginning before the child was seven while 41% of male clinicians did so ( $\chi^2(1, N=117)=7.94$ ;  $p<.01$ ). No differences were revealed on this variable when it was cross tabulated with profession, experience or training.

No differences were revealed when the age at which incest ends was cross tabulated with the four variables of gender, profession, experience or training.

Clinicians ranked the frequency of occurrence of four methods used to gain a child's consent in incestuous abuse. Responses on this question revealed a substantial amount of missing data (e.g., only 1 or 2 categories coded) and incorrect responses (e.g., checking several categories rather than ranking them). Partial responses such as these were transformed by summing the rankings which would have been assigned to the number of checked or blank categories. Each category was given the mean ranking. The transformation precluded analysis with the four factors in contingency tables. Instead, the mean rankings applied to each category were examined using a 2 (gender) x 2 (profession) x 4 (method) repeated measures ANOVA. As indicated in Table 9 there was a main effect for method ( $p=.001$ ). Multiple comparisons using the Studentized range statistic were calculated for the differences between means. The use of non-physical coercion ( $\bar{X}=1.89$ ) and the use of special favours used to gain consent ( $\bar{X}=2.14$ ) were ranked highest. These means

Table 9. Summary of Repeated Measures ANOVA on  
Profession, Gender and Method of Consent

Source	Sum of Squares	df	Mean Square	F
prof(p)	0.00240	1	0.00240	0.91
gender(g)	0.00240	1	0.00240	0.91
gp	0.00001	1	0.00001	0.00
ERROR	0.30507	116	0.00263	
method(m)	113.93153	3	37.97718	31.48***
mp	7.78437	3	2.59479	2.15
mg	3.37972	3	1.12657	0.93
mpg	9.24349	3	3.08116	2.55
ERROR	419.76664	348	1.20623	

\*p<.05    \*\*p<.01    \*\*\*p<.001

did not differ significantly. Physical coercion ( $\bar{X}=2.73$ ) was ranked next, followed by no coercion ( $\bar{X}=3.24$ ). The latter two means differed significantly ( $p=.05$ ) from one another and from the former two means ( $p=.05$ ). When the frequency of primary rankings was examined, it was noted that some clinicians (10%) reported that incest occurred most often in the absence of any type of coercion.

No significant differences were demonstrated on cross tabulations of gender, profession, experience or training, with the concomitant occurrence of physical abuse and incest. The mean rating for the extent to which physical abuse co-occurs with incest was 3 on a 5 point ordered scale indicating that clinicians see physical abuse "occasionally" in conjunction with incest.

Nine relationships between perpetrators and victims of incest were presented in the questionnaire (see Appendix A, question 10). Clinicians ranked the three most frequent patterns of incest reported in their practices.

As can be seen in Table 10, three quarters of clinicians (75%) reported that father-daughter incest was seen most often in their practices. The second pattern reported most frequently in the first ranked position was that involving a male relative and a female child (15% of clinicians). The third pattern to be ranked as most frequently occurring was incest between siblings (8% of clinicians).

Table 10. Clinicians' Rankings of Incest Patterns

Pattern	Rank			Not Ranked
	1	2	3	
father-daughter	89	23	6	8
other male relative-girl	18	66	17	25
siblings	9	21	34	62
other male relative-boy	3	7	19	97
father-son	0	7	10	109
other female relative-girl	0	3	3	120
mother-son	0	2	2	122
other female relative-girl	0	1	1	124
mother-daughter	0	0	2	124

Examination of the distribution of patterns in the second ranked position indicated that "other male relative and girl" was most often reported as the second ranked pattern. Sibling incest was most often reported as the third ranked pattern. This distribution replicates the frequency of reports of patterns of the first rank position.

A 2(gender) x 2(profession) x 9(pattern) repeated measures ANOVA of the pattern ranking was calculated. As indicated in Table 11, a main effect for pattern was found ( $p=.001$ ). Multiple comparisons were calculated utilizing the Studentized range statistic for means of father-daughter ( $\bar{X}=2.54$ ), other male relative-girl ( $\bar{X}=1.58$ ), and sibling incest ( $\bar{X}=0.81$ ) patterns. The three means differed significantly ( $p=.05$ ) from one another.

The following a priori hypotheses were tested in the analyses of perceptions of incest.

It was hypothesized that psychiatrists would report more violent forms of coercion perpetrated against their patients than would psychologists (Hypothesis 2). This hypothesis was not tested due to missing data.

It was hypothesized that non-physical coercion or the endowment of special favours by perpetrators of incest would be most frequently reported by clinicians (Hypothesis 3). This hypothesis was confirmed.

Table 11. Summary Table of Repeated Measures ANOVA of  
Profession, Gender and Incest Pattern

source	sum of squares	df	mean square	F
prof(p)	0.11488	1	0.11488	0.74
gender(g)	0.07566	1	0.07566	0.49
pg	0.06379	1	0.06379	0.41
ERROR	18.11754	117	0.15485	
pattern(i)	583.63779	8	72.95472	168.69***
ip	3.81272	8	0.47659	1.10
ig	3.49046	8	0.43631	1.01
ipg	6.13396	8	0.76675	1.77
ERROR	404.79909	936	0.43248	

\*p<.05    \*\*p<.01    \*\*\*p<.001



It was hypothesized that psychiatrists would report concomitant physical abuse with incest more frequently than would psychologists (Hypothesis 4). This hypothesis was not confirmed.

It was hypothesized that the most frequent pattern of incest reported in clinical practice would be father-daughter incest (Hypothesis 5). This hypothesis was confirmed.

#### Perceptions of Assessment and Treatment

Clinicians rated the extent to which clients or patients reported incest as the presenting problem; as a secondary problem; and the extent to which incest is reported, but is not considered a problem by the patient or client. Due to the small sample size, only pair-wise analyses of the independent factors could be calculated. A 2(gender) x 2(profession) x 3(problem) repeated measures ANOVA was calculated. As shown in Table 12 there was a significant main effect for problem ( $p < .001$ ) and a significant problem by gender interaction ( $p < .05$ ). Specifically, female more than male clinicians reported incest as a presenting problem ( $p = .05$ ).

A 2(training) x 2(experience) x 3(problem) repeated measures ANOVA was calculated. There was no main effect or interaction effect for experience. A significant problem by training interaction was found ( $p < .05$ ).

Table 12. Summary Table of Repeated Measures ANOVA of Profession, Gender and Problem

source	sum of squares	df	mean square	F
prof(p)	4.38139	1	4.38139	3.24
gender(g)	2.56864	1	2.56864	1.90
pg	0.88733	1	0.88733	0.66
ERROR	151.52221	112	1.35288	
problem(p)	45.24355	2	22.62177	23.69***
po	2.61650	2	1.30825	1.37
pg	7.99468	2	3.99734	4.19*
pog	1.50659	2	0.75330	0.79
ERROR	213.88363	224	0.95484	

\*p<.05    \*\*p<.01    \*\*\*p<.001

The relationship of gender and training effects was analyzed. A 2(gender) x 2(training) x 3(problem) repeated measures ANOVA was calculated. As indicated in Table 13, significant main effects for training ( $p < .05$ ), and problem ( $p < .001$ ) was demonstrated. A significant interaction effect for problem by training ( $p < .05$ ) was also found. The results of the 3 ANOVA's suggest that training effects overpower gender effects when the two variables are included in one analysis.

The significant training by problem interaction was investigated using the Studentized range statistic to compare means. Relative to untrained clinicians, trained clinicians more frequently saw patients who reported incest as a primary problem ( $p = .05$ ). Relative to untrained clinicians, trained clinicians also more frequently saw patients who reported incest as a secondary problem ( $p = .05$ ). The groups did not differ on the frequency of seeing patients who reported non-problematic incest.

It was hypothesized that a presentation of incest as a secondary problem would be reported more frequently than as a presenting problem (Hypothesis 6). This hypothesis was confirmed.

When asked whether they would refer incest victims to a self-help group, mental health centre or rape crisis centre there were no significant differences between trained and untrained clinicians, between male and female clinicians or

Table 13. Summary Table of Repeated Measures ANOVA  
of Training, Gender and Problem

source	sum of squares	df	mean square	F
train(t)	7.05811	1	7.05811	5.40*
gender(g)	1.07034	1	1.07034	0.82
tg	4.88278	1	4.88278	3.74
ERROR	146.28183	112	1.30609	
problem(p)	49.38023	2	24.69012	26.37***
pt	6.23319	2	3.11660	3.33*
pg	5.35857	2	2.67929	2.86
ptg	2.18146	2	1.09073	1.16
ERROR	209.73032	224	0.93630	

\*p<.05    \*\*p<.01    \*\*\*p<.001

between the two professions. The majority of clinicians (59%) would refer their patients or clients who report incest to a self-help group. Approximately one third of clinicians (37%) would refer victims to a mental health centre, while a smaller percentage (27%) would refer to a rape crisis centre. (One respondent wrote "never" beside the latter option.)

No differences by gender, training, or profession on referrals to a professional who specialized in working with incest or abuse were found. One significant difference was found for clinician's experience. Clinicians who had practiced 11 or more years were less likely than those who had practiced fewer than 11 years to refer to another professional ( $\chi^2(1, N=120)=8.52; p<.01$ ).

Clinicians indicated their willingness to ask new patients or clients about prior incest in several situations (see Appendix A, question 14). The type of inquiry (ask a general sexual history vs. ask about prior incest) in two situations (sexual problems presented vs. no sexual problems presented) was compared using a 2(gender) x 2(profession) repeated measures ANOVA. The summary of this analysis is shown in Table 14. There was a main effect for profession ( $p<.01$ ) question type ( $p<.001$ ), and problem type ( $p<.001$ ) as well as an interaction effect between question and problem type ( $p<.001$ ). To examine the significant question by problem interaction, multiple comparisons of means using the Studentized range statistic were calculated. The mean score of willingness to ask a general

Table 14. Summary Table of Repeated Measures  
ANOVA of Profession, Gender, Problem and Question

source	sum of squares	df	mean square	F
prof(p)	11.63329	1	11.63329	7.57**
gender(g)	3.85939	1	3.85939	2.51
og	1.38190	1	1.38190	0.90
ERROR	187.57386	122	1.53749	
prob(p)	26.27729	1	26.27729	79.52***
po	1.18570	1	1.18570	3.59
pg	0.80123	1	0.80123	2.42
pog	0.00769	1	0.00769	0.02
ERROR	40.31238	122	0.33043	
quest(q)	37.51486	1	37.51486	48.27***
qo	0.00043	1	0.00043	0.00
qg	0.01028	1	0.01028	0.01
qog	0.15371	1	0.15371	0.20
ERROR	94.82481	122	0.77725	
pq	27.61445	1	27.61445	66.59***
pqo	0.29684	1	0.29684	0.72
pqg	0.38464	1	0.38464	0.93
pqos	0.00277	1	0.00277	0.01
ERROR	50.59571	122	0.41472	

\*p<.05    \*\*p<.01    \*\*\*p<.001

sexual history ( $\bar{X}=2.52$ ) did not differ significantly from the mean score of willingness to ask about incest ( $\bar{X}=2.44$ ) when sexual problems were presented. The mean score of willingness to ask a general sexual history ( $\bar{X}=2.52$ ) differed significantly ( $p=.05$ ) from the mean score of willingness to ask about incest ( $\bar{X}=1.31$ ) when non-sexual problems were presented. The difference between the two differences was not significant.

A repeated measures ANOVA of the experience variable was not significant. A 2(training) by 2(victims seen) by 2(problem) by 2(question) repeated measures ANOVA was calculated. There were no main effects for training or the number of victims seen (0 to 20 or more than 20). A small but significant ( $p<.05$ ) 4-way interaction effect of training by victims seen by problem by question was found.

It was hypothesized that clinicians with special training would be more likely to ask new patients about incest (Hypothesis 7). This hypothesis was not confirmed.

It was hypothesized that the more incest victims seen during the past year, the more willing a clinician would be to ask new patients or clients about prior incest (Hypothesis 8). This hypothesis was not confirmed.

It was hypothesized that clinicians would be more willing to ask a general sexual history than specifically about incest in cases presenting with non-sexual difficulties. (Hypothesis 9). This hypothesis was confirmed. Clinicians were more willing to

ask a general sexual history than specifically about incest when assessing patients with non-sexual presenting problems.

Clinicians' assessment inquiries did not differ for patients presenting with sexual problems.

Using a checklist of 25 items, each with a 5 point ordered scale, clinicians indicated the frequency of association between checklist items and a history of incest among their clients or patients. The items included behaviours, symptomatology and psychosocial variables identified in the literature as associated with a history of incest. Browne and Finkelhor's (1986) review of research was used as a guideline to group the items for analysis. Where there was strong agreement among studies supporting the association of a phenomenon with a history of incest, e.g., chronic depression, the item was included in the "Strong Association" group. The association of a phenomenon with incest which was supported by some studies but not others was included in the "Medium Association" group. Phenomena which have been related to incest, but the equivocally demonstrated empirically, e.g., homosexuality, comprised the "Weak Association" group. In addition, several items which have not been thought to be associated with incest (e.g., delusional thinking) were included in the last group. The three groups and the items included in each can be found in Appendix G.

As in other analyses in the present study, analysis of the 3 item groups for the effects of gender, profession, training and experience were performed. The number of incest victims seen in



the past year was also cross tabulated with item frequency ratings. Contingency tables were constructed for the sums of ratings on items in the 3 groups with each of the 5 factors. Cross tabulations utilizing 5 categories of sums yielded minimum expected values which were too small to be meaningful (less than 1). The 5 categories were collapsed into 2 categories, "infrequent" and "frequent" reports, such that scores of less than 60% of the possible total score fell into the "infrequent" category.

Significant gender differences were demonstrated on the strong and medium association item groups. Female clinicians (94%) were more likely than male clinicians (74%) to report that strong association items occurred frequently among their incest cases ( $\chi^2(1, N=105)=3.92$ ;  $p<.05$ ). Female clinicians (81%) were more likely than male clinicians (51%) to report frequent occurrences of medium association items ( $\chi^2(1, N=107)=6.71$ ;  $p<.01$ ). No gender difference was found for the weak association items. It is interesting to note that 94% of female clinicians and 77% of male clinicians reported seeing these items frequently among their patients or clients with a history of incest.

No significant differences were found when contingency tables of the 3 groups with the factors of profession, or experience were analyzed. There were no differences between trained and untrained clinicians on the reported frequency of strong or medium association group items. A significant

difference was found on the cross tabulation of weak association items and training. Clinicians with special training (23%) were more likely than nontrained clinicians (4%) to report frequent occurrences of weak association items ( $\chi^2(1, N=108)=7.16$ ;  $p<.01$ ).

Cross tabulations of the item groups and the number of victims seen in the past year demonstrated significant differences on medium association group items. Clinicians (86%) who had seen more than 20 incest victims in the past year were more likely to report frequent observation of medium association items than were clinicians (52%) who saw fewer than 20 victims ( $\chi^2(1, N=109)=5.67$ ;  $p<.05$ ).

A three-dimensional contingency table of gender, number of victims seen and medium association items was constructed. A nested sequence of all log-linear models (which included an interaction term of gender and victims seen) was fitted to the data shown in Table 15. The model including three 2-way interactions was sufficient to account for the data. The effects of gender and victims seen with frequency ratings of medium association items are not due to the effects of only one of the independent variables.

It was hypothesized that female clinicians would be more accurate than male clinicians in reporting the long term effects and behaviours associated with a history of incest (Hypothesis 10). This hypothesis was confirmed. However, it was also found

Table 15. Contingency Table and Summary of Log-Linear  
Analysis of Gender, Victims Seen and  
Medium Association Items

Victims Seen(v)	Gender(g)	Medium Association Items(a)		Total (Frequency Reported)
		Infrequent	Frequent	
0-20	male	34	30	64
		(53)	(47)	(100%)
	female	5	14	19
		(26)	(74)	(100%)
over 20	male	3	8	11
		(27)	(73)	(100%)
	female	1	11	12
		(8)	(92)	(100%)

Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
v,g,vg	4	16.80	.0021
v,g,vg,a	3	13.00	.0046
v,g,vg,a,ga	2	4.27	.1181
v,g,vg,a,va	2	5.87	.0532
v,g,vg,a,ga,va	1	0.04	.8469

that female clinicians more than male clinicians reported frequently seeing behaviours and symptoms which are sometimes associated with incest.

Hypothesis 11 stated that the more patients or clients with a history of incest seen by a clinician during the past year, the more often behaviours and symptoms which are strongly associated with incest would be reported. This hypothesis was not confirmed. There was, however, a difference between groups on behaviours and symptoms which are sometimes associated with incest.

Several symptoms were hypothesized to show effects due to profession. Cross tabulations of profession with repeated victimization, abuse of one's own children, a history of running away in adolescence, prostitution and substance abuse demonstrated a significant difference on only one symptom. Almost half of psychologists (46%) reported that substance abuse occurred frequently among their clients compared to approximately one quarter of psychiatrists (27%) ( $\chi^2(1, N=119)=3.96; p=.05$ ).

It was hypothesized that psychiatrists would report more frequently than psychologists observing a history of prostitution, adolescent running away from home, substance abuse and a cycle of violence including repeated victimization and abuse of one's own children (Hypothesis 12). This hypothesis was not confirmed. A profession effect for substance abuse was

demonstrated but it was opposite to the expected direction.

Clinicians rated the importance of several therapy goals using a 5 point ordered scale of values which ranged from "never important" (1) to "always important" (5). Few differences were found on clinicians' ratings. Contingency tables of the 5 point ratings on each of 5 therapy goals yielded minimum estimated expected values which were too small to be meaningful. Ratings were collapsed into 2 categories: always important (scored 5); and less important (scored 4 or less).

Cross tabulations of therapy goals with gender revealed one significant difference. Female clinicians (73%) were more likely than male clinicians (51%) to rate improved coping (by skills training) as always important ( $\chi^2(1, N=124)=4.45$ ;  $p<.05$ ). Cross tabulations of therapy goals with training revealed the same pattern as that found for gender. Trained clinicians (73%) were more likely than untrained clinicians (51%) to rate improved coping as always important ( $\chi^2(1, N=124)=4.45$ ;  $p<.05$ ).

A nested sequence of all log-linear models that included interactions among the 2 independent variables was fitted to the data shown in Table 16. Models which included a 2-way interaction term of the independent variables, and a 2-way interaction term of gender and therapy goal, or training and therapy goal, were sufficient to account for the data. A method to determine which of the two models is better is controversial at the present time. The patterns of gender and training in

Table 16. Contingency Table and Summary of Log-Linear  
Analysis of Training, Gender and Importance of  
Improved Coping

Training(t)	Gender(g)	Improved Coping Importance(i)		Total
		Not Always	Always	
Not Trained	male	37	30	67
		(55)	(45)	(100%)
	female	6	14	20
		(30)	(70)	(100%)
Trained	male	6	14	20
		(30)	(70)	(100%)
	female	4	13	17
		(24)	(76)	(100%)

Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
t,g,tg	4	12.33	.0150
t,g,tg,i	3	9.71	.0212
t,g,tg,i,gi	2	4.21	.1219
t,g,tg,i,ti	2	4.21	.1219
t,g,tg,i,gi,ti	1	0.61	.4365

relation to the therapy goal (described above) were 'true' pattern differences. The data were not sufficiently accounted for by gender or training alone.

One significant difference was found on cross tabulations of the 5 goals and profession. Proportionately more psychiatrists (22%) than psychologists (12%) rated attaining insight (into the psychodynamic meaning of the experience) as always important ( $\chi^2(4, N=128)=10.63$ ;  $p<.05$ ). The same cross tabulation indicated that psychiatrists (3%) were less likely than psychologists (17%) to rate this goal as never important.

No significant effects were revealed for the experience factor.

Clinicians were requested to provide the diagnosis which they most commonly applied to the psychopathology presented by incest victims. They were also requested to provide any differential or secondary diagnosis which they would utilize. The data on primary diagnosis is shown in Table 17. Approximately one fifth of the psychiatrists (21%) but more than half of the psychologists (57%) did not provide any diagnosis. Of those who provided at least one diagnosis, the most common diagnosis made was that of affective disorder, usually chronic depression. The diagnoses provided by respondents were grouped into five categories: Borderline Personality Disorder; Affective Disorders; Post-Traumatic Stress Disorder (PTSD) and Adjustment Disorder; Personality Disorders other than Borderline; and

Table 17. Primary Diagnosis Given by  
Psychologists and Psychiatrists

Diagnosis	Profession		Total
	Psychologist	Psychiatrist	
Borderline Personality Disorder	5	1	6
Affective Disorder	7	26	33
PTSD	7	19	26
Personality Disorder (other than Borderline)	2	8	10
Other	5	2	7
No diagnosis given	35	15	50



"other diagnoses" such as Anxiety Disorders, marital and family problems.

There was a significant difference between the primary diagnosis given by psychiatrists and psychologists ( $\chi^2(4, N=82)=15.1$ ;  $p<.01$ ). As a group, psychiatrists diagnosed Affective Disorders and PTSD or Adjustment Disorder more than any of the other disorders whereas psychologists as a group showed a more uniform distribution of diagnoses. However, compared to psychologists, psychiatrists seldom diagnosed Borderline Personality Disorder.

The two groups did not differ on differential or secondary diagnoses. Furthermore, there were no gender differences on these variables when cross tabulations with gender, experience, or training were examined. Cross tabulations of the diagnosis of PTSD or Adjustment Disorder by gender revealed no significant differences.

It was expected that Borderline Personality Disorder would be the most frequent diagnosis (Hypothesis 13). This hypothesis was not confirmed.

It was hypothesized that female clinicians would utilize a diagnosis which acknowledges environmental stressors (such as Post-Traumatic Stress Disorder) more than would male clinicians (Hypothesis 14). This hypothesis was not confirmed.

Clinicians' perceptions of the importance of several intervention strategies were examined. Significant gender differences were found on three variables. More female clinicians (65%) than male clinicians (45%) considered individual long term therapy often important ( $\chi^2(2, N=118)=7.26$ ;  $p<.05$ ). The same contingency table indicated that female clinicians (15%) were less likely than male clinicians (41%) to consider this form of therapy as infrequently important ( $\chi^2(2, N=118)=7.26$ ;  $p<.05$ ). A different pattern emerged for importance ratings of family therapy. About one third of male clinicians (35%) considered it to be frequently important compared to roughly one sixth of female clinicians (14%) ( $\chi^2(2, N=119)=6.86$ ;  $p<.05$ ). More female clinicians (37%) than male clinicians (11%) rated group therapy with other incest survivors as always important ( $\chi^2(2, N=120)=12.56$ ;  $p<.01$ ).

No significant differences were found on cross tabulations of intervention strategies with profession, or experience. A significant training effect was demonstrated for long term individual psychotherapy. More clinicians with training (68%) than clinicians without training (44%) rated this form of therapy as often important ( $\chi^2(2, N=118)=6.4$ ;  $p<.05$ ). However, fewer trained clinicians (6%) than non-trained clinicians (20%) rated long-term individual psychotherapy as always important ( $\chi^2(2, N=118)=6.4$ ;  $p<.05$ ).

A nested sequence of all log-linear models including interactions among the independent variables (gender and

Table 18. Contingency Table and Summary of Log-Linear Analysis of Training, Gender and Long-Term Psychotherapy

Training(t)	Gender(g)	Psychotherapy Importance(p)			Total
		infreq	often	always	
Not Trained	male	26	26	12	64
		(41)	(41)	(18)	(100%)
	female	4	11	5	20
		(20)	(55)	(25)	(100%)
Trained	male	8	12	0	20
		(40)	(60)	(0)	(100%)
	female	1	11	2	14
		(7)	(79)	(14)	(100%)

#### Summary of Log-Linear Analysis

model	df	likelihood- ratio chisq	prob
t,g,tg	8	40.24	.0000
t,g,tg,p	6	17.88	.0065
t,g,tg,p,gp	4	9.90	.0421
t,g,tg,p,tp	4	10.97	.0269
t,g,tg,p,gp,tp	2	3.49	.1747

training) was fitted to the data shown in Table 18. As indicated in Table 18, the model which included three 2-way interaction terms of gender and training, gender and therapy, and training

and therapy was sufficient to account for the data. The data were not sufficiently accounted for by gender or training alone.

It was hypothesized that female clinicians would rate skills training to improve coping effectiveness and group therapy for incest survivors as important more frequently than would male clinicians (Hypothesis 15). This hypothesis was confirmed.

## CHAPTER IV

### DISCUSSION

The data obtained from clinicians in the present study differed from that obtained in previous studies that have surveyed clinicians. Finkelhor (1979) provided clinicians with hypothetical cases and assessed case management strategies. Attias and Goodwin (1985) asked their participants to estimate the prevalence of incest. Child psychiatrists surveyed by LaBarbera et al. (1980) were asked to assess prospectively the nature and severity of the long-term effects of incest.

Participants in the present study were asked about their experiences working with incest victims seen in their practices. By focussing on experience rather than on hypothetical cases, it was hoped that more interest would be generated and a higher response rate would be obtained. The obtained response rate was not higher than that obtained in other studies but it was comparable. Attias and Goodwin (1985) obtained a 43% response rate when questionnaires were mailed to all psychiatrists, pediatricians, psychologists and counsellors listed in the yellow pages of the telephone directory. The current study was restricted to clinicians who worked with adults. When the questionnaires returned by other clinicians are included, the current study obtained an overall response rate of 45%. LaBarbera et al. (1980) obtained a 32% response rate from a mail questionnaire survey of psychiatrists. They randomly selected an

equal number of female and male psychiatrists to survey. Of the responses received, 59% were from males and 41% were from females. In the present study random selection of subjects was not used. Although more respondents were male than female, the sample distribution of males and females within the two professions appears representative of the gender distribution in the population of the two professions. However, the generalizability of the study's findings to the population can not be assumed on the basis of gender representativeness alone.

Finkelhor's (1983) study differed from the other studies and from the current study in sampling method as well as type of measures. Questionnaires were distributed to 790 professionals from a broad spectrum of agencies who were attending meetings and teaching-conferences about child sexual abuse, thus obtaining a high participation rate (the exact percentage was not given) but a highly selected sample which is unlikely to be representative of all professionals. One example of this is the fact that his sample was predominantly female (80%), with a median age of 31.8 years and 5.5 years of professional experience. The precise number of psychologists and psychiatrists who participated in the study was not given. Finkelhor's sample was probably biased toward the professional who is interested in and works with at least some sexual abuse victims. Indeed the demographic profile obtained by Finkelhor is similar to the profile obtained in this study of the therapist who reports seeing many incest victims (i.e., female, young and

fewer years of experience).

The clinician in the present sample who sees more than 20 incest victims in one year tends to be a woman who has obtained some special training in working with incest or sexual abuse victims. Her patients or clients are likely to be women who have been incestuously abused by their fathers or another male relative. The abuse often began before the victim was five years old, through the use of non-physical coercion or special favours. The clinician most often treats victims who enter therapy for reasons other than incest, but incest is considered a secondary problem. Reasons for entering therapy may be due to the consequences of incest as suggested by Gelinas (1983) and Lindberg and Distad (1985a). The clinician is willing to refer incest victims to a self-help group, and she considers this an important intervention strategy. She observes many behaviours and symptoms associated with incest among her clients or patients. Finally, she does not consider therapy involving incestuous family members to be as important as long-term individual psychotherapy for the victim herself.

Another purpose of the study was to compare reports of symptomatology by victims to reports of symptomatology by clinicians working with victims. In effect, the question was raised: do clinicians hear what incest victims are telling them? Alternatively, the question may be posed: are victims' reports of symptomatology to clinicians similar to victims' self-reports in research studies? The present study's findings appear to

offer positive support that clinicians and victims' reports are similar. Female clinicians observed more of the behaviours and symptoms with a strong or medium association with incest than did male clinicians, although the two groups did not differ on weakly associated items. More importantly, high percentages of both male and female clinicians frequently observed these items among their incest cases. Training had an effect on weakly associated items as demonstrated by an increase in the frequency of reports by trained clinicians. If 20 or more victims were seen, clinicians more frequently reported the items that are commonly associated with incest.

The most interesting pattern in these differences is not that strongly associated items are reported by large percentages of clinicians but that weakly associated items are reported too, by as few as one quarter of trained clinicians and as many as nine tenths of female clinicians. Exposure to the phenomenon of incest, through training or through working with at least 20 victims in one year (or both), appears to increase a clinician's sensitivity to the range of long-term effects that are associated with childhood incest.

This finding may not be surprising given the somewhat arbitrary inclusion criterion of items in one of the three groups for analysis. Also the generality of many terms probably allowed for considerable interpretation by clinicians. For example, while phobias in general may not be associated with prior incest, specific phobias such as aversion to particular



sexual activities which occurred during the abuse have been reported in the literature.

Limitations exist in comparing the present data on frequency of reporting long-term effects to previous studies on severity of long-term effects. Differences in wording prevent direct comparison of the two measures. Nevertheless, frequency data may serve as a general or broad indicator of severity if severity is defined as extent of occurrence among victims. If one consistently sees chronic depression among one's patients or clients reporting a history of incest, it can be assumed that chronic depression represents a serious problem for incest victims (at least in a clinical population). If one seldom sees delusional thinking exhibited by incest victims, regardless of the severity experienced by some individuals with the symptom, clinicians will not likely consider delusional thinking to be a serious problem for incest victims as a group (in a clinical population).

The results of the current study did not support the findings of LaBarbera et al. (1980), as hypothesized. Among child psychiatrists, the researchers found a negative relationship between severity ratings of incest's long-term effects and the number of incest victims treated. Clinicians in the present study rated frequency rather than severity of incest's long-term effects. If frequency ratings can be considered a measure of severity, then the present study found a positive relationship between these two variables, at least on

long-term effects that have been commonly associated with incest. This conclusion must be made with caution since frequency and severity are not synonymous. The more incest victims a clinician treats the more frequently she or he is likely to observe the long-term effects of incest. It is also the case, however, that as the number of incest victims treated increases, the more consistent and 'accurate' a clinician's observations are likely to be. For example, some clinicians reported that an item was 'always' associated with incest, and stated that their observation was based on a sample of 1 or 2 incest victims. In comparison, if clinicians who saw more than 20 victims reported that an item was frequently associated with incest the prevalence of that symptom suggests its severity among incest victims. LaBarbera et al. asked clinicians about the potential long-term effects that incest victims may experience whereas the present study obtained observations about symptomatology currently experienced by adult survivors of incest seen in clinical practice. The method used in the present study probably increased the frequency of reported long-term effects and the consistency of reports by clinicians. The lack of agreement among clinicians found by LaBarabera et al. may have been a function of the inconsistency of immediate effects manifested by incest victims which Browne and Finkelhor (1986) noted. On the other hand, it is possible that clinicians in the present study may be observing and reporting symptomatology that is temporary but which may be severe enough to prompt a victim to seek treatment (e.g., delusional thoughts, fear of abusing

one's children [Herman, 1981]). Such symptomatology may be neither chronic nor long-term effects of incest.

It must be noted that clinicians were not asked about symptomatology that was unique to incest survivors. The symptomatology reported by clinicians may, in fact, be common among people in therapy regardless of having had incest experiences. Incest survivors in a clinical population, however, appear to suffer more severe and generalized symptoms than do incest survivors who do not seek treatment (Tsai et al., 1979). It would be interesting to survey clinicians regarding their perceptions of the long-term effects of incest in a clinical population, and in the general population. Significant differences in perceptions might be revealed that would reflect the differences found between studies on the long-term impact of childhood trauma when different populations (e.g., university students versus patients admitted to a psychiatric hospital) are studied.

It would also be of interest to survey incest survivors who are in therapy and those who are not in therapy to better distinguish the effects of incest in these two groups. Tsai et al. (1979) provided some data of this nature. They studied women who had been molested and were seeking treatment and women who had been molested but considered themselves well-adjusted. Only women in the latter group were asked what helped them to cope with their molestation experience, suggesting that the researchers biased their findings of differences between the two

groups. It is also unclear how the request for "well-adjusted" women may have biased the subjects' responses. Although research exists on the psychopathology of incest survivors much of it has been done with incest survivors in treatment programs or therapy (e.g., Herman, 1981; Meiselman, 1978; Scott & Stone, 1986a, 1986b). The lack of a non-clinical comparison group prevents generalization to all incest survivors.

A number of effects due to gender, profession, years in practice and training were demonstrated in the present study. The most numerous of these were effects due to gender. In a study of clinicians' views of incest, Attias and Goodwin (1985) found that gender was an important variable. Differences due to profession were not demonstrated in their study. As expected in the present study, women estimated a higher incidence of incest victims in their practices and estimated that they had seen more victims in the past year than did men. The effect of gender was not as strong when the effect of training was considered in relation to incidence estimates. Attias and Goodwin found that female clinicians were more accurate in their estimates of the prevalence of incest than were male clinicians. The current study suggests a similar conclusion. More men than women estimated an incidence of less than 5%. Studies of psychiatric populations suggest that between 10% and 35% of all patients have experienced incest (Rosenfeld, 1979; Westermeyer, 1978). The rate is often much higher for special groups (e.g., substance abusers, prostitutes). An incidence of incest

exceeding 5% in a clinician's practice would be expected. The results of the present study support the notion that women are more accurate in their estimates of incest's incidence in a psychiatric setting.

A more accurate estimate of incidence by women may reflect a greater acknowledgement of incest by their patients and clients. Female clinicians more often than male clinicians reported that incest constitutes the presenting problem in their practices. If fewer incest victims reveal their victimization to male clinicians at the outset of therapy, then male clinicians may have to guess more about incest's incidence. Guessing may lead to inaccuracy. In general, both male and female clinicians more often reported incest as a secondary problem than as the presenting problem of their clients or patients. This finding is similar to Briere's (1984) study in which fewer than half of sexually abused women reported it as a presenting complaint at a community clinic. Despite the finding that clinician groups distinguished among the status of incest as a presenting problem in the present study, the distinctions (primary, secondary, non-problematic) should be regarded as continuous rather than discrete and inflexible situations. The importance attributed to incest by survivors, and by clinicians, may alter as therapy proceeds. For example, an initial presentation of incest as non-problematic may be due to denial or repression. Incest-related issues may later become the focus of therapy. Lindberg and Distad (1985a) noted that women in their study did

not attribute their symptomatology to their incest experience despite the fact that they considered the experience to have had a significant impact on their lives.

More female than male clinicians reported having acquired special training for working with incest or sexual assault victims. A relationship between having training and making high estimates was found in the present study. Such training often focusses on the prevalence of incest in the general population, and on long-term effects of incest for which incest survivors may seek treatment. As noted by Gelinias (1983) an incest history may not be revealed until late in therapy. Women's greater awareness of the sequelae to incest may lead them to assume an incidence greater than admitted by their clients or patients at the beginning of therapy. Similarly, trained clinicians may assume a high incidence based on their knowledge of prevalence. Men, on the other hand, (or untrained clinicians) may base their estimates on the number of victims who have disclosed an incest history. Having completed the questionnaire for the present study, some clinicians commented that they had probably overlooked cases of incest by failing to ask about it or by not relating some symptoms to a possible history of incest.

A gender difference in the opposite direction was found for estimates of male incest victims. Male clinicians estimated a higher incidence of male incest victims than did female clinicians. Two factors may have contributed to this result. One factor is that female clinicians probably work with fewer males

than do male clinicians, which will contribute to low estimates of incidence of male victims. A second factor is that male incest victims may be more likely to reveal their victimization to male clinicians. Several male clinicians reported that they worked exclusively with males, usually in correctional settings, and incidence estimates from these clinicians was as high as 100%. Male clinicians may be more sensitive to male cues regarding the impact of incest.

There was agreement between male and female clinicians on most of the perceptions of incest. Female clinicians reported an earlier age of onset for incest than did male clinicians. There was no difference on reports of the average age at which incest ends. According to research, incest may stop when the child reaches puberty, leaves home, or when the incest is discovered. These events are likely to be quite clear in victims' memories because there may have been witnesses or dates to recall in relation to the time at which incest stops. Cessation of incest is also closer to the present time when the victims recall and describe it; memory will be less disorted by the passage of time. All of these possibilities suggest that the age at which incest ends is more easily pinpointed, verified or described, increasing the veridicality of victims' reports. Agreement between clinicians on this variable likely reflects the relatively objective nature of the event.

The onset of incest is not as clearly defined. Incest may begin as behaviour that is not overtly sexual but which is

inappropriate to the situation, to the developmental status of the child or which causes confusion or discomfort for the child. Due to confusion, the nature of the events that initiated the incest relationship (e.g., hugging, tickling, being held on a person's lap), or the distortion of memory due to age and time, the adult incest survivor may be unclear as to when the incest began. Thus onset may be considered a more subjective event by clinicians. A gender difference on this variable is interesting; it suggests that attitudes may differ between men and women as to what constitutes the onset of incest.

There appears to be a widely accepted view in the literature that the earlier the onset of incest the more traumatic will be the consequences for the child (Courtois, 1979; Hyde & Kaufman, 1984; VanGijseghem, 1975). Tsai et al. (1979) found some support for the impact of early onset on adult maladjustment. The finding that female clinicians in the present study reported an earlier onset of incest and more long-term effects than did male clinicians may contribute to a perception among female clinicians more than among male clinicians that incest is harmful. Not all researchers agree, however, with the view that an earlier onset is more harmful (e.g., Peters, 1976). More importantly, Courtois and Watts (1982) have cautioned that variables such as onset, duration, use of force and relationship to the offender should not be examined singularly.

Gender differences were also demonstrated in the present study on the long-term effects of incest, treatment goals and



strategies. It had been hypothesized that female clinicians would be more accurate than male clinicians in their endorsement of frequently and commonly associated symptoms and behaviours. While this hypothesis was supported, both male and female clinicians also frequently endorsed symptoms which have been equivocally associated with a history of incest. This finding suggests that clinicians consider a wide variety of symptoms and behaviours to be associated with incest. It further suggests that the impact of incest can be wide ranging and can result in poor adjustment among incest survivors.

Clinicians had been requested to report the frequency of symptoms seen among their patients or clients. The extensive reporting of symptoms by clinicians may reflect the population being observed. Incest survivors in treatment settings are likely to be less well-adjusted and display more psychopathology than incest survivors in other settings, such as university populations.

The finding of numerous symptoms associated with incest may also be related to the finding of father-daughter incest as the most frequently reported incest pattern in the respondents' practices. Incestuous abuse by one's father or stepfather appears to be especially harmful (Browne & Finkelhor, 1986) and the extensive reports of symptoms by clinicians provides some support for the relationship between abuse by a father and negative outcome. The incidence of father-daughter incest found in the present study is similar to the incidence reported in

other clinical studies (e.g., Briere [1984] found that 40% of abusers were fathers).

Female clinicians reported higher frequencies of symptoms than did male clinicians, despite the extensiveness of symptoms and high frequencies of reports. This may have been due, in part, to the fact that men in the present study had seen fewer victims in the past year. Men may have reported less frequent occurrences due to the small number of cases on which their reports were based.

As suggested earlier, women may consider the long-term effects of incest to be more serious than do men. One measure of this may be the type of therapy considered important in the treatment of incest survivors. Women more than men considered long-term psychotherapy as always important. This finding appears to contradict a political view which holds that traditional psychotherapy ignores the social context of the person's problems by focussing on intrapsychic functioning. Due to its medical origin, psychotherapy patients are often stigmatized by the myth that only "sick" or "crazy" people need therapy. Female clinicians' endorsement of long-term psychotherapy may reflect the view that such an extensively harmful experience as incest would require substantial attention in therapy. Short-term therapy may be considered insufficient to resolve the impact of the incest experience.

Women in the present study considered group therapy to be a more important form of therapy than did men. Group therapy with other incest survivors plays an important role in decreasing feelings of isolation and ostracism often experienced by incest survivors (Tsai & Wagner, 1978). Recently, an evaluation of a group therapy program for incest survivors suggested that the group therapy experience may not decrease depression but does alleviate feelings of isolation (Beauregard, 1986).

Women also considered skills training, to increase effective coping, as more important than did men. Taken together, the gender differences on long-term effects and intervention strategies suggest that women consider incest to have multiple effects for which several types of intervention will be beneficial.

Few differences between psychologists and psychiatrists were found in the present study. Although a difference was found for profession on incidence estimates, an interaction with gender was also demonstrated. A difference between professions was found on willingness to inquire about prior incest or to ask a general sexual history in several situations. Psychiatrists were more willing than psychologists to ask questions in all situations, which may be due to differences in professional education rather than to differences in client populations. The lack of differences between professions in this study is comparable to Attias and Goodwin's (1985) findings. Their study of psychiatrists, psychologists, family counsellors and social

workers failed to demonstrate differences among professions. Gender differences accounted for the main findings in their study. The frequency with which the diagnosis of Affective Disorders, usually depression, was found in the present study is also consistent with Attias & Goodwin's finding that clinicians ranked depression as the primary problem in managing incest victims. Studies of symptomatology reported by adult survivors of incest and sexual abuse reveal that depression predominates.

Not surprisingly, psychiatrists considered attaining psychodynamic meaning about the incest experience to be more important than did psychologists in the present study. This probably reflects the psychodynamic orientation of the former group's training.

It is of interest that so few psychologists provided any diagnosis. The survey question was phrased, "If you utilize diagnoses, what is the most common diagnosis which you give to incest victims?" Many psychologists noted that the question was not applicable while some psychiatrists commented that they were required to give diagnoses. Few clinicians responded that giving a diagnosis was inappropriate or irrelevant. Thus it appears that psychologists do not use diagnoses extensively in their work.

Differences in education may account for the difference in diagnostic practice between the two professions. It is possible that medical training predisposes psychiatrists to attend more

to physiological symptoms and to utilize diagnoses such as depression more frequently. However, psychiatrists diagnosed Affective Disorders, and Post Traumatic Stress Disorder (PTSD) or Adjustment Disorder with similar frequency, suggesting that the impact of environmental or nonphysiological traumatic events such as incest on mental health is being recognized. The high rate of diagnosing PTSD found in the present study may also be due to the current popularity of the diagnosis (Lindberg & Distad, 1985a). Conversely, psychologists may receive more educational instruction in personality development and may tend to use diagnoses which reflect this orientation.

Further research will be required to determine more accurately the information which is used in applying a diagnosis to psychopathology and dysfunctional behaviour presented by incest survivors. One important variable to be examined is the effect that specialized training for working with sexual abuse exerts on clinicians' diagnostic practices. Frequent reports of substance abuse, running away and suicide attempts were found in the present study. The high incidence rate of incest among women in substance abuse programs, runaways and psychiatric inpatients may be discussed in therapist training programs. It is possible that training sensitizes clinicians to associate these behaviours with a history of incest, and to look for a history of these behaviours among their patients who are incest victims. A history of engaging in these behaviours, if sufficient in number, fits the DSM-III (1980) criteria for a diagnosis of

Borderline Personality Disorder (BPD). Training probably also sensitizes clinicians to the social and political context of dysfunctional behaviours associated with incest which may increase the use of the PTSD rather than the BPD diagnosis.

The poor treatment prognosis which accompanies the BPD diagnosis is of more concern than the prevalence of the diagnosis itself. If current training programs increase clinicians' awareness of the long-term effects of incest (which may influence the diagnosis of BPD), hopefully it also influences their intervention strategies for working with incest survivors. A focus on working through incest issues which contribute to adult dysfunction will likely promote a better therapeutic outcome than that usually expected for the BPD diagnosis (Briere, 1984).

In the present study, analysis of the effects of training yielded quantitatively few significant results. Nevertheless, training had an impact on several interesting variables. A relationship between gender and training was found on estimates of the incidence of incest in clinicians' practices. Although proportionately more women than men reported high incidences, training was also related to clinicians' perceptions of incidence. Furthermore, all trained clinicians reported seeing at least one incest victim in the past year. Trained clinicians also tended to see more than 20 victims in the past year. Training was a more powerful variable than gender on this measure. The causal direction of the relationship could not,

however, be determined in the present study. At least two situations are possible. The high rate of victims seen, and the frequency of incest as a presenting complaint, reported by trained clinicians may be due to clinicians' profiles in the mental health community as 'specialists' who work with incest survivors. It is also possible that clinicians who see a high rate of victims and frequent presentation of incest as the primary complaint (for unknown reasons) seek special training. Clinicians' motivations for acquiring training, for example due to interest or due to perceived need, would be useful information for training program development.

The majority of clinicians, trained and untrained, frequently reported long-term effects which have strong empirical support, and long-term effects which have moderate empirical support. The most interesting effect regarding long-term effects was found on reports of symptoms and behaviours which are equivocally associated with incest. Trained clinicians were more likely than untrained clinicians to endorse these items as frequently occurring, suggesting that trained clinicians have been sensitized to the relationship that potentially exists between childhood incest experiences and adult dysfunction. Trained clinicians more than untrained clinicians endorsed the importance of improved coping through skills training and long-term individual psychotherapy.

Rather than hesitating to attribute long-term harmful outcomes to incestuous experiences, clinicians demonstrated

general agreement in their perceptions of its negative consequences. LaBarbera and Dozier (1981) have suggested that clinicians may be overly willing to assume an adverse outcome to an incest experience. Their recommendation is based on the fact that harmful consequences of childhood incest have not consistently been demonstrated in studies of incest victims' immediate and later adjustment. The problems associated with the studies of victims cited by LaBarbera and Dozier have been reviewed in the present study. The most conservative approach a clinician might take is to assume that incest always has an impact with potentially harmful consequences, but that individual victims may circumvent or overcome its consequences (e.g., with the support of family and friends). The consensus among studies on incest's negative impact does not warrant a position such as that of LaBarbera and Dozier, that is, to be hesitant in considering incest harmful. Such an attitude may perpetuate the myth that incest is not harmful and may lead clinicians to invalidate a victim's perceptions of the experience as harmful. Furthermore, data from outcome studies of incest victims who are not in therapy may not be applicable to the experiences of incest victims who enter therapy, and may be inappropriate guides for clinicians.

The clinicians in Attias & Goodwin's (1985) study most often requested information and training to improve their effectiveness in working with incest victims. The present study offers some support for the hypothesis that training has an



impact on clinicians' perceptions. The present study, however, did not explore this variable in detail. Variation in clinicians' reports of their training experiences suggests that future research should clearly specify the parameters of the training experience. The most common description of training given by trained clinicians in the present study was attendance at workshops and conferences. Some clinicians stated, however, that they had attended workshops yet considered themselves to be untrained. Thus, an overlap between the two groups in training experiences may have contributed to the lack of differences found between them.

A more direct evaluation of the influence of training on clinicians' perceptions and intervention strategies would be useful. A program evaluation with pre- and post-testing (and periodic follow-ups) might distinguish among trained and untrained clinicians' perceptions more clearly than was possible in the present study. Such research will elucidate the directions in which training should move to be most effective for working with incest survivors.

Beauregard (1986) defined incest survivors as those who have experienced incest and as adults are able to talk about it. The continued implementation of training programs for clinicians to develop sensitive, efficacious intervention strategies will increase the number of women and men who are survivors, rather than victims, of incest.

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## APPENDIX A

### Experience Working with Incest Victims

1. Please check the appropriate box to indicate the situation(s) which you consider to constitute incest:

	Intercourse by coercion	Intercourse by mutual agreement	Other sexual activity by coercion	Other sexual activity by mutual agreement
Between related persons of similar age				
Between related persons of disparate age (e.g., 3 yrs )				
Between non-related persons of similar age in a 'familial' relationship (e.g., foster child and sibling)				
Between non-related persons of disparate age in a 'familial' relationship (e.g., step-parent and child)				

2. What types of sexual activity did you include in your response to the above question? (Check as many as are applicable)

( ) kissing    ( ) exposure    ( ) molestation    ( ) oral-genital contact  
( ) attempted intercourse    ( ) other - please specify:

3. What percentage of your clients would you estimate have been victims of incest? Check one of the following:

0-5%( ) 6-10%( ) 11-15%( ) 16-20%( ) 21-30%( ) 31-40%( ) 41-50%( ) over 50%( )

4. Of these clients, what percentage are male? \_\_\_\_\_

5. How often would you estimate that physical abuse has occurred in conjunction with incest in the cases you have seen?

(Circle the appropriate number)

1                      2                      3                      4                      5  
never              seldom              occasionally              often              always

6. Please estimate the number of incest victims you have seen in your practice during the last year. (Check one of the following)

0( ) 1-10( ) 11-20( ) 21-30( ) 31-40( ) 41-50( ) more than 50( )

7. If you thought that referral was appropriate to which of the following would you refer a client with a history of incest?  
(Check as many as are applicable)

self help group ( )    rape crisis centre ( )    mental health centre ( )  
professional who specializes in incest/abuse ( )    other ( ) Please specify:

8. If your client considers a past incest experience to be a source of distress, please indicate the importance which you would attribute to the following therapy goals:

	1	2	3	4	5
	never important	seldom	occasionally	often	always important
recall & discussion of incident(s)	1	2	3	4	5
emotional catharsis of anger, guilt etc.	1	2	3	4	5
recognition & change of beliefs related to the experience	1	2	3	4	5
skills training to make current coping more effective	1	2	3	4	5
attain insight into psychodynamic meaning of the experience	1	2	3	4	5
other (please specify):	1	2	3	4	5

9. Indicate the frequency with which incest victims have presented the following problems in your practice during the past year:

	1	2	3	4	5
	never	seldom	occasionally	often	always
For incest as the presenting problem	1	2	3	4	5
For other problems; incest is a secondary problem	1	2	3	4	5
For other problems; incest is reported but not as a problem	1	2	3	4	5

10. Of the following categories, indicate the THREE most frequent patterns of incest reported in your practice: (e.g.,  
1=most frequent, 2=second most frequent, etc.)

_____ mother - daughter	_____ father-daughter
_____ mother - son	_____ father - son
_____ other female relative - girl	_____ other male relative - girl
_____ other female relative - boy	_____ other male relative - boy
_____ siblings	

11. In your experience, the average age of the victim at the time incest begins is: \_\_\_\_\_
12. In your experience, the average age of the victim at the time incest stops is: \_\_\_\_\_



- ☐ special favours (e.g., bribery)  
☐ physical coercion (e.g., force)  
☐ non-physical coercion (e.g., threats, showing pornography, emotional appeals)  
☐ no coercion or special favours used

- |  | Ask general sexual history | Ask specifically about prior sexual assault | Ask specifically about incest | Not advisable to ask about incest |
|--|----------------------------|---|-------------------------------|-----------------------------------|
| Client reports sexual difficulties                                 |                            |   |                               |                                   |
| Client reports problems with relationships                         |                            |   |                               |                                   |
| Client reports incest as presenting problem                        |                            |   |                               |                                   |
| Client reports incest but not as a problem                         |                            |   |                               |                                   |
| Client reports none of the above problems (but you suspect incest) |                            |   |                               |                                   |
| Client reports other problems                                      |                            |   |                               |                                   |

- |           |        |              |       |           |
|-----------|--------|--------------|-------|-----------|
| 1         | 2      | 3            | 4     | 5         |
| never     | seldom | occasionally | often | always    |
| important |        |              |       | important |

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16. Please indicate the frequency with which you find the following items associated with a history of incest in an adult patient in your practice:

	1 never	2 seldom	3 occasionally	4 often	5 always
Delusional thinking	1	2	3	4	5
History of early caretaker role in family, pseudomaturity	1	2	3	4	5
Bodily complaints	1	2	3	4	5
Homosexuality	1	2	3	4	5
Guilt	1	2	3	4	5
Repeated victimization (e.g., rape, battering)	1	2	3	4	5
Sexual dysfunction	1	2	3	4	5
Suicide attempts/gestures in adolescence	1	2	3	4	5
Insomnia	1	2	3	4	5
Hallucinations	1	2	3	4	5
Low self-esteem	1	2	3	4	5
Phobias	1	2	3	4	5
Recurrent Nightmares	1	2	3	4	5
Eating disorders	1	2	3	4	5
Anger; problems controlling temper	1	2	3	4	5
Poor relationships	1	2	3	4	5
Confusion (in non-psychotic person)	1	2	3	4	5
Chronic depression	1	2	3	4	5
Abuse of own children	1	2	3	4	5
Depersonalization (e.g., observing self from far away, feeling outside own body)	1	2	3	4	5
Suicide attempts/gestures in adulthood	1	2	3	4	5
Substance abuse	1	2	3	4	5
Prostitution	1	2	3	4	5
Running away from home in adolescence	1	2	3	4	5
Obsessive-compulsive behaviour	1	2	3	4	5

17. If you utilize diagnoses, what is the most common diagnosis that you give to incest victims? What other diagnoses might you give (e.g., secondary or differential diagnoses)?

1.

---

2.

---

3.

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Please turn page to Demographic Section

DEMOGRAPHIC DATA

1. Within psychology, what is your area of specialization, if any?

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---

2. In what types of settings do you work?

---

---

3. Please state the number of years you have been in practice: \_\_\_\_\_

4. Sex: male \_\_\_\_\_ female \_\_\_\_\_

5. Age: \_\_\_\_\_

6. Do you have any special training in working with incest (or sexual abuse) victims?

No \_\_\_\_\_

Yes \_\_\_\_\_ Please describe briefly:

Do you have any thoughts about this survey?

Any additional comments:

Thank you for your co-operation.

Please return the completed questionnaire, in the provided envelopes, to:

Janet O. Scalzo  
c/o Dr. M. Kimball  
Dept. of Psychology  
Simon Fraser University  
Burnaby, B.C. V5A 9Z9

## APPENDIX B

### The Long Term Effects of Incest

#### *Statement of Purpose*

The current study will examine the experiences of clinicians assessing and treating incest survivors. This information will be compared to research findings on treatment strategies, demographic information on victims, long term effects and presenting symptoms of childhood incest victimization.

The study has implications for education of mental health professionals regarding identification (e.g., masked presentations) and treatment of long term effects of incest. Clinicians' attitudes regarding the relationship of prior incest to current functioning may have implications for treatment strategies and outcome of therapy among their patients.

#### *Subjects*

1. All clinical psychologists in the Lower Mainland (approx. 200) except those who have practices restricted to non-relevant clinical populations (e.g., neuropsychology). Names and areas of specialization will be obtained from professional registers of practitioners in the Lower Mainland.
2. All psychiatrists in the Lower Mainland (approx. 200), whose names have been obtained in a manner similar to that described above (same restriction as above).

### *Measures and Data Collection Procedure*

The "Clinical Experience Working With Incest Victims" questionnaire, developed for use in this study, will be mailed to subjects for completion.

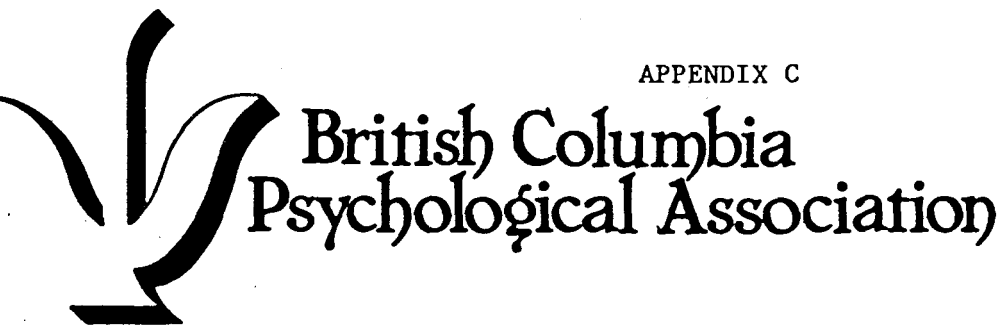
Topic areas include:

- definition of incest
- patterns of incest seen in their practices(e.g., father-daughter, sibling)
- types of coercion used
- long term effects associated with a history of incest
- presenting symptoms
- treatment strategies (e.g., assessment, types of therapy, case management)

### *Consent and Confidentiality*

Consent to participate in the study will be considered to have been given if the participant returns a completed questionnaire. Respondents may choose not to reply to some questions; this is considered to constitute partial withdrawal of consent to participation. Anonymity of responses will be ensured through use of a double envelope return system, similar to that used in voting by mail. Respondents will enclose their completed questionnaires in plain envelopes. These envelopes will be enclosed in envelopes addressed to the senior supervisor (Dr. M. Kimball) and will include the respondent's return address. A

master list of returned responses will be kept by Dr. Kimball and the questionnaires will be given to me for coding. A follow-up mailing, based on the master list of non-returned questionnaires will be done. All completed questionnaires will be kept confidential. Upon completion of the study, all materials will be destroyed.



APPENDIX C

# British Columbia Psychological Association

*Members of the Board:*

K. S. Dobson, Ph.D.  
E. W. Muir  
O. Spreen, Ph.D.  
E. Z. Stevens  
L. B. Trentadue, M.A.  
P. Wilensky, Ph.D.  
K. Wood, Ph.D.

Susan Mackey-Jamieson, Ph.D.  
*Registrar/Executive Director*

#308 - 2150 West Broadway,  
Vancouver, B.C. V6K 4L9  
Telephone: (604) 738-8117

January 9, 1986

Dear Member:

Enclosed you will find a questionnaire regarding incest and its impact upon adult functioning. This study is being conducted by a student at Simon Fraser University. The Board of Directors reviewed the project, and has agreed to support it and encourage members to respond to the enclosed questionnaire. We are taking this step to encourage research in the Province, and because we believe that the issues addressed in this study and studies like it are central to our understanding of human function and dysfunction. The researcher has agreed to make the findings of the study available to all members of the Association, so you will be hearing the results of the study in the future.

Again, we encourage you and thank you for responding.

Sincerely,

James P. Schmidt, Ph.D.  
for the Board of B.C.P.A.



# SECTION OF PSYCHIATRY

APPENDIX D

March 6, 1986



Dear Colleague:

On behalf of the Executive of the Section of Psychiatry of the B.C. Medical Association, I am asking for your support in filling out this survey submitted by Ms. Janet Scalzo from Simon Fraser University Department of Psychology.

We have reviewed the questionnaire entitled, "Experience Working With Incest Victims", and we are satisfied that filling out this questionnaire will not compromise patient confidentiality or treatment. We believe this to be an important area of research in provision of care for incest victims.

Although filling in this questionnaire will take a few minutes out of an already very busy day, the Executive of the Section would encourage your support of this project by taking the time to complete the questionnaire and returning it to Ms. Scalzo. She assures us that, after the study is completed, results of the questionnaire will be sent to members of the Section.

Thank you for taking the time to consider this questionnaire, and I encourage your cooperation with the University to obtain further information into this important area. I remain

Yours respectfully

R.J. O'Shaughnessy, M.D., F.R.C.P.(C)  
Chairman  
Section of Psychiatry  
B.C. Medical Association

# SIMON FRASER UNIVERSITY

## APPENDIX E

DEPARTMENT OF PSYCHOLOGY



BURNABY, BRITISH COLUMBIA V5A 1S6  
Telephone: (604) 291-3354

Enclosed you will find a questionnaire regarding your work with adults, some of whom may have experienced incest during childhood or adolescence. The long term effects of incest are of increasing concern to clinicians. Nevertheless, little research to date has focused on clinicians' experiences regarding detection, treatment and the impact of treatment on adult incest survivors' functioning.

If you do therapy with adults, we would very much appreciate it if you would take 15 to 20 minutes of your time to fill out the enclosed questionnaire. Your experiences and thoughts will contribute to an increased understanding of the long term consequences of incest.

If you do not do therapy with adults, please complete the section on demographic data (page 5 of the questionnaire) and return it in the envelopes provided.

All responses will be kept confidential. To ensure anonymity, please seal your completed questionnaire in the unmarked envelope (provided in the survey package). This envelope should be enclosed in the addressed envelope and returned to Dr. M. Kimball.

Everyone who completes the questionnaire will receive a summary of results in the fall.

If you have any questions or comments regarding the study, or the questionnaire, please feel free to contact me or my supervisor, Dr. Kimball, at 291-3354. We are most appreciative of your cooperation in completing and returning the questionnaire.

Sincerely,

Janet O. Scalzo  
Graduate Student  
Clinical Psychology

Meredith M. Kimball, Ph.D.  
Associate Professor  
Dept. of Psychology

# SIMON FRASER UNIVERSITY

## APPENDIX F

DEPARTMENT OF PSYCHOLOGY



BURNABY, BRITISH COLUMBIA V5A 1S6  
Telephone: (604) 291-3354

Several weeks ago you received a questionnaire regarding your work with adults, some of whom may have experienced incest. In case you have not yet had time to complete it, or if for some reason you did not receive it, we are enclosing a second copy of the questionnaire. (If you have already returned your questionnaire, please disregard this letter.)

If you do therapy with adults, we would very much appreciate it if you would take 15 to 20 minutes of your time to fill out the enclosed questionnaire. If you do not do therapy with adults, please complete the section on demographic data (page 6 of the questionnaire) and return it in the envelopes provided.

Your responses are being solicited, together with those of other clinicians, to add to the profession's understanding of incest's long-term effects, and effective treatment strategies.

Your responses will be kept confidential. To ensure anonymity, please seal your completed questionnaire in the unmarked envelope (provided in the survey package). This envelope should be enclosed in the addressed envelope and returned to Dr. M. Kimball.

A summary of results will be mailed to you in the fall.

If you have any questions or comments regarding the study, or the questionnaire, please feel free to contact me or my supervisor, Dr. Kimball, at 291-3354. We are most appreciative of your contribution to this study.

Sincerely,

~~J~~anet O. Scalzo  
Graduate Student  
Clinical Psychology

Meredith M. Kimball, Ph.D.  
Associate Professor  
Dept. of Psychology

## APPENDIX G

### Symptom Checklist Items

#### 1. Strong Association Items

bodily complaints  
repeated victimization (e.g., rape, battering)  
sexual dysfunction  
suicide gestures or attempts in adolescence  
insomnia  
low self-esteem  
recurrent nightmares  
poor relationships  
chronic depression  
suicide attempts or gestures in adulthood  
substance abuse

#### 2. Medium Association Items

history of early caretaker role in family  
("pseudomaturity")  
guilt  
eating disorders  
anger  
confusion (in a non-psychotic person)<sup>1</sup>  
depersonalization (e.g., seeing self from far away,  
feeling outside one's own body)<sup>2</sup>

-----  
<sup>1</sup>This item was taken from Gelinas' (1983) work on the symptomatology which accompanies a history of incest.

<sup>2</sup>This item derived from 2 items of a dissociation scale developed by Briere and Runtz (1985) for inclusion with the SCL-90.

prostitution

running away from home in adolescence

3. Weak Association Items

delusional thinking

homosexuality

hallucinations

phobias

abuse of one's children

obsessive-compulsive behaviour