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WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE: CLINICAL SEQUELAE AND TREATMENT

by

Patricia M. Fisher
B.Sc., University of British Columbia, 1983
M.A., Simon Fraser University, 1986

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY in the department of PSYCHOLOGY

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SIMON FRASER UNIVERSITY
July, 1991

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Women Survivors of Childhood Sexual Abuse: Clinical Sequelae and Treatment

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ABSTRACT

Literature concerning childhood sexual abuse and adult survivors is comprehensively reviewed: demographics, abuse characteristics, historical record, professional attitudes and responses, theoretical models of the dynamics of child sexual abuse at individual, family and socio-cultural levels, models of therapy, and issues in treatment.

The research comprises two inter-related studies of adult women survivors of childhood sexual abuse. Study I examines intake profiles of 103 depressed women presenting for treatment at a Community Mental Health Center. A four-way typology of child abuse histories was used: physical, sexual, both physical and sexual, and without abuse. Those with abuse histories differed significantly from those without in terms of clinical sequelae and more global adult functioning. Severity of childhood abuse was paralleled by severity of adult sequelae. Experience of childhood sexual abuse was shown to be more harmful over the long term than that of physical abuse.

Study II comprised a psychotherapy process/outcome study of a 26 week intensive group therapy program and compared therapy completers (n=32) with therapy dropouts (n=22). Both had suffered extreme levels of childhood sexual and physical abuse but dropouts had experienced more specific and localized abuse within their families of origin. Adult abuse histories of both demonstrated continuity of victimization but dropouts were more solidly embedded within current abuse relationships. At therapy onset, clinical profiles of both were similar although completers appeared more globally pathological.

Clinical test-batteries were applied four times during treatment and at three-month and six-month follow-up points. Completers had long standing histories of recurrent depression, suicide attempts, and repeated contact with mental health services. Most lived in poverty and were unemployed mothers with adult histories of rape and spousal battery. Most met DSM III-R Axis I criteria for major depression and anxiety spectrum disorders, and Axis II criteria for Borderline Personality Disorder, together with mixed personality disorder patterns involving prominent schizoid, avoidant, dependent and passive-aggressive features (confirmed with MCMI). At therapy termination, all MCMI score means had retreated to subclinical levels and remained there at the six-month follow-up point. Therapy process in terms of changing test-battery results was followed and interpreted. Using illustrative quotes from members’ journals, a comprehensive treatment guide is provided for the group psychotherapy program.
ACKNOWLEDGMENTS

This research grew out of my work at the Haney Mental Health Center and was made possible by the helpful and good-natured cooperation of the Centre staff and the Regional Office Director, Christine Kline. In particular, I would like to thank my friends and colleagues at the Centre, Patricia Douglas and Bill Dickerson, for their unflagging support, encouragement and assistance. I am indebted to my committee for their wisdom in appreciating my independence and for their assistance when requested. I have the good fortune to live within a literary family and would like to thank my mother, Joan Cannon, my sister, Jean McLeod, and my husband, Fulton, for their invaluable editorial assistance.

Finally, respectful thanks are extended to the women who participated in the research. Their courage, their pain, and their journeys served as the primary foundations of this work.
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Part I

THE PROBLEM OF CHILD SEXUAL ABUSE
attention to the issue of child sexual abuse, let alone recognition of its existence at any meaningful level, remains a very recent phenomenon. Over the past fifteen years we have become alerted to the problem by the increase in clinical reports of incest. This initial, clinical-anecdotal, literature has led to a succession of empirically-based studies of both clinical and nonclinical populations. Accordingly, our appreciation of the full extent of the problem has became increasingly elaborated over the past decade. While initial studies tended to focus exclusively on incest, more recent work has considered the full range of child sexual abuse - both intrafamilial and extrafamilial in origin.

As knowledge and concern about the problem have expanded and matured, the methodological sophistication and levels of information detail have increased apace. Consequently, earlier studies often provided data which are not strictly comparable with more recent work - likely a necessary condition in any rapidly elaborating field of investigation. Allied with this is the problem of sample comparability with respect to age cohorts, socio-economic factors, self-selection and other forms of sampling bias. Surveys of adult samples, from clinical, college student, and community-based populations, as well as from identified sexually abused children, provided both differing, as well as convergent perspectives.

This chapter has chosen to focus on the data arising from larger, empirically-based studies, as opposed to earlier clinical-anecdotal reports which served to motivate the later empirical studies. As the chapter unfolds, the reader will note the frequent appeal to Russell’s (1983, 1986) definitive, community-based study of child sexual abuse and incest in a group of 930 women. This meticulous and methodologically rigorous study continues to provide a benchmark against which other data bases may be compared.

Prior to the 1980s, adult retrospective studies of nonclinical populations tended to be based upon less restrictive definitions of child sexual abuse and incest. However, recent larger scale studies have featured restrictive definitional criteria requiring physical contact, and either significant age differences between victim and abuser, or the use of coercion or physical force. Typical of the more stringent criteria is Russell’s definition of abusive incest which applies readily to both intrafamilial and extrafamilial child sexual abuse:
1. The respondent had to be less than eighteen years of age at the onset of the sexual contact or attempted contact.
2. Sexual contact of a physical nature had to have occurred or been attempted by the relative; exhibitionism and verbal propositions did not qualify as incestuous abuse.
3. Incest included sexual contact with all relatives, no matter how distant the relationship, no matter whether they were related consanguinely or not.
4. If the relative with whom the respondent had sexual contact or attempted sexual contact was five years or more older than the respondent, the experience qualified as abusive regardless of whether or not she considered it to be a neutral or positive experience.
5. If the relative was less than five years older than the respondent, the experience qualified as abusive if there was evidence that it was unwanted, for example; if it was initiated by the relative and caused the respondent some degree of distress or some long-term effects, either at the time or in retrospect. (Russell, 1986, p.55)

This chapter also concentrates on data regarding the sexual abuse of girls and women. This is not intended to convey the impression that the sexual abuse of male children is considered as any less important or harmful. However, data regarding the long-term effects of male victimization and its effects remains preliminary. Given that same-sex incest carries the dual stigma of incest and homosexuality, it has been termed the "too-too taboo" (McDonald, 1986). Thus, information regarding its incidence, prevalence and characteristics is minimal, and has largely arisen from reports of male children identified by child-protection agencies. The available data would suggest that approximately 2% to 9% of males experience some form of child sexual abuse (Finkelhor, 1984) and that the abuse is typically carried out by a non-relative. For boys under 13, the abuse most often represents a single incident, while for those over 13, it more typically involves multiple incidents (Courtois, 1988: Fromuth & Burkhart, 1987). A recent study of 87 boys referred to a child protection service (Faller, 1989) found that over half of the boys were abused under age six and in almost two-thirds of cases that the abuse was extrafamilial in origin. Notably, the boys were most often sexually mistreated by authority figures in a professional relationship with them (i.e., teachers, daycare workers, camp counsellors, scout leaders, etc.). It was found that in the cases of incest, the offender had almost always also sexually abused other members of the household. Boys abused in the home were significantly younger than those abused out of the home. In terms of offender gender - 63% were males. 29% were males aided by females, and 8% were females. As will become
evident throughout this chapter, the primary characteristics of childhood sexual abuse do appear to differ significantly for boy and girl child victims. Boys tend to be offended out of the home, by a non-relative on a limited, non-progressive basis. Girls, on the other hand, are most likely to be offended within the home, by an adult relative, on a progressive, long-term basis. Both boys and girls, however, are overwhelmingly offended by males.

INCIDENCE & PREVALENCE

The last few decades have witnessed an explosive increase in the estimated incidence of child sexual abuse. Prior to the late 1970s, psychiatric textbooks (e.g., Weinberg, 1955) provided an incest prevalence rate of one or two per million population (i.e., 0.0002%). In contrast, recent retrospective community-based studies have yielded female child sexual abuse rates approaching 40%, and incest rates approaching 20% (see Table 1). Thus, over the past two decades, estimates of incest and child sexual abuse have increased by more than four orders of magnitude. Clearly, quite apart from the methodological and scientific issues examined in this chapter, powerful social and cultural forces are involved in such a perspective shift, and these are examined in Chapter 2.

Reporting Rates

A number of problems arise in terms of population estimates of child sexual abuse. Typically, the empirical data have come either from nonclinical samples, or from professionals and agencies working with reported or acknowledged victims. Predictably, the figures arising from the latter source reflect the "tip of the iceberg" phenomenon (Alter Reid, Gibbs, Lachenmeyer, Sigal & Massoth, 1986). Just how few women or girls report their childhood abuse is becoming increasingly apparent, with recent studies indicating reporting rates of 2% to 17% of cases (Kendall-Tackett & Simon, 1988; Murphy, et al., 1988; Russell, 1986). Reporting rates themselves have also increased dramatically over the past two decades, in response to changing social awareness of the problem. As noted by Russell and Trainor (1984), the number of reported cases of child sexual abuse in the United States rose ten-fold (from 1,975 to 22,918) over the six year period from 1976 to 1982. The increase in child sexual abuse reports has occurred within the context of an increase in the reporting rates of child abuse and neglect in general (Green, 1988).
Despite the overall increase in reporting rates, the complete picture has yet to be revealed. Reports from professionals are most likely to be substantiated (Eckenrode, Powers, Doris, Munsch, & Bolger, 1988; Groenveld & Giovanni, 1977; Jason et al., 1982) — a phenomenon which may be due to increased cooperation during investigation, greater source credibility and increased pressure on agencies to react (Eckenrode et al., 1988). A socioeconomic status bias is also reflected, in that abuse cases occurring in lower social class families are more likely to be reported (Hampton & Newberger, 1985; Jason, Andereck, Marks & Tyler, 1982). Although reporting rates have risen, the overall proportion of substantiated cases of reported child sexual abuse seems to be decreasing. Eckenroade and colleagues (1988) provide the example of New York state, where substantiation rates fell from 50% in 1974 to 35% in 1984. Arguably, the decrease may be due, in part, to the overwhelming escalation of demand on the child welfare system and the absence of a concomitant increase in funding and staffing.

Russell's (1986) meticulous community-based study of adult women survivors of childhood sexual abuse probably provides the best estimate of past reporting rates. She found that while 6% of those abused by a nonfamily member had reported their abuse, only 2% of incest victims had reported. A second community-based study by Murphy and colleagues (1988) provided similar overall rates of female child sexual abuse, and found that only 7% of those assaulted had reported their abuse, and that in less than 4% of cases was an arrest made. In addition to historical cohort effects on reporting rates, a recent study of girls sexually abused by their fathers appears to reflect differential self-disclosure rates across developmental stages (Farrell, 1988). The rates are very low in the preschool group (5%), rise among latency aged girls (28%), young adolescents (51%), and then drop off sharply with 16 to 17 year olds (13%).

Thus, in summary, it would appear that while overall rates of reporting are increasing, action on behalf of the victims has not moved apace, and the number of reported cases still reflects only a small minority of actual cases.

Population Estimates of Child Sexual Abuse Incidence

As shown in Table 1, over a dozen large-scale nonclinical retrospective studies of adult women have attempted to establish incidence rates for childhood sexual abuse and incest. Rates differ according to the group under study, the method of data collection, and the definitions of abuse. College students, household, and community samples have been examined, drawing on
### Table 1. Incidence of child sexual abuse and incest based on nonclinical samples.

<table>
<thead>
<tr>
<th>Study</th>
<th>Date</th>
<th>N</th>
<th>Population</th>
<th>% CSA</th>
<th>% Incest</th>
<th>Definition of abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. Landis</td>
<td>1940</td>
<td>295</td>
<td>hospital patients, middle class</td>
<td>23.7% by age 14</td>
<td>12.5% by age 14</td>
<td></td>
</tr>
<tr>
<td>Kinsey</td>
<td>1953</td>
<td>4,441</td>
<td>community, middle class</td>
<td>24% by age 14</td>
<td>5.5% by age 14</td>
<td>includes noncontact</td>
</tr>
<tr>
<td>J. Landis</td>
<td>1956</td>
<td>1,028</td>
<td>college students (76% women)</td>
<td>35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gagnon</td>
<td>1965</td>
<td>1,200</td>
<td>community, middle class</td>
<td>28% by age 14</td>
<td>4.0% by age 14</td>
<td>includes noncontact</td>
</tr>
<tr>
<td>Finkelhor</td>
<td>1979</td>
<td>530</td>
<td>college students</td>
<td>19.2% by age 17</td>
<td>10% by age 17</td>
<td>includes noncontact</td>
</tr>
<tr>
<td>Russell</td>
<td>1983</td>
<td>930</td>
<td>probability household sample</td>
<td>28% by age 14</td>
<td>12% by age 14</td>
<td>excludes noncontact</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38% by age 18</td>
<td>16% by age 18</td>
<td>19% over 18</td>
</tr>
<tr>
<td>*Kilpatrick &amp; Amick</td>
<td>1984</td>
<td>2,004</td>
<td>random household sample</td>
<td>36% by age 14</td>
<td>17% by age 14</td>
<td>excludes noncontact</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>45% by age 18</td>
<td>21% by age 18</td>
<td></td>
</tr>
<tr>
<td>**Wyatt</td>
<td>1985</td>
<td>248</td>
<td>probability household sample (18-36 year olds)</td>
<td>21.7% by age 16</td>
<td></td>
<td>excludes noncontact</td>
</tr>
<tr>
<td>Bagley</td>
<td>1986</td>
<td>377</td>
<td>random community</td>
<td>22% by age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fromuth</td>
<td>1986</td>
<td>383</td>
<td>college students</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Green</td>
<td>1987</td>
<td>90</td>
<td>college students</td>
<td>15.1% by age 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Lupfer</td>
<td>1987</td>
<td>586</td>
<td>college students</td>
<td>32.2% by age 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(52.9% lifetime)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murphy et al.</td>
<td>1988</td>
<td>391</td>
<td>random community</td>
<td>14.7% by age 15</td>
<td></td>
<td>excludes noncontact</td>
</tr>
<tr>
<td>Briere &amp; Runetz</td>
<td>1988</td>
<td>278</td>
<td>college students</td>
<td>15.1% by age 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burnam et al.</td>
<td>1988</td>
<td>3132</td>
<td>probability household sample (53% women) (40% Mexican American, 40% nonhispanic whites)</td>
<td>16.7% lifetime</td>
<td></td>
<td>excludes noncontact</td>
</tr>
</tbody>
</table>

**Note.** *Kilpatrick & Amick as reported in Russell, 1986  
**Wyatt as reported in Russell, 1986  
**Lupfer, as reported in Alexander & Lupfer, 1987
both random as well as biased samples of those populations. It is argued that college samples underestimate both the incidence of, and effects of, child sexual abuse because more dysfunctional victims are less likely to reach to college (Runtz & Briere, 1986). Survey data have been gathered from either self-administered questionnaires, or from interviews. For the most part, recent studies have used conservative definitions of child sexual abuse which specify physical contact. These definitions exclude a wide range of more generically sexually abusive experiences such as the "covert incest" definitions provided by Evans & Schaefer (1987) (i.e., being forced to view pornography, household voyeurism, sexualized ridicule, etc.).

Overall, the nonclinical surveys provide rates of child sexual abuse ranging from 15% to 45%, and incest rates ranging from 1% to 21% (see Table 1). As noted by Finkelhor and Baron (1986), in their review of the variations in incidence rates across surveys, "the higher rates tend to come from the more meticulous studies with the more carefully designed questionnaires, the better trained interviewers, and the more intensive attempts to achieve candor. This suggests that underreporting is a serious problem, especially in the less meticulous studies" (p. 45). On all these counts, Russell's (1983, 1986) study still stands as the most reliable, methodologically rigorous and informative investigation of the problem of female child sexual abuse. Based on a probability household sample of 930 women, the data were gathered by trained interviewers who spent considerable time with each respondent, allowing them to build rapport and supporting them in their disclosures. Definitions of abuse were conservative and a high degree of detailed information was obtained. Nevertheless Russell anticipates that her rates of child sexual abuse (38% by age 18) and incest (16% by age 18), are still low, given the proportion of women either unable or unwilling to disclose (i.e. those with early onset abuse and subsequent memory repression, and those unwilling to disclose). When incidents of noncontact sexual abuse were included, the Russell figures rose to indicate that 54% of women experience abuse by age 18 and 48% experience abuse by age 14.

High though these rates of child sexual abuse and incest appear to be, they are greatly surpassed by those arising from clinical populations of adult women presenting for treatment of a range of clinical problems (see Table 2). In groups of alcoholic women, somatization patients, eating disordered women and chronic pelvic pain patients, we find child sexual abuse rates of 55% to 67% and incest rates of 17% to 36%.
Increased Incidence of Child Sexual Abuse

Although reporting rates of child sexual abuse have drastically increased over the past two decades, these have generally been attributed to increased sensitivity to the issue and greater willingness to report suspected cases, rather than to any increase in basic incidence. As Finkelhor (1979) put it "what we are witnessing is a revolution in consciousness, a situation where, because of changing mores, professionals are more sensitive to identifying instances of sexual abuse and victims and their families are more willing than before to seek help" (p. 132). This assumption of a steady-state rate of incidence has, however, been challenged by Russell's cohort analysis of rates of extrafamilial child sexual abuse and incest. She found that both nonfamilial and familial child sexual abuse before the age of 18 had roughly quadrupled from the early 1900s to 1973. More specifically, 8.0% of women over age 60, 12.0% of women in their fifties, 22.5% of women in their forties, and 24.0% of women in their thirties had been victims of incest before the age of 18. The high abuse rates in the last two groups are supported by Wyatt's (1986) study of 18 to 36 year old women, which found that 19% had experienced childhood incest, and 43% had suffered either intrafamilial or extrafamilial child sexual abuse. Notably, Russell's linear pattern of abuse increase over cohorts was broken by the youngest cohort (age 18 to 29) who reported a 17.7% rate of incestuous abuse. At this point, the drop in data arising from the latter group remains unexplained. However, the fourfold increase over the course of the other four cohorts is particularly compelling, and speaks to significant increase in the overall rates of child sexual abuse.
CHARACTERISTICS OF CHILD SEXUAL ABUSE

Research into the various characteristics of childhood sexual abuse has been much elaborated over the past decade. Data arise both from retrospective studies of adult women survivors and from contemporary studies of identified child victims. Discrepancies between these sources have yet to be clarified and may arise variously from differential age-specific recall, sampling biases, methodological problems or actual cohort differences.

Identity of Abuser(s)

EXTRAFAMILIAL. Despite myths to the contrary, children are least likely to be sexually assaulted by a stranger. The vast majority of offenders are known to the child, either as family members or acquaintances. In adult nonclinical samples, only 15% to 25% of offenders were not known to the child (Finkelhor, 1980; Russell, 1986), and in studies of sexually abused children, only a small proportion of offenders were not known to the victims (see Tables 3 & 4). In Russell’s detailed community study, 31% of respondents had been sexually abused by a nonrelative by age 18, and 20% had been sexually abused by a nonrelative by age 14. This compares with the studies of sexually abused children, which found that 17% to 59% were offended by a nonrelative acquaintance (Tables 3 & 4). The higher proportion of extrafamilial abuse found in the child samples may well be an expression of the previously noted differential found between reporting rates for intrafamilial and extrafamilial sexual abuse.

Empirical information remains somewhat sparse for known nonfamily abusers’ relationships with their child victims. However, Russell found that 41% of the extrafamilial offenders were intimately related to the victim, either as family friends, mother’s boyfriend, victim’s date, etc. As will be discussed below, victim age seems to be a significant variable: preschoolers are more likely to be offended by a relative in the home, while school age children are more likely to be offended by an extrafamily abuser. The overwhelming proportion of offenders are male (in the range of 96%), and female perpetrators tend to be unwilling confederates of the primary male abuser (Finkelhor & Hotaling, 1984; Russell, 1986).

INTRAFAMILIAL. Although overall rates vary, recent adult retrospective studies of nonclinical populations (Finkelhor, 1979; Lupfer, 1987; Russell, 1983; Wyatt, 1985) generally report about one-third of the childhood sexual abuse as being incestuous (or intrafamilial) in
<table>
<thead>
<tr>
<th>Study</th>
<th>Date</th>
<th>N</th>
<th>Population</th>
<th>victim sex</th>
<th>victim age</th>
<th>relative acquaintance</th>
<th>father figures</th>
<th>brothers</th>
<th>multiple perpetrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrazek, Lynch &amp; Bentovim</td>
<td>1983</td>
<td>1072</td>
<td>questionnaires to 622 professionals in the U.K.</td>
<td>f &amp; m</td>
<td>under 16</td>
<td>43%</td>
<td>31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DeLoe, Hereda &amp; Emmett</td>
<td>1983</td>
<td>566</td>
<td>children presenting at inner city hospital sexual assault centre</td>
<td>f &amp; m</td>
<td>6 mo. to 16 years</td>
<td>23.7%</td>
<td>29.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peters</td>
<td>1976</td>
<td>300</td>
<td>children seen at hospital emergency room</td>
<td>f &amp; m</td>
<td>2 to 12</td>
<td>32%</td>
<td>59%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mian et al.</td>
<td>1986</td>
<td>125</td>
<td>outpatients</td>
<td>76.8% female</td>
<td>under 7</td>
<td>60%</td>
<td>36%</td>
<td>41.5%</td>
<td>4%</td>
</tr>
<tr>
<td>Cupoli &amp; Sewell</td>
<td>1988</td>
<td>1059</td>
<td>children seen at hospital emergency room</td>
<td>88.8% female</td>
<td>mean = 8.3</td>
<td>32.8%</td>
<td>58.1%</td>
<td>23.8%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Stephens et al.</td>
<td>1988</td>
<td>191</td>
<td>social services filers</td>
<td>84% female</td>
<td>mean = 8.4</td>
<td>79%</td>
<td>21%</td>
<td>54%</td>
<td>9%</td>
</tr>
<tr>
<td>Coate &amp; Schuerman</td>
<td>1988</td>
<td>369</td>
<td>Children seen at sexual assault centre</td>
<td>f&amp;m</td>
<td>4 to 17</td>
<td>51%</td>
<td>37.5%</td>
<td>29%</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Identity of the offender as determined in large scale studies (n > 100) of identified sexually abused children:
### Table 4. Identity of offender as determined by smaller scale studies (n < 100) of identified sexually abused children.

<table>
<thead>
<tr>
<th>Study</th>
<th>Date</th>
<th>N</th>
<th>Population</th>
<th>Victim sex</th>
<th>Victim age</th>
<th>Relative acquaintance</th>
<th>Father figures</th>
<th>Brothers</th>
<th>Multiple perpetrators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Abuse Victims</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adams-Tucker</td>
<td>1981</td>
<td>28</td>
<td>outpatients</td>
<td>78.6% female</td>
<td>mean = 9</td>
<td>64%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wolfe, Gentile &amp; Wolfe</td>
<td>1989</td>
<td>71</td>
<td>outpatients</td>
<td>88% female</td>
<td>mean = 9.9</td>
<td>83% 17%</td>
<td>60% 17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Incest Victims</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Browning &amp; Boatman</td>
<td>1977</td>
<td>14</td>
<td>outpatients</td>
<td>98% female</td>
<td>4 to 15</td>
<td>100%</td>
<td>64%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molaar &amp; Cameron 1975</td>
<td>1975</td>
<td>10</td>
<td>inpatients</td>
<td>100% female</td>
<td>mean = 15</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emshie &amp; Rosenfeld</td>
<td>1983</td>
<td>65</td>
<td>inpatients</td>
<td>100% female</td>
<td>mean = 13.9</td>
<td>100%</td>
<td>67% 33%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
origin (see Table 1). The Russell study likely provides the best population estimate with a finding that 16% of respondents had been sexually abused by a relative by age 18, and 12% had been abused by a relative by age 14. Fathers or father figures consistently appear as the major intrafamilial offender and up to 8.1% of all child sexual abuse offenders drawn from the nonclinical population studies are identified as fathers or stepfathers (see Table 5). Russell's detailed breakdown found that 14% of of intrafamilial offenders were fathers, 8% were stepfathers, and .02% were foster or adoptive fathers. Thus, father figures accounted for over 22% of the intrafamilial abuse. The other most significant family member offenders, in order of frequency (percent of incest cases), were uncles (25%), male first cousins (16%), brothers and half brothers (13%), grandfathers and stepgrandfathers (6%).

On the whole, studies of identified sexually abused children (primarily female) have found that relatives accounted for the majority of cases (23% to 83%) (see Tables 3 and 4). However, a recent large-scale study of sexually abused children (Mian et al., 1986) indicated that preschoolers were much more likely to be abused by intrafamilial offenders (72.5% of cases), while school age children were more likely to be offended by an extrafamilial offender (73% of 6 year olds). Although less strongly differentiated, the analogous investigation of sexual abuse cases by DeJong, Hervada and Emmett's (1983) supports this general trend. Child-based studies cite father figures as the most frequent offenders overall, with rates ranging from 23% to 60% of child sexual abuse cases.

The very high percentage of offences by father figures occurring in adult clinical samples (Table 5) contrasts significantly with nonclinical samples. In seven nonclinical studies (totalling nearly 10,000 cases), estimates of the incidence of father-figure incest ranged from 0.4% to 8.1%, whereas 32% to 100% of women identified as child sexual abuse or incest survivors, and 10% to 17% of women in treatment for other disorders (i.e., alcoholism, eating disorders, somatization) were identified as childhood victims of father incest (Table 2). These figures support the observation that father incest is particularly destructive and most often associated with more severe clinical sequelae (Alexander & Lupfer, 1987; Briere & Runtz, 1988a; Harter, Alexander & Neimeyer, 1988; Herman, Russell & Trocki, 1986).

The Russell study moreover, provides the best analysis of incest perpetrator age and sex. Russell found that in 16% of cases the abuser was 40 or more years older than the victim, in 32% of cases he was 20 to 39 years older, in 30% of cases he was 5 to 11 years older, and in 13% of cases he was less than 5 years older. Ninety-six percent of perpetrators were male.
### Table 5. Percentage of father figure offenders in nonclinical and clinical samples.

**Note.** *Kilpatrick & Amick as reported in Russell, 1986

**Wyatt, as reported in Russell, 1986*
Type of Sexual Abuse

AGE OF ONSET. Detailed data regarding age of sexual abuse onset remains sparse, and differing figures are provided by the retrospective nonclinical and contemporary clinical studies. In the first instance, Russell's examination of incest victims found that 11% were first offended before age 5, 19% between age 6 to 9, 41% between age 10 to 13, and 29% between age 14 to 17. Finkelhor's (1980) study of college students found that, of the 19% of women who had experienced childhood sexual abuse, over half had been abused before the age of 12 by an adult, and over one-quarter had been abused before age 12 by a child or adolescent more than five years older than the victim. Thus, over 75% had been offended prior to age 12. The mean age of sexual abuse onset provided by the other nonclinical studies ranges from 9 to 11.7 years (Table 6). Thus it seems clear that the majority of child sexual abuse cases begin prior to the onset of puberty.

Compared with the above nonclinical results, clinically based studies of sexually abused children (Table 7) indicate a somewhat younger average age of onset (6.8 to 9.9 years), with victim ages ranging from two months to 16 years. Note, however, that these are generally cases of severe long-term abuse. Consequently, it is not possible to generalize to the population of abused children as a whole. Growing concern is being focussed on the rates of sexual abuse in very young children. We anticipate serious underreporting from this group, both in retrospective accounts and in contemporary cases. Given the very young child's level of cognitive operations and their preverbal status, memories of abuse are largely unretrievable either due to massive repression (Herman & Shatzow, 1987), or to their storage as exclusively somatosensory memory traces (Courtois, 1988). However, with increased practitioner awareness, there has been a considerable increase in the detected cases of sexual abuse in babies and toddlers over recent years. Russell (1986) cites Dr. Michael Durfee, who circulated information gathered by the Los Angeles County Department of Health Services between 1983 and 1984. They found that "more suspected cases of sexual abuse were reported for babies of two years old than children of any other age up to 16 years old, followed by three- and then four-year-olds" (p. 75).

SEXUAL BEHAVIORS. Russell (1983, p. 141; 1986) provided a useful taxonomy of sexual abuse behaviors and their degree of severity, which takes into account the actual sexual behaviors, their progression over time, their frequency and duration, and the extent to which
<table>
<thead>
<tr>
<th>Study</th>
<th>Date</th>
<th>N</th>
<th>Population</th>
<th>Mean age of onset</th>
<th>Frequency</th>
<th>Duration</th>
<th>use of force or threat</th>
<th>multiple perps</th>
<th>completed genital intercourse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NONCLINICAL SAMPLES</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Kinsey</td>
<td>1953</td>
<td>4441</td>
<td>community, middle class</td>
<td>9.5</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>J. Landis</td>
<td>1956</td>
<td>1028</td>
<td>college students</td>
<td>11.7</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Gagnon</td>
<td>1965</td>
<td>1200</td>
<td>community, middle class</td>
<td>9.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finkelhor</td>
<td>1979</td>
<td>530</td>
<td>college students</td>
<td>10.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russell (note: figures refer specifically to incest victims)</td>
<td>1983</td>
<td>930</td>
<td>probability household sample</td>
<td>11.5</td>
<td>43% single incident</td>
<td>35% under 6 mo.</td>
<td>7%</td>
<td>16%</td>
<td>20%</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>31% 2 to 5 times</td>
<td>31% 6 mo to 2 years</td>
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<td></td>
<td></td>
<td></td>
<td>17% 6 to 20 times</td>
<td>28% 2 to 10 years</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10% over 20 times</td>
<td>6% over 10 years</td>
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<tr>
<td>Fromuth</td>
<td>1986</td>
<td>383</td>
<td>college students</td>
<td>60% single incident</td>
<td>13% over 1 year</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Briere &amp; Runtz</td>
<td>1988</td>
<td>278</td>
<td>college students</td>
<td>9.0</td>
<td>41.4% single incident</td>
<td>12.2% over 1 year</td>
<td>51.2%</td>
<td>39%</td>
<td>7.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>46.4% multiple</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>mean = 7.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>CLINICAL SAMPLES</strong></td>
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<tr>
<td>Keedall-Tackett &amp; Simon</td>
<td>1988</td>
<td>365</td>
<td>referred to CSA treatment center</td>
<td>7.5</td>
<td>85% over 1 year</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Table 6. Characteristics of the child sexual abuse reported from adult retrospective nonclinical and clinical samples.
## Table 7. Characteristics of abuse experience among groups of identified sexually abused children.

<table>
<thead>
<tr>
<th>Study</th>
<th>Date</th>
<th>N</th>
<th>Gender</th>
<th>Population</th>
<th>Mean age of onset</th>
<th>Abuse experience</th>
<th>frequency &amp; duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams-Tucker</td>
<td>1981</td>
<td>28</td>
<td>78.6% female</td>
<td>outpatients</td>
<td>9 years</td>
<td>54% adult contact with child’s genitalia</td>
<td>61% long term mean = 2.7 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31% child forced to perform fellatio</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>26% genital-genital intercourse</td>
<td></td>
</tr>
<tr>
<td>Mian et al.</td>
<td>1986</td>
<td>125</td>
<td>76.8% female</td>
<td>outpatients referred to sexual abuse team</td>
<td>under 6</td>
<td>Intramily:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43% fondling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13% oral genital</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17% vulvar intercourse</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Extrainamily:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>42% fondling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16% oral genital</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9% vulvar intercourse</td>
<td></td>
</tr>
<tr>
<td>Stephens et al.</td>
<td>1988</td>
<td>191</td>
<td>84% female</td>
<td>Social Services, reported cases</td>
<td>8.4 years</td>
<td>46% genital fondling</td>
<td>21% single incident mean = 21.7 mo. for girls</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24% vaginal penetration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7% attempted vaginal penetration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5% anal penetration</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5% oral genital intercourse</td>
<td></td>
</tr>
<tr>
<td>Cupoli &amp; Sewell</td>
<td>1988</td>
<td>1059</td>
<td>76.8% female</td>
<td>pediatric hospital emergency; referred for sexual abuse assessment</td>
<td>8.3 (42% under 7 years)</td>
<td>3 mo. to 16 years</td>
<td>69% of girls with vaginal, oral, rectal penetration:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 20% under 6 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 30.9% 6 to 11 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 48.9% 12 to 16 years</td>
<td></td>
</tr>
<tr>
<td>Dube</td>
<td>1988</td>
<td>511</td>
<td>85.5% female</td>
<td>outpatients; referred for sexual abuse assessment</td>
<td>6.8 fem. / 7.4 male</td>
<td>2 mo. to 12 years</td>
<td>30.9%* verbal coercion</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>31.9%* physical coercion</td>
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<td>(* in 191 cases examined)</td>
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<td>Wolfe et al.</td>
<td>1989</td>
<td>71</td>
<td>88% female</td>
<td>outpatients; referred for sexual abuse assessment</td>
<td>9.9</td>
<td>5 to 16 years</td>
<td>42% 6 times or less 58% 10 to 100 times</td>
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<td>16% oral genital intercourse</td>
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<td>42% vaginal or anal intercourse</td>
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<td>33% status difference enforced compliance</td>
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force was used to gain compliance. Very serious sexual abuse was defined as progressive, long-term and frequent abuse involving "completed and attempted vaginal, oral, anal intercourse, cunnilingus, analingus, forced and unforced". Serious sexual abuse was defined as progressive and long-term abuse involving "completed and attempted genital fondling, simulated intercourse, digital penetration, forced and unforced". Least serious sexual abuse was defined as non-progressive and involving "completed and attempted acts of intentional sexual touching of buttocks, thigh, leg or other body part, clothed breasts or genitals, kissing, forced or unforced". Using these definitions, she found that 53% of those experiencing extrafamilial abuse were very seriously abused, compared with 23% of incest victims. Twenty-seven percent of extrafamilial and 41% of incest victims were severely abused, and 2% of extrafamilial and 37% of incest victims were least severely abused. Thus, the majority of incest and extrafamilial victims experienced serious or very serious levels of sexual abuse (64% and 80% respectively). The Russell study comprises the only detailed nonclinical adult retrospective examination of actual abuse experienced. Somewhat confirmatory, however, were the results of the Canadian community-based study (Bagley 1984, 1985), which found that one-third of the sexual assaults against women and female children, and one-quarter of those against males, were considered serious offenses under the Canadian criminal code.

In terms of the information arising from studies of identified sexually abused children (Table 7), extremely high levels of very severe abuse were noted. The largest of the studies (Cupoli & Sewell, 1988) considered over 1,000 children referred for sexual abuse assessment to a hospital-based pediatric emergency department. In total, 69% of the girls had suffered either vaginal, anal, or oral penetration: this applied to one-fifth of those under age six; almost one-third of those aged six to eleven, and almost one-half of those aged twelve to sixteen. Similarly, although detailed information is not presented, minimally 40% to 58% of children were reported to suffer abuse involving oral, anal, or vaginal penetration (Adams-Tucker, 1981; Stephens et al., 1988; Wolfe et al., 1989). Thus, it would appear that the proportion of sexually abused children suffering penetration abuse is most likely to come to the attention of child protection services.

FORCE, VIOLENCE & COERCION. Clearly, given that definitions of child sexual abuse require an unequal power relationship between victim and offender, the implicit use of coercion by means of power and status inequality is a given. However, the explicit use of verbal and physical threat or violence has been a prominent feature in many cases of child sexual abuse.
Russell’s detailed examination of this issue found that 36% of incest survivors experienced the use of some force by the perpetrator, when the term "force" includes "physical force, threat of physical force, or inability to consent because of being unconscious, drugged, asleep, or in some other way totally physically helpless" (p. 226). Recourse to force varied significantly between incest abusers, with brothers and first cousins among the most violent (44% of cases), followed by father figures (39%), uncles (23%), and grandfathers (18%). The greatest use of force was employed by "other" male relatives (59%). Thus, the need to use force to gain the victim’s compliance appears to be moderated by the implicit power status of the offender vis a vis the child victim. The Briere and Runtz (1988b) college-based study found that over half of those suffering sexual abuse in childhood were subjected to the use of force or threat by their abusers. The higher rate of force in this sample, compared with Russell’s, is probably due to its inclusion of both intrafamilial and extrafamilial abuse.

Two of the child-based surveys examined the incidence of force and coercion in the sexual abuse incidents (Table 7). Dube (1988) found that 30.9% of cases involved verbal coercion and 31.9% involved physical coercion. These figures are remarkably similar to those obtained in the study by Wolfe and her colleagues (1989), who found the use of physical force in 31% of cases, and of the threat of physical force in 16% of cases. They note that in 33% of cases the status difference alone served to enforce the child’s compliance.

DURATION & FREQUENCY. Nonclinical adult retrospective studies of this issue provide a range of responses (Table 6). The college-based studies report that 41% to 60% of child sexual abuse was experienced as a single incidence (Briere & Runtz, 1988b; Fromuth, 1986), while Russell’s broader based study found 43% of incest cases were single incident experiences. Thirty-one percent of Russell’s incest victims were abused 2 to 5 times, 17% 6 to 20 times, and 10% over 20 times. Sexual abuse duration also differed significantly between the college child sexual abuse, and community-based incest samples. Twelve to 13% of the college victims were abused for over one year, while 65% of the incest sample were abused for over six months, 34% were abused for over two years, and 6% were abused for over ten years.

Figures arising from the child-based studies (Table 7) suggest higher frequency and duration levels even than those of Russell. The majority of the reported abuse experiences were long-term, with duration means of 15 to 31 months (Adams-Tucker, 1981; Stephens et al., 1988; Wolfe et al., 1989), and involved multiple incidents.
FAMILY VIOLENCE & THE SOCIAL CONTEXT

North American society has a unique relationship to the ethics and culture of violence:

Through stories, plays and film, the American society glamorizes the violence in its history. The western cowboy image of a well-armed man riding tall in the saddle is a stereotype that American society views with pride... American Society places value on individualism and success in competition. It emphasizes winning. It emphasizes this for children in Little League and adults in big business. The goal of getting to the top is clear, although the rules for achieving that goal are not at all clear. And the pressure is considerable for Americans, particularly men, to be aggressive, to move up. Violence is a form of aggression which can be used to obtain the goal or to compensate for failing to obtain the goal. (Lystad, 1986, pp xiv-xv)

This cultural reverence for aggression and violence in American society has led to the highest murder rate of any of the technologically advanced nations (Glaser, 1986), with at least one-fifth of homicides involving family members, and with 40% of female homicide victims being killed by family members (Lerman, 1986). The violence, whether directed at men, women, or children, is overwhelmingly perpetrated by men (Brand & Kidd, 1986). According to the FBI statistics for 1984 (Federal Bureau of Investigation, 1985), 89% of those arrested for violent crime, and 86% of those arrested for "offenses" against families and children were male.

Physical Abuse

Research in the area of physical abuse falls into two major categories: child physical abuse, and wife battery. Interest in the area of child physical abuse is generally dated to the seminal 1962 paper which first called attention to the "battered child syndrome" (Kempe, Silverman, Steele, Droegemuller & Silver, 1962). This paper initiated widespread discussion of the issue, and helped to motivate legislation providing funds, both for research into the topic, and for the provision of treatment to victims and families. Legislative requirements for professional reporting of abuse were also promulgated in most North American jurisdictions (Toro, 1982).

Cross-cultural examinations of the topic (e.g., Eisenberg, 1981; Korbin, 1980; Levinson, 1981), demonstrate the comparative violence of the North American culture. Most telling is the fact that ninety percent of American parents use physical punishment as a
socialization technique (Strauss, 1977). As reviewed by Steinmetz (1986), studies throughout the 1960s and early 1970s found that "spankings" occurred in 84% to 97% of all families, and that a very high percentage continued to use corporal punishment up until the tenth grade level. In fact, spanking was found to be a form of punishment used on almost half of a sample of 100 infants under one year of age. In one quarter of cases, the mother stated that spanking had begun before six months of age (Korsch, Christian, Gozzi, & Carlsen, 1965). Wittenberg (1971) extended this finding across social classes with the finding that 41% of the sample used physical punishment on babies under six months and 87% used force before age 2.

The most definitive data regarding child physical abuse remain those provided by Straus and his colleagues who carried out large, methodologically sophisticated, community-based studies of 1,146 (Straus, 1979), and 2,143 (Straus, Steinmetz, & Gelles, 1980) randomly-selected intact families, with children aged 3 to 17 in the home. The interview-based information was obtained from one parent about one randomly-selected child in each family. Noteworthy was the exclusion of children under age three - the highest risk group for physical abuse. Child physical abuse was defined by strict criteria, and had to have occurred within the year prior to the interview. The parent had to have kicked, bitten, punched, hit the child with an object, beaten-up the child, or have actually used a knife or a gun against the child. Under these criteria, 14% of parents were found to have abused a child in the previous year, with a mean number of 10.5 assaults per year (median = 4.5). Extrapolated to a national rate of 6.5 million abused children per year, this figure contrasted radically with official sources, and was 26 times greater than the .25 million yearly incidence provided by the US National Center on Child Abuse and Neglect. In terms of the actual forms of abuse: 8% of children were kicked, punched or bitten on an average nine times per year; 4% were beaten on an average of six times per year; 3% had a knife or gun used on them. Straus cautioned that the figures certainly underreported the actual incidence of child physical abuse given that: 1, children under three were specifically omitted; 2, the data were derived from self-reports of the parent (offenders); 3, no data were gathered on other forms of child physical abuse, such as burning, scalding, etc.; 4, data were only gathered from one parent per family - the actions of the other parent were unknown; 5, the data were based on two-parent families, whereas single parent families may actually be more at risk.

Rosenthal (1988) carried out an extensive study on the over thirty-eight thousand reported cases of child abuse and neglect in Colorado, over the period 1977 to 1984. The most prominent findings of the study concerned the gender-by-age dynamics of victim-offender pairs. Under the age of 12, male victims outnumbered female victims for all forms of abuse.
other than sexual abuse. However, over the age of 12, girls were the most frequent victims for all types of maltreatment. Men were the most frequent offenders in cases of serious injury, while women were the most frequent offenders in cases of child neglect. Overall, the percentage of male perpetrators rose significantly from 55.2% to 64.6% comparing victims under 13 with those over 13 years of age. Victimization patterns were different for boys and girls. Boys became progressively less likely to be abused as they grew from birth through to adulthood, while the reverse was true for girls. Conversely, male perpetrators became increasingly more likely as the child victims aged. Rosenthal summarized these powerful gender effects:

Patterns of adolescent physical abuse parallel patterns of spouse abuse - males are the predominant perpetrators and females the predominant victims. This correspondence is particularly strong for older adolescent victims... Male adolescents are abused much less often in adolescence because they can hit back. In particular, females' abuse of male adolescents becomes a rare event: the balance of physical power is with the adolescent.

If physical abuse of males decreases in adolescence, this is compensated for by the more frequent and more severe physical abuse which is directed toward younger boys. One might speculate that boys, perhaps because of greater socialization toward aggressive behavior, would sustain more physical abuse during their elementary school years. Yet, even among boys aged 0 to 1 years, physical abuse was more frequent and more severe. The more intense physical abuse sustained by young boys, often inflicted by male perpetrators, perhaps offers a partial explanation as to why men are the predominant perpetrators of physical abuse. (Rosenthal, 1988; p. 270)

As to changes in the relative incidence of child physical abuse, opinions are mixed. However, it is suggested that the actual incidence has not increased over the past three generations, and that increased rates reflect changes in reporting practices. Straus, Gelles and Steinmetz (1980) examined rates of parent-child violence over three generations and found that slightly over one-third (37.3%) of parents had used physical punishment over the previous year. This was matched by an almost identical rate in the grandparents' generation. Thus parents had been punished by their own parents at the same rate that they were in turn punishing their own children.

With respect to wife battery, Straus and his colleagues (1980) determined that 16% of wives had been battered by their husbands in the previous year. Steinmetz' (1986)
encompassing review of the literature concluded that between 50% to 75% of all women have experienced physical violence from their partners at some time. However, Steinmetz goes on to caution that these figures are probably underestimates, since the figures are based on intact couples and only deal with the current mate. It has also become apparent that, for about 20% of women, battering occurs repeatedly (Straus et al., 1980; Walker, 1979), and is "severe" for about 5% to 7% of women (Gelles, 1974; Steinmetz, 1977). For approximately 1,700 American women per year, the battery results in death (Steinmetz, 1978). While homicides committed by women against men decreased by about one-quarter over the period of 1976 to 1983 (Browne, 1987; Walker, 1989), the homicides committed by men against women have increased dramatically over that period (Browne & Williams, cited in Walker, 1989). Walker attributes the decrease in female-originated violence to the concurrent increase in the number of shelters and transition houses for women victims of spousal violence. She reasons that most of the homicides perpetrated by women were acts of self defense, which became less necessary as viable alternatives arose. The unfortunate corollary to this is that increased lethal violence is directed by men toward their abused partners. As Walker (1989) states "Two-thirds of family violence deaths are women killed by their male partners, often at the point of separation. Over half of all women homicide victims are killed by current or former partners. These data support the seriousness of battered women's perceptions of danger. They have reason to believe the man's threats to kill them if they leave the relationship." (p. 697).

**Physical and Sexual Abuse**

**CHILD VICTIMS.** With the exception of Cole's (1988) retrospective study of college students, there has not yet been any significant research regarding the co-occurrence of child sexual and child physical abuse. Cole's study of male and female students found that while 19.6% acknowledged child sexual abuse, and 16.4% reported child physical abuse, only 5% were found to have experienced both forms of abuse. These figures are clearly preliminary, given the constraints of the sample, the method of data collection, and the lack of differentiation between genders. Russell's (1986) study did not examine the rate of child physical abuse among respondents, but instead, examined the use of physical force or violence in the commission of incestuous abuse. To this end, Russell developed a three-point violence scale which combined the use of verbal threats of physical violence, weapons, and other physical force or violence by the offender. Application of this scale determined that, 3% of incest cases involved "substantial
violence", 31% involved "some force or violence" and 65% of cases were completely nonforceful (p.96). This led Russell to state that "incestuous abuse and non-sexual physical abuse of children are probably very separate phenomena, with very different causes and dynamics" (p. 394). Following his review of the literature surrounding child sexual and physical abuse, Green (1988) concluded that the two forms of abuse were similar, in that they both involve the intentional misuse or exploitation of a child by a parent or caretaker. Both result in immediate and long term sequelae for the child victim, and both are considered reportable offenses by the judicial system. However, he cautions, they differ in that child sexual abuse is much less likely to be detected, as there is generally no evident physical injury and the child is less likely to disclose, due to more pervasive guilt and shame feelings. While child physical abuse is committed almost equally by mothers and fathers on boys and girls, child sexual abuse is overwhelmingly inflicted by males on primarily female victims.

Despite the lack of good data, the separate incidence/prevalence rates for both forms of child abuse lead us to anticipate a strong likelihood of their co-occurrence in any given female child (i.e. child sexual abuse in almost 40% of females under age 18 (Russell, 1986), and child physical abuse in over 14% of children in any given year (Straus et al., 1979)). However, a full understanding of the interactions between these two forms of child abuse must await future research.

ADULT VICTIMS. Significant research efforts have been directed at determining the incidence of sexual and physical assault experienced by adult women. A growing body of literature has revealed that over half of the women who are dating have experienced sexual aggression (Korman & Leslie, 1982), and that milder forms of physical abuse, such as grabbing, slapping and shoving, are more common than the severe forms, such as beating and attacking with a weapon (see Stets & Pirog-Good, 1989, for a review). Two recent studies of college women have provided provocative results. The first of these (Stets & Pirog-Good, 1989) enquired about the 169 women’s dating experience over the previous year and found that 27% had been physically abused, while 36% had been sexually abused. Of these, 2.4% had experienced violent vaginal rape, 9% had experienced non-consensual intercourse without physical violence, and over 13% had experienced forced oral intercourse. The second study (Grey, Lesser, Rebach, Hooks & Bounds, 1988) gathered lifetime data from 301 women college students. Using mutually exclusive categories, they found that 12% of the women had been raped, 21% had experienced attempted rape, 30% had experienced non-consensual sexual contact
accompanied by physical force, and 33% had experienced forced sexual manipulation (i.e.,
verbal threats and psychological pressure). Of the women who had been raped, 14% of the
cases had occurred prior to grade nine and 57% had occurred after high school. Previous work
with college women has determined that those who are physically assaulted are more likely to be
sexually assaulted and vice versa (Sigelmand Berry & White, 1984).

Data regarding wife assault, both physical and sexual, also provide alarming
information. Finkelhor and Yllo’s (1985) community survey of over 300 women found that
10% had been sexually assaulted by their husbands, 10% had experienced date rape, and 3%
had experienced stranger rape. These figures were echoed and extended in Russell’s (1986)
study which found that 14% of her sample had been sexually assaulted by their husbands and
that 40% of these women described physical assaults followed by sexual assaults. Repeated
physical assaults (over 20 times) were reported by half of these women. Additionally, it was
found that the battered women were twice as likely to be repeatedly sexually assaulted. Russell
was also able to determine that more than twice as many incest victims were battered by their
husbands compared with non-incest victims. Studies of battered women in transition houses
have found that 39% to 59% have been raped or sexually assaulted by their battering partners
(Somers & Check, 1987; Walker, 1979).

As with the child picture, the high base rates for the physical and sexual assault of adult
women thus suggest a strong co-occurrence of the two forms of abuse, strictly on a statistical
basis. Moreover, the data suggest that battered women are more likely to be sexually assaulted,
and that sexually assaulted women are more likely to be battered. A community-based survey by
Murphy and colleagues has captured the overall context of violence within which women live:
only 24.6% of the 391 women had not been criminally victimized at some time in their lives
(Murphy et al., 1988)

**Risk Factors**

Finkelhor’s (1980) study of almost 800 college students defined eight major risk factors associated with a history of child sexual abuse: 1) presence of a
stepfather, 2) ever lived without a mother, 3) not close to mother, 4) sexually punitive mother,
5) mother never finished high school, 6) no physical affection from father, 7) income under
$10,000, 8) two friends or less in childhood. He found that, for those living with none of these
factors, the risk for child sexual abuse was almost nil. However, 66% of those with five to
eight of the factors present reported a child sexual abuse history. Factor presence was additive, in that with each additional factor vulnerability increased by 10% to 20%. Finkelhor and Baron's (1986) later review of the community-based nonclinical studies further elaborated upon major risk factors for childhood sexual abuse. Female victims were predominant, with an average of 2.5 girl victims for every boy victim. A bimodal distribution with respect to age of onset was noted, with peaks at the 6 to 7 and 10 to 12 year old ranges. However, they caution that the overall incidence among younger children is probably underestimated, given both underreporting and repression of recall among very young victims of abuse. Although lower social class is a significant risk factor in child physical abuse, this is not the case with child sexual abuse. In fact, Russell (1986) found higher rates of child sexual abuse among those from middle and upper income families compared with those from lower income backgrounds. With respect to ethnicity, Russell found no difference in the incidence of child sexual abuse among black and white women, although there was a suggestion of higher rates among Hispanic women. Jewish and Asian women appear to be at significantly lower risk for abuse. Finkelhor's and Baron's review again concluded, however, that the most consistent association, across studies, concerned attributes of the parents of sexually abused girls. Abused girls were more likely to have: lived without their natural father; their mother employed outside the home; a mother who was disabled or ill; witnessed conflicts between parents; reported a poor relationship with one of their parents. However, they underscore the fact that two things do not increase risk for abuse – social class and black versus white membership. Child sexual abuse is a "very democratic" problem.

CHILD PHYSICAL ABUSE. A number of risk factors associated with child physical abuse were suggested by Straus's work (1979; 1980). It was found that, overall, mothers were 75% more likely than fathers to physically abuse children. However, gender rates equalized when men were compared with those women who were employed full time outside the home. Thus, Straus suggests, the burden of full time child care, allied with financial dependence on the father, and the generally disempowered status of the stay-at-home mothers, puts them at greater risk for abusing their children. Socioeconomic factors also proved predictive in that lower income families experienced 62% greater rates of physical abuse than did middle income families. Unstable employment histories, and husband's status as manual (vs white collar) workers were also predictive of higher levels of abuse. A strong correlation was also found between levels of verbal and physical abuse. Overall, parents who verbally abused their children
were six times more likely to physically abuse them also. Men who were verbally abusive to their wives were about three times more likely to abuse their children physically, while women who verbally abused their husbands were three-and-a-half times more likely to physically abuse their children.

Thus, taken in the aggregate, physically abused children most frequently exist within a matrix of economic hardship and uncertainty, verbal abuse, and parental discord. The conclusions arising from the Straus studies have been confirmed and extended by other research over the past decade. Green's (1988) extensive recent review of the research literature concerning parental risk factors concluded:

In summary, abusing parents are characterized by childhood exposure to inadequate and abusive parenting, low self-esteem, psychiatric disorders, cognitive impairment, and increased environmental stress and social isolation. These adverse factors are likely to exert a cumulative negative impact on their parenting ability and directly contribute to an "abuse-proneness". Their social isolation and paucity of peer contacts reduces their exposure to potentially normal and corrective parenting models. (p. 594).

Not surprisingly, similar factors have been implicated in wife battery. Walker's (1984; 1986) work with battered women, representing a range of cultural backgrounds, ages, and socio-economic status, found that low self-esteem and social isolation were the most prominent characteristics of victims. Evidence also suggests that lower socio-economic status and lower educational levels of both victim and aggressor are significant risk factors for domestic or other dyadic violence (Carlson, 1977; Coleman, Weinman & Hsi, 1980; Ulbrich & Huber, 1981).

CROSS-CULTURAL RISK FACTORS FOR CHILD ABUSE. The occurrence of child abuse in general, and child sexual abuse in particular, are not restricted to western cultures. However, attention to the circumstances of the world's children is only beginning to become a concern, and much work remains to be done in terms of establishing incidence figures along with strategies designed to address the problems. Finkelhor and Korbin (1988) have recently provided a valuable background discussion paper, discussing risk factors and suggesting strategies for an international approach to policy development concerning child abuse. Child abuse is defined by them as "that portion of harm to children that results from human action that is proscribed, proximate and preventable" (p. 3). Thus, abuse is differentiated from all the other
forms of harm which befall children. The cross-cultural research points to five categories of children who are particularly vulnerable to abuse: those in poor health; females; unwanted children; those born under difficult circumstances, or with disvalued traits; and those living under conditions of rapid socio-economic change. Three forms of child abuse occur widely across cultures: parental child battering, selective neglect and sexual abuse (Korbin, 1987). With respect to sexual abuse, and incest in particular, Finkelhor (1984) points out that the dynamics of incest "thrive on family isolation, male sexual domination and female sexual shame... all conditions which exist in many societies" (p 11).

SOCIAL CHANGE & INCREASED RISK. Overall, it would appear that the rates of child sexual abuse (Russell, 1986) and child physical abuse (Green, 1988) are increasing. Given our current understandings of risk factors, demonstrable changes in our social structures are thought to play a role in overall increased risk. Lystad's (1986) documentation, in conjunction with Lein's (1986) wide-ranging review of the literature, provide a useful analysis of the dramatic changes experienced by the North American family over the past three decades. Women's participation in the work force has increased dramatically. In 1950, only 18% of women with children under 18 years were employed, compared with 54% as of 1980. As of 1984, six of every ten mothers with preschool or school age children were working. Thus, the situation has virtually reversed from 1950 to the late 1970s when only 12% of American households continued to embody the stereotype of father working while mother stayed home with the children (Johnson & Hayghe, 1977). Not only are more mothers working, but most are working out of clear economic need — either as the only employed adult, or with a husband earning less than $15,000 annually (U.S. Dept. of Labor, 1984, cited in Lein, 1986). While facing increased financial pressure as significant wage earners, women continue to earn about 60 cents for every dollar earned by men (U.S. Dept. of Labor, 1984, cited in Lein, 1986):

Thus, women are at a significant disadvantage in wage earning and in supporting a family. Hour for hour, they bring home less money, while carrying substantial responsibility for earning at least part of the family living. (Lein, p 34)

The rise in divorce rates, and the resulting social and economic fallout are also areas of real concern. The parental divorce rate has steadily risen over the past three decades and has almost doubled for children born in the 1970s (18%), compared with those born in the 1950s.
The rate continues to rise such that, as of 1982, 8.4 million women in the United States were living in households without the biological fathers of children living at home. Lein underscores the serious economic effects of family breakup, in that when a single household splits into two, the father usually maintains his previous standard of living, while that of the mother and children tends to "plummet". In general, child support levels are very low and, furthermore, are not paid in more than one half of the cases. "Overall, the partner with the more limited earning ability is left with the remaining major family responsibility and relatively little financial support" (Lein, 1986, p 36). Changes in birthrate patterns also provide precursors to increased risk for child abuse. While birth rates are decreasing, the past two decades has seen the average maternal age diverge into a more bimodal distribution with a large increase in both teenage pregnancies and older first pregnancies (i.e., thirties and forties). The first group are clearly more globally at risk and because the mother's education is generally terminated, a lifelong impact is placed on her earning capacity.

Although not empirically investigated with respect to child abuse, other social forces have also been implicated:

The proliferation of physical and sexual abuse is felt to be related to the alarming general increase in violence in our society, demonstrated by the rising incidence of violent crimes, delinquency, suicide, substance abuse and lethal accidents. (Green, 1988, p 595)

It is not difficult to see how these social shifts, both without and within the family, play into the risk factors of poverty, stepfather presence, mother absence, emotional distance from mother, poor mother self esteem and social isolation. We can only hope that these forces will be, in part, mediated and ameliorated by the ever-increasing social awareness of child abuse and the burgeoning number of victim-survivors who are coming forward and demanding redress.
Perceptions of any social phenomenon – its prevalence, effects and causes – are largely determined by the belief systems of the perceivers. These belief systems set the constraints by which data regarding the phenomenon are both gathered and assessed. In the case of child abuse, and in particular child sexual abuse, belief systems have played a critical role in maintaining the disjunction between reality and social and professional perception. The primary taboo, in fact, has been the open recognition and discussion of incest and child sexual abuse, rather than its perpetration (Armstrong, 1978). A brief tour of child abuse perceptions in the western world over the past three centuries provides a helpful perspective on the more recent struggles for recognition of the issues involved. Noteworthy is the causal interplay between theory, data gathering, interpretation and social policies over time.

PRIOR TO THE TWENTIETH CENTURY

The maltreatment of children is hardly a novel occurrence within the history of western cultures. However, the degree to which the various forms of maltreatment were socially discouraged, condoned, or even encouraged has varied over time, cultures and forms of abuse (DeMause, 1974, 1988).

Alice Miller’s (1983, 1984) literature-based explorations of the European historical record provide a portrait of physical, sexual and emotional abuse as the everyday reality of most children. In particular, she documents the extreme forms of sexual liberties taken by adults with prepubescent children in the seventeenth and eighteenth centuries. These forms of sexual abuse were overt, public, and socially sanctioned, and stood in contrast to the supposed high degree of modesty and sexual probity manifested between adults.

Additional evidence regarding 19th century child sexual abuse is detailed in Cunningham’s (1988) historical review. In 1857, Ambroise Tardieu, Dean of the faculty of Medicine at the University of Paris and President of the Academy of Medicine, began publication of the *Etude Medico-legale sur les Attentats aux Moeurs* (A medico-legal Study of Assaults on Decency) which extended over seven editions and detailed the number of sexual assaults in the city and discussed their characteristics and effects on victims. The fourth edition
reported on the 420 cases of sexual offenses against children under age 15 that Tardieu had examined. The majority of cases comprised girls under the age of 12, and he noted that in 126 cases the abuse had continued over years with no obvious physical evidence (Tardieu, 1862). Tardieu discussed many of the issues which, over 100 years later, are again being addressed. He differentiated between cases of sexual abuse with and without the use of violence; he designated "rape" as occurring in cases of complete intromission, while non-intromission constituted "simple sexual assault". Tardieu also described the physical and psychological effects of sexual abuse using many referents familiar to today's workers:

In cases where deflowering has been followed by repeated sexual contacts, particularly on little girls still far from the age of puberty, we see the whole constitution undergo change at the same time that the genital organs become the seat of the deformity that has been described. The pallor of the face, the livid complexion, the dazed stare, the sunken eyes, the dry skin, hyperventilation, digestive disturbances, extreme weakness, all combine to reveal the pernicious influence on the whole organism of acts which damage the body and the mind equally. (Tardieu, cited in Cunningham, 1988, p 347)

Unfortunately, Tardieu's victim-oriented perspective was not shared by his successor, Paul Brouardel, who was greatly influenced by the views of Jean Martin Charcot; a practitioner who was much more interested in the offenders whom he viewed as "ill", rather than as "vicious". Broudel's 1909 publication described the sexual offender as being "often an honest family man", and went on to minimize the incidence of child sexual abuse by stating that up to 80% of reported cases were false. He provided a view of the child as suggestible and deceitful. This victim-blaming stance was extended by Paul Garnier (1896), the Chief Physician at police headquarters in Paris, who attributed child sexual abuse to "hereditary mental degeneration" present in the child victims:

When they have become better known and better interpreted, it will be advantageous to discern the sexual propensities of the child, to discover (in these) certain abnormalities (which lead) in those impregnated with a morbid heredity... to pederastic prostitution." (Gamier, cited in Cunningham, 1988, p. 348)
Taylor's (1985) examination of nineteenth century British and American medical records revealed regular findings of venereal disease on children's mouths, genitals and anuses when their parents had the disease. Worthy of note is her finding that the majority of cases occurred in children under the age of five. These findings were generally attributed to wetnurses or to the child's own "wickedness". Clearly, given the transmission requirements for the bacteria, the children had been subjected to contact sexual abuse, usually by a father figure.

Thus, from Tardieu in the 1850s, to Charcot, Brouardel and Garnier at the end of the century, we see the transformation of the issue of child sexual abuse from an empirically based, victim-oriented reality to a non-empirical, offender-oriented, victim-blaming perspective. The last stage, a virtually complete denial of the extent and reality of incest, was marked by Freud's repudiation of his "seduction theory" and its replacement with his "oedipal theory" (Masson, 1984, Miller, 1984). Based on Freud's clinical experience, the seduction theory suggested that patients' "hysteria" symptoms were caused by childhood incest. Conversely, the oedipal theory denied the reality of incest and appealed to the child's psychosexual developmental need to fantasize sexual contact with father. The wider social consequences of this "had the ... effect of exonerating the involved adult while allowing for both the continuation of the incest and society's denial of it." (Cortoise, 1988, p. 7).

It is important to recall that the sexual abuse of children occurred within an overall context of physical and emotional violence directed toward children (DeMause, 1974). Miller's (1983, 1984) discussions of European child-rearing beliefs and mores provides a chilling account of the perceived need to obtain the complete obedience of and mastery over the child. Physical beatings were seen as essential tools to be used in early childhood, while the use of shaming and humiliation were the techniques applied to older children and adolescents:

It is quite natural for the child's soul to want to have a will of its own, and things that are not done correctly in the first two years will be difficult to rectify thereafter. One of the advantages of these early years is that then force and compulsion can be used. Over the years children forget everything that happened to them in early childhood. If their wills can be broken at this time, they will never remember afterwards that they had a will, and for this very reason the severity that is required will not have very serious consequences. (J. Sulzer, 1748, An Essay on the Education and Instruction of Children, cited in Miller, 1983)
Thus, within the European tradition, child battery was viewed as a part of the moral, educative duty of a parent toward his child. Miller points out that this traditional perspective remained overt and active up until at least the very recent past.

The American history of family violence has been interpreted within the larger context of social violence (Glaser, 1986). The United States and the initial thirteen colonies which preceded it

... was a land of immigrants whose living conditions fostered more lethal violence than England had or any of the other countries from which they had come. Gun ownership was a monopoly of the aristocracy in Europe, but colonial America was unique in averaging at least one gun for every adolescent or adult male. (Glaser, 1986, p. 8).

The settlers feared the Native Indians, the African slaves and the ex-convicts sold as indentured laborers. Once again, we see the legitimization of power and of the use of violence by men and adolescent boys. However, the range of adversaries was more broadcast and extensive than that prevalent in contemporaneous European culture.

Official concern for child abuse in America was initiated in 1874 with the case of Mary Ellen, a nine-year-old battered child who was removed from her parents on the grounds that she was a member of the animal kingdom and thus entitled to protection under the laws against animal cruelty. This action gave rise to the formation of the Society for the Prevention of Cruelty to Children (SPCC), an outgrowth of the previously formed SPCA. However, it was not until over a century later that all states possessed laws mandating the reporting of child abuse, and requiring investigation (Lystad, 1986; Steinmetz, 1986). In the interim, child protection was largely the province of volunteer organizations with little actual power to effect change, and we can safely assume that reported figures highly underestimated the actual incidence of child abuse. Nonetheless, a review of the records provided by three Boston child protection agencies between 1880 and 1930 provided 502 cases of family violence (Gordon, 1983). Ten percent of these cases were also noted as involving father-daughter incest.
THE TWENTIETH CENTURY "AGE OF DENIAL"

Freud's oedipal theory has been viewed as ushering in the "Age of Denial" (Armstrong, 1982), which endured until the reluctant rediscovery of incest in the late 1970s. Meiselman's (1978) discussion of American incest/sexual abuse research up until 1978, found only 47 articles or books reporting cases of overt incest. Bender's and Blau's (1937) examination of sixteen court-referred patients constituted the first American study. The majority of subsequent research publications were based on case studies, and were characterized by small sample sizes and the absence of control groups. Only two studies (Bender & Grugett, 1952; Sloane & Karpinski, 1942) with sample sizes of four and five respectively, discussed clinical sequelae for survivors.

Prior to the late 1970s, the child sexual abuse literature displayed three major orientations: 1. it hardly ever happens (denial), 2. if it does, it causes no significant harm (minimization), and 3. it's the victim's fault and/or her mother's anyway (blaming). The denial perspective was firmly entrenched with the adoption of Freud's oedipal theory. Thus, psychiatric textbooks provided an incest prevalence figure of one to two per million population (Weinberg, 1955).

Minimization of the effects of incest has a lengthy record in the literature (Gelinas, 1983; Scott & Stone, 1986). The Bender and Blau (1937) study of sixteen sexually abused children, which included four incest victims, two of whom were girls, concluded that no emotional problems were present in any of the children. Subsequent studies supported the view that incest experiences were either not harmful (Gagnon, 1965; Henderson, 1975; Landis, 1956; Nelson, 1979; Weiner, 1962), or were possibly beneficial (Rascovsky & Rascovsky, 1950). In 1953, Kinsey, Pomeroy and colleagues embarked upon a major study of American women's sexual behavior and experiences. Over 4,000 interviews were conducted with white, educated, middle class women. Although the data regarding sexual abuse sound familiar to the contemporary worker, Kinsey's interpretations do not. The study found a 24% incidence of sexual abuse prior to puberty with a mean onset age of 9.5 years. Over 5% of the women were abused by a family member and 1% were abused by a father figure. Eighty percent of the abused women reported fear and distress as accompanying the abuse. Kinsey's treatment of these data was masterfully minimizing (Herman, 1981). He concluded that the children "should not" be upset by the abuse, that the fault lay not with the abuser but with prudish parents and teachers who caused the child to become "hysterical". As he stated:
It is difficult to understand why a child, except for cultural conditioning, should be disturbed at having its genitalia touched, or disturbed at seeing the genitalia of another person, or disturbed at even more specific contacts... Some of the more experienced students of juvenile problems have come to believe that the emotional reactions of parents, police officers, and other adults who discover that the child has had such contact, may disturb the child much more seriously than the sexual contacts themselves (Kinsey, Pomeroy, et al, 1953; p. 121)

This view was echoed by Maisch (1972) almost two decades later, based on his study of 78 West German incest victims:

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 incest (Maisch, 1972; p. 208)

The victim-blaming defense "provides two major culprits in the incest romance, the Seductive Daughter and the Collusive Mother" (Herman, 1981; p. 36). Herman discusses this professional perspective in the context of wider social teachings such as the biblical story of Lot who was "made drunk and seduced by his daughters". The seductive daughter was first described in the American literature by Bender and Blau (1937). It is useful to recall that this definitive statement was based upon four incested children, two of whom were female.

These children undoubtedly do not deserve completely the cloak of innocence with which they have been endowed by moralists, social reformers, and legislators. The history of the relationship in our cases usually suggests at least some cooperation of the child in the activity, and in some cases the child assumed an active role in initiating the relationship... It is true that the child often rationalized with excuses of fear of physical harm or the enticement of gifts, but these were obviously secondary reasons. Even in the case where physical force may have been applied by the adult, this did not wholly account for the frequent repetition of the practice.

Finally, a most striking feature was that these children were distinguished as unusually charming and attractive in their outward personalities. Thus, it was not remarkable that
frequently we considered the possibility that the child might have been the actual seducer, rather than the innocently seduced (Bender & Blau, 1937; p. 39)

The daughter as active seductress remained a tenet of mainstream psychiatric theory and teachings until very recently (eg. Henderson, 1975; Langley, Schwartz, & Fairbairn, 1968; Luckianowicz, 1972), and was elaborated by the myth of the collusive mother.

Since father-daughter incest usually occurs when the daughter is in her mid-teens and struggling with her own reawakening of her oedipal interest in her father, the combination of the mother's encouragement, the daughter's desires and the father's lack of self-control results in the consummation of father-daughter incest (Langsley, Schwartz & Fairbairn, 1968; p. 219)

Thus, according to traditional psychiatric thinking, the mother is equally as culpable as the daughter in cases of incest (Koch & Jarvis, 1987). She abdicates from her "maternal and conjugal responsibilities" and pushes her daughter into taking on the role of wife to the husband, and mother in the home (eg. Browning & Boatman, 1977; Machotka, 1966; Poznanski & Blos, 1975). Family systems theory has also adopted the perspective of the wife as "cornerstone" in the dynamic of incest (Basini & Kentsmith, 1980; Brant & Tisza, 1977), while the father remains essentially peripheral:

Despite the overt culpability of the fathers, we were impressed with their psychological passivity in the transactions leading to incest. The mother appeared the cornerstone in the pathological family system. (Lustig et al, 1966; cited in Finkelhor, 1986; p.57)

CURRENT PROFESSIONAL & PUBLIC ATTITUDES TOWARD CHILD SEXUAL ABUSE

Although the empirically-based literature in this area remains meager, a number of recent studies provide support for the sexual abuse myths noted by those working with sexually abused women and children over the past decade. The myths are deeply enculturated and apply both at the lay and professional levels.
Recently, a number of studies have examined college students' attitudes toward child sexual abuse (Broussard & Wagner, 1988; Green, 1987; Holtz, 1985). Common findings included males' perception of the victim as more blameworthy, while females viewed the sexual abuse act both as more serious, and as the responsibility of the offender (Green, 1987; Holtz, 1985). Victim response to the assault also proved a significant variable, with passive victims being held more responsible for their assault than resistive victims (Broussard & Wagner, 1988; Holtz, 1985).

O'Hare and Taylor (1983) both work at a New York center which pioneered work with adult survivors. They enumerate the six key myths held by professionals: 1. incest is a child's fantasy rather than an adult's behavior; 2. incest happens only among social outcasts or the psychologically disturbed; 3. a "Bad Mommy" is responsible for incest; 4. incest only happens to the one "special daughter" in a family; 5. some types of incest are worse than others (brother-sister is not very serious, father-daughter is not so bad, mother-son is most damaging); 6. sexual abuse is just a way of expressing affection.

A number of empirically-based studies have recently been conducted with representatives of the professions typically involved in incest and sexual abuse cases. A number of the myths were addressed by a large-scale survey of private practitioners representing psychiatry, pediatrics, psychology and counselling (Attias & Goodwin, 1985). On the whole, gender was the best predictor of response, as opposed to profession. Almost half the men and fewer than a quarter of the women believed that only one in 200 women had experienced incest. Twice as many men (16%) as women believed that natural fathers were atypical incest offenders, and more than 25% of men believed that over one-quarter of children's incest reports are fantasy. Notably, only 57% of professionals identified males as the majority perpetrators in child sexual abuse, and almost three-quarters endorsed the highly dysfunctional family as the typical location for Child Sexual Abuse. Forty percent of psychiatrists estimated that one-quarter of children's accusations were fantasy, as opposed to the under 5% found in the research literature.

With respect to the "victim blame" variable, gender provided a significant main effect - with male lawyers, judges, psychiatrists, psychologists, social workers and psychology graduate and undergraduate students, all placing more blame on the victim than did their female colleagues (Doughty & Schneider 1987; Grannis, 1986; Jackson & Sandberg, 1985). Psychiatrists were more blaming of the victim than were social workers or psychologists.
(Grannis, 1986). However, there is support for the proposition that as professionals of both genders become more knowledgeable about child sexual abuse, they place less blame on the victim (Doughty & Schneider, 1987; Grannis, 1986). Within the context of the judicial system, victim blame was mediated primarily by role, with District Attorneys, police and social workers being the strongest victim advocates, while public defenders placed more blame on the victim and less on the offender (Saunders, 1988). Nevertheless, despite their recognition that the offender bore primary responsibility for the abuse, both attorneys and judges continued to place some blame on the victim of child sexual abuse (Jackson & Sandberg, 1985) - a finding which led the authors to consider the implications:

Attorney and judge attribution of anything less than strong disagreement with victim blame raises concerns about the way in which victims and offenders are regarded in the legal arena, and suggests the possibility of an underlying bias in the legal system as a whole (Jackson & Sandberg, 1985; p. 50)

In terms of sensitivity to the possibility of a child sexual abuse history in a presenting client, Sagal's (1989) study of 500 certified psychologists in seven states found that over half the psychologists were placed in the high sensitivity range. The lowest sensitivity to child sexual abuse was found either in those who had been practicing for over twenty-five years, or those who had obtained their terminal degree twenty-five or more years ago. A British study examined the views of physicians and nurses regarding the seriousness of child sexual abuse involving intercourse as opposed to fondling (Eisenberg, Owens & Dewey, 1987). Both groups believed intercourse was more harmful, although 10% felt that the majority of children would derive some enjoyment from the abuse, and only 42% believed that few, if any, would enjoy it. Both professions greatly underestimated the incidence of child sexual abuse, with over half estimating an incidence of 1,500 or less.

PROFESSIONAL RESPONSES

As they progress through the "system", child victims and adult abuse survivors generally encounter professionals representing a range of disciplines. Initially, physicians, psychologists and social workers are likely to be encountered in terms of detection and disclosure. Subsequently, social workers and therapists may be involved in therapy and social
welfare issues. Members of the law enforcement and legal professions become involved in cases involving child protection and/or the laying of criminal or civil charges. Victims' experience through this process can either contribute to their healing or, too frequently, result in additional "secondary injury" (Symonds, 1980).

In terms of client disclosure of incest during counselling, Josephson (1986) found that clients needed to be either asked by the counsellor, or encouraged to disclose to the counsellor by some important other. Given the highly emotionally laden quality of disclosure, it is not surprising that clients need encouragement and the assurance of safety in order to disclose. Unfortunately, a very high proportion of counsellors are unable to provide those conditions and simply avoid the topic, particularly with adults who may have an abuse history (Stern, 1985).

Although laws requiring the mandatory reporting of child abuse have existed in all states since 1964, actual compliance by professionals has been poor. As late as the mid-1970s, almost one-third of psychologists were unaware of state reporting laws, and many of the remainder were reluctant to report suspected cases (Swoboda et al., 1978). A decade later, Pope and colleagues (1987) found that approximately one-third of the surveyed members of the American Psychological Association division 29 (Psychotherapy) were unwilling to break confidentiality to report cases of child sexual abuse. A more recent investigation of the factors influencing psychologists' reporting (Kalichman, Craig & Follingstad, 1989) found that, although the vast majority are aware of the laws, fewer than one-third of psychologists would definitely report a child's disclosure of sexual abuse. However, half stated that they would report if the father admitted to the abuse; while only 24% would report if father denied. Fifty-one percent of therapists anticipating a positive victim response would report, and only 33% of those anticipating a negative victim response would report. Overall, the authors concluded, that:

Frequent nonreporting of sexual abuse by licensed clinicians and their interpretation of the reporting laws pose a serious added dimension to the current child abuse problem... Clearly, clinicians in the study were aware of the legal requirement to report, but they indicated that they considered the welfare of the abused child above the law, as if the two were independent. (Kalichman, Craig, & Follingstad, 1989; p. 88).
Similar results have been obtained from studies of physicians. As of the early 1970s, almost half the physicians in Nova Scotia were unaware of the specific laws regulating the reporting of child abuse (Anderson, 1973). Over 20% of an American sample of physicians stated that they would not report known or suspected cases of child abuse (Silver, Barton & Dublin, 1967). By the late 1970s, a survey of general physicians and pediatricians (James, Womack & Strauss, 1978), found that over half had seen at least one case of incest in the past year. Although almost all the physicians who had seen an incest victim felt that the patient had been severely traumatized, only 42% said they would report, and only 32% urged a family member to report. Overall, only 58% of all those surveyed said that they would report a confirmed case of child sexual abuse.

Unfortunately, once disclosure has occurred, the likelihood of treatment or support services is limited. As previously discussed, there has been a rapid escalation in the number of reported cases of sexual abuse over the past decade. Sadly, this has been accompanied by an actual decline in funding to mental health and social services facilities. All states are required to investigate following a report. Yet, few jurisdictions finance any treatment and many provide none at all. Conte and Berliner (1988) cite the example of Cook County, Illinois, where fewer than 10% of the 1,300 founded cases of child sexual abuse received state-financed treatment

Their discussion of this issue concluded:

Legal and ethical questions are raised about the purpose of state intervention under child protection legislation. The primary intent of such legislation is to remediate those conditions that have placed the child at risk initially and required the state to intrude into family life. Intervention, such as child protection investigations, in the absence of any kind of service likely to alter or improve the conditions responsible for the child's sexual abuse may not be sufficient. Indeed, unless it is assumed that discovery stops the abuse and that there are no residual effects, what is the purpose at all for state intervention, if the child is to be left as she or he was before the state intervened?... For professionals and state policy makers to know the identities of abused children and to provide no service likely to prevent or lessen the risk of these effects in the future is indefensible (Conte & Berliner, 1988; p. 74).

As in the other professional disciplines, the legal/judicial community has also been challenged by the emerging reality of violence against women and children. Over the past ten years, virtually all American states have enacted changes in the areas of general rape and
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domestic violence, and half have altered laws on marital rape. As discussed by Caringella-MacDonald (1988), female victims of marital rape were denied access to the legal system by a range of standards and definitions unique to rape and domestic violence law. Chief among these unique rules were corroboration requirements which necessitated substantiating evidence; the assumption of consent unless resistance standards were met (which required victim "resistance to the utmost" throughout the duration of the attack); the admissibility of evidence regarding victim reputation and character (including cross examination of victims regarding past sexual activities and relationships).

Legal reforms over the past decade have addressed a number of these issues, particularly in terms of sexual assault. A wider range of sexual behaviors have been criminalized, in addition to the previous standard requiring vaginal penetration. A number of states have abolished the corroboration and resistance requirements and most have limited the admissibility of the victim’s past sexual character as evidence. Many states have also enabled suppression of the victim’s name in press releases, and there has been a trend toward grading sexual assault offenses in terms of severity as determined by such factors as victim age, presence of aiders and abettors, use of a weapon, etc. As of 1988, 24 states allowed victims to launch civil suits for damages against offenders. Despite the legislative changes, there has been little change in the arrest or prosecution record in most states, and many of the reforms have met successful counterattacks. In particular, the suppression of victim’s names, and character evidence, are being fought on the bases of the constitutional arguments of violation of freedom of the press and violation of equal rights to protection respectively.

The actual criminal court experience of the child sexual abuse survivor is frequently traumatic:

As in rape cases, the burden of proof for incestuous activity is placed on the victim, and this in itself has the potential for exacerbation of psychological damage caused by the sexual abuse... This, combined with the reality that a majority of judges and attorneys in the criminal justice system are male, calls into question the fairness and degree of objectivity with which incest victims are dealt with in the legal arena (Jackson & Sandberg, 1985; p. 52).
Given the inbuilt barriers to prosecution, there is a huge attrition rate from the stage of disclosure to actual prosecution. Even should a case reach the stage of a successful prosecution and a guilty finding, sentencing standards present an additional issue:

The inbuilt bias of the criminal justice system ensures the filtering out of cases at every stage of the criminal process, by cautioning, plea bargaining and special evidential requirements, such as that of corroboration. Even at the sentencing stage the “correctional” function of the criminal process has increasingly been substituted by therapeutic aims. Whilst the number of custodial sentences for property offenses remains high, there has been a tendency for sexual offenders to be released readily into the community (Mitra, 1987; p. 126).

Reviewing the recent British record, Mitra (1987) found that of 63 appeals against sentence in incest cases, almost eighty percent were successful. Major mitigating factors provided by the judges were "provocation" as demonstrated by the daughter's failure to actively resist or by her status as a non-virgin. Marital discord was also accepted as a mitigating factor; in particular, the "understandable" cases wherein the wife had denied the husband sexual access. The final mitigating factor was the presence of the wife's willingness to accept the offender back into the family.

The recent passage of legislation enabling the launching of civil suits by child sexual abuse survivors has met with mixed reviews. Civil suits differ from criminal actions on a number of important variables (Berliner, 1989). On the positive side, a number of procedural and outcome factors favor the victim. In criminal law, a case must be proven "beyond a reasonable doubt", compared with the civil action requirement that a victim "must prove by a preponderance of evidence" that sexual abuse has occurred. Under criminal law all jurors must agree on the verdict, while civil law requires only 10 of the 12 to agree. In civil cases, the victim has much greater abilities to gather evidence. Under civil actions the victim is generally seeking damages for loss and harm. Thus, a guilty finding may lead to substantial monetary awards to the victim. However, civil suits may also present some serious dangers to the victim (Barbieri, 1989; Berliner, 1989). Fundamental to the success of a civil action is the establishment of the degree of injury sustained by the plaintiff: the greater the injury, the greater the compensation. Consequently, therapeutic and judicial imperatives may conflict. It is her lawyer's role to prove how "hopelessly and irretrievably damaged" the victim is, while the therapist's role is one of mobilizing the victim to wellness. Barbieri discusses the characteristic two-pronged attack
generally mounted by the defense. First, the adult victim is characterized as "lying, scheming, vindictive and avaricious", while the child victim is presented as "confused, manipulated and attention seeking". Second, even if the assault is proven to have taken place, any psychological damage will be attributed to other factors in the victim's life: "the victim will be portrayed as a distasteful or pathetic person who was damaged long before any sexual assault took place" (Barbieri, 1989; p. 111). The wider rules of evidence permitted in civil cases also allows the defense to engage in profoundly intrusive information gathering, which may probe into every aspect of the individual's life in support of the two defense strategies. Although theoretically feasible, access to the civil process and eventual financial awards, are severely limited in reality (Berliner, 1989). Attorneys generally work on a contingency basis. Therefore, if the defendant is unlikely to provide significant award sums, attorneys are unwilling to take the case. Thus, this avenue is effectively barred to those in the lower income levels. Additional problems also arise in enforcing award payments even when cases are successful.

Thus, a disclosing victim runs a terrible gauntlet. Initially, her abuse is unlikely to be reported by the therapist or physician to whom she disclosed, thus perpetuating the secret and protecting the offender. Secondly, even if it is reported, the likelihood is that charges will never be laid and that no treatment or therapy will be available for her or her family. Thirdly, should charges be laid, the likelihood of conviction is slim, and she will be subjected to frightening and demeaning cross-examination practices in the presence of her abuser. Should he be convicted, he will spend little time in jail, certainly less than that of a man convicted of a crime against property. Additionally, he is much more likely to receive treatment than she is. Throughout this process she will be exposed to all the overt and covert societal myths regarding sexual abuse – myths she was reared with and ones generally shared by the professional communities she will interact with.
3

CLINICAL SEQUELAE

This chapter provides a review of the empirical literature documenting the links between a history of childhood sexual abuse and a wide range of clinical sequelae. As will become evident in the next chapter, the range of sequelae is most usefully viewed as secondary elaborations of the primary injury suffered by the child victim — the best adaptations the individual could make within an impossible situation. Unlike trauma suffered by an already mature adult, child sexual abuse has a profound impact upon the child's developmental processes. Thus, the wide-ranging array of symptomatology is such that the necessary (mal)adaptations often affect virtually all aspects of the individual's adult functioning.

Given the relative youth of research into the area, a range of methodological problems characterize much of the research — chief among these are the small sample sizes, noncomparable and inadequate measures, inadequate demographic information, biased sampling and the absence of appropriate controls (Briere and Runtz 1988a; Finkelhor, 1984; Sirles, Smith & Kusama, 1989). Theoretical problems are also evident. In particular, given that many of the measures were taken on subjects either in therapy or post therapy, there would seem to be an underlying assumption that symptomatic and characterological pathology is enduring. Notwithstanding these shortcomings, the overall body of research is now sufficiently elaborated to provide a fairly complete and complex portrait of the long-term effects of a childhood sexual abuse history.

CHILD & ADOLESCENT SEQUELAE

Although the focus of this work is on adult survivors of child sexual abuse, it seems important to provide a brief review of the clinical sequelae observed in children and adolescents. Although many of the findings form part of the experience recalled by adult survivors, issues surrounding different cohort and socio-cultural milieus undoubtedly result in some discrepancies. One has to keep in mind that sexual abuse, its disclosure and its legacy in the adult, all occur within a larger social context that has been undergoing rapid change over the course of this century.

Brown's and Finkelhor's (1986) extensive review of the literature concluded that at least
20% to 40% of all sexually abused children manifest pathological distress in the immediate aftermath of the abuse. However, unlike the adult picture, the range of psychiatric labels applied to sexually abused children is more constrained than that applied to adult survivors. The most frequent diagnoses include: adjustment disorder with mixed emotional features, major depression, attention deficit disorder, psychosis and overanxious disorder (Sirles et al., 1989).

Psychological and Behavioral Symptoms

As with their adult counterparts, infants, children and adolescents respond to sexual abuse with feelings of depression, anxiety, hopelessness and anger. The ways in which these feelings are manifested depends on the child's developmental stage and social setting. Courtois (1988) provided an excellent clinically-based review of child and adolescent incest symptoms and the following discussion is drawn largely from it. Infants and very young children manifest acute anxiety symptoms often resulting in crying, fretfulness, clinging behavior, feeding disturbance, withdrawal and more global "failure to thrive" symptoms. During early childhood a wide range of nonspecific anxiety and depressive symptomatology becomes evident, including thumb-sucking, tics, enuresis, sleep disturbance, crying, withdrawal, self-injurious behaviors, speech problems and aggressive acting-out. Trauma-specific behavior may also emerge at this point. Children may engage in compulsive and inappropriate sexual behavior (e.g. excessive masturbation, insertion of objects vaginally or rectally), or they may become sexually aggressive with other children. They often display clearly age-inappropriate sexual knowledge and may either be seductive or avoidant and fearful of men. During middle childhood, these symptoms continue and elaborate as children become more socially interactive and verbal. A range of depression and anxiety symptomatology may be evident, including concentration problems, sleep disturbance, nightmares, suicidal thoughts and feelings, phobias, fears, destructive acting-out and eating disorders. Adolescents tend to either withdraw further into the "good girl" role, or to act out their distress more overtly with increased rates of rebellious, self-destructive and delinquent behaviors.

Good empirical support exists for the above clinical observations. Much of it has been provided by larger scale, controlled studies of identified sexually abused children presenting at treatment centers. In comparison with nonabused children, sexually abused children and adolescents have been found to suffer from significant cognitive effects in terms of poorer concentration (Conte & Schuerman, 1988a; Lusk, 1989), lower overall cognitive functioning and school achievement (Einbender, 1988; Einbender & Friedrich, 1989; Tong, Oates &
McDowell, 1987), and significantly poorer body image and self-esteem (Conte & Schuerman, 1988a; Gaensbauer, 1982; Gaensbauer & Sands, 1979; Sebold, 1987; Tong et al., 1987). Significant developmental delays were found consistently in 25% to 50% of abused children (Goodwin, 1988), and impairments in verbal abilities (Elmer, 1977; Steele, 1983), as well as in visuo-spatial and object concept abilities (Anthony, 1983; Fish-Murray, Koby & van der Kolk, 1987) have also been found with significantly higher frequency. The abused children consistently presented as more depressed, fearful and anxious (Conte & Schuerman, 1988a; Einbender & Friedrich, 1989; Helfner, McKinnis & Kempe, 1976; Rimza & Berg, 1988), and were more likely to have attempted suicide (Rimza & Berg, 1988). Social withdrawal, regressed behaviors, aggressive acting-out (Conte & Schuerman, 1988a; Einbender & Friedrich, 1989; George & Main, 1979; Tong et al., 1987), adolescent runaway behaviors (Hartman, Burgess & McCormack, 1987; McGarry, 1988; Rimza & Berg, 1988), and incarceration for felony offenses (Kelly-Garnett, 1989) were also found at much higher rates in the sexually abused groups.

Physical Symptoms

As elaborated by Courtois (1988), most children do not show primary evidence of genital trauma. However, trauma to mouth, genital, urethral or rectal areas are all vital cues to likely sexual abuse. Physical trauma include lacerations, bruises and tears, abnormal swelling or dilation, or insertion of objects into body cavities. Children may experience difficulties on urination or defecation, and blood or semen stains may be found on the underwear or bedclothes. Violent abuse may also result in soft tissue damage to the buttocks, breasts, lower abdomen or thighs. Secondary physical symptoms are common in sexually abused children and include gastrointestinal disturbances such as gagging, nausea, ulcers, stomach cramps, and eating disorders. Sleep disturbances including nightmares, night terrors, and insomnia are also frequently noted. A wide range of somatic depression and anxiety symptoms may appear including enuresis, encopresis, migraines, exaggerated startle response, dissociation, fear of being trapped or attacked, and a general demeanor of "frozen watchfulness". Children may appear passive and lethargic, have difficulty concentrating, engage in repetitive self-soothing behaviors or in self-injurious behaviors. In general, children attempt to hide or disclaim any injury as part of maintaining "the secret".

The Rimza and Berg (1988) controlled study of children referred to a pediatric sexual abuse hospital unit, found that 33% experienced pain on urination and 22% had abnormal
vaginal discharge. Children who had suffered sexual abuse over more than a six-month period were most likely to experience gastrointestinal problems, while those who had been abused over a two-year, or more, period were additionally likely to suffer from skeletal muscle tension symptoms. A large-scale hospital-based study of 125 sexually abused children under age 7, found that 24% of the children showed only physical symptoms (e.g., vaginal discharge, bleeding, sexually transmitted diseases, abdominal pain, genital bruising), 30% showed only behavioral symptoms, 12% showed both physical and behavioral symptoms, and 26% presented with no overt symptomatology. No significant differences were observed between those suffering from intrafamilial versus extrafamilial abuse (Mian, Wehrspan, Klajner-Diamond, Le Baron, & Winder, 1986). Levy and Sheldon (1986) discussed the importance of physician awareness of child sexual abuse somatic symptoms, and strongly recommended culturing for sexually transmitted diseases in these children (and their potentially abusing fathers). They noted the significant frequency of gonorrhea and chlamydia in young children as a serious cause for concern.

ADULT-BASED RESEARCH

An extensive and somewhat unruly literature now exists regarding the sequelae of childhood sexual abuse in adult women. The remainder of this chapter has attempted to organize that information in an approachable form by separating the information under the major headings of: emotional effects, behavioral effects, cognitive effects, interpersonal effects, overall pattern of functioning, special populations, and factors associated with effect severity. Although this represents a somewhat arbitrary attempt to "fit" the research content, it is intended to provide the reader with some useful structure. Of course, considerable overlap exists between the above noted areas.

EMOTIONAL EFFECTS

Depression

Depression has been the most commonly reported symptom among child sexual abuse victims, and is frequently the principal presenting problem when survivors seek treatment. The empirically-based literature primarily derives from either small clinical samples or larger community-based samples. The clinical samples have been restricted to the association between depression and incest, and thus, probably underestimate the rates of depression among the
broader category of sexual abuse survivors in treatment. The community-based samples, in contrast, have compared child sexual abuse survivors with non-abused controls, and overall, it would appear that at least two-thirds of child sexual abuse survivors suffer from symptoms of depression, many on a recurrent basis and at a level requiring health care intervention.

Meiselman's (1978) examination of psychiatric records found depressive symptoms in 35% of incest victims compared with 23% in nonvictims. Herman (1981), however, found major depression symptoms in 60% of incest victims. This figure was contrasted to the 55% rate found in her comparison group of women subjected to "covert incest" or non-contact sexual abuse. A more recent controlled study of child sexual abuse victims and nonvictims in therapy (Feinauer, 1988) also demonstrated that the abused women were significantly more depressed than the other group.

Community and college-based studies have examined depression within the broader context of child sexual abuse. Sedney's and Brooks' (1984) survey of 301 college women found that 65% of abuse survivors manifested depressive symptoms, versus 43% of nonvictims. Eighteen percent of the victims had been hospitalized for depression compared with only 4% of the nonvictims. A more recent study of 278 female undergraduates (Briere & Runtz, 1988) also found that child sexual abuse survivors were significantly more depressed than nonvictims, although none of the survivors were in treatment, and less than 1% had ever been in treatment. Peter's (1984) community sample of 119 women demonstrated an association between contact sexual abuse and higher incidences of depression, recurrent depressive episodes and likelihood of hospitalization for depression. Multiple regression, controlling for other family and social class variables, retained child sexual abuse as an independent contributor to depression. Other community-based studies have also found two- to three-fold greater levels of depression in child sexual abuse victims compared with nonvictims (Bagley & Ramsay, 1985; Burnam, et al., 1988).

In summary then, it would seem that child sexual abuse victims are more than twice as likely to suffer from depression than non-victims, and are four times more likely to be hospitalized for depression.

Anxiety

The presence of anxiety-related symptoms, both chronic and acute, have long been noted in the descriptive clinical literature (eg. Butler, 1985; Courtois, 1988: Herman, 1981), and are confirmed in the emerging empirically-based literature. In a clinical sample, Briere
(1984) found that 54% of sexual abuse victims had experienced anxiety attacks, compared with only 28% of nonvictims. Feinauer's (1988) controlled clinical study also found that victims of child sexual abuse were significantly more likely to suffer from anxiety-related disorders such as somatization, obsessive-compulsive symptoms and phobias. The Sedney and Brooks (1984) study also found symptoms of anxiety and nervousness in 59% of victims, as compared with 41% of nonvictims. Within a large sample of undergraduates (Briere & Runtz, 1988), the child sexual abuse group was found to exhibit significantly more acute and chronic anxiety, somatization and obsessive-compulsive traits. At the community level, the Bagley and Ramsay (1985) survey found that child sexual abuse survivors reported somatic anxiety symptoms more than twice as frequently (19%) as nonvictims. A more recent community-based study, examining the risk for various problems following sexual assault, found that in comparison with a non-assault group, assault victims were four times more likely to experience panic disorder, phobias and obsessive-compulsive disorder (Burnam et al., 1988). The risks were significantly greater for those assaulted in childhood than for those assaulted as adults.

BEHAVIORAL EFFECTS

Eating Disorders

The empirically-based literature in this area is still very recent and began with the observation that two-thirds of a sample of 78 anorexic and bulimic patients reported a history of coercive sexual abuse prior to the onset of the disorder (Oppenheimer, Howells, Palmer & Chandler, 1985). Subsequent investigations have also found high proportions of eating disordered inpatients with previously undisclosed childhood sexual abuse histories (Devenys, 1988; Sloane & Leichner, 1986). More recently, a range of studies present a greatly elaborated picture.

In a study comparing bulimics with a matched control, it was found that the bulimics had experienced significantly more childhood rape, sexual, physical and emotional abuse. They had also experienced significantly more rape, sexual assault, battery and emotional abuse in adulthood (Devenys, 1988). When compared with outpatient bulimics, the inpatient bulimics were found to have suffered more extensive and severe physical and emotional abuse in childhood and adulthood. Root and Fallon (1988) in a study of 172 patients in a bulimic treatment program found that almost half had been sexually and/or physically abused as children, and 34% were later raped, and/or battered as adults. Sixty-six percent had suffered
rape, childhood sexual abuse, childhood physical abuse and adult battery; and many of those had experienced a number of the abuse types. A subsequent large hospital-based study by Hall and his colleagues (Hall, Tice, Beresford & Wooley, 1989), screened eating disordered patients for abuse histories. While 28% of a comparable group of patients had been sexually abused, half of the anorexic and bulimic patients had a sexual abuse history, and in 85% of cases the abuse occurred before age 17. Over 60% of the sexually abused patients were victims of incest, with fathers as perpetrators in one-third of the cases. An additional 38% were victims of rape; 12% had been fondled; and 14% were multiply offended. Almost one-fifth of the abused patients had previously attempted suicide. Most patients did not reveal their sexual abuse history until they had been in treatment for some time, although they had been asked at intake. The authors stated that, following disclosure, "dramatic change" occurred in the course of treatment, and they concluded that treatment of the abuse history is central to treatment of the eating disorder.

Two studies with university students provide additional information. A survey of 690 undergraduates (Preuss, 1988) revealed a significant relationship between bulimic behaviors and a history of child sexual abuse in female students. A further relationship between bulimia and alcohol abuse was also found. The Runtz and Briere (1986) retrospective study of undergraduates’ teenage behavior found adolescent anorexic behavior to be a major discriminator between the sexually abused and nonabused groups.

**Substance Abuse**

The case history literature began noting the presence of incest histories in women alcoholics in the mid 1970s (Armstrong, 1978; Forward & Buck, 1978; Hornick, 1977). These observations led to a burgeoning empirically-based literature arising from both the substance abuse and the sexual abuse research communities. Empirical studies of substance abuse populations were initiated by Berward and Densen Gerber's seven-state survey of 118 young women in recovery, which found that 44% of the women acknowledged an incest history. More recent studies of female alcoholics, both in recovery and in treatment, have provided incest history rates ranging from 25% to 50% (Carson, Council & Volk, 1988; Kovach, 1986; Sterne, Schaefer & Evans, 1983; Hammond, Jorgenson & Ridgeway, cited in Evans & Schaefer, 1987). Investigations regarding the incidence of childhood sexual abuse, including incest, within this population provide even higher incidence figures ranging from 67% to 90% (Miller, Downs, Gondoli & Keil, 1987; Roshenow, Corbett & Devine, 1988). Roshenow et al. also
note that, prior to regular questioning regarding sexual abuse history on intake, only 20% of female patients disclosed a sexual abuse history. This figure rose to 75% after abuse history became a standard part of the intake questionnaire.

Empirical research examining the overlap between identified sexual abuse survivors and alcohol abuse has found rates ranging from 17% to 18% in community samples (Burnam et al., 1988; Peters, cited in Burnam, et al. 1988), to 27% to 35% in clinical samples of adults (Briere & Runtz, 1988a; Herman, 1981), and 71% to 90% in clinical samples of adolescents (Flanigan, Potrykus & Marti, 1988; Roshenow, Corbett & Devine, 1988). These data were compared with non-sexual abuse control groups at both the community and clinical levels and yield two- to four-fold rates of alcohol abuse in the sexually abused groups.

Analogous investigations into the overlap between drug abuse and childhood sexual abuse history provide similar results. Between 28% and 50% of adult women in treatment for drug abuse were found to have incest histories (Cohen & Densen-Gerber, 1982; Densen-Gerber 1981; Yeary, 1982). Conversely, between 20% and 27% of sexual abuse survivors from community samples were found to have drug abuse problems (Burnam et al. 1988; Peters, cited in Burnam, et al. 1988). This compares directly with the 21% of community mental health center clients with a sexual abuse history, who presented with a drug addiction problem, compared with only 2% of the nonvictims (Briere & Runtz, 1988a).

Thus, overall, it appears that women with sexual abuse histories are much more likely to become involved in substance abuse than are nonvictims, although at least half of the survivors do not abuse alcohol. The substance abuse rates are much higher in adolescent victims than they are in adults and may reflect both maturational and cohort effects. The overlap is even more striking when both female adolescent and adult substance abusers are examined jointly. In this group, it would seem that the majority possess sexual abuse histories.

Recent work with adolescent substance abusers provides insight into the dynamics of drug and alcohol abuse. Edwall's and Hoffman's (1988) study of adolescent girls in treatment for substance abuse found that significantly more of the incest victims began using alcohol before age nine than did the nonvictims (45% versus 21%). They also exhibited a significantly greater preference for alcohol and stimulant use than did the non-victims, while rates of marijuana, sedative and tranquilizer use were similar. The incest victims were also much more likely to have come from homes with higher rates of family violence (74% vs 33%), and with higher rates of other sexually abused victims in the home (52% vs 4%). Incest victims were also much more at risk in terms of previous history of suicide attempts (55% vs 27%) and
psychiatric hospitalization (29% vs 10%). A study of female adolescent substance-abusing girls provided different age-of-onset patterns from the adolescent norms (Flanigan, Potrykus & Marti, 1988). Thirty-two percent of the incest group began using alcohol before age 12, compared with under 10% of the normal population. By the age of fourteen, 71% of the incest victims were using alcohol, compared with the 55% norm. Marijuana use followed a similar pattern, with over 14% of the clinical group using the drug before age 12, compared with only 3% of the normal population. Overall, it was determined that the incest group used drugs and alcohol significantly earlier, more frequently and more heavily. A study of alcoholic and nonalcoholic adult incest survivors noted that the alcoholic women were more likely to have abused alcohol and engaged in "acting out" behaviors during adolescence, in contrast to the nonalcoholics who had feared "losing control" (Hurley, 1988). The alcoholics seem to have used drink to repress and alter negative feelings, and to enable them to socialize and fit in with peers.

Somatization

The frequent occurrence of somatization, or physical symptoms, in sexual abuse survivors has consistently been noted in the descriptive clinical literature (eg. Courtois and Watts, 1982), and was first empirically stated in Meiselman's (1978) study of incest victims, which found that 52% suffered from "physical problems", compared with 39% of a control group. Similarly, Sitley (1988) found that 52% of 84 women evaluated at a university-based pain program revealed a previously undisclosed history of physical and/or sexual abuse. Notably, the abused group was significantly younger than their nonabused counterparts. Significantly higher rates of somatization have since been confirmed in controlled university-based samples of child sexual abuse survivors and nonvictims (Briere & Runtz, 1988a; Feinaurer, 1988). However, little empirical attention has yet been addressed to this issue by either the sexual abuse or medical research communities. Morrison's (1989) review of the medical and psychiatric literature noted that only two of the 75 articles published on somatization disorder provided any information as to the childhood experiences of the women patients.

However, a primary coping style which involves somatization implies that many survivors will seek medical avenues of treatment. Thus, the failure to explore childhood abuse issues often leads to excessive and unhelpful applications of the expensive medical health care system (Sitley, 1988). One area which has received some attention over the past decade is that
of chronic pelvic pain (CPP). CPP is one of the most common gynecological presenting problems (Reading, 1982) and accounts for 5% to 10% of all laparoscopies performed in the United States, at an average cost of $1,500 per procedure (Walker, Katon, Harrop-Griffiths, Holm, Russo & Hickock, 1988). There is currently a lively debate within medical circles as to the percentage of CPP arising from an organic basis, with estimates ranging from 8% to 83% (Cunningham, Pearce & Pearce, 1988, Walker, et al., 1988). In the midst of this is an emerging consensus that psychological factors are central and primary, and lead to subsequent organic problems.

An early study into this issue found that 36% of a group of 25 gynecological patients with CPP, but normal pelvic examinations, had been childhood incest survivors (Gross, Doerr, Caldirola, Guzinki, & Ripley, 1980-1981). An analogous study of 60 patients diagnosed with DSM-III criteria somatization disorder, found that 55% were victims of child sexual abuse and one-quarter of these had been abused by more than one offender (Morrison, 1989). Recently, two controlled studies have further examined the abuse histories of adult women patients suffering from chronic pelvic pain (CPP) (Cunningham, et al., 1988; Walker, et al., 1988). The Walker study, comparing 25 CPP and 30 other laparoscopies patients, found significant differences on an array of abuse and symptomatic variables. Sixty-four percent of CPP patients disclosed a childhood sexual abuse history, compared with 23% of the control group. Similarly, 48% of the CPP patients had been sexually abused as adults compared with 13% of control, and 64% of CPP patients had experienced major depression (17% of control). Lifetime drug abuse occurred in over half of the CPP patients, as did functional dyspanuria (compared with 20% and 7% respectively in the control group). The second study (Cunningham et al., 1988), compared 27 child sexual abuse survivors with a matched group of 33 nonabused controls, on a wide range of somatic/medical problems. Abuse survivors suffered significantly more from CPP, other gynecological problems, gastrointestinal problems (ulcers, spastic colitis), hypoglycemia, headaches, heart palpitations and asthma, than did the control group. Comparisons within the abuse group found that those who had been offended by the father (37%) had sought significantly more medical help over the six months preceding the study, and were more likely to complain of reproductive system problems. Those abused for the longest periods (over 5 years) were also most demanding of the health care system and were most likely to have had gynecological problems.

Explanations of the role played by a sexual abuse history in the development of somatization, and CPP in particular, remain speculative. Gross at al. (1980-1981) proposed
CPP as an expression of repressed guilt and anger over the incest, while Haber and Roos (1985) suggested that CPP reflects a conversion of psychological into physiological distress. However, citing the theoretical contribution of Gidro-Frank et al. (1960), Walker and colleagues (1988) suggest the following functional explanation:

> Chronic pelvic pain may be a metaphorical way of describing chronic psychological pain and may act as a defense or coping mechanism to protect against painful, emotion-laden memories. Moreover, the symptoms of pelvic pain have social efficacy; the pain often leads to avoidance of adult sexual contact due to dyspeneuria. Thus... pelvic pain may result from intrapsychic conflicts about sexuality and intimacy that lie repressed with the beginning of regular sexual activity, at which time the pelvic pain develops so that sexual activity and intimacy - and severe anxieties and painful memories associated with this activity - are avoided (p. 79).

The association between childhood sexual abuse and adult borderline-type pathology has also been frequently noted. One symptomatic aspect which is widely cited is the presence of self-mutilating behavior. However, little empirical work has been done surrounding self-mutilation and sexual abuse and only one pilot study (Shapiro, 1987) has been located. The study examined 11 incest survivors in treatment and found that over half self-mutilated via burning or cutting. The self-mutilators were differentiated from the others by histories of particularly violent, sadistic sexual abuse. They gave their reasons for mutilation as: self-punishment, a way to drown their emotional pain in physical pain, and a way to assure themselves that they were "real" and could feel.

**Suicide**

The finding of increased risk for suicide attempts among victims of childhood sexual abuse was first noted in the clinical/anecdotal literature (e.g. Harrison, Lumry & Claypatch, 1984). These findings were subsequently supported by empirical studies of clinical (Briere & Runtz, 1988a; Goodwin, 1981; Herman, 1981) and nonclinical (Sedney & Brooks, 1984) groups. A recent large scale study of mental health center clients (Briere & Runtz, 1988a) found that half of the victims had histories of suicide attempts compared with 34% of the nonvictims. Goodwin (1981) examined the records of 201 incest families referred to an agency over a two-and-a-half year period. Altogether, five mothers and eight daughters attempted suicide. All of the daughters were between 14 to 16 and had either not been believed by their mothers, or had
been blamed by their mothers for the incest. The attempting mothers, on the other hand, fell into two types; those who were themselves incest survivors and who attempted within the first week after disclosure; and those who attempted when forced to choose between husband and daughter. The latter group ultimately chose to remain with their husbands and rejected their daughters who, in turn, attempted suicide.

Thus, within clinical populations of sexual abuse survivors, risk for suicide presents as a very real concern and one which must be addressed in assessment and treatment.

COGNITIVE EFFECTS

Attributions and Beliefs

The experience of child sexual abuse demonstrably has profound negative effects upon the way the victim learns to think about herself and the world (McCann, Pearlman, Sackheim, & Abrahamson, 1988). People, it is generally agreed, require some kind of coherent version of the world. These basic assumptions and beliefs have been characterized as: a belief that people are trustworthy and worth relating to (Epstein, cited in Roth & Lebowitz, 1988); a belief in personal invulnerability; an assumption that one is a worthy person and that the world is ordered, predictable, fair, meaningful (Janoff-Bulman, 1985); and a belief that the world is just (Lerner, 1980). All these assumptions are shattered for the sexually abused child - particularly the incestuously abused child. One of the most central effects is the child victim's assumption of guilt and responsibility for the abuse (Summitt, 1983). Victim-guilt generally exists in the context of a shame-based identity, an inability to trust, and a sense of pervasive powerlessness.

Victims commonly experience feelings of isolation, alienation and stigmatization (Finkelhor et al., 1986; Harter, Alexander, & Neimeyer, 1988; Meiselman, 1980). In a clinical sample, Briere and Rutz (1988a) found that 64% of sexual abuse victims reported feelings of isolation, compared with 49% of nonvictims. All of Herman's (1981) clinical sample of father-daughter incest victims reported a sense of stigmatization and negative self-evaluation: "with depressing regularity, these women referred to themselves as bitches, witches and whores. The incest secret formed the core of their identity" (p. 97). Both at the clinical (e.g. Courtois, 1979; Herman, 1981) and the research (Jehu, Gazan, & Klassen, 1985-1986) levels, more than half of survivors have been found to suffer from significant levels of impaired self esteem. Victims are significantly more likely to have adopted a "learned helplessness" (Seligman, 1975) attributional style (Gold, 1986). Thus they attribute bad events to global, stable and internal
elements, while good events are attributed to external factors.

While self-blame and the assumption of responsibility for the abuse is clearly maladaptive in the adult, it may be viewed as an important survival tool for the child. Janoff-Bulman (1979, 1982) suggests that by blaming herself the victim can establish some sense of control over her abuse, thus providing the illusion that if she can only do the right thing it won't happen again. Given the notion of a "just world" (Lerner, 1980), self-blame buys the victim some sense of stability (at a terrible cost): in a stable, just world, bad things only happen to bad people, so she must be bad. Roth and Leibowitz (1988) extend a more comprehensive explanation of how self-blame protects the victim from overwhelming affect:

Blaming herself for the event protects the victim from the knowledge that she was reduced to a state of helplessness, a condition where what she typically recognizes as herself, was irrelevant. As long as she believes that she was influential in the inception of the trauma, she remains in possession of some sense of efficacy and, by implication, identity (p. 102).

Memory Functioning

Many survivors experience flashbacks to the abuse, both in waking states and, symbolically, in nightmares (e.g., Briere & Runtz, 1987; Gelinas, 1983; Lindberg & Distad, 1985a, 1985b). The adaptive corollary to this — amnesia for all or part of the abuse — has been well noted among clinicians working with abuse survivors (e.g., Agosta & Loring, 1988; Hyde, 1987; Gelinas, 1983; Herman, 1986; Herman & Schatzow, 1987). Herman and Schatzow's (1987) study of 53 women in group therapy found that 64% had only partial recall of their abuse and 28% experienced "severe" memory deficits regarding their abuse. Those without memory blocks used less extreme forms of dissociative defenses to protect themselves from overwhelming affect: self-descriptions of "numb", "frozen", "in a fog", or "behind a glass wall" were common. The study found strong parallels between the extent and severity of the abuse and the degree of memory repression. Those whose abuse began earliest, and who experienced the most violence tended to have the strongest memory repression.

Repression of abuse memories has been reported along a continuum of dissociative defenses ranging from cognitive disengagement (or "spacing out"), derealization, depersonalization, out of body experiences, and discontinuous memory, to full amnesia for events (e.g., Blake-White & Kline, 1985; Briere, Evans, Runtz & Wall, 1988; Briere & Runtz, 1987; Lindberg & Distad, 1985;). Briere (1989) recently provided a consensually endorsed
view of the role of the dissociative defenses:

The frequency of such experiences in the sexual abuse survivor suggests that dissociation may represent a powerful defense against memories or events that contain abusive elements... they appear to function as a way for the victim to state that "this isn't actually happening" (derealization), "it isn't happening to me" (depersonalization), or "it never happened to me" (amnesia). (p. 9).

INTERPERSONAL EFFECTS

Sexual Dysfunction

Although early studies found serious levels of sexual dysfunction in incest survivors in treatment [87% in Meiselman's (1987) group and 55% of Herman's (1981) group], little additional work in this area was conducted until recently. In part, the impetus for research in this area arises from the burgeoning number of women who have been in individual therapy and who are now presenting with their partners for sexual/marital therapy (Maltz, 1988). The most recent crop of studies based on outpatient groups has found rates of sexual dysfunction ranging from 45% to 94% (Becker, Skinner, Abel, Axelrod & Cichon, 1984; Briere & Runtz, 1988a; Jehu, 1989; Maltz, 1988).

Sexual problems appear to arise from two related sources at both the intrapersonal and extrapersonal levels. Adult sexual contact often leads to a wide range of intrusive somatic, emotional and cognitive recall experiences surrounding the original abuse. Secondarily, survivors very often moved into relationships with men who "were at best aloof and unreliable, and at worst frankly exploitive" (Herman, 1981, p. 100) — hardly a recipe for satisfying, mutually caring sexual relationships. Two primary adaptational styles have been noted: inhibition and avoidance of sexual relations, or hypersexuality and promiscuity (Maltz, 1988; Westerlund, 1987). We note from our own clinical experience and other's anecdotal reports that these styles may either be consistent or sequential over time. The hypersexual/promiscuous style is often associated with other self-destructive behaviors, such as drug and alcohol abuse (Maltz & Holman, 1987).

In terms of experienced sexual dysfunction, problems arise at all levels of sexual experience. At the cognitive level, body image is often seriously distorted, with false convictions of physical ugliness and abnormality (Westerlund, 1987). The body is frequently
blamed as the deserving object of the abuse. Sexual behaviors, sounds and smells can trigger flashbacks to the original abuse, thus making it difficult for the survivor to differentiate between their current partner and the original abuser(s) (Maltz, 1988). Dissociation is a common response during sexual activity, as survivors "move into their heads". At the emotional level, feelings of fear, shame, helplessness, anger, guilt and confusion are often triggered by sexual activity – feelings which were deeply conditioned during the childhood abuse. Physically, many survivors report the dissociative experience of sensation numbing, particularly in the sexually sensitive breast and genital areas.

Outpatient studies (Becker et al., 1984; Briere & Runz, 1988a; Jehu, 1989; Maltz & Holman, 1987; Westerlund, 1987) have found that up to 80% of women experienced at least one type of sexual response inhibiting problem: phobic aversion, fear of sex, arousal dysfunction, or desire dysfunction. Painful intercourse and vagismus are also common. Not surprisingly, the rates of general inorgasmia and impaired orgasm are also high (in excess of 50%).

Repeted Victimization

Although the increased likelihood for repeated adult victimization has been well noted in the clinical-anecdotal literature (e.g., Butler, 1985; Courtois, 1988; Herman, 1981), Russell’s (1986) study appears to represent the only empirically-based data. She found that 68% of incest victims and 61% of extrafamilial sexual abuse survivors were victims of rape, or attempted rape, by a nonrelative at some point in their lives. This compared with a rate of 38% among the non-sexually abused women. The marital relationships of incest victims were also more problematic, and were about twice as likely to feature sexual or physical spousal assault. Nineteen percent of incest victims and 7% of nonvictims reported being victims of wife rape, and 27% of victims, compared with 12% of nonvictims, reported being battered by their husbands. In terms of nonfamily authority figures, 53% of incest victims reported unwanted sexual advances by figures such as teachers, doctors, ministers, employers, etc., compared with 26% of nonvictims. Incest victims were also more than twice as likely to be asked to pose for pornography (27% vs 11%), and were also more than twice as likely to have been asked to enact behaviors seen in pornographic pictures, movies or books (18% vs 8%). Victims of father-incest were about four times more likely to have been asked to pose for pornography (43% vs 7%), or to have been asked to re-enact it (31% vs 8%).
OVERALL PATTERN OF FUNCTIONING

Personality Disorders

In terms of the diagnostic criteria, many child sexual abuse survivors meet the criteria for a borderline personality disorder (BPD) diagnosis:

A pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation.
2. impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance use, shoplifting, reckless driving, binge eating (do not include suicidal or self-mutilating behavior covered in [5]).
3. affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting only a few hours and rarely more than a few days.
4. inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights
5. recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior
6. marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values
7. chronic feelings of emptiness or boredom
8. frantic efforts to avoid real or imagined abandonment (Do not include suicidal or self-mutilating behavior included in [5]). (Diagnostic and Statistical Manual of Mental Disorders, 3rd. ed., revised (DSM III-R), 1987, p.347)

A small and recent literature has examined the overlap between BPD and childhood sexual abuse, and from 67% to 86% of BPD patients were found to have childhood sexual abuse histories (Bryer, Nelson, Miller & Krol, 1987; Clifton, 1988; Herman, 1986; Stone, 1981; Stone, Unwin, Beacham & Swenson, 1988). Alternatively, Barnard and Hirsch (1985) found that 57% of private psychiatric patients who were incest survivors had been given a primary BPD diagnosis. When constrained to those who had been victimized by a father or
Three studies, in particular, have investigated the abuse histories of BPD patients compared with other diagnostic groups. In the first of these, BPD patients (80%) were much more likely to have experienced childhood sexual, physical and/or verbal abuse compared with antisocial personality disorder patients (38%) or depressed patients (50%). Fifty-eight percent of the BPD patients reported a history of childhood sexual and/or physical abuse, and borderline patients were four to seven times more likely to have experienced child sexual abuse than were the other two groups (Zanari, Gunderson, Marino, Schwartz, & Frankenburg, 1989). When compared with other psychiatric inpatients, BPD patients were found to be significantly more likely to have experienced childhood sexual abuse, to have suffered both incestuous and non-family sexual abuse, and to have been abused by more offenders (Clifton, 1988). Herman and her colleagues recently compared BPD patients with non-bipolar patients (Herman, Perry, & van der Kolk, 1989). They found approximately two-fold increases in rates of childhood sexual abuse (67% vs 26%), childhood physical abuse (71% vs 39%), and witnessing of domestic violence (62% vs 30%) in the borderline group. Overall, the BPD patients had experienced more types of childhood trauma, which were more severe and of longer duration, and which were perpetrated by greater numbers of offenders.

While the DSM III-R borderline personality disorder entity is an essentially atheoretical symptomatic cluster, psychodynamic formulations of the borderline state posit a much more global, stable and pathological personality structure (e.g., Kernberg, 1967, 1975; Kohut, 1971; Masterson, 1981). Consequently, the poor treatment prognosis traditionally associated with a borderline diagnosis presents serious concerns when applied to child sexual abuse survivors (Briere, 1984, 1989; Gelines, 1983; Wooley & Vigilanti, 1984). Herman and her colleagues (Herman, Perry, & van der Kolk, 1989) have extended this discussion with their conceptualization of BPD as a complicated form of posttraumatic syndrome:

Posttraumatic states are often undiagnosed in cases in which secrecy or stigma prevents recognition of the traumatic origins of the disorder; such patients may show remarkable improvement when the connection between symptom and trauma is recognized. Whether some of the negative therapeutic reactions so frequently observed in borderline patients might be avoided by early and appropriate recognition of the relationship between the patient's current symptoms and traumatic experiences in childhood remain to be determined. (Herman, Perry, & van der Kolk, 1989, p. 494)
Post Traumatic Stress Disorder

Taken in the aggregate, a post traumatic stress disorder (PTSD) formulation seems to best capture the complex set of sequelae which characterize child sexual abuse survivors. While the following discussion is focussed on the clinical picture, theoretical aspects of this, and other approaches to the short and long term effects of child sexual abuse, are examined in chapter five. The PTSD analysis has been usefully applied both to children and adult survivors, and the DSM III-R criteria are provided below:

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been , or is being seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)

(2) recurrent distressing dreams of the event

(3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, dissociative (flashback) episodes, (even those that occur upon awakening or when intoxicated)

(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

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

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

(2) efforts to avoid activities or situations that arouse recollections of the trauma

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

(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)

(5) feeling of detachment or estrangement from others

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

(7) sense of foreshortened future, e.g., does not expect to have a career, marriage, or
children, or a long Me
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response
(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering an elevator)
E. Duration of the disturbance (symptoms in B, C, and D) of at least one month (Diagnostic and Statistical Manual of Mental Disorders, 3rd. ed., revised (DSM III-R), 1987, p.250, 251)

Recent, clinically-based, studies have specifically examined the incidence of PTSD in sexually abused children. Kiser and colleagues (Kiser et al., 1988) found that 9 of 10 preschool children who had been sexually abused at a daycare center met the DSM III criteria for a PTSD diagnosis. The most common symptoms included re-experiencing the trauma, sexual acting out, development of general and specific fears, nightmares, sleep disturbance and avoidance of activities stimulating recall. As in Ten's (1988) study of children abused in early childhood, psychic numbing was found in terms of withdrawal, lack of empathy, schizoid characteristics and sadness. Overall, the children functioned in the bottom 10% on measures of personal/social development. A recent study of 31 latency aged children (81% female) found that approximately half met the DSM III criteria for PTSD, and 58% met the criteria for clinical depression (McLeer, Deblinger, Atkins, Foa & Ralph, 1988). Notably, the proportion of PTSD diagnoses rose to 75% for those abused by their natural father as opposed to 25% in those who were abused by some other adult. None of the children abused by an older child warranted a PTSD diagnosis. While only half of the children met the full criteria for a PTSD diagnosis, over 80% exhibited trauma re-experiencing symptoms, 64% displayed two or more symptoms of autonomic arousal, and almost half presented with three or more avoidant behaviors. Thus, the great majority of children presented with at least some of the PTSD symptoms. A large-scale Canadian study of 71 sexually abused children referred for outpatient assessment found that the majority met the PTSD diagnostic criteria. They also found that the youngest and most severely
abused children suffered the highest rates of adjustment problems (Wolfe, Gentile, & Wolfe, 1989).

Goodwin (1985, 1988) has also been a critical thinker in terms of applying a PTSD analysis to the symptoms reported in abused children. Her wide-ranging, synthetic discussion of 1988 provided a helpful developmental stage approach to the PTSD symptoms commonly appearing in sexually abused children. These are summarized and presented in Table 8. It is taken as a given that the initial PTSD criterion - the existence of a significant psychologically distressing event, which would be disturbing to anyone - is satisfied for a child suffering sexual abuse.

Although confirmatory in nature, the literature examining the presence of full PTSD diagnostic criteria in adult survivors of child sexual abuse is still very preliminary (e.g., Briere, 1989; Donaldson & Gardner, 1985; Edwards & Donaldson, 1989; Kovach, 1986; Lindberg & Distad, 1985a). However, the separate literatures examining subunits of the PTSD diagnostic criteria have been relatively elaborated (see Table 9). John Briere (Briere, 1984, 1989; Briere & Runtz, 1987, 1988a) has probably been the most significant contributor to the development of a PTSD model as applied to adult survivors of child sexual abuse. He notes that, taken in total, the symptomatic sequelae of child sexual abuse provide a special, elaborated, case of PTSD which he terms "Post Sexual Abuse Trauma". This extended model takes into account the profound developmental impact of child sexual abuse on the individual in terms of secondary elaborations to the primary psychological injury.

SPECIAL POPULATIONS

Attention has recently been directed toward the abuse histories of both chronic and acute psychiatric patients. A series of studies have clearly demonstrated that both sexual and physical abuse histories are seriously underreported on patient charts (Post, Willett & Franks, 1980). When considering both physical and sexual abuse histories a 9:1 ratio of actual abuse incidence to reported chart incidence was found (Jacobson, Koehler, & Jones-Brown, 1987), with actual totals falling within the 70% to 80% range (Bryer, Nelson, Miller, & Krol, 1987; Jacobson & Richardson, 1987). Fewer than half of the sexually abused patients' charts noted the presence of a sexual abuse history (Craine, Henson, Colliver, & MacLean, 1988; Jacobson, 1989), and histories of child sexual abuse rates in the order of 50% were found within the patient population (Beck & van der Kolk, 1987; Bryer et al., 1987; Craine et al., 1988; Jacobson,
<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>B: Trauma Reexperiencing</th>
<th>C: Response Numbing &amp; Avoidance</th>
<th>D: Persistent Increased Arousal</th>
<th>E: Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool victims</td>
<td>• fears often of men, certain activities or a room, being alone</td>
<td>• attitude of immobility</td>
<td>• &quot;frozen immobility&quot;</td>
<td>• whimpering, sadness</td>
</tr>
<tr>
<td></td>
<td>• sexual experience fragments (e.g., inappropriate undressing, sexualized touch, stereotypic sexual play, etc.)</td>
<td>• lost ego functions (e.g., exploration, ability to sleep alone, toilet training, speech)</td>
<td>• diffuse irritability &amp; tantrums</td>
<td>• clinging to mother</td>
</tr>
<tr>
<td>4 to 6 years old</td>
<td>• nightmares &amp; night terrors</td>
<td>• less verbal than younger child as more guilt and fear about consequences of disclosure</td>
<td>• exaggerated startle response</td>
<td>• more fear of punishment than younger child</td>
</tr>
<tr>
<td></td>
<td>• fear of abandonment as a consequence of impending family breakup for which she is responsible</td>
<td></td>
<td>• hostility directed at mother</td>
<td>• self now sensed as &quot;bad&quot;</td>
</tr>
<tr>
<td>7 to 13 years old</td>
<td>• fear of retaliation against mother &amp; sibs by abuser</td>
<td>• well differentiated fear of retaliation by abusing parent if she resists or discloses</td>
<td>• reminders of abuse may trigger somatic memories rather than verbal memories</td>
<td>• suicidal thoughts</td>
</tr>
<tr>
<td></td>
<td>• may reenact abuse with peers or younger sibs</td>
<td></td>
<td></td>
<td>• ego constriction most evident at school where biology, history &amp; phys. ed. may require skills that must be repressed leading to pseudo retardation and conversion symptoms</td>
</tr>
<tr>
<td></td>
<td>• frequent nightmares</td>
<td></td>
<td></td>
<td>• increasingly solidified sense of self as guilty, inadequate and bad</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• tends to move into victim-aggressor relationships with attempts at intimacy</td>
</tr>
<tr>
<td>Early adolescent</td>
<td>• incest fears crystallize around pregnancy possibility</td>
<td>• fear of intimacy</td>
<td>• irritability, anger, inability to relax. May use drugs and alcohol as coping strategy</td>
<td>• increased sense of self as guilty, inadequate and bad</td>
</tr>
<tr>
<td></td>
<td>• flashbacks during sexual activity</td>
<td>• emotional deadness</td>
<td></td>
<td>• tends to move into victim-aggressor relationships with attempts at intimacy</td>
</tr>
<tr>
<td></td>
<td>• recurrent nightmares</td>
<td>• poor reality testing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Expressions of post traumatic stress syndrome at progressive developmental stages in incest victims. Adapted from Goodwin (1988).
**SYMPTOM TYPE (PTSD FORMULATION)**

<table>
<thead>
<tr>
<th>B: Trauma Reexperiencing</th>
<th>C: Response Numbing &amp; Avoidance</th>
<th>D: Persistent Increased Arousal</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* pessimistic about future, world as dangerous &amp; unpredictable (McCann et al., 1988; Summitt, 1983)</td>
<td></td>
<td>* borderline adjustment (Barnard &amp; Hirsch, 1985; Bryer et al., 1987; Clifton, 1988; Herman, 1986; Herman et al., 1989; Stone, 1981; Stone et al., 1988; Zanari et al., 1989)</td>
</tr>
</tbody>
</table>

Table 9: Summary of post traumatic stress syndrome symptoms found in women sexual abuse survivors.
Over half of the abused patients had not previously revealed their abuse histories to anyone, and over 70% had never disclosed to a therapist (Jacobson, 1989). One-third to one-half of those with child sexual abuse histories also reported suffering adult sexual abuse, and about 80% of those with child physical abuse histories reported experiencing adult physical abuse (Bryer et al., 1987; Jacobson & Richardson, 1987). When considering the four-way typology of child sexual abuse, child physical abuse, adult sexual abuse, and adult physical abuse, over 60% of patients experienced two or more types of abuse and 22% to 48% experienced all four types (Jacobson, 1989; Jacobson & Richardson, 1987).

Incest was reported in 46% to 78% of the child sexual abuse cases (Beck & van der Kolk, 1987; Bryer et al., 1987; Craine et al., 1988), with fathers and step-fathers accounting for three-quarters of incest cases (Beck & van der Kolk, 1987). The sexual abuse tended to occur over the long term, with age seven as the mean age of onset (Beck & van der Kolk, 1987; Jacobson & Richardson, 1987). Half of those with child sexual abuse histories were also physically abused in childhood, compared with only 10% of nonabused patients (Craine et al., 1988). Family pathology was also found at significantly greater levels in those with child sexual abuse histories in contrast to those without: 70% vs 51% had family histories of psychiatric illness; 64% vs 20% had family histories of substance abuse (Craine et al., 1988). Clearly, failure to recognize the presence of a child sexual abuse history may also have important implications with respect to diagnosis and subsequent treatment. This was made particularly evident by the finding that, although 66% of patients with child sexual abuse histories met full DSM-III post-traumatic stress disorder (PTSD) criteria, none had received either a primary or secondary PTSD diagnosis (Jacobson, 1989).

**FACTORS ASSOCIATED WITH EFFECT SEVERITY**

To date, three general areas have been scrutinized with respect to their potential impact upon symptom severity: characteristics of the abuser, of the abuse suffered, and of the family context. Overall, intrafamily sexual abuse is associated with greater clinical symptom severity than is extrafamily abuse (Hartman, Finn, & Leon, 1987; Mitchell, 1988; Schultz & Jones, 1983; Sirles, Smith, & Kusama, 1989; Wyatt & Newcomb, 1990), and abuse by a father figure seems most destructive (Alexander & Lupfer, 1987; Briere & Runtz, 1988b; Harter, Alexander, & Neimeyer, 1988; Herman, Russell, & Trocki, 1986). Compared with other types of sexual abuse, father figure abuse has been linked with increased chronic somatization, anxiety and
dissociation symptoms (Briere & Runtz, 1988b). The greater the age discrepancy between the victim and the abuser, the more severe the effects (Furniss, Bingley-Miller, & Van Elberg, 1988; Herman et al., 1986), and the more prominent are symptoms of chronic anxiety, and acute and chronic dissociation (Briere & Runtz, 1988b). Those who had suffered sexual abuse from multiple abusers were also identified as more clinically impaired than those who had been victimized by a single perpetrator. Increased levels of chronic somatization, anxiety (Briere & Runtz, 1988b; Murphy, et al. 1988), obsessive compulsive symptoms, paranoia, depression, and psychoticism (Murphy, et al. 1988) have been found in multiply-abused groups.

In terms of the actual abuse experienced, earlier age of onset is associated with increased severity of symptom sequelae for both child victims (Browne & Finkelhor, 1986: Conte & Schuerman, 1987b; Price & Valdeserri, 1981; Sirles et al., 1989) and adult survivors (Burnam et al., 1988; Furniss et al., 1988; Hartman, Finn & Leon, 1987; Herman, Russell, & Trocki, 1986; Walsh, 1986). Greater frequency and longer duration of abuse are also strongly associated with increased effect severity (Briere & Runtz, 1988b; Furniss et al., 1988; Hartman et al., 1987; Herman et al., 1986: Sirles et al., 1989; Tsai, Feldman-Summers & Edgar, 1987; Walsh, 1986). Effect severity has also been associated with increased numbers of types of sexual activities demanded of the child (Conte & Schuerman, 1987b; Walsh, 1986), and with the more physically violative and intrusive forms of sexual abuse (Harter, Alexander & Neimeyer, 1988; Hartman et al., 1987; Morrow, 1987; Herman et al., 1986; Sirles et al., 1989; Tsai, Feldman-Summers & Edgar, 1987; Walsh, 1986). The use of force, or the threat of force, has also been implicated as predictive of increased sequelae severity (Briere & Runtz, 1988b; Conte & Schuerman, 1987b; Elwell, 1979; Herman et al., 1986; Furniss et al., 1988; Schultz & Jones, 1983; Sirles et al., 1989; Walsh, 1986).

A number of family-related variables have also been found predictive of symptom sequelae severity. Overall levels of family dysfunction (Conte & Schuerman, 1987b; Fromuth, 1986), the presence of family violence and physical abuse (Carter, 1987; Sirles et al., 1989), negative response by mother following disclosure (Furniss et al., 1988; Morrow, 1987), denial of guilt by offender following disclosure (Conte & Schuerman, 1987b; Morrow, 1987), general lack of maternal warmth (Carter, 1987), and the absence of a good relationship with any adult or sibling (Conte & Schuerman, 1987b) were also associated with increased effect severity.

Thus, the effects of child sexual abuse are most extreme when the abuse begins early, occurs over a long time, is frequent, takes place within a dysfunctional, maternally absent
family, and is perpetrated by more than one offender, but most particularly when the offender is a physically violent father figure, who engages in numbers of violating and intrusive sexual practices.
THEORETICAL MODELS

The issue of child sexual abuse has stimulated considerable theoretical discussion and associated empirical investigations over the past few years. Generally speaking, three levels of analysis have been prominent: individual, family, and sociocultural. At the individual level, attention has focused on: (1) the victim's immediate and long-term adjustment to abuse; (2) the mother's characteristics and response to the abuse; (3) the offender's characteristics and properties. The family level formulations seek to understand the nature and characteristics of the families within which sexual abuse occurs, while the sociocultural levels of explanation examine the role of the culture within which individuals, and families exist. Although frequently appearing as competitive routes to understanding, it is probably more accurate, and certainly more helpful, to see these as nesting levels of analysis which may usefully shape a dialectic directing all three levels to a more comprehensive understanding of this personal, familial and social phenomenon.

INDIVIDUAL LEVEL: THE VICTIM

Previous chapters have detailed what happens to sexually abused children, how they typically respond and adjust to their injuries, and aspects of the larger sociocultural matrix within which their abuse occurs. The following discussion, however, is concerned with conceptualizations as to how, and why, the individual responds as she does. Although thinking in this area remains preliminary, considerable insights have been gained.

The Child Victim

The victim's response (both short- and long-term) to her abuse needs to be conceptualized along a temporal/developmental continuum. Very young children are least aware of sexual functions and are thus, less likely, at the time of the abuse, to experience shame and guilt over the sexual aspects of the abuse. However, they are most severely traumatized by threats accompanying the abuse (McFarlane, Waterman, Conerly, Draiman, Durfee, & Long, 1986). Given that very young children bear the least resemblance to appropriate sexual objects, families within which such abuse occurs are frequently profoundly dysfunctional, and thus
more likely to feature emotional and physical abuse in addition to the sexual abuse. We also know that the earlier the onset of abuse, the more the child will be offended over a longer period; with greater frequency, with more severe and violative forms of abuse, and with greater probability of multiple offenders (Walsh, cited in Courtois, 1988). Latency aged children and adolescents are aware of the social proscriptions regarding sexuality, and thus experience severe guilt and shame associated with their abuse. Abusers of adolescent girls are more likely to be sexually aggressive and to engage in more violative sexual behaviors involving penetration. Father-offenders often become jealous and punitive as their daughters begins to assert their independence, and adolescent victims are much more likely to engage in self destructive (e.g., substance abuse, mutilation, promiscuity) and escape (e.g., running away, early marriage) activities.

In order to understand the child’s responses to her victimization, it is important to view the abuse within the child’s experience – a perspective eloquently summarized by Gelinias (1983):

Incest takes place within the context that is supposed to nurture, protect and care for the child, where she should be able to get a reasonable interpretation of reality and relational life, and upon which she is utterly dependent. Incest is a profound abandonment and betrayal, a travesty of the parental love and care that is a young child’s inherent right. But the child grows up inside the incestuous system, with no perspective, no language and no experience base with which to stand outside these relational and sexual forces and form a health personality and relational templates uncontaminated by incest. (p. 319)

One of the central effects of incestuous abuse is to place the child within an inescapable "double-bind", conceptualized by Wooley and Vigilanti (1984) as "a non-win situation in which the person who is sexually abused receives conflictual messages from the system (i.e., the family) in a manner that does not allow escape" (p 348). Within this existing framework, the victim receives the primary negative injunction from the abuser in the form of "If you do not submit to my sexual advances, I will punish, ignore, or reject you". Implicit in these threats is the child’s perception that the mother is unable to help or protect the child. The double-binding occurs with the secondary negative injunction: "Do not see me as making sexual advances, because this is not really sex", or "This is really good for you", or "This is your fault for turning me on". Either way, the victim is given responsibility for the abuse, which is
not even labelled as abuse. The third negative injunction, they state, is the child's inability to escape from the situation. Thus, few possible defenses may be employed, and dissociation becomes a legitimate defense against an impossible situation (Spiegel, 1986).

An allied discussion of child psychological maltreatment, in general, (Gabarino, Guttman, & Seely, 1986) proposed five major types of abuse and considered their effects on the child's development. Consistent with the experience of sexual abuse, they define psychological maltreatment as "a concerted attack by an adult on a child's development of self and social competence, a pattern of psychically destructive behavior" (p. 8). The first "rejecting" type of abuse occurs when the adult refuses to acknowledge the child's worth, and denies the legitimacy of the child's needs. The "isolating" type is typified by the adult's actions to isolate the child from normal social interactions and to prevent her from forming friendships and bonds with others. This leads the child to believe that she is all alone in the world, and thus totally subject to the demands of her abuser. The "terrorized" child is verbally assaulted, bullied and frightened by the adult and lives in a climate of fear, believing that the world is hostile and capricious. The "ignored" child experiences the adult as depriving her of essential stimulation and responsiveness — thus stifling her emotional growth and intellectual development. The final form of abuse, the "corrupting" type, is said to occur when the adult "missocializes" the child, and stimulates her to engage in destructive antisocial behaviors. The adult reinforces the deviance and makes the child unable to participate in normal social experience. Gabarino his and colleagues conclude: "Psychological maltreatment is the core issue in the broader picture of abuse and neglect. It provides the unifying theme and is the critical aspect in the overwhelming majority of what appears as physical and sexual maltreatment cases" (p 8).

Sexual abuse has also been considered within the more generic rubric of trauma response. A literature review by Kiser and colleagues (Kiser, Ackerman, Brown, Edwards, McCollgan, Pugh & Pruitt, 1988) summarized the five basic threats associated with the presence of traumatic stress in children — all of which are frequently present for sexually abused children: (a) threats against the child's life, (b) fears about physical harm, (c) concern over the safety of attachment figures, (d) threats to self-image, and (e) a sense of isolation surrounding these threats and fears. Symonds (1980) has provided a useful four-phase typology of victim response, which considers both immediate and longer-term problems. The phase one, initial response to trauma, is one of shock, disbelief and denial. The victim suffers a temporary paralysis of action and denial of sensory impressions. When the denial is overwhelmed by reality the victim moves into the second phase of "frozen-fright". Symonds
described this as a terror-induced state of pseudo-calm, detached behavior. The victim enters a regressive posture with ingratiating and compliant-appearing behaviors. These first two phases are restricted to the victim's response during the traumatic event. Subsequent to the event, the victim enters the third phase of "traumatic depression" – characterized by circular bouts of apathy, exaggerated startle reactions, and flashbacks to the traumatic event. At this time the victim generally begins to engage in self-recremation, and judges her actions as if the circumstances were normal. It is during this stage, prior to a final stage of resolution and integration of the trauma, that the victim is vulnerable to "second injury". Second injury is conceptualized as the revictimization experiences encountered by victims as they suffer negative personal and professional responses to their original trauma. Butler (1985) delineated four such levels of betrayal specifically encountered by child sexual abuse victims: (a) the original betrayal by the abuser, (b) lack of response by the non-offending parent and relatives, (c) non-response by professionals (e.g., physicians, teachers, social workers, etc.), (d) the child's own self-betrayal as she is forced to deny the reality of her own experience in order to cope. As van der Kolk pointed out (1987), when faced with an inescapable and intolerable reality, only three accommodations are available: (a) denying the abuse, (b) altering the affective response to it, or, (c) changing the meaning of it. Thus, the child has no option but to betray her own reality in order to survive.

Summitt (1983) provided the most comprehensive dynamic model of childhood response to sexual abuse — the Sexual Abuse Accommodation Syndrome — which posits five sequential factors. The first two, "secrecy" and "helplessness", are both seen as necessary preconditions in order for abuse to occur. Thus the child must be forced to keep the secret and must experience herself as incapable of seeking relief or assistance. Stage three, "entrapment and accommodation" deals with the child's need to accommodate to the reality of her abuse and its inescapable nature. She has to cope with the contradiction between what the parent/perpetrator is versus what they are supposed to be. This contradiction is too great for the child to reconcile, and the only resolution is to see the perpetrator as good and the self as bad — a perspective often explicitly reinforced by the perpetrator. Primitive psychological coping mechanisms such as splitting, repression, and reaction formation are often employed in the child's attempt to maintain a semblance of "normality". The child's rage is necessarily buried and is not able to be expressed directly toward the abuser. Although most children remain stalled at this stage, some progress to a fourth stage of "delayed, conflicted and unconvincing disclosure". This refers to those cases when the child, generally in adolescence and in conflict
with the offender, discloses long-standing abuse. The disclosure is very often met with disbelief — the child is just getting back at her father, she looks "normal", he's a pillar of the community and could never do such a thing, etc. Typically such a disclosure is followed by the fifth stage, "retraction":

This simple lie [the retraction] carries more credibility than the most explicit claims of incestuous entrapment. It confirms adult expectations that children cannot be trusted. It restores the precarious equilibrium of the family. The children learn not to complain. The adults learn not to listen. And the authorities learn not to believe rebellious children who try to use their sexual power to destroy well-meaning parents. (Symonds, 1983, p 188)

But, for most children, adjustment remains at the stage three level:

If the child did not seek or did not receive immediate protective intervention, there is no further option to stop the abuse. The only healthy option left for the child is to learn to accept the situation and to survive. There is no way out, no place to run. The healthy, normal, emotionally resilient child will learn to accommodate to the reality of continuing sexual abuse. There is the challenge of accommodating not only to escalating sexual demands but to an increasing consciousness of betrayal and objectification by someone who is ordinarily idealized as a protective, altruistic, loving parental figure. Much of what is eventually labelled as adolescent or child psychopathology can be traced to the natural reactions of a healthy child to a profoundly unnatural and unhealthy parental environment (Symonds, 1983, p 184).

The Adult Victim/Survivor

The abused child becomes the victim/survivor adult — a woman who, as discussed in the previous chapter, is often laden with deep burdens, and who experiences repeated victimizations, has difficulties in relationships, and expresses a wide array of clinical symptomatology. Briere and Runtz (1988a) have summarized the adult presentation as including" (a) classically conditioned emotions that generalize and elaborate over time, (b) negative cognitions and perceptions regarding self, others, and the future, and (c) archaic coping behaviors that cease to be adaptive in the post-abuse environment" (p 376). In terms of the conditioned emotional responses and their elaborations, Evans and Schaefer (1987) provide an eloquent portrayal of the impact of abuse on long term relationships:
When boundaries are violated by emotional, physical and sexual intrusion it is as if someone rips open the victim, reaches in and "steals their soul". In later relationships, they often experience a terror of being "swallowed up" and losing their sense of self, for they have learned that closeness takes away rather than "gives" to them. This struggle to protect themselves from intimacy feels like a life/death struggle for survival. Requests are seen as demands by these persons, closeness is perceived as losing oneself, and affection puts one in touch with the "empty, gaping hole" inside: The "hole" that carries all the unmet childhood needs; for many experienced as a hollow bottomless pit of neglect and despair. (p 147)

Appealing to Kelly's (1955) personal construct theory, Harter and colleagues have discussed the process by which survivors of child sexual abuse come to their characteristic cognitive set (Harter, Alexander & Neimeyer, 1988). According to personal construct theory, each individual develops a system of personal constructs, or templates, through which they understand and interpret the world. This is a necessary process in order for the individual to predict and interpret her social reality. However, we need shared theories in order to interact effectively. Sexual abuse survivors have a very different theory of the world than that of nonvictims. This, in part, describes their need to confirm that reality by remaining in, and seeking out associations with others reared within a network of abuse and dysfunction - their world may be a very painful place, but at least it is known and predictable.

It was recognized early that the individual's long-term response and adjustment to childhood sexual abuse must be construed within a traumatic response model (e.g., Gelines, 1983). However, it is also recognized that the experience of ongoing childhood trauma differs substantially from that of a single traumatic episode in adulthood (Terr, 1988). As discussed in the previous chapter, during the mid 1980s, workers began to note the overlap between Post Traumatic Stress Disorder (PTSD) and the symptomatic expressions of adult child sexual abuse survivors. Finkelhor's (1987b) recent discussion of the PTSD formulation acknowledged its heuristic value in that it provided a "clean label" and a description of the symptoms victims suffer from. It also served to place child sexual abuse within a larger context and linked the symptoms with other forms of trauma, thus helping to reduce some of the stigma associated with child sexual abuse. Most importantly, the formulation suggested that the effects of childhood sexual abuse may be approached as a defined syndrome with a core etiology, as opposed to a collection of symptoms. However, as Finkelhor (1987b), Briere and Runtz (1988a) cautioned, a PTSD formulation fails to account for all the symptoms associated with a
child sexual abuse history. While PTSD focusses on intrusive imagery, nightmares, numbing and deadness of affect, and social relations, additional features of a child sexual abuse history include suicidality, substance abuse, revictimization, and other Borderline Personality Disorder symptomatology (Briere & Runtz, 1988a), self blame and sexual problems (Finkelhor, 1987b) – all symptoms falling outside a PTSD formulation. Finkelhor also cites the finding of PTSD symptoms in less than half of a sample of child sexual abuse survivors (Kilpatrick, Amick-McMullan, Best, Burke, & Saunders) as militating against a PTSD model. However, this objection may be somewhat dubious, given that not all adult victims of severe trauma manifest PTSD symptoms. At the theoretical level, Finkelhor is concerned with a PTSD formulation, in that it fails to provide a dynamic theoretical model; but rather, serves as a syndromal classification. Formulations of PTSD generally characterize it as arising from catastrophic, overwhelming events under conditions of violence, danger and threat. This, however, is not generally the experience of child sexual abuse:

"The trauma of sexual abuse can result from the meaning of the act ("I am being exploited") as much as from the physical danger. Moreover, sexual abuse may be less an "event" than a "relationship" or a "situation". It often goes on for a period, and may change in meaning over time. The trauma may come from the betrayal in the relationship or from being trapped in a situation, rather than from an overwhelming event. The fact that it goes on over a period of time and derives its trauma from meanings as much as from physical threat makes it quite different [from the traditional PTSD model]. (Finkelhor, 1987b, p 352-353).

Thus researchers are challenged to develop models of long-term adjustment to child sexual abuse which account for the wide range of symptoms and their variations as found in survivors. Terr (1988) proposed a dual PTSD classification system which would differentiate between response to a single traumatic episode (Type 1), and repeated trauma response (Type 2). The second type requires adaptations to ongoing stress, and results in coping strategies such as denial, psychic numbing, rage, and unremitting sadness – response mechanisms which may become core personality styles for individuals with PTSD type 2 disorder. Finkelhor's and Brown's (1985) proposed "four traumatic dynamics" model of child sexual abuse attempts to provide a developmental model of long-term adaptation:
The model proposes four traumagenic dynamics to account for the impact of sexual abuse: traumatic sexualization, betrayal, stigmatization, and powerlessness. A traumagenic dynamic is an experience that alters a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's self-concept, worldview, or affective capacities. For example, the dynamic of stigmatization distorts the children's sense of their ability to control their own life. When a person tries to cope with the world through these distortions, what we see are the psychological and behavioral problems that are characteristic of sexually abused children and adults... The assumptions and coping mechanisms the child develops may be adaptive and well integrated to the experience of the abuse and its aftermath, but may be dysfunctional in coping with a world where abuse is not the norm. (p 354-355)

An alternate, but not antagonistic, model of "post sexual abuse trauma" has been developed by Briere and Runtz (Briere, 1989; Briere & Runtz, 1987, 1988c) which accounts for the full range of cognitive, affective, behavioral, and interpersonal symptoms characteristics of survivors.

We suggest the more global notion of "post sexual abuse trauma" to describe these long-term effects. This latter construct refers to "symptomatic" behaviors that were initially adaptive responses, accurate perceptions, or conditioned reactions to abuse during childhood, but that elaborated and generalized over time to become contextually inappropriate components of the victim's adult personality. The development and adaptive aspects of such post sexual abuse trauma distinguish it, to some extent, from the more static aspects of "delayed PTSD" (Briere & Runtz, 1988a, p 374).

An additional "information processing of trauma" model has also been recently proposed by Hartman and Burgess (1988). This model appeals to aspects of the cognitive sciences, information theory, and stress syndrome response theory to provide a conceptual model of long-term response to child sexual abuse. The model assumes that information is processed at the sensory, perceptual and cognitive levels, and that the effects of memory apply at each level of information processing:

The presumption was made that traumatic information is kept in active awareness until it can be placed in distant memory, and that trauma resolution occurs when there is sufficient
processing for the information to be stored, that is, when the event is remembered, the attendant feelings are neutralized, and the anxiety generated by the event is controlled. (p 444)

Thus, within this model, unresolved traumatic events either remain in active memory or become defended by cognitive mechanisms such as denial, dissociation, or splitting. Consequently, the individual continues to experience the original trauma both consciously and unconsciously. Building on their previous work (Burgess, Hartman, McCausland, & Powers, 1984; Hartman & Burgess, 1988), Hartman and Burgess (1988) outlined the four major phases of their information processing model. The first, "pretrauma", phase considers the properties of the individual child and her environment which are brought to the trauma situation. The second, "trauma encapsulation", phase deals with the mechanisms employed by the victim to regulate her experience of the ongoing abuse. Three components are seen as involved: (a) the input — the offender's behaviors as processed by the child's sensory, perceptual and cognitive domains, (b) the throughput — the coping mechanisms used by the child to deal with the input (e.g., dissociation, denial, repression, fragmentation of self, splitting, etc.), and (c) the output — the primary trauma learning, involving trauma replay (e.g., flashbacks, dreams, symbolic play, etc.) and causal attributions regarding the abuse. The third "disclosure" phase considers the response to disclosure by the child's social network. The final, "posttrauma" phase envisioned five patterns of adjustment: (a) the "integrated pattern" where no trauma related symptoms are apparent, (b) the "anxious pattern" where the acute physical symptoms become chronic and distress remains high regarding the trauma, (c) the "avoidant pattern" where the victim is psychologically well defended against the trauma with little or no recall, (d) the "disorganized pattern" which features marked cognitive and/or psychotic features, and (e) the "aggressive pattern" where the individual masters her anxiety by, herself, becoming abusive and exploitive of others.

INDIVIDUAL LEVEL: THE MOTHER

As with the data regarding offenders and families, data surrounding mothers of sexually abused daughters is limited to women with children who have been identified as abused. Given the very low rates of disclosure and intervention, mothers in these samples may provide only one component of a more heterogeneous population.
Abuse History and Individual Adjustment

The empirically-based literature is very sparse and preliminary in nature. However, a portrait of mothers as adult survivors of childhood abuse themselves is beginning to emerge (Korbin, 1986). Approximately 60% of mothers of sexually abused daughters have reported a childhood history of sexual abuse themselves (Sansonnet-Haydn, Haley, Marriage, & Fine, 1987). When compared with a control group, mothers of sexually and physically abused children were found to have experienced childhood incest at a rate eight times greater than that of the control (24% vs 3%), and to have experienced child sexual abuse at almost twice the rate of the control group (38% vs 24%) (Goodwin, McCarthy, & DiVasto, 1981). Notably, only 4% of the abused mothers were able to successfully disclose their abuse to a parent or other adult, compared with 33% of the control group. A comparison of mothers of incested children – with and without child sexual abuse histories themselves – found that the abused group were far more likely to have also experienced both physical and emotional abuse as children (Steen, 1987). The portrait of mothers as victims extends into their adult experience. As adults, 73% of mothers of incested daughters reported battery and emotional abuse by their partners, and 23% had experienced life-threatening levels of battery from their spouses (Truesdell, McNeil, & Deschner, 1986). A parallel line of evidence is provided by work with battered women, where it is found that a high proportion are also incest survivors, and that the battering husband often sexually abuses both the woman and their children (Walker, 1984).

Although not identifying mothers of incest victims as survivors themselves, the early work of Justice and Justice (1979) identified three major personality types: dependent, caretaking, and submissive. More recent work (Steen, 1987) has differentiated between mothers of incested children, with and without child sexual abuse histories themselves. The sexual abuse survivors differed significantly in that they exhibited lower educational levels, less emotional stability, greater submissiveness and shyness, poorer self discipline, more tension and emotional disturbance, and greater self-deprecation. These women were also less emotionally available and less open and trusting. Gelinas (1983) summed up the adjustment and outcome for the survivors as the "parentified daughter who becomes the depleted wife of the next generation’s abuser" (p 326):

Typical problems occur in parenting. Because they tend to feel depleted, helpless and unselfconfident they have difficulty providing their children with an organizing structure and with a reasonable balance of discipline and affection. Former incest victims are often
ambivalent toward their children, especially as the children's needs shift from the more biological toward the more purely relational (identified by some patients as the onset of their children's speech).

They tend to be easily overwhelmed by their children, and if they eventually attempt to muffle that effect by withdrawal or alcohol,... they may feel guilty about setting limits, correcting behavior and enforcing schedules. (p 323)

Maternal Response to Daughter's Disclosure of Sexual Abuse

To date, three major studies have examined the issues surrounding mothers' response to their child's disclosure of abuse, and it seems clear that maternal response plays a central role in the daughter's prognosis. It is important to bear in mind that these studies undoubtedly underestimate the levels of maternal disbelief in that — by definition — only cases in which mother, or some authority, has believed in the abuse are included in the samples. Thus, the following studies deal with substantiated cases, in which a significant population continue not to believe their children. The first of these (Meyer, 1985), examined 43 mothers differentiated into three major response types: those who protected their daughter and rejected their mate (56%), those who rejected their daughter and protected their mate (35%), and those who were immobilized and did nothing (9%). In the first "protective" group, the greatest proportion were classified as meeting the DSM III criteria for Dependent Personality Disorder. Over half of these women protected their daughter without any ambivalence and showed empathy for their daughter. These women placed no blame on their daughters and were very angry with the offenders. The majority of these women had been sexually abused themselves as children. The remaining protective mothers displayed some ambivalence and showed empathic feeling for the abusers, on whom they depended emotionally and financially. Most of these women had been childhood incest victims. The second group, of "rejecting" mothers, were all classified as meeting criteria for Narcissistic Personality Disorder. All sided with their mates at the expense of their daughter, denied the abuse, and continued to live with the offender. Only one of these women acknowledged a childhood sexual abuse history, and their daughters described them as passive, dependent women who were fearful of their domineering, abusive husbands. The husbands in this group battered the mothers as well as sexually abusing their daughters. The last group, of "immobilized" mothers, persisted in their denial of the incest, yet sided neither with their daughter nor their mate. All these women met the criteria for Borderline Personality Disorder, and all had daughters who had been sexually abused as very young preschoolers.
These women all had histories of neglecting their children, and none objected when their children were apprehended. These women’s childhoods were characterized by hostile maternal relationships with mother either absent or psychotic. None of these women reported a childhood sexual abuse history.

The second study examined response differences between 171 mothers of father-figure offended children, and were segregated into three groups of approximately equal numbers of those whose children were offended by: biological father in-home offenders, non-custodial father offenders, or, step-father or live-in offenders (Faller, 1988). Overall, it was found that the mother’s response was directly mediated by the degree of her dependency on the offender. Thus, maternal protectiveness, mother-victim affective relationship, and maternal independence from the offender were all highest in the non-custodial father group, followed by the step-father or live-in father group, and were most impaired in the biological in-home father group.

Sirles and Frank (1989) provided the most detailed examination to date of factors affecting each mother’s belief of her child’s disclosure of abuse. Their data were based on mothers of 193 child victims in treatment. Overall, they found that the vast majority (78%) of mothers believed their children – a figure comparable to the 84% found in a large non-clinical group (Pierce & Pierce, 1985). In terms of offender identity, the largest proportion of mothers believed the disclosure when the offender was a relative other than father (92%), followed by the father (86%), and only slightly over half believed their daughters when the offender was the step-father (55%). Mothers generally believed their children in cases of digital-genital (87%), oral-genital (90%), and genital-genital (71%) abuse. It is interesting to note the greatest resistance was associated with genital-genital abuse. Mothers who were at home during the abuse found it more difficult to believe their children’s disclosures (64%) than did those who were not at home during the abuse (89%). Victim age was also a major predictor of maternal belief, in that 95% of mothers with preschoolers, 82% of mothers with latency-aged children and 63% of mothers with teens who were offended believed their children’s disclosures. In cases where the child was also physically abused, only 58% of mothers believed, compared with 86% of cases where the child was not also subjected to physical abuse. Finally, mothers were less likely to believe the child when the offender was an alcohol abuser (70%), than when he was not (88%). Thus, within this study, mothers were most likely to believe the youngest, least protected and most vulnerable victims, who were most distant from the abuser.

In summary, the existing studies suggest that the healthiest women, who are least financially and emotionally dependent on the abuser are most likely to believe their children’s
disclosures and to protect them. Those who are wholly dependent on the abuser, and who have often been actively battered and emotionally abused by the offender seem least able to believe and to protect their children — they can't even protect themselves.

Women Offenders

Women offenders are rare and form only about 4% of all child sexual offenders. They also tend to be unwilling confederates of the primary male offender (Finkelhor & Hotaling, 1984; Russell, 1986). Given that they are such a sparse group, little work has been done with them, and up until Goodwin's and DiVasto's (1979) addition of one more case history, only five cases of mother-daughter incest had been reported worldwide. However, two recent studies examining the characteristics of female offenders have added substantially to the knowledge base, and are related in considerable detail below. The first study (McCarty, 1986) considered 29 mother-offenders at an American incest treatment program, who constituted 4% of the total offender population. In six of the 29 cases, the mother was the sole offender; in six cases she offended in the presence of a male; in nine cases mother co-offended with a male partner; and in five cases she acted as an accomplice of the primary male offender. The childhood histories of these women were characterized by sexual and physical abuse (95%), traumatic parental separations (41%), alcoholic parents (29%), multiple caretakers (29%), and teenage marriages (85%). All but two of the "independent" offenders suffered "severe emotional disturbance" and had a history of psychiatric hospitalizations or testing. Almost half of the independent offenders were serious drug abusers, all were of normal intelligence, and three-quarters had regular employment histories. About a quarter of the "co-offenders" seriously abused drugs; only 11% had a regular work history; and over half were functioning at a borderline IQ level. The "accomplices" fell midway between the two groups with a 20% rate of drug abuse, an 80% work history, and 80% fell within normal IQ levels. Thus, it would appear that the co-offenders were seriously socially and intellectually handicapped, with severe childhood abuse histories themselves. The independent offenders appeared to function at higher intellectual and vocational levels, although the incidence of drug abuse was very high, as was the presence of a psychiatric history.

The second study by Faller (1987) concerned 40 female perpetrators referred for treatment over the decade prior to publication. Eighty-five percent of these women had offended against at least one of their own children, 55% had abused only their own children, and 30% had abused their own children and others' (i.e., nieces, nephews, step-children,
grandchildren, friends’ and neighbors’ children). Faller derived a five-way typology describing these offenders and their situations. The first of these, the "polyincestuous" type, accounted for 73% of the total, and described family situations where at least two perpetrators and two or more victims engaged in sexually abusive relationships and group sex with children of both genders. The abuse was generally instigated by the father, with the mother often following instructions. This form of abuse was most often found transmitted across and within generations, with multiple involvements across the boundaries common. The second most common type, "single parent" abuse, accounted for 15% of the women. These women had no ongoing relationship with a man, and the abused child (male and female) was usually the oldest, and seemed to be elevated to the role of surrogate partner to the mother. The child was often given a full range of adult role responsibilities as well. "Psychotic" abusers accounted for 7.5% of cases, as did adolescent abusers. The latter group seemed to experience difficulties with their peer relationships, and sought access to younger children to meet their relationship and sexual needs. The final category of "non-custodial" abuse, had only one member — a woman who offended her child, who was living in the custody of the father, during visitation/access.

The demographic and clinical profile of all these women featured relatively: youth, socioeconomic disadvantage, drug abuse, impaired cognitive functioning, and a general context of abuse and neglect. The women were substantially younger on average (26.1 years) than their male counterparts (35.8 years), and the greatest proportion (83%) were categorized as low socioeconomic status members. About one-third of their victims were male and two-thirds were female, with over 60% of victims being age six or younger. One-third of the women were either mentally retarded or brain damaged, with poor judgement and impulse control; and 18% were periodically psychotic. A substance abuse history existed in over half the cases, as did physical neglect of their children. Physical abuse of the children was present in one-third of cases. In terms of the type and prevalence of different forms of sexual abuse, Faller reported: group sex (55%), fondling (37%), oral sex (27%), digital penetration (25%), intercourse (20%), child forced to watch sex (20%), children made to have sex (15%), pornographic pictures of children (12%), and exploitation of children by allowing others to sexually use them (7%).

Thus, in summary, mother offenders appear to represent a highly impaired group, most of whom come from an extremely abusive background themselves, and who continue, as adults, to remain in exploitive and victimizing relationships.
INDIVIDUAL LEVEL: THE OFFENDER

Adolescent Offenders

It was not until the early 1980s that the seriousness and extent of adolescent sexual offending became acknowledged. Prior to the 1980s, the focus was on an adult stranger, and father offenders, and little credence was given to the possibility of adolescent offending as a serious contributor to the overall rates of abuse. Although one form of adolescent sexual abuse, sibling incest, had been previously noted in the literature, it was dismissed as neither prevalent nor as having any significant impact on either victim or offender (e.g., Strong & Reynolds, 1982; Luckianowicz, 1972). In the late 1970s, it became recognized that sibling incest could be harmful, but only if certain conditions such as a five-year age difference and the use of physical force or coercion were present (Finkelhor, 1979; Justice & Justice, 1982). However, as pointed out by Cole (1982), the power differential by virtue of gender, renders legitimate consent impossible in cases of brother-sister incest. She also notes that retrospective victim disclaimers of negative impact are consistent with women’s acculturated coping strategies of denial and avoidance.

The more general issue of adolescent offending has been obscured by an array of social, legal and structural reasons. As discussed in a survey document by Health and Welfare Canada (1990), until recently, adolescent sex offenses were usually recorded as assaults rather than as sex offenses. Thus, the arrest record greatly underrepresented the extent of the problem. As with victims of adult offenders, victims of adolescent offenders are highly unlikely to disclose. Additionally:

Sexually abusive acts committed by adolescents are often downplayed or dismissed as sexual curiosity or experimentation. Professionals called upon to intervene in these cases often minimize the behavior, rather than treating it as a sexually deviant offense. The desire to protect adolescents from what has often been viewed as a harmful label extends into the criminal justice system; plea bargaining has allowed adolescent offenders to plead guilty to a simple assault, or even a property crime, rather than be convicted of a sexual offense. (Health and Welfare Canada, 1990, p.2)
PREVALENCE. Prevalence estimates of adolescent sexual offending arise from three major sources: the victims, the justice system, and from offenders themselves. The highest estimates, attributing about one-third of all child sexual abuse, arise from community-based and nonclinical surveys of adult women (Badgley et al., 1984; Finkelhor, 1979). These figures probably represent the most accurate estimate of the proportion of offenses committed by adolescents, although they probably underestimate overall prevalence rates — for the same reasons as found in retrospective estimates of child sexual abuse generally. The criminal justice system is beginning to reflect this fact: over recent years, nearly one-quarter of all sexual offenses recorded in Canada were perpetrated by adolescents — accounting, between 1979-1984, for nearly 1,400 convictions of adolescents in the province of Ontario alone (Mathews, 1987). It is also becoming increasingly apparent that adolescent sexually offending is simply one end of a lifelong offender profile, as evidenced in the finding that 57% of 411 adult offenders acknowledged the onset of deviant sexual interest in adolescence (Abel, Mittleman, & Becker, 1985).

OFFENDER CHARACTERISTICS. As in the adult offender picture, adolescent offenders are overwhelmingly male, and thus most studies have been exclusively concerned with male offenders. Although varying with different samples, high rates of prior sexual abuse have been found among them — ranging from 23% to 86% (Becker, Kaplan, Cunningham-Rathner & Kavoussi, 1986; Groth, 1977; Pierce & Pierce, cited in Health and Welfare Canada, 1990). As with other offender categories, high rates of childhood physical abuse (14% to 60%) and neglect (33% to 70%) have also been found among these adolescent offenders (Awad, Saunders & Levene, 1984; Becker, Kaplan, Cunningham-Rathner & Kavoussi, 1986; Groth, 1977; Pierce & Pierce, cited in Health and Welfare Canada, 1990). Furthermore, the parents of 72% of adolescent incest offenders were found to have been childhood sexual abuse victims themselves (Smith & Israel, 1987), so that generational transmission is also implicated. Significant levels of psychopathology were found within a sample of 22 convicted adolescent offenders by Becker and colleagues (1986). In particular, one-quarter were substance abusers, one-third were diagnosed with Attention Deficit Disorder, 64% were labelled as conduct disordered, and fully half of the group had records of previous arrests for nonsexual crimes. Margolin (1983) characterized the adolescent offender’s view of the world as a basically hostile and antagonistic place — a view that suggests their offending to be, in some measure, a retaliative gesture.
CHARACTERISTICS OF THE OFFENSE. The use of force, or threats of force, appears to vary as a function of the power discrepancy between victim and offender. The most violent abuse was directed toward older victims, while less violent use of power and authority was employed with younger, more vulnerable children (Sternac & Mathews, 1987). A pattern of long term multiple abuse seems common. By the time they were apprehended, almost half of the offenders acknowledged having committed prior offenses (Becker et al., 1986; Saunders et al., 1986), and 8% of sibling incest offenders were found to have abused more than one member of the family (Smith & Israel, 1987). Father-daughter incest with the same daughter occurred prior to the brother’s participation as a perpetrator in 32% of Smith’s and Israel’s (1987) brother-sister incest offenders. Victims were primarily identified as female children (64% to 89%), and in 77% of cases victims were five or more years younger than the perpetrator (Becker et al., 1986; Smith & Israel, 1987). In 14% of incest cases, the victim was close in age to the perpetrator and the assault was classified as forcible rape (Becker et al., 1986).

CHILD OFFENDERS. As a group, child offenders have been even less-researched than adolescents and only two recent reports have been located dealing with this issue. The first of these was a retrospective study of over 1,000 undergraduates (61% female), in which 42% reported a sexual encounter with another child before they turned thirteen, and before the other child turned 16 (Haugaard & Tilly, 1988). In general, the encounters occurred around age nine with a child about six months older, and most respondents characterized the activities as sexual hugging or kissing with friends. However, about 10% of cases involved intercourse. Traumatic responses were associated with higher levels of force and coercion from the other child, and were more likely to be found in homosexual experiences.

The second study deals directly with child offenders and is thus reviewed in considerable detail. Johnson (1988) examined 47 boys aged 4 to 13 (average age 9.7 years), who had sexually assaulted another child at least two years younger than themselves. Over half the boys lived with a single mother and about half were from middle income families. There was no evidence of major psychopathology in the children themselves, although there was clear evidence of drug and alcohol abuse in 73% of the parents and/or grandparents of the children. Moreover, in 67% of families one or more of the parents, or grandparents, had been sexually abused as children. Sixty-six percent of the children acknowledged having been either sexually or physically abused, and those who began offending at the youngest ages had
experienced the highest rates of physical and sexual abuse: 72% of the 4 to 6 year olds had been sexually abused, compared with 42% of the 7 to 10 year olds, and 35% of the 11 to 12 year olds. Physical abuse rates were greatest in the 7 to 10 year old group (29%), and lowest in the older group (12%). All children were offended by people known to them. In terms of the sexual behaviors perpetrated by the child offenders, almost 30% involved penetration of the victim's vagina or anus (with finger, penis, or object); over 35% involved fondling; 10% involved oral copulation; and almost 20% involved genital contact without penetration. Extreme force (e.g., use of co-perpetrators to restrain victim) was used in 6% of cases, and physical coercion was used in 17% of cases. Verbal coercion was employed in 60% of cases, and no coercion was reported in 17% of cases. The average age of victims was 6.7 years, with a range of 1 to 15 years, and all the perpetrators knew the victims. Almost half the cases involved sibling incest and the average number of victims per offender was over two.

Adult Offenders

The great proportion of research on adult offenders deals with father-figure abusers, and data regarding them has been drawn from both their victims and from studies of identified offenders themselves. Information arising from the first source indicates that father-figure offenders comprise the largest single group of offenders, accounting for about 8% of all female child sexual abuse and about 22% of incestuous abuse. Russell (1986) has shown that stepfather abuse tends to occur at more severe levels than does father-abuse. Information derived from the second source, identified offenders, remains preliminary, and is presumably seriously distorted, given the ratio of incest incidence to disclosure and prosecution. Thus, those incarcerated likely overrepresented the more socially disadvantaged, multiproblem, and overtly pathological end of the offender spectrum. Nevertheless, despite this fundamental sampling bias, some provocative data has been usefully provided by studies of identified father-figure offenders.

OFFENDER CHARACTERISTICS. It has been generally accepted that the father offender's own childhood experience is critical in the etiology of their status as offenders. Yet, notwithstanding previous findings that father offenders appear to have a significantly higher rate of childhood sexual abuse (Erickson, Walbeck & Seely, 1987; Groth & Burgess, 1979; Pelto, 1981; Stephens, Grinnell, & Krysik, 1988), a recent comprehensive review of all such studies to date (Williams & Finkelhor, 1990) has revealed that the absolute percentage of father
offenders with a sexual abuse history may not be much greater than that found among other members of the community. However, the same comprehensive review did show that significantly higher rates of childhood physical abuse (in excess of 50%) had occurred among the father offenders. While a childhood history of physical abuse was equally common among both father and stepfather offenders, stepfather offenders were significantly more likely to have experienced childhood sexual abuse as well (Erickson, Walbeck, et al., 1987). Pelto (1981) showed that, in addition to having been direct abuse victims, 50% of these father offenders also reported having witnessed incest between their fathers and sisters. Offenders are also generally found to have had an inadequate and poor bond with their own parents (Parker & Parker, 1986).

Attempts to discover a characteristic psychopathological profile for offenders generally, including father offenders, have not proven fruitful (Lanyon, 1986). Although more typical profiles were found among extra- and intrafamilial offenders, no profile type accounted for more than 15% of any one offender group (Erickson, Luxenberg, Walbeck, & Seely, 1987; Erickson, Walbeck, et al., 1987), and about 20% of all profiles were within the normal range. Apart from elevations on Scale 4 (Psychopathological Deviate) which measures antisocial and amoral traits, no characteristic was truly typical. Other small-scale personality-based investigations have suggested that incest fathers demonstrate poorer reality testing and perceptual accuracy than do a control group (Owen, 1987); that offenders score as less "masculine" on trait measures (Brandon, 1987), and that they are less likely to repress sexual thoughts and feelings (Parsons-Kraft, 1987). A comparison of father offenders found that those abusing younger (prepubertal) daughters were significantly more dominant and authoritarian than those abusing older daughters (Owens, 1988).

Based on their summary of the last decade's published and unpublished research with incestuous fathers, Williams and Finkelhor (1990) suggest six major features as emerging from the work to date:

1. Incestuous fathers are consistently and widely reported to have difficulties in empathy, nurturance, and caretaking; (2) social isolation and lack of social skills is also quite widespread; (3) histories of being sexually abused themselves are given only by a fifth of offenders, fewer than the popular stereotype suggested; (4) a history of physical child abuse is more common than sexual abuse, and other parental maltreatment, particularly rejection by fathers, is quite common; (5) a certain proportion of incestuous fathers, estimated to be between a fifth and a
third, show signs of general sexual arousal to children, while a more widespread response is a pattern of low sexual arousal to, or even disgust with, normal adult sexual partners; (6) studies have failed to find that incestuous abusers are identified with traditional masculine sex roles, but rather, they seem more likely to have weak masculine identification. (p 252)

Perhaps greater insight into offender behaviors may be garnered from two recent clinical-empirical examinations of offenders, which provide very similar results. The first of these (Taylor, 1986), was based on extensive casework with 650 offenders. Taylor identified six central themes as arising in therapy with offenders. Almost universal was the "power-in-sex" notion, where child sexual abuse was seen as a means of gaining, or regaining, power and control. The offenders found children easy targets on which to work out this issue, given their vulnerability, accessibility and trust in the offender. Taylor provided a particularly illustrative quote from one client who had repeatedly molested his two stepdaughters over a six year period:

I've always seen sex as a method of control, of power. My father had power — power over Mom and my sisters. I always saw him as big and powerful and very sexual. He used to try to "hit on" my girlfriends. He even got a few! He was a sultan, a king with a harem. Whenever I've felt bad or inadequate, I turn to sex. It [sex] always makes me feel strong and in control. (p 456)

The second dominant theme regarded the pairing of "real men and sexual competence" — real men must be "sexually prolific and technically excellent". When they felt inadequate in other life areas, these men turned to sex for validation: "I've always felt small — not big enough or good enough to be a real man. With my daughter, I felt big and manly. I was safe and looked up to. I was a real expert" (p 456). Offenders also tended to see "sex as play" — a form of excitement and a remedy for boredom. Love and sex were also generally confused. The men often blamed others for their inadequacies and some even sought liaisons with their daughters in order to replace absent wives.

The second clinically-based analysis is documented by Gilgun's and Connor's (1989) study of 14 convicted perpetrators who had volunteered to participate in a study examining their subjective experience of their abuse of children. Overall, they report, the men did it because it felt good and they saw the children as objects only, and they had no empathic connection to a child's experience of the abuse. The experience of orgasm provided sufficient major motivation
for most of these men, along with their feeling of control over the situation. One offender’s statement eloquently captured the latter aspect of the experience:

The planning was almost more exciting than actually having sex with her, setting everything up, just to get her alone. It took up a lot of my time, a lot of energy to do that. There was a lot of preoccupation, a lot of planning involved... Being in control of her life completely was a thrill for me. (Gigun & Connor, 1989, p 250)

OFFENDER TYPOLOGIES. Justice and Justice (1979) provided an early elaborate four-way typology based on clinical-anecdotal work with incestuous fathers. The first major type, the "symbiotic" father offender, was believed to account for the majority of perpetrators. These were seen as men who had experienced abuse and neglect as children and who retained strong unmet needs for affection and intimacy - needs they had attempted to meet in sexual ways. Four types of symbiotic fathers were proposed: (a) symbiotic introverts, (b) symbiotic rationalizers, (c) symbiotic tyrants, (d) alcoholic symbiots. The introverts were typified as distant, withdrawn and isolated men who distrusted the outside world and depended on their family to meet their emotional needs. It was suggested that their pattern of depression and neediness led to sexual and emotional estrangement from their wives, and their subsequent transfer of attentions to their daughters. The rationalizers would deny the reality of the incest abuse and frame it as "a special love game" or some other such rationalization. The symbiotic tyrant was seen as an aggressive, often violent, male dominant aggressor who held rigid views on male/female roles. The second major type of father-offender, "psychopathic-sociopathic" fathers, were described as showing no empathy and as using their daughters sexually for stimulation and as an outlet for excitement and hostility. These men were seen as indiscriminate with respect to sexual objects and were equally likely to offend boys and girls, women, their own or others’ children. The third offender type, engaged in pedophilic incest. These men were only attracted to prepubertal daughters and lost sexual interest in their daughters with the emergence of secondary sexual characteristics. These were seen as immature, inadequate men who turned to their children for comfort when under stress. The fourth category, "other types", contained the leftovers – psychotic offenders, culture permissive offenders, etc.

A subsequent atheoretical description of "preference" versus "situational" offenders (Howells, 1981), differentiated between those whose primary orientation was toward children, and those whose behavior was episodic, impulsive and stress-related. A similar formulation, the
regressed versus fixated offender, was later proposed by Groth and colleagues (Groth, Hobson & Gary, 1982). Fixated offenders were conceptualized as exhibiting arrested psychosexual development, while regressed offenders were seen as exhibiting psychopathological regressed behavior under stress, after more or less normal psychosexual development. This taxonomy has since been elaborated by Knight and colleagues (Knight, Carter & Prentky, 1989; Knight & Prentky, 1990; Rosenberg & Knight, 1988) to incorporate a dual axis scheme (Figure 1). Axis I provided four typologies using two constructs: degree of fixation, and level of social competence. Axis II, on the other hand, provides six typologies using the four constructs: amount of contact, meaning of contact, level of physical injury, and sadistic versus nonsadistic abuse. This classification system has been developed on populations of offenders and controls by simultaneously following deductive-rational and inductive-empirical research strategies (Knight, Rosenberg & Schneider, 1985; Knight, 1988).

MODELS. The most elaborate and integrative model of the etiology of sexual offending, in general, is provided by Marshall and Barbaree (1990). The reader is referred to their extensive review of the research evidence arising from the biological/physiological, psychological, anthropological, and sociological literatures, which led them to the following summary model:

Biological inheritance confers upon males a ready capacity to sexually aggress which must be overcome by appropriate training to instill social inhibitions toward such behavior. Variations in hormonal functioning may make this task more or less difficult. Poor parenting, particularly the use of inconsistent and harsh discipline in the absence of love, typically fails to instill these constraints and may even serve to facilitate the fusion of sex and aggression rather than separate these two tendencies. Sociocultural attitudes may negatively interact with poor parenting to enhance the likelihood of sexual offending, if these cultural beliefs express traditional patriarchal views. The young male whose childhood experiences have ill-prepared him for a prosocial life may readily accept these views to bolster his sense of masculinity. If such a male gets intoxicated or angry or feels stressed, and he finds himself in circumstances where he is not known or thinks he can get away with offending, then such a male is likely to sexually offend depending on whether he is aroused at the time or not. (Marshall & Barbaree, 1990, p. 271)
Figure 10: The Knight and Prentky flow diagram of the decision process for classifying child molesters on Axis I and Axis II. (From Knight & Prentky, 1990, p. 31)
Finkelhor's (1984, 1986) "four preconditions model" provides the only model specific to child sexual abuse offending. The model is theoretically and empirically based and operates at a high enough level of generality to apply to all types of child sexual abuse. The model is not in conflict with either individual or family systems models, but, instead, readily incorporates them as special instances. The four specified factors come into play sequentially and all must be met in order for abuse to occur. Precondition one deals with the requirement for the offender to possess the motivation to offend. Three components to this are proposed: (a) emotional congruence – the sexual abuse of a child must satisfy some important emotional need for the abuser (e.g., power, control, re-enacting own childhood abuse, etc.); (b) sexual arousal – the abuser must be sexually aroused toward children; (c) blockage – for many abusers, more appropriate sources of sexual interaction are not available, either for internal or external reasons. Precondition two is the requirement that the offender overcome internal inhibitions against acting on their motivation to offend. Internal inhibitions may be overcome by stress, learned rationalizations, culturally weakened taboos, personality factors, substance abuse, etc. The third precondition requires the overcoming of external impediments against acting on the motivation to offend. Environmental restraints are undermined in as much as the offender has access to child victims. The final precondition requires that the offender overcome any resistance from the child. Thus, secure, well protected children are much more able to deter an offender or seek help than are needy, unprotected children. As Finkelhor states: "children who are emotionally insecure, lack knowledge about sex or have a relationship of great trust with the abuser, may be more vulnerable because their motivation or capacity to resist the abuser is reduced" (Finkelhor, 1986, p. 61).

FAMILY LEVEL MODELS

Clearly, the occurrence of child sexual abuse within a family has profound implications for the structure and functioning of that family. In cases of father-daughter incest – the most common form of child sexual abuse considered by family theorists – the role of the family as a unit designed to serve the needs of developing children is destroyed (Adams, 1987). In cases of extrafamilial child sexual abuse, the family is also severely challenged by both the needs of the victim and, by extension, by the trauma suffered by other family members. Given that children grow up within the context of the family and go on to form their own, it is manifestly important to gain a better understanding of the wider family context within which child sexual
abuse occurs. This literature, at the empirical level, remains sparse, and much work remains to be done in terms of the mitigating, permitting, and dynamic factors involved at the family level (Pelletier & Handy, 1986). As with the data in the previous sections, the results arising from family studies must be approached with great caution. By definition, only those families in which abuse has been disclosed have been studied. Given the small proportion of these, the data base is clearly severely compromised.

Characteristics of Families with Sexually Abused Children

Despite its infancy, the empirical literature has begun to provide a number of suggestive characteristics with respect to families with sexually abused children. While father-figure offenders generally present within normal ranges on clinical instruments (e.g., Scott & Stone, 1986), they have been found to exhibit more functional levels of psychological distress than control groups (Strand, 1987). Incestuous families have been characterized by elevated levels of substance abuse (Kolito, 1989), strict paternal authoritarian rule, emotional distance and rigidity, lack of empathy (Alexander & Lupfer, 1987), sexual estrangement within the marriage (Waterman, 1986), and stereotypic views of male and female roles (Strand, 1987). Incest most frequently occurs within two-parent families, and other siblings have also been abused in up to 40% of cases (Stephens, Grinnell, & Krysik, 1988).

A characteristic range of traits and injunctions common to incestuous families has been identified (Calof, cited in Courtois, 1988), which serves to maintain the status-quo within these dysfunctional units. Chief among these are: collective denial and secrecy about a range of family problems, including the incest; social isolation, role confusion and boundary diffusion between generations; intolerance for violations of family norms; highly moralistic and rigid belief systems; no touch other than abusive touch; parentified role of the children; low humor and high sarcasm (children constantly criticized and belittled); inconsistent and unpredictable family life; a climate of violence; no respite for the child from ongoing exposure to sexual abuse/emotional abuse/physical abuse. Courtois (1988) delineates the subjective experience of the child victim in such a family in terms of her internalized "family rules":

- Don't feel. Keep your feelings in check. Do not show your feelings, especially anger.
- Be in control at all times. Do not show weakness. Do not ask for help.
- Deny what is really happening. Disbelieve your own senses/perceptions. Lie to your self and to others.
Don't trust yourself or anyone else. No one is trustworthy.
Keep the secret. If you tell you will not be believed and it will not get help.
Be ashamed of yourself. You are to blame for everything. (Courtois, 1988, p 45)

Only one empirical study was located which investigated abuse severity as associated with family characteristics (deChesnay, Marshall, & Clements, 1988). The data were derived from over fifty mental health center clinicians across the United States. Contrary to the community-based results of Russell's (1983, 1986) survey, it was found that natural fathers engaged in more severe forms of sexual abuse than did stepfathers. Patriarchal families were associated with more severe levels of sexual abuse than were egalitarian families, and no examples of matriarchal families were identified. Ninety-six percent of families exhibited marked evidence of maternal distance, thus this characteristic was not available to be factored in as a severity predictor. Paternal alcohol consumption was found to be significantly associated with the form of the incest – the greater the amount of alcohol consumed per week, the more forceful and violent the abuse. One of the most interesting findings surrounded socioeconomic status and geographic stability – the most severe and violent abuse occurred within stable "pillar of the community" families.

**Intergenerational Transmission**

The frequent finding of three-generational incest histories was often noted within the earlier clinical-anecdotal literature (Cooper & Cormier, 1982), and mounting empirical evidence supports and extends this perception (Ney, 1988). A Canadian study of almost 200 incested children found that approximately 60% of the mothers and 10% of the fathers reported a child sexual abuse history themselves (Kolito, 1989). The likelihood of a childhood sexual abuse history within either of the parents' families of origin is even greater (Pelto, 1981). In a study of 1,500 sexually abused children, approximately 80% had an adult family who had either been sexually abused as children, or raised within a family where a sibling was sexually abused (Deighton & McPeek, 1985).

Gelinas (1983) provided a theoretical explanation of the transgenerational transmission of incest which revolves about the "parentification" of the victimized daughter. In a non-reciprocal manner, the victim-daughter comes to see herself as responsible for the caretaking of others, without expecting them to provide any care for her. Thus, he paints the scenario of the parentified daughter who marries an emotionally immature, dependent, insecure and needy man
with strong narcissistic features. With the birth of the first child the father finds his wife receding from him. She is emotionally depleted by the demands of her new role and the couple become increasingly alienated. This spiral escalates with succeeding births. And, as mother becomes increasingly depleted, she looks to her oldest daughter to assume adult responsibilities. Thus, the oldest daughter, in turn, becomes the parentified child – a ready target for father who looks to his daughter to meet his need for nurturing, which he confuses with sex. And, thus, the cycle begins again.

Allied with this concept of the parentified child is that of the "triangulated" child who is compelled to meet the need of her parents while her own needs go unmet and her development consequently impaired (Rist, 1979). Krugman (1987) frames triangulation across generations as the basic template for the transmission of family violence:

In effect, it means that adults take it out on children when they cannot manage tension and conflict among themselves... In one pattern, the classic scapegoating sequence, parents maintain their alliance and stabilize the family system by blaming and punishing the child. In another pattern commonly associated with sexual abuse, the child is elevated into the parental hierarchy and the system stabilizes through role reversal. The child may thus be either covertly allied with one parent against the other, or parentified and obliged to care for a parent suffering from alcoholism, depression, or other disability. The child may also be assigned the role of surrogate parent for other children or, in the case of father-daughter incest, the role of surrogate wife. (p 139)

**Typology of Families**

A number of different, yet overlapping, typologies of incestuous families has been proposed. An early differentiation was made between "chaotic families" and "normal-appearing families" as the two most common types within which incest occurs (Kempe & Kempe, 1984). Chaotic families were previously considered the prototypical incest family and were over-represented amongst the cases coming to official attention. They are characterized by relatively low socioeconomic status, a history of dysfunction spanning generations, high likelihood of sexual interactions occurring across and within generational boundaries, and marginal levels of functioning by individual family members (e.g., drug and alcohol abuse, public assistance, criminal involvement, limited education, unstable intimate relationships). Children reared within these families receive little appropriate parenting and are basically left to
raise themselves. Normal-appearing families, on the other hand, were conceptualized as appearing solid, economically stable and well functioning. Traditional male-dominant structure was normative, and the parents were seen as both being emotionally impoverished and needy individuals who parentified the oldest daughter – the mother in terms of placing maternal, household, and child-care responsibilities on the girl; while the father placed his daughter in the role of meeting his nurturant and sexual needs. This type of family was seen as least likely to come to light, in that the father's credibility is generally substantial and these families have sufficient economic resources to get aggressive legal assistance which will militate against the daughter's disclosure.

An alternate taxonomy was proposed by Larson and Maddox (cited in Trepper & Barrett, 1986a) whose examination of incestuous families led to four types: The "affection seeking" type, wherein the sexual abuse focussed about affectionate exchange, seduction and an attempt at connection; the "pansexual" type which featured oversexualization of relationship patterns; the "hostile-negative" type with a pattern of displaced anger, and a desire to harm, with anger and sexuality paired. These first three types accounted for 94% of Larson's and Maddox's sample. The remaining 6% fell within their fourth "violent rape" type, in which the entire family was organized toward violence. These families often exhibited paranoid tendencies, with poor reality testing.

Barrett (Trepper & Barrett, 1986a, 1986b) has also developed an incestuous family structure classification based on Minuchin's (1974, 1981) structural family therapy model. This model defines family members in terms of boundary divisions, separations and violations. Barrett suggests five types of family structures as most vulnerable to incest. The first of these, the"father-executive" model, sees the father as sole executive with the mother either physically or emotionally absent, so that the daughter reverses roles with mother. This occurs most often in "traditional", male-dominant families which hold rigid views of male and female relationships and roles. The second, "mother executive" type, is suggested as most often found in step families and common-law families. The mother acts as the sole executive with the father functioning as one of the children, having little parental responsibility. Thus, his sexual needs are met by a generational peer – his step-daughter. The "third generation" type sets up two boundary layers with mother acting as parent to the father, who, in turn, acts as a forceful executive with the children. In the absence of the mother, the daughter is promoted to a peer-wife role with father, while in the mother's presence she functions as a daughter. In the "chaotic" type of family, no operational boundaries exist. "Emotionally, this structure finds
most members of the family showing immature judgement, displaying little impulse control, and expressing the need for immediate gratification" (p 20). The father's and daughter's sexual behavior is seen as more akin to that of sibling incest. The final "estranged" type is characteristic of separations and divorces where the husband maintains an incestuous relationship with a daughter outside her primary residence with mother.

**Family Models and Critiques**

Despite a range of problems and criticisms of the family systems models of child sexual abuse, their influence has been recognized as helping to put the issue of child sexual abuse on the public agenda, and to act as "an important antidote to the traditional psychoanalytic view" (Finkelhor, 1986, p 53).

Three major model types appear to have developed under the general rubric of family models of incestuous families. The first of these, and the oldest, may be characterized as the "bad mother" (and seductive daughter) model, which rests on the central concept of maternal collusion. Although few practitioners or theorists continue to subscribe to this model, its roots are deep and continue to influence more recent conceptualizations of incest dynamics (see Chapter 2 for an extended discussion). Perhaps one of the most blatant examples of this is provided by a recent theoretical contribution from a psychoanalytically oriented source (Gartner & Gartner, 1988) which suggests that:

For the daughter, the paternal attention which frequently precedes and accompanies incestuous sexual activity gratifies preoedipal wishes to be cared for and nurtured and may serve, at least initially, to reduce separation anxiety apart from mother. (p 107)

Wattenberg (1985) provides a thoughtful and comprehensive review of this issue and the following discussion is largely drawn from that source. She points out that the early studies of incest families were carried out primarily by male psychiatrists in the 1960s and 1970s, and that these reports were accepted as authoritative statements primarily on the basis of the practitioners' status. Acceptance of the sex role stereotype — of mother as bearing the chief responsibility for child rearing — led to a secondary assumption of maternal culpability when children were victimized. Unfortunately, this literature had possessed its own "incestuous" features, with investigators frequently quoting and requoting each other, with little appeal to more appropriate, empirically-based authority. Wattenberg credits two major theoretical
assumptions as central to the construction of the bad mother myth. Firstly, the mother had been seen as possessing inherent personality traits and sexual inadequacies which provoked the incest, and the daughter had been seen as having "seductive" characteristics that tempted and provoked the father. Thus, both mother and daughter became responsible collaborators in their own victimization by father. Secondly, the mother had been indicted for not fulfilling her traditional roles, particularly in terms of meeting the sexual needs of her husband. Mother absence from the home had often been cited, especially if she were working. The economic necessity for the mother to be employed, often as major breadwinner, had not been noted. Wattenberg's analysis of this perspective concludes:

A sexist framework pervades the myth-making. Most studies assume it is the mother's role to provide sexual satisfaction and shoulder the entire burden of child care and nurturing. A notable exception is the Herman and Hirschman report (1977), which points out that when mothers were ill, disabled, or overwhelmed by repeated pregnancies, the fathers, characteristically, did not assume a child-caring role. Rather, the burden of the mother's traditional duties was most often imposed on the oldest daughter. The fact that most victims of sexual abuse are overwhelmingly female and perpetrators are male, and that the occurrence of mother-son incest is rare, is seldom dealt with. (p. 208)

The second model type deals with the sequential dynamics operating within families experiencing both extrafamilial and incestuous sexual abuse. Originally conceptualized at the individual victim level by Summit (1982) as the "child sexual abuse accommodation syndrome", the model has been elaborated to a family systems level by Sgroi, Blick and Porter (1982). They conceptualized a five-stage model comprising: the engagement phase, the sexual interaction phase, the secrecy phase, the disclosure phase, and, the suppression phase. The first, "engagement", phase requires that the perpetrator has access to the child as well as opportunity to offend. The perpetrator is generally well known to the child, and possesses power over the child by virtue of his kinship and/or authority role. The authority of the offender communicates to the victim that the behavior is acceptable, and a range of inducements, from the subtle to the forceful, are applied as needed. The second, "sexual interaction", phase most commonly progresses from less to more intrusive forms of sexual interaction. The next, "secrecy", phase refers to the conditions of concealment used to protect the offender and to allow for continuation of the abuse. The "disclosure" phase occurs when
the "secret" escapes, either voluntarily or by accident. In the case of an extrafamilial offender, the family is more likely to support the child following disclosure. However, disclosure of incest frequently results in family denial and blame of the child. This latter response leads to the final "suppression" phase, wherein family members attempt to suppress, minimize and deny the child's report of abuse. Under these circumstances, the pressure on children to recant is immense, and is most often irresistible for the child.

A much more elaborate family system model of incest has been posited by Trepper and Barrett (1986a, 1986b), who differentiate between the individual therapist model of the innocent victim and the guilty offender, and the family systems model which "views incestuous activity as the product of a problematic system rather than as its cause, and sees all family members as victims and perpetrators" (p 5). Specifically, they propose a vulnerability model of incest, parallel to the vulnerability models (Gottschalk, 1983; Zubin & Spring, 1977) and stress-diathesis models (Rosenthal, 1971) of major mental illness extant in abnormal psychology. These conceptualizations are allied, by them, with the multiple factor models (e.g., Gabarino, 1977; Gelles, 1980; Straus, 1980), and family sexual abuse models (e.g., Finkelhor, 1978; Tierney & Corwin, 1983) of family violence and sexual abuse. Thus, the underlying premise of their model is that:

There is no cause of intrafamily sexual abuse. Instead, all families are endowed with a degree of vulnerability based on individual, family, and environmental factors, which may express as incest if a precipitating event takes place and the family's coping skills are low. (p 14-15)

Trepper and Barrett have delineated a range of vulnerability factors including: parents' families of origin, personality factors of the family members, family systems factors, and socioeconomic factors. The personality factors considered as predisposing for fathers included sociopathic characteristics, degree of dominance and aggressiveness, presence of a sexual disorder, need for constant love and attention, and the presence of obvious psychopathology. Mothers' predisposing characteristics were noted as degree of passivity and dependency, poor self esteem, and sexual dysfunction. Vulnerable daughters were seen as passive, dependent and sociopathic. The family systems factors incorporated into this model subsume the Larson and Maddox (1984) typology of family styles (previously discussed), as well as family structures which feature either rigidly or chaotically enmeshed families (following Olson's Circumplex Model; Olsen, et. al, 1982). Also incorporated was Barrett's, previously
discussed, five-way typology of incestuous families. Family communication styles within vulnerable families are described as featuring conflict avoidance, secretiveness, hostility and double-binding communication patterns. These families are seen as able to communicate instrumental content, while completely avoiding affective communication. The fourth, socio-environmental vulnerability factors, were seen as chronic stress, social isolation, community tolerance of incestuous behavior, and cultural acceptance of male dominance. Trepper's and Barrett's discussion of precipitating events is less elaborated and cites substance abuse, mother absence from the home, and major acute stress. The family coping mechanism component of the model suggests that the presence/absence of a strong social network, consistent religious beliefs, and the availability of a local support or therapy group largely determines a family's ability to cope.

Following an extensive review of the past and current family-oriented literature on child sexual abuse, Conte (1986) synthesized the characteristic elements of the family perspective as including:

The importance of a multi-generational view in understanding problems; the notion that the problem (sexual abuse) is symptomatic of a dysfunctional family in which every member of the family contributes to the development and maintenance of the problem; and the belief that the problem (symptom) may not in itself have significance, but rather have a meaning within the family which is not readily apparent in the behavior (e.g., sexual abuse) as a tension-reduction mechanism or as a means of displacing feelings of isolation. (p 115)

Conte points out that the family models also rely on mother as the "cornerstone" of the pathological family system. Mother is generally viewed as cold, hostile, demanding, and rejecting — the figure who pushes her daughter into relieving her of her maternal and marital responsibilities. This assignment of "moral responsibility" to mother for having failed her husband and permitted the abuse of her daughter ignores the stronger likelihood that mother's behavior is more probably an effect, rather than a cause, of the abusive system (Finkelhor, 1986).

Conte described both general empirical and theoretical problems within this literature. The literature is virtually exclusively based on small samples and case study information, with no objective data measurement or control procedures. Much of the work appeared at a time when few child sexual abuse cases were identified, and those were primarily father-incest
cases. There has been an assumption in the family literature that incest offenders, *a priori*, were fundamentally different from other child sexual offenders. However, subsequent literature suggests that both incestuous and nonincestuous child sexual offenders share more similarities than differences, and are differentiated primarily by the incest offenders’ abuse of younger victims (an access issue). There has also been the assumption that incest offenders restrict their abuse to their daughters – an event precipitated by their wife’s sexual-maternal absence. However, both Conte and Finkelhor (1986) state that the data indicates a much more complex pattern. In particular, Conte cites Abel’s (1983) study of 142 fathers who had sexually abused their daughters: 44% had abused other female children outside the home; 11% had also abused male children outside the home, and 18% had raped adult women outside the home – all at the same time as they were sexually abusing their daughters.

Theoretical weaknesses were also addressed by Conte. The family model’s focus on the characteristics of the nuclear family as the most important level of analysis is challenged in that mounting evidence indicates that the majority of offenders actually began to sexually abuse children as adolescents and young men – long before they entered the family in which they abused their own daughters. Thus, he argues, there is a need to expand and elaborate the family systems view to include a range of subsystems under each major system. In particular, Conte points to the cognitive, emotional, behavioral and physiological systems:

Examination of the contribution of these subsystems to the development and maintenance of sexual abuse may be profitable. For example, a systemic view of sexual offenders directs attention toward a number of variables, some historical (e.g., punitive child-rearing experiences) and some contemporary which describe the current life functioning of men who sexually use children. These contemporary influences include cognitive distortions which provide excuses for sexual use of children (e.g., “I was only teaching her about sex”) and learned behaviors which are emotionally and physically reinforced (e.g., sexual arousal to children). It appears that many clinicians emphasize family process variables over other potentially powerful systemic ones. (p 119)

Finally, Conte is concerned with the notion that the sexual abuse is symptomatic of other problems: "as translated in these cases, this means that the sexual abuse isn’t really sexual abuse at all" (p 119). Although all sexual expression contains both sexual and nonsexual dimensions, abuse is sexual in that offenders are sexually aroused to children and the children
experience themselves as being sexually violated (along with all the other forms of violation experienced). The models’ concentration on father-daughter incest, as Conte emphasizes, fails to address the experiences of male child sexual abuse victims, and has limited much of the professional sensitivity to cases of suspected father-daughter incest (Finkelhor, 1986) - a form of child sexual abuse accounting for only about 8% of the total (Russell, 1986).  

**SOCIO-CULTURAL LEVEL**

The issue of sexual assault and violence against women and children has been examined both within a cross-cultural, sociological framework, and within a feminist analytic context. Both literatures share much, and serve to extend our understanding of these phenomena. Certainly, as was apparent from the previous sections, answers are not to be found by concentrating on abuse exclusively as an individual or family problem - it is vital to conceptualize sexual aggression within the broader social context (Stermac, Segal & Gillis, 1990).  

**CROSS-CULTURAL PERSPECTIVES**

Although little cross-cultural work has been carried out with respect to child sexual abuse, it has been confirmed that most cultures have strong prohibitions against incest (Levi-Straus, 1969). Yet, existing anthropological research suggests that it has been embedded in and covertly allowed in most cultures (Miller, 1984; Rush, 1980; Ward, 1985). Considerable data, however, have been accumulated surrounding the characteristics of societies in which rape is prevalent. Sanday’s (1981) large-scale study of 156 tribal societies found that high levels of rape were associated with: (a) the acceptance of violence as a primary problem-solving strategy (both within the tribe and against other groups); (b) the ideology of male toughness; (c) the ideology of female inferiority, lack of power, and generally negative attitudes toward women. Quinsey’s (1986) cross-cultural examination also concluded that violent patriarchal cultures exhibited the highest levels of rape. In contrast, in societies where rape was rare, interpersonal violence was all but absent, as were negative attitudes toward women (Sanday, 1981). Given the prevalence of the "rape-prone" themes in North American society, it is not surprising that the rate of rape is higher in the United States than in any other western society (Chappell, 1976; Scanlon, 1982; Schiff, 1971, 1974), and that it has repeatedly been found that 30% to 35% of
American men report themselves as likely to rape if they were certain of not being caught (Malamuth, 1981a, 1981b; Malamuth & Check, 1980; Malamuth, Haber & Feshbach, 1980). Consistent with the cross-cultural findings, a study of American men (non-offenders) has found that those who indicated a high likelihood of raping if they could get away with it, also thought that non-sexual aggression against women was normal and legitimate (Tieger, 1981).

Rape has been seen as functioning to maintain a society's system of "sexual stratification" (Wilson, Faison & Britton, 1983). Thus, male dominance in social power relationships is maintained via the experienced and internalized sexual intimidation of women through all forms of sexual abuse and harassment (Brownmiller, 1975; Medea & Thompson, 1974; Russell, 1975). By extension, the sexual abuse of daughters further consolidates this process, in that they become socialized as victims who will not challenge male authority as adults and who will be less able to protect their own children from assault. And thus, the cycle continues and perpetuates itself.

**FEMINIST THEORY**

Beginning in the mid 1960s, the women's movement first began to draw public attention successfully to the issues of gender inequality, and to the financial and social exploitation of women in western societies. As this perspective slowly gained credibility, it was augmented, over the next two decades, by an ever-increasing awareness of the prevalence of wife battering, rape, child battery and child sexual abuse. Over this time, feminist theorists have struggled to come to broader understandings of the mechanisms, structural properties, and imperatives of a society which tolerates (supports) such treatment of the majority of its population – women and children.

Before moving into the theoretical precepts, it may be useful to review briefly the social data, in addition to the previously discussed cross-cultural material, which forms a part of the substratum of feminist theory regarding child sexual abuse and family violence:

- 38% of adult women have suffered childhood sexual abuse and 18% have been victims of incest (Russell, 1986).
- the rate of female child sexual abuse has increased four-fold from the early 1900s to the 1970s (Russell, 1986)
- child sexual abuse offenders are overwhelmingly male (96%) (Finkelhor & Hotaling, 1984; Russell, 1986), and father-figure offenders form the largest group of intrafamilial offenders (Finkelhor, 1979; Alexander & Lupfer, 1987; Russell, 1983; Wyatt, 1985).
- children are most likely to be sexually abused by someone known to them. Strangers comprise only about 15% to 25% of offenders (Finkelhor, 1980; Russell, 1986).
- between one-third to one-half of women who are dating have experienced sexual abuse from their dates (Korman & Leslie, 1982; Stets & Pirog-Good, 1989)
- 10% to 14% of women experience spousal rape (Finkelhor & Yllo, 1985; Russell, 1986), and almost half of these had been physically assaulted prior to the rape (Russell, 1986).
- 14% of parents were found to have physically assaulted (i.e., kicked, bitten, beaten-up, punched, hit with an object, used a knife or a gun) a child within the previous year (Straus, 1979; Straus et al., 1980).
- 90% of American parents use physical punishment as a socialization technique (Straus, 1979)
- between 50% and 75% of all women have experienced physical violence from their partner (Steinmetz, 1986), and for about 20% of women battering is frequent (Straus et al., 1980; Walker, 1979).
- violent crime is overwhelmingly carried out by men, with 89% of those arrested for violent crime, and 86% of those arrested for "offenses" against families and children, being male (Federal Bureau of Investigation, 1985).
- approximately 25% of all murders in the United States occur within a family context (Klingbeil & Boyd, 1984) and two-thirds of those are women killed by their male partners, often at the point of separation (Walker, 1989).
- 40% of women homicide victims are killed by family members (Lerman, 1986).
- the availability of pornography has increased dramatically over the 1970s and 1980s and the pairing of it with violence and degradation is much greater (Donnerstein, Linz & Penrod, 1987). This escalation in violence, explicitness, and availability has paralleled the increased force and social impact of the women's movement over that time (Sommers & Check, 1987).
- over the late 1970s and early 1980s "we have seen a rapid escalation in the quantity of pornography portraying children as sex objects. In some pornography stores and in some
areas as much as a quarter or a third of the book titles refer to incestuous sex or sex with underage children" (Finkelhor, 1982, p. 99).

- the 1985 United States Attorney General’s Commission on Pornography concluded that "there is a causal relationship between exposure to sexually violent materials and an increase in aggressive behaviors directed toward women" (Attorney General’s Commission on Pornography, 1986, p. 326).

- almost 40% of battered women in shelters had been upset by partners asking them to imitate pornography (compared with 3% of the control group) (Sommers & Check, 1987).

In order to provide any explanatory and heuristic power, an overarching theoretical model must account for: (a) the structural characteristics of the society; (b) the internalization of congruent belief sets and identity constraints by social members; (c) mechanisms of transmission, such that the structure, and its carriers (the individuals) continue to perpetuate themselves over time. At this time the elaborating body of thinking arising from feminist theoreticians and clinicians would seem to go a long way toward meeting these criteria.

**Social-Structural Properties**

Sommers-Flanagan and Walters (1987) have provided a useful structural framework within which to examine the presence of family violence, sexual abuse and incest. They define four interrelated areas in which specific conditions must exist to allow for the abuse: ownership; power; power and individualism and achievement; and dehumanization of the victims. In terms of the first issue, western societies have a long-standing tradition of chattel laws and codified regulations regarding men’s ownership of their wives, children, sisters and slaves — laws reaching back to early biblical, Greek and Roman societies. This traditional system of laws also regulated notions as to the proper treatment of that property (e.g., the "rule of thumb" which sanctioned the beating of wives with a stick no wider in diameter than a man’s thumb). Thus, from the earliest recordings of western culture until the present, the culture has deeply embedded the principle of adult male ownership of "their" women and children, and implicit methods of establishing their chattel value. As pointed out by Herman and Hirschman (1977), in that men make the laws, they are also able to make choices around their implementation:
Since virtually all known societies are dominated by men, all versions of the incest taboo are agreements among men regarding sexual access to women. Because the taboo is created and enforced by men, we argue that it may also be more easily and frequently violated by men (p. 740).

Western cultures have traditionally vested power—political, economic, legislative, judicial, military, religious, educational, and physical—in adult males. Women have only gained the right to vote and participate in the political process within this century. Thus, women's representation in the ranks of politicians and senior bureaucrats remains minor as does their representation in the various professions and corporate management hierarchies. Although significant gains have been made over the past few decades, women's power base remains marginal and does not begin to equal that of males within western societies.

As pointed out by Sommers-Flanagan and Walters (1987), western culture is saturated with cultural messages of the macho "might is right" variety which makes normative the notion of using force and violence to solve problems—and be heroic while you’re at it. This ethic permeates everything from network television to foreign policy. The corollary to this is to stigmatize, penalize, blame, and further disempower the victim. Again, examples of this orientation function at all levels of social interaction and policy implementation: "she asked for it", cuts in social services spending, regressive taxation policies, two-tiered medical health care and educational systems, etc. This victim-blaming orientation is reinforced by the American ethos of individualism and achievement which characterizes "the hero" as an isolated, potentially dangerous and assaultive individual who is in control at all times—characteristics antithetical to the requirements of community, intimacy and nurturance.

Dehumanization of the victim, which enables the withdrawal of empathy, is central to the dynamic of family violence and child sexual abuse. And, as has been discussed previously, dehumanization of victims is a deeply embedded characteristic of our society, and relies on a "we" versus "they" dichotomy—one readily available when visible differences exist (e.g., adults vs children, men vs women, whites vs non-whites, etc.). In terms of this issue as applied to sexuality, pornography provides the most publicly available cultural statement and is characterized by: "violence, dominance, and conquest. It is sex being used to reinforce some inequality, or to create one, or to tell us that pain and humiliation...are really the same as pleasure" (Steinem, 1980, p. 37). At the level of adult male sexual abuse of children, only by
dehumanizing their victims are men able to benefit from their abuse, and displace the burden of their own distress:

While victims are assumed to suffer, offenders are assumed to benefit from the occurrence of incest. The most obvious payoff is sexual gratification. There are other benefits as well. Offenders deal with their problems by inflicting them on others. Whenever they get close to experiencing pain, anxiety, insecurity, lovelessness, or any other conflict, they inflict this pain on other vulnerable people, in this case small children, rather than feel it themselves. This is the essence of victimization, the ability to force other people to carry your burdens for you... Consequently, offenders often present as healthy, upstanding, conflict free, if somewhat rigid individuals, whereas victims are ashamed, miserable, distraught and conflict-ridden (Brickman, 1984, p.65)

Internalization of Beliefs

Even in the absence of overt physical and sexual abuse, women are socialized from birth to accept their subordinate role as submissive caretakers who make minimal demands on others. The constructs of "shame" and "shaming" provide a useful vehicle for understanding how this orientation is internalized and maintained as a constraint on the individual woman’s lifetime functioning.

Every woman in this culture is shamed from birth because she is born female. From birth we carry the shame and the burden of the male supremacist mythology that we are second best and possess little value in and of ourselves. Our mothers as women also carry the shame and the burden. To be a separate, individuated person is fraught with anxiety and guilt for women. "Selfish" flashes in neon lights in every woman’s psyche who focuses on her own needs and feelings, indeed her own life. Our culture dictates that a woman has her needs met through a man who is her primary relationship. Culture further dictates that it is the woman who is responsible for taking care of the man’s emotional needs and the relationship needs. What is kept a closely guarded secret is that men are not taught to be emotional caretakers so that when a woman, in her neediness, turns to a man to take care of her, the man cannot respond and so gets angry or withdraws into work or business or alcohol or shaming the woman. (Hyde, 1986, p. 75)
Incest and child sexual abuse provide for an even more compelling internalization of shame and guilt, and prepare "the female to accept a subordinate role; to feel guilty and ashamed... (and) prepare her to submit in later life to the adult forms of sexual abuse heaped on her by her boyfriend, her lover, and her husband" (Rush, 1974, p. 73-74). The experience of incest within a family also provides profound and painful lessons for all the victims.

Incest is the extreme expression of a patriarchal society. It trains the young victims from the start that their place/purpose/function in society is for the needs of others, especially of males. Brothers of incest victims often assault their own children because they have learned that this is how men treat their children. Male victims may also identify with their assailants and become abusers. Females generally tend to adopt the victim role and maintain it since it is supported and accepted by our patriarchal culture. (Swink & Leveille, 1986, p. 120)

Male socialization, in contrast, teaches boys to externalize their distress and anger and to direct it toward vulnerable targets. Thus, both male and female children are co-socialized to the roles of abuser and victim:

Men beat women to gain the power to which they feel entitled because of the structure of a patriarchal society which teaches men to expect to be dominant. Religious teachings reinforce the male-supremacy viewpoint and encourage battered women to endure and pray for their mate's salvation... Little boys are taught to turn all their unpleasant feelings into anger and strike out, while little girls are not expected to show their angry feelings while they nurture and care for others. Any deviation from these stereotypical standards is seen as a breach of the norm and is not acceptable behavior. Such unacceptable behavior is punishable by men, the dominant class. Women, as members of the oppressed class, must learn to accept punishment when they are wrong. (Walker, 1986, pp. 73-74)

In terms of the male propensity for sexual abuse, Finkelhor (1982) argued that four major socialization factors predispose men to sexually offend children. Firstly, men are generally denied the maternal/caretaking experiences of women which allows them to differentiate at an early age between sexual and nonsexual forms of affection. Secondly, men are socialized to perceive their heterosexual success as much more important to their gender identity than are women – thus, their need for sex to confirm their sense of adequacy.
Thirdly, while women’s sexuality is relationship focussed, men are socialized to focus their sexual interest around the sexual act outside the context of a relationship. Consequently men "could experience arousal because the partner, even though a child, had the right kind of genitals, or could engage in the desired sex act" (p. 101). Fourthly:

Men are socialized to see their appropriate sexual partners as persons who are younger and smaller than themselves, while women are socialized to see their appropriate sexual partner as being older and larger. It is less of a contortion for a man to find a child attractive, because it is merely an extension of the gradient along which his appetites are already focussed. (Finkelhor, 1982, p. 101)

Mechanisms of Transmission

Given the social-structural conditions and the internalized beliefs and consequent actions of male and female social members, it is not difficult to see how this dynamic is transmitted across generations. At the simplest descriptive level, abused little girls who have internalized the victim role, grow up to marry abused little boys who have internalized the aggressor role. The victimized and depleted mother is unable to protect herself, let alone her children, from the abusive, isolated, and angry father who displaces his distress by acting out sexually, physically and emotionally against vulnerable members of his family — and so the story continues.

The Prospects for Change

Clearly then, the long-term solutions to the institutionalized sexual, physical and emotional violence directed toward women and children by men will require profound levels of social change. Rather than relying on the principle of power as deriving from exclusionary hierarchical male structures, we must move toward the principle of power as a consensual entity derived from communities of equals. This principle of structural equality implies equivalent access to, and participation in, decision making and policy implementation in political, economic, legislative, judicial, military, religious, and educational domains. Further, the style of participation is required to move past a strictly power-based authoritarian hierarchical one to one defined by principles of community, respect, tolerance and compassion. These requirement apply equally at the level of the couple and the family:
If this culture considered it unmasculine for men to want sexual or romantic relationships with partners who are not their equals—partners who are younger, more innocent, vulnerable, less powerful, deferential and uncritical—then the prevalence of child sexual abuse would also be likely to decline. (Russell, 1984; p. 290)

and:

As long as fathers retain their authoritarian role, they cannot take part in the tasks or the rewards of parenthood. They can never know what it means to share a work of love on the basis of equality, or what it means to nurture the life of a new generation. When men no longer rule their families, they may learn for the first time what it means to belong to one (Herman, 1981, p. 218).

Clearly, also, we are a long way from reaching this goal, and formidable objects remain even in terms of addressing the specific issue of child sexual abuse:

Sexual abuse is a problem which incriminates a particular sex—a rather uncomfortable fact for many men to deal with. It makes it harder for them to work as enthusiastically on this problem and to avoid defensive responses that transfer blame from the male offenders to the (often female) victim. Since men occupy powerful policy-making decisions, the gender politics of sexual abuse can often hamper effective policies and public action around the problem. (Finkelhor, 1982, p. 100)

However, on the positive side, an array of accomplishments and circumstances provide hope. In the first instance, the issue of abuse, in all its forms, is now up on the table, and, contentious as it may be, it is at least becoming a matter of public record. Research into abuse incidence, prevalence, dynamics, sequelae and interventions has exploded over the past few years and the data are rapidly amassing. Increasingly, advocacy groups for women and children are learning the tactics of power and are accessing both funding and attention. More alternatives for abused women and their children are now available than were a decade ago, although this remains fragile and constantly subject to “cutbacks”. Self-help groups for victims are burgeoning even as access to publicly funded counselling services is generally decreasing. Finally, two issues in particular speak to an interruption in the generational transmission of
abuse: 1, the number of abused children now being identified, protected, and given counselling; 2, the beginning of an emergence of men who are seeking treatment for their own childhood abuse histories.

For those involved in the abuse field, it is very easy to despair and become demoralized if one attends only to the immediate realities. It is helpful periodically to pull back the frame of reference to that of a 20 year interval – on that basis we can see modest, but real, changes and improvement in the overall situation.
5

THERAPY FOR SURVIVORS

Although a great deal of empirical effort has recently been addressed to the demographics, circumstances of, and sequelae attendant to childhood sexual abuse, empirically-based studies of therapy for survivors have yet to be done. However, a significant and helpful body of clinical, experiential and anecdotal literature exists regarding treatment of adult survivors of childhood sexual abuse. The issues involved include the appropriate models of therapy, the role of the therapist and the demands placed upon her, the process and content of therapy, and the relative merits of group versus individual therapy.

MODELS OF THERAPY & TREATMENT IMPLICATIONS

Before considering therapy for sexual abuse survivors in particular, it may be helpful to consider the differing models of therapy in general. To this end, Brickman (1984) has provided a cogent discussion of the structural properties and assumptions underlying three major models of therapy – traditional, non-sexist, and feminist – and their implications with respect to incest and sexual abuse. Traditional therapy, she stated, relies on the male as its central reference point for person, while females exist as "imperfect males". Males are seen as motivated by sexual drives, while women are propelled by reproductive drives. Thus, males are measured in terms of dominance, and are accountable for their actions in relation to other males outside the home. Females, in contrast, operate within the sphere of the home, are accountable to the dominant male and are judged by how well they "meet male needs without appearing to be making sacrifices" (Brickman, 1984, p. 51). Therefore, the objective criteria for both genders is that of male self-interest. As previously discussed, in the most traditional form, incest disappears and becomes female wish fantasy. Alternatively, in an equally malignant version, incest is seen as the fault of a cold domineering mother who twists the development of her son such that he marries a woman who deprives him of his sexual and conjugal rights and then delivers him into a sexual relationship with his seductive daughter – and thus, he becomes a victim possessing no responsibility for the incest.

A non-sexist model, argues Brickman, retains a male reference point, but views women as not having been socialized into all the advantages of maleness. This is a "fair" model which
seeks gender neutrality by advocating that women aspire to male status. It does not challenge the existing power structure and continues to overvalue "masculine" traits (e.g., power, autonomy, authority, etc.) and undervalue "feminine" traits (e.g., community, nurturance, empathy, etc.). When applied to the issue of incest, this "gender-free" analysis ignores two central realities: about 96% of offenders are male, regardless of the victims' gender, and little girl victims generally grow up to be women victims while little boy victims often grow up to be male abusers. Instead, this model views everyone as victim, thus diffusing male responsibility. Therapeutically, men are expected to stop offending, and women and daughters are encouraged to be powerful. However, endorsement of the power model gives the mother and daughter responsibility for preventing the abuse and fails to deal with the father's inability to enter into positive nurturant relationships with others.

A feminist model of therapy, in contrast, attempts to use women's own experience as its reference point, and rejects the "adjustment model" of mental health which seeks to help women conform to social expectations and norms. Feminist therapy carries as central the socio-cultural understanding — articulated in the previous chapter — that all is not well in society and that women and children represent an oppressed group. However, the enterprise of charting women's experience and epistemology is a recent one, and much remains to be done. Brickman's 1984 statement remains relevant:

> The complex map of female experience is just being charted. It has to be painstakingly separated from the male versions of female experiences, the projections, objectifications, and fantasies about women that have dominated clinical and popular theories. (p. 60)

A diverse array of non-traditional treatment implications are associated with a feminist orientation. The power imbalance between professional and client is minimized in that the orientation construes the therapist as a carrier of expertise (knowledge and skills) while the client is seen as the expert on her own experience and the best judge of what is right for her (Brickman, 1984; O'Hare & Taylor, 1983; Swink & Leveille, 1986). Thus, therapists do not present as "perfect human beings", but as "fellow humans who may have worked out more of [their] own issues" and they do not use the therapy relationship as a place to work out their own problems (Swink & Leveille, 1986, p.131). This perspective also seeks to empower clients to be educated and conscientious consumers of psychotherapy services. Thus, inquiries regarding therapist competence, credentials, orientation, values, etc. are welcomed. Rather than acting as
directive, or prescriptive authoritative figures, therapists "act as facilitators or guides and as companions or witnesses in the client's therapeutic journey" (Laidlaw et al., 1990, p. 4). As Herman and Schatzow (1987) put it "The role of the therapist ... is to protect, to bear witness, and in so doing, to make it possible for unspeakable things to be told and unbearable feelings to be borne" (p. 13).

Based upon their extensive pioneering therapy work with incest survivors at a major New York Center, O'Hare and Taylor (1983) summed up the feminist orientation toward psychotherapy with incest survivors:

Incest cannot be understood and treated solely as an example of isolated family pathology. It must be placed in its social and political context and that means in a feminist context. Like other forms of sexual assault, incest is a crime of power and coercion; one of its cultural functions is to maintain the power and structure of our patriarchal society. The relationship of incest to other forms of family violence and the oppression of women, children and vulnerable men is not irrelevant to treatment. This means that one cannot effectively cope with the overwhelming guilt and feelings of being a "freak" which incest survivors experience, unless one has a perspective informed by a broad understanding of the actual practice and function of incest in our society" (p. 226)

THERAPIST ISSUES

A general consensus holds that same-gender therapists are important and fundamental for effective work with female sexual abuse survivors (e.g., Briere, 1989; Herman, 1981; Laidlaw et al., 1990). Given all the ways in which men are the abusive carriers of power, both in the woman's history and within the broader social context, it is not really possible for a woman client to be able to work through her abuse with a male therapist. No matter how skilled or well intentioned he may be – an immutable Y chromosome comes between a male therapist and a female survivor client.

By virtue of his male stimulus value, the therapist may be blocked from making real therapeutic connections with his female client. He is, in a sense, asking the female survivor to forget that he is male, with all the power and dangerousness that she associates with that gender. Thus even the most nonexploitive, caring male begins treatment with female survivors of severe
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abuse at a disadvantage; until he proves otherwise (if he can), he is likely to be seen as someone to service, maintain, or vilify rather than someone who can assist. Further, even his assistance may be relatively unhelpful, since it may reinforce the notion that "mental health" is a gift bestowed upon a subordinate female by a powerful male with whom she is intimately connected. (Briere, 1989, p. 160-161)

Given then, that women therapists will be the predominant workers with women sexual abuse survivors, a whole range of issues arise regarding the therapist's life experience and orientation. At the most basic level, the therapist has been reared as a female in our culture, and as Ellis (1990) stated "My basic assumption in working with women in therapy is that all of us have been abused. No one escapes the world's prevailing attitude that women and children are less valuable than adult males" (p. 243). Also, since about 40% of American women have been victims of child sexual abuse, a high proportion of therapists are likely part of that statistic. Unless the therapist has worked through her own sexual abuse history, and her understandings around being a woman in our culture, she runs the risk of being, at best, ineffective, and, at worst, harmful to her clients. Bergart (1986) articulated six of the most common countertransference traps awaiting women therapists who have not dealt with their own issues: 1, an excessive need to be seen as the "good mother"; 2, fear of the client's rage; 3, pushing the client to act out their own rage toward the client's abuser; 4, being too cautious about pushing clients; 5, overidentification with the client and anger with her over her passivity; 6, the powerfully evocative response that the client's history may simulate in the therapist with respect to her own sexual abuse history. Thus, it becomes imperative for the therapist working in the field, at the first level, to work through her own abuse history, and at the second level, to have an ongoing support system in place.

The problem of ensuring and protecting the therapist's mental health has been addressed by a number of writers (e.g., Cole, 1985; Kelly-Garrett, 1989; O'Hare & Taylor, 1983), and Briere's (1989) recent book provided an extended and thoughtful discussion of this issue. He described two challenges in particular which confront therapists who specialize in abuse-related work -- isolation and dealing with the internal impact of the material. In terms of the first, psychotherapy with victims is "a relatively autistic process, a closed system where the therapist absorbs the client's pain and is often unable to fully unburden it to others" (p. 164). Thus, therapists often develop a sense of isolation and experience themselves as working alone without support. A second level of isolation is also often experienced, in that the same society
which minimizes abuse in the first place, tends also to minimize and devalue those who work with it. Thus, therapists within mental health centers, and similar institutional environments frequently find themselves isolated from colleagues who "do not understand", and administrators who discount the value of their work. Briere also discussed the impact on the therapist of routinely dealing with levels of victimization, cruelty and violence which "can slowly produce a PTSD by proxy" in the therapist. Being an effective therapist necessarily requires strong empathic abilities – a double edged sword in terms of therapist vulnerability to her own reactions to the horror stories she encounters daily. It is not uncommon, Briere states, for therapists to begin experiencing irritability, nightmares, anxiety responses, interpersonal problems, and a general sense of helplessness. For the therapist entering "burnout" two primary avenues are noted – either over- or under-investment in the client. In the first case the therapist assumes the role of "rescuer", and in the second she numbs herself to the suffering of the client and essentially dissociates herself from the experiencing and empathic component of psychotherapy.

Briere proposed five strategies to remedy and ameliorate the special stresses faced by psychotherapists working with abuse survivors: individual therapy, sharing the load, mixed case loads, social partitioning, and macro-interventions. In the first instance, all psychotherapists are enriched by having undergone psychotherapy themselves, both in terms of dealing with and identifying their own issues, and in terms of understanding the process from the clients’ perspective. For therapists working with survivors this exercise becomes essential. It is also recommended that abuse-focussed therapists continue in some form of ongoing therapy as a means of providing an ongoing sounding board. Sharing the load via regular consultations with other abuse-focussed clinicians helps to form a sense of community and battles the inherent isolation of abuse work. Additionally, it is strongly recommended that therapists set up regularly scheduled sessions with a consultant or clinical supervisor, to whom the therapist may discharge painful affect and thus deal with the impact of the material on their work as therapists. Networking with other abuse specialists both at the local and wider levels further fosters communication, the sharing of knowledge and the sense of being part of an effective community. By maintaining a mixed case load the therapist avoids falling into the trap of seeing all the world through the lenses of abuse. A more balanced perspective is gained by working with the "worried well" – a reassurance that not everyone is as damaged as those on their caseload. Briere also encouraged the abuse-focussed clinician to "partition her or his life: focus on victimization during one’s work and try to live a ‘regular’ life outside it". Thus,
developing a social network outside the therapy community, engaging in regular physically demanding activities and taking regular "mental health breaks" are recommended. The final self-care strategy refers to the therapist's need to change focus from that of working only with the already harmed individuals, to working at a more proactive, preventative level. Consequently, involvement in research, education, and citizen-activist roles are also therapeutic for clinicians, and help to combat the feelings of helplessness and isolation that "emptying the ocean with a teaspoon" can invoke.

ISSUES IN THERAPY

Therapy Process

Although the goals of therapy with childhood sexual abuse survivors have been variously framed according to orientation, there is general agreement that survivors do not need to be "restored" to previous levels of functioning. Rather, they need to be assisted in their movement to a new way of being in the world. In terms of the therapy process underlying this development, some consensus also exists regarding the more broadly construed phases in the process (e.g., Blake-White & Kline, 1985; Brickman, 1984; Briere, 1989; Butler, 1985; Edwards & Donaldson, 1989; Hartman & Burgess, 1988; Laidlaw et al., 1990; Mudry, 1986; Swink & Leveille, 1986). Firstly, the client needs to be given permission to see her reactions and adjustments to her history as normative and valid and to understand that her problems exist within the context of a total syndrome. This, and subsequent processes, may only occur within the anchoring safety of a therapist who is caring, non-exploitive and reliable. By validating the survivor as the authoritative expert on her own experience, she is then able to begin to recall her trauma, bring it up to the surface, and achieve a level of self-awareness. Processing of the trauma facilitates integration of her fragmented selves and experiences, thus allowing for self acceptance – a necessary precursor to her subsequent individuation and independence.

A complementary conceptualization of this process is suggested by Belenky's (Belenky, Clinchy, Golderger & Tarule, 1986) developmental taxonomy of the epistemological perspectives by which women know and view their experience. Based on work with 135 women, Belenky and her colleagues defined five major, sequentially staged categories, beginning with:
Silence, a position in which women experience themselves as mindless and voiceless and subject to the whims of external authority; received knowledge, a perspective from which women perceive of themselves as capable of receiving, even reproducing, knowledge from the all-knowing external authorities but not capable of creating knowledge on their own; subjective knowledge, a perspective from which truth and knowledge are conceived of as personal, private, and subjectively known or intuited; procedural knowledge, a position in which women are invested in learning and applying objective procedures for obtaining and communicating knowledge; and constructed knowledge, a position in which women view all knowledge as contextual, experience themselves as creators of knowledge, and value both subjective and objective strategies for knowing. (Belenky et al., 1986, p. 15)

Although their study was concerned with investigating cognitive processes, the research group found that a very high proportion of the study participants had experienced child sexual abuse (CSA) and incest: 38% CSA with almost 20% incest in the college group, and 65% CSA with almost 50% incest in the community and social services group. The distribution of sexual abuse, both in terms of severity and presence was substantially weighted toward the lower three levels of epistemological processing. All the "silent" women had experienced "some form of gross neglect and physical and/or sexual abuse, by one or both parents" (p. 159). The sense of outrage regarding their abuse was greatest in the subjectivist group who located their abuse back in their state of silence. As discussed in previous chapters, abused and incested daughters generally find themselves silenced and divorced from their reality and have to adopt and conform to the "received truths" given by their abusers and their social context. In many ways, the process of therapy parallels Belenky’s outline of the developmental shift from the first and second epistemological stages to subsequent levels:

...the move away from silence and an externally oriented perspective on knowledge and truths [which] eventuates in a new conception of truth as personal, private and subjectively known or intuited... as she begins to listen to the "still small voice" within her, she finds an inner source of strength. A major developmental transition follows that has repercussions in her relationships, self-concept, and self-esteem, morality, and behavior. Women's growing reliance on their intuitive process is, we believe, an important adaptive move in the service of self-protection, self-assertion, and self-definition. Women become their own authorities. (p. 54).
The ways in which Belenky's conceptualizations may apply to the therapy process are further discussed and elaborated in chapter 9 as they apply to the writer's research.

Therapy Content

The content of the three general therapy processes outlined above (i.e., safety-validation, trauma recall, and working through) have been widely discussed over the past decade (e.g., Blake-White & Kline, 1985; Briere, 1989; Butler, 1985; Edwards & Donaldson, 1989; Herman, 1981; Hyde, 1990; Laidlaw et al., 1990; Leland-Young & Nelson, 1987; McBride & Emerson, 1989; Swink & Leveille, 1986; Terr, 1988; Weiner, 1988; Wooley & Vigilanti, 1984). The following represents a synthesis of those discussions along with the writer's own observations based on group and individual work with adult survivors (see chapters 10-13 for a detailed account of therapy content).

SAFETY & VALIDATION. Initially, survivors need to understand and make sense of their symptoms and adjustment as valid responses to the trauma — providing a PTSD formulation offers such a framework. A range of other safety issues tend to wax and wane throughout the therapy process and require therapist attention and ability to respond appropriately. Among these are: self-destructive behaviors, such as substance abuse, eating disorders, self-mutilation, etc.; ongoing victimization, by husbands, boyfriends, employers, members of her family of origin, etc.; depression and risk for suicide, some survivors may require referral for medical management (i.e., antidepressant medications) and the risk for suicide must be taken seriously.

RECALL. During the recall process, previously repressed trauma may surface in any, or all three of the domains of experience: cognitive recall, may arise through dreams, nightmares, and/or flashbacks; affective recall, via intense feelings of fear, anxiety, dread, helplessness, etc., either on a non-specific basis or in response to trigger situations; somatic recall, via abdominal, vaginal, and/or rectal pain, choking sensations, nausea, muscle cramping, pain or weakness, blurred vision, migraines, etc. Often repressed memories first begin to emerge in the non-cognitive domains, and then begin to rise into intellectual awareness (especially for trauma experienced in early childhood). This process needs to be validated for the client and provided as further evidence of her trustworthiness in regard to herself — she is telling the truth, her truths.
WORKING THROUGH. In that all aspects of a survivor's functioning have been affected by her experience, a wide array of issues arise and need to be addressed within the context of therapy. At the intrapersonal level affective issues include guilt, fear, shame, anger, grief, pain and isolation. Cognitive issues such as self-concept, body image, control, internalization of the family roles and double-binds, are also prominent. At the interpersonal level, issues around family dynamics, gender roles, boundaries, communications, role-reversals, double-binds, power, control, trust, intimacy, friendships and sexuality also need to be considered. Also vital are issues regarding the woman's role as a parent, the intergenerational transmission of abuse, her relationship with her abuser, and her ability to defend herself and move on from the victim role.

INDIVIDUAL & GROUP THERAPY

The development of treatment protocols and strategies for use with child sexual abuse survivors remains recent and has its roots in the clinical-anecdotal literature of the late 1970s (i.e., Armstrong, 1978; Butler, 1978; Forward & Buck, 1978; Herman & Hirschman, 1977; Meiselman, 1978). The literature regarding therapy for adult survivors remains sparse, as witnessed by Zimpfer's 1987 review which found only seven published group therapy programs directed toward abuse survivors, leading him to conclude that "as a group they represent a typical 'first wave' of investigation in any professional helping field: case-oriented, descriptive, 'one-shot' studies" (p. 175). Although the literature on child sexual abuse, its characteristics, and its effects, has burgeoned over the last few years, there remains "no systematic research of any kind of treatment for adult victims of incest" (Alexander, Neimeyer, Follette, & Harter, 1989, p. 480).

A number of constraints and characteristics of the therapy process have been discussed and debated: individual versus group, short-term versus long-term, time-limited versus open-ended, and programmatic versus unstructured. With regard to the first of these issues, individual therapy has generally been viewed as properly carrying the weight of the long-term depth psychotherapy required by many survivors, whereas group treatment has been seen rather, as a helpful adjunct modality (e.g., Briere, 1989; Cortois, 1988). Most workers agree, however, that the group format is particularly effective for: accessing the interpersonal issues facing survivors (Herman & Schatzow, 1984), effectively counteracting family denial of the problem (Goodman & Nowak-Scibelli, 1985), alleviating feelings of stigma (Cortois, 1988),
and decreasing the sense of isolation experienced by survivors (Deighton & McPeek, 1985). It is also recognized that group therapy treatment models for abuse survivors necessarily differ from more traditional models of group therapy:

Traditionally run therapy groups operate similarly to the incestuous family: the leaders are clearly in the controlling authoritarian position, they make judgements and decisions about the clients, ostensibly for the client's benefit, give the clients all the responsibility for their own growth but very little control over it. They discourage communication and interactions among members except through the leaders so that secrets and unresolved, unexpressed feelings abound. Traditional therapy groups perpetuate patriarchal values and authoritarian structures and thus are dangerous to the incest victims. (Swink & Levelle, 1986, p. 131)

While short-term therapy, within either group or individual formats, is not able to address the more complex dynamics and embedded effects of an abuse history, it may be useful to stabilize and educate, to intervene in crisis situations, and to prepare survivors for longer-term therapy (e.g., Cole, 1985; Cortois, 1988; Hazzard, King & Webb, 1986; Herman & Schatzow, 1987). Thus, while short-term therapy is generally directed toward the "safety and validation" issues previously outlined, longer-term therapy usually operates at all three levels - safety and validation, recall, and working through.

In general, group programs are time limited, while individual therapy tends to be open-ended. Quite apart from the practical considerations which tend to keep group therapy to a limited number of sessions, it has been argued that time boundaries provide a therapeutic contrast with the lack of boundaries or structure commonly found in incestuous families (Goodman & Nowak-Scibelli, 1985). The issue of time limitations is allied to that of open versus closed group memberships. On the whole, it has been found that closed groups seem more comfortable for survivors in that they provide stability and facilitate trustful bonding - processes which are threatened by membership turnover (Bergart, 1986). With respect to the final therapy characteristic, both at the individual and group level, short-term therapies tend to be more programmatic than do longer-term interventions.

Although the literature contains a number of reports on various group treatment programs, few comparable reports are provided for individual therapy. Rather, the literature surrounding individual therapy tends to be more anecdotal, and relies upon therapist's experience and case-history information. Two recent publications, in particular, stand out as
providing excellent references for therapists working on an individual basis with sexual abuse survivors: John Briere's (1989) *Therapy for Adults Molested as Children*, and Christine Cortois' (1988) *Healing the Incest Wound: Adult Survivors in Therapy*. The group therapy literature, in contrast, tends to be somewhat more empirically oriented, although few reports provide measures of treatment outcome of efficacy, but rely, instead, on clinical judgements. The following discussion considers the short-term, longer-term and open-ended group therapy programs for adult survivors reported in the literature.

**SHORT-TERM GROUP PROGRAMS.** Five short-term group programs are reported. The first of these (Herman, 1984), describes a co-led ten-session program which treated 30 women over five separate groups. This study was notable in that it made provision for a six-month follow-up assessment of client status. The participants were all higher functioning incest survivors who were involved in ongoing individual therapy, and who had been referred in order to address specific person goals. As described, the sessions were sequentially structured to first help members define their goals for group, then to facilitate group bonding, and finally, to help members deal with such issues as secrecy, isolation, shame and helplessness. Almost three-quarters of the participants responded to the six-month follow-up questionnaire and 75% reported improved self-esteem, 80% felt less guilty, 80% felt they were better able to protect themselves, and 75% felt less isolated. However, respondents did not feel that they had improved with respect to work issues, their experience of sexuality, or their interpersonal relationships. A subsequent report by Herman and Schatzow (1987) described a twelve-week group program provided for 53 middle-class, primarily professional, well-functioning survivors who were also involved in concurrent individual therapy. The goal of the groups, which was successfully reached, was to facilitate recall and integration of repressed traumatic memories. The authors report that hearing others' histories acted as a powerful stimulus for trauma recall in members.

Cole (1985) described a structured support group for survivors which met for 2 hours over 6 weeks, after initial individual intake and screening interviews. The group was described as primarily psychoeducational with members defining their individual goals for the group. The primary topics addressed included: the impact of the secrecy, isolation, self-esteem, the perpetrator's responsibility for the abuse, and the rights of children. A final goal of the process was noted as helping participants identify future counselling opportunities. A similar 8 week program described by McEvoy (1990) has been primarily focussed on boundary issues.
A recent empirically-based study has compared a specialized interpersonal transaction group format (based on Cortais (1988) model) with a less structured group format and a wait-list control (Alexander, Neimeyer, Follette & Harter, 1989). Both therapy groups as well as the control group ran for 10 weeks, and pre-treatment and post-treatment measures of social adjustment, depression, fearfulness, and general distress were taken along with a 6-month follow-up. On the whole, the 65 women recruited through the local media, represented a fairly well functioning, well educated group. Members of both therapy groups showed improvement, while the women on the wait list deteriorated on measures of social adjustment. The women in the specialized group demonstrated the greatest improvement on the social adjustment measure. The maintenance of gains at the 6 month follow-up was difficult to attribute solely to the group intervention in that many of the women apparently went on to engage in individual therapy subsequent to their participation in the research groups.

LONG-TERM GROUP PROGRAMS. Three longer-term groups have been reported. Deighton and McPeek (1985) described a 30 week group which ran for two hours per session with 5-7 group members. They report that members experienced significant improvement over the course of therapy. Bergart's (1986) work with group treatment of sexual abuse survivors began in 1978 and she described its evolution into a six-month long weekly group which she identified as being comprised of three phases: 1, dealing with the fears, self-hate, shame, anger at the abuser, and encouraging a sense of belonging; 2, dealing with issues of power and control, personal autonomy and boundaries; 3, dealing with issues of intimacy, loss and grieving, and the termination of therapy. The third long-term program (Swink & Leveille, 1986) described an 18 week protocol in which members were in individual therapy either on a concurrent basis, or preliminary basis. The group was intended to counter the sense of isolation experienced by survivors and the authors noted the strength and immediate nature of the bonds formed between group members. The stages in therapy were described as; disclosing the secret, relinquishing the guilt, catharsis, orphanization, reintegration, confrontation with family members (symbolically if not actually), rebuilding the new self.

OPEN-ENDED GROUP PROGRAMS. Four open-ended, unclosed groups have been reported. Wooley and Vigilanti (1984) describe an open group which ran for 3 to 12 months, in which the leaders focussed upon issues surrounding the pervasive double-binds experienced by survivors. An alternative open-ended group modelled upon those developed for Viet Nam
veterans suffering from PTSD was reported by Blake-White and Kline (1985). The group ran for three years and during that time over 100 women attended at least one session. Of the 54 women considered, 37% dropped out after 1-5 sessions, 33% stayed for 6-20 sessions, 17% stayed for 21-50 sessions, and 13% were also in long-term individual therapy. Before adopting the closed, time-limited group format, Bergart (1986) ran open-ended, unclosed groups. However, the disruptions caused by the addition of new members was seen as counter-therapeutic, resulting in Bergart’s abandonment of that model. Most recently, Urbancic (1989) described open groups run by two nurse specialists for non-psychotic psychiatric inpatients. On average, they found participants staying for two months, and session themes included: disclosure, shame, guilt, women’s roles, mothering, and the instillation of hope.
Part II

THE RESEARCH STUDIES
The two related research studies described here were directed toward the identification and treatment of adult survivors of childhood sexual abuse. Given the high incidence of sexual abuse, its frequent pathological sequelae, and the powerful sanctions against disclosure, the generation of reliably suggestive diagnostic profiles is important. Too frequently, women with abuse histories enter the revolving doors of the mental health system only to receive repeated doses of symptomatic treatment without any recognition of their abuse histories. Although a range of individual diagnostic indicators have been implicated, more global constructs of personality structure and psychopathology have yet to be empirically investigated.

Study 1: Differentiation of Clients with Childhood Histories of: Sexual Abuse, Physical Abuse, Sexual and Physical Abuse, no Overt Abuse

This component of the research was directed toward the identification of sexual abuse survivors. It compared the intake profiles of adult women with and without overt childhood abuse histories who presented for treatment within the community mental health centre system. The study differentiated between those with sexual, physical, or sexual and physical childhood abuse histories. The study was restricted to those women exhibiting a history of recurrent depressive episodes — a significant proportion of the women seeking treatment within the system. The assessment devices employed generated profiles consistent with DSM III-R diagnostic categories.

Given the the clinical observations and research previously reviewed, we expected to find both the degree of personality pathology and symptom severity arrayed along a continuum with sexual and physical abuse survivors at the most extreme end, followed by sexual abuse survivors, physical abuse survivors and finally clients with non-overt abuse histories.

Study 2: Group Therapy for Childhood Sexual Abuse Survivors: A Process and Outcome Study

The second component of the study comprised a process/outcome study of a standardized group psychotherapy program designed for childhood sexual abuse survivors. Participants were restricted to those women presenting at the Centre with recurrent episode
depressive profiles and acknowledged histories of childhood sexual abuse. The psychotherapy program, Life Review Integration Therapy (LRIT) (see Part III of this work, Chapters 10-13), had already been successfully piloted by the author with the population under consideration. The program involves an initial intensive segment of 26 weekly 3 hour sessions, followed by a six month follow-up schedule. The intensive segment of LRIT is essentially comprised of three phases. First, after a general orientation, group members began writing out their "emotional life histories" in their journals. Writing was done between sessions and was shared in group. This initial phase occupied the first 8 to 9 weeks and was followed by the "working through" phase (weeks 9 to 21) where members worked on the issues arising from the first phase. Themes such as betrayal, abandonment, trust, structure of the family, their role within the family, etc. were dealt with. The final "integration" phase of the intensive segment of the therapy focussed on integrating the insights and understandings gained by members into their current functioning. The six month follow-up period included group meetings on a monthly to bimonthly basis, with individual appointments as required. During the immediate post-therapy follow-up period, clients were seen as being in a "training wheels" phase as the resolutions and insights gained through therapy were tested and tentatively lived through in the wider environment. Depending on the levels of real world stressors, different women needed more or less support as they forged new ways of being in the world.

Throughout the program, members continued working on their issues in their journals. This "homework" was shared in group. Members also maintained a daily journal after completion of the emotional life history phase. Pilot work demonstrated that writing out these "testaments" to their own reality was vital to the therapeutic progress of survivors.

It is generally accepted that disclosure of the abuse is fundamental to the therapeutic process for survivors. As previously discussed, their histories have generally featured profound levels of isolation, denial, self-betrayal, avoidance, repression and minimization of their experiences. Thus, a major requirement for healing is the reconstruction of the woman's life history in realistic terms which acknowledge her abuse. During phase 1 of LRIT, women doubly committed themselves to the reality of their histories; firstly, via their journal documentation and secondly, by reading out their journal work in group. Group members accomplished this task within the context of strong peer support and acceptance. For clients with strong borderline features, in particular, observing other group members tolerate their histories provided powerful constructive modelling. The group format also allowed participants to externalize their own conflicts and dilemmas as they listened to the material of other
members. Survivors are often very skilled and vigilant at reading others, and this feature was adaptively employed as they inspected their own issues via other members’.

Beyond the need to work through the specific issues arising from a sexual abuse history, is the need to undo the developmental arrests and distortions consequent to the abuse. Of primary importance are the issues of basic trust and adequate parenting, both of these being prerequisites for separation/individuation. Through the community which evolves in group, members experience self- and other-trust and internalize the experiences of therapy, so that they are enabled to become their own adequate parents.

Research Issues

ETHICAL. Castor-Lewis (1988) provided a provocative examination of the ethical issues involved in research with incest and, in particular, with child sexual abuse survivors. Specifically, she was concerned with two issues which may result in participants’ experience of the research as a recapitulation of their abuse. Firstly, Castor-Lewis argues, the gaining of information constitutes a boundary violation for a person "whose boundaries were flagrantly, aggressively, often repeatedly, and sometimes violently violated in the context of early trauma" (p. 74). The second issue lies in the inherent power differential between the researcher and the survivor. These role differentials are often augmented by other social role differences: e.g., researchers are white, affluent, heterosexual, male, and professional, compared with victims who are poor, non-white, female, lesbian, non-professional, etc. Survivors, she cautions, necessarily possess an extreme sensitivity to the "powerful other".

Thus, Castor-Lewis argues, research with this population must be carried out with great sensitivity, and research protocols therefore require: absolute confidentiality; participant control of interviews and all procedures; and researcher sensitivity and flexibility. This latter requires that researchers are fully aware of the research and issues regarding abuse and have, themselves, dealt with their own issues regarding abuse.

METHODOLOGICAL and STATISTICAL. Given that a major portion of the research constituted a psychotherapy process/outcome study, discussion of the methodological and statistical issues involved is necessary. A good deal of recent concern has been focussed on the state of psychotherapy research - a concern which culminated in the simultaneous special
edition publications of the *American Psychologist* and the *Journal of Consulting and Clinical Psychology* in the spring of 1986, both being dedicated to this matter.

An emerging concern in the area was also faced by the current study: the investigation of dynamic processes underlying both successful and unsuccessful therapy experiences in a manner which addresses both the richness of the individual case, as well as the shared characteristics occurring across individuals. This issue is partially represented by the substantial debate surrounding the relative merits of group-based inferential statistics versus ideographic descriptive techniques. Barlow (1981) provided three major criticisms of the former: (a) the inappropriate reliance on statistical versus clinical significance, (b) the heterogeneity of clients grouped by disorder (ignoring social, demographic and personality factors), which prohibits the generalization of results to individual clients, (c) the inadequacy of factorial designs for the determination of client organismic and treatment interactions. Sizable interactions are suppressed because only interactions reaching a significant F value are considered.

Yeaton and Sechrest (1981) have also been critical of statistical techniques and suggested the substitution of "quantification of effect" for "percentage of variance accounted for". Group comparisons have also been faulted "for obscuring the very phenomena which must be understood in psychotherapy research and that constitutes its very essence" (Strupp & Hadley, 1979, p. 113). Frank (1979) was also concerned about the averaging impact of group comparisons. He suggested, instead, that research should concentrate in the defining characteristics of those few, highly successful, therapy outcomes. Thus, Frank endorsed the systematic application of the case study method based on Cronbach's (1975) "intensive local observation". Such individually oriented techniques allow for the comparative study of the failures and successes in psychotherapy. Thus, the case study method has received renewed attention over the past decade, and is now seen as a plausible method for studying a wide range of therapeutic orientations. Traditionally, the case study was generally accepted as an heuristic tool. However, it was considered an inadequate method from which to draw scientific inferences (Kazdin, 1981): the primary objection being the inability to rule out rival alternative hypotheses. Although methods for dealing with threats to internal validity, and for providing truly experimental single case designs have been proposed (Hersen & Barlow, 1976), they have been constrained by their special requirements of treatment withdrawal or withholding. Thus, it is argued that these designs cannot be applied in a clinical setting for ethical, methodological and practical reasons (Kazdin, 1981).
A new generation of behaviorally-oriented experimental single-case studies have been proposed for use within clinical settings (eg. Hayes, 1981; Horn & Heerboth, 1982). Nelson (1981) argued for the use of such procedures within clinical settings because they: tend to improve the quality of client services by providing feedback to therapists and clients, thus allowing for treatment modifications as indicated; provide an accountability system for evaluating client outcome; and allow for clinically relevant research.

Kazdin (1981) suggested three methods for ruling out threats to internal validity using the case study method. Firstly, objective data should be collected, as opposed to the traditional reliance on anecdotal reports. Thus, measurable change may be demonstrated. Secondly, client performance should be assessed on a number of occasions. This procedure rules out testing artifacts due to either statistical regression or instrumental problems. Finally, data should be accumulated over many cases. Such increased client heterogeneity also controls for historical and maturational confounds.

A detailed specification for single-case time-series designs was provided by Hayes (1981). Like Kazdin, he not only advocated the use of repeated measures, but also endorsed a multiple replication format. He also considered the temporal schedule appropriate to measurement administration. Hayes advocated an attitude of "investigative play", that is, the investigator must be willing to let emerging trends modify the design. Although an antithetical position to that of the rigid group designs, this approach is much more in tune with actual clinical practice.

A range of empirically significant issues also arises with respect to psychotherapy process research. Recent theorists note that the process of therapy varies over time (Greenberg, 1986), and may more properly be viewed as a dialectic wherein "independent" variables that influence outcome may also be affected by the emerging outcome of the treatment (Glass, 1984). Thus, we see the need for identification of stages in therapy and the investigation of change processes specific to those stages. Over the past decade, patient factors have also been considered as important elements in psychotherapy process research. Empirical studies have pursued two major lines of investigation: the motivational and personality characteristics which clients bring into the therapy situation; and the in-therapy patient characteristics associated with successful therapy. Apart from Frank's (1975) demonstration of the characteristically "demoralized" client, little has been achieved within the first area of enquiry. This lack of progress has led to calls for more research attention to the heterogeneity of personality types.
found within homogeneous DSM III classifications (Koss, Strupp & Butcher, 1986; Frank, 1979).

While few specific client in-therapy characteristics have been proven predictive of therapy outcome, a number of more global constructs have been demonstrated as significant outcome predictors [e.g. overall level of client participation (Gomez-Schwartz, 1978; O'Malley, Suh & Strupp, 1983), patient positive contributions (Marziali, 1984; Horowitz, Marman & Weiss, et al., 1984), and the total number of client utterances in therapy (McDaniel, Stiles & McGaughy, 1981)]. Therapeutic alliance, currently defined as client "collaboration" in the task of psychotherapy (Frieswyk, Allen & Colson et al., 1986; Frieswyk, Colson & Allen, 1984) is also generally accepted as vital to therapeutic change and improvement (e.g. Parloff, 1986; Stiles, Shapiro & Elliot, 1986).

Psychotherapy process/outcome research also faces a specific set of challenges to its external validity. It is now widely accepted that psychotherapies are not reproducible technologies; but rather, are composed of many intricate components featuring changing dialectical interactions between client and therapist (Glass, 1984). Thus, elements of concern involve patient, therapist, therapy and interactive factors. Psychotherapy research has been criticized for relying on good prognosis, or YAVIS-type (young, attractive, verbal, intelligent and successful) patients (Rachman & Wilson, 1986). Clearly, therapy outcomes based on such clients seriously compromise any ability to generalize to more representative client populations. With respect to the current research, the clients seeking treatment at the mental health centre were typically poor, uneducated, socially isolated, dysfunctional parents. They generally approached the centre for treatment during a depressive episode and typically had suicide attempt and substance abuse histories. Most of the women had also been involved in serial abusive adult heterosexual relationships. In summary, these women formed the opposite pole to that of the YAVIS clients. Thus, external validity was hampered only in terms of the applicability of the results to more socially advantaged women.

With respect to the therapist factor, the research was restricted to data arising from one therapist (the author). While the work will clearly need to be replicated with other therapists, it is hoped that the buffering effect of the group format, along with adequate training for future therapists, will provide the conditions necessary to generalize treatment efficacy across therapist-group units. To assist this process, a program manual has been developed during the study (see Part III, of this work)). In terms of interactive effects, the research included a
number of different, temporally sequenced groups. Thus, although the same therapist was involved, different groupings of individuals provided for a wider range of interactive effects.

The current research attempted to address a number of the foregoing issues currently confronting clinical and psychotherapy research. Attention to demographic variables, the selection of clinically relevant measures, the intervals of measurement and choice of the number of measurement points were all designed to meet the above-noted concerns.

Most importantly, perhaps, is the recognition that the form of data analysis appropriate to studies of this sort diverges markedly from standard experimental, or quasi-experimental, methods. The fundamental assumptions underlying classical inferential statistics, such as random sampling, normality, independence and homogeneity, are all likely to be violated within clinically-based research. An alternative – exploratory data analytic techniques, introduced by Tukey (1977; see also Erickson & Nosanchuk, 1977) – provides an appropriate approach to meaningful and useful data analysis. Exploratory tools are computationally simple, and robust with incomplete and small-n data. They are detective in nature, lending themselves to generating, rather than strictly testing, hypotheses. Classical techniques, on the other hand, are judicial in nature and are designed to test hypotheses.

Given the preliminary state of empirically-based psychotherapy research with sexual abuse survivors, and the nature of clinical research data in general, an exploratory data analytic format was adopted as appropriate to the current research.

The use of two major data analytic tools was advocated by Tukey: initial single-measure stem-and-leaf plots (stemplots), followed by comparative box-and-whisker plots (boxplots). Stemplots readily show features and patterns in data distribution for a particular measure (e.g. separation, asymmetry, irregularity, centering and width). Boxplots permit useful comparisons of different groups on the same scale. Their form relies on the robust statistics of the median and the first and third quartiles, which are resistant to distribution anomalies relative to the mean and variance. Visual inspection can suggest differences between adjacent boxplots and subsequent application of the effect size statistic (Cohen, 1977; Wolfe, 1986) permits quantification of the difference. The effect size represents the number of standard deviations by which the mean value differs between measures.

Erickson (Erickson & Nosanchuk, 1977) pointed out that the application of exploratory analytic techniques to a given body of data may provide a sufficient rationale to apply more standardized confirmatory tests (with all appropriate caveats). Thus, where warranted, simple confirmatory tests of significance have been applied to the data.
STUDY 1: DIFFERENTIATION OF CLIENTS WITH CHILDHOOD HISTORIES OF: Sexual Abuse, Physical Abuse, Sexual and Physical Abuse, No Overt Abuse

METHOD

Participants
The 103 study participants were recruited from the client population presenting for treatment at the Maple Ridge Mental Health Center in British Columbia, Canada. The Center provides service to three bedroom communities adjacent to the major urban center of Vancouver, British Columbia (population approx. 1.5 million). The total catchment area served by the Center possesses a population in excess of 50,000. All the participants were depressed, and were either self- or other-referred to the Center. The majority were referred by either their physician or a social services agency. All women who approached the Center and who met the DSM III-R criteria for depressive disorders were directed into the study sample. Thus, prospective participants were selected either on the basis of the initial intake referral form, or during their first assessment interview with a Center therapist. Normal intake procedures provided the demographic and clinical information required for the research, and arrangements were made for participants to complete the test battery within two weeks of face-to-face contact with Center staff (prior to the initiation of therapy). Test battery results were provided to the treating therapist for incorporation in the initial assessment report required for each new intake at the Center. The final sample groups comprised 21 caucasian women with childhood physical abuse histories, 18 caucasian women with childhood sexual abuse histories, 46 women with childhood histories of sexual and physical abuse (42 caucasian and 4 native indian), and 18 caucasian women with no overt childhood abuse history.

Definitions of Abuse
For the purposes of this study Gold's (1986) definition of sexual abuse was adopted: Sexual contact (i.e. sexual touch) between a child (under 12 years) and a postpubertal person at least five years older than the child; sexual contact between an adolescent (13 to 16 years) and
an adult at least 10 years older; or, any sexual contact between any child or any adolescent under 16 years of age and a person or persons who used physical force.

Physical abuse was defined using a version of the Straus (1979) criteria as applied to children and adolescents under the age of 16: parents or primary caretakers who kicked, bit, beat up, punched, hit with an object, burned, or threatened with a knife or a gun. The same criteria were applied in defining victim experience of physical abuse as adults.

Measures

Demographic information about the participant's family background, personal history, and victimization experience (if any) was detailed on the intake referral form and was confirmed by the therapist in the first interview and then noted on the information cover sheet (Appendix A).

The following test battery, completed by all participants, consisted of the individual test items in the sequence listed below.

2. The State-Trait Anxiety Inventories (STAI, Forms X-1 & X-2; Spielberger, Gorsuch & Lustere, 1970) were used to assess both contemporary situational based anxiety levels and more stable, enduring levels of anxiety.
3. The Internal-External Locus of Control Scale (I-E; Rotter, 1966): a measure of locus of control expectancy, comprising a 29-item forced-choice test (including 6 filler items).
4. The Millon Clinical Multiaxial Inventory (MCMI; Millon, 1982): a clinically derived, DSM III referenced, diagnostic inventory. Three sets of scales are provided: the basic personality pattern scales - schizoid, avoidant, dependent, histrionic, narcissistic, antisocial, compulsive and passive aggressive; the pathological personality disorder scales, comprising schizotypal, borderline and paranoid; the clinical syndrome scales of anxiety, somatoform, hypomania, dysthymia, alcohol abuse, drug abuse, psychotic thinking, psychotic depression, and psychotic delusions.
RESULTS

Demographics and Abuse History

The four groups differed little in terms of age structure. There were 18 women in the childhood sexual abuse (CSA) group with a mean age of 33.4 years ($s = 8.9$); 21 women in the childhood physical abuse group (CPA) with a mean age of 32.6 years ($s = 8.2$); 46 women in the childhood sexual and physical abuse group (CSPA) with a mean age of 31.4 years ($s = 7.9$); and 18 women in the control group with no overt history of child abuse, with a mean age of 36.3 years ($s = 8.6$).

As detailed in Table 10, the groups differed substantially in terms of their spousal living arrangements: 71% of the CSA group were either married or living common-law, followed by 66% of the CPA group, 59% of the CSPA group, and 50% of the control group. Education levels also differed significantly between the groups, with the majority (60%) of the CSPA survivors having failed to complete high school. This was followed by 53% of the CPA and 41% of the CSA groups, who had failed to complete high school. Notably, over 80% of the control group had completed high school, and 23% had even obtained post secondary level education.

In terms of current and past employment history, the abuse groups, in particular the CSPA group, were also greatly disadvantaged compared with the control group. Less than one quarter of the CSPA group were currently employed, and only three-quarters had ever been employed. The majority (64% to 72%) of abuse group members either lived at or below the poverty line, compared with only 44% of the control group. Almost half of the CSPA group were solely dependent on social assistance, compared with about one-quarter of each of the other groups. In a larger context, 79% of the CSPA group were "other-dependent" for financial survival (i.e., social assistance or spousal support), compared with 38% to 58% in the other groups.

Some of the most striking contrasts were provided by the differential adult abuse histories exhibited by the four groups. Although only 20% of the control group were physically abused as adults, the majority of all childhood abuse groups experienced physical abuse in adulthood (generally spousal battery). The CSA and CPA groups experienced adult physical abuse at similar levels (59% and 62%), but the CSPA group reported a substantially higher rate of 85%. The data on adult sexual abuse is also suggestive. While only 6% of the control group had experienced adult sexual abuse, almost one third of CPA survivors had been sexually
abused. However, the figures rose dramatically to 59% for the CSA survivors to 80% for the CSPA survivors.

**Clinical Profiles**

Examination of stem-and-leaf plots (stemplots) revealed no particularly anomalous distributions within any given group, and mutually consistent results were provided by the four-group MCMI box-and-whisker (boxplots) (Figures 2a to 2f) and by the means (Table 11). With the exception of the psychotic thinking scale, where the median was below 70, all clinically significant means showed also as clinically significant medians. Given this level of mean-median agreement, and the simililarity of score distribution characteristics across MCMI subscale (Table 11), it was seen as appropriate to carry out further effect size analysis.

Overall, a clear severity order effect was observed between the four groups and these showed similar patterns of MCMI score peaks (Figure 3). The CPSA group provided the highest overall pattern of pathology, followed in order by the CSA group, the CPA group and the control group. The overall profiles of the four groups, however, were very similar and differed primarily in terms of severity (Figure 3). Clinically significant means were reached on three scales by the control group, on five scales by the CPA group, on six scales by the CSA group, and on nine scales by the CSPA group. This pattern was echoed with respect to the MCMI scale types. In terms of the eight Personality scales, the Control<CPA<CSA<CSPA pattern was maintained, with the CSPA group mean attaining clinical significance on the schizoid, avoidant, and dependent scales, and with the CSA group means reaching clinical significance on the avoidant and dependent scales. The order effect differed on the passive aggressive scale (CSA<CPA<CSA) with all three abuse groups reaching clinical significance. Notably, none of the control group means reached clinical significance on the Personality scales. At the level of the three Personality Disorder scales, the Control<CPA<CSA<CSPA sequence was maintained with all three abuse group means reaching clinically significant levels on the borderline scale. The nine Clinical Syndrome scales provided similar results. All four of the group means reached clinically significant levels on the anxiety, somatization and depression scales while the CSPA group mean exceeded 70 on the psychotic thinking scale. Although the CSA and CPA groups were reversed in the order effect with respect to the anxiety and somatization scales, this difference was small and no useful inferences were drawn from it.

Table 12 provides the effect size (ES) differences between all possible pairings of the four groups. Effect size refers to the number of standard deviations by which the mean value differs between measures. The effect size statistic (d) was calculated using Cohen's (1977)
formula for unequal ns which uses pooled, weighted standard deviations in the denominator. As in Briere's (1988a) study, Cohen's definition of ES strength is used: "small" as 0.2 < d < 0.5; "medium" as 0.5 < d < 0.8; "large" as 0.8 < d. As in the results discussed above, the CSPA group was the most pathological and most different, with the greatest number of large ES differences from the control group (5), and medium level ES differences from the CPA group (3), and from the CSA group (5). The CSA group provided two large and four medium ES differences from the control group, and two medium level ES differences from the CPA group. The CPA group provided nine medium level ES differences from the control group.

At the level of the MCMI Personality scales, the CSPA group were differentiated from the control group by large negative ES values on the clinically significant schizoid, avoidant and passive aggressive scales and medium level positive value on the compulsive scale. Compared with the CSA group, the CSPA group were also characterized by a medium level negative ES value on the histrionic scale. The CSA group provided a large negative ES difference from the control group on the schizoid scale, and moderate negative and positive differences on the avoidant and histrionic scales, respectively, compared with the CPA group. The CPA group was characterized by moderate negative ES differences from the control group on the schizoid, passive aggressive and compulsive scales.

The MCMI Personality Disorder scales provided similar rank orders of severity, with the CSPA group exhibiting medium or large negative ES differences from the control group on all three scales and from the CPA group on the schizotypal and borderline scales. The CSPA group was differentiated from the CSA group by a moderate ES difference on the borderline scale. The CPA group provided a moderate ES level difference from the control group on the paranoid scale and displayed only small ES differences from the CSA group.

The overall severity pattern was again echoed in the Clinical Syndrome scales with the CSPA group showing moderate to large ES differences from the control group on all but two of the nine scales. The most significant differentiation between the CSPA and the CPA occurs on the psychotic thinking scale, which provided a moderate ES. The CSPA group showed moderate differences from the CSA group on the somatization, hypomania and drug abuse scales. The CPA group differed from the control group at a high ES level on the psychotic thinking scale and at moderate ES levels on the psychotic depression and psychotic delusions scales. The CSA and CPA groups provided no significant ES differences. The CPA - control group comparison showed the same pattern of differences as the CSA control group with the addition of moderate ES differences on the anxiety and alcohol abuse scales.
Comparison of the four groups on the BDI (Table 13, Figure 4) show the abuse groups as somewhat more depressed than the control group. However, the measure is clearly not as sensitive as the MCMI depression subscale. The Locus of Control scale comparisons (Table 13, Figure 4) registered all group means within a similar, mildly internalized range (ie. 10.5 to 12.1). No useful differentiation between groups was evident, however. Both the State and Trait Anxiety Scales (Table 13, Figure 4) provided a similar mild trend, with the means increasing: control < CPA < CSA & CSPA. Again, this provided confirmatory, although less powerful, support for the results of the MCMI anxiety subscale.

Summary

The majority of the women approaching the mental health center were in their late twenties or early thirties. All presented with depression as the primary complaint and between two thirds to one quarter had had previous contact with mental health services. While very few of the women in the control group acknowledged a prior history of suicide attempts, the women in the abuse groups acknowledged very high rates of previous suicidal behaviors. Those with childhood sexual abuse histories were almost twice as likely to have attempted suicide in comparison with those with childhood physical abuse histories. Most striking was the childhood physical and sexual abuse history group, where only 15% had not previously attempted suicide. In terms of adult physical and sexual abuse experience, the control group rates were comparatively low, essentially at population norm levels. Women with either childhood sexual or physical abuse histories were equally likely to have been physically assaulted as adults. However, women with childhood sexual abuse histories were more likely to be sexually assaulted as adults than were those with childhood physical abuse histories. The women with dual child abuse histories were again profoundly disadvantaged, with only 15% and 20% not having been both physically and sexually assaulted as adults. It seems that while those physically abused as children ran a very high likelihood of being battered as adults, their risks for sexual assault were not correspondingly elevated. Those sexually abused as children, however, were equally likely to be assaulted both physically and sexually as adults. Those suffering dual abuse as children were very unlikely to escape either form of assault as adults.

While the control group was equally likely to be living with a spousal partner or living in a single-parent-headed household, the abuse groups were all more likely to be living with a spousal other. However, although only about a third of the childhood physical abuse survivors were dependent on others for financial support, the majority of those who had experienced
childhood sexual abuse were other-dependent (i.e., social assistance and/or spouse). This figure peaked with the dual abuse group, only 12% of whom were self supporting. In contrast with the control group, the majority of those in the abuse groups were living in poverty. Education levels were also a significant element with 41% to 60% of the abuse group members having failed to complete high school, compared with the more normative levels in the control group.

Similar peak profiles were provided by the abuse groups on the MCMI, with relative elevations on the schizoid, avoidant, dependent and passive aggressive Personality Scales. All four groups provided inverse-V borderline peak profiles on the Personality Disorder Scales. The Clinical Syndrome Scales also provided consistent peaks on the anxiety, somatization, and depression scales. Thus, the abuse groups were primarily differentiated in terms of level of severity, rather than profile per se. The same rank ordering as in the demographic/history variables was observed with the childhood physical and sexual abuse group providing the most severely disordered profiles, followed by the childhood sexual abuse group and the childhood physical abuse group. The control group was primarily characterized by elevations on the anxiety, depression and somatization Clinical Syndrome Scales. These results are not surprising given that the presence of depression was the initial screening variable for participation in the study.

Overall, in terms of adult social and clinical history, the three childhood abuse groups were clearly more disadvantaged and harmed than the control group. Within the abuse groups, there seems to be a relative ranking of the women with both childhood physical and childhood sexual abuse histories as most impaired and beleaguered, followed by those with childhood sexual abuse histories and least by those with childhood physical abuse histories.
## CHILDHOOD ABUSE HISTORY

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<th>Control (% (n=18))</th>
<th>CPA (% (n=21))</th>
<th>CSA (% (n=18))</th>
<th>CSPA (% (n=46))</th>
<th>χ²</th>
<th>p</th>
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<td>24</td>
<td>46</td>
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Table 10: Demographic characteristics and adult abuse histories of four client groups: childhood physical abuse (CPA), Childhood sexual abuse (CSA), childhood sexual and physical abuse (CSPA), and the control group with no overt abuse history.

Note: χ² results reflect Yates correction where appropriate.
Figure 2a: Four group boxplots for MCMI Personality Scales schizoid, avoidant, dependent and histrionic.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Dashed line shows level of clinical significance (70).
Figure 2b: Four group boxplots for MCMI Personality Scales narcissistic, antisocial, compulsive and passive aggressive.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Dashed line shows level of clinical significance (70).
Figure 2c: Four group boxplots for MCMI Personality Disorder Scales schizotypal, borderline and paranoid

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Dashed line shows level of clinical significance (70).
Figure 2d: Four group boxplots for MCMI Clinical Syndrome Scales: anxiety, somatization, hypomania and depression.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Dashed line shows level of clinical significance (70).
**Figure 2e:** Four group boxplots for MCMI Clinical Syndrome Scales: alcohol abuse, drug abuse, psychotic thinking and psychotic depression.

**Note.** Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Dashed line shows level of clinical significance (70).
Figure 2f: Four group boxplots for MCMI Clinical Syndrome Scale: psychotic delusions.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Dashed line shows level of clinical significance (70).
<table>
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<th>MCMI SCALES</th>
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<td>SD</td>
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Table 11: MCMI mean scores and standard deviations for the three childhood abuse history groups and the control group.

Note: MCMI mean scores: **bold** = clinically significant level (> .70)
Figure 3. Mean MCMI scale scores for four groups: childhood physical abuse, childhood sexual abuse, childhood physical and sexual abuse, control.

Note. Clinically significant level indicated by horizontal line at scale score 70.
### II: Study 1 - Method & Results

#### EFFECT SIZES

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<tr>
<th>MCMI SCALES</th>
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<th>CPA &amp; CSPA</th>
<th>CPA &amp; CSPA</th>
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<td>-.16</td>
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</table>

#### PERSONALITY DISORDER SCALES

| Schizotypal  | -.55          | -.31       | -.74       | .35        | -.20       | -.53       |
| Borderline   | -.27          | -.23       | -.84       | .10        | -.52       | -.69       |
| Paranoid     | -.39          | -.78       | -.60       | -.30       | -.17       | -.12       |

#### CLINICAL SYNDROME SCALES

| Anxiety      | -.38          | -.50       | -.78       | -.11       | -.35       | -.25       |
| Somatization | -.12          | -.29       | -.66       | -.20       | -.60       | -.38       |
| Hypomania    | .17           | -.33       | -.41       | -.48       | -.53       | -.03       |
| Depression   | -.22          | -.18       | -.57       | .07        | -.30       | -.40       |
| Alcohol Abuse| -.31          | -.52       | -.57       | -.16       | -.23       | -.10       |
| Drug Abuse   | -.05          | -.41       | -.57       | -.37       | -.51       | -.09       |
| Psychotic Thinking | -.85 | -.53 | -.92 | .33 | -.36 | -.58 |
| Psychotic Depression | -.50 | -.63 | -.75 | -.04 | -.31 | -.30 |
| Psychotic Delusions | -.57 | -.55 | -.39 | -.02 | .19 | .20 |

**Table 12:** Effect size comparisons between all possible pairings of childhood abuse groups and control group: sexual abuse (CSA), physical abuse (CPA), sexual and physical abuse (CSPA).

**Notes**

1. ES calculated with pooled, weighted standard deviations.
2. **Bold** = large effect size (> .80); **medium** = medium effect size (.80 < d < 50; **small** = small effect size (.50 < d < 20)
### CHILDHOOD ABUSE HISTORY

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**Table 13**: Mean scores, standard deviations and standard errors of the four groups on the Beck Depression Inventory (BDI), The Internal/External Locus of Control Scale, and the State/Trait Anxiety Inventories.
Figure 4. Four group comparisons of mean scores and standard errors on the Beck Depression Inventory, the Internal-External Locus of Control scale, and the State/Trait Anxiety Inventories.
STUDY 2
GROUP THERAPY FOR CHILDHOOD SEXUAL ABUSE SURVIVORS: A Process & Outcome Study

METHOD

Participants and Process

In total, 64 of the women in the first study had childhood sexual abuse histories with or without childhood physical abuse. All were offered the opportunity to participate in the group therapy program and the 54 who attended at least the first session formed the basis of this study. Thus, no additional screening for group participation was carried out. This choice was based on the very limited therapy resources available at the Center and helped avoid biasing participation to more highly functioning clients. The criteria for participation, and definitions of abuse types used in the first study were continued. All 64 women signed an informed consent document prior to participation in the study (Appendix B).

The group therapy program (see Part III, Chapters 10-13) was offered over a 30 month period, and as its existence became known in the medical and social services community, increasing numbers of referrals were received. When the study was terminated, a wait list of 46 women existed. Group size ranged from 5 to 10 members, with the larger groups being more characteristic of the last year of the program. Seven sequential groups were included in the study. As discussed previously, the groups met weekly for three hour sessions over a six month period. A subsequent six month follow-up provided supportive group sessions at increasing intervals (i.e., 2 week interval, 3 week interval, monthly intervals, three monthly interval).

The study distinguished between therapy completers (32) and therapy dropouts (22). In total, therapy completers filled out six sequential test batteries over a one year period. However, all the women had completed the initial test battery at intake and subsequent test batteries were administered to the completers at meaningful points throughout the therapy process. The intensive six month portion of the therapy was divided into three segments: the "emotional life history recall" stage (8-9 weeks); the "working through" stage (weeks 9 to 21); and the
"integration" phase (weeks 22-26). Test batteries were completed at the end of each segment as well as at the three and six month follow-up points.

Measures

Demographic information about each participant’s family background, personal history, and victimization experience was detailed on the intake referral form, and was confirmed by the therapist in the first interview and then noted on the information cover sheet (Appendix B).

The following measures comprised the test battery completed by all participants at each administration. They completed the individual test items in the sequence listed below.

2. The State-Trait Anxiety Inventories (STAI, Forms X-1 & X-2; Spielberger, Gorus, & Lustere, 1970) were used to assess both contemporary situational based anxiety levels and more stable, enduring levels of anxiety.
3. The Internal-External Locus of Control Scale (I-E; Rotter, 1966): a measure of locus of control expectancy comprising a 29 item forced-choice test (including 6 filler items).
4. The Millon Clinical Multiaxial Inventory (MCMI; Millon, 1982): a clinically derived, DSM III referenced, diagnostic inventory. Three sets of scales are provided: (1) the basic personality pattern scales - schizoid, avoidant, dependent, histrionic, narcissistic, antisocial, compulsive and passive aggressive; (2) the pathological personality disorder scales - schizotypal, borderline and paranoid; (3) the clinical syndrome scales - anxiety, somatoform, hypomania, dysthymia, alcohol abuse, drug abuse, psychotic thinking, psychotic depression, and psychotic delusions.
RESULTS

THERAPY COMPLETERS VERSUS THERAPY DROPOUTS

Demographics and Abuse History

No significant age difference was evident between the 32 therapy completers ($M = 31.5$ years; $SD = 8.2$) and the 22 therapy dropouts ($M = 33.4; SD = 7.1$). Ninety four percent of the therapy completers (TC) group were mothers, and 87% had an average of two dependent children ($SD = 1.2$) in the home. Likewise, 91% of the therapy dropout (TD) group were mothers, and 86% had an average of 2 dependent children ($SD = 1.3$) in the home. However, as detailed in Table 14, the two groups differed significantly in terms of their spousal living arrangements: 71% of the dropout group were married compared with only 44% of the completers. At a more general level, only one quarter of the dropout group were single parents, while almost half of the completers were (a difference which approached statistical significance). Education levels also differed significantly between the two groups, with the majority of the dropouts (68%) having failed to complete high school contrasting with less than half (41%) in the completer group.

Although both groups were primarily unemployed at the time of the study, the dropout group was greatly disadvantaged in terms of past employment history. Thus, 94% of the completer group had an employment history, while only 59% of the dropout group had been previously employed. At the time of the study, both groups were largely financially "other-dependent" (TC = 72%; TD = 86%), and the majority were living in poverty (TC = 71%; TD = 68%).

The abuse histories of the two groups also provide useful insights (Table 15). While both groups had experienced very high levels of physical abuse as adults (82% vs. 84%), primarily in terms of spousal battery, the dropout group had endured significantly greater levels of childhood physical abuse (95%) compared with the completer group (69%). The majority of the women in both groups had also experienced sexual assault as adults (87% vs. 95%).

The majority of women in both groups had been victims of incest (85% vs. 86%), and the two groups were differentiated by the higher likelihood that dropouts had suffered exclusively intrafamily sexual abuse (64%). In contrast, 41% of the completers had experienced both intra- and extra-family sexual abuse. Half of the completer group had been sexually abused by more than one offender compared with 36% of the dropout group. Fathers (54% vs. 56%),
and step-fathers (68% vs. 72%) were the most frequent offenders, followed by other male family members. While none of the dropouts were sexually abused by mother's boyfriend, 16% of the completers reported such experiences. None of the women reported being sexually abused by a female. Fewer than one-third of the women had been sexually abused by a non-family member (28% vs. 31%), while only 14% of the dropout group and none of the completers had been abused by a stranger.

Clinical Profiles

As noted in Table 15, approximately three-quarters of the women in both groups had sought mental health services in the past, and most had previously made suicide attempts (75% vs. 86%).

Examination of MCMI stemplots revealed no particularly anomalous distributions within any group. MCMI boxplots (Figures 6a - d) and means (Table 16) provided mutually consistent results. With the exception of the TC dependent scale measures (mean = 69.4, median = 77.5), all clinically significant means showed as clinically significant medians, and all nonsignificant means and medians were in agreement. It was thus again seen as appropriate to carry out further analysis with the Effect Size (ES) statistic.

Overall, both groups presented with similar patterns of MCMI score peaks (Figure 6). The completer group presented with the highest overall pattern of pathology, with clinically significant means on eight scales, compared with six scales in the dropout group (Table 16). With the exception of the medium level ES on the dependency scale, all other clinically significant scale score ES differences were small. In terms of the MCMI Personality Scales, both completers and dropouts showed clinical levels on the avoidant and passive aggressive scales, while the completers reached clinical levels on the schizoid and dependent scales. The dropouts showed stronger narcissistic and antisocial characteristics (ES = -.62 and ES = -.78 respectively) while the completers showed stronger dependency features (ES = .73).

For the MCMI Personality Disorder Scales, both groups provided clinical level means on the borderline scale with a medium level ES differentiating the completer group’s higher score. At 69.4, the dropout group mean on the paranoid scale provided one of the highest ES differences between the two groups (ES = -.78). The nine Clinical Syndrome Scales provided similar clinically significant peaks for the two groups on the anxiety, somatization and depression scales, with the completer group displaying small ES level increases. Only one ES difference reached the moderate level and that was on the psychotic delusions scale where the
dropout group almost reached the clinically significant level (TD = 66.9). Notably, both group means approached the clinical level on the psychotic thinking and psychotic depression scales.

Comparison of the two groups on the BDI (Table 17, Figure 7), show no significant differences. The Locus of Control Scale comparisons likewise failed to discriminate between the two groups which both appear in the IE mid-range (13.5 - 14.7). Both groups appeared highly anxious on the State/Trait Anxiety Inventories, although no important difference between them was observed.

Summary

The majority of the women entering therapy were in their early thirties and most had sought mental health services previously. The majority of the women had also attempted suicide at some time in the past. Almost all were mothers with an average of two dependent children in the home.

The women in the dropout group were most often married, poor, unemployed, high school dropouts with little or no employment history. The vast majority had been physically abused as adults, primarily in the form of spousal assault, and they had almost all experienced child physical abuse. Only 5% had not been sexually assaulted as adults. Most had been childhood incest victims and had been abused by one family member only - most often a father figure. In contrast, the women in the completer group were most often unemployed single parents living in poverty, who had completed high school and had some sort of work history. The majority had been physically abused as children and as adults. The physical assaults in adulthood were largely attributed to spousal battery. Only 13% had not been sexually assaulted as adults. Most of the women had been victims of incest by a father figure, and half had been abused by more than one offender; most frequently, a non-family member.

Similar peak profiles were provided by both groups on the MCMI, with elevations on the schizoid, avoidant, dependent and passive aggressive Personality Scales. However, the dropout group showed comparative elevations on the narcissistic and antisocial scales. Both groups provided inverse-V borderline peak profiles on the Personality Disorder Scales. The dropouts, however, showed marked comparative elevations on the paranoid scale. The Clinical Syndrome Scales also provided consistent peaks on the anxiety, somatization and depression scales, with high subclinical levels on the psychotic thinking, psychotic depression and psychotic delusion scales. This latter scale provides the only moderate level ES difference between the two groups on the Clinical Syndrome Scales.
Overall, the two groups possessed both extensive and severe abuse histories and were extremely socially disadvantaged and clinically impaired. They differed primarily in terms of their current social, spousal situations. The dropouts were most likely married and completely economically dependent on their husbands. They had few job skills and little education. Anecdotally, most stated that their husbands were verbally and physically abusive, and we repeatedly found that the husbands were hostile to their wives' desire for therapy. Thus, these women appeared more actively enmeshed within the abuse cycle at the time of therapy, and had few realistic alternatives to enable their escape. Their relative elevations on the narcissistic, antisocial, paranoid and psychotic delusion scales may well have mirrored their ongoing adaptations to their abusive, victimized lifestyles.
### Table 14: Demographic characteristics of therapy completer group and therapy dropout group.

**Note:** $\chi^2$ results reflect Yates correction where appropriate.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Therapy Completers % (n=32)</th>
<th>Therapy Dropouts % (n=22)</th>
<th>$\chi^2$</th>
<th>p</th>
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<td>Children in the home</td>
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<td>86</td>
<td>.01</td>
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<td>Single</td>
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<td>9</td>
<td>.08</td>
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<td>Separated</td>
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<td>5</td>
<td>.26</td>
<td>ns</td>
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<td>9</td>
<td>.35</td>
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<td>Common law</td>
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<td>.02</td>
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<td>Living Situation:</td>
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<tr>
<td>with spousal other</td>
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<td>76</td>
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<td>.10</td>
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<tr>
<td>single adult headed household</td>
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<td>3.27</td>
<td>.10</td>
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<td>High School dropout</td>
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<td></td>
</tr>
<tr>
<td>assistance or spouse)</td>
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<td>86</td>
<td>1.58</td>
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<td>Living below the poverty line</td>
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<td>.08</td>
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</table>
Table 15: Abuse history characteristics of therapy completer group and therapy dropout group.

Notes. 1. \( \chi^2 \) results reflect Yates correction where appropriate.
2. * groups sum to 100% of abuse origins.
II: Study 2 - Method & Results

Figure 5a: Therapy Completer and Therapy Dropout boxplots for MCMI Personality Scales schizoid, avoidant, dependent, histrionic, narcissistic and antisocial.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 5b: Therapy Completer and Therapy Dropout boxplots for MCMI Personality Scales compulsive, passive aggressive and Personality Disorder Scales schizotypal, borderline, paranoid.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 5c: Therapy Completer and Therapy Dropout boxplots for MCMI Clinical Scales: anxiety, somatization, hypomania, depression, alcohol abuse, drug abuse

Note: Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
**Figure 5d**: Therapy Completer and Therapy Dropout boxplots for MCMI Clinical Scales: psychotic thinking, psychotic depression, psychotic delusions.

*Note.* Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
## II: Study 2 - Method & Results

<table>
<thead>
<tr>
<th>MCMII SCALES</th>
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<th>Therapy Dropouts</th>
<th>Effect Size</th>
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<td>n=32</td>
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</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
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<td>PERSONALITY SCALES</td>
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<tr>
<td>Schizoid</td>
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<td>Avoidant</td>
<td>78.6</td>
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<td>76.0</td>
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<tr>
<td>Dependent</td>
<td>87.5</td>
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<td>Histrionic</td>
<td>48.6</td>
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<td>Narcissistic</td>
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<td>22.1</td>
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<tr>
<td>Schizotypal</td>
<td>64.5</td>
<td>17.5</td>
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<tr>
<td>Borderline</td>
<td>81.3</td>
<td>13.4</td>
<td>75.4</td>
</tr>
<tr>
<td>Paranoid</td>
<td>58.4</td>
<td>13.3</td>
<td>69.4</td>
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<tr>
<td>CLINICAL SYNDROME SCALES</td>
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<td></td>
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<tr>
<td>Anxiety</td>
<td>97.1</td>
<td>12.2</td>
<td>92.8</td>
</tr>
<tr>
<td>Somatization</td>
<td>82.7</td>
<td>14.2</td>
<td>76.8</td>
</tr>
<tr>
<td>Hypomania</td>
<td>50.3</td>
<td>34.3</td>
<td>58.2</td>
</tr>
<tr>
<td>Depression</td>
<td>88.4</td>
<td>18.3</td>
<td>87.5</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>66.0</td>
<td>17.1</td>
<td>62.9</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>56.7</td>
<td>23.8</td>
<td>66.6</td>
</tr>
<tr>
<td>Psychotic Thinking</td>
<td>67.3</td>
<td>13.2</td>
<td>69.8</td>
</tr>
<tr>
<td>Psychotic Depression</td>
<td>68.4</td>
<td>17.4</td>
<td>68.4</td>
</tr>
<tr>
<td>Psychotic Delusions</td>
<td>57.8</td>
<td>18.2</td>
<td>66.8</td>
</tr>
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</table>

Table 16: MCMII mean scores, standard deviations and effect sizes for therapy completer group and therapy dropout group.

Notes. 1. MCMII mean scores: **bold** = clinically significant level (> .70)
2. ES calculated with pooled, weighted standard deviations.
3. ES: **bold** = large effect size (> .80); **bold** = medium effect size (.80 < d < .50);
   *italic* = small effect size (.50 < d < .20)
Figure 6. Mean MCMI scale scores for therapy completers and therapy dropouts.

Note. Clinically significant level indicated by horizontal line at scale score 70.
<table>
<thead>
<tr>
<th>SCALE</th>
<th>Therapy Completers (n=32)</th>
<th>Therapy Dropouts (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>BDI</td>
<td>25.6</td>
<td>11.8</td>
</tr>
<tr>
<td>Internal/External</td>
<td>13.5</td>
<td>14.1</td>
</tr>
<tr>
<td>State Anxiety</td>
<td>57.3</td>
<td>12.6</td>
</tr>
<tr>
<td>Trait Anxiety</td>
<td>59.4</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Table 17. Mean scores, standard deviations and standard errors of the therapy completers and therapy dropouts on the Beck Depression Inventory (BDI), the Internal/External Locus of Control Scale, and the State/Trait Anxiety Inventories.
Figure 7. Therapy completer and therapy dropout groups; comparisons of mean scores and standard errors on the Beck Depression Inventory, the Internal/External Locus of Control Scales, and the State/Trait Anxiety Inventories.
THERAPY COMPLETERS: PROCESS & OUTCOME

The Nature of the Therapy Process

Before examining the results, it is helpful to review the context within which they were obtained (for a fuller account please refer to Part III, Chapters 10 to 13). The MCMI constituted the primary empirical measure of client change over the one year period of therapy and follow-up. The measurement points were chosen as meaningful in terms of the therapy process. Subsequent to the initial measurement, clients repeated the MCMI at the 8-9 week point. During this interval, group members had written out and shared their "emotional life histories". This was a powerfully emotional and cathartic period during which group cohesion and trust was tested and developed. The majority of members had never previously disclosed their abuse histories, let alone recognized their more globally painful and constrained childhoods. The third measurement at the 21 week point, followed the second "working through" phase (weeks 9-21). During this period, group members addressed the issues naturally arising from the first phase. Essentially, the women began to change their perspective from "something is (was) terribly wrong with me" to "something is (was) terribly wrong with the picture". They became more centered in their role as strong and honorable survivors of terrible distress and pain. This identity shift also required that they begin to attend to and recognize their own needs - a revolutionary notion for most of them. The fourth measurement, at the six month point, represented the completion of the intensive weekly therapy. During the third "integration" phase, members began incorporating their gains into current relationships and functioning. Thus, at this point, the women were generally both excited by the prospect of moving on in their lives, and anxious about the termination of the weekly sessions. Over the following six months, groups met on a diminishing schedule as they moved through the "training wheels" follow-up phase. The fifth and sixth MCMIs were completed at the 3 and 6 month post therapy points.

Therapy Outcome

Characteristics of the Time 1 data have been discussed in the previous section. Examination of the MCMI stemplots for the remaining five measurement points revealed no particularly anomalous distributions within any given group, and the MCMI boxplots (Figures 8a-j) and the means (Tables 18a-b) provided mutually consistent results. With the exceptions of
the Time 2 passive aggressive scale \((M = 66.0, \text{Md} = 82.0)\), and the Time 2 borderline scale \((M = 71.7, \text{Md} = 69.5)\), all clinically significant mean and median scores were in agreement.

As previously shown, the 34 women completing therapy initially presented with clinically significant elevations on 8 of the 20 scales, specifically: the schizoid, avoidant, dependent and passive aggressive Personality Scales; the borderline Personality Disorder Scale; and the anxiety, somatization and depression Clinical Syndrome Scales. Both at the one year (time 6) and six month (time 4 - conclusion of weekly therapy) points, all scale means were at subclinical levels (Table 18a-b, Figure 9). From Time 1 to Time 4 the effect size shifts (Table 19, Figures 11a-c) on the clinically significant scale scores were large (from \(-.77\) to \(-1.75\)). Notable also were the large ES shifts from Time 1 to Time 4 of the just barely subclinical level scores on the alcohol abuse, psychotic thinking and psychotic depression Clinical Syndrome Scales (from \(-.56\) to \(-.80\)). All the gains on the initial eight clinical level scales were maintained and extended by the one year (time 6) point, with ES shifts ranging from \(-1.00\) to \(-2.07\). Effect sizes on the alcohol abuse, psychotic thinking and psychotic depression scales also increased to the \(-.93\) to \(-1.37\) range.

**Therapy Process**

As detailed below, MCMI scale score means decreased steadily over the course of the 6 month intensive therapy and the 6 month follow-up (Tables 18a-b, Figures 9 & 10), reflecting large Effect Size (ES) shifts on most scales (Table 19, Figures 11a-c).

**PHASE 1.** During this validation phase, members break out of their secrecy, find their voices and discover the full range and extent of their abuse histories.

**MCMI Personality Scales:** By the second measurement point, the schizoid and passive-aggressive means had decreased to subclinical levels, while the avoidant and dependent means remained at clinical levels (Table 18a). Small ES downshifts were evident in the schizoid and dependent scales and a medium ES downshift was shown by the passive-aggressive scale (Table 19).

**MCMI Personality Disorder Scales:** Mean scores on all three scales had diminished by the Time 2 point (Table 18a), and the borderline scale, while remaining at a clinical level, exhibited a medium ES downshift (Table 19).
**MCMI Clinical Syndrome Scales:** All clinical scale means had improved by Time 2 (Table 18b). Although the time 1 clinical peaks on the anxiety, depression and somatization scales persisted at clinical levels at Time 2, medium ES downshifts were evident (Table 19).

**PHASE 2.** During this phase, members had worked through many of the issues surrounding the consequences and outcomes of their abuse histories.

**MCMI Personality Scales:** By the third measurement point all scales had diminished to subclinical levels (Table 18a), with medium ES downshifts on the schizoid, avoidant and dependent scales and a large downshift on the passive-aggressive scale (Table 19).

**MCMI Personality Disorder Scales:** At this point all scale score means were at subclinical levels (Table 18a), reflecting a medium ES downshift on the schizotypal scale and a large downshift on the borderline scale (Table 19).

**MCMI Clinical Syndrome Scales:** With the exception of the anxiety and depression scales, which remained just above clinical level cutoff, all scale means were subclinical (Table 18b). Medium ES downshifts had occurred on the depression, psychotic thinking and psychotic depression scales, and large ES downshifts had occurred on the anxiety, somatization and alcohol abuse scales (Table 19).

**PHASE 3.** This was the last phase of the intensive weekly therapy. Members worked on integrating the gains made over the course of therapy into their current and future functioning.

**MCMI Personality Scales:** All scale score means remained at subclinical levels (Table 18a), and a medium ES level downshift was evident on the schizoid scale, while large ES downshifts were apparent on the avoidant, dependent and passive-aggressive scales. Still at subclinical levels, a medium ES upshift was demonstrated by the narcissistic scale and a large upshift by the compulsive scale (Table 19).

**MCMI Personality Disorder Scales:** All scale score means had diminished to subclinical levels (Table 18a), and a large ES downshift was shown by the borderline scale (Table 10)

**MCMI Clinical Syndrome Scales:** All scales score means were at subclinical levels (Table 18b), while large ES downshifts had occurred on the anxiety, somatization, depression, alcohol abuse, psychotic thinking and psychotic depression scales (Table 19).
3 MONTH FOLLOW-UP. This measurement point occurred 3 months after the final intensive weekly session (week 26). Since that point group members had been attending biweekly, and later monthly follow-up sessions.

**MCMi Personality Scales:** All scale score means remained at subclinical levels (Table 18a) and a medium ES downshift was apparent on the dependent scale, with large ES downshifts on the schizoid, avoidant and passive aggressive scales. A large ES upshift was shown by the compulsive scale (Table 19).

**MCMi Personality Disorder Scales:** All scale score means remained at subclinical levels (Table 18a) and medium ES downshifts were shown by the schizotypal and paranoid scales, with a large ES downshift on the borderline scale (Table 19).

**MCMi Clinical Syndrome Scales:** All scale score means remained at subclinical levels (Table 18b), and medium ES downshifts had occurred on the hypomania, drug abuse, and psychotic thinking scales. Large ES downshifts were shown by the anxiety, somatization, depression, alcohol abuse, and psychotic depression scales (Table 19).

6 MONTH FOLLOW-UP. This measurement point occurred 6 months after the final intensive weekly session (week 26), and one year after the start of therapy. From the 3 month follow-up to the 6 month point, members had attended a monthly, then a 2 monthly session. This point represented the last formal gathering of group members at the mental health center, although most continued to meet outside the centre in weekly or bi-weekly support groups.

**MCMi Personality Scales:** All scale score means remained at subclinical levels (Table 18a), and large ES downshifts were apparent on the schizoid, avoidant, dependent, and passive-aggressive scales. A medium ES upshift was shown by the narcissistic scale and a large ES upshift was shown by the compulsive scale (Table 19).

**MCMi Personality Disorder Scales:** All scale score means remained at subclinical levels (Table 18a), with large ES downshifts on the borderline, and schizotypal scales (Table 19).

**MCMi Clinical Syndrome Scales:** All scale score means remained at subclinical levels (Table 18b) with large ES downshifts shown by the anxiety, somatization, hypomania, depression, alcohol abuse, psychotic thinking and psychotic depression scales (Table 19).
Summary

The 34 women who completed therapy had initially presented with mean clinical scale score elevations on: (1) the schizoid, avoidant, dependent and passive aggressive MCMI personality scales; (2) the borderline personality disorder scale; (3) the anxiety, somatization, and depression clinical scales. Mean scale scores on these decreased over the course of therapy such that all had subsided to subclinical levels by the end of the six months of intensive weekly therapy and had remained at subclinical levels at the 6 month follow-up. Significant scale score reductions were also obtained on the schizotypal personality disorder scale, and on the alcohol abuse, psychotic thinking and psychotic depression scales. The overall level of mean scale score improvements fell within the category of large effect size differences.
Figure 8a: Therapy Completer sequential timepoints boxplots for MCMI Personality Scales schizoid and avoidant.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 8b: Therapy Completer sequential timepoints boxplots for MCMI Personality Scales dependent and histrionic.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 8c: Therapy Completer sequential timepoints boxplots for MCM1 Personality Scales narcissistic and antisocial.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 8d: Therapy Completer sequential timepoints boxplots for MCMI Personality Scales compulsive and passive aggressive.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 8e: Therapy Completer sequential timepoints boxplots for MCMI Personality Disorder Scales: schizotypal and borderline.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 8f: Therapy Completer sequential timepoints boxplots for MCMI Personality Disorder Scale: paranoid and Clinical Syndrome Scale anxiety.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 8g: Therapy Completer sequential timepoints boxplots for MCMI Clinical Syndrome Scales: somatization and hypomania.

Note: Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
**Figure 8h:** Therapy Completer sequential time point boxplots for MCMI Clinical Syndrome Scales: depression and alcohol abuse.

**Note:** Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 8: Therapy Completer sequential time point boxplots for MCMI Clinical Syndrome Scales: drug abuse and psychotic thinking.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
Figure 8j: Therapy Completer sequential time point boxplots for MCMI Clinical Syndrome Scales: psychotic depression and psychotic delusions.

Note. Box limits are defined by first and third quartiles. Center bar is median and upper and lower lines denote data range. Solid line shows level of clinical significance (70).
### Scale Scores

<table>
<thead>
<tr>
<th>MCMi Scales</th>
<th>Time 1 (n=32)</th>
<th>Time 2 (n=30)</th>
<th>Time 3 (n=32)</th>
<th>Time 4 (n=31)</th>
<th>3 mo. (n=20)</th>
<th>6mo. (n=16)</th>
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</table>

**Personality Scales**

- **Schizoid**
  - Mean: 73.8
  - SD: 25.4
- **Avoidant**
  - Mean: 78.6
  - SD: 23.6
- **Dependent**
  - Mean: 86.8
  - SD: 21.7
- **Histrionic**
  - Mean: 48.6
  - SD: 29.0
- **Narcissistic**
  - Mean: 44.3
  - SD: 24.6
- **Antisocial**
  - Mean: 44.2
  - SD: 23.3
- **Compulsive**
  - Mean: 50.3
  - SD: 18.1
- **Passive Aggressive**
  - Mean: 80.1
  - SD: 22.1

**Personality Disorder Scales**

- **Schizotypal**
  - Mean: 64.8
  - SD: 17.6
- **Borderline**
  - Mean: 81.3
  - SD: 13.5
- **Paranoid**
  - Mean: 58.4
  - SD: 13.3

*Table 18a: Sequential MCMI Personality Scales and Personality Disorder Scales mean scores and standard deviations*

*Note: MCMI mean scores shown bold are at clinically significant levels (>70)*
### SCALE SCORES

<table>
<thead>
<tr>
<th>MCMi SCALES</th>
<th>Time 1 (n=32)</th>
<th>Time 2 (n=30)</th>
<th>Time 3 (n=32)</th>
<th>Time 4 (n=31)</th>
<th>3 mo. (n=20)</th>
<th>6 mo. (n=16)</th>
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<td>CLINICAL SYNDROME SCALES</td>
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<td>20.0</td>
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**Table 18b:** Sequential MCMi Clinical Syndrome Scales mean scores and standard deviations.

**Note:** MCMi mean scores shown **bold** are at clinically significant levels (>.70)
Figure 9. Mean MCMI scale scores for therapy completers at the start, six month and one year points.

Note. Clinically significant level indicated by horizontal line at scale score 70.
Figure 10. Mean MCMI scale scores for six sequential time points throughout intensive six month therapy (times 1 to 4) and the six-month follow-up period (times 5 and 6).

Note. Clinically significant level indicated by horizontal line at scale score 70.
### Table 19: Sequential MCMI effect sizes for therapy completers. All effect sizes calculated in reference to time 1

<table>
<thead>
<tr>
<th>PERSONALITY SCALES</th>
<th>EFFECT SIZES (from time 1)</th>
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<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
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<td>.28</td>
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<td>Borderline</td>
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<td>CLINICAL SYNDROME SCALES</td>
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<td>-.30</td>
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<td>Psychotic Thinking</td>
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<td>-.03</td>
<td>-.19</td>
<td>-.30</td>
<td>-.11</td>
</tr>
</tbody>
</table>

**Notes:**
1. ES calculated with pooled, weighted standard deviations.
2. ES *bold* = large effect size (> 0.80); *bold* = medium effect size (0.80 < d < 50); *italic* = small effect size (0.50 < d < 20)
Figure 11a: Sequential MCMI Personality Scales effect sizes (ES). All effect sizes calculated in reference to time 1 (see table 10)

Note. Scales noted in bold refer to clinically significant time 1 mean scores (ie. mean >70)
Figure 11b: Sequential MCMCI Personality Disorder Scales effect sizes (ES). All effect sizes calculated in reference to time 1 (see table 10).

Note: Scales noted in bold refer to clinically significant time 1 mean scores (ie. mean >70)
Figure 11c: Sequential MCMI Clinical Syndrome Scales effect sizes (ES). All effect sizes calculated in reference to time 1 (see table 10)

Note. Scales noted in bold refer to clinically significant time 1 mean scores (ie. mean >70)
STUDIES 1 & 2
DISCUSSION and CONCLUSIONS

SEQUELAE ASSOCIATED WITH DIFFERENT CHILD ABUSE HISTORIES

Comparisons of the four groups suggest that the depressed women with childhood sexual and/or physical abuse histories differ significantly from those without, both in terms of clinical sequelae and more global adult functioning. Consistent with theoretical expectations, it also seems that the severity of childhood abuse is paralleled by the severity of adult sequelae. Further, it would appear that the experience of child sexual abuse is more destructive over the long term than that of physical abuse.

Clinical sequelae

The presenting profile of women suffering from depression, anxiety and somatic problems is a familiar one to most mental health workers. However, effective treatment is manifestly enhanced by also understanding the etiology and recurrent nature of these difficulties. Robust individuals with "reactive" depressions generally require less intensive work to restore them to normal functioning than do more seriously impaired and needy individuals. Unfortunately, the goal of merely restoring the client to previous "normal" functioning is less than adequate for those who have never yet been able to function well, or "normally", in the world. Thus, the ability to identify those clients whose childhood histories provide a powerful etiologic component within their current clinical presentation would be strongly helpful. Rather than writing such clients off as "mixed personality disorders" or "borderlines", it would be more effective, and humane, to associate their specific personality patterns with the legitimate childhood abuse coping mechanisms that may have become incorporated into their adult functioning – adaptations which are now maladaptive and costly for the individual.

Despite the small sample sizes involved in the present study, and the controversies surrounding the MCMI (see review by Dana & Cantrell, 1988), the results suggest that the MCMI personality pattern and personality disorder scales may provide a useful screen to indicate the presence of an abuse history in depressed women clients. Although all four groups presented with similar clinical syndrome symptoms (i.e., depression, anxiety, and
somatization), and were differentiated only in terms of symptom severity, the MCMI personality patterns and disorder scales provided the best discriminators between those with a childhood abuse history and those without. The non-abused group showed no personality pathology, and appeared to be a fairly robust set of individuals who were temporarily overwhelmed by immediate crises and life stressors. In contrast, those who had undergone development within an abusive environment seemed to bear long-lasting effects in terms of personality formation and adjustment. Characteristic adjustment differences are also evidenced in terms of the particular kinds of abuse suffered.

The physically abused women were least "pathological" and had taken on a passive-aggressive response to their world, with significant borderline features. Strong avoidant and dependent adjustments were shown by the sexually abused women, in association with their passive-aggressive and borderline features. As previously discussed, sexually abused children are generally in a physically inescapable situation, and the coping strategies of denial and avoidance are often fundamental to survival - adaptations which appear to persist and to have become incorporated into the adult's personality structure. Sexually abused children who are additionally not protected, also fail to have their legitimate needs met for parental nurturance, caretaking and safety. Thus, the high scores on the dependency scale suggest that such nurturant needs persist as a core feature of the individual's interactions with others. Women who had grown up within the most overwhelming and destructive environment of physical and sexual abuse had had to make the most crippling adjustments simply in order to survive. In addition to high levels on the dependent, avoidant and passive-aggressive scales, these women also showed clinical elevations on the schizoid scale - indicative of a more profound need to separate themselves from their experienced reality. These women also provided the highest clinical level scores on the borderline personality scale.

Thus, in terms of personality development and adjustment, the three groups of abused women were differentiated both by specific maladaptive personality characteristics and pathology as well as by their degree of severity. This suggests a more general potential use of the MCMI personality scales as a screening and predictive tool in the assessment of depressed women clients, with respect to the possible presence of a child abuse history. The presence/absence of clinical score levels on five of the personality pattern and disorder scales appear to differentiate clients with respect to specific types of child abuse histories (Table 20). Notably, similar MCMI-based findings have been reported in a small group of psychiatric inpatients with childhood histories of: sexual abuse, sexual together with physical abuse, and no
abuse (Bryer et al., 1987). Clearly, investigations with larger sample sizes need to be undertaken to test these suggestive yet theoretically plausible findings.

**CHIL D ABUSE HISTORY**

<table>
<thead>
<tr>
<th>MCMI SCALE</th>
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<th>Physical abuse</th>
<th>Sexual Abuse</th>
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<td>-</td>
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<tr>
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<tr>
<td>Borderline</td>
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</table>

Table 20. Suggested personality scale profile differentiation of depressed women clients in terms of childhood abuse histories. (* indicates clinical level scale score)

**Adult functioning**

The life milieu of each of the four groups appears to differentiate sharply between those with and without abuse histories. The non-abused women were, generally, employed members of the middle class with at least a high school education. Few had experienced physical abuse as adults, and adult sexual abuse in this category was rare. This portrait provides a stark contrast with the grim circumstances of the abused individuals, who were characteristically unemployed, poor, under-educated women, who had also experienced abuse as adults. As with the clinical picture, the situation was bleakest overall, for the dual abuse survivors (i.e., sexual and physical abuse), followed by the sexual abuse survivors, and lastly, by the physical abuse survivors. Thus, at the worst extreme, the dual abuse survivors had overwhelmingly experienced spousal battery and adult rape, had made previous suicide attempts, lived in poverty and were dependent on social assistance and/or a spouse. Although still grim, the circumstances of the physical abuse survivors differed from those of the dual abuse group primarily in terms of lesser risk for adult battery and rape, suicide attempts, and dependence on social assistance and/or a spouse in order to maintain themselves in poverty. The sexual abuse group fell about midway between the two extremes.

Thus, the social and economic environments within which abused women live provide extremely high levels of everyday stressors which would represent a serious challenge even for
a healthy, psychologically robust individual. Given the psychologically compromised state of these women, one finds it remarkable that they function as well as they do. However, the life circumstance profiles of these women certainly mirror identified child abuse (physical and sexual) risk criteria (Finkelhor, 1980; Finkelhor & Baron, 1986; Green, 1988; Ubrich & Huber, 1981; Walker, 1984), clearly putting these women’s children at high risk for abuse themselves. Thus, effective treatment for these women must be embedded within an overall context of care, both for them and for their families. Reporting is frequently required, and it is vital to link each woman to the relevant supportive social agencies and programs available in the community. Generally, it is necessary to help stabilize the woman’s external living situation prior to any significant work on her internal issues – an individual coping with chaos and despair on a daily basis cannot be expected to give her full energies to her own healing.

THERAPY COMPLETERs VS. THERAPY DROPOUTS

Comparison of these two groups suggests that, while both suffered extreme levels of childhood physical and sexual abuse, the women in the dropout group experienced more specific and localized abuse within their families of origin. Further, while the adult abuse histories of both groups demonstrated a continuity of victimization and abuse, the dropout group appeared to be more solidly embedded within current abusive relationships, and with less apparent capacity to extricate themselves from their overwhelming problems. Paradoxically, while the clinical profiles were similar, the completers appeared more globally pathological at therapy onset.

Childhood abuse histories

While the childhood histories of both groups were characterized by extreme levels of sexual and physical abuse, only two characteristics appeared to differentiate between them. A generalized portrait emerged of the dropouts as having been both physically and sexually abused almost exclusively within the family and by a single perpetrator who was generally a father-figure. This contrasted with the completer group who were more likely to have been sexually abused by numbers of offenders (including father-figures) both within and outside the family, in addition to having been physically abused at home.

In terms of the possible impact of these differential histories on therapy readiness, it may be that the pressure of maintaining the secrecy, and "keeping up the front" had been more
successful for the dropouts, in that they had avoided extrafamilial child sexual abuse. Thus, it may have been more difficult for them to contemplate the "coming out" implicit in therapy. However, it was the writer's impression that a high proportion of the dropouts were currently involved in abusive spousal relationships, in which the men were hostile to the women's participation in therapy. Thus, those women's current levels of danger, as well as their inability to conceive of safety, seemed the primary reasons for their dropping out of the therapy program.

Adult functioning

The majority of the women in both groups were in their early thirties, living in poverty, with two dependent children. Most had sought mental health services in the past and the majority had made previous suicide attempts. The adult histories of both groups featured extreme levels of violence and abuse – over 80% had been battered, and over 87% had been raped – and the greatest proportion of their assaults had been perpetrated by husbands and/or boyfriends.

The biggest difference between the two groups seemed to be their current embeddedness in an abusive relationship and their relative potential ability to extricate themselves from it. Although members of both groups were generally unemployed at the time they entered therapy, the completers were much more likely to have completed high school and to have some kind of employment history. While only about half the completers were living with a spousal other, most of the dropouts were living in such a relationship. Thus, the dropouts were generally dependent on abusive spouses and, given their lack of education and work experience, had few realistic alternatives. Although data could not officially be gathered, many of the women who dropped out let it be known that their husbands were hostile to their participation in therapy.

Clinical profiles

Although the MCMI peak profiles were similar for both groups, the completer group were more pathological overall – particularly in terms of the personality organization as shown by the personality scales. Completers showed clinically significant means on the schizoid, avoidant, dependent and passive-aggressive scales; while the dropouts showed such clinical means only on the avoidant and passive-aggressive scales. Notable also were the comparative elevations on the narcissistic and antisocial scales for the dropouts. Both groups provided clinical levels on the borderline personality disorder scale, and both showed similar clinical
syndrome pictures with clinical level elevations on the anxiety, somatization and depression scales.

Thus, while both groups showed similar presenting problems of depression and anxiety, the underlying personality organization and structure appear to have differed. The dropouts' personality profile looks less trusting, more self-involved, and angrier with more acting-out, compared with the completers who were initially more isolated, dependent and in greater overall distress. Given what we know about the contemporary living conditions of the dropouts — their levels of dependency on abusive spouses and their lack of realistic options — the personality profiles appear as legitimate adaptive consequences of their past and present realities.

In order for therapy to be successful with clients such as those in the dropout group, it would seem essential that concerted effort be directed toward resolving their current abusive situations. It is the writer's observation that only after these women and their children were safe would they be likely to successfully enter treatment. Abuse begets abuse. Thus, as adults, a high proportion of these women were currently existing within violent, disadvantaged, and economically marginal conditions — with all the predictable consequences for their children. It is clear that, ultimately, coping with the legacies of abuse necessitates intervention over a wide range of social, economic and health-care domains. Before tackling therapy directed at their abuse histories and consequent sequela, these women need adequate access to women's shelters, educational upgrading, job-training programs, quality daycare, livable levels of social assistance payments, child support workers, etc. for effective psychotherapy to become a reality.

THERAPY PROCESS & OUTCOME

Clinical issues

The Life Review Integration Therapy (LRIT) program, as offered by the writer, appears to provide a highly effective group therapy intervention for use with severely clinically impaired, socially disadvantaged women survivors of childhood sexual abuse. As discussed previously, the group members generally had long-standing histories of recurrent depression, suicide attempts, and repeated contact with mental health services. The majority lived in poverty, and were unemployed mothers with adult histories of rape and spousal battery. Upon entering therapy, most met DSM III-R Axis I criteria for major depression and anxiety spectrum disorders, as well as Axis II criteria for Borderline Personality Disorder, together with mixed
personality disorder patterns involving prominent schizoid, avoidant, dependent and passive-aggressive features (all confirmed by MCMI test results). At the end of the six month intensive weekly therapy, all MCMI score means had retreated to subclinical levels, where they remained at the six month follow-up point. The success of this group psychotherapy program provides two challenges, in particular, to our previous understandings: both of this population, and of the type of therapy necessary for child sexual abuse survivors. Firstly, it has been shown that members of a particularly psychologically impaired and socially disadvantaged population may be effectively and economically assisted toward psychological health and social mobility. Secondly, the research suggests that group psychotherapy, alone, can achieve the therapeutic goals previously considered possible only through long-term individual therapy with group therapy employed in an adjunctive role.

Within the first phase of the program, members experienced the process of discovering, labelling, and disclosing their painful abuse histories within a context of validation and acceptance. This allowed the women to begin letting go of their avoidant and embattled defenses and began to reduce their sense of helplessness, isolation and shame. Thus, concomitant shifts downward were demonstrated on the relevant MCMI personality scales (i.e., avoidant, passive-aggressive, dependent, schizoid, borderline), to the extent that the schizoid and passive-aggressive scale means were reduced to subclinical levels. Significant symptomatic improvement occurred over this early period, although scale score means for the anxiety, somatization and depression scales did remain at clinical levels. The subsequent working-through phase of the program addressed the issues arising from the members' abuse histories. This process permitted the women to jettison previous views of themselves as unworthy, shameful victims so that they were able, even further, to let go of their old and painful defenses. This was clearly evident in the reduction to subclinical levels of mean scores on all the personality scales. The clinical symptom picture also continued to improve, such that only the anxiety and depression scale means remained just above the clinical level. By the end of the third phase in intensive treatment (at the six month point), group means were subclinical on all personality and clinical syndrome scales. All scale score means remained subclinical at the three month and six month follow-up points.

Two major psychotherapy process issues arise from these findings. Firstly, it would appear that internal structural change (as measured by the MCMI personality pattern and disorder scales) preceded and facilitated symptomatic change. Secondly, the results call into question assumptions regarding the stability and enduring nature of personality disorders –
particularly borderline personality disorder. The evidence provided by this study supports the view that borderline presentations among survivors of childhood trauma should be viewed as part of a set of developmental adaptations to overwhelming circumstances. These adaptations have necessarily been incorporated into the woman's adult functioning, and have generally remained "appropriate", given survivors' vulnerability to ongoing victimization as adults. When considered in this light, personality adjustment and functioning may be seen as just one more aspect of Briere's (Briere, 1989; Briere & Runz, 1988a, 1988c) "post sexual abuse trauma" response. Thus, dealing with the basis and origin of the (mal)adaptations is fundamental to resolving the secondary elaborations. This observation cycles back to the first issue, that of internal personality shifts as necessary precursors to symptomatic improvement. As discussed in chapter four, Belenky and her colleagues (1986) have provided a compelling model of women's epistemological and cognitive development which appears to mirror the transitions experienced by the women in therapy - from an initial position of "silence" through the acquisition of a language and ability to label their experience, to a state in which they are able to engage in abstract and reflective thought regarding their experiences. Having reached this point, survivors are then able to move past their isolation, and are then able to begin processing their experience. Clearly, an extremely interesting avenue for future psychotherapy process research is suggested by the theoretical implications of Belenky's work as applied to abuse survivors.

At a more global level, the field's traditional reliance on separate disorder-by-disorder constructs is called into question. "The depression", or "the eating disorder", or "the personality disorder", may not be the problem - instead, they may be legitimate alternative manifestations of the real problem - the individual's traumatic and painful experience of herself and her world. Recall that, as a society, we carry an extremely high load of child abuse and neglect. When 40% of women have been sexually abused as children, and almost 30% have been victims of incest, should we be surprised by the high levels of "personality disorders", depression, anxiety, etc. found among women? Logical corollaries to this view include the need for rethinking treatment provisions for these "difficult" clients. Rather than applying repeated doses of symptomatic treatment, it would seem imperative that we address the underlying issues of childhood abuse and trauma. And, as previously discussed, given the continuity of the abuse cycle, this also mandates the provision of treatment within an overall social services safety net.

**Research issues**
The results of this study recommend the MCMI as a useful, standardized, DSM III-R referenced test for repeated measurement of client status. The instrument has the advantage of tapping into both Axis I and Axis II dimensions, thus allowing for monitoring of internal structural change in addition to change in symptomatic clinical syndromes. Client resistance to the test was low, and it seems sensitive enough to discriminate usefully between groups and within groups over time.

Given the very early stage of empirically based research into treatment modalities for adult survivors of child sexual abuse, it seems imperative that practitioners attempt to incorporate a research component into their clinical practice. Whether it be aggregates of data derived from single case studies, or data derived from group treatment, the field needs to begin accumulating comparable therapy process-outcome data. Quite apart from the clinical measures such as those provided by the MCMI, it would seem appropriate also to incorporate more direct measures of functional adequacy. Most of the group members in this study, for example, moved on from their status as welfare moms to become employed, or to enter educational and job skill programs. In future, it would be helpful to gather such data as the basis for cost-benefit analyses regarding the advantages of providing treatment to such populations.

In terms of the research presented, follow-up studies by different therapists are needed. Also, comparative studies of women in individual therapy would be useful. More finely detailed intake data regarding characteristics of the family of origin and characteristics of all forms of child abuse suffered would also be recommended for future studies. Among the questions confronting the field are:

1. What intake profile is most likely to profit from individual vs group therapy?
2. How do this, and other group programs compare with long-term individual therapy for similar clients?
3. What is the cost-effectiveness of providing therapy for adult survivors? (i.e., for women such as those in this study who were largely dependent upon social services prior to therapy, but who moved into further education and employment and therapy).
4. What are the characteristics of those who do best in therapy, and those who do most poorly?
5. How important is the follow-up protocol and the survivor support group?
6. Would this program be equally effective with less clinically and socially impaired women?
7. What is the effect of being on a substantial wait list for the program?
8. Could the program be more effective with those women fitting the profile of the dropout group, if preliminary work had been possible to stabilize their domestic situations?

9. What are the epistemological orientations and information processing capacities of survivors at intake, and how do these change over the course of therapy?

Doubtless, many other questions will occur to practitioners and researchers in the field, and may be addressed by future research arising from these and other studies.
Part III

THE THERAPY PROGRAM
III: LRIT Therapy Program

10

THE LIFE REVIEW INTEGRATION THERAPY (LRIT) PROGRAM

Life Review Integration Therapy (LRIT) is a standardized group psychotherapy program designed for child sexual abuse survivors. The following chapters are limited to the results of its use with adult women clients at a Canadian mental health center. Fifty-four women were referred to the program, and thirty-two completed it. As detailed in Part II, the women in the study possessed extensive and severe abuse histories and were extremely socially disadvantaged and clinically impaired. While the following provides a manual of the program as applied to the clients who participated in the research, it is, however, suggested that the demonstrated efficacy of the program with this highly impaired group argues for its utility also with less severely wounded women. This chapter provides a general orientation to the program and chapters 11 to 13 provide detailed examinations of the three phases within the program. Rather than restricting the material to that of the therapist's (writer's) observations, illustrative quotes from the women's journals have been used throughout. All the personal and place names have been changed to protect the identity of the women. The wording of the quotes remains unchanged from the original; although, when necessary, spelling corrections and minimal punctuation changes have been added to assist in readability. All quotations are presented in a sans serif typeface and any editorial explanatory notes within the body of a quote are in italic typeface.

GROUP COMPOSITION & STRUCTURE

Groups were composed of adult (i.e., over 18 years) women and were run by a single woman therapist (the writer). They were initially composed of 8 -12 members with the expectation of attrition to 5 - 10 member levels. The groups were closed, in that no new members were admitted after the first session and the group continued for a specified number of sessions. The groups were partially "programmatic" (Briere, 1989), in that the three major phases of the process had been defined: i.e., the emotional life history phase, the working through phase, and the integration phase. However, non-programmatic features are also present in terms of flexible and reflexive assignments of homework, and the clarification and discussion of issues in group.
Therapy Duration

Clinical Resources were (and are) extremely limited for child sexual abuse survivors, particularly for the economically and socially disadvantaged clients typically presenting at the mental health centers. Thus, the therapy program was not designed as an introductory or support group in association with other therapeutic resources, but to meet the very real need for a "one-shot" major clinical intervention, one which would move the client to a "well" and functional status. It was recognized that this would probably represent the client's only substantial interaction with the system. Therefore, weekly three hour sessions (with a 15 minute intermission/coffee break) were conducted for six months, with a diminishing schedule of follow-up sessions continuing over the subsequent six months. Some individual sessions were also scheduled, as needed, during the six month follow-up period.

Screening

In terms of the groups included in the research program, the only screening criteria were a known history of child sexual abuse and presentation at the mental health center for treatment of depression and other problems. Given the modest resources of the community, alternate referrals were not available. There was no restriction in terms of suicidality, substance abuse, or evidence of psychoticism. It was true however, that the first two issues were fairly characteristic of group members, along with other self-destructive behaviors such as self-mutilation and eating disorders. Many group members also met DSM III-R criteria for obsessive compulsive disorder, and for panic disorder. As part of the intake protocol, many of the members were referred to their physicians for medical management of their depression — a particularly important issue given the as much as five months wait list for treatment. Although not documented, it was our impression that the condition of many of the participants deteriorated over the waiting period. Thus, the groups included multi-symptomatic women experiencing very high levels of distress.

Concurrent Therapy

Although many clinicians recommend the provision of concurrent individual therapy for group members (e.g., Cole & Barney, 1987; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984), this option was unavailable in the study's community. Therapeutic resources are extremely limited, and provision of supportive individual therapy was simply not an option. However, results of the study suggest that members of the therapy dropout group, in particular,
were characterized by their current embeddedness in an abusive lifestyle. Accordingly, connecting group members with appropriate government and community agencies in order to stabilize their situation is probably an important precursor for effective therapy.

**Ground Rules**

Given the uneven level of injury and dysfunction found within groups, it was necessary to apply sufficient structure to the group process to ensure safety, and to avoid either monopolization of group attention or alienation of other members by any given client. Thus, the following ground rules were set out within the first two sessions.

1. **CONFIDENTIALITY** All information arising from discussions in group and the identity of group members would remain completely confidential. The women would not talk about each others’ stories outside the group. This fundamental safety net would be a touchstone for group members — women who had generally, and regularly, experienced violations at all levels.

2. **ATTENDANCE** Members would make every effort to attend all sessions over the six months of weekly intensive therapy, as well as over the scheduled sessions during the six-month follow-up.

3. **OUTSIDE CONTACT** No constraints would be placed on outside contact between group members, although issues regarding confidentiality, and the need to avoid forming subgroups would be discussed. Fifteen-minute coffee breaks in the middle of the three hour sessions would serve to facilitate an out-of-center group cohesion (most groups went on to act independently as support groups after the six month intensive portion of the program was over).

4. **HOMEWORK** Group members would commit themselves to maintaining their journals and doing their homework between sessions. This would facilitate their own sense of agency and industry as well as helping empower them as active participants in their own healing — rather than leaving them as passive recipients of "therapist magic" during sessions.

5. **AIR TIME** Sessions would be structured around members’ journal work over the previous week. Each member would read out her journal work without interruption, salient issues would be clarified and discussed, new homework would be assigned, and only then would the next member go through the same process. The last 30 to 45 minutes would be reserved for group discussion of salient issues. Thus, every member’s work would be heard, witnessed, respected and entered into the elaborating body of cumulative experience and understanding to be shared by the group members as a whole.
THERAPY CHARACTERISTICS

Session Structure

Both across sessions and within sessions, structure was seen as an important safety matrix for the participants, whose past and current lives were frequently chaotic and highly dysfunctional. The application of reliable and respectful limits facilitated the participant's progress through their own healing, and helped them to integrate those qualities into their own self-schemas.

Most groups began with a quick check around the group to see what kind of a week members had had. This served to alert both the therapist and other group members to any particular distress being experienced by a member. Following this "checking in", each group member took her turn reading out her journal work for the previous week (about 15 minutes each, on average). She was not interrupted during this, and all members focussed respectfully on her narration. Following each reading, salient issues were discussed, insights were highlighted and the member and the therapist agreed upon the member's next journal homework. In this way, each group member participated in the session, and about 30 minutes at the end of the session was reserved for group discussion and a recapping of major themes and issues that had arisen during session. The fifteen-minute half-time intermission not only served as a coffee and washroom break, but also had other important functions. In terms of the emotional tone of sessions, the introductory checking-in was generally relatively mild, but during the journal readings the sessions frequently became intense. Emotions were expressed not only by the particular reader, but also frequently and non-verbally by other members who resonated with the content of that reader's work. The half-time break, therefore, also provided a necessary punctuation and release of intensity, which permitted members to come back and work for the last half of the session. The group summing-up and recapping at the end of session allowed for a kind of closure on a generally intense and painful three hours. As the therapy program unfolded, the range of affect widened. Initially, the fear, pain, guilt and shame, which dominated the initial disclosure phase, broadened to include expression of anger, sadness, grief, and towards the midpoint, considerable humor. By the final two months of the program, tears and laughter were almost equally represented.
Homework

Homework consisted of historical and issue-related journal work as well as the completion of two self-monitoring instruments: the Personal Projects Matrix (PPM) and the Daily Mood Chart. These self-reports served not only as indicators of ongoing client status, but also provided powerful individual feedback. Historically, most abuse survivors have had to devote their energies to observing the responses and actions of abusive others, and thus they remain virtually illiterate regarding their own internal landscapes. By getting survivors to attend to themselves both on a daily and weekly basis, they began to develop that internal language and awareness. They also came to see certain patterns, regularities and causalities among their own responses — knowledge which permitted them to begin making more adaptive moves. At a more symbolic level, survivors’ experience and lives had previously, in large part, been unseen, unacknowledged and undocumented — the documentation built into the LRIT program helps to give substance and value to their pasts, presents, and futures.

PERSONAL PROJECTS MATRICES (PPMs) The PPM (Figure 12) (Fisher, 1986; Little, 1972; 1983) is a weekly self-report measure which group members completed the evening before therapy. The PPM has particular appeal for work with survivors in that it uses the individual’s own subjective experience and interpretations as its sole referent, rather than appealing to external judgements of their functioning. Originally derived from Kelly’s (1955) personal construct theory and repertory grids, the PPM asks respondents to list the issues (projects) with which they had been involved with over the previous week. They are then asked to rate each of the projects in terms of: its importance, enjoyment, difficulty, long term importance to quality of life, and actual versus desired time demands. Respondents also classify each issue in terms of which of the ten life domain areas it falls within. However, no matter what the project, it is classified under the “emotional concern” life domain if it carries significant affective loading for the respondent. The PPM allows clients to assess many aspects of their current situation and responding. While initial reports generally reflect highly stressful, painful and unbuffered systems, as time proceeds, clients begin to effect positive and evident changes in their systems. The information provided by the PPM is definitional, personal, and meaningful to the respondent and gives them powerful feedback regarding their status and the changes they have made. Appendix C provides the detailed instruction set provided with the PPM to group members.
Name: ___________________________ Date: __________________

How would you describe your present state of health?

Low | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | High

How satisfied do you feel with your life right now?

Low | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | High

How depressed or happy do you feel right now?

Low | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | High

How close do you feel to your spouse or living partner right now?

Low | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | High

**LIFE DOMAINS**
1. Academic, Career, Job
2. Family
3. Home
4. Friends
5. Recreation
6. Health
7. Group Activities
8. Financial
9. Emotional Concerns
10. Self Improvement

**Personal Projects Matrix (PPM)**

<table>
<thead>
<tr>
<th>List of Projects</th>
<th>Importance (1-10)</th>
<th>Difficulty (1-10)</th>
<th>Importance to QoL (1-10)</th>
<th>Actual Time (% working that)</th>
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**Figure 12:** The Personal Projects Matrix (PPM) completed weekly by group participants.
**Figure 13.** Daily Mood Chart completed by group member and turned in at the end of the month.

**Note.** Mood state: 10 = high end, 0 = low end. Participants first noted the modal daily mood and then bracketed with best and worst mood experienced in the day.
MOOD CHARTS  The subjective mood chart (Figure 13) is completed at bedtime by each group member. The mood chart notes the dominant (modal) mood for the day, as well as the high and low for the day, and members are instructed to complete the graph in that sequence. Menstrual periods are noted along the base as are medications or other potentially mood-altering events. Participants are able to visually inspect a range of features pertaining to their temporal mood experiencing: mean mood fluctuations, variations in mood range, response to menstruation, response regarding therapy day, cyclic phenomena, and general improvement over the duration of therapy. Initially, most group member start with low average mood state and low mood lability, this rapidly changes with increased lability and elevated means. As they begin to master issues and make real improvements in their current functioning, the lability again decreases whereas modal levels continue to increase.

THE JOURNAL  Group members begin their journals after week two and continue working in them throughout the program (and after). Members are encouraged to find a time every day when they can be undisturbed and work in their journals. The women were provided with hardcover bound journals — "serious" recipients for their work. They were reassured that the journal work was not to be judged in terms of composition, spelling, etc., but was meant to provide an authentic repository for their thoughts and feelings. The journal serves not only as the vehicle by which the survivor finds her voice, but also as an important physical symbol: she needs to treat it with respect, to guard it against violation, and to find it a trustworthy recipient of her experience. It also serves as a cumulative store of her own accruing truths and emerging wisdom. Although many members initially had difficulty with their journals, they rapidly came to value them:

  "Funny how I feel about this book now. At first I didn't like it, it was a chore that had to be done. Now it's mine. This is me and I can't wait to write in it and nobody had better touch it. " (Jean)

  "Lately when I write it doesn't take too long before I have a sick feeling in my stomach. I think I must have felt like that a lot when I was little. " (Karen)

  "It's 12:30 at night and I know I won't be able to sleep. My journal seems to be a comforting place to come to when I need help. " (Chris)
The Three Phases of Therapy

Chapters 11 to 13 detail the three phases comprising the therapy program, and Table 20 provides an outline of the issues addressed in each of the phases. The initial "emotional life history" phase, occupying the first 8 to 9 weeks, was concerned with reconstructing the woman's life history in realistic terms that acknowledged her abuse and the overall family context within which it occurred. During the next "working through" phase (week 9 to 21), members worked on the issues arising from the first phase, while the third "integration" phase focussed on integrating the insights and understandings gained by members into their current functioning.
**LIFE REVIEW INTEGRATION THERAPY (LRIT)**

### Phase I: EMOTIONAL LIFE HISTORY

A. **The Family & Social Context**
   1. Parent's Relationship
   2. Family Violence
   3. Parental Neglect
   4. Relationship with Mother
   5. Relationship with father
   6. Sibling Relationships
   7. Child's Role as Caretaker
   8. Experience at School

B. **Childhood Sexual Abuse**
   1. Primary Offender
   2. Secondary & Multiple Offenders
   3. Pregnancy resultant from Abuse
   4. Injunctions to Secrecy
   5. Sexual Acting-out & Role as Abuser

C. **The Child's Self-Context**
   1. Anxiety & Terror
   2. Abandonment & Losses
   3. Child as Tormented
   4. Self as Different, bad & Unworthy

D. **The Child's Adaptations**
   1. Attempts to Escape
   2. Self-destructive Behaviors
   3. Suicide Attempts

E. **Moving Into Adulthood**
   1. Adolescent Sexual Relationships
   2. Marital and Dating Relationships
   3. Adult Victimization
   4. Role as Parent

### Phase II: WORKING THROUGH

A. **Confronting the Abusers**
   1. Father letter
   2. Mother Letter
   3. Other Abusers

B. **Intrapersonal Issues**
   1. Cognitive Issues:
      a. Family myths
      b. Awareness of the splitting
      c. The Flawed equations
      d. Recognition of the Tragedy in Their Lives
      e. Responsibility for Everything
      f. Physical vs Intellectual vs Emotional Attributes
   2. Affective Issues
      a. Guilt
      b. Fear
      c. Shame
      d. Anger
      e. Pain
      f. Grief & Sadness
   3. Self-Destructive Behaviors
   4. Self-Integration

C. **Interpersonal Issues**
   1. Continuity of Abusive Relationships
   2. Power & Control
   3. Betrayal
   4. Trust
   5. Intimacy

### Phase III: INTEGRATION & FOLLOW-UP

A. **Intrapersonal Issues**
   1. Changing Sources of Satisfaction
   2. What She has to Forgive Herself For
   3. Recognition of Accomplishments
   4. Permission to Fail
   5. Expectations
   6. Awareness of the Broader Context

B. **Interpersonal Issues**
   1. Coping With the Legacies of the Past
   2. Moving Forward as a Parent
   3. Future Relationships

C. **Anticipation of the Challenges Ahead**

D. **Personal Bill of Rights**

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**Table 20:** The three phases of the Life review Integration Therapy (LRIT) program.
PHASE I: EMOTIONAL LIFE HISTORY

The purpose of this first phase of therapy is to recapture and acknowledge the child's subjective reality. Necessarily, this process goes far beyond recall of specific instances of sexual abuse, but rather, embraces the more global family experience of the child at affective, cognitive and sensory levels. This phase occupies the first 9 weeks of the program — while allowing for some individual flexibility.

SESSION STRUCTURE

Session 1

In the first hour of the first session, group members and the therapist introduced themselves by first names, and the members briefly outlined their current life situations. The therapist discussed the basic demographics, dynamics and sequelae associated with childhood sexual abuse and laid out the ground rules pertaining to the therapy program (i.e., confidentiality, attendance, duration, participation, etc.) Special attention was directed to the issue of confidentiality and the requirement for reporting child abuse — many of the women had high risk children, and many of the original abusers continued to remain at risk for re-offending other children. Reporting was presented as a joint responsibility between the client and therapist, and was framed in terms of the need for advocacy both for themselves and for other children. Members were also provided with information regarding other pertinent community resources (e.g., Transition House, Family Resource Centre, Public Health Programs, etc.) After a 15-minute coffee break, the research component of the therapy program was discussed, informed consent was obtained (Appendix B), and members completed the first test battery. This occupied about one hour, and those who finished the testing early were encouraged to take a coffee break until hour three. During the last hour, group members completed their first Personal Projects Matrix (PPM) (Figure 12, Appendix C), and discussed the results, following which they were introduced to the Mood Chart (Figure 13). Finally, the first homework assignment, the future focus exercise, was given (Figure 14). This exercise asks the respondent to consider where they want to be in 5-10 years with respect to each of the 10 life
domain areas noted on the PPM, and how they rate those desires in terms of importance and difficulty. Members write their responses out on the exercise form. Clients are asked to bring in their weekly PPMs for each session, and to maintain their daily mood charts which are turned in monthly.

This first session contains a great deal of information and demands a good deal from the participants – having got through it, and learned so much about themselves within a safe environment, they leave with an enhanced commitment to the process. It is the sense of the writer that the high demand level of the first session is actually more effective in gaining commitment than would be a less demanding first session – perhaps this represents results congruent with "cognitive dissonance" theory (Festinger, 1957).

Sessions 2-9

During the second session each group member takes her turn reading out her future focus exercise. The results alert both the clients and the therapist to the individual’s ability to realistically foresee a future for herself. Frequently, clients have difficulty with this exercise and focus on what they expect their lives to look like in the future – generally a pretty bleak vision which is consistent with their past and present situations. The degree to which clients are able to extend their focus is also noteworthy and ranges from 6 months to the full 10 year span. This exercise usually generates discussion on such themes as: fear of the future; dependency on others’ actions; personal despair; distrust and hope. Group examination of these themes sets the stage for the next phase in the program – an examination of their emotional life histories. Members are encouraged to understand that their difficulties in future-focussing are consistent with the themes arising from their individual histories. Thus, the need for the next phase, which provides the raw materials for the longer term therapeutic process.

During the second half of the second session, members are introduced to the "emotional life review", and are provided with journals for homework writings. Participants are told that they need to start writing out their life stories, not from the perspective of the adult, but as they experienced them at the time. We do not want a "first we lived on Maple street, then we moved to Vine street" type of narrative. We want full subjective descriptions of their histories, beginning with their earliest memories and continuing to the present. Participants are reassured that memory is very much an unlayering process and that a strict temporal narrative is not necessary – a four-year-old memory can take them to a 12-year-old memory and back to an 8-
**FUTURE FOCUS EXERCISE**

<table>
<thead>
<tr>
<th>LIFE DOMAINS</th>
<th>Importance</th>
<th>Difficulty</th>
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<tbody>
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<td>1. Academic Career, Home</td>
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<td>2. Family</td>
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<td>10. Self-Improvement</td>
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**Domain Description:** Where would you like to be in 5-10 years in terms of each of the 10 above life domains? Please use the other side of this sheet and second sheets if necessary. Next, how important is it that you get there, and how difficult do you think it will be for you to get there?

**Figure 14.** The Future Focus Exercise. Participants write out descriptions of where they want to be in 5-10 years in terms of each of the 10 life domains. They then rate the desired descriptions in terms of how important that is to them and how difficult they think it would be to get there.
year-old one – they are asked to just relax and "go with it", and are told that there is no "right way".

When members return for the third session, the tension levels are usually extreme. Members read out their journal material one at a time, and then group discussion follows. The therapist takes brief notes during the journal reading, so that she is able both to chart the information flow, and to come back to themes during the discussion. In large groups it is difficult otherwise, for the therapist to retain the more nuanced information. This first disclosure session is frequently highly emotional, and participants often reveal information they have never before shared. After the cathartic outbursts typical of this session, members settle down to more controlled descriptions of their experience, although frequent highly-charged smaller episodes continue to occur. The group format acts as a particularly potent context for disclosure. Frequently, participants have never before revealed their abuse histories and are ashamed and guilty. The experience of witnessing mirror images of their own experiences acts as a powerful releaser and validation of their experience. The information revealed within these sessions provides the therapist with the material necessary for a fuller formulation of the individual cases. The themes revealed are noted and prioritized for investigation during the next phase of the program. The therapist's role during this phase is largely that of providing a language (labelling) and framework for the experiences shared by members. Thus, they are able to begin forming a more coherent sense of their lives and of the actions they have had to take.

SESSION CONTENT

As outlined in Table 20, the historical journal themes and content may be conceptualized within five major areas: the family and its social context; the actual childhood sexual abuse; the child's self-context; the adaptations made by the child; the experience of the survivor in adulthood. Needless to say these divisions are ones of convenience only, given the causal ebb and flow between them. However, much like map grids, they assist us in examining the issues and to prevent the survivors from becoming overwhelmed. The remainder of this chapter is devoted to the journal voices of the group members as they recalled their lives. Therapist commentary surrounding the quotations is intended to clarify some of the issues and the kinds of themes relevant for group discussion.
THE FAMILY AND SOCIAL CONTEXT

The family context within which the sexual abuse occurs is frequently characterized by profound levels of dysfunction. In this section the material is organized around the central themes of the parents’ interpersonal relationship, the experience of family violence, parental neglect of the child’s needs, the child’s relationship with mother, father, and siblings, the child’s frequent role as caretaker, and her experience of the school system. Needless to say, these themes are not separate and distinct, but interact and augment each other.

Parents’ relationship

The parents’ relationships were frequently characterized by early marriages, extramarital affairs and physical, emotional and verbal abuse.

My dad was married at 17 with three kids and divorced at 21 to be married to my mother—8 years and another three kids later. My ma was raped at 16, had Sandy, met my dad and the rest I’ve said. (Mary)

My parents fought an awful lot. I hated it when they fought, it really scared me. (Joyce)

I hated to see her (mother) cry. A lot of nights I would hear her in her room crying, while my dad would yell and hit her. I just wanted to burst in the room and kill my dad, but I was too scared to. I felt so sorry for her. All of us kids knew that he was having an affair with my mom’s best friend. We would listen in on their phone calls. When he talked to his girlfriend on the phone, he would talk about us kids sometimes, but he would never mention our names—he gave each of us a number like a code. He would also sneak out in the middle of the night to see her. My mom eventually found out but there was nothing she could do. (Paula)

He had different affairs and mom would pack us up and I was glad and so was Jill. When we got home from school they would be happy and she would say she would try again. I knew he was having affairs because the kids in the neighborhood knew about it. Also, their fights at night would be loud enough for us to hear....(Diane)

Family Violence

The child’s subjective experience of family violence was generally terrifying, and frequently experienced as life threatening. The family environment was often highly chaotic and unstable, and provided the child with little in the way of reality-testing anchors. Their experienced terror was rarely acknowledged and was, in fact, most often denied by their
parents' subsequent behavior. The terrorization within the household featured absolute power as father's prerogative (frequently backed up by invocations of "God's Laws"). Mother was generally experienced as also being one of father's victims, and therefore powerless to protect her children from father. Children learned never to question father's likelihood to make good his threats, and to take responsibility for their own abuse. Physical abuse was often shaming and humiliating and was generally accompanied by verbal-emotional abuse.

I wake up to loud noises - Mom comes in the bedroom we all shared and shuts the door. Dad throws every dish in the house against the bedroom door. I feel terrified, scared and exiled. Next morning I'm anxious and nervous - what will happen when they face each other, the floor is covered in broken glass - everything in the house is smashed, I feel that a terrible thing has happened. They act like nothing bad has happened - we go shopping for new dishes, they forget about the whole thing, but I don't. (Laura)

Here I am sitting in group listening to everyone else's background which is zapping memories into my head. I think I know why Christmas is depressing to me. It's because every year when we went visiting, Dad always threatened us. If we asked for anything or even moved off the chair, he would kick the shit out of us. He used to smash me in the back of the head. The threat worked on me because one time I did ask for a drink of water and I found out that what he says he means. (Ellen)

The first few times Dad threatened to shoot us I was terrified - I remember one time crouching behind a chesterfield chair and peeing my pants I was so scared. But it happened so often and he never fired it - I got less scared every time. (Laura)

My dad was a very strict and religious man. He always liked to make sure we knew who was boss in the family - and he reminded us every day. We couldn't do anything without asking him first - that included getting up in the morning and even going to the bathroom. The worst time of the day was always suppertime, because we all knew (5 of us kids) that we would get a strap afterwards. Most of the time we never knew why - we just got it anyhow. It was so quiet at the table, you could hear a pin drop. I would always have to sit beside my dad, and right behind him was the fridge, where the strap was kept on top of it. He would keep it in full view just so we could see it. He liked to think of it as our medicine for the day. It was a homemade strap that he made himself - a thick wooden stick about one and a half feet long with about four thick leather straps about that same length attached to the end. After supper we would all go out to the breezeway and we would have to line up. And then we would watch them all, one by one, get their strap and run crying to their rooms. I hated being the last one - I just wanted to hurry up and get it over with. It hurt so much. Sometimes when he came to our bedroom at night for us to say our prayers, he would start to cry and say "Daddy punishes you because he loves you". I wouldn't say anything - I would just wonder why I was strapped when I didn't do anything - but then, maybe I did do something bad, but just didn't know what it was. Maybe by strapping me, I would be a better person when I grew up.
After all, he was an adult, and he knew what was right from wrong more than I did. Maybe he really does love me. (Paula)

How do I remember things that just won't come. I keep trying to go back into time. Lisa (her older sister) getting strapped with that razor. I can remember running home so I wouldn't be late. Going through that back door. Seeing my dad hitting her over and over not even caring what part of her he hit. My mom in the kitchen not stopping him, just standing there. Both of them calling each other names. Her running out the door saying she was going to kill herself. The police looking, searching under the bridge. Just sitting in the chair. No questions, no answers. Always out of control. Never knowing what is to come. (Anna)

Another time I can remember my (severely mentally retarded) brother, Joey, throwing a couple of cushions from the couch into the fireplace and they were burning. George (the stepfather) was out of town and wouldn't be back for a few days, and I recall knowing when he did get back he would be really angry. I was right. It was really late at night when he came back and he started beating mom. Then he went downstairs and dragged Joey out of bed and started whipping him with his belt. My two oldest brothers heard him and when he was finished with Joey he called them into the kitchen and started yelling at my sister and I to get out there as well. He wanted to know where we were, how come we weren't watching Joey and we tried to tell him we were all doing our chores, but it wasn't good enough. He was hitting whoever he could get his belt and fists on, and I had kind of hung back out of reach so he didn't get me. When he was just about finished beating on the other kids, he spotted me and grabbed me by the hair because I was hiding behind mom's chair. And mom managed to convince him to leave me alone so I got away that night with just a couple of welts and bruises. (Jean)

When we got spanked – not too often, but it was gross and disgusting – we would have to bend over and he'd hold our head between our knees and our bums would be up in the air. How humiliating. There wasn't much else that he could have done that would have been more humiliating. (Karen)

She (mother) was always calling us dummies, stupid asshole, animal, slut and pig, bitch, ungrateful dog, thick-heads, grab some brain, and a list of more. She always had other names too. Then she would tell us she loved us – bullshit. (Gail)

Parental Neglect

Parental neglect was a common feature among group members, and ranged from failing to meet basic food and shelter needs to placing the child in dangerous age-inappropriate situations.

I remember when we had to steal money from her (mother) purse, or turn the beer bottles in for money to get school lunches. Or just pretend to go home for lunch hour and sit down in the
ditch so the teacher wouldn’t find us. Couldn’t go home – mom was screwing boyfriends all the time. I remember that sometimes she was so drunk she would sleep in her throw up and piss, and make me dean it up when she finally got up. And said "you’re a pig, you can stay out of my room and not piss on my bed". The house or home – is that what you call them? If the health man came in he would throw us out and put a match to the place. She had a boyfriend with three boys about the same age as us. The boyfriend would come over and bring food. And she would let them eat and say "the girls have eaten". (Older sister) would break into the freezer or cupboards because mother had locks on them. But there was no lock that could keep (sister) out. She would make me eat some of the food so mom wouldn’t find out – or mother would think it was me and hit me for it. (Gail)

I remember when I had to go across the street to go to the store to buy some milk and bread, that’s all I can remember anyways. Anyhow, I made it to the store but I got hit by a car on Frontage road. I think I was four then. Oh now I remember I did something wrong so mom made me stand in the corner, then she told me to go to the store. Anyway, when I got hit by the car the ambulance came and brought me to the hospital. All I could remember is that I was so frightened because I was going to get in trouble by my parents for ruining the bread. I couldn’t stop shaking or crying. My brother still reminds me of what happened and its such a big joke to him. Anyways, when I got hit my brother started laughing and running around saying "she’s dead" and my sister was crying - so she got a popsicle and he wasn’t allowed. He got into trouble. But I did get in shit when I got home, but I expected that to happen. (Ellen)

Relationship with Mother

At best, abused daughters in the groups felt alienated and unseen by their mothers. At worst, mother was also experienced as another significant, malicious abuser. Daughters often assumed that mother was aware of the abuse and that mother’s failure to stop it implied approval.

I’m going to write about mom first. I don’t ever remember her hugging or kissing me or just even holding me. I was always afraid of her. She was always hollering at us and strapping us. Guess she was just one of those people that should never have had children. My fingers are going numb, but I’ll go on and see what happens. She always was very distant with me. I tried so hard for her to like me. I was always doing little jobs around the house to help her out but it never changed how she treated me. So I would try a little harder each time but to no avail. It seems as though I was always trying so hard for her to notice me and give me some nurturing. (Joyce)

Feel sad, so sad, for mother - she slapped and slapped my brother while bathing him in the sink. Later I overhear her talking and crying how she lost control and couldn’t stop hitting - says she called the S.P.C.A. to take my dog away and she had told me it ran away - could never let her know I knew what she had done. (Laura)
Mom nags at me every time I do something wrong, I feel so guilty. She nags and yells - I deliberately put a defiant look on my face, but inside I feel hurt and guilty. I hold back the tears and act like I don't care - which just makes her madder and then she really hurts me - saying things that make me feel awful and worthless and shamed. I cry inside. But I'm thinking - nobody is going to make me cry again. I'm not going to let you know how much you are getting to me - I'll defy you, I'll never show you I care. You can never make me show any emotion - every night I stay awake feeling guilty for hurting her. (Laura)

Why didn't mum say anything? She must have known something was going on. But then again she hated me too. She even told me so when I left home at 14. That was when dad was in the hospital having open heart surgery...Mum thought dad was going to die and that if he did it would all be my fault and I would pay for it. But I had hoped the son of a bitch would die. I didn't care anymore. I felt like telling everyone, but I couldn't - they wouldn't believe me anyway. (Ellen)

Mum and I are as close as can be as long as she's not drinking. She was molested as a child by her uncle, bastard....(Mary)

One thing that I have often wished is that me and my mom could be closer. She has never been the type to sit down and talk with you about life, even if something was bothering you. She would rather not talk about a problem and just hope it goes away. It bothers me a lot, but I don't blame her for being that way. When we lived with my dad, he didn't allow her to get close to us kids. If we were crying or something, she wasn't allowed to help us. He did not want us to love her - he just wanted us to respect and love him. I guess when I was young I didn't really understand the way my mom was. When my dad would strap us, she would just stand there and watch or just walk away. I would just look at her and wish she would say something or tell my dad to stop, but she wouldn't. I would wonder if she really cared. But, then, I guess she couldn't do anything or my dad would hit her... I think of my mom and I feel that I needed and longed for some acknowledgement of love from her. Where was she when I sat in my room and cried alone - where was she when the wall went up. I tried so hard for her to notice me - to just talk to me. I would get straight As at school - I would spend the whole day cleaning up the house to surprise her when she came home from work, and half the time she didn't even notice - it seemed all in vain. (Paula)

Like many survivors, Diane possessed an exquisite sensitivity to the appearance of "normality".

I resented mom's time in the garden. She wore her uniform or old pants and dad's shirt. I always wished she would wear house dresses and aprons like my friend's moms. If my friends saw her in her nurses uniform, I was proud. If she was in her work clothes with men's boots on, I felt ashamed of her appearance. This is hard to think about as I feel ashamed as she worked so hard for us always. (Diane)
Relationship with Father

A father-figure was the primary offender for most of the group members. Their recollections consistently described violent, authoritarian tyrants who were emotionally absent, enforced social isolation, and were often experienced as potentially lethal. In many cases, the birthfather had abandoned the family and the daughter was offended by the subsequent stepfather. These daughter often fantasized about how things would have been different if their "real" father had stayed. Issues of loss, abandonment, isolation and terror were prototypic.

The trouble with trying to feel anything is that I cry and I never knew a person could have so many tears. How did I feel when my dad held me underwater? I thought he hated me. I can remember choking on the water. Not being able to get away. My head hurt and I didn't understand why he always had to hurt. I can't ever remember him telling me I was good. He's my dad, he should like to be with me. I wish I could remember some good times. Oh God, it hurts so much to try and remember. When I try and write things down my head starts spinning. (Anna)

Our stepfather told us often how strictly he had been raised. He always used the phrase "children are to be seen and not heard from". We were not allowed to speak at the table, our meal was to be completely finished and if we had a dislike he would force feed us himself. When he came home from work each day he would ask mom how Many and I had been. If mom complained that Harry and I had been arguing he would order us each to our room. He would tell us to pull our pants down and lay on our beds. While I waited for him to come in I would wonder why he was so cruel, if his father had done the same to him. Why would he do this to us? He would always come to my room first, then to Harry's. Whatever the number of times I was strapped, Harry would get double and twice as hard. I could tell by the sound of his belt as it hit. (Chris)

No one stayed over at our house as we were afraid to have them. We told them our dad had problems because of the war. All our friends were quiet around him if they came over to play. They told me when I was older they were afraid of him. He swore about everything and I was so embarrassed. He said the f-word in front of our friends. In those days it was totally ugly. My sister and I hated him for that. He called me a little whore and I didn't even know at that time what he meant. he called me other ugly names. I tried not to be alone with him ever. (Diane)

My dad was not around — he lived in the house but any chance he got, he would retreat to his workroom that was always locked. I only remember, ever in my whole childhood, being in that room twice. It was fascinating but I just wanted to be with him, a part of what he was doing. He locked us all out. I hate that he did that. Why? (Karen)

Let me tell you the whole story. My real mother and real father were married in Mexico. My father divorced his first wife down there and married my mother. So living in the USA or Canada doesn't make it legal up here. So when the ex-wife found out when they were back from Mexico,
she threatened to have my father thrown in jail. But he didn't listen. Then things got worse. He went to Australia to find work. When he got back from there I was his only legal daughter so he put me as his only heir to his life insurance. Then he tried to kill mother and himself. But mother asked the police to come and get him. When they did they put him in the drunk tank in (the city). And he asked to talk to his brother. But the police held his brother back. His brother said that he had done this before and that my father was planning to kill himself. The police said "bullshit, he can't in there". Within 10 minutes he had ripped sheets and hung himself. Most of the time I feel that's why mother hits me more – because she couldn't get the money because she was not his real wife in Canada. But I was his real daughter by law. I never wanted to talk about him. I was mad he was not my father – the bastard didn't watch me grow up. He never loved me. Asshole. Just couldn't stay alive. Never let mother say anything about him. I was so damn mad at my mother for telling me too. And what a bitch she was. She was drunk when she told me. I can't remember how old I was when she told me. (Gail)

Sibling Relationships

Members frequently recalled their extreme sense of helplessness, responsibility and guilt over their inability to protect younger siblings from abuse (physical, sexual, and emotional). Clients often felt guilty also for not supporting the attempts of younger siblings to escape from the abuse.

On the way home my brother was cleaning the windows while dad was driving. The spray got in my other brother's eye. I knew it was an accident, but dad pulled the car over. He pulled Bobby out of the car and started shaking him. Bobby just kept saying "I didn't mean to" over and over again. Then dad started smacking him. I asked mom to stop him and she said "it's no use". I sat there crying wishing I could stop him, but was scared if I got out of the car he would beat me too. (Anna)

When I was six my mom remarried. Harry would have been four. What I can remember of the marriage seemed to be quite happy. Our new step-father accepted me quite well, but not Harry. My brother by this time had become quite a troublesome child. My memories are not good ones as my brother was strapped on a regular basis by our step-father. He used his leather belt which left scars on my brother. I remember Harry screaming for him to stop and my mom doing nothing. Never stopping my step-father and never comforting Harry when it was over. (Chris)

I cried and cried when I learned he (sexually abusing older brother) had gone to my (younger) sister. I felt so responsible. If only I would have told someone then he would have been stopped before he could've touched my sister and abused her. I had allowed it to happen by keeping my mouth shut. I felt more guilt and responsibility. I've never - no. I don't ever remember - feeling close to my sister from that point on. I felt like a failure. I had tried so hard and wanted to protect her and I had failed. The wall that I had started when I was 8 went a little higher and I fell deeper into my guilt and shame. (Joyce)
I'm remembering so many things he (father) did to me, but to write them down is another story. He's still alive, and my ma, I think, doesn't know. Yah, she does because my younger sister spilled the beans but I denied everything so she was labelled a liar and has been on her own since 13. Poor thing, I feel so guilty for all the trauma she had to deal with. But she dealt with it since day one and copes with life fairly good. Dad thinks it's all a joke, even says she enjoyed it – bastard. (Mary)

Client's relationships with older sisters were often characterized by admiration toward the older daughter for leaving and resentment and despair around being left as the target of the father-offender. In some case, older sisters also acted out their distress on the client, thus adding to the client's multiple victimization.

I remember my oldest sister, Dianne, running away. George went after her but he couldn't get her to come back. He was furious of course, and lit a fire in the fireplace. Then he made all the rest of us watch while he burned all her things one by one. As he did this, he ranted and raved at us about her being a slut and that he'd kill us if we tried a stunt like that. Now I was alone in my bedroom and he took advantage of that as often as he could. Seems like he was at me just about every night then. Dianne was working by that time and he made her give him most of her money. Between that and the beatings, I guess I don't blame her for getting out when she could. But at the time I was angry with her for leaving. (Jean)

I remember that my older sister would do strange things to me like hang me upside down out a window. And say if I told mother she would stuff pepper up my ass. Then I tried to tell my mother and she just laughed. (Gail)

Brothers were often experienced as dangerous younger versions of the father-offender, and, in some cases, also offended the client.

My brother is a mean son of bitch. I remember this mentally retarded kid used to come over. He was an okay kid with problems. He used to make us laugh. My brother would make him drink out of the sewer ditches. He would tell him to go into the house and sing to our parents. My brother would get him to eat bugs and say they were good for him so he would. Gross pig. My brother used to beat me up all of the time in front of his friends and get me crying. I finally sprouted up past him but he still thought he was so tough. He's just like my father. Puke! Finally I lost my temper and beat the shit right out of him in front of his friends. (Ellen)
Child's Role as Caretaker

From very young ages, survivors were often placed in the role of major family caretaker. This tended to take either the form of an abused quasi-wife "Cinderalla" role, or the role of valued confidant, protector and servant of the parent.

I think when I was younger my parents made me make supper after school. Then I had to clear the table and do the dishes. Then I had to do homework until it was time for bed. I've always thought that all they had me for was to be a slave. (Ellen)

I don't remember my mother being pregnant with my youngest brother. Dad took her to the hospital and came home and told us that we had a new little brother. My sister and I were disappointed, we wanted a girl to even things up. When they came home from the hospital he became my real live doll. I cared for all of his needs when I was home. While they were in the hospital I kept the house clean and cooked the meals, baked, did the laundry – just a regular little Suzie Homemaker, at 10 weeks from being 8 years old... I cared for my brother and sister always looking out for them and doing their chores so they wouldn't get in trouble. (Joyce)

Ma and (sister) never got along, they always fought. I got along with her. they all called me "mama's angel". But I was a good kid. I did my chores, not always but (the other two sisters) always bitched about it and I just did it so I'd save the hassle. Mom and dad could be so bitchy when they were drunk and sometimes give us the world on a silver platter. (Mary)

Chris was about 10 years old when her mother and stepfather separated. Mother depended on her for one year before remarrying another highly abusive man, and abandoning her daughter again. Chris remember this one year as one of the happiest times in her life.

It was about one year after Harry (younger brother) left that mom and my stepfather were separated. My mom was devastated to learn that Jim had been having an affair with a woman he worked with. The months before he left were shattering. Jim would come home from work each day, spruce up, and leave to spend the nights with the other woman. My mom clung to me for comfort. We began to sleep together and each night she would cry herself to sleep hugging me. Their young son, Tim, who was only five, was at my side always. His mom was falling apart and his dad no longer had time for him. After Jim finally left we were an incredible family. We had weathered a storm together and became so close for it. Mom went back to work full time and I took on the household responsibilities. I prepared the evening meals each night and was so excited for mom to come home to see that I had done. We had wonderful weekends shopping, a visit to Grandma's and spending time together. Every Sunday night I would go to bed so unhappy that the weekend was over – already missing Mom as she had to go back to work the next day. We had such a wonderful year together. I had grown to love my Mom and brother so much. (Chris)
The child was often also put in the position of protecting the abusive parents from the adult world outside the home:

The next thing I remember is waking up late one night to someone banging on the front door. I got up and went to answer the door to an R.C.M.P. officer. He was furious and asked me when my parents got home. So, I told him I had no idea. He got even angrier then, and shouted at me to go and wake them up. So I tried, but they were both passed out and I couldn't get them up. When I told him this he started to leave, but mom had gotten up. She was so drunk she couldn't even talk so the cop gave up and left. I was so angry with her and disgusted that I told her to go to bed and went back myself. But I couldn't sleep because the cop said mom had run into somebody. (Jean)

Even as adults, survivors went to great lengths to protect their parents - even at risk to their own children.

When Joey was six months old, Glen (her physically and emotionally abusive husband) still had no job. He bitched because I was working and he had to look after the boys. I finally had the guts to tell him to get out. That we were finished. He started packing. My dad found out that we were breaking up and rushed right over. He gave Glen a severe scolding then turned to me and said "don't worry now Judy - he'll smarten up". That was the summer we found out that dad had cancer. He'd probably die. I couldn't cross him. I let him believe he had done a good thing. (Judy)

Experience of School

Few survivors recalled their school years with pleasure. For most, their recollections were characterized by a sense of isolation, loneliness, inadequacy and the feeling of being tormented and unworthy outcasts. These problems were augmented by the frequent moves and instability experienced by many of the clients.

Feelings of aloneness - being different from other kids - day dream - play alone. Another school (the third) in grade 2 - hated that school. When I was late (often) stood outside in the hall terrified of opening my classroom door - felt shy and insecure. (Laura)

All through school I was the kid who was either at the farthest corner of the classroom, or at the desk at the front, as close as possible under the teacher's nose. These were not my choice. It was really the shits. I guess the position in the class was determined by the commitment of the teacher. Some thought they could help - most didn't give a damn and couldn't be bothered to try. In elementary school there were some who really cared and those were easier years. But I never felt I belonged in school. (Karen)
All those people from school – I remember them all. I can see myself now, sitting in my desk. I never want to sit in another classroom again. I hated it. Who was it that said your school years are the best years of your life and that you'll miss them when you're gone? Well, I may remember them, but I don't miss them. I think the worst part of school was the lunch hour because I had to try to fit in and socialize with the other kids. Sometimes I would just take off by myself and hide until it was over. You never seen a kid who was so happy when lunch was over. I've always felt more comfortable around adults than around people my own age. To me, kids have always seemed so cold and cruel. They always have to test you, to see if they'll accept you into their little clan. You never know where you're at or what they're saying about you behind your back. Adults, on the other hand, are more direct and tell you – if they want you to do something, they tell you. I'd rather have someone yell at me, than sit there and ignore me. I guess it's easier when someone orders me around than to be stuck with making my own decisions. Yet I hate it and get defensive when people tell me what to do. (Paula)

I remember being outcast at school at this point. The kids made fun of my hearing-aid and the fact that I wore a bra, I developed quite early and was the first girl in my age group to need one. I used to try and sneak off without both the hearing aid and the bra. I hated them both! Unfortunately, mom caught me 9 times out of 10 and I'd go to school in tears. (Jean)

It was not uncommon for survivors to report abuse arising from teachers:

I remember in grade one the teacher asked me to read the black board, but I didn't know how. She kept me in at lunch and made me read the board. I told her I couldn't. She called me "dumb, lazy, stupid", and slapped the back of my head and pushed my face into the board. When I told my mother she said I was stupid and lazy. And said the teacher did what she had to, to knock some sense into my fat head. And she hit me just as hard. (Gail)

CHILDHOOD SEXUAL ABUSE

Primary Offender

In cases of father incest a range of themes came up in addition to those of abandonment, shame, guilt, helplessness and responsibility. For some, there was additional shame and guilt involved when the abuse was experienced, in part, as pleasurable:

From my earliest memories of dad touching me I felt it was a secret. Whether or not I'd been told that I don't know, I'm just going on what I felt at the time. It was sneaky, it was something between us. It even felt kind of good at first. In fact I think there were many times I wanted it except toward the end. I'd just lie there and let him touch me. I wanted it over. I think sometimes I felt more like a girlfriend than his daughter. I touched him back after a while too, like it was something both of us wanted. And a lot of times I liked it. we never had intercourse and no oral sex. He french-kissed
me only once. It was just touching and him rubbing his penis on me and I actually liked it a long time. I remember the first time I touched him it was my choice. I did it and I think he was very pleased. I remember he was hard and he liked it. It was in his bed. I think it went both ways – sometimes he came to me and sometimes I came to him. He used to set it up so we could lie together under a blanket – usually while watching T.V. with Tim (younger brother) in the room. I remember being in his bed with him and he used to get me to get on top of him and he’d rub his penis on my crotch, and sometimes try to put it in, and he used to use his fingers in me a lot. And all the time I liked it. I was used to it and this is the way it was. (Kelly)

Others had disclosed their abuse in an attempt to get help, only to endure additional abuse – thus amplifying their sense of helplessness and abandonment

I was only seven. We had learned to stay away from dad anyway we could. It was sometimes between seven and ten that he started touching me when no one was around. My sister and I had our own rooms but we always slept together. We were both scared of the dark. I knew I was safe with her. He never touched her. He yelled at us and complained about things, but didn’t hit me then. Mom would try to keep things okay, but when she was at work he was nicer to us. He couldn’t seem to share her with us. She was different to us when he was around. If she did things for us he would say we were being spoiled. We heard "stupid, useless, spoiled, snot-faced brats". Mom would tell me he said I was the only one he really loved. He never told me. He bought me extra things more than Jill so she stuck to mom more. I never told mom that he tried rubbing my bum. I don’t know why. One day he rubbed his penis against me when Kim and I were in bed with him and mom. I was scared so I told a neighbor lady. I didn’t know then (but I found out in my teens) that she threatened him and he never touched me or tried to again. This is when the physical abuse started (I think). When I reached in front of him at the table, he hit me with the back of a knife on the knuckles hard. When he told me to do something and I didn’t right that minute, he would smack me in the head. I always rolled up on the floor and he would kick me and yell "lazy bitch" at me. My sister would hug me and we would cry together. He never hurt her. She always stood up to him and told him she would go tell the police on him. .. (Diane)

Most group members felt that their mothers were aware of the abuse and were either helpless to prevent it, or were supportive of it in that it relieved them of spousal roles.

My dad is hugging and kissing me. He is drunk - it makes me sick. He never even looks at me let alone talks to me when he is sober. Sometimes when he sits on my bed when he is drunk and yaks and talks, I feel that Mum is pushing him off on me so she won’t be bothered with him. Where was my mother when he was bothering me? Didn’t she know I hated his drunk hugging and kissing, she could have told him to leave me alone. I couldn’t escape, I couldn’t get away from him. I couldn’t be rude - I couldn’t hurt his feelings - I wish I could, but I couldn’t. (Laura)
Father offenders were generally experienced as having absolute control over the victim's behavior, reducing her to a condition of completely helpless compliance. Control was generally based, either implicitly or explicitly, on the potential for terrible, even lethal, consequences.

On the way home he (father) would take the back roads and ask if I wanted to drive and while both my hands were on the wheel he would fondle me. And I couldn't stop him, because if I took my hands off the steering wheel he'd say we would crash. (Mary)

Dad always wanted me home only because he wanted to get his rocks off. Fuck, his penis had such a gross smell to it. I used to want to puke but all I could do was lie there and let him get it over with. (Ellen)

The long-term nature of father abuse, the entrapment, progressively more violent sexual abuse, the increasing sense of helplessness, shame and isolation are eloquently drawn in the following passage.

One night when mom was at her lodge meeting, I was almost eight years old then dad called me from the bottom of the stairs to come down and change Dan's diaper. I thought nothing of it, so I went downstairs, I changed his diaper and put him back to sleep. That routine happened a few times. Then one night it changed. Dad was in his bedroom when I came out of Dan's bedroom. As I started to go back upstairs to go to bed dad called me into his room. He sat me down on his bed, he was in his shorts. He told me we were going to play a game and I was to never, never tell anyone about it. I don't remember him threatening me, but there was something about the way he said never, never tell. I loved my dad and trusted him. I don't remember ever being afraid of him like I was with mom. He started to touch me very loving, he talked to me and hugged me and made me feel that I was really special. I felt very good about those times. As I see it now, he was instilling love and security in me and a lot of other emotions as well—all of the things that my mother was taking from me. He even talked to me about mom. I was able to tell him how I felt about her. The meetings with dad started to advance after a while. He would take my pajamas off and caress me all over. I was starting to develop a bust and he liked that. As I grew a little older he called me his "sweater girl". Oh how I hated that. I'd stretch my sweater out front as far as I could so that they would be baggy and no one could see my chest. It didn't take him long before he was nude as well. He would take my hand and show me what to do to him to give him pleasure. From there we went to oral sex. He started with me first for a few times. I always felt afraid, I didn't really understand what was happening. This is the area that my fear and uneasiness for and with dad began. I wanted him to leave me alone and he just wouldn't. Dad started having me give him oral sex. God how I hated this, I just hated it but I could never get away from him. I remember feeling choked and I couldn't breath. It all made me feel sick. I used to pretend being asleep when he would stand at the bottom of the stairs and call for me to come and change Dan's diapers, but that never worked. He would just come up and get me. I used to lay under the covers and cry and pray that he would go away and leave me alone. I always knew what he wanted, ALWAYS knew what HE wanted. I was almost nine...
years old when I began getting sick to my stomach a lot. The doctors said that I just had a nervous stomach and gave me some medicine that I took for about five years. I was still sick even taking the medicine. I don't remember just when he first penetrated me. I do remember there being blood in my pants when I put them in the pile to be washed. I was so scared that someone would see them and know what I had been doing. But no one said a word to me. What I mean is, I was afraid that mom would see them and she would know and I would be in really bad trouble. I think today that she did know and that is why she was mean with me and favored my sister. (Joyce)

Stepfather abuse was generally more assaultive and violent, and the following set of excerpts describes the progressively violent nature of the abuse experienced by Jean from her stepfather. The abuse began when Jean was 4 or 5 and intercourse occurred before she started school at age 6. Notably, each time she challenged him, he escalated the levels of violence and coercion.

The next thing I can recall is George being beside my bed. I woke up because he was touching my breast and genitals. I recall I had no idea what he was doing or why. Anyways, I told him to stop, but he wouldn't. I continued telling him, but he kept doing it especially when he was drinking, which was often. Eventually, this touching progressed to him actually having intercourse with me. I can remember the first time very well, the pain was incredible and I actually screamed. No one heard except my oldest brother. George heard him coming and told me to tell him I'd had a nightmare or he'd have to kill him. Then he'd make me watch him kill everyone else before he'd kill me, then he'd do himself. I was so afraid! Needless to say I repeated to my brother what George had instructed me to do. When my brother had gone back to bed, George came out from where he had hidden under the bed and told me I was a "good girl", he "wouldn't have to kill anyone yet". But, if I ever told anyone, well, I knew what he would do, right? I was terrified and of course I believed him capable of carrying out his threat. I didn't feel like a "good girl" and felt as though I couldn't move, I hurt everywhere. I do recall curling up in a ball, wondering if I was going to die and I cried for a long time. I remember it hurt to walk for quite a while.... The next thing I remember is moving to a house in ---. I was still in elementary school. The abuse continued and one night on particular stands out in my mind. George had come into the bedroom as usual but I didn't want him to touch me and I kept fighting. He left but was back a few minutes later. He had a knife and asked me if I was going to make him use it. He put it on my throat and told me to lie still and be quiet or he'd kill me. Anyways, when he had finished that night he sat on the edge of the bed and told me he was going to have to teach me a lesson for fighting him (he took her to a hairdresser and had her head crew cut). ...George came into the bedroom and I woke up to him touching me. I remember being really tired and I got angry and hissed at him to leave me alone. He did, which surprised me, and I was relieved – but not for long. I had started to drift off to sleep again but he came back. This time he had something cold in his hand and he was rubbing it all over me, and whispering about how I knew what it was and what he was going to do now. He held it up in front of my face. I started crying because what he had was a gun. I pleaded with him not to use it and he kept repeating that he had to. And then he put it inside me. I don't know how long he continued to torment, but it
seems like forever to me. He finally decided he wouldn't do it if I told him how good he made me feel and how much I liked him loving me. I remember him saying "I know you like it, I can tell. Now I'm going to teach you to love me". He made me masturbate him and then he taught me oral sex. When he climaxed I got up, ran for the bathroom and got violently ill. When I was finished I went back to the bedroom and he was gone. I didn't go back to sleep. I was terrified he was still going to shoot us all. When I got up the next morning George gave me hell for making so much noise when I was sick during the night. So right away mom asked me if I had the flu. I remember saying "I guess so", and she told me that maybe I should stay home from school, but George got mad and said I'd be alright, just don't give her anything to eat. Then he told me to get the hell going. As I was going out the door, he smiled at me and winked. I walked up the road a bit and vomited into a ditch. (Jean)

Members who were abused by a non-family member also often felt either that their parents knew and would not protect them, or that they would be blamed for the abuse. The sense of being hunted and inexorably tracked down was also prominent for these clients.

That S.O.B. with his luring eyes and his weird soft fingers, ruined that freedom for me. That asshole. Why did he have to do that? He ruined me. He wrecked me. He hurt my soul. I need to seek revenge, but I can't. I don't know where he is — probably dead, and I hope rotting and burning in hell. I hope he is screaming and agonizing. I'm so sad that he took my freedom and made me focus on myself to linger and ponder what happened to me. That S.O.B. lured me into his fucking ugly room with candy. I am remembering him peering out the window as if he were hunting, waiting for the right moment to prey on his victims. I hate that man. Why didn't my mother know and protect me? She says she didn't know, but I think she did — I'm sure she did and she still denies it saying she only suspected him. (Karen)

I can remember Harold closing the door, putting the knife in the door so his kids wouldn't walk in. Sitting on the bed I remember him kissing me. His breath stunk, he used to chew snuff. I can't remember taking my clothes off. Thinking he looked funny, his big stomach. I don't think he ever got a hard-on. Taking my hand and putting it on his penis, I remember he felt all squishy. Laying me over the side of the bed, my face in a pillow. I thought it would never end. Shooting his sperm on my back. I thought it would never end. Then lying on the bed. His wife playing with him. I tried to turn my head but they pulled it back again. Will I ever feel clean again? I still went back there to visit. Harold climbed the stairs. This time by himself. I didn't say no, just laid there. The next time I remember crying. If my dad had sat down and asked me if anything had happened then maybe I could have told him. Instead he was standing in the kitchen, arms crossed, just like he did before he got the strap out... He asked me if Harold had ever tried to touch me. I said no. I thought I was going to be in trouble, like it was all my fault. I went back outside just walking. Now I'm hungry — pain in my stomach, head and throat. Oh God, I'm tired of the pain. I've had a good cry but I feel empty, numb. Who are you Anna, or what are you. Sure not feeling very good about myself tonight. The thing that bothers me the most is why I didn't say no. (Anna)
Secondary and Multiple Offenders

A very high proportion of the survivors had been multiply offended—generally in addition to the primary father-figure offender. Bear in mind that these girls were already experiencing themselves as terrified, shamed, guilty and helpless to protect themselves from abuse at home, and were thus profoundly vulnerable to secondary abusers. In a number of cases older brothers or stepbrothers also offended the client—generally after father had ceased:

Sometime in the next months my oldest brother took over where dad had left off *(her sexually abusing father died when she was 12 years old)*. He began his abuse by being really nice to me and giving me money. Then all of a sudden I owed him or there would be no more money and he'd turn mean. I took his money, this added to my guilt and shame. I was cheap and all of this reaffirmed it. I hated what was happening but I resigned myself to the idea that I was really trash and that it was just for the money. At some point I put a stop to it all. Well, I tried. my brother told me he would go to my younger sister then. I begged him not to touch her. so I continued going along with him thinking that I was protecting my sister. I don't recall just how I found out, but I did—he had gone to my sister anyhow and was doing the same to her. *(Joyce)*

I had been having problems with my stepbrother. He started living with us because he was having problems at home. We both had our rooms in the basement. By this time, my sisters had all moved out. In the middle of the night, he would come home and knock on my window because he had locked himself out. I tried to pretend I was sleeping and didn't hear him, but he kept knocking so I had to let him in. He was drunk, as usual. he was nice to me at first but then he started touching me and wanting me to touch him. He was very strong, so I couldn't fight back. I wanted to scream, but I was afraid my mom and stepdad would wake up and get mad at me. They might think it was my fault. He would finally pass out in my bed. I would have to drag him out of my room before my mom got up. What would she think if she saw him sleeping in my bed. I never did tell. He finally moved out . I was very relieved that he was gone, I never wanted to see him again. I could never understand why people would say that sex was so great, and I still can't understand it. I have never enjoyed it and am afraid I never will. It scares me just to think about it. *(Paula)*

As children, members were often targets of abusive adolescents and adults in the neighborhood, and there was often a predatory flavor to these experiences.

I had two friend at this point *(age 9, 10)* and I got to go over to one friend's place once in a while. She introduced me to an old man who owned the shoe shop. He talked to me and I thought he was nice. I used to stop in his shop on the way home from school and he'd give me candy. One day I asked to use his bathroom, he showed me where it was and when I came out he took my hand and pulled me into the back room. He told me he slept there and told me he had my candy in the dresser. Anyhow it started with him just touching my breast and asking me if I had been with someone else. The next time I went there he climbed on top of me and had sexual intercourse...
with me. When he was finished he told me not to come back again because I was a dirty girl and I was going to get him into trouble, so I didn’t go back there anymore. My girlfriend also had a brother who was a couple of years older than us. He was really nice too, I thought. I really liked him and we used to kiss a lot until one day I went over there and he was there alone. He had intercourse with me too. I quit going over there because I didn’t like being dirty. I didn’t like being dirty, and couldn’t figure out why people always wanted me to be that way. (Jean)

When I got my period she (mother) didn’t know for four months and got mad because I asked the lady next door. Her name was Ann. I thought I could trust her and her kids. They were clean and nice. Ann drank once in a while. Her daughter, Tracy was about my age. She had an older sister — I can’t remember her name. I could sleep there once in a while, and then every now and then Tracy and the older one would climb in bed with me and play with my bum and top. I was scared and would not say a word. Then in the morning Ann would say “That was nice of Tracy and (what’s her face) to sleep with you. Did you have bad dreams again?” Then if I couldn’t get in my house, I would sleep by the door. Ann would come and say “don’t be silly. Come in”. And then Tracy and what’s her name started to bring in the dog. His name was Lad or Lucky. They put some bacon between my legs and covered my mouth with a pillow and the dog bit at the meat and then they took pictures and laughed at me. When the mother would yell “what’s going on in there?” they yelled back “we are telling jokes. Things are fine. we are going to sleep so good night mother. We love you”. Then they kept me there and the dog did what it wanted to do. They show the pictures at school or tell my mother. So I better come back for more, or everyone would know. I was 9 or 10 then. I just did not know what to do. I started to tell mother but she didn’t have time; her friend and the boys were having problems again so “go to Ann’s kids, they will play with you”. And I said “you’re right, they will play with me and the dog”. She slapped my face and called me a pig, and not to talk like that again. (Gail)

When I was ten I rode my bike to the show some Saturdays, and one day a strange teenager sat beside me. He touched my private parts and I just sat there. the next Saturday he was there again but I sat with friends and he sat behind me. He followed me home (three miles) but never touched me again. I felt very foolish when I saw him around town after that. (Diane)

Having recalled and disclosed their sexual abuse by the primary offender, a number of members went on to recall previously repressed episodes of abuse by secondary offenders. The following passage eloquently describes the process of ongoing recall of early abuse. The filling-in-the-gaps phenomena, and its attendant pain and validation of the individual’s experience.

I was talking about John across the street. I now see him, and our relationship, as abusive. He sexually abused me for years. I’m not sure how old I was, but maybe 7, 8, or 9, I’m not sure. He would want me to come over to his house. Sometimes it was his mother who would phone my mother so I felt I should go. I guess he was bored. Sometimes I would not go. He would talk me into going downstairs to look at his dad’s magazines. Sometimes dirty ones, sometimes not. We would
go through the magazines together. Then he would take down his pants and want me to touch him. He would have an erection. Then he would talk me into removing, first my slacks, then my underpants. Then he would want our bottoms to touch. He was warm and even though I was doing these things reluctantly, it felt warm and nice. Frequently I would get scared, get dressed and go home. I'm not sure how long I would stay there, but maybe sometimes 40 minutes or maybe a few hours. Funny, I just realized, I don't think he was at our house more than a few times. A few times he would try to enter me, but I was young and it just wasn't happening. I wonder why he did these things.... I'm realizing slowly just how abusive this was. It wasn't like the usual "show me yours and I'll show you mine" with the usual amount of giggling. This was serious stuff. Sometimes he wanted me to lick his erected penis. I would, but he smelled funny and musty, and his penis smelled even worse. I think other things happened, but I can't remember what they were. Maybe later, maybe never. I'm feeling shaky and frightened. I'll stop for now. I put in a really shitty night, I lay in bed after writing and was remembering all the other things John made me do. He would rub his penis on my buttocks and back. Then, all of a sudden, I was remembering a love making session with my husband and things got all jumbled up - God, I'm sad. What in hell has happened to my life. I woke up this morning feeling like a sad and crushed little girl, but in the mirror I saw a woman looking more haggard than the day before. This is a really awful time. Last night was horrifying. I went to sleep remembering more and more things that John did to me and all the time searching, hunting for a memory. My mind scanning through all the men that touched my young life searching for yet another abuser. Not knowing what I'd find. Used again, abused again, but not seeing a face. Is there a face or is it the feeling of my whole life. What a lousy feeling. (Karen)

The following excerpt provides an example of the type of offender survivors often found themselves ostensibly "voluntarily" becoming involved with in adolescence. Common themes arising from these instances were those of responsibility for the rape, life threatening levels of danger, and discounting of its seriousness.

I'm about 14 years old - I've met this older, dangerous man, my friends tell me he just got out of jail, I think he's exciting. We drive out to the dock and he takes me onto his fishing boat. When we get to the cabin he throws me down on the bunk and roughly starts pulling my clothes off - I start getting scared - I fight back - he pushes me down and presses his arm against my throat, I realize the situation is totally out of control and I think he is going to kill me if I keep fighting so hard. He's a wild man, he's going to break my arm, he's hurting me, I can't stop him. He says "put your knees up - bend your knees". But I don't. He rapes me and it hurts so much, the pain is so sharp I feel as if he is damaging me, ripping my body open. There's blood all over. I get up and blood is running down my legs, I'm so scared. Suddenly he changes - he starts crying and says he is sorry he didn't know I was a virgin and would I forgive him. I feel so relieved - I'm not going to die after all - I tell him its alright I won't tell anyone. I have bruises all over my arms and legs and I hurt all over. I feel used and powerless. I get home and never tell anyone until now. (Laura)
It was also not infrequent for survivors to have been "given" to secondary offenders by their father-figure abusers.

Mr Gordon. He was one of my dad's friends. He was about 40 when we met him. We started going fishing with them. I really don't know when this first started. But it was like my dad had told him he was allowed to fondle me because every time we went fishing which was every weekend my dad would make me go on the motorbike with him to go for a drive. I kept saying no, but dad would get pissed off and make me go. I would try to get on the back but he would make me sit on the front. As we were driving he would make me steer the bike so that he could pull my zipper down and put his hands on my crotch. He would then take me to a seduced area and fuck my brains out. When we got back to the camp site my dad would do the same thing to me. I couldn't handle the smell of myself and my whole insides of me would cringe. Mom always said that dad favored me. If that's what you call favor you can have it. (Ellen)

Pregnancy Resultant from Abuse

A significant number of the women became pregnant as a result of the abuse, either directly (generally in cases of father-figure abuse), or indirectly by parental collusion.

Dad (the offender) always said if my sister or I ever got pregnant we were to pack our bags and get the hell out of the house. When I was 13 I went through a stage where I couldn't stop crying. Even when my mom said hi, I would cry. She took me into her bedroom finally and said I had to talk. I finally told her that I think I am pregnant. She made an appointment the next day. I begged her not to tell my dad or he would kill me. When I went to the doctors the test came out positive. I was already 3 months by this time. My dad called me a ditch pig, slut, whore and whatever else he could think of. I didn't know if it was my dad's or my boyfriend's. I couldn't tell anyone either. The day I found out I was pregnant I had to babysit for our neighbors. I was just shitting my pants waiting for my father to come over. I knew he was going to kill me after he screamed out everything he had to say to me. He told me I had to be out by morning. So that evening while everyone was asleep I packed 2 garbage bags of clothes and walked...all the way to my boyfriend's. (Ellen)

When I was almost 19 there was a boy that was in our crowd that chummed together. I had fallen in love with him. we had dated a few times. he was like an octopus, hands all over me. But I fought him off all of the time and I felt good about that. I went to mom and told her how I felt about Ken, and what was happening and what could I do about it. Her motherly advice was "some men you have to have sex with to prove how much you care for them". I remember feeling very uncomfortable about her advice, and it was something I just couldn't do. About six weeks later, just after my nineteenth birthday, I had invited Ken to go with me to our staff party. We had a really good time. When he took me home, he came in and we sat with mom for a while watching T.V. A few of the boys from our crowd showed up and wanted to play cards (which they often did). Ken joined in with them. So, after a while I excused myself and went to bed. My room was off of the living room. the door knob of my room was broken, only the long end was there. I was asleep when Ken
popped his head in and said that he was leaving and he would see me the next day. When all of a sudden he flew in the room and the door slammed shut and the door knob was removed and mom was laughing. Ken sat on the side of my bed and we talked and had a few cigarettes waiting for the door to open. All of a sudden it was quiet, everyone had left, and she had gone to bed and not opened the door. We talked for a little while. I was so embarrassed about what she had done and yet my heart was beating so fast and so loud because he was there.

My beautiful, lovely and dear daughter came from that night. It was the one and only time Ken and I were ever intimate. I had morning sickness about two months later and mom said that I'd better go to the doctor's. We never ever talked about that night. When I came home from the doctor's and told her that I was pregnant she immediately went into a rage and I was a tramp and slut and what could I bring such shame to my two younger brothers and the rest of the family. I was so devastated and confused. I already felt the enormous mountain of shame and 27 years ago it was not socially acceptable to have a baby out of wedlock - that was reserved for the sluts, tramps and all of the girls that were "EASY". (Joyce)

Injunctions to Secrecy

Father-figure offenders generally enforced their victim's silence by giving them responsibility for the abuse, and by telling them that their disclosure would result in family break-up, maternal rejection, abandonment and, finally, death.

I don't know why he (father-offender) never beat me when mum was around. I used to tell her I fell down or something as I thought she might leave him and our family would be apart. I was afraid I would live with him and Jill would live with mom. (Diane)

The first thing I can remember my dad said to me is that this was secret so I'm not allowed to tell anyone. Not even my mom because she would get jealous that he loved me better than her and that she would want to divorce him and I would be sent to a stranger's house and they would beat me all the time and if I did anything wrong they would probably kill me. So I held this inside me. (Ellen)

He (stepfather) used the threat of killing everyone for a long time and the sexual abuse continued on a frequent basis. It seemed to all blur into one. (Jean)

In a few instances another family member disclosed the abuse and the client had to deal with her guilt over refusing to confirm the abuse when questioned by authorities.

I remember all hell breaking loose when (sister) went to the cops. We all had to go to the cop shop and answer a million questions. Dad was shitting his pants but by this time he had quit with me. He had taken me out for dinner and said "I will never touch you again" and I told him he'd better not. But how was I to know I'd have to live with it for the rest of my life. (Mary)
Sexual Acting-out and Role as Abuser

Many group members were able to recall and disclose instances of their own sexual acting-out. This included compulsive masturbation as well as sexual acting-out with siblings and pets. In some cases the client had sexually abused a baby or child in her care. Sharing these recollections required great courage and was indicative of the degree of acceptance and trust within the groups.

I remember when I was in school this feeling would come on and I found myself going to the washroom to play with myself. Sometimes when I went to bed I would wait for my sister to fall asleep then I would put a stuffed animal or a pillow down my crotch and rock back and forth until I got off. Sometimes I found myself waking up in the middle of the night doing this. When I used to go down to the park I would climb the pole and by the time I reached the top I would have an orgasm. It seemed that I was horny all the time. (Ellen)

(Another group member) triggered this disaster, so here goes. I was 5 or 7, I don't remember. We were being babysat by a guy down the street, Harry. It's faint, but I think he was fondling my privates because after some time my older sister and I started fondling each other. It was sick. I don't know what we did, but I remember my mom finding a piece of cardboard of a game saying I "love to eat black cunt". I don't remember doing that, but I know I wrote it — so sick. I also remember playing with myself. I remember making my dog, or putting the dog's face at my privates — again, I'm sick. I know Pat's gonna say "it's not your fault, it's your dad's". But my actions are sick, therefore I feel sick. I don't think I have a conscience when it comes to sex. After all, if I did, my conscience would have killed me by now. (Mary)

I had some more things come up and I feel like I'm going to have an anxiety attack but I have to get it off my chest. I've been listening to all of you about your past and all I've heard is about being mean to animals. I have hurt many animals but most of all I have hurt little babies. When I babysat for this couple who lived just down the road from us - I would get a feeling through me like I had to have an orgasm. I would take the baby out of the crib and lie him on my crotch and move him back and forth until I got off. Then I would wash him up and feed him. I used to get him to suck on my nipples because the sensation got me off. I have only done this a few times. I was scared I would get caught. (Ellen)
THE CHILD'S SELF CONTEXT

Anxiety & Terror

Many clients recalled extreme levels of anxiety and terror, both toward their abusers directly, and indirectly in terms of night terrors and phobias. Bedwetting, sleep disturbance, nightmares, and vomiting were all common responses to the more pervasive sense of fear and dread. A number of clients attempted to control their terror by keeping weapons (usually knives).

I woke up to screaming and yelling and scuffling. We got up and here was mom and George's sister having a fist fight. Anyways, George and his brother-in-law got them apart and mom told me to get my things and her and I left and started walking home. Mom was staggering and we didn't get far when George pulled up in his car. Mom wouldn't let us get in at first, but he eventually convinced her. So, we got in the car and George started driving fast, so mom told him to slow down. He gave her a slap on the face and told her he'd teach her to cause trouble. He kept making the car go faster and faster and at one point he went through a red light and we ended up in a car accident. It wasn't really bad, but I was terrified and George was arrested. I can't remember how mom and I got home. To this day, I get uptight if I'm in someone's car and they're speeding. (Jean)

I now remember peeing my bed—every night until puberty—it was the same sort of feeling. Being in the bed all alone and cold, almost ready to sleep then I would pee and the warm blanket would surround me and I'd be comfy and warm and I'd sleep. My mother took me to many doctors to find out what was wrong with me. She did not know that I needed someone to lay beside me at bedtime—to take the time for me. I could not tell her. She should have known. (Karen).

I don't remember a time in my life when I had, according to my mother, normal sleep habits. I, then and now, don't feel I need the sleep others need. My mother used to try and make me go to sleep by ten. What a dumb, stupid thing. I couldn't fall asleep, so instead I was forced to endure hours and hours of dark endless torture. I felt so stupid because I was so abnormal. I believed I was a freak. At this time a totally immobilizing panic would come over me. I do not know what the fear was compounded of, but at these times I would not sleep all night. I also would vomit on myself, or wet myself. When I would vomit I would not even be able to sit up I was so terrified. I tried sitting and sleeping on the floor by the door but she caught me, and ranted and raved about how abnormal I was, what an animal I was and gosh knows what else. I was very alone and afraid of the big, big darkness—my room was just a small darkness. I know that at first I just hid under my bed with a large butcher knife and stayed awake until morning and slept in the day... Also I never really can remember a time when my sleep was not disturbed with nightmares. These were snakes, worms, coming out of my body or birds, mice or snakes trying to get into my body. Falling, fire, lightning trying to consume or devour me. I never called my mother, what would she have done for me anyway? (Alice)
When I was four or five we lived in ______ a couple of doors down from Temple Elementary. I still had a bed wetting problem. My parents had made a cellar room into a bedroom where I had to sleep. They still had me in a crib at that age and that’s all they could fit into that room. They used to turn the light off and shut the door. Now if someone even tries to play a game on me by throwing me in the closet and holds the door shut - I freak. I guess I’m claustrophobic now. (Ellen)

My sisters would always go out with their friends and boyfriends, while I just sat in my room. I would be at home alone at night a lot, and get really scared because I could always hear noises in the house. I would sit in the corner of the living room where I could have a full view of everything, and carry a knife in my hand for protection. I was afraid that a demon would come and get me. This was when my mom and dad were separated. When we had lived with my dad, scary things used to happen in our house a lot – just like in a horror movie. My dad used to always take us kids out to these strange church meetings where the preacher would cast demons out of people. It was really scary. The times when my mom and dad would go alone was when strange things used to happen in the house. All five of us kids saw it. The bedroom doors would lock and unlock, and open and close by themselves. We would find footprints up and down the stairs when no one had been there, and hear weird noises. My dad didn’t believe us when we told him. My dad would sometimes also cast demons out of people in our own house. He always knew everything that went on – even when he wasn’t there. He always said that he had eyes in the back of his head and that’s how he knew everything. I really believed him. For years and years I was afraid of demons. I still am sometimes, especially when I wake up in the middle of the night and it’s dark and I’m alone. I just stare at the wall and I am afraid to turn around because something might be there. I just close my eyes and pray to God that I will go back to sleep. To this day I cannot hang my arm over the bed because I’m afraid that there is something under there. (Paula)

Abandonment and Losses

An extensive history of family instability, abandonment and loss were common among group members. Children were often uprooted, separated from siblings, and left in the care of others – often in conditions of high risk and further abuse.

I must have missed something because one night Mom says "get your dog, we are walking to the bus depot." We went to (the city) and stayed with mom’s mom - another school - oh no! I’m left at my Grandmother’s, mum goes back to dad in (home city). I’m mostly happy until Nana goes on a drunk for days. Then Grandpa, Uncle and me all disappear to keep out of her way. My dear sweet little Nana turns into a drunken raging stranger. This lasts for days, I feel awful - go hide in the basement - if she catches me I have to pay attention and listen to her drunk talk and pretend I understand what she is saying. (Laura)

I don’t remember the day, the week or even how old I was when my grandparents took Harry (her younger brother) to live with them. I don’t remember his suitcase being packed, or a particular
incident that caused it. I only remember him gone and not even saying good-bye. My mom told everyone it was because Harry was uncontrollable, that we fought so much and that she couldn’t cope anymore. It was years later that my Grandma told me the real truth. That she had kept little Harry over for a weekend and was horrified to discover the scars from (stepfather’s) belt on his bottom and legs. She confronted my mom and demanded that Harry be allowed to live with them or she would take the matter to the authorities. It was a blessing for Harry, but the scars left are unrepairable. Our relationship as brother and sister were sadly taken away from us, but as grownups we have an unspoken bond of having suffered together. (Chris)

For some, there was recall of some relatively stable and caring adult who was lost through death or some other disruption over which they had no control. These losses only confirmed the child’s sense of the world as an arbitrary, cruel and painful place – their only certainty was abandonment and uncertainty.

I was ten. An old lady came to stay with us. Her name was Grandma Harris, she was very round, and looked soft with lovely white hair. She slept up on the third floor. I could hear her walking in the night. She liked me, I liked her. We had tea and cookies. She always giggled and shook when she laughed. Everyday after school I went to see her. She always said I was so nice. I helped her and went to the store for her. I saved my money and bought her a tea cup and saucer with yellow roses on it for Christmas. She got sick one day and died. Mother said I was too young to go to the funeral. Mother threw away the tea cup. I went to the graveyard though, and asked the graveyard man, where was her grave. He showed me and I would always go out late at night when everyone else was asleep and visit her. I went through the bush so no one would see me, because my mother would have a fit. When winter came and I couldn’t go anymore, I used to lay in bed and with my head make her footsteps happen until I could fall asleep. One day I said to mother that I missed Grandma Harris and she said that I was silly - she was just an old lady and old people have to die and quit having her in my head or visiting her. (Alice)

I have to write about my mom’s parents - my grandpa and gramma. They were my rock as a child growing up. Oh how I loved them. They provided me with a safe and happy place to go to. They lived on a farm. I loved that farm... My memories of grandpa and gramma and the farm are so precious to me. They’ve always left me with a feeling of love and safety. At the farm I really could be a little girl. My grandpa died two months after my dad (dad was the primary abuser and died when she was 12) and everything changed. Nothing was the same. Gramma left the farm and moved into town. I went to see her as much as I could but the spark had left her eyes and the zip was not there. She was still my gramma and I loved her so much and I really miss them both. (Joyce)

I have had only two men in my life that liked me – the relationships we could have had would have been very special. I’m not sure how old I was, maybe 8, but my uncle would come over to visit and he always had time for me. He was so special to me but he died. They didn’t even give me a chance to grieve. I was not allowed to go to the funeral. He was just no longer in my life. He was so
nice to me. He really liked me and he's gone. My hope of having a nice friendship because he saw
something in me that charmed him and in return he charmed me. He's gone and I'm so sad. My
friend Earl, he also died. We were on the road to becoming friends — he didn't come on to me. He
was my friend. (Karen)

A heightened sensitivity to death, in general, was also evident in many survivor's
childhood recollections, and functioned as a powerful metaphor for their own losses.

A couple of years ago my Aunt Jane died. I went to the funeral with my dad and grandma. I
didn't get very upset when I heard the news, but once the funeral was underway I bawled my eyes
out. I even went up to see the body. She honestly looked better than she did when she was alive.
She had cancer for years and was going to chemotherapy and lost most of her hair. They had a wig
and make-up on her. I really got upset when I saw the body. What was worse was when I was up
there. I looked at her husband and kids and they were majorly upset. The fact that a life was gone
was upsetting but what was worse was the fact that they had (my cousins) lost their mother. Even
though they're about 20 I thought that was really the shits since at that time me and my mom were
starting to get along really well. I thought how awful it would be to lose her. I kept thinking of that all
through the service. (Kelly)

Child as Tormented

A significant number of the group members were systematically terrorized, tormented
and even physically tortured by their abusers. Clearly, numbers of the abusers did this not only
to ensure the child's compliance, but to derive some sadistic pleasure from their abuse of the
child.

I think I was around 11 when dad, (her younger brother) and I went camping. We were in a
tent next to a river. It was just before midnight and dad told us a story of a headless horseman. He
was an Indian who had his head lopped off and used to ride up and down the river in his canoe
looking for revenge. Anyone up past midnight he'd chop their head off. We were terrified and
couldn't get to sleep of course. (Kelly)

Sometimes I was afraid he (offender-father) might kill me. He would tell me to watch out when
he made the soup as he might have fixed it up. He had a big bottle of turpentine in the kitchen. He
would tell Jill and I if we acted up like being little bitches, he would put it in our food. He chased us
with a dead rat one day for hours. We are both afraid of rats today. (Diane)

Dad is stirring his coffee he puts the hot spoon on my arm, he lights a cigarette and asks me
can a match bum twice, I say no, then he blows the match out and touches my arm with it - it burns, I
let him do these things to me, to try and please him. He says "I bet you can't rub a raw onion in your
eyes" - so I do it, I feel proud I can do things that hurt myself and withstand pain without flinching so
dad will be proud of me and keep on playing with me. He would say "watch the smoke come out my ears" - when I was looking at his ears he would put a lit cigarette on the back of my hand... I had to do these things to myself because these were the only times Dad paid any attention to me when he was sober. (Laura)

I'll never forget the time when my dad's watch went missing. I was about 6 years old at that time. He woke me and one of my sisters up about 6 in the morning, and demanded to know where it was. He figured that, since we were the youngest, we took it. That was his logic. We both told him we didn't take it, which we didn't. We told him the last we saw it was on the ledge in the breezeway where he had put it the day before while he was putting a cement sliding along the driveway. Of course, he didn't believe us. We had to of taken it because there was no way he could have lost it - he didn't do anything wrong. Finally, when he was losing his patience, he took us into the breezeway and tied a wooden match around our finger (the same finger he had accidently shot off his own hand a while back). He told us that in 10 seconds, he would burn our finger off, just like his finger was off. He started counting. We were both crying and didn't know what to do. Finally, when he was almost at ten, my sister burst out and said that I took it. She said I had put it in the cement on the driveway. I hadn't, of course, but I was just glad that my sister had thought of something before he had counted to ten. He took me over to the cement sliding and told me to point out where I put it. I just picked out a spot in the middle and said it was there. Thank God the cement had hardened because he wanted to dig it out. We both got straps and were grounded in the back yard for two weeks, only to come out for bed, school and the bathroom. (Paula)

I remember from age six and on, Mom would throw our food on the floor or outside on the ground – and tie your hands behind my back and say "you want to eat like an animal, then bloody well eat like one". Push our face in the food and stand there and hit us if we didn't eat fast enough for her. She would save food for weeks if we didn't eat it and make us eat it for breakfast, lunch and dinner. And we couldn't eat anything until it was gone. I remember about the age of 6 or 7, about the time she was in a good mood for about two weeks. And she had made some ice cream in the summer, about July. And we sitting down around the table. She was serving the ice cream up. It was chocolate. It was in a big ice cream bucket. I said (older sister) got a little more than my mom. And she took my bowl away. I said "sorry". And then she made me eat all the ice cream. And when I would stop to throw up, she made me start again. And when I would fall asleep she would throw water on me. I hated her and told her that. She sat on me and poured tabasco in my mouth – half a bottle. I couldn't eat for about five days. The teacher noticed the sores around my mouth and phoned the house, and my mother said that I had got into some Mexico hot sauce. (Gail)

**Self as Different, Bad and Unworthy**

The development of a core sense of the self as stigmatized, shameful and worthless was central for survivors.

I feel humiliated and worthless, I feel like I should slink around with my head down and be ashamed of myself - I can't really say why. (Laura)
Just got home from group meeting and am going to write as I've had a few more "flashbacks" I'll call them. When I was a little girl I wet my pants until I was 10 or 11. I remember feeling so embarrassed and ashamed. I was nicknamed "pee-pants Polly" and "pissy-pants Patterson" (my maiden name). the other kids laughed at me and my mother was so mad at me. I used to feel so awful, but I didn't seem to have any control over it. I never wet the bed, just my pants during the day. (Joyce)

Why do I always condemn myself? I still feel really funny when I'm alone. It's like I'm waiting for someone to get me. Never let my guard down. (Anna)

Very often this sense of shame and stigma was experienced as a public event – something visible to others.

What the fuck do guys get out of doing this to an innocent little child. There is goddam hookers out there for them to get their rocks off on. I feel it's plastered all over my face. Easy target, go for it. Every time I walk down the street or in the mall I feel I'm being watched or I know what they want. I hate walking. I'm so insecure. I want to get over this fear. (Ellen)

I can always remember having a small pouch on my stomach that is just below my belly button. I only noticed it after that shit-ass next door molested me. When I was young I thought that I had that because of what he did to me and that everyone would know because I now had this bulge on the lower part of my stomach. I never ever told anyone -- not a soul, about this. My better judgement tells me that this is not so, but I'm afraid that if I tell someone and make a joke of believing such a silly thing, that they might tell me that is why my stomach bulges that way. I know it is wrong, but I still believe it. I feel sick just writing about it. I have this bulge on my stomach because I was molested and that's how men know. That's how everyone knows, but it's such a taboo that no one would dare come up to me and talk to me about my bulge. I am 37 years old and I'm writing this because I believe this. Yet, my better judgement is telling me it is not so. (Karen)

Given the profound levels of stress under which they functioned, many survivors did poorly in school – another "failure" they took responsibility for, and another source of shame.

Grade four when I failed. I remember the shock of opening my report card on that last day of school in the classroom. All the kids were milling about and asking each other if they passed or failed. I said I passed and I must have done it okay because no one questioned me a second time. I wanted to cry but I didn't, what was I going to do. The walk home was a long one, and when I got home my mother had company. I felt like I was going to burst, I was so ashamed. I took one look at the company and ran down into the dark, dirty basement and hid. I think I was crying. What a stupid thing to do cause it was my fault anyway. I should have worked better and harder. My brother had straight As. (Alice)
Peer relationships were also profoundly affected by survivors' sense of themselves.

I felt dirty, felt like everyone knew I was dirty. Between that and the cruelty dished out by the other kids because I had to wear my hearing-aid, it was more than I could cope with. (Jean)

In grade five I had my first real friend. Never told her what it was like at home nor confided in her. Continued to do poorly in school but became motivated with leaving home as soon as possible. (Alice)

This Jim guy that I was friends with when I was 13-14 had a friend, I can't remember his name. Anyway the three of us went to this party outside with a big bonfire. I was with Jim, even though we only went as friends. After I'd had a few I started talking more and more to the friend who I had been attracted to from the start. Anyhow, he took me back to his truck and we made love, if you can call it that. I don't think he really gave a shit about me anymore. Then I think it was a couple of days later when I saw Jim again. I think he came and picked me up. I think he was kinda upset with me. I remember sitting on his knee crying because I felt so bad and so stupid for sleeping with this guy in the first place. I remember telling Jim "please don't hate me, I'm not usually like that". He was such a good friend. He consoled me and told me it was okay, and didn't judge me like I expected. I never had a friend quite like him. He was just there, no questions asked. I'll never forget that night, that moment. I felt so safe in his arms. After I moved from the group home we lost contact. I'd love to see him again. (Kelly)

**Onset of Menses**

Typically, the mothers of many of the survivors had not discussed puberty or the onset of menses with their daughters. They learned either from friends, or older siblings, or found out for themselves.

Anyways, my mom had never told me about the facts of life. I went to the washroom and saw blood all over my private area. I took off bawling my head off. When I got home mom asked what was wrong and I told her I was dying. That the bleeding wouldn't stop and all she did was laugh in my face and finally she told me about the facts of life. She let me take the afternoon off from school and go with her to the drug store. Of course everyone in the family found out. Mom thought it was such a big joke the way I reacted. I hated having to go to the store for pads. I felt everyone knew when it was, all the time. The smell just grosses me out. I've just got to cringe thinking about it. (Ellen)
THE CHILD'S ADAPTATIONS

Attempts to Escape

Many survivors began running away from home, for short periods, in early childhood.

I don't remember why I was always running away. I can remember sleeping in parks and the cars. (Anna)

A common experience for many group members was that of escaping the home only to be returned by the authorities:

The next thing I remember is being at school. I had a black eye from George the night before. He was beating mom and I had to stop him, so he let me have it. Anyways, I was really upset about everyone staring at me. We had a break between classes and I went to the washroom. There was a couple of other girls there and one of them was telling the other what sex was like. I burst into tears and fled because I realized that George was raping me and that it was wrong. My girlfriend, Sarah, came after me and insisted I tell her what was I so upset about and I eventually broke down and told her what George was doing to me. She was shocked that I hadn't said anything to anyone before or that I didn't know what George and I were doing. I felt so incredibly humiliated and stupid. I made her swear not to tell anybody and she promised not to. The next day Sarah confessed that she had told her mom about George and told me I should run away. I didn't take her advice right away, but eventually the abuse progressed to the point where I felt if I didn't get out of there I wouldn't survive. So I ran away to Sarah's house. Mom wasn't happy about it, but she let me stay with them for a while. She was on welfare so she didn't have much money and there wasn't very much to eat. But I didn't mind, I was glad George couldn't hurt me anymore. But I was terrified of being caught and being taken back there. After a few days the R.C.M.P. caught me walking down the street and took me to the police station. The staff sergeant was a real asshole and of course I didn't like him because he was sending me back to George. They phoned mom and George and he came to the police station to pick me up. All the way home he kept telling me how worried they were and how I'd hurt mom. I had nothing to say so kept quiet. When we got home George beat the hell out of me and I had to remain in my room till it was time to go to school the next morning. When I came home my brother told them he saw me in the smoking area of the school, smoking and talking to a boy. I tried to tell mom and George that yes I was in the smoking area, but I didn't smoke and I was talking to my girlfriends who were out there. Of course I was lying, and by the time George was finished I was a mass of bruises, welts and cuts and it hurt to breathe. I was grounded and went through 4 days with no food and beatings if I so much as looked at anyone the wrong way. (Jean)

As they moved into adolescence they were more able to make effective escapes from the family home.
The older I got the more I stayed away from home. I used to pretend I was grown up and had my own place. No one would hurt me there and I would be pretty and have fancy furniture and lots of friends. I daydreamed a lot. I thought I would be a nurse like my mom or a famous singer. (Diane)

When I was 14 I left home and lived at a friend's house which was only three houses away from my parents. I never seen any of my family for one and a half years. I was allowed to stay there as long as I kept going to school. (Ellen)

**Self Destructive Behaviors**

A wide range of self-destructive and self-punitive behaviors were evident in the childhood histories of the survivors. At the least malignant level there was significant property damage (their own possessions usually), and antisocial acting-out.

I'm in the garage smashing the head of my best doll that I really liked. After I break it, I wonder why I did it - I don't feel anything - I had no feelings for that doll. Someone made me a beautiful blue taffeta dress - I went in the bedroom to try it on - suddenly I threw the dress on the floor and kicked it around and stomped on it. I don't have any feelings for this beautiful dress, I just don't care. I know I should be feeling happy but I have no feelings - I'm empty inside. Why can't I feel happy when something good happens or when I get something I really want? (Laura)

I used to shoplift a lot when I was younger. For a while I couldn't go into a store without taking something. It was the thrill and on the other hand it was so easy. I got pretty good. In the small town where I started there was no such thing as a store detective. The time I did get caught I was taken to the police department and they called mom from a party. She was asked to come and get me. She was not too happy. She made me phone dad and tell him. I wasn't charged. Then when I came to ___ a good friend, Janet, and me used to steal big chocolate bars from a grocery store. Mostly we stole from a Mac's store. We'd go in stoned and off our heads laughing and steal them blind. There was a fat woman working there and we used to make fun of her saying she was so stupid because we were so obvious. One time we took some bulk nuts in a store and walked around in the store eating them. The people got us when we left the store. Again we went to the cop shop but we were never charged. Actually I think we just sat in the office and the cops came there. I never stole again, twice caught was enough. (Kelly)

Although the following is a lengthy passage, it has been left intact as it provides an insightful description of the client's developing eating disorder. At the time she joined group, she had been hospitalized on three occasions and was still severely eating disordered. Eating disorders were very common among group members.
I don’t quite remember when I started dieting, but I think it was around grade 8. I started becoming very conscious of my body. Me and Jean, my best friend, would go on these great diet and exercise programs that would last a mere two weeks at the most. Sometimes we even took the afternoon off school just to plan it all out. It had to be perfect. We did this all the way through high school, and not once did we stick to a diet very long. One day we’d be eating a diet plate at the Dairy Queen, and the next day we’d be eating banana splits. Near the end of grade 12 I had put on weight because I had gone on the pill. I was about 125 pounds, which was chubby for my height. I felt really bad about it, especially when my boyfriend made a comment on it. He was only asking, but I didn’t think it was funny at all. It was time to get serious and really lose weight. It started out as a healthy diet, but somewhere along the line, it took a major turn into something that I would be struggling with for years to come. I had cut down on my eating and lost a few pounds, but the time came when I finally found a new way of losing weight. I started taking laxatives. The first time I tried it, I only took one of them. I was so sick and had such bad cramps that I swore I’d never do it again—until the next time. Gradually, the dose got larger and I started taking them more often. When one wouldn’t work anymore, I took two, and when two didn’t work anymore, I took three, and on and on. It went until I was taking up to nine laxatives every three or four days. I was addicted to them. I would get so sick that I would almost pass out from being so weak. It took everything I had to get through a day at work. By the time I got home, I would collapse on the couch and not move from that spot all evening until bedtime. I hated taking laxatives, but I couldn’t stop. No one knew I was taking them—It was my secret. Gradually the pounds came off and my friends started getting concerned. My family never knew what was going on because I never saw them, since I didn’t have to be with them anymore. A couple of friends at work forced me to go to a doctor. The doctor didn’t say much— he just sent me to a man psychiatrist. It was alright for the first movie on it before and couldn’t understand that someone could be that way. For some reason I went back again. I never reported it because I thought I wouldn’t work anymore, I took three, and on and on. It went until I was taking up to nine laxatives every three or four days. I was addicted to them. I would get so sick that I would almost pass out from being so weak. It took everything I had to get through a day at work. By the time I got home, I would collapse on the couch and not move from that spot all evening until bedtime. I hated taking laxatives, but I couldn’t stop. No one knew I was taking them—I was so scared. I wanted to run from the room, but I was frozen and my legs wouldn’t move. Needless to say, I never went back again. I never reported it because I felt to blame since I didn’t fight back. My friend finally sent me to another doctor—a woman. Right away, she said I had anorexia nervosa. I had seen a movie on it before and couldn’t understand that someone could be that way. For some reason I couldn’t see myself as being like that woman when really I was. The doctor threatened to put me in the hospital if I lost any more weight, but I didn’t think that could ever happen to me. Then one day at work, the doctor phoned me and said I was to be in the hospital by that evening. I held the phone to my ear and couldn’t speak—I just cried as I had never cried before. How could they do this to me. The secret was out now, and I had no control over myself anymore. They were now taking control and I hated it. My friend took me to the hospital that night. I was 89 lbs at that point, but still felt fat. I was forced to eat three meals a day, and if I didn’t eat everything I wouldn’t be given a day pass for Christmas. The next thing I knew, my body functions wouldn’t work anymore because I didn’t have any laxatives. I had to have a catheter and was given enemas. I got very sick then and went down to 84 lbs. I was so afraid of food that I started hiding it and throwing it away. But they eventually caught me and I got in a lot of trouble. After that they watched my every move because they didn’t trust me any more. One day I couldn’t take it any more and completely blew up. That was the first and only time I ever really let my anger out. I started crying and yelling at everyone and throwing things around. All my emotions which I built up so long inside myself, were coming out,
and it frightened me because I felt out of control. I even tried to escape but I was stopped. I finally started eating properly because I wanted out. I was released six and a half weeks later at 95 lbs. (Paula)

Alcohol and drug abuse were commonly noted coping strategies among survivors, and, as a result, members were frequently placed in dangerous situations either directly or indirectly.

I started drinking when I was around 11 and every weekend around 13.... Joyce was constantly trying to set me up and I was just turning them down when I was straight. But when I was drunk I was so vulnerable. All I ever wanted was a hug or someone to talk to. But, unfortunately, I'd get drunk and the next thing I knew I was being fucked so I'd simply just blank it out. After all, why stop now. (Mary)

When I was fourteen I was sent to a psychiatrist, a middle aged man who only listened and scratched notes on paper. The only help I got from him was regular prescriptions of tranquilizers. I began to have great pleasure in taking more and more each day. Their effect was numbing and I enjoyed it. (Chris)

We always drank Saturday nights. He (her boyfriend, and later husband) was often quite drunk when he picked me up, as he went to the beer parlors Saturday afternoons. I was a little bit worried about this but a lot of guys drank and somebody said "he's sowing his oats and he'll slow down after he's married with a family." I went to a beer parlor when I was 17. I was scared, but it was kind of exciting at the same time. I always looked older and was seldom asked for I.D. Drinking and driving never seemed to bother me except when he would speed or race with someone. Sometimes I would crawl under the dash. One time we hit a stop sign in the middle of the windshield just above the glass; went down into the ditch and up the side into the woods. I was really frightened. After that I tried to get someone sober to drive. All our friends drank and it seemed the thing to do on Saturday night. (Diane)

Instances of self-mutilation was also noted by a substantial number of survivors.

I was only thirteen, starting my first year at high school. Still so young, but had grown up fast with many hurts and responsibilities cast my way. I began to suffer with depression — severe low moods that resulted in suicidal thoughts. I cried to God to let me die, I didn't want to be hurt anymore. There were uncontrollable periods when I would use a razor blade to cut long gashes on my arms. The scars are a constant reminder of my irrational behavior. (Chris)
Suicide Attempts

The vast majority of members had attempted suicide in the past. Many first began considering it seriously while still in early childhood.

During that winter (age 6) I thought of crawling underneath a train and letting the train cut me to bits. (we lived on the opposite side of the main C.P.R. line). I didn't though because this little boy Joey was playing on the tracks and got his legs (both) cut off and had to live in a wheel chair, and that to me was worse than the nuns (she attended a catholic school). (Alice)

I tried to kill myself (age 12) by cutting my wrists with a broken ceramic doll. But I had to punch too hard on my wrists and it wouldn't cut deep enough – just scraped the shit out of the arm and hurt like hell. (Mary)

The day I overdosed was planned. I knew the morning I got up and went to school that it would be that day. My mom was not there when I came home. Left, as usual, was a note on the cupboard with a long list of chores to do before she got home. Signed Mom. The love was never there anymore, not the XXXs and OOOs she used to write on the bottom of every note. I went in the bathroom, closed the door and swallowed all the pills left in my prescription bottle – 32 pills. I knew this would certainly be enough. My step-sister found me lying in my bed. The next thing I remember waking up in ___ General Hospital. I kept crying for my mom, pleading to the nurse to get her for me. She told me that mom had phoned, that she was busy with the baby and was sending my step-father to pick me up. The move to my dad's parents was as cold and callous as it had been for Harry years earlier. There were no goodbyes, my suitcases were packed and I was gone. Only this time it was me, my heart broken for having lost my brother Tim. (Chris)

Police have come and informed mum I was at a wild party, where a girl was raped and everyone was drinking. After they leave I can't face mum for some reason? I go in the bathroom and drink poison - want to die, can't stand her talking with dad about how bad I am. (Laura)

MOVING INTO ADULTHOOD

Adolescent Sexual Relationships

Many of the group members became sexually active with peers at a young age – there was little sense of boundaries or the "right to say no".

It seems like from really early on I was always preoccupied with sex. There was no such thing as non sex in a relationship and since my first time was at such a young age it was no problem if some guy wanted it – I didn't have to worry about my virginity being broken since it was long ago. My one boyfriend who I spoke of before, Ken and I used to sleep together in a sleeping bag which was beautiful in the middle of the summer. But he used to bend me around like a pretzel and only
cared about getting his own rocks off. I was terribly in love with him though. He was older, good looking, and kind of sophisticated (to me anyhow). In the end I found out he was seeing another girl and he lied to me to send me on my way. I was very upset. But it wasn't long before I was doing it with someone else. There's always been a steady since I was about 13 years old. (Kelly)

Although seeking love and safety, most often members became involved with boys and men who carried on the abuse traditions of their father-offenders: critical, over-controlling, betraying, and profoundly insensitive to the needs and responses of the young survivor.

My first steady relationship with a guy wasn’t until grade 12. I was 16 years old at the time and he was 22. He was also my student teacher in English class. I just couldn’t believe it when I found out he liked me — why in the world would anyone want to go out with me. Our relationship had to be a secret because student teachers weren’t allowed to go out with students. We had to go out to (the city) or somewhere else if we wanted to go to a movie or out to dinner, or something, for fear of being seen. We spent a lot of time at his apartment. I would get really scared when we were alone together because I thought he might try something. I was pretty naive when it came to sex because it was never talked about at home. Not long after I'd been seeing him, he wanted to go to bed with me, but I wasn’t ready. After pressuring me about it so much, I finally gave in. I was so terrified I couldn’t speak — I just laid there and shook. I tried to hold back the tears, but I couldn’t, so I turned my head so he wouldn’t see me. I could feel the pressure. I tried to pretend I enjoyed it, but he could tell I didn’t. It didn’t stop him though. Time and time again, the same thing happened. I would lay there like a puppet while he did his thing. Not once did I enjoy it, I was too scared to. I never did say anything though, because I was afraid he would leave me — he was all that I had. Eventually I found out that he was seeing another student on the side — I was completely devastated. We were supposed to get married in four months. (Paula)

At 13 years old my brother was born. He was always sick. Made a decision to go to bed with a man who was about 22 years old, whom I baby sat for. Everyone had someone except me. It was neither bad nor terrible. Didn’t make me feel important or special. My mother was always in the city with my sick brother and this was good. Dad worked two jobs and my other brother mainly stayed with friends, so I was alone. No one bugged me. During this time my bedwetting stopped. People described me as sullen and withdrawn, I was safe. (Alice)

My first real boyfriend and I began dating when I was 12. His name was John and he was three years older than me. We went steady for three years and became engaged for the last year. I couldn’t say anything about this relationship was bad except that John was hypercritical. I’m finding out that I can be very athletic and that I can sing and be a classy person and be well liked. John always made me feel like I had no talents and that I wasn’t too good at anything. He and his friends and family were superior to me. Three months before the wedding he left me a note saying he didn’t want to see me again. On the date that was supposed to be our wedding he married another girl. With the exceptional write-up in the paper about the lavish wedding I knew that he must have
been seeing both of us at the same time. I guess he didn't know which one of us he really wanted. (Judy)

The parents' role and response to the girl's dating was generally confusing and degrading. Mothers frequently seemed to push their daughters out into sexual relationships, while offender fathers were generally jealous, possessive and punitive.

I remember being about 10 or 11 and it was another party at (parents house). There was this guy, Gord, there. We were sitting on the couch and mom was asking me if I'd ever french-kissed with a guy and asked if I'd do it with Gord. So I did. I kind of liked him anyway. He was 19 at the time, tall, dark hair, and kind of handsome. Soon after that we were seeing each other on a regular basis. I soon lost my virginity in the front of a truck up the mountain. When dad found out he was so choked he yelled at me and called me a slut over and over again. I could never figure out how he knew, but I think about it now and with his doing what he was doing it was only obvious someone had touched his toy other than himself... Soon after it was a fuck here, a fuck there, or anywhere. Head on the way to the store - I remember feeling so sick, confused and shallow. (Mary)

I went out with guys when I was 13. Sometimes we went out with a bunch. Dad never allowed any of my boyfriends in the house. If he was at work, mom would invite them in for dinner or coffee. They would drive up and I would run out quickly. He made remarks about what they wanted from me. Some mornings he would say "you sure got bags under your eyes, I know what you were doing." He said "whoring around". I necked with them and some of them touched my breasts, but I never had sex with any of them. If they bought me a gift dad would say "well, we know how you earned that". (Diane)

Marital and Dating Relationships

A very high proportion of the women became pregnant in their teens and "had to" get married. This only reinforced their sense of powerlessness, badness and shame.

I am pregnant at 16, I am a tramp, cheap, common, and my mother will be disgraced in the eyes of the family for what I have done. My Dad can't even look at me, he turns away. My mother says - you don't have to get married if you don't want to - but I can feel her feelings and my dad's feelings and I don't have the guts to go against their feelings. I don't want to get married but why can't I believe in myself, why can't I be who I am even if no one approves of the real me. (Laura)

Bob, my first husband - I didn't even like him, but for the first and only time I enjoyed sex. Became pregnant but I didn't want to marry. Everyone said I should, him included. I did. Three kids later I walked out. Divorced, worked and supported the kids. Let the girls who were older live with their father, they could stay wherever they wanted. Everyone said I was wrong but then everyone wasn't right about Bob either. (Alice)
The day of my seventeenth birthday my pregnancy was confirmed. My immediate concern
was forwhat my f a d y wouM think, doubting that anyone would support me. Dave's reaction was
very hostile, he insistedthat 1 have an abortion, that he was not ready to settle down. My mind was
made up. With orwithout himlwasdeterminedto keepthe baby and raise il myself. Dave did marry
me when lwas three months pregnant - unfortunatelyforatlthe wrong reasons. He felt it was the
right thing to do for the sake of the child. My marriage to Dave lasted only four years. During that
time I was avictimof physical and sexual abuse. My memories ate painfuland very ugly, and in order
for me to cany on with my life Iforced to try to shelve them. Iworked hard to master a disguise, a
portrayalof someone that is nearly perfect. (Chris)

At best, the women married distant, authoritarian, and critical men who restricted
themselves to emotional abuse
Ionly really knowthat life's sometimes a real bitch and when your time comes you die. Iguess
beingaround (her husband)doesn't help. He means well but he picks on all the wrong of me, and
never says the good in anything except as far as dinner. He always thanks me after a meal. He
doesn't understand me and my problem, therefore no compassion and Imust need it because I
sure desire it. Ifeel unwanted when not commented on the good, and if I'm starting to feel
unwanted I'm historyand d f uded up. (Mary)

At worst, the women became involved with very dangerous, antisocial men who
rapired the women to support them while they abused the swivor and her children
Imet my next steady boyfriend at the
Hotel, he was a waiter in the bar. He was a real
jerk. Even when we were l i i g together, he foobd around with any woman who was available. I
was such afooi i had never met anyone so sneaky and deceitful. He was so wild, so mean, so totally
rotten he kept me interested. The worse he treated me, the more turned on Iwas. He became a
junkie and to keep me off his case he started gbing me acid and M.D.A. Iworked graveyard shift
and he would meet me and we would get stoned in the morning and stay that way ail day. I did
dntgs heavilyfor about a year. One day Iredizedhe was redly wired on junk and he needed more
moneyandthat he was doing robberiesand other criminaladiviiies. The cops started taking me In
for questioning and stopping me and searching my car and ripping il apart. Iredhed I was very
dose to beingarrested and maybe goingto jail, this scared me. SomehowIpulfed myself out of this
mess- Itokl himto keep d thejunk iliwayfiomhome. ISopped using d r ~ g and
s stopped hanging
aroundwith the drug aowd-(she had two young daughters in the home at this time) (Laura)

Even though he Wed with me and I supported him, we literally had no contad except at
night He WWM Sleep d day then he would want sex about 9 or 10 o'dock. After that he would
showerand change and then go out onthe tam. Gkk wouM come and pick him up or even drop
h'm off ab dt hoursofthe eatfy morning, He figured he gave good sex and he felt it was just a part of


him to give any girl he wanted pleasure. He told me that as long as he didn’t advertise what he did and that he always made sure I had lots of sex, that I had no right to complain. That it took a strong woman to love him and I had to be or else he would find another woman. He would steal from me, beat me, beat my kids, force us all to eat scraps that he left behind after he gorged himself on the dinners I cooked.  

Judy

An ex-boyfriend of mine just got out of jail and he called me tonight. This is the day I’ve been dreading for the last two years. If it had been anyone else, it would have been fine – but not Curt. I had gone out with him for one and a half years and then I broke up with him – too many mind games, too much guilt. After that he put me through terror for the next couple of years. All the letters – the phone calls – the visits to the apartment in the middle of the night – the spying. I was afraid to open my curtains. I was going crazy. He eventually went to jail for rape. But now he’s back and those fears are overwhelming me. I’ve never been so scared of anyone else that I have been with him. I don’t know how to control all these feelings inside me.  

Paula

Most of the members had been involved with men who not only emotionally abused them, but battered them as well.

I did love him at the beginning. Then when I moved in with him his drinking would bother me sometimes. I didn’t really pay much attention to it at that time. I was 16 when we first met and when I was 18 we got married. He had gotten drunk from that day on, even on our honeymoon he passed out on me. Things started to get out of hand, then I got pregnant. I thought things would change after I had told him. I was so excited. I know now I should have waited. We had only been married for four months at that time... When we got married Rob started to rule my life. I wasn’t allowed to have anyone over when he got home from work. He came home from work one day and Sally was over. Fuck, that jerk embarrassed me. He started yelling at her and I told him to shut the fuck up - he then decked me. Finally my friend, Joyce who lived two doors away from me had talked me into leaving him. He knew I was going to leave him after I had healed from the eight ribs he had cracked. Fucking jerk. I was supposed to take care of (the baby) with this pain. Boy was I scared. I phoned the Transition house and one of the ladies come to Joyce’s at four o’clock that afternoon.  

Ellen

The last time he (her husband) hit me was about one and a half years ago. Now that I look back it was almost right off the bat that he started to control, or try to, my emotions. For instance he was famous for, whenever we had a fight, he would say "if you don’t like it, leave" or that he was gonna leave me. For a long time it worked. I’d end up in tears, begging him to forgive me, or not to leave me. The first time he hit me was in his truck. He was driving and he back-handed me. On whole side of my body went numb like pins and needles – from shock I guess. Right after he said "I guess it’s over". I said "oh no, it’s okay". Stupid move. Now I wonder if I was too young to know better, to understand the way relationships work, or if I was simply used to it. The second time he hit me was not too painful physically, but it scared and embarrassed me because it was in front of other people. John’s best friend was there, Ted – I begged him to help me and he just sat there. I hated him for a long time after that. Nobody did anything. I couldn’t believe it. The third time we
were BBQing with another couple in our back yard. And I made hamburger patties, they were too mushy and kept falling through the grill. He got ticked off and threw the flipper at me. It hit my bum as I was walking away. It hurt but again it was twice as bad because it was in front of friends. The fourth time he just gave me a light swat on the back of my head in front of Ted again. The fifth was the worst. He had been drinking — the only time he hit me when alcohol was involved. We were driving to see friends in the bush near ______. We had another couple in the truck with us and John had been drinking the whole time driving. On the way up the mountain he scared us several times. Finally I asked him to stop and told him when we did I wasn’t going to drive with him because I was scared. I said I was gonna walk. This is in the middle of the bush with no lights in the night. Finally he told me to get back in the truck and I did. He seemed to be okay. When we got up there we were unloading the truck and he said he wanted to talk to me. I didn’t want to fight so I walked away and he threw a rock at me. It hit me on the back of the neck and it hurt. My glasses flew off then, I ran into the house. I heard him start up the truck and I thought he was going to run me down in there. Then he turned it off and he talked at me some more. Then we went to sleep. Things were never the same after that and it was about one and a half to two years before I got an apology. The best apology I got was him agreeing to work on our relationship. I can’t help but wonder if my past had been different, if I wouldn’t have met him — what would someone else be like? Now he says some hurtful things, but not too much anymore. (Kelly)

Spousal rape was also a common experience for group members.

I was living with my common law husband. Things seemed to be good, but I guess things weren’t. I remember that he would always ask me to do sex things that I didn’t like. But he kept asking me if he could tie me up all the time, and it made me feel uncomfortable. But one night I gave in and did it. But things were okay, he didn’t hurt me. So he asked me a little later if he could and I said no. Then he kept saying “if you love me you would trust me”. But that was a lie. He was okay for the first one hour, he was nice, he did not hurt me. Then he wanted me to give him a blow job, and I didn’t want to. I never liked it and he knew that. So I asked him to untie me. But he didn’t and I couldn’t scream or yell at him — I didn’t want to wake up (her infant son). He made me do that blow job and then I threwed up. He got mad and started to punch my crotch and I told him that hurt. He said good, and started to screw me. But it hurt and I was crying and he laughed. Soon he stopped and untied me and went to the other room to bed. But about two hours later I got up. I went in the other room and I was going to hurt him back but he was crying. He told me he was sorry and it would never happen again. Things were pretty stupid. I should have moved out but I was scared that no man would want me because I had a son. (Gail)
I know the best sex is spontaneous. Not these right tit, left tit slam bang thank you mams. Then I felt used. Finished before I got started. When Tina was two she came running around the corner and smashed into my pelvis. She floored me. It took three years for the pain to go away. After a half dozen thrusts the pain would become so bad I would cry – didn’t matter, he wouldn’t stop. Or force himself down my throat so far I would gag. It was like I had no feelings, he just kept it up. Sometimes when I was really starting to enjoy he would try putting it up my anus. No warning, just pain. Or thrust in and out and hit my womb. Or be so stinky and dirty I’d want to vomit. Or be so drunk it would go on and on and on and on. Or the time he and his friend brought two girls home. Woke up and she was in my bed. Kidced her out and threatened to cut John’s balls off. It was like everything else in his life – he took what he wanted, when he wanted, how he wanted, and be damned for anyone else’s feelings ... Fuck him, Fuck him All that pain. He even had to fuck up our sex life. Anything to hurt me. Thank God that part of my life is over. (Anna)

Adult Victimization

A significant proportion of the women experienced stranger rape – generally in the context of their own substance abuse. Survivors tended to take responsibility for the rape, thus confirming and extending their sense of self as bad, shameful, and deserving of abuse. The notion of reporting their assaults never occurred.

I had had too much to drink. For me that was four beer. The thing was over and everyone started milling about. I was still laughing and then I felt arms around me and I was being propelled forward through the club. We went through, out into the lobby and down the aisle and into an employees only door. I was feeling really dizzy and was fighting not to get sick. This was strange and I wondered what was happening but I couldn’t stop, nor speak enough to get an answer. The guy was the bartender I could see by then. We went through one last door and we were in a sauna. I was fighting this nausea and fighting not to pass out, but I kept going in and out of consciousness. My head kept falling back. I couldn’t seem to say “what’s going on?” or nothing. Maybe I’d had more to drink than I thought, but by then it was too late. This guy was tearing at the buttons and zippers of my pants and he ripped them down to my ankles along with my underclothes. I started to giggle. This bothered me but now I found out that whenever I’m in a bad sexual encounter and I’m really uncomfortable but have no control over what’s happening, I giggle. It’s like being afraid, but too scared to say “stop”. Anyway - he pushed me down onto the bench nearest the floor. He ripped my shoe off and took my pants off that leg. All this while I was passing in and out. I couldn’t do anything or say anything. I knew he was fucking me but I couldn’t feel anything. My leg was pushed up against the charcoal stove and I could feel its edge but I couldn’t feel this guy’s penis. He was old and ugly. He was bald and had a beard. I knew that I should hurt him. I wondered if I could just stop him. He thinks he’s so great – what if I told him he was so fucking small that I couldn’t even feel his dink. I wanted to scream at him but I just couldn’t stop the room from swirling. I would be so embarrassed if I threw up - I had to at least seem like I had some control, but I didn’t. Suddenly he yanked me to my feet and pulled up my clothes. I tried to put some order to my clothes, but I just couldn’t get them back together. They were twisted and wet. I didn’t have
time - again, I was being pushed and within seconds I was back in the milling crowd. I finally found my friends and they were still laughing. They asked me just where did I disappear to and I realized that they didn't even realize that I had just been used to get some asshole's rocks off. I was just stunned. (Judy)

(A group member) triggered a lot on Thursday. I went through the same things. One time at a Halloween party I guess I'd asked for it. I was talking to a guy at the party and the next thing I knew I was in his truck. He kept my panties to show all his buds he'd succeeded. Another time I was at the bar. I was so drunk a guy got my keys, put me in his car, drove me to his house, and did his thing. When I awoke I knew what had happened. I went to the doctor - he told me I had gonorrhea. God, I feel so sick. I wanted it. I wanted to be treated like shit, to be disregarded and not thought about and I was. I had no respect for my body and therefore no one else did either. There was never a wonderful feeling. I don't know why I'd keep doing things that way, but I guess I was just another fucking thing I did to fuck my life up. (Mary)

Victimization was an ongoing and current concern for group members. The following passage details a sexual assault experienced by one of the group members during the first few weeks of therapy. It draws attention to the current abusive context in which many of the women existed as they entered the therapy process:

My friend's dad walks by my place in the mornings almost every day, so I talk to him quite a bit as I'm going out to work. I've known their family since elementary school because I used to go over there quite a bit - though I haven't really talked to this particular friend for quite a while. Her dad used to be an alcoholic and get quite violent, but he hasn't had a drink in a long time now, and goes for walks twice a day for exercise. He seems to have completely changed for the better since he stopped drinking. Anyways, he came up yesterday morning for a coffee - I didn't think there was anything wrong with that, although it took only a couple of minutes before I knew I had made a mistake. He started telling me that he loved me and then tried to kiss me. I pushed away and told him to stop, but he was too strong for me. He had his arms all around me and I couldn't move. I quickly ran to the couch on the other side of the room and he came after me. He kept telling me how nice I was and that he could never hurt me. He said he had liked me for years. He cornered me on the couch and there was no way I could get away. His hands were all over me and he tried getting my clothes off. All the while he kept saying how he loved me and stuff and that he would never hurt me. I even started to believe him. And even though this man was all over me, I almost started thinking that he wasn't really a bad person. It was almost an hour before I finally got him to go because I had to go out. But before he would let me go he made me tell him that I liked it. I felt horrible saying that, but that was the only way he would leave. When he left, I kept wishing it was all a dream, but it wasn't. He didn't rape me, but he saw and touched every part of my body, and I feel so ashamed and humiliated. I feel like crawling in a corner and dying. As I sit and write this, he is outside right now ringing my apartment. I will sit here and pretend I don't hear it, and pretend it never happened. But God help me, he will never come up here again. (Paula)
Role as Parent

Many of the women had to confront and deal with the sexual abuse of their own children. Initially, as group began they were able to acknowledge non-family sexual abuse of their children. As group continued, a significant number found that their children had been sexually abused by their ex-husbands and boyfriends.

I'm sitting at (the treatment center) right now trying to write in this book and all of a sudden I'm crying. Man I would love to find that bastard who molested Jessie (her four year old daughter). I can hear her screaming in the room next door. I'm so upset. Why the fuck did it have to happen to her. Its so hard to deal with all this shit. (Ellen)

The following passage was written by one of the members about her 5 year old daughter who had just recently disclosed sexual abuse by a male babysitter. Karen came to recognize the parallels between her distancing from, and judgements of, her daughter and her own child-self who had been first abused at about the same age.

I'm really concerned about my five year old daughter. I love her so desperately and with all my heart, yet I am pushing her away. I cry when I think about it. She loves me and wants to be near me, but I end up saying something hurtful so she'll go away. What the hell am I doing to my baby. I love her so much, I'm disappointed in myself. I'd love to draw her close to my heart, but I can't. I hurt so badly, but I'm also hurting her too. Oh God, I do not want to keep hurting her, but do not know how to stop. I can't stand this. I sometimes wonder if she wouldn't be better off without me. I see her so desperately trying to give me her love – I'm afraid she will stop, but it hurts me so deeply to see her continually trying – like butting up against a stone wall. I tell her I love her but I don't think that in her heart she really believes me, because my actions don't show it.... When she was a baby her and I always were connected. I knew all her feeling and could usually act appropriately. When she began to talk, we had wonderful conversations and wouldn't take our eyes off each other. We connected very well and our love flowed. It does not flow now and I am sick. We need each other but don't have it. What in hell have I done. (Karen)

Beginning to recognize their own history as abusive and inadequate parents also began to appear during this first phase of therapy. Issues around child protection arose and had to be handled safely and firmly by the therapist – reporting, and the resultant provision of child care workers and mandated parenting programs were often appropriately employed.

Right after last week's group, I felt pretty shitty. When I listened to Laura's account of what her mother was like I felt ashamed. I am like that. Oh, of course I'm not as bad as that anymore. Though I
used to know I felt such an uncontrollable anger at the frustration of like - I couldn't stop nagging at my kids. Prodding them and degrading them. (Judy)

It has been three days since I wrote anything - since the last group day. I still have a knot deep inside my stomach that sickens me. I can't believe I told the group that I thought if I'd had boys, instead of girls, that I might have killed them. I'm sick and frightened by that thought. My anger is horrific. I'm frightened and the knot in my stomach is starting to make me feel like I could throw up. I haven't eaten much and I'm afraid. I'm afraid of my lousy life and what I'll have to deal with. (Karen)
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PHASE II: WORKING THROUGH

The purpose of this phase of therapy is to begin to process the issues arising from the previous phase. In a sense, we have now put the pieces of the puzzle onto the table, some preliminary assembly has already taken place, and we now need to assemble all the pieces together into a coherent and workable whole.

The process of working through the issues necessarily integrates cognitive, affective and behavioral experiences. This process of integration is particularly salient for survivors who, at many levels, have had to split off so much of themselves and their experience.

SESSION STRUCTURE

Sessions 9-21

Session format continued as it did in the previous phase, with each member taking her turn reading out her journal work and engaging briefly with the therapist in its interpretation and clarification. The therapist then assigned the next week’s homework for the member before moving on to the next participant. As before, about 20-30 minutes were reserved at the end of the session for group discussion of the themes arising during session. As in the previous phase, the therapist took notes during the members’ journal readings.

SESSION CONTENT

As shown in Table 20, four major themes were addressed throughout this phase: confrontation with the abusers (metaphorically, not actually); intrapersonal issues; interpersonal issues; and the members’ changing experience of their world as they continued their healing. Although the general flow of the process followed this sequence, it was not strictly adhered to in the individual case. Rather, the therapist directed individual’s attention to the topic areas in the sequence, appropriate for each individual. The experience of hearing another member’s work on the various issues clearly resonated for the rest of the group and prompted their own insights and integrative experiences. The therapist needed to be flexible and inventive in terms of
framing homework assignments such that each member could usefully approach an issue – there needed to be enough structure, as well as enough freedom, for the client to continue feeling safe and exploratory. Clinical judgements regarding an individual’s levels of readiness and capability were important. Examples of the types of homework phrasings are provided throughout the current chapter.

CONFRONTING THE ABUSERS

For most members, phase II in the process begins with their letters to their abusers (sexual, physical & emotional). Thus, the letters are not intended for actual forwarding to the abuser in the real world, but provide each survivor with total safety to express, without censoring, whatever she would want to say to the abuser. The therapist recommends that actual confrontations, if desired, be deferred until group members have completed their healing. In so many cases, members are still far too fragile and abusers too dangerous, for confrontation to be safe. Subsequent to their therapy, a number of participants did confront their abusers and were even able to lay charges.

The homework instructions for this exercise were: "Write a letter to your _____, telling him or her everything you want them to know and need to say to them. You will never send this to them; it’s an absolutely safe place to do this. This will probably be an installment letter over the next week, just let it roll."

The letters provide a valuable transitional exercise in their own right. Both the tone and content of the letters tends to shift from a deferential seeking tone, through to recognition of the realities of the abuse, and from there to a repudiation both of the abusers’ right to harm, and the victim’s sense that the abuse was deserved.

Sexually abusive father letter

The following letter is reproduced in its entirety, as it nicely demonstrates the actual process occurring throughout the letter writing exercise. Starting with her child-sense of responsibility for the abuse as being due to some property of herself, she came to give father full responsibility for it. Themes arising included her role as substitute spouse, mother’s caretaker, her multiple losses, the impact on her development, etc.

Dear Dad: I adored you and loved you so much and trusted you with my life. You always made us laugh, and when you laughed your eyes would wrinkle. We used to tease you about it. I do
I remember feeling loved by you and safe. Then you changed and I’ve never known what I did wrong. I wanted you to hug me and tease me, but I never wanted you to hurt me so much. Daddy, all of those nights that you made me come downstairs, I wanted to stay in my bed where I was safe. But you wouldn’t leave me alone. Then you died, leaving me all alone. Your pain ended while mine began. I remember when I was in my early teens and I realized what you had done to me and what we had been doing was so very wrong. I was so angry at you because you had left me behind to feel the shame and guilt. There were times when I hated you for what you had done. You had awakened feelings in me that I didn’t know how to deal with and so I tried to suppress them. I wanted to be a good girl so bad, you never even gave me a chance. You robbed me of so much with your self desire. You know dad, I kept your picture on my wall all of those years until 1981, twenty-eight years, I never looked at it with love, always anger. It reminded me constantly how unloved I was. On a day (her younger brother) said he didn’t have a picture of you, so I gave it to him. It has brought him more joy than it ever did me. I don’t miss it at all, but I still feel the guilt. I’ve made a lot of bad choices in men that I let into my life. I never felt as though I was somebody. I’ve never felt as though I was somebody. Dad, I was your daughter, not your wife.Why couldn’t you have felt the same way? Why couldn’t you have loved me and protected me? I need these to be answered by you, but it’s not to be. I’ve needed you to put your arms around me and tell me how sorry you are. Why couldn’t you have lived and helped me? Dad, I have so many mixed emotions over our relationship or lack of one. You never touched (younger sister) in a sexual manner, why me? What was it about me that you wanted to hurt me so badly. Was it because I looked so much like mom. I know that you two didn’t get along. I remember the awful fights that you used to have. Mom sitting on the floor leaning up against the sofa, crying hysterically. Us kids getting cold cloths to put on her forehead. Was it because I showed an excessive amount of responsibility. Whatever it was that triggered an ugly monster inside of you was not my fault. Dad, you were the trusted adult, it was your responsibility to nurture and love and protect me. I was your little girl you had no right to abuse and hurt me so bad. You robbed me of my self esteem and self worth. You had no right to do that to me, they were mine and now I’m fighting to regain them. I feel so much anger toward you now. What do you mean by telling me not to tell anyone about what was going on. Bullshit. Sure you knew if anyone ever found out then you’d be in big trouble. What kind of person were you to inflict that kind of shame, guilt, responsibility and hurt on to me. Sometimes it’s all just too much for me that adults have that kind of control over their loving, trusting and beautiful children. Yes, I was all of those things once. You’ve robbed me of so much. I wanted a loving, close family, a mom and dad that I could be proud of, that would meet all of the needs of a loving little girl. I used to be so jealous of my girlfriends and the relationships that they had with their dads. I used to wish that we could’ve been like them. I was, what happened to you?

I grew into adulthood feeling used, abused, not trusting, angry, confused, dirty and unloved. I spent a lifetime pushing all these feelings down or aside, all because you had laid your trip on me. As an adult I can’t stand up for myself. I’ve let people treat me exactly the way you conditioned me to. I take everything so personally and I hurt. I just cower away, confused as to why they would hurt me – never, ever thinking of myself as a worthwhile person. Dad, I have very few memories of my childhood of being a happy little girl feeling safe and protected. You took away the innocence of my childhood. I lost myself during your abuse of me. I felt betrayed, fearful and lonely. How could you
instill all of this ugliness in a little girl who just wanted you to love her? The rejection that I felt was so enormous. I took it all so personally. I used to think that as a very young girl I must have done something really bad that I couldn’t remember and I was being punished for it. I ran away from the pain that you inflicted on me. Trying oh so hard to prove to everyone that I was a good person, and yet never believing it myself. I grew up blocking out the abuse, pushing it deeper and deeper. It kept rearing its ugliness from time to time and I’d tell myself “don’t be such a baby, stop crying, you can’t do a thing about it”. It was always there, never going away and I felt helpless.

Dad, I have been victimized all of my life because of your selfish needs. You set me up for all of the relationships I would have. This is the first time in my life that I can say and believe I was and am your victim. You were so powerful over me, brainwashing me into your abuse of me. You were the adult and I the child. Oh, how powerful you must have felt. How could you feel good about yourself and me, you were such a monster. No wonder I had nightmares and stomach problems. I’ve grown up constantly on the verge of tears, always crying on the inside, never knowing why. Never happy with myself or anything that I’ve done, and yet being a perfectionist about everything that I did do – sometimes a perfectionist to a fault. Dad, I did grow up and I do live with my past. It’s still painful and I still feel cheated out of my innocence, but I can make it. God only knows how I made it this far. I lived a shattered life because of you, not because of anything I did or said. I was a little girl that you had produced to love and cherish, not abuse and use for your own pleasure. You know dad, I always had trouble with the fifth commandment “honoring thy father and thy mother”. Today, in my heart, I know I don’t have to live by it. First of all, you have to earn it as a parent. You never did that dad – from the first day you began abusing me, you see, you were not an honorable father. Dad, I have two children today. My daughter ___ is 26, and my son ___ is 16. They know that you sexually abused me. I’ve taught them that their bodies belong to them and are not to be abused by anyone. If you were alive today they would never have to fear their grandpa. I would never have left them alone with you and now they are old enough to stand up for themselves.

I’ve missed my father since you died, but you were not my father when you were alive and I do not miss my abuser. (Joyce)

Some members were not able to approach the sexual abuse by father initially, but first needed to state and clarify the overall context of neglect, emotional and physical abuse.

Dear Dad: Well, there is a lot of anger in me father. You know this. It’s just too bad I never had the guts to say it to your face. All those nights you were with your girlfriends – I hated you for that. When I was a little girl and you would help me with my schoolwork. I remember I was in grade 2 – you would hit me and slap me and tell me I was stupid. You would repeat yourself while you were hitting me, just because I didn’t understand the work. I was in grade 2 dad. If I needed help in my schoolwork, why didn’t you get someone who was especially trained in that work, like a tutor. I was so scared when I knew you would be sitting down with me and going over my homework. You would get so frustrated because I could not understand. You made me feel like such a terrible little girl. I mostly remember the look on your face and the terrible slaps you would give me. For the rest of my schooling I truly believed I was stupid and could never be a successful person in the work force or school. Every year was hard for me in school. I was put with the rest of the stupid kids in my
classes. When I look back you were never there for me. You were always working or with your girlfriends. All those mean things you said to mother. Why? Did you hate her that much? Wasn't she ever the wife you wanted? I hated the way you kept your bedroom, it was a nightmare. And that car you had – how could you drive a car that let the gas fumes back inside. You had enough money to buy a new one. Why at the last few weeks of your life did you then sit down and be my friend and father? Why? You changed so much at the end of your life, and then you were gone. You gave me money and material things whenever I wanted them. I became a spoiled female. If only you could have spent a little more time with me. I don't think I was asking that much in the way of love.

Our family life was wrong, it was wrecked because of your girl friends. You just had to see. It's true what the bible says: for whatever a man sows, that he will also reap. Dad, you died screwing a prostitute. I hated to go to her house and get your car. She was only 19 years old. Why? Your daughter Barb

On occasion, the women are not able to directly confront the father-offender via the letter format. This was most often found in cases where the offended remained a threat and where extreme violence had occurred. Using the frame of "describe ____ for us, what kind of person was he?" tends to be an effective alternate method to help the woman place the offender in context and to permit herself to acknowledge her legitimate feelings toward him:

Okay. George (stepfather) is a male Caucasian, stands about 5’4” tall, weighs about 189-190 lbs., and is of medium build. He has brown hair which is rapidly greying and has cold blue eyes. He is a violent alcoholic who is concerned about his own needs and wants. Everyone else can go to hell is his attitude. He works no matter how badly hungover he is, and is good at his job as a sales manager. He makes a good living although he spends all his money long before he gets it on his alcohol and frivolous luxuries to comfort himself. He cares about himself, his son and two daughters, but he comes first even before them. He is suicidal and has attempted to end his life on numerous occasions. He is a liar and a cheat who will take advantage of anyone he can, no matter if he likes them or not. He is not capable of showing affection except in sick and perverted abusive activities. He is as dangerously unpredictable as thin ice – you never know when, or if, you will fall through. He also has the ability to seek out and find a person’s vulnerabilities and use them to force said person to conform to his wishes and desires. A con man of the worst kind. He is a sick, sick animal and must control and hold power over all the human race. He does not acknowledge or remember what he does when he is drinking. But, that is an untruth, he knows exactly what he does, or did, and why. He is very capable of taking another person’s life and would not hesitate to do so if someone was foolish enough to “threaten” him in any way, shape or form. Easily feared and easily hated by all who come in contact with him. a psychological parasite or the devil himself – take your pick! I hate him – God, how I hate him! (Jean)
Non-Sexually Abusive Father letter

Members also came to see non-sexually offending fathers as additionally abusive in other ways. Very often, these women had idolized their distant, authoritarian and inadequate fathers and had gone to great lengths to try and gain their approval. Letters to these fathers generally started with an appeal to the idealized father and then moved through to some recognition of their failures as appropriate parents. However, validation of their own experience was bought at the price of giving up the notion of the ideal father – an emerging source of grief as therapy proceeded.

Dear Dad: You are another confusing thing to have to write about. The first thing that comes to mind is when you told me I was your favorite daughter, but also I was to keep that comment to myself as you said it wasn't fair to the rest of my sisters and brother. Well, if I was your favorite I don't think I have ever felt it. Though you never gave me a licking. I wonder if that was the way you chose to show it. You are very persistent to keep us on a child level. You refuse, and can't let us talk to you on an adult level. You maybe feel it is a threat if you would just once listen to what we had to say, but you always make us feel young and stupid and we don't know a thing about life... The only real thing I want to say is let go and treat us as we are – adults – and not your little girls anymore. I guess I love you. But, like mom, you can ignore me just the same. I don't know why it is we have to have your love and support. But I guess Pat summed it up when she told us that when we are born that it is instinct to want love for now and always from our parents. You were famous for always telling me how over-sensitive I was. But was it your way to say you were under-sensitive? I hate you for that. When I was over today something wanted to tell me that maybe I don't love you that much either. Whether I'm saying that because you can't love me without a condition, or whether it's because what I learned in group. But whatever or however – I feel I can accept whatever condition you want and I'm not going to let it bother me anymore. I blame you for talking me into trying again at my marriage. I blamed you then and I still blame you now and I will blame you for a long time to come.

(Lisa)

Dear Dad: I've always wished I could really talk to you. But I've never been able to tell you this. You just wouldn't have known what to say. Dad, I was always proud to be your daughter. To me you were really great. You could do no wrong. A lot of people didn't understand you, but I really thought I did. I used to wait patiently for you to come home from camp. I thought you were so smart, you had an answer for everything and I loved to ask you questions so you could tell me things. You gave me lots of work and little praise. But you would brag to mom and others just how hard I worked. That just made me work harder. I think I could have been your perfect wife. I knew just the time you wanted to eat, I knew where to find your slippers and where your paper was. I worked overtime to please you. You never wanted money wasted and I never have. And when I was young I never asked for anything. I didn't want you to waste your money on me. You and me could of saved a fortune as you hardly ever spent on yourself either. Mom did all the wasting of money. Anyway dad, I don't think I ever lied to you. I couldn't. I tried to be the best girl. I always wanted to be a boy as then I could be
just like you. Your word to me was God's word. You were never wrong, you knew everything. Then you got stuck with mom and us kids. You always complained about that. There were so many other rich women in your life before you met mom. I guess that was one thing mom never was and that was rich (maybe that's why I always wanted to be rich and take care of you dad). You know, I almost hate talking to you now – you forget what you said 5 minutes earlier. You never listen to what anyone says. You don't stand up for yourself you just run to your bedroom like a little boy out of control. You laugh at yourself now when you make mistakes or can't find anything. I remember when we were young, if we forget something you'd give us a licking. If we didn't put everything back where we got it we were useless son's of a bitch. We were never allowed to make a mistake or we paid with our hide. You would make us find a stick and then whip us with it. I don't remember the spankings much, but I know I got some. I never got as many as everyone else as I was too busy pleasing you. I knew what you liked and would put up with it. But I felt so sorry for my brothers and sisters as they didn't know. They took chances, got caught and you beat them. I just could not stand it when you hurt them, dad. They never were really that wrong, they might of been a little out of line. Most of the time everyone tried to please you. But no one could please you enough, you always wanted more and gave no reward. Or the reward you gave us, like getting to eat supper or getting to play for 10 minutes, was what most kids we knew got for doing nothing. So it never made us feel special or important or anything, it just made us feel like why try to please dad.

Guess what dad, I just burned 2 pieces of toast and put them in the garbage. One year ago I would of ate them anyway. Because I burned them I must eat them – your motto. Dad, do you remember pulling burned toast out of the garbage can and making Tina (oldest sister) scrape the other garbage off it and then eat it before she could eat anything else in the house. Or taking half eaten apples or food out of the garbage, or even if we didn't like some food on our supper plates and we snuck it into the garbage, and you found it even a day later – you would make us eat it as we should not waste food. Boy, did that make me sick. You made our life a living hell. I remember when you were watching your news no one was to talk. It was hard to keep 6 of us quiet and that's when your arm began to swing. "you goddamn kids, why don't you listen, you might learn something. " We all hated the news. But I remember endless nights sitting on your lap or at your feet trying to impress you by watching the news. Dad, that's another thing I don't do anymore. I still hate the news. I really hate it now that you forget everything. I'd like to tell you a thing or two but every time I try, you say you don't remember being that. You make up these weird stories like me and (brother) loved working for you. We didn't need any breaks as we had fun just working with you. That story is Bullshit. We always hated working for you as you never knew when to quit. I know you worked hard but you seemed to love it. You loved to be the boss with all of us working around you. I never seen you rest or play even once. You always worked around the house. I guess that's all you knew how to do. Mom used to say when you laughed a funny voice used to come out of you and that was because you never laughed much and didn't know how to laugh. Well dad, it's time to take you off that pedestal I built for you. You're just a regular old man who never appreciated his kids. Who was mean and strict and never let his little girl be a little girl. I don't know what you wanted from us dad. But I know you sure didn't want us to be just regular kids.

Dad, it's hard for me to come up with stuff about you. As most of the things I do are your way and if I tear you apart I will be tearing myself apart. I was always afraid of you dad, afraid you would disapprove of me in any way. I just couldn't stand that. You could of not made yourself out to be
such a perfect person and then we all could of loved and accepted ourselves even when we made mistakes. But you made that impossible. We only seen life through your perfect vision – either black or white, right or wrong, no in between. You never accepted the judges decision in my baton, if I was second you always said I should of got first. That always made me mad. I felt bad enough with second place without you embarrassing me in front of everyone and saying Susan should of won first. Oh well, second will do. You never accepted me just for myself. Every time I did something wrong at school or baton, it was always there fault not mine. You never let me take my own blame, so I never learned to look after myself. So I ended up always passing the buck for everything that ever went wrong and I hate that.

To finish up my letter to dad, I hope I have brought you down a peg or two so I can look you in the eye and realize you are not a god. But a poor father who never went out of his way for his kids while they were growing up. It was always your way and no other way at all. You’re a very stubborn man dad. It could have been so different if you had of had some emotions to give. If once you could of listened to me instead of yourself or anyone. But there was only one way dad, and that was your way. Everything had to be your way. Not the way you did it, but the way we were supposed to do it. You did a lot of not doing what you said – do what I say, not what I do. (Susan)

In addition to the other problems, a number of women were still struggling with the belief that their fathers were aware of the sexual abuse – a belief supported by father’s behavior and sexually demeaning comments.

...This last while I have stood up to you when I haven’t wanted to do things you want. You make me feel so guilty, like I owe you for all you’ve done for me. Yes, you have provided well for me and I have never wanted for anything – except your acceptance of me as a person. I don’t understand either, how you never could have seen what was going on with Grandpa. It was like you weren’t interested. I remember one time when Johnny got a van. You told him he wouldn’t know what to do in a van, but that I would. That really hurt me. You loved me so much as a little girl, but from about 12 on it was like I wasn’t what you wanted. I was no longer your puppet – “Daddy’s girl”. I still feel very much like a disappointment to you... Who is the real you? When you are in the public eye, you know just what to say. But you are different at home. I think that home should come first and then what everyone else thinks should come after. Even outside of work you think of yourself. You never worry about what mom wants to do. I think it was very easy for you to play the hero with us as kids. But mom was the one who raised us. She had the hard job. Anyhow, dad, I feel as though I’ll never be what you really want. I’m not even sure I know what that is. (Helen)

Special issues came up for stepfather-offended survivors with respect to their biological fathers

... I hate him for all the things he never gave me. Never his love, never his praise. I just existed. Well dad, I wasn’t a scared little girl you were talking to. You brought back those memories and I don’t want them. You failed as a father. A happy girl doesn’t keep running and if you had just
listened to me then I wouldn't have run away. But then it was always one-sided... Our family outing was going to church - you in one building, me in another. Look at that disgrace our house was. That's not all mom's fault, those messes in the basement were yours. You stopped your life. Just sat in that chair either reading or watching T.V. When did you ever sit down and just talk to me. Never, unless of course I wasn't living up to your standards. You couldn't live up to them. How in the hell's name did you think a little girl could... I said happy birthday to you yet you never even phoned me. I doubt you even knew what day I was born on. You never even supported your own son when you left. And if I ever hear Sandra (father's second wife) say one more time about how good her kids treated you then maybe Sandra should hear how you treated us. Tell me dad, why could you give yourself to her but not to your own. And you think I'm not dealing with my kids.... (Anna)

Mother letter

Some of the women experienced their mothers as caring, co-victims, who were unable to protect them from father. Although the feelings toward mother were often ambivalent, a strong sense of identification with mother and need for a loving relationship tended to dominate.

Dear Mom: I've always wanted to send you a letter for you to know how I felt and feel now. I am glad you were my mom. You taught me so much about caring. I never understood why you stayed with dad. You deserved better. But now my life is similar to yours. I feel pity for Len like you did for dad. I am like you were - finding love from people outside. I love my kids the way you loved us. The only thing that ever made me mad at you was you never stood up for Jean and I. We were your little children and you went to work and left us with that sick man. For years I felt abandoned, but I couldn't say anything as everyone told me what a great lady you were. But what about us! We were little and his ugly cruel mouth never let us have any peace ever. I loved your kindness, you were totally unselfish and sacrificed a lot for us. You worked so hard as a nurse. I remember all the nice clothes you made us, how to plant a garden, caring for the sick old neighbors, and you told us many time "if you can't say anything nice, don't say anything at all." I have your patience and love for children. I thank God for you. I know you were disappointed when I quit school, as I wanted to be a nurse too. But I had to get away from him. I work with (handicapped persons) now and feel very fulfilled with my job. You used to tell us it feels better to give than receive. I didn't understand this as I was a pretty selfish person. I now know what you meant. I am feeling very good about so many things today. I wanted to write this and I feel better for it. (Diane)

Many members were attempting to forge relationships with their mothers now that they were both adults. They recognized that their mothers had been neglectful, unprotective and very inadequate as parents, but retained a strong sense that some kind of positive relationship was still possible.
Dear Mom:

First of all I love you very much. You have helped me through some hard times recently and been there for me. You helped me like a friend, not a mother. I don't think you were meant to be a mother. When I watch you with Jessie (Kelly's 2 year old daughter) it looks kinda funny, like it's a bit awkward for you. You are wonderful with her though, very patient and loving. And she loves you. I don't think you were that way with me. At least not at an age I can remember. Since most of my memories start about age 12, my memories of you are of a woman with new found freedom after the separation. I remember you having dates, not being with me. You were not involved, not like I want to be with Jessie. I love and respect you and think you did the best you could at the time. Now that I'm older and independent we get along beautifully, you're no longer authority and I'm no longer dependent. You make a better friend than a mom. I feel regretful that I have so few memories of close moments with you. I also cannot believe how much I hated you at one time. I felt no respect for you at all and I'm not sure I knew why at the time. I feel like you are trying to pay me now for your mistakes. You've been overly generous at times. All at once I want the gift and don't. Because I don't want you to think you have to buy me. Just be loyal, love me for what I am and you'll get the same in return. I respect you a great deal also. You've survived an abusive relationship and finally pulled out of it instead of staying with it for the wrong reasons. You've managed to stay in very good jobs and you're in great shape despite the way you treat your body sometimes. I wish I could talk to you about quitting drinking. I know you're an alcoholic even though you can't see it yet. I would speak to you about it except I think you'd only deny you have a problem. So I've waited not too patiently, for 5 years now - that's how long I've known it - for you to do something about it. As much as I disliked you in the past, I love you very much now and try and tell myself you're human, not perfect. But sometimes I regret not having the kind of mother I could turn to, and I hope I can be that way for my child. I need the support you have given me over the last couple of years very badly. And the thought of losing you now is scary. I feel so close to you now, almost over-protective. I find myself dependent on that love - something I had given up on and thought I had no use for. I love you! (Kelly)

Mom: I don't know where to start - I mean by being mad, angry or thinking about the good stuff. I really don't feel like you were ever there for me. You never talked to me about lady things and I was confused when I started my periods. Hilda (older sister) was there to help me. When I cut my thumb you weren't there and I think auntie Bess took me to the hospital. You weren't there when I broke my arm, Cousin John took me to the hospital. But you were always there when we came home from school. I will always be grateful for that. You did stand up for me once that I remember - when I wanted to go out with friends, and dad might as well called me a slut. But you let me go calling him a fricken jerk. But that's about it. When I married Ken I know you really didn't approve. But what was harder was the things he did to me (severe battering) and I don't know whether you didn't believe me, or couldn't until I left him and didn't tell anyone, and then he came to your house and said what he had been doing. Then you were concerned. Auntie Ann and auntie Sue both say the same thing about you, I guess it's true, but I don't know if I want to accept that because I do feel love for you. They say you can't, or won't, feel anything, you just put it aside. I see you do that a lot. Not too long ago I cried for you because you seemed friendless and I had to ask you why. I'm glad you told me and now I wish I could do something for you to take the pain away... But I suppose in your own way you tried to be a good mom. But there are so many things I want to
be different from you. I hope always to be home for the kids when they get out of school. But I want to include myself with them in their likes and dislikes — but sometimes I feel too shy or out of place. It’s hard to say why. I can feel excited for them but I know I should really apply myself more. You didn’t really seem to be all that happy when I did something good, or won ribbons at the ___ shows. You always said that it was good but then you never made any real attempts to come and watch us at the shows... But when I come over you don’t even let me finish a sentence. You either talk to someone else or say “just a minute” and get up and walk away for a minute. When we are alone we sit there not talking much — or if dad’s home he will keep things going for awhile. What did I ever do to you that was so wrong? Sure I told lies. But we all did. Sure I didn’t become a nurse but then none of us became what you wanted, — with the exception of Jean now, which she is doing good for herself now. I don’t even know if it’s something I did, or if you just don’t like me that much. Oh well, it makes me very sad to sit here and reread what I have wrote so far. (Lisa)

A large proportion of the women experienced their mothers as emotionally inaccessible, distant and exclusively self-involved. Their letters confronted the mothers with these issues as well as with their deep sense of abandonment and betrayal in that these mothers had frequently delegated mother/wife duties to the survivor.

Mom: I haven’t been able to look you in the eye for a very long time. We’re distant. I think you want it that way. Maybe you’re afraid I’ll see something I don’t like — I already don’t like. Why didn’t you hug me when we had to share a bed at grandpa’s or just put your arm out to touch me – you don’t want me any closer than I am right now — Well, fuck you. I’m having trouble with my anger for you. When it wells in me, I stifle it. I can feel it. I’ll be bloody mad at you yet before I’m done, I’ll be sniffling and crying like a wounded pup. You spend a great deal of energy keeping your distance — what in the hell are you afraid of? I’ve needed so much and you’ve given so little. You went to work every fucking day, just to avoid us. You ran out on me. I needed you at home and you weren’t there. You couldn’t even see how much I was suffering and alone. I hate you. I hate you for dumping all that shit on me. I had nothing — no wonder I couldn’t sort through my school work — I couldn’t even sort through the day’s chores. You just ran out on me. I really hate you for that. You didn’t see my pain — you must have. Where the hell were you, you bitch? You weren’t a mom to me, you weren’t even a housekeeper — I did it the best I could and it was all overwhelming. Too much for a little person. I went through so much all alone. No wonder everything is so difficult for me, and I truly enjoy so little. But I’ll get through this and leave you behind. I have already surpassed some of the damage you have left me with and I’ll get through the mountain that’s left. (Karen)

Mom: I told you Mom that every Friday I attend a stress management course. I did so not to spare your feelings, but rather, my own. You see, Mom, I couldn’t admit to myself that you were the cause of me seeking further therapy. I tried to convince myself that this time it was for me, that you are not the source of another of my depression states. The truth is, you’ve done enough damage to my life and I need for it to end. I want to be responsible for my own happiness and unhappiness, and I don’t want you influencing either way. I have faithfully waited for you to be the kind of mother
that loves her children, wants to be with them, and would do most anything to help them. I've lived in the hope that you would realize one day what you have in your children. That you would do anything in your power to make up for the past. I've wasted so many years of my life dwelling on it, waiting and expecting you to change. I've tried desperately to keep my brothers close to you mom, not for your sake, but rather theirs. I didn't want them to experience the hurt that I have for so long. I've covered for you. I've planned the birthday celebrations, the wedding shower for (brother's wife) and have always shared the credit with you. It's not worth it anymore mom, for I have the truth, I know you don't love them as I do. Two days ago you phoned and complained about your hectic day. I've gotten used to you not asking me about mine. You said on your list was to take flowers to Grandma's grave, did I know it was her birthday, and how hard it was on you. You started to cry, as you have so many times before, and I get angry. I want to scream at you "Grandma's dead and I'm alive, why do you give her so much of your time?" I did remember it was her birthday, mom. I loved her too! You cry for your mom and she's dead – I cry for mine and she's alive. There's no happy ending Mom. This letter can't be neatly finished. It's a letter of bottled up hurt and disappointments that I seem to bring into each day of my life. I've lived with an agonizing thought, Mom. What if something were to happen to you? My hope for you to be a part of my life would finally end. My long and lengthy struggle for a daughter's recognition would rest. (Chris)

The following reflects the deep hurt and sense of betrayal felt by the women whose mothers denied the abuse following the child's disclosure. Pain over their denial and refusal to help is increasingly mixed with a sense of outrage, anger and grief.

Dear Mom: Why are you doing this? After all he's done to you, why do you stay? I'm not sure you care about me or the rest of the kids. You were supposed to protect me! You turned away and it hurt unbearably. I was alone, all alone. But that was okay for me as long as it wasn't you. Did you want me to fear loneliness as you do? Does it bother you that I'm not afraid of being alone? How can you sit there and allow him to destroy you? When I last saw you, I talked a bit about the abuse. I needed to tell you and for you to listen. But you got up and said "I don't believe this so I'm going to walk away" and you shut me out again. I wanted to shake you! Scream, I was screaming inside. Hurt, and I was fool enough to think I had shielded myself against it. I have been hurt enough! When you drink, and when you drank, it was disgusting! You couldn't even talk, you never made sense and I hate it! Always it was me who got out of bed to play referee between him and you. And I always paid for that. It was me who cleaned the empty bottles, blood and garbage after the parties. An unpaid maid, but you couldn't even drag up a thank-you. You were too busy wallowing in your hangovers, black eyes and bruises... When you found out about the sexual abuse that George put me through – I needed you, but you weren't there. I needed someone to put their arm around me and believe me and most importantly, to tell me it would be okay. But you were busy – you're always busy. I was all alone. Sure, Aunt ____ and Uncle ____ took me in, but I didn't belong there. They didn't love me. I needed closeness and they didn't have any to spare. I tried daily. I really tried. I tried to pretend like them, that I was an ordinary little girl, but it just didn't work. I was different. I tried so hard to pretend everything was okay, but I failed. (Jean)
Some of the women were terrorized and physically abused by their mothers in addition to their sexual abuse by a male offender (usually a father-figure). The survivors’ ability to confront this terrifying figure was a real breakthrough.

Dear Mother: There you stand so clean, white, perfect — never a spec of dirt on you, a hair out of place, nor any inappropriate or imperfectly matched clothing, or accessories. You were like this at 6:00 a.m. in the morning. There was me — a shabby, unruly, mismatched mess, to quote you, by my own choosing, laziness and wasted time. But I will tell you this, the time you called wasted was the time I needed to survive. You, to me, were like a large, cold, intimidating iceberg. You always accused me of being so distant. Well, who in the hell wanted to be frost bitten? Your mark on me left me with the inability to fall in love, or see beauty — just an incessant compulsion to work. I am so bloody insecure as I can not allow myself any enjoyable times, or if I do set aside some time for pleasure, I am frustrated and exhausted by my own guilt for it. You left me with the inability to cry, so I will probably get cancer, arthritis, or any number of stress related diseases. Did you ever care how I felt? No, you just decided for me. I will tell you this — it takes all my will power and inner strength not to spend my days in resentful bitterness. I feel like I would love to just scream and scream. My insides tremble and shake, my head pounds, my heart feels bandsed and constricted, my knees and ankles hurt, and when I try to scream a tiny squeak escapes. Or if I try to run, an iceberg of guilt drops upon me and freezes me in place. When someone cares about me I freeze also. The more people try to become close with me, the more devoid of emotion I become. The only love and warmth that I know of is from books, poets, songs and what others talk about. You made me so empty, hollow and searching for that which I never had, but also with the futility of the search because I don’t know what it is I am looking and searching for. You were always so competent and perfect. I hate myself for ever giving in to you and doing what you wanted... Why in the hell do you think I was so uncommunicative and secretive? If I hadn’t been you would have destroyed all of me. You were overpowering and to this day, whenever I am in a stressful situation, I can’t breath. Just like I couldn’t breath as a kid. You suffocated me. Stilled me. My body is frozen, my mind is frozen, my emotions are frozen, my thoughts are frozen. In fact, I am just a robotic ice cube propelled forward by compulsions. In fact I am so messed up that most times I am totally unaware of it. But sleeplessness, headache, aches and pains, driving on the wrong side of the road, etc. are the signs that tell me all is not well. I know you were jealous of my relationship with my father. Even as a kid I sensed this. But, damn it all, the little bit of life and warmth and security came from him. (Alice)

Mom: You tried to make Dad feel guilty about himself. You nagged, ridiculed, put him down — it didn’t seem to have any effect on him. But I was just a kid. You didn’t have to go after me as strong as you did. Dad: you couldn’t make him feel bad about himself. But you broke me apart before I ever had a sense of myself. My self confidence wasn’t even formed when you said I was no good, cheap, common. How was I supposed to keep a sense of who I really was. How was I supposed to feel confident that I was okay when you were telling me I wasn’t. I never had a confident feeling that I wasn’t what you said I was. I rebelled, but I felt confused inside — always trying to talk to myself, telling myself I’m not worthless, lazy, uncaring, promiscuous. I’m okay. If I did
something stupid and wrecked the iron or something, I didn't do it on purpose. How was I supposed to think I was okay when you kept saying I wasn't. Dad was an adult. He already knew himself. How could I stand up under your onslaught? Why did you come down on me so hard? It was overkill. You nagged, put me down, tried to make me feel bad. Why did you try to make me feel bad about myself every time I made a mistake or did something by mistake. You never let me get myself together or feel good about myself. Before I could feel good about myself you had already told me how cold, unfeeling and bad I was, how I hurt you. I burnt something with the iron and it stuck on it, then I took a coat hanger and tried to scrape it off - putting big gouges and scratches on the iron. You said "You don't appreciate anything, you have no respect for my things. I worked hard to pay for that iron. You don't care or have respect FOR ANYTHING. What's WRONG with you. Anyway, you can't go on through your life not thinking and caring about anything. You don't care about anything but yourself. You can't get away with doing things like this. You can't go through your life treating other people's things like this. How could you do this to my new iron? You don't think, you don't care about anything. If you keep on acting like this, I don't know what's going to become of you. If someone did this to something of yours, you wouldn't like it. Why didn't you think before you did it. Wipe that smirk off your face. Look at me when I'm talking to you. I don't know what I'm going to do with you. If you think you can just go through life acting like this, you've got another think coming. You can't even look me in the eye, can you? I'll smack that smirk right off your face. Get up on your feet, I never hit you that hard. What are you, flinching, flinching for. Put your arm down or I'll really let you have it. Don't put on that phony act like I beat you up all the time. What did I do to deserve a child like you? What makes you think you're so smart, what makes you think you know it all? I'll show you a thing or two. Do you think the world revolves around you and what you want? Don't you think about anybody but yourself? You're never going to amount to anything if you keep on going like this. You got no feelings for anyone, do you? Nothing I say gets through to you, does it? Well, answer me. Does it? Wipe that look off your face, I know what you're thinking. You don't know how to be sorry, do you? I'll make you sorry. I'll make you sorry. You'll wish you were never born. You don't look sorry and you're not crying. Obviously what I'm saying isn't getting through to you".

Mom, I had to put a wall up around my feelings. It was like being brainwashed. I had to resist giving in and breaking down. You drove me to the edge. How often I came to the breaking point, but somehow I didn't. Why were you trying to break me? I know what you wanted from me. You wanted me to fall down at your feet, crying and saying: "I'm sorry, I'm sorry. You're right, I've been acting terrible. I'm bad and I will change. Please don't be mad at me any more." You couldn't make dad sorry, so you tried to make me. Maybe I should have given in to you. Why didn't you leave that violent, cold, bad-tempered asshole, instead of screwing up your kids. (Laura)

Other Abusers

The following letter to a stepfather offender nicely demonstrates a progressive letter format. The writer was able to move in deeper to the reality of the abuse and to clarify her own position in it increasingly over the 13 days she wrote the letter's installments:
(July 22). Mr. C: You fucking idiot – what did you do to me? How did you insinuate yourself into our family. (July 23) I remember the feeling of an empty house, everything still, and the dull heat of the day. I turn and find you standing over me, you push close to me. Your breath smells and I have an image of jagged teeth, yellow and old and worn down so I can see layers of the tooth structure, like growth rings on a tree. I'm suffocating. I feel your huge penis in my mouth and I think I will die – I feel like throwing up – all I can see is your oatmeal fisherman's rib sweater, and I can't breathe. Your weight is crushing my chest. Oh God, please make him stop. I'll be good. I won't fight with my sisters, just make him stop. Daddy, where are you, please tell him to stop. My throat hurts! (July 25) How many times did you abuse me. Was it just the once or will I have more images – more flashes. I hated you because you took my mom way. I hated accepting money from you – it felt dirty - did you think because you gave us money you had the right to do those awful things to me? I hear the snap of the screen door as it slams shut, then I hear heavy footsteps and a man's voice calling “anybody home”. I'm in the back bedroom that we all share. Sarah is supposed to be looking after me but she's gone out. I'm shaking with fear but I can't move. The rest is blank. My chest feels tight. (July 26) I think I have partially exorcised you. I remember how I felt when I first saw you kissing my mom, sick to my stomach. I hated it when you pressed money on me – and I hated my mom for making me take it. We kids all thought you were creepy, and now I know you were, and I don't feel bad anymore for being judgmental about you. (July 27) Mr C: How I hate you, you disgusting creepy excuse for a man – you said it wouldn't hurt but you lied. I can feel the scratchy stubble of your old man beard face, and you smell – I feel my heart beating fast. (Aug 5) Mr C: I hate you, you have near, succeeded in destroying my life – and through me, destroying others. I wish I could remember more clearly what you did to me. I don't think my mom knows what you did because she was too involved with herself to notice – I feel like my heart is breaking, literally crumbling up and disintegrating. You have made me dirty and ashamed. You are a monster – like the monster government in your (third world) country – hateful, hateful, hateful excuse for humankind. Why do creatures like you exist? I wonder if you have any idea of how much pain you have caused. Now I understand why I used to hide in the laundry basket when mom was out and sisters left me to go and play with their friends. I was afraid you would come back and 'hurt me again – with your big, fat, ugly penis. Maybe that's why I was always suffering with "bad kidneys" as my mom used to call what I now know was a bladder infection. How I hate you – I hope you are dead – I hope you suffered in your dying. (Betty)

Many members also needed to confront their abusive ex-husbands, both on their own and their children's behalf. Again, the letters permitted them to reconstruct, more realistically, their understanding of those relationship and their own victim roles within them.

Dear Gordon: You know Gordon (ex-husband), I've spent most of my married life not liking you. I've spent the past 5 years of our separation hating you and being angry with you. So now I've learned not to be angry with you at least in as much as I will stop berating you and belittling you. I'm going to let all that hostility die because it was hurting me more than it was hurting you. But I just want you to know that I think it's so shitty that I've had to raise these children all on my own. We would've been better off with you dead. At least then I would have had the insurance money.
Sometimes I get so tired of all the responsibilities. The worries and headaches take away all the joy of having children. My kids and I have to scratch out pennies here and there just to buy a pop or some such other treat. Sometimes, if it weren't for my mom helping out here and there – we would still be half starving. I resent you for your freedom. I resent the system who is usually handing out money for you here and there for every little whim. They put you in work programs to increase your U.I.C. They get you jobs, they finance your schooling. They are so intent on getting you off the ground, yet you never do anything worthwhile. Why don't I get some of that help. Why don't you care for the kids occasionally so I can have a break. If I weren't so wary of you and your drug habits and weird friends, I'd make you take the kids on weekends. Only thing is that my kids' futures are better off without your influence. Your mom is a nut case. You are a slovenly, unkempt, unclean tub of lard. And I do hate you. I can only pray that somewhere, somehow, some good will come out of all this mess. In the meantime I keep up the payments on the insurance and hope that not only the good die young! (Judy)

John: This letter will never reach you which is probably just as well – you would never really understand what I'm saying, having the characteristics that you do... I worked real hard raising your children and my daughter with very little assistance or interest from you. Your life was the bottle! Then after living with your alcoholism for 7 years, and in some ways becoming sicker than you, we found A.A., Al-Anon and Aateen. these programs changed our lives forever. We all grew as individuals and strengthened our family unit which had suffered enormously. We reached a point in our lives when things had become so much easier for us. We had lived with sobriety for almost eight years and all of the benefits that come with it. Our girls were grown and living their own lives successfully. We had just Tim left at home. We had a new home, two cars, we could afford to take holidays. Financially we were secure, we had both worked really hard to get there. I trusted you totally and loved you more then than the day we started our lives together. Then, with no warning to me, you moved out New Year's Eve day, when Tim and I were out. When I returned home to find your clothes gone, I sat downstairs for four hours unable to move or cry. During the next seven months you became such an ugly monster. I suppose the characteristics were there all of the time, but I was blinded by my feelings. I grew to be ashamed that I was related to you. I was embarrassed to go out because I knew that people were talking and discretion was not in your vocabulary. You and I have never talked on a one and one about the breakdown of our marriage. I don't know when it went bad for you but that doesn't matter to me. I learned in time that you had been running around on me for years. So, you see, all you ever did was sober up. You kept all of your character defects. During those seven months I went through some changes of my own. At first, it hurt so much, there were times that I could actually feel my heart hurting. I felt betrayed, used, ugly, weak, dirty and abandoned. You almost destroyed me as a human being. I thank God for my friends. After five months of nothing but your shit and temper tantrums, I was angry and mad and fought you with everything that I had. Two months later your habit of pulling me into court on one of your whims ceased because I refused to play the game your way. A year after you had left us, I found out about your sexual abuse of Janet (Joyce's daughter) from the time she was a little girl. You are nothing but an animal, a slimy slug. Where in the hell do you get off hurting an innocent little girl, my daughter. You've changed her life forever. That was not your right. Do you have any idea how low you are, you bastard. How could you have abused her for so long and lived with yourself? What do you see
when you look in the mirror? It's just as well your mother didn't live to see you as a supposed grown, mature man. You know that she would've been so horrified and disappointed. You're scum. (Joyce)

Dear Sam (ex-husband): I need to write you this letter. There is so much I need to tell you. I have 10 years of stuff dammed up as I never wanted to hurt you. I loved you so godammed much. I always tell everyone I never really loved you. I guess that way I don't allow you to hurt me. Oh God, you hurt me. I've really thought I had done all my crying over you. I thought you were gone out of my mind, out of my life last spring when I let you go. But now I realize I'm very angry at you. I've never been able to tell you a damn thing about me. I started a few times but you never allowed me to finish so I'm going to tell you now. You know how I told everyone that when I met you I saw was your dollars, well, that's not quite true. I did see the money, but I saw more than that. I saw that you and I had a lot of the same dreams. We shared these many times. We wanted a good home and a good family. You wanted to do your part by working and bringing home the money. You wanted me to stay home and look after our family. I was going to bring up the girls the best I could, and you were going to love and support us. That wasn't that much to ask for. I would live anywhere with you and I would work part-time if we need the money. I would look after the home and kids and we would go out with friends on the weekends. Take the kids to parks, zoos and beaches together. Oh God Sam, did I ever believe it, hook line and sinker. I did my part. I worked and then I had the babies. I worked part-time. I even lived anywhere you could work and make money for our dream and our house. But you, you bastard. How dare you bullshit me for 10 years. You rotten, rotten bugger. Then let me take all the blame for our separation. You prick. I was so godammed nice to you. I was always there for you. I never complained about the money that you lied about. You said our house money was in the bank and for me not to worry, in two more years we would build our house and raise our kids. But that never happened because you were gambling all our money away. You were lying to me. You lied right from the beginning. You knew I never lied to you. You knew I trusted you and I thought you would never lie to me. But you were. You gambled my house, my future, my life right down the drain. Then you lied and said you didn't. I always believed you, I never believed the others that said different. I guess I was just a gambler too. I know you wanted me and you wanted the kids too. But you wanted to drink and gamble too. I feel like the lowest sucker that there ever was. I slept with you when I didn't want to. I sacrificed my whole self. I cheated myself out of 10 years of life so I could have my dreams of a home and a family come true. I lost everything, all my self-esteem. I was worse than Tina (oldest sister), I sold myself so cheap. I was the lowest of people. I would of done anything for that dream of a home and family. But you ruined it, you took everything I had. And then you used me and I let you. Oh God, please help me. You know I probably would of stayed with you forever as I felt I was not worth anything. But then I had Ashley to think about. I would not allow anyone to sacrifice my daughter. I could see no future for her with you. As I knew by then that there was something wrong with my parenting, that I was miserable all the time and had no time or patience for her. And I kinda knew she was a reflection of me and I didn't like that little girl very much. She was too hard to live with at 3 years old. And you used to say "that girl will leave home when she is 14 as you can't even control her at 2 years old". And I knew you were right, we were already fighting. I was so afraid of losing my baby to the streets. I wanted to get along with her so bad, but nothing worked. So it was Ashley that I left you for. And thank
goodness. I was so sick mentally. And you are very sick. I don't know if you will ever change Sam, I hope so. Not for me, as I'm through. I took enough shit. Let you dump and dump on me. I allowed you to push me to my bottom. I am so disgusted with the girl I was. Thank goodness I only get glimpses of her now and again when she falls back into her old ways. I love the new Susan all the time now, even when she falls down. As now I have people around me to help pick me up, to pull me back to today when some of yesterday escapes. I now have a wonderful, loving 4 year old who loves the new me and respects the new me. And I love and understand her more than I ever have. And each day I try harder to make us better people. Today, Ashley is not mean. She has some patience, some kindness and lots of love to give. I can see us now when she is 14 and she will still be here with me - a happy girl and not a hard girl. We will be friends as we already are. But I will be, and stay, her mother and she will be my daughter. I also have a wonderful one year old, Terry, she is a darling. She will never have to be as hard as Ashley. She has had total love and understanding. She is very bright and soft, gentle and she does not miss a minute. She is the apple of my eye. Both my girls will be successful to themselves as I give them love and understanding and time to grow. I love them so.

So Sam, you robbed me of 10 years, but you’ve planted two wonderful seeds who are growing and blooming. And who I will cherish for all of my life. They give me more happiness than you could ever have taken away. So thank you for my girls. they make up for anything you ever could have taken from me. I keep feeling that you are close by now. I don't know if it's Intuition or not. But Sam, unless you have cleaned up your act, I do not want to ever see you again. I don't even hope that you could clean up your act. But if you ever do, you will be welcome to see the girls. If not, stay away, they do not need your lies. You have lied enough to all of us. You never keep your promises. I know now where Ashley gets her acting skills. I hope to put her's to good use. So she won't need to use them on other people to gain access to their heart. I never questioned your honesty, that was my mistake. You just were what I wanted on the surface. But underneath there was a man I never cared to know, maybe that's why I never dug. Anyway, when I think of you or visualize you in my mind I really get sick. I really fooled myself. I will never do that again. Even if I stay single the rest of my life. I will never settle for so little. It was a long game, but guess what Sam - I won. (Susan)

INTRAPERSONAL ISSUES

COGNITIVE ISSUES

Family Myths

Members were asked to consider the personal and family myths, both explicit and implicit, in their families, and to contrast them with the realities. Challenging the myths helped the survivors to see how the myths had imprisoned them in their victim roles and invalidated their painful and abusive experiences.
"We were so lucky to have the parents we had" – yes, I feel fortunate in a lot of ways, but there was also a lot of negative things. "My dad is the GREATEST, everyone likes him." I really wonder what other people do think of him now. I know I see him as being very human with faults. "They did so much for us, like taking us on holidays, etc." I realize now by revolving themselves totally around us, they needed us. That’s why their lives are so empty now. It also made me feel owing to them, and when I pull away from them at all I feel guilty. Like I am responsible for their happiness. (Helen)

I think my family wanted to be healthy and prosperous and nothing can go wrong type of family. We wanted others to see that we were happy and fairly close knit. My dad used to and still does repeat quite often that he is perfect. Nothing really stands out with mom. I don’t know what she wanted – myth or reality... Me, I live in a fantasy land and want people to see us as a close family with no major faults. But my fantasies in regards to my family are shattering faster than I can handle... I don’t really know if mom and I have ever faced up to it – that the family isn’t all that close and not all that healthy and not all that prosperous. But we all go on one day at a time and we usually do enjoy each others’ company. All good myths must come to an end. (Lisa)

Myths: I was (do): Truths: I was (do):

- cold and lazy
- lazy
- not a good mother and don’t care enough
- selfish
- sexually cold & frigid
- make mountains out of molehills
- always get my own way
- private and careful
- a workaholic
- I always liked my kids & was there emotionally
- giving, but careful so I don’t do it all
- I don’t know if this is true, but I won’t submit to rape anymore
- wrong. I let off steam in small things so my inner rage doesn’t turn me into a machine gun killer
- this may be true, but I’m not settling for less than what I know is best for me (Alice)

Awareness of the splitting:

It was important to help survivors recognize the depth and extent of their historically necessary splitting defenses. Homework assignments aimed at this issue included such things as “How do you experience the three parts of yourself – thinking, feeling, and your body? How often do they seem separate and do they ever seem to be working together?”

Continue to be functioning at the two different parts of my person and nothing in the middle. It’s like I live and perform from my head which I seem to have as reasonable and controlled – or from a part from deep down inside like a whelming up life force, which is not in my control. But no feelings in between. I am such a contradiction to myself. And I can really count on my fingers the times when the separate parts of me came together. I don’t know as if I am really so afraid to feel, as
much as I don't know how to feel. Feeling, or my reactions maybe to feeling, have always seemed to be inappropriate in accordance with others. I watch others and try to mimic their ways and whens of feeling. So even on the outside if I display feelings, on the inside the lack of feeling is almost always there. There is such an empty void in my life. I really have no idea what brings pleasure or enjoyment to me. I can and do sometimes participate in what everyone else enjoys, to a point. But, mostly, its a neither here nor there feeling. I do, though, understand the things I really dislike. So I obviously have some feelings. As long as I can overwork and accomplish a lot, I can feel an exhausted satisfied feeling, but this feeling is about as close to pleasure as I ever come. (Alice)

Another route in, was to ask the member to write about "that feeling of being distanced from your own life and experiences – where does that take you?"

I am so afraid of being alone, of not living as a projection or appendage of someone else. Change makes me feel depersonalized. I feel that way a lot but I never knew what it was. That awful feeling of being out of whack with the world. That everything is going on around me and I'm going through the motions, but not really here. Very hard to explain the feeling. When I'm on my own or doing something by myself, especially if it is a new thing, I feel that way. It scares me, it's very uncomfortable and makes me feel unreal. (Tina)

During those seven years I had my children: I have to grieve over not existing while I had them and watched them grow. Not like a ghost, as before, but like a spirit being trapped in a bubble. I cannot really touch or feel anything, nothing can really touch me. I exist in the deep dark reaches of my being, but not in the world in which I go through motions. Every feeling and thought and emotions only a mild collection of what could have been. How could a world exist for me when I didn't belong there. I grieve for the terrible emptiness in which existed and I grieve for the emptiness in which my children were born into. (Judy)

Providing a member with the phrase "masks I needed to survive" was also useful:

My marriage to John lasted only four years. During that time I was a victim of physical and sexual abuse. My memories are painful and very ugly. And in order to carry on with my life, I was forced to shelve them. I worked hard to master a disguise, a portrayal of someone that is nearly perfect. An all round mother that devotes faithfully every living breathing moment to the welfare and happiness of my children. A perfect daughter to my mom – one that has never allowed the painful memory of my childhood to be detected. A perfect sister to my brothers – always there when they need me, full of encouraging words and wisdom. And last but not least, a perfect wife, who has strived for the past six years to keep our marriage free of the haunting memories that consume me and threaten my marriage. For whatever reason, the conflict within me has become overwhelming. I no longer have the strength to suppress them. Each waking day is a struggle. My childrens' happiness brings me the pain of my childhood. A phone call from my mom causes
disturbances of hate, and my husband's sexual advances cause uncontrollable panic attacks.

(Chris)

The metaphor of the internal child was consistently used throughout the therapy process. Asking members to "find that child inside — What is she saying to you? What is she feeling? Who is she?" was also a useful way of tapping into the profound level of splitting from their child experience.

Well it's Tuesday and I'm sitting here looking at the little girl (photo of herself as a child). She seems to look happy and content enough, but there seems to be a look of unsureness. She was sure cute when she was younger but I see a vacant spot and can't seem to find whatever it is she's looking for. I feel her crying sometimes in me, so unhappy. What is she looking for? She looks like she is saying "Am I doing the right thing". She feels empty. I can see her, but can I feel her? Why does she look like she is hiding something. I need to touch her but where is she? She likes to hide, but from what? I know I hide behind fantasy — did and does she? She had many imaginary friends but George was a stick man. Even I remember George, he will be someone I'll always remember. She looks questioning. I think her and I fight a lot amongst ourselves. I guess I need her but she is here so seldom. Or do I just ignore her? We have to come to terms. At least let me hold her. Why is it I want to cry when I look at her? ... She looks like I feel — vulnerable.

Wednesday: Well, I'm sitting here looking at the little girl again. Today she looks scared and, although she has sisters, she looks alone. She is trying to tell me something, but I don't know what it is. I want to go back in time and hold her and kiss her and tell her I love her. But I can't go back and she's not coming to me. I feel very insecure now when I look at her. I think she lacks inner peace. It's like the dead that can't quite go to rest because they still have just one more thing that they have to do. I get a feel of "I dare you to love me". She is still scared. I can hear her yelling and screaming at me, but I can't make out what she is saying. What does she want from me? She's gone. I think. I scared her off.

Friday: Well, I am looking at her again and I feel so hurt all of a sudden. What is she hiding? I think I will show Pat her today. She is so sweet and innocent. She is making my stomach flutter when I look at her. It's like she is in there. She is too little to hurt and feel the way she does. I want her to hug me, or should I hug her. I can't think of anything to say to her. All I want to do is just look at her. If I touch her maybe she'll break. At least now I have to stop writing and go and get ready for group. I hope I can find the answers there. (Lisa)

Often, members self-directed musings take them into territory surrounding this issue, and it is vital to pick up on these issues and discuss them subsequent to the member's reading.

I often wonder if I was born this way or if life's experiences brought me to this point. I don't know the answer, but I need to know because it could determine whether I can change or not. If it was just experiences, there is always hope. But if this is the real me (how I've always been) I know for sure what the answer is. Am I unable to love, or have I chose to hate. Am I unable to give, or
have I chose to take. Am I unable to be free or have I chose to be a prisoner. Am I unable to live or have I chose to die. But is it really a matter of choice or a matter of capability. I guess no one knows anything for sure. Nothing's black and white. There always has to be some little element to make it more difficult. I think I tend to pull apart and evaluate these elements a little bit too much and perhaps create a few of my own before their time. (Paula)

The flawed equations:

Otherwise known as "cognitive distortions", this phrase was used to denote the wide-ranging and all-pervasive sets of beliefs and judgements about themselves and the world which had been given to survivors. Beliefs which had legitimately developed from their experience. It was important to challenge these beliefs as belonging to only a small abusive subset of human experience – not as the "rules of the universe" survivors assumed them to be.

Members were asked "How is your identity defined? How do you know who you are, or are supposed to be?" They were encouraged to see these versions of themselves as necessary (at that time) coping strategies, but were asked to consider how they would find their own authenticity.

THE FALSE SELVES: "The Tough Image". I used that one a lot during my growing up years, or now, when I'm moving to a new place or if something really scares me. I wear really tight clothes. When I was younger I used to carry a blank gun in my purse. I swear a lot more. More makeup. Went and got a tattoo. "Always Happy". Laughing, smiling, cracking jokes, lots of energy. Around certain people I would portray that. My dad is a lot like that. I found I would even be angry with myself if I couldn't keep up that image for very long. As I thought that was the way I should be. "Church Role". Submissive wife, very conservative clothing. Knew what to say like "The Lord ..." but to a large degree was very much in that role for the last four and a half years. People who knew me before said it was like I was acting, and always trying to be kind, say the right thing. Repenting for every little thing. Staying home all the time, canning, etc. It seems whenever (ex-husband) and I split up I came out of that role. No wonder he treated me like shit. I was like a doormat waiting for him to wipe his boots on me. "Hippy Type". Wanted to grow my hair long and straight. Trying to be really mellow all the time. Do like a lot of things about that role though. Think that some of the real me is in there. Nature, animals, hiking, walking. "Super Mom". Knowing all the right parenting skills. All the classes. the children performers. Talking all kid-talk around other moms. Keeping up on all the issues. "Really Naive". Sort of the dumb one who listens to everyone. (Helen)

My own identity is defined by others in many ways. The way they judge me is very important to me. It starts with how I dress. I'm very concerned that what I wear is appropriate for the occasion. Even wearing make-up. I wear it even when I'm going to be home so that if I choose to go out, I'll be prepared. So that I'm presented in a polished way, looking for their approval. How shallow – I see others for who they are but do not see that others would do the same for me. I can only see that
what they see is on the exterior, just as what I see. I even had trouble accepting that my children see something else and love me – it's difficult for me to feel that there's something deeper that others see... I not only look for approval of people in authority but from all: my peers, strangers, people I do business with, people who really care for me. The last is the hardest. It's difficult for me to see that people could care for me for what's underneath when I'm not sure what's there myself. I only see my outer shell being presented as my outer shell – so it should be well presented. WHAT SHIT! (Karen)

Members were also asked "What labels were you given about yourself – which ones did you believe were true? How did they affect you?"

The old labels about me: tough, strong, cold, frigid bitch, bitter, vindictive, miserable, competent, efficient worker, too serious, no fun, unfriendly, no friends, not outgoing, catastrophe. (Laura)

Labels I was given: slut, whore, no good for nothing, ditch pig, scum, stupid, retard, sheep dog, mouthy, four eyes, lard ass. (Ellen)

When some of us went for coffee after group, one of the women said something to me that has changed my opinion of myself very much. She said I was smart, or was it intelligent. At the time I was so shocked I remember I went blank. Those words went deep in an area in my mind that has set solid opinions about myself. All my life I received negative words about my intelligence. I was the stupid blonde, I always had problems at school, terrible grades. Seven years ago I had aptitude tests taken. The results were that I could never get my grade 12 because my mind could not do the work. So I completed my opinion of myself on the basis of those tests. He told me my mental development regarding school is at a grade 7 or 8. And I might be able to get my grade 9 or 10 equivalency. But when Janice told me those precious words I accepted them with hope. All day, and for days after it, I felt anything is possible. There was such great hope for a good paying job for me. If we don't get positive feedback from anyone outside the group, we have the group to encourage us. So I thank you Janice from deep in my heart. (Barb)

Members were also asked to think about the "rules of life" they were given, both explicitly and implicitly, and asked to consider their impact.

Mom, you didn't let me know I didn't have to live in miserable situations. I have the idea stuck in me that life is a constant struggle of bearing the actions of someone else and living from one crisis to another. I never learned until now that I had a choice. (Laura)

It was also important to get members to recognize their reliance on dichotomous thinking – black vs white, good vs bad, etc. – and to introduce them to the notion of continua and
graded judgements. The corollary consideration was the bases on which they made their harsh self-judgements.

Black & White: Either its one or the other. I never realized how strict I was with myself. If I wasn't an A student, then I was failing myself. If I wasn't perfect at something, then I would say I had no talent for that or another thing. What I loved to do was to excel at a certain activity - then I would say I loved that activity. If I could not do it well - I would purposely avoid it saying I had no interest in it. In my business, others would exclaim at my sales quotas, yet I was never satisfied. Always I could have done better - made more sales, or larger sales. I had no competence at all because I couldn't hit the predetermined level that I myself had set. I expect my kids to be perfect and they aren't, so I've failed as a parent. The thing is that I've probably made them nervous wrecks because of my harping. Either my house is perfect or its a mess and I'm a lazy housekeeper. All the times I've done never stacks up to over ride the one time that I've flopped. I'm fine until something goes wrong and then even if it wasn't my fault I start chastising myself by review. (Judy)

Recognition of the tragedy in their lives
Survivors needed to locate themselves accurately in the midst of their own, very real, tragedies. This natural and important stage in the process, facilitated members’ recognition of their own courage, validated their pain and grief, and gave permission for them to proceed to a different way of being in the world.

I guess what I mourn and long for is the loss of innocence, not just theirs (her sons) but mine. To be a child is such a wonderful, special thing but how it can be ripped away and tainted for us by the adults we are placed in the care of. I hear the little girl in me crying out for that wondrous, nurturing, learning, innocent time that was missed. The girls at work talk about using slender tampons because super ones are too big and uncomfortable. Oh to be 20 again. I find myself wondering what happened to me. How did I end up here - a 36 year old woman with half grown children. Just yesterday I was like them, full of hope and life and planning my family and committing myself to being the perfect wife and mother. It was all supposed to work out so happily. Now I am middle aged, confused, malcontent, with too many bills, dirty carpets, never ending laundry, no social life and a feeling that I'm running out of time. What ever happened to the real me hidden behind the husband, the marriage, the motherhood. The doer, the pleaser, the problem solver. Over the years everything else seems to wash away and I find nothing underneath. Is there no me? It is a sad person who cannot live with themselves. (Tina)

A babe was born one winter's eve. The home she had was full of turmoil/ Never praised always criticized/ Never loved just beaten/ Promising to try harder. Never realizing harder wasn't good enough/ Defeated she gave up her will/ Never knowing what was next/ Sleeping in cars/ Sleeping in parks/ She cried out for help that no one heard/ Married to escape, but went to worse/ Until one day looking at her children/ She saw the past repeating/ So she left breaking the cycle of abuse/ Struggling to regain her sanity/ In a house full of strangers she learned to trust/rebuilding
her life one step at a time/With her courage to change all the wrongs she was taught/Now her life goes on/A home with laughter/A home with love/A home with praise/A home with security/But most of all a home with peace. (Anna)

Watched the movie on sexual abuse – heard the judge pass the horrible, unfair, ridiculous judgement. So she killed the abuser. Well, if a few more abusers were to die, perhaps the more of a civilized place our world would be for us. The way it stands now, we are so alone and cope b / living on the outside fringes of life. Carrying a deep, perpetually ingrained shame. living with an underlying current of no rights. Sacrificing ourselves for others and hoping for small crumbs of affection, and if more affection was to come our way we would automatically run from it. I could sure identify with her cold, distant decision to kill. She should have been sentenced to a mental institution where she could have cried her pain and screamed her wrongs out until she was healed and whole. My husband watched the movie with me, and two moments after it was over he starts to talk about racing semis (trailers). All of a sudden I could not breathe. So I got up and went outside and ran about a mile. Didn’t sleep all night. Saw my frozen pain clearly, and how debilitating it has been in my life. Coughed and choked most of the night (my body). But sat absolutely still and couldn’t even punch anything. I was aware of rage but could give it no vent – constructive or destructive. (Alice)

Responsibilities for everything

As parentified children, illegitimately made responsible for meeting the abuser’s needs, and overall family functioning, survivors generally took the adult position of being "responsible for everything”. Members were asked "What are you responsible for? How did you learn that? What did that feel like? Where has that taken you?"

Carly told me mom and dad and Carly were very happy before I came along. then mom got sick because she had me. And that’s when dad started to find other women. At that time I believed her and felt responsible for our unhappy family. (Barb)

When the abuse began, I played the role of being so strong. I could do anything at eight years of age: babysit, cook, clean, bake and so on. I never asked for anything for myself. I was always looking out for my sister and brothers. I had to be the neatest, most responsible, the protector, always eager to please everyone. My part of the bedroom that I shared with my sister was always neat and clean all of the time – a real contrast with my sister’s. I became the little mother when my youngest brother was born. I was constantly caring for him, trying to protect him from mom’s temper. My role of protector began as a child. I would work real hard around the house and outside so that mom wouldn’t strike out at the others. I was always trying to keep a step ahead of her. I would take the blame and punishment from her so that she wouldn’t hurt any of them. I played daddy’s little girl – so nice to him, waited on him, always making him laugh. Thinking that if I could just keep him laughing then everything would be okay. (Joyce)
The things I was responsible for as a child: 1. doing dishes, 2. watching what I said, 3. answering the phone, 4. dealing with bill collectors, 5. looking after the kids, 6. housework, 7. cooking, 8. acting, 9. leading separate lives, 10. soccer practice, 11. school, 12. friends, 13. my life at home, 14. parties at the house, 15. mom and dad's drinking, 16. their problems, 17. their responsibilities, 18. brushing my teeth, 19. putting my mom to bed, 20. the feelings of loneliness, 21. the way I looked, 22. the talk about the family, 23. the approval of my family, 24. my life. (Mary)

I haven't done too much this week other than thinking about responsibility - mine as well as some that I seem habitually take on that aren't rightfully my own. It's funny that a lot of people don't look at these things until some wise and daring individual points it out. Thanks Pat. What would I do without any responsibilities? I always had lots, so the prospect appears scary. This is something that requires work so I'm planning a weekend away without any responsibility at all. I won't even be responsible for my own actions, never mind anyone else's. I need this, just to find out what it's like. There's only one thing I worry about - what if I like it too much? Oh well, I'll deal with that then. (Jean)

Physical vs intellectual vs emotional attributes

A variant of the splitting defense, this exercise clarified the very different attributes, and resultant treatment and expectation that members had of their physical, intellectual and emotional selves. They were also asked to consider where these judgements came from.

Physical needs - proper nutrition, rest, and the ability to relax. Whenever I become aware of my physical needs and somewhat in tune with my body, my nightmares increase a hundred fold. I begin to vomit uncontrollably, my body says things like I'm tired. My intellect says I am a lazy slob. My compulsions to withdraw into a dark closet are almost uncontrollable. If I am into continuing to persist into taking care of my body and my thoughts, my actions become disoriented. When I try to take care of me I feel so out of control and engulfed with an utter undefined host of terrors. I have always hated my body and its limitations. My body makes me visible. With being visible comes a deep emptiness. I am no good. I am a burden to the people who have to lie with me. I always try to control my eating habits. I know what good nutrition is. My body will either accept or reject food and it's not always in my control. I hate my body. I am repulsed by my body and I don't know why. I can't seem to have any control over these feelings. (Alice)

Characteristics under "mind" are muddled, confused, slow, old, damaged, dumb, childish, opinionated, selfish, oversensitive, emotional, arrogant, superior, bad, kind, clever and stupid! I'm really quite enjoying this homework, I'm handling it the way I would write an essay or school assignment. And now I realize one word I have left out and one that will go in all three columns detached/withdrawn! Body: constipated, chest pains, difficulty breathing, tense muscles, migraines or cluster headaches, upset stomach, blurred vision, flabby, sexually aroused, sexually frustrated, fat, sluggish, hurting, tight chest, sore breasts, and in the past week a sensation of bad breath/sore throat. I find myself constantly brushing and flossing my teeth. Emotions: fragile,
nebulous, angry, scared, anxious, resentful, jealous, nebulous, sad, distraught, happy and confused. Next question: where did it come from? The mind stuff – mostly from mother, some from older sister, some from teachers, some from past acquaintances, some from me. Body stuff – messages from mind stuff and from emotional stuff. And where does the emotional stuff come from – I think from the mind stuff and from interactions with other people. (Betty)

AFFECTIVE ISSUES

It was important for survivors to recognize that feelings of guilt, fear, shame, anger, pain, grief and sadness, represented the ground-state of their experience. Having lived with these emotions as their norm, they had never really labelled or recognized them. Part of the process of healing was one of recalibrating their emotional expectations, and of recognizing painful feelings as valid signals for current painful events – signals permitting them to take appropriate corrective action.

Guilt

Survivors were asked to write around the word "guilt" as they had experienced it. This permitted them to recognize the all pervasive quality of it, and to understand how it was used by their caretakers as a means of controlling the child. Survivors recognized how guilt kept them from seeing their own needs as legitimate, and was fundamental to the equation "Someone has to be in pain – if I don’t take it, then someone I care about will and it will be my fault."

I think everything I did or wanted, I was left feeling guilty for. (Karen)

For as long as I can remember my concerns and caring have centered around someone else. Be it my brothers, mother, husband or my four children. There has always been someone needing my time and energy. Somehow the rewards are not as gratifying as they used to be. At times I feel an uncomfortable resentment for the time I give to others, which leaves basically nothing left for me. The remedy, I know, is to give myself some of the caring and devotion I would so easily give to others, Placing myself last on the priority list has been a life long habit, one that will have to break. Guilt is my number one enemy. It somehow has a way of setting in when I take time out for myself. I have the strong belief that someone is going to suffer for me not being there. It is so uncomfortable that I most often dismiss my own needs and wants. I recognize my weak characteristics more than my strong ones. I often use the phrase "I am my own worst enemy", and I am. I rarely allow myself the choice to do something for me, rather than someone else. Yet, I criticize others for being too hard on themselves and offer encouraging suggestions. Why can’t I do the same for me without guilt? What I should give myself as a parent seems, at this point, very far away. I would have to recognize what actually makes me happy and that has always been difficult. For so long I have concentrated on others and have never developed my own needs. (Chris)
For some, the experience of guilt was located and focussed about some key event, as in the following excerpt. Joyce, like many child victims, had prayed for her father's death as a way of stopping the abuse. Her intense feelings of guilt and responsibility for his death further disempowered her with respect to her older brother's subsequent sexual abuse of her - beginning in the week following the funeral.

Then all my praying did come true, dad did stop abusing me. Twelve days after my twelfth birthday he was killed in a car accident. I felt sadness and cried with everyone else. But I was afraid I didn't know what I was going to do, or what was going to happen to me. Dad had always stuck up for me against mom. I don't remember too much about the days before the funeral. the day of the funeral I remember the funeral director asking us to come and take a last look. I was in line behind mom and my two older brothers. the whole time "last look, last look" was ringing in my head. When it got to be my tum, I remember hanging on to the coffin and that's all. the next thing I remember is sitting on the floor in the corner of the washroom and my two aunts were putting cold cloths on my head. they said that I had started screaming. This is so sad now because everyone must've thought that I was a little girl who was grieving for her dad. Instead my prayers had been answered! He had stopped - no more abuse. Oh, the guilt that I felt for feeling those things. I never wanted him dead, I just wanted him to stop. But he did stop, he was dead and I had prayed. I was so relieved that it was going to stop but I felt so guilty that he had died. No one but me there, knew why I was really crying, I didn't even know myself. I guess that I've blamed myself all these years for his death. The adult me knows that I wasn't responsible, but the lonely, rejected and abused little girl felt very responsible because prayers come to you and are answered when you pray hard enough. (Joyce)

Fear

Members were encouraged to write about fear - to recognize how global an experience it was, and how they coped with it (e.g., substance abuse, self-betrayal, etc.).

See so much fear in my mom. Realize how much I am like her. Dad let her know that he thought her fears were stupid, so I tried so hard to pretend I wasn't afraid like her. So I put on a good front and drank myself silly. I remember about three years ago dad saying to me - of all the family he never would have thought I would be the one with the problems, as he thought I was so strong. I must have done a pretty good job of painting my picture. But really I was afraid of everything and am just realizing now how fearful I am. (Helen)

Tina the Child: She is very scared. Scared of being overwhelmed by the adult world. Scared of not being able to cope. Needing someone to take care of her because she can't survive on her own. She is so afraid of being alone and unloved. Afraid of dying. I can't be responsible because if I am, I have to do something and I'm incompetent. I blindly trust and give people the responsibility so
I can hide from my own fear of rejection and being discovered as incompetent and unworthy.

(Tina)

Many survivors recognized how fearful they were of their own feelings, and of their sense of themselves as potentially lethal. This latter fear was generally evident in women who had been subjected to extreme, life-threatening violence as children.

Why aren't I allowed to feel? Whatever I feel is judged wrong by others. If I express what I feel, it's not in accordance with what, or how, I should feel. When I feel I don't know how to do it in an appropriate way. I can't even remember my feelings being accepted, except at Compassionate Friends (a support group for bereaved parents) and (therapy) group. If I don't feel, I am cold, hard and tough. And if I do feel, I am over reacting, dramatizing, making mountains out of mole hills. These are tapes in my head that I can't remember when they didn't play. It was easier to be cold, hard and tough because the other side of the coin left me vulnerable to the depletion of energy in feelings, plus the almost annihilation of me. When I am attacked on feelings I may show, I literally can't breathe. Inside me is like a psychotic killer fighting to get out and take revenge. The blood seems to rush to my head and a horrible, piercing, burning pain shoots out of my ears, eyes, and the top of my head, and the severe vomiting occurs. I am so afraid I will kill or be killed in feeling. If I want to die, I will choose the time and place. Not by others' hands -- that terrifies me, and has done all my life. I always felt like my mother wanted me destroyed, but maybe dead was the word. (Alice)

Members were encouraged to investigate fear as a contemporary problem, which impacted on all levels of functioning.

I have this horrible, nervous feeling in the pit of my stomach today - a scary feeling that something is going to happen -- something is coming my way and step by step it's getting closer and I feel helpless. It's like being drawn into the pit of hell. Its grasp on me is so tight that I cannot seem to let go -- to get free. It's almost as if I've taken too long to choose my path, that it's chosen it for me. I'm afraid of it and afraid of myself. (Paula)

I find that I'm not very confident in too many things. I'm scared of showing my true feelings, the things that bother me anyways. I always feel that a fight is going to start if I say what's bothering me. I don't like fighting so I hold it inside because it's usually not no big deal anyways. I lack in confidence when it comes to word games because I feel I'm stupid because my vocabulary is very poor. When I play a game that I haven't played before my body trembles because I'm scared of fucking up or I will look like an idiot. (Ellen)

It followed that fear played a significant role in the women's spousal relationships -- often crippling them in terms of protecting themselves.
I like feeling secure but not squashed. Before I married I traveled around never fearing I might get lost. I went to Saskatchewan, Alberta and throughout B.C. and never got lost. Now I don't even try taking short cuts for fear of losing my direction. I HATE feeling this unsure of myself. Where did all my nerves go? How can one man make you fear so much? How could I let him make me fear so much? I don't like me and I don't like all the changes I have made or when I let him change things. Why did I sacrifice myself to him like that? To mold and remold the things he wanted. Why did I just stand back and let all this happen? Did I do it out of love or did I do it out of fear for him? Now I want back on my own two feet and I don't know where to start. Is it because I'm too scared to stand up for me now? (Lisa)

I am afraid of being hit by a man I love and trust. I am afraid of having nothing should (her husband) and I split up, no way of supporting myself. I am afraid that I might not be a wonderful parent and at the same time I'm confident that I will. (Kelly)

**Shame**

Before asking members to work on these issues, the therapist differentiated between guilt and shame. Guilt was defined as belonging to what the person did, whereas shame belonged to who the person was. While they could hope to modify guilt feelings by their actions, shame was inescapable.

I have been thinking about that shame ever since Thursday. I used to think it was guilt that was my prevailing emotion, but now I think I lived and breathed shame. I remember being ashamed of some things as I was growing up. I don't remember when I became a completely shameful person. Intellectually, I had battles with myself over my right to exist. Whether or not I was deserving of the good things in this world. I would say that I could do and get whatever I worked for, but inside I felt that I was detected somehow and the truth would be found out. (Judy)

Members recognized how global and fundamental their sense of shame was, and how it barricaded them from self-care and meaningful relationships.

Shame. I have never known anything but this – from deep within every corner and crevice of my body, being, etc. When I met my biological mother, at 38 years old, the first thing she informed me of was how ashamed she was when she carried me. She was married, but her husband was off at war. She said that the birthmark that I had, that faded, was a mark of sin. She was so ashamed of me when I was born, and if she hadn't given me away the army would have cut off her pension. I feel ashamed of my body, all of it. I am so ugly. I am so ashamed of my sleep disturbances – I know they are not normal and I can't make them normal. I have always felt shame coming from my mother to me, and at the most, tolerance, from my father. I am ashamed of any needs that I have. I have never had any rights. I am so ashamed of my life because it has been such a failure. I know right now I have only touched the surface of the subject, but the deep stuff has to be allowed to grow before it can
be examined. I am so ashamed of everything I think, or do, or say. It's like I am covered by an umbrella of shame. I am shame, and I am so ashamed. How can I ever get well when shame is who I am. All I do or not do is shameful. I can't trust me, I can only hope to control me, to keep my nose above the shit pile of shame I live in. (Alice)

I feel that I've worked my way past resentment, hate and bitterness, and what do I find under these? I feel like an onion - I peel one layer off and there is another layer. Now I recognize I feel shame and guilt and humiliation. These are more subtle than hate and resentment. I haven't done anything against my own standards to be ashamed of. How and why is it that other people's thoughts and opinions can make me feel so low - like worthless scum. The first memory I have of feeling like this is when my parents discussed what they thought of me, when they didn't realize I could hear them. I can't quite figure out how or where these feelings come from and how I can get over them and let them go? (Laura)

I think my whole life is filled with shame and I'm spreading the shame without even realizing what I've done... I think I feel shame for absolutely everything in my life. I can't think of anything that doesn't have shame tagged on to it. Today I looked at a nightgown in Eatons. It cost $60. It looked cozy and pretty. I felt guilty for even thinking about having such a nice thing for myself. never mind that it was so expensive or that I can't afford it. I always seem to buy the cheapest or the biggest bargain, never minding that I might just want something else for me, for my personal body. I think I feel shame for every single thing I want or do. More so when it is what I really, really want. The degree of guilt and shame accompany in the same level... I feel shame for wanting, for needing, for showing, for doing, for liking, maybe even for loving or being loved. (Karen)

I think I have been shamed from love because I always thought I knew what love is. But lately I have been getting a rush over my body which feels great but scary at the same time just from a hug from Alan. Alan is constantly on my mind and I miss him so much that I am constantly looking at the clock waiting for him to pull into the driveway. Then when he does arrive my heart starts beating harder and stronger, almost like I'm feeling ridiculous or childish over my feelings or just uncertain of my actions. I have been shamed from my good feelings and only know how to deal with the bad. I've been shamed from my confidence because the only thing I've been told is the shit I've done wrong so I don't feel right when I do feel some confidence in myself. I've been shamed from happiness and only been told to wipe that smile off my face, and friends are always telling me to smile, it won't crack my face. I've been shamed from looking so well or else I wouldn't feel so uncomfortable when I wear make-up and dress nice. I feel shamed from leaving my children at home with Alan but I don't mind him leaving his children at home with me... I've been shamed from my body. All I see when I look in the mirror is ugliness. I've been shamed from speaking my thoughts. I feel I've improved tremendously though I know I have a long way to go. (Ellen)

For many, feeling of shame became centered on their bodies - a way of externalizing, localizing and splitting off the distress. These individuals were generally the most severely eating disordered.
I am going to a dance on Saturday night with Joe. He offered to buy me a dress. I felt very apprehensive at first, but then decided to do it. I tried on about 10 dresses. I could hardly stand looking at myself in the mirror - felt so fat. Came home with nothing. Felt so ashamed I couldn’t even buy myself a goddamned dress. Started to think about it. Most of my clothes have been given to me by my girlfriends - I would say at least half, probably more. Suddenly I feel embarrassed of that. Were they trying to tell me in their own ways to take better care of myself. Anyway I ended in tears and felt so worthless. I always wanted to be skinny so bad. All my life. But even when I went down to 98 pounds, I wasn’t happy. I hate my body. I remember being so ashamed as a young girl. I tried to think of her last night, she didn’t seem quite so disgusting at that moment. I said good night to her. (Helen)

Anger

Survivors needed to differentiate between their experience of anger as abusive, violent and dangerous, and anger as a safe, legitimate emotional signal that "something is wrong with this picture. How can I fix it?" Members were asked to consider how they had traditionally dealt with their anger, how that affected them, and what they had to feel angry about.

I find anger such a waste of energy. So I guess I have never really wanted to deal with it. I’m not even sure I could get that mad - well, I could, but how to show it and keep it under control. I know I let it build up and up and I’m not sure how to release it, so I just get depressed. I don’t want to say the wrong things in the heat of the moment, so to speak. That makes me angry. What really is the meaning of anger? I get angry when Ken’s mom butts in and she does it almost every time we are around there. And I hate it even more when Ken sticks up with her, even when she’s wrong.

- I get angry when people have more than me, but at the same time I don’t really care all that much
- I’m angry at myself sometimes for getting married.
- I know I could kick myself for not continuing my career with ___
- I get more angry for coping out on myself. Such as things I want to do, people I would like to associate with. I’m angry for the little girl in me. I know I have not thought about her for awhile.
- I guess the list could go on. (Lisa)

Today’s a good day to write because I’m full of anger. Angry at Cheryl (oldest daughter) for wearing my new shoes to school. Jealous too! She gets everything new, always looks in fashion and preppy! I’m on the bottom of the list, that’s where I place myself. So, finally a new pair of shoes and they’re on her feet, and I’m, too damned guilty to tell her to take them off! Heard her yelling at (her brother) this morning. Poor kid, always a target for her domineering ways. Hollered out at her, told her not to be so nasty, that she was becoming a schmit. Smarten up, I yelled! She left for school without saying good-bye. (Her husband) stopped by his mom’s today to pay her the $100 we owe her. He used the phrase “I stopped by my mom’s to take care of business!” I replied in an instant “Sounds like you stopped by and blew her head off with a gun”, then started jumping up and down shouting “hooray!! No loss. She’s a senile old bitch that makes people miserable!” Oh,
by the way, she only took $50, that's so she can remind us constantly of the favor she's done for us. I feel like a snarly old bitch just looking for trouble..." (Chris)

Angry at the world. I've been tricked into letting down my guard and it struck out at me. I want to kill it. Now father's day. A day to pay tribute to your dad — well here's one person who won't be thanking her dad for being such a wonderful father. He was nothing but an insane maniac. I wish they had locked him up and thrown away the key. The only thing he ever taught me was the meaning of fear and guilt. Why couldn't he have taught me love. I wouldn't have gone through all this shit if it hadn't been for him. Well thank-you Mr. ___ for screwing up my life. You should be real proud of yourself now. (Paula)

Anger was reframed as a safe and useful source of energy to be employed, non-abusively, in their own healing.

I am damn angry and frustrated... I am the one who is living in this body and living this life, not them. And I have to learn to be more for myself than them. I also know I'm not wrong or bad and I have made mistakes but I will not condemn myself because of them. Tina is doing okay and she is starting to really get her shit together here. (Tina)

Pain

Members were asked to consider the relationship between love and pain in their lives. For many the terms were synonymous — love = pain — thus, their judgements that "if it hurts, it must be love".

LOVE & PAIN: Sometimes when I've had love given to me — when it was real — I felt very good. I wait for nice things to happen, but they don't between Len and I. I know the pain he feels he dumps on me. I want and need to be held and loved. My friends are great huggers and no pain. My three granddaughters sit on my knee and I rock them, and we talk, and I brush their hair and tell them stories. They phone me and sing their new songs to me, they kiss me hello and goodbye, and no pain. My sister and I hug each other, sometimes we cry if we talk about old times — some pain. (Foster son) cares about me and does nice things and tells me great stuff about my good qualities. He has a hard time hugging me, but has his own way of showing me love — very little pain and lots of laughs. When I try to give Len attention or love I feel pain and rejection. When I try to show Cindy (adoptive daughter) that I really do care what is happening in her life, I feel pain, not by what she says, but by the tone of her voice. It is very cold. Friends I used to have that no longer come around because of things that have happened in our home and they know about — I feel sadness, loneliness and pain... My dad's love was very painful. My mom's love was off and on and I know she was a very unhappy lady. There was love in her. Sometimes it's easier to stay away from the people you love, then there is no pain. But loneliness is painful also. Does this make any sense? It feels good to write. (Diane)
Members were encouraged to recognize their current pain, and their frequently self-punitive ways of coping with it. We discussed how these methods at least provided some sense of control over the pain, and were consistent with their sense of being deserving of the pain.

Here I go again – I lose and the food wins. Good becomes bad – sun becomes rain. I think I should abolish weekends – then maybe I'd be okay. Work, work, work – too busy to play, too busy to screw up. But even better than work: sleep – hide far away in my dreams. Who knows – maybe I'd do better in fantasy than reality. Or is this reality? Maybe I'm in the middle of a bad nightmare, and if I hit myself hard enough I'll wake up. If it is true, it's a hell of a longest nightmare I've ever had. It seems like forever and a day. So then, what is real and what is not – what is true and what is false. Does anybody know – does anybody care to think about it. My eyes are open – I talk, I walk – what if this isn't a dream. What if I am me and this is life. Then what? (Paula)

It's funny how I used to feel about killing myself when what had I done to really hurt anybody? I can't think of anything. Do the people that hurt me so badly ever think? I don't like this but I will never give up the hope that tomorrow will get better. (Anna)

Grief & sadness

Members were asked to consider and then list the things they had to grieve for in their lives – this was experienced as particularly validating by most members.

What did I have to grieve for – what are the dreams that have died:
1. Loss of my childhood dreams of sleep without fear
2. Loss of innocence – I read all of Madame X books plus Happy Hooker and such by the time I was ten. What was worse is that I understood it all.
3. Lost my youth because of guilt that I carried knowing I couldn't protect my sister. Knowing that at times I saved myself at her expense.
4. My loss for never quite belonging. Seeing everything around me as though I were a ghost and not part of the picture.
5. Always feeling inferior – not worthy of the smallest courtesies. Though I was given the courtesies, I never felt I deserved them.
6. Loss of trust in my brother. Loss of trust with my family that they didn't see and do something to stop it.
7. Loss of being young and carefree. Instead feeling shame – every part of me was shame for what I was.

Grief for the death of my father, the death of my marriage, the death of freedom, the death of trust, of security, of dreams, of wishes... Grief for the small person inside of me who had no idea that she didn't deserve every bit of every beating – verbal and physical – that she was getting. Grief that she thought it was her shame and to ask for help only focussed every one on her and her shame. To be found out that I was beaten was more shame. I could never win – I could never be a winner – I never deserved to be more than what I was. A shrew, having to scratch for every little grain. To
starve so I could buy a bag of grapes and sneak off to the schoolyard and call my children over at recess and see the glee on their faces to be given such a rare treat. And to grieve to know that if I were found out, that I would be ridiculed or beaten. To grieve for them and for me, to not even feel that we deserved to escape -- to feel only guilt that we were bad. We were not worth the ground we walked on nor the food we ate. I grieve for all those hells and years that we lived through and the thing that programmed me for that abuse. And I swear that never ever is anything ever going to do that to us again. Never. (Judy)

SELF-DESTRUCTIVE BEHAVIORS

It was important for survivors to identify and understand the functions served by their various self-destructive behaviors, in order for them to be able to relinquish them and meet those needs in more appropriate and adaptive ways. Eating disorders were particularly prominent among members, and it was important for them to recognize the role played by the disorder -- e.g., control, externalization, self-punishment, desexualization of the body, localization of the self-loathing, etc.

ME AGAINST MY BODY: As far back as I can remember I have always hated my body. As a little girl I was chubby. And coming from a weight conscious family -- that was no blessing. Through my teen years I went up and down with my weight. When I graduated I was very heavy at 165 pounds. I felt terrible about myself. I moved up to my grandmother's house and lost 30 pounds. Was feeling pretty good. Met a guy and moved in with him. That was when my girlfriend told me about throwing up. I still remember the first time I tried it. It was at my parent's place for thanksgiving dinner. I thought it was great. But it was shortly after that it started becoming a daily habit. I was severely bulimic for about four years after that. I would shut my drapes, unplug my phone and binge all day. I ended up in the hospital from my abuse of laxatives. Through my pregnancy I felt pretty good about my body. I quit binging and was working extremely hard around the farm. I also felt okay about my body when I was nursing, as I could eat a lot and my boobs were bigger so I felt more in proportion. But thinking about it -- even then I felt fat. At one point I went down to 98 pounds and I still felt big. When I look in the mirror I see fat legs, ass and arms. Now it's even worse as I have a lot of stretch marks on my boobs from getting so fat and then losing all that weight. I still see very fat legs, bum, stomach and Biafran-looking boobs. I try hard to accept my body but I see it as very ugly. I used to really like the feeling when I took laxatives, because I felt as though I could waste away to nothing. (Helen)

Recurrent illness and somatization were also prominent, and many came to recognize that often the only nurturing they received as children was associated with physical illness. Physical illness was also "real" and "legitimate" in a way that their internal pain was not.
I used to resent her (mother -- a nurse) caring for the old people all day and then we would see her an hour or two. I liked being sick because then she would slow down long enough to care for me. I often faked stomach aches to get the attention. She would rock me and rub my back or legs. I would tell her I had leg cramps and I didn't. (Diane)

A wide array of self-mutilating behaviors were evident, ranging from slashing to unnecessary surgeries. Slashing was generally used as a self-punitive focussing technique – a way of contacting and integrating with their bodies, and of expressing their internal pain. However, other needs were also met by self-mutilation. The following provided an example of the lengths to which one survivor needed to go in order to amputate that part of herself she identified with her abuse.

When I was thirty, after I had (her fourth child), I caught a pelvic infection. I made sure the infection would keep going. I got sicker and sicker, and finally convinced the doctors I had to have a hysterectomy. I had to do this. I had to get rid of my female organs – they were so dirty. After I decided to have no more children, I was so repulsed by them, I had to drive them away. This was in the form of a compulsion. I faked the outside responses, but I knew what I was doing. I had to do it. I couldn't carry on until I did it. I was obsessed with this and it took me two years to succeed. It was so freeing when I got rid of it. I was so glad. I am still not sorry. I never felt a loss or guilt. Did I do this because of the past? I couldn't help myself, but I knew what I was doing. I wish I knew how to get rid of the rest of the stuff that makes me a female down there, but I don't know how. My anger is overwhelming, suffocating and exhausting. I can't think. (Alice)

Given their childhood experience, survivors often carry the internal equation "something awful will happen, and has to happen at regular intervals". This exists in the form of a universal law for them, thus their anxiety escalates when life is proceeding well without the necessary doses of pain. Rather than waiting and waiting for the, by now, really bad thing to inevitably happen, anxiety is reduced by taking charge and creating the pain. Thus, self-sabotage occurs pervasively and at many levels. Member's recognition of this constant dynamic was important in helping them to move to the place where they could form an alternate, and more humanely realistic, "law of the universe".

I am angry with myself for a multitude of things lately. I'm always beating myself up -- mentally, and I don't seem to have any control over it. God forbid that something good should happen, because it always costs me something. Why do I do this? I'm tired of being beaten over the head, even if it is self-inflicted a lot. (Jean)
SELF INTEGRATION

Clearly, a fundamental goal of therapy is that of self-integration for individuals who have had to fragment and split-off so much of their own experience and self. The central metaphor of the "little girl" inside, the hurt child-self, is a very powerful and appropriate one for survivors. Coming to an awareness of their child-self and experiencing a sense of compassion for her pain is a vital step along the road to healing and integration.

I was thinking of my little girl. I know I have to love her. I went for a walk last night and I kept looking at the shadow of my body (it was in front of me). I could hardly stand to look at it at first. But then I started saying to myself "it's you, it's your body". Then I thought of my little girl. It's me. Don't feel a lot of compassion yet, but I am at least aware now of what needs to be done. (Helen)

I feel very sad for the little girl who felt so trapped. What a fighter and survivor she was. I feel like crying as I am writing this. How could anyone handle all of this without faith? I don't know how they could – that's probably why people feel like ending it all. I thank God for the strength he gave me then and now. I know I don't have to be a victim ever again and I don't want to make anyone in my life a victim. I never realized how tragic my life was until I wrote it down. there are many things I can do today to make things pleasant for me and others. I have very little fear compared to before.

(Diane)

Survivors need to move to the recognition that they have to become their own "good parents". Consequently, they need to recognize the needs and sensitivities of the child-self. Exercises such as "What does your little girl need?", and "Let's hear the dialogue now between the hurt child and good parent", help to provide support and perspective to members.

My little girl needs patience, tolerance, understanding, time and a lot of love and hugs – all of which I can give her. Patience in knowing that she is young and needs to be nurtured along at a very slow pace. She needs to grow slowly. To be willing to wait for her to trust that it will be okay and it will be safe. To know she can be happy with my help, as long as I don't get impatient. Tolerance: I must be tolerant of her needs, knowing that they are many. Not demanding, but normal needs. She is to be handled carefully without judgement and criticism, to be recognized as a hurting and loving human being. Understanding is something that is coming easier and easier for me as the adult – to give to her as she has truly been misunderstood through the years. I want to understand when her old tapes begin to play and help her to recognize them for what they are – excess garbage that neither one of us needs to carry with us anymore. Time to let my little girl know that all of this will take time and that I can, and will, give her all of the time that both of us need. Love is something that I have enough of for both of us. I will hug and love her whenever she needs it, at least daily. She in turn will give it back to me whenever I need it. We are going to be best friends.

(Joyce)
Dialog between child (C) and parental (P) selves:
C: I'm so scared
P: It's Okay honey, you're not alone
C: I am alone. Nobody knows
P: I know now and we'll do it together
C: I can handle it
P: Never alone again
C: But "mind over matter"
P: That's bullshit. Your child mind has been damaged, you're a survivor.
C: Then I can be helped?
P: With lots of love and confidence you'll be okay.
C: But where do I start?
P: With yourself
C: What do you mean?
P: Love yourself. Know that you weren't wrong, that you are a child of innocence that was subjected to abusive situations.
C: You mean mommy and daddy are bad?
P: Yes
C: But they're my life line
P: Not no more
C: Why
P: You will learn to get away from all the abuse
C: How?
P: By dealing with your inner child (you). You will see how wonderful you really are.
C: Okay, I hope you're right
P: Trust me, I'm you. (Mary)

Members also need to recognize the differences between their relationships with others and their relationship with themselves, in terms of implied value judgements, expectations and investment.

I have always had people hanging on and confiding in me. I know now that that was mainly so I could find my story in them. And if I did, and they got well, I could. I am a good friend to others - even very well read and knowledgeable, but a lousy friend to me. My relationship with me is almost nonexistent. I don't know who I am. I don't know where I am at, and I don't know where I am going. I feel desperate and frantic, yet peaceful and solidified in where I am at. I believe because I didn't know these things, I have gone along with a lot of abuse. A part of me feels quite desperate because if I say no to the abuse, I will be nothing. I have never functioned without it, so how do I know if I am any better if I say no to it. Because I have lived no other way, how do I know if I can. Because I keep myself so private and distanced from everyone, I could easily drop all these
relationships. But then I would just read books because I don't know what else to do. How does a wooden puppet function without any motivating strings attached? (Alice)

It is necessary to highlight and clarify members’ emerging sense of how it is to function as an integrated whole – past-present, mind-body-feelings, etc.

Last night my girls came over to visit. Everything was fine. After they left I sat alone in the quiet and felt calm and strong. I feel I am going to make it this time. This is the first time in my life I have faced my own hurt, pain and anger and tried to work through it. My lifetime pattern has been to try to get involved with a man and feel happy for awhile. But the happiness never lasts and I have always found myself back with all the anger, pain and depression I thought the relationship would cure. (Laura)

I rode yesterday and when I really think about it, I don't actually think at all when I ride. My mind is at peace with itself. I just enjoy the feel of the horse and the scenery. My mind, body and emotion self we'll say just comes together and I'm relaxed taking it all in. Of course when I first start my ride I'm thinking of all kinds of things but by the time it's over my mind is ready for another day. (Lisa)

INTERPERSONAL ISSUES

Continuity of abusive relationships

As part of gaining a larger perspective, survivors need to situate themselves within the context of generations of abuse. They look back through the generations and examine the legacy of abuse (in the largest sense) and its impact on their adult functioning.

I remember Granny saying how Grandpa didn't like the boy grandsons and would have nothing to do with them. Maybe she knew to a degree. Granny is really into men and boys – it's weird. Like I've lived with her for quite a while and I do quite a bit with her – but she can't really be bothered with me or my sister. But when my brother is down, she's really receptive. It's really noticeable (not trying to be unreasonable). I see that my mom is like that with my brother too. Like my mom blew my mind when she couldn't even hug me. Brought back floods of memories and thoughts. (Her ex husband) used to do the same thing to me. I would literally beg him to hug me and he would tell me to fuck off. Never realized how sick my family was. (Helen)

Now a glimmer of new feeling is coming through – I'm beginning to think "what is good for me". I'm beginning to realize what is good for me far more clearly. My perceptions of what was best for me were distorted – I didn't realize that. How am I supposed to know what's best for me, that there is another way, when my childhood model was that life was one crisis after another. You never
felt safe, calm or happy. Your parents fought constantly and acted like they hated each other, and then said they loved each other. My mother was always angry or sad or putting up with things that made her unhappy. My dad treated her abusively, drank and had great fits of violence, abused me sexually when he was drunk, cried on my shoulder, filled me (when I was young) with great hopes and expectations that things were going to be different and we would be doing happy things. He used to get my hopes up so high when he was drunk. I believed everything he said. Time after time I was disappointed. When he was sober he didn’t remember anything and things went on as before. This went on for years before I finally gave up hope that anything would come true. I grew up thinking life was just one big unhappiness and disappointment, and you just had to put up with it and manage the best you could. Now I’m an adult and I’ve recreated this way of living in all my relationships. I was trapped when I was a child, I’m not trapped now. But I thought that was the only way to live – that it was normal. (Laura)

I could blame my mother for never being a mother, but then it could turn into a cycle. Her mother, her father – same thing. Or my dad. we live as we have learned. Instead of beating my kids I yelled at them. I grew up with double whammies. How can people be blamed for the things they do if they have repeated the thing they’ve learned. How can I blame myself for things I never knew. I can’t. (Anna)

More specifically, members are asked to consider the similarities between their abusers (generally father-figures) and their husbands and boyfriends.

Dad and Len (husband): the way they are alike. Len never used to swear as much as he is lately. He knows it upsets me so he uses the cussing when he is mad at me. They both have the anger. My dad had few days without screaming rages. Len curses the drivers in front and all ministers and people that believe in God. My dad threatened me when I was young, what he would do if I went to Sunday school. I am frightened sometimes by his behavior, it’s getting worse. More anger, more often. I know he feels guilty but doesn’t know what to do with it. He refuses to believe anything is wrong with him. He resents my friends and so did my dad. Why is this happening? I know it’s not my fault, it’s his problem. But he cannot forgive himself, so he’s mad at me and (foster son). I feel happy and he knows my buttons and seems to feel some kind of release by picking me or the house apart. I don’t feel hate toward him, but I pity him as he never has any peace. He works hard, almost like a punishment. I like to visit friends and talk on the phone – often, when he comes in he says “is that all you’ve got to do?” He’s nice to me when most people are around, but still slips up and makes one or two sarcastic remarks. God, is he unhappy. I will make my life as happy as I can, with or without him. He doesn’t have the power over me like he used to. My dad had a bad childhood. But Len’s dad cared for him a lot. Len really changed when his dad died in 196_. They both have denial that anything that ever happens to anyone is their fault. Len has only said he was sorry to me two times in 30 years. My dad never said sorry to me. (Diane)

It’s difficult for me to try and think of what I didn’t like about the guys who I’ve gone out with in the past because I’ve always thought that the problem was me and not them. Although I’ve been
hurt many times, I always thought (and still do at times) that I somehow deserved it for the way I was - I must have not given them enough love - enough of my time - done enough things for them. I do know that with each relationship I have had, I have progressively gotten more scared of men, of sex, less trust, more on my guard, more independent from them, wanting to spend less time with them. So I would hope there must be a reason for that. As I look back on my relationships, there are things I didn't like about some of the guys who I've been with. I would say that most of them were the domineering type. They naturally always got their way whether I liked it or not, because usually I was too afraid to say anything - always afraid that I would get in trouble or something if I didn't go along with what they wanted. In some cases (more than I want to remember), I was taken advantage of sexually (sometimes I just quietly went along with it and sometimes I was forced - especially when alcohol was involved). I now find it almost impossible to think of sex as a wonderful thing between two people - I think of it more as a one-sided, aggressive activity - the man's side, the man's pleasure. Some of the guys I've gone out with were very possessive. Always calling, always wanting to know my every move, jealous if I went out with my friends, or just talking to another guy. And in one case I was followed, spied on, tested as to my whereabouts, when he already knew where I had been, just to see if I was telling the truth. I hate being possessed - I always have this great need to be free, to have a lot of space. Then when I am free I don't like it. All my relationships with guys have gotten serious very quickly. I'm not sure whether it was me, them, or combinations of both. Before I know it, I'm into something too deep for me to handle and the relationship ends because I get scared. A lot of times, I seem to choose guys who are lonely and then I feel sorry for them. No matter what they're like, if they say something nice to me, I'm hooked. They probably know it too. There wasn't much communication in my earlier relationships, although there was more in my recent one. There also wasn't too much as far as social activities in my earlier ones. So what have I summed up with all of this - probably the average man. (Paula)

Members also explored the continuity of the abuse cycle internally - starting with their own shameful sense of self, their consequent functioning in relationships, and how that only reinforced their painful and negative sense of selves.

I have been seeking approval from everyone, my friends, my children, my brothers and sister, my relatives, my employer. I have always had this feeling of being a bad person and I have searched to feel better about myself through other people. I grew into adulthood realizing what had been going on between us was wrong and I was the only one here to feel all of the pain and confirming my feeling of being a bad person. Whenever anyone that I trust hurts me, I withdraw taking it all personally. That it must have happened because of something I did - just like it did years ago. I have no self-confidence when I'm down. I don't know what to do to get back up. My lack of self confidence has held me back so many times - especially my feeling of being a whole person. I've had to struggle so hard, always feeling like a failure. As a child I felt like I had failed dad somehow as his daughter and that was why he hurt me like he did. The feeling of being a failure carried on through my teens and all of my relationships, as well as into adulthood and my marriage. When my husband left us for another woman, I felt like I had failed him somehow - that was why he turned to
another woman. I've never known how to deal with failure. My expectations and dreams aren't so high and when they fail it all reinforces what I feel about myself. (Joyce)

Many survivors tended to become involved in non-reciprocal relationships with needy, dependent people. While this allowed them to feel worthy in the role of helper, it further isolated them from support and reinforced their sense of shame over their own needs. Changing these relationship patterns was a difficult, but necessary, task.

The abuse game: I'm only just starting to get familiar with it. I guess I've played it all my life—either the victim or the abuser. I know I'm the one usually to go the extra mile, to stick my neck out and be there for those who need me. And when I say need me, I think that's where it starts. Because if people need me that's almost a control for me, and when I am needed I feel good. But when the opposite feeling appears, I go right down. (Husband) thinks I'm fucked. He feels that I should never expect anything from anybody and I'll never be disappointed. But I can't. I don't know where to start. Not expecting anything from anybody means being lonely. I do have good friends—people who approve and respect the changes I'm trying to make with myself. But it's so fucking hard having to associate with people who don't. (Mary)

**Power and control**

Survivors had generally experienced power and control as all-or-none phenomena, and had not previously experienced equivalent relationships. Recognition of this, and of the continuity of their experienced sense of helplessness were important.

Over the last while I have been realizing that in most or all of my relationships there are power and control issues. Either I am with a very domineering person, or else, where I dominate. When I was driving home last night it was stormy. I felt scared, like I wanted someone (a man) to take me in their arms and make everything okay. To protect me. I realize within my relationship with men I have always been looking for that. Always looking for the same feeling I got from my dad. Total dependency on him. Equal relationships with men or women is totally foreign. I have always had some authority figure to run to and ask for all the right answers: AA sponsor, pastor, dad, (ex-husband). I realize that I think that control is all or nothing. But it doesn't have to be that way. Either I want all the control or no control. (Helen)

Well, I've been trying to think of times when I felt helpless or not in control of what's going on. The main one I think is that night when I'm 8 or so lying in bed listening to mom telling dad to leave her alone. Or the last time (her husband) hit me. He was just in an uncontrollable rage and I couldn't get away. The worst thing is when someone you love and respect hurts you. That night I lost respect for (her husband) for a long time. The time that dad hit me I didn't feel in control, I felt weak and humiliated. I remember this one time when I was 14 or 15, this guy (I don't remember his name
now) was rubbing me between my legs. He was way too strong and I didn't like it but I pretended I did because we were in a car with other people and also because I kinda liked him. (Kelly)

Members were asked to consider the relationship between power and control in their experience, and the to think about the ways they had tried to access them.

Power is control. I used to focus my power on friends by being extra nice. Because then they'd owe me a friendship. But not no more. I finally realize that the people that are around me want to be. They choose that without me being extra nice. They enjoy my company and holy shit, it feels good to finally have honesty. (Mary)

They were also asked what they had to do to feel in control, and to examine the self-punishing component of these coping mechanisms.

Black and white. Keep my physical environment neat, tidy and organized and feel secure and in control. Stay busy and feel important and worthwhile. Deny myself pleasure and feel my non-existence. I have spent years in exhaustion and years of overworking – avoiding the untouchable, denied feelings. I can't even control my compulsion to work – it's like a drug. I am addicted to it. (Alice)

I've lived by my self-will all my life. Now I realize I have to give it up. It's hard for me because I have never trusted anyone or anything except myself. If I could have faith and hope that what has happened to me is for my best and not fight and try to control an outcome that I am powerless over anyway. To realize I am powerless over anyone but myself. Yesterday I found myself in a difficult situation, but I thought what is best for me? I deliberately turned my thoughts from hate, resentment and bitterness to a feeling of faith in myself. Faith that circumstances in my life are going to be the best for me. I have to believe that when things don't turn out like I want, or people don't act like I want – I have to accept this and admit that I'm powerless. And then the hard part – I have to believe and have faith in myself or some power in myself that I will act in my own best interest. The concept of thinking what is best for me is strange. The concept of seeing, in reality, that in the past my idea of "what is best for me" was nonexistent. I never thought what was best for me. (Laura)

Members also examined the distribution of power and control in their current relationships, and the ways in which it was manifested.

My need in this relationship is to be as free as I was before I married with only a change on the commitments. Ken doesn't like me to do anything unless it's his decision. I can't even get on my horse and go for a ride unless he knows where I'm going. About the only thing thing I can do without his knowing or asking is taking a shit. (Lisa)
Some of the ways Ken has power over me are financial and that's a biggy since we're trying so desperately to save right now. There isn't much extra. Mind you, he's loosening up his wallet a bit more lately than usual. Another way is since he has hit me in the past, when he loses his temper now it frightens me to the point where I won't push him. And every now and again he uses that. I think those are the only ways since I'm feeling a lot stronger and more sure of who I am. He can't control my moods anymore because I won't let him. I have a lot of control and power over Jessie. Since I'm her mother and main caretaker, I can control what she does and who she sees, her environment in general. I don't abuse it though. I try to show her a positive way to be and expose her to a lot of things and people. People whom I think will make a positive impact on her although that is not always possible. (Kelly)

One of the exercises asked members to list their beliefs about "what men are" and "what women are". This always tied in neatly with discussions of power and control in terms of gender attributions.

**Men**: Physically strong, less emotional than women, harder (emotionally), more confident, not vulnerable, stronger emotionally, more mature, private about their thoughts and feelings and less willing to discuss them, more superficial, crueler, capable of being harsher, more judgmental than women, not as understanding (especially regarding emotions and private thoughts), more aggressive and assertive, more in control, bound by their masculinity to project an image and play a role, less able (because of society's ideas) to be emotional, vulnerable or open - have to live up to certain standards, less forgiving, more independent - freer lives and don't have to answer to anyone. To me I guess men are a mystery. I am surprised at my own ideas and I tell myself not all men are like that but that's how I have always felt. I have always felt misunderstood by most men, that they are emotionally unapproachable. Most men I do not trust and would find it hard being as close to men and as comfortable emotionally with them as I would with women. I guess I've never thought of them as just people but as a separate, mysterious species. **Women**: Gentle, softer, more understanding and compassionate, vulnerable, more dependent, more emotional, open about their emotions and private thoughts and more able and willing to discuss them, misunderstood, less assertive and/or aggressive, must work harder to be successful, also burdened by a feminine image forced on us by society (i.e.: magazines, have to be slim, pretty, smart, etc.), have to play certain roles that make their lives harder: mother, wife, employee - a juggling act, more responsible (the buck stops here). In a relationship, even if the man is a good helpmate, I feel the woman is ultimately responsible, i.e., if she works she still has to make sure house and children are looked after and the home runs well. I think women are, as a rule, dumped on if things go wrong. A woman's work is never done means more than doing the dishes. **Pleasers** - (women) have to subject themselves, compromise more often. Have less choices - usually the man's choice wins over - the bottom of the pecking order. If a woman behaves any differently they are disliked or thought of as a bitch or trouble maker or poor wife, etc. I have always thought women are bound together in a kind of emotional sisterhood and universal understanding that a man could never understand or be part of. Men as a sex don't share this bond with each other. (Tina)
Betrayal

Journal work around the issue of betrayal allowed survivors to see and label it as a pervasive, life-long experience - as normative and expected by them in their relationships with others.

Betrayal: My parents have betrayed me and my sisters and brother. I used to do it for attention - talk, talk, talk. But not no more. I feel if people's lives are so boring, which mine used to be, that they have to talk about my life, then I'll save them the time and write a book and at least make some money. I've been betrayed most of my young life. I've become accustomed to being betrayed or betraying. (Mary)

My father made me believe I was useless because schooling was so difficult for me. Later on in years I quit because it was too hard. He made me feel like I was very stupid. That females are to keep the house clean and keep their mouths shut. He also made me believe that all men are disloyal to their wives. My uncle, my cousin, my father, male friends, boyfriends, sister's boyfriends - all were disloyal to their wives or girl friends. Even two doctors I had wanted to use me in a totally wrong way. (Barb)

As far as betrayal goes, I think the person who betrayed me most would be my father. He used my love and trust of him to satisfy his own sick desires. The next would be Ken (her husband) who also used my trust in him and my vulnerability as far as understanding the world, men and relationships to mold me to the woman he was looking for - whether or not he realized it or not. In the beginning of our relationship I was vulnerable to him because I needed him more than I knew. more than he knew too. He knocked down my trust in him when he hit me, making me more vulnerable to his moods. Our relationship definitely started off on the wrong foot. (Kelly)

They also recognized that this expectation of betrayal had been internalized, such that self-betrayal was virtually reflexive.

Many times when compliments are given to me I go red in the face and I don't know what to say. Except in my mind I'm usually saying "ya, right" or "well, it's good enough" or "I wish I had an imagination instead of having to look at a picture before I can draw it or even think of it". I always have people telling me I should get into commercial arts, but I don't have the confidence in myself to do it. I feel stupid that I have to look at something before drawing it. I feel stupid when I get compliments when I wear a dress and make-up, which is very rare. And after I'm complimented on that, I find I'm very uncomfortable and I don't know why. I always have people tell me that I cut myself too short. I guess that's the only way I know. I hope to have more confidence in myself soon, but I do catch myself doing it all the time and I don't know how to change it. There are a lot of good things I do that I am very proud of. I can fix appliances. I can remodel a home. I can cook a great meal. I love to bake. I can keep my house very organized. I can write poetry. I do landscaping. I can build a
Trust

Asking members to write about trust allowed them to realize it either as foreign to their experience or as having had profoundly painful consequences in the past.

I don't think I have ever really trusted anyone — man or woman. (Helen)

These past few weeks I have found it so very hard to write and I keep asking myself why. I want so much to come to terms with all this unhappiness and hurt. There seems to be this enormous wall in front of me — it's fear. Fear of what? Trust is the first thing that comes to mind. My past record of trusting is the pits. I trusted my parents and they both hurt me so much by betraying that precious feeling of mine towards them as a little girl. My uncles whom I loved and trusted also betrayed me, they waited until I was 21 — well, at least two of them did. A fellow employee took the trust that I gave to him and destroyed it with no emotion at all. My first husband, whom I trusted to help me build a new life for both of us, used me to further his own needs. He not only verbally beat me, he physically abused me robbing me one more time of my trust. I booted him out and ended the relationship and marriage. I was much stronger then. My ex-husband John, to whom I grew to trust and respect with no boundaries — my love for him had grown so completely, I trusted him with my heart. After sixteen and a half years he tossed it all aside almost totally destroying me in the process. My Al-Anon "friends", one of whom sent me a typed, unsigned letter a year after John had left us — among her vicious attacks of me were the words "God is finally being kind to John. God will get even with you too, all in good time." The trust I had for the Al-Anon program and people was a confident feeling — after all, the 13 steps and 13 traditions were our guidelines. I'm terrified to trust. My most recent betrayal of trust has been with my employers. After three and a half years of total loyalty, my female employer went behind my back and took my friend, another employee, out for a drink and proceeded to rip me to pieces. I can't help but wonder, from time to time, when is all of this going to come back at me? I'm really afraid to let anyone know too much about me, that way I can't be hurt. They say in Al-Anon "take a chance". I've taken so many chances and lost, I feel like I'm running out. It is so hard for me, there are parts of my life and me that you already know more than anyone else. (Joyce)

They also began to recognize how little they had trusted themselves, and some of the consequences of this self-distrust.
I think if I was to trust myself to say just what I think automatically, I think people would think I was a bitch. If I never thought before I spoke I don't think I would even like me. I've never really tried it. But I'd be afraid I'd hurt people's feelings. I'd end up with no friends, not even myself. I really don't think I'd like the stuff on my old tape and that's what I'd be afraid would come up—lots of negative stuff. I try to control myself long enough to think about what I say before I say anything. So long as I control what I say I trust myself. I do trust myself with men. I know I'm in full control as I can see if something is coming down and I steer it in the direction I want it to go—usually away from me. I trust myself with my kids. I know my parenting is good and getting better. I trust myself with men only when I control myself. I don't know how I would be if I didn't think about what I was going, or not going, to do first. Now I see a pattern here. So maybe in all situations, as long as I am in control of my senses I guess I trust myself to get by. But I don't think anywhere I'm just spontaneous. Even with hugs and kisses with my kids, I usually think about it first then decide. Even to pet a dog. I think about it first. So I guess I'm not spontaneous. Sometimes I think about something and still come up with the wrong decision....I would like to loosen up my control over myself as I always please people and say what they want to hear and not what I really believe. And then be able to accept the consequences of what I say without judging myself or what I think or the way I think or how much I have to learn or how much I have learned. (Susan)

As therapy proceeded, members began to experience an emerging sense of self-trust, and recognized it as a new way of being in themselves.

I am just beginning to know what it means to trust myself. I look inside myself for answers and though they might be hard to follow through, I do trust them to be correct for me. I trust myself in situations where before I had felt pushed and pulled in outside currents. Now I make my own way and I have confidence in the route I choose. I trust myself to take care of me. I once heard someone say that you had to be loyal to yourself first because you are the only one that you can be sure you'll wake up with for the rest of your life. I thought that was great when I heard it, but now I know just how deep that goes. (Judy)

As far as trust goes, I'm learning to trust people and let more people in. I realized I'm pretty lonely without friends. I'm the type of person who goes on first impressions a lot. Some people think that's bad, but 99% of the time I'm right. I think I have a few friends I can trust, especially the people in group. With me, I trust (her husband), mom, and I'm starting to trust (her brother) a bit. (Kelly)
Intimacy

For many, group represented their first experience of emotional and personal intimacy. This was recognized as a real and legitimate struggle for them — pitting their need for intimacy against their deep fear of the consequences.

I feel such a strong sense of the group — like sisters in the broadest, worldly sense. I feel united with them — Pat included. Although I look to her for my needs and guidance, I also see her as a sister, the same as the others. It's scary because I know it will end. But by living in the middle of the road nothing will change. To benefit, I must risk. I feel to open my arms to include the group leaves me vulnerable. But instead of getting hurt, I just might gamble and feel their warmth — their love. I cry for their pain, I feel their sorrow and hurt, their losses and grief. I can laugh at their humor. To think that maybe they, in turn, are doing the same for me, is strange. It feels odd. I hope that I can accept that they do. I'm afraid of when this will end. (Karen)

I used to really like being alone all the time, but now I like the presence of people around me a lot. It makes me feel better and sort of gives me a feeling of belonging instead of an outcast all the time. (Paula)

How does it feel to begin to separate? Well, I am not ready. I can't do it. I need a lot more time. But I knew when I started that this point was coming. So big deal, it's close to arriving. I was lucky to have gotten what I have had. I will survive. I am angry somewhat. It's like, if it's good it goes. But, at least this time, it's leaving me with some tools and supports, not just marooned and isolated. I do need more of the caring and family atmosphere, but I have been careful to guard me for when it will happen. Short, sweet, good while it lasted — so what else is new? (Alice)

Members also came to recognize the need for a stronger and safer sense of themselves before they could allow others close.

After when I do something nice for Ted, I can't look him in the eyes. I've noticed that I'm terrified to eyeball certain people, it feels too intimate — except when I feel good about myself, then I can meet people's gaze. (Betty)

Sexuality

Virtually all members experienced their own sexuality as a highly conflicted and difficult area of their lives. Most equated it with victimization and stereotyped male-female roles.

Things men can do: The very first thing that comes to mind is men can have sex with anyone, anytime, anyplace, anyway they please and this only makes them more he-men. Then they feel great, feel superior, have more power over women. With no consequences whatsoever to pay for this exercise. the whole experience for men is great. (Men can't fake an erection, women can fake
enjoyment or an orgasm). They can work on a career without having and looking after children, the home, housework, etc. All they have to do is work on a career, make a few bucks and women will find them. They can go to work, stop for drinks on the way home with the boys. Get home when they want to or by 6 p.m. and dinner is ready, job for today is over. Eight hours work and then play. On the other hand women can have sex with anyone but must pay the price first: if it's a one night stand she could pick up a disease. If anyone sees or hears of this she will be named easy or a slut, pig, etc. Then if she sees the guy again I will feel guilty, embarrassed, cheap, easy, not good enough to date. Second, if the man is married I will not be able to date him or be seen in public as his wife will find out and blame me. And he will not be there for me when I need him as his wife will come first. Also it's sneaky and it would be hard to keep my head up and how would I explain this to family and friends and my children. Third, if it's my husband — in the past sex has been to show me the power he has over me. It kept me feeling guilty over my lack of being good in bed. I was afraid that if I ever let my body go and enjoyed what he was doing to me then he'd really be able to control me. Also then I'd really be a slut if mind and body enjoyed what I was taught was wrong. (Susan)

While the majority of survivors were non-orgasmic, those that were orgasmic frequently expressed distress and disgust with their sexual response.

Lately I've been aware of being angry with each orgasm I have. Almost like flogging myself, repeated floggings and anger with clenched teeth. But I think I was like that even then. Guys think I'm great because I'm multi-orgasmic. Boy, if they only knew — their bloody delicate egos would be crushed. It wasn't because of their greatness. I didn't even want them to be great. I didn't want their bloody intimacy or shared experiences. If one was wanting intimacy, a touching of souls, I ran like hell. I didn't even want a guy who held my hand or showed affection in public. I guess I wanted abusive guys. (Karen)

Many of the women in group were terrified of sex and were actively avoiding sexual relationships. However, many began to hope that they would, some day, become involved in a loving and satisfying relationship.

Right now I'm still too scared of men. Better for me not to get involved sexually, at least until I get over the feeling that they will hurt me. But I do believe that somewhere out there there is a man who could treat me gentle. I will never again feel forced into intercourse. (Anna)

The following lengthy passage is included as it demonstrates the long-term, evolving nature of the relational-sexual dysfunction experienced by so many survivors.

When I was a young child "nice" people didn't discuss sex. I was told not to touch myself and genitals were referred to as "your little place". My breasts were never referred to as such, rather "bust" or "chest". I heard rude jokes from friends who were older than me. My mother gave me a
booklet about 10 pages long. I put it in my drawer, not understanding it, but somehow knowing it was important. One day, the next door neighbor girl came to me crying and terrified. She said she was bleeding. A light went on in my head and I said “I think I know what’s the matter” and went and fetched the booklet which she read and we sort of sorted it out together. Her mother was an alcoholic who later committed suicide so I think she had to ask her dad about sanitary towels. I once thought you could get pregnant if a boy kissed you! When we immigrated to (Canada) I started school halfway into the year and was put one grade ahead. All the students were a year older than me and about 3 years more emotionally and socially more mature than me. The girls would talk about sex in euphemisms, but I had a vague idea what they were talking about. I could never understand why I was so afraid of boys, but at the same time attracted to them. In grade 12 I had my first date. I always marveled that the school’s star football player asked me out. This was towards the end of the school year – I only dated him for about 3 or 4 months. It all came to an end after a heated and embarrassing necking session and he was angry that I would not “come across’. The rest of the year was a disaster as was grad. Knowing absolutely nothing about sex, I thought I might be pregnant. I was 21 before I had what I now know was real intercourse. Alan was 26 and I went out with him for about 2 years. But I would not have sex with him until we were engaged. So he bought me a ring. The first encounter was a terrible disappointment and sex with Alan was totally and consistently unfulfilling and frustrating. He would fall asleep and I would be so keyed up I had to masturbate. Thank God I never married him. After we broke up I was devastated and went on a five year binge of men and alcohol. By 26 I finally got over him, but by then was wearing my heart on my sleeve, and could accurately be considered promiscuous. I just loved men – any size, shape, or colors. I realize now I was wielding a sort of power. I got involved with a crowd who used drugs and it was at one of these parties that I found out the guy I was sleeping with at the time had another girlfriend. And at this party he tried to set up a menage a trois. The sexual revolution was in full swing but I was inhibited enough to keep away from unusual sexual practices. I did feel incredibly attracted to her though, and was frightened and disgusted at the same time, also badly stoned. I managed not to get involved further with them and ended up trying to seduce his roommate, only to discover in the morning that he only, and I mean only, liked men. I was so embarrassed. I had no idea. Later when I started work at ___ I became infatuated with one of my co-workers. he was so gorgeous and had a super personality. I misunderstood his friendliness to me and invited him to dinner. The next day another one of my co-workers, and also a close friend of his, gently let me know that Eric had a lover – this lover was another man! Eric and I became very close (but strictly platonic). I really loved him as a friend and felt very safe with him. In the following years I became involved with several men on and off. All years younger than me – as many as 7 -12 years younger. I found their innocence and gentleness very appealing. Any sign of aggressiveness, no matter how small, and I terminated the relationship. I went out with a fair share of jerks too. Shortly after Alan, a guy I met at work took me out to dinner. And when I would not have sex with him he called me frigid. That night for the second time since I was 16 I tried to kill myself. Slashed my wrists, but not deep enough to do any real damage. For the next two weeks I had to go around with long sleeved shirts in the middle of the summer! Then I went through my man-hating stage and in 197 homosexuality was coming out of the closet. And I thought it was a great way to deal with worldwide overpopulation. Also I was working for a prominent (professional) who was homosexual and didn’t hide the fact. In fact, just the opposite – he had a huge photo of himself and his long-haired
lover on the wall in his office. I only saw him four or five times, but often had to help his secretary typing his notes. I thought he was just WONDERFUL. Talk about star-gazing. He seemed like an incredibly gentle and sensitive person. And one day, as he passed my desk, he winked at me and said hello. I nearly fainted with delight! I still don't understand this feeling he invoked in me. I think I have a fair understanding of human sexuality, but I'm still slightly confused with the morality aspects of sex. I enjoy sex, but after (her daughter) was born, Ed and I started to have problems around sex. It is an area of concern for me within my marriage, and one that I've been hesitant to talk about when we see Jan (marriage counsellor) (but I know we are going to have to talk about it and soon). I also mentioned before that when I was fighting or very angry at Ed, I would feel very sexually aroused. In the past one or two months I have not noticed this feeling to the same degree as before. I have a vague notion of why I felt this way, but I can't really verbalize it. (Betty).

Old family roles

Members are asked to consider their place, and role, within their birth family and the roles played by other family members. A range of techniques can get at this — from direct questioning, to specific relational roles, to recollected scripts.

**MOTHER:** - Martyr. Kept everyone in as much need of her as possible — made her feel in control of others
- doing everything for me (washing, clothes, cooking, etc.) which made her look like a bit of a hero for still loving me after all I had done.
- also wanted me to stay the problem so eventually dad would look at me and realize he still loved mom. She was winning if I had a problem. She didn't have to look at herself.

**DAD:** - looked like the perfect father to everyone. But one child who was really a mess made him look like the hero — that he would still love me through all my problems.
- As long as he felt in control he didn't have to look at himself.

**OLDER SISTER:** - little babysister was a bother. I made her feel a little jealous but also sort of powerful and in control.

**OLDER BROTHER:** Felt powerful and in control. Didn't have to look at himself.
- set up same pattern as mom and dad. (Helen)

The emotional role I played with mom: Is like a roller coaster. She drank all my life, so my emotions depend on whether she's drinking or not. When she's drinking I'm cruel and hard towards her — there's no compassion towards her whatsoever. We don't get along and I usually leave. When she's sober, she's opposite and therefore my emotions are too. We get along, we talk and I feel good and safe. But yet never saying much because a drinking scene will be following and my privacy is violated. I have to say I'll always love my mother. She's just doing her time and her way of spending it justifies our relationship. (Mary)

Mom says "I can't do everything around here Tom (father). These kids keep me too busy". Susan (the writer) says "I'll help mom". Tom says "Janet (mother), when are you going to do the
Members are also asked to examine the implicit and explicit rules arising from the family roles.

I just realized last night that I have always felt that if I were to be happy, that someone else had to be unhappy. That we all couldn’t be happy and come to a mutually happy decision — all the more
reason for me to take the parenting courses again. I realize now, that being the oldest, I was expected to sacrifice for the happiness of the younger ones. (Karen)

Also examined was the function that their role as the identified "family problem" served for other family members (as well as themselves).

For Sara (her daughter), the function that my illness serves is that it keeps me centered on her! She has me where she wants me, I'm easily manipulated by her. I can't visualize myself without Sara, I'm still very fearful that if I go out to work and leave her with someone, she may come to harm. The other side of that is I can use an excuse to not try to accomplish for myself. For my mom and Janet (sister) the function that my illness serves for them is probably quite similar. Janet has probably been a surrogate mother for me. We three were very close in our activities from the time we landed in (Canada) to the time Janet got married. After that my mom leaned on me more because Janet moved to Toronto. I think my being ill focuses the attention on me. I'm always the one in an emotional crisis (financial too). I've always been the problem and I think it might give them a feeling of superiority. We're O.K., she's not O.K. I've given them a lot of my time and energy, also expensive gifts. I drop what I'm doing to help them when they need it. But after the cesarian section delivery of Sara, they didn't come once to help me -- I felt it was so unfair. But I guess if they can focus their attention on my mental health, they don't have to look at their own. Also, if I'm feeling insecure I do more for them, a way of winning their love and approval. If I'm feeling needy I'm more likely to run when they call me! (Betty)

Members were also asked to consider the roles and dynamics within their nuclear family:

This is not a very close or communicative family -- no one is really aware of how the others feel or think and there is a lack of understanding. There is so much under the surface that goes unnoticed and unresolved except when there is a pressure point and everyone notices. We are almost always together but never really doing anything, very superficial, no real meaningful communication -- except I am starting to with the boys. There is a lot of tension just below the surface. A lot of resentment and anger. We are all strangers to each other although I am starting to get to understand and get closer to the boys. I see now how Paul makes demands to the boys, how unaware he is of how he is handling them and the effects of what he says and does has on them. The boys get little or no support, encouragement or guidance from Paul. I am getting better at it. I don't think the boys feel very close to Paul or can rely on him to discuss problems or feelings. They are slowly starting to get to me but things change slowly. Tommy is very clingy to me. The boys take a lot of aggression out on each other fighting, hitting and yelling. They seem to handle their problems that way. James is very withdrawn emotionally. He is not sullen or seemingly depressed. But feelings, emotions, thoughts are not at all discussed. I am trying to get to work on that area. I feel very responsible for the family unit and I take out my control on my house. I do housework endlessly and Paul, Tommy and James, I'm sure, view that as ultimately my responsibility. Like "I'll throw my clothes here, Mom will pick it up". When I am at home there is more control but Paul is the same way so they have learned from him. Paul's solution to problems i.e., if the boys acts out is to
yell, and demand if he wants them to do something, some procedure. He often makes ultimatums to them or refuses them requests with no explanation, just because he said so when they deserve an explanation. I'm sure the boys see him as total authoritarian. They don't act afraid of him and it doesn't stop them from certain behaviors. But Paul carries a big loud stick. There is a huge power struggle going on – Paul over the boys, Paul over me, me over the boys, the boys over me, and the boys over each other. The way to solve a problem is to yell, demand and use force. I have tried to break that pattern but they haven't yet and I still see it happen between the boys and Paul. When Paul demands, the boys react in anger because of that "do it because I told you" attitude. It is degrading them and makes them feel worthless and unimportant. It also makes them feel (especially James) like "what's the point of talking about how I feel, no will listen or understand, just demand". The boys, I'm sure, are aware of the distance between Paul and I and the lack of communication and understanding between us. They react to it. Sometimes with anger (toward each other) or by bad behavior. I wonder if they feel torn between Paul and I on who to give affection to or get close to. And my guess is that they gravitate toward me. I think they are lonely and afraid even though it is never obvious or brought out in the open. The boys also have little structure in their lives and feel very insecure. This reflects in their school work and social behavior with other kids. Paul, I think, is fairly oblivious to all this. As long as there is no outward friction and things remain more or less the same for him he either doesn't want to, or can't, delve any deeper than that. James sometimes is a bully and real loudmouth, very obnoxious. I wonder if some of that is just his age. Tommy plays the wimp, causes trouble then comes to us for a response. (Tina)

Setting limits

Given that boundary issues are fundamental for most survivors, it was considered important to help them identify and enforce appropriate limits. Techniques included writing up customized "separation and divorce agreements".

DIVORCE & SEPARATION AGREEMENT: This is to verify that (father and mother) are no longer responsible for, or attached in any way to (self and 3 year old son). From this day forth there will be no acceptance of abuse. I will no longer be responsible for meeting the needs of (father) and/or (mother) and along with that will no longer accept the pressure through guilt. I will no longer accept interrogation by my father pertaining to any part of my life. I will no longer accept the fallacy that I owe. I will not stay in the family system as a "fuck-up". I will no longer accept treatment as such. Visiting rights to myself or (son) are in my control, not on their demand. (Helen)

The notion of setting appropriate limits around their self-judgements was also necessary. Members were asked to use their judgements and expectations of others as a benchmark against which to compare their self-judgements.

Look at my own judgements: It is in the same light as I feel others are judging me. But I need to draw the line and understand what is judgement and what is self-gratifying. My sewing is self-
gratifying and I like the end result to be of good quality. I think when it becomes destructive judgement of myself is when I am not at peace with myself over my work. When I'm beating myself up, expecting perfection instead of just enjoying it for what it is. There's a big difference but its from within. No one could see it from the outside – maybe. When I'm concentrating on what someone's reaction to what I'm making will be, and worrying that they will find fault, I feel this is hindering and self-destructive. But when I enjoy for what it is, and what I'm enjoying doing – I'm truly satisfied. (Karen)

Members also had to learn to consciously and humanely set limits around their self-destructive and self-punitive behaviors.

Had an excellent weekend. Went out for dinner Friday night and I actually enjoyed it. I was conscious of my eating of course, but not so much as I have been in the past. Saturday I spent the whole day in Vancouver with Stan, the new guy I've been seeing. I had such a feeling of freedom and happiness all day that I couldn't believe it. I've only felt like that a couple of times in my life before and I don't even remember when it was. We went to Granville Island, listened to some live entertainment at a couple of pubs, went out for dinner, and then saw the show at the planetarium. After late, I felt really full and panicky for a while, but then it went away. On Sunday I spent the day with my girlfriend. I was so sure I was going to take laxatives that day. I was going to put them in my purse before I left. but on the way over I realized I forgot them. Talk about having a panic attack. What was I going to do. I was going to be (in town) all day and wouldn't have them. I almost turned around to get them but then I decided NO! I can't do it. Now is the time to find out how strong I really am. Then I felt better because I was really determined. I don't want this hanging over me for the rest of my life. Well, believe it or not, I made it. But what a close call. On the way home I decided I was going to have to take them when I got home. I just couldn't bear that full feeling all night. But no such luck. My friend decides she wants to come over and spend the night. What could I say. Needless to say, it was the best thing that could have happened. I survived the night. The next morning I still felt full, but it went away later on. So Congratulations to myself. I made it through the long weekend, didn't break down and take them, and still had a great time. It feels good. (Paula)

Relationship with husband

About two-thirds of the way through therapy, most married members were ready to look at their relationships. Many recognized that they functioned as non-reciprocal emotional caretakers for undemonstrative "strong, silent types", and they began to view these relationships as inadequate. However, they also began to see how they were feeding into this form of interaction, and started taking some appropriate responsibility.

There's not much of an emotional role with him. We both have a hard time showing them. He's a very hard man and emotionless. We bring out our emotions, or he brings it out at night in bed. Sometimes we're up till all hours talking, and I'm dealing with his emotions while he tries. My
emotional role with *(husband)* is love, care, and look up to him, but don't really let my emotions flow. It's easy with him because he don't really know about the emotional side of me. I gave it up long before I met him. *(Mary)*

I think what I have been grieving is the loss of what my relationship was. It's undergoing a change. One of the changes is that I have to stop depending on Ted for so much. And I think I have to realize that Ted depended on me for a lot, emotion, etc. But I can't take the whole load any more, and I haven't been able to these last months. And that's left Ted out on a limb, probably made him very insecure, but he is not very good at expressing himself. Even Jan *(a marital therapist)* has to keep rephrasing her questions because his answers are so closed. And she keeps at him, she won't let him off the hook until he gives a "feeling" answer instead of a logical, theoretical answer to how he feels when I say such and such. I've protected Ted emotionally. I have not allowed him to fight his own battles. I've really stifled him — and it's me who always tells him that I feel like the wife in "Peter, Peter Pumpkin Eater". But maybe I've put myself in the pumpkin shell. *(Betty)*

Some began to clarify the dynamics and history of their abusive relationships.

Ken, so now it's your turn for me to write about. Where do I begin? You were night and day different when we were married. You didn't approve of hitting women before, but after you thought it was okay. Before we shared things now you want distance. You once, not too long ago, told me where I fit in in your life. I was shocked that I was so low on the list. But at least you put the kids up near the top. But it doesn't excuse you for where I stand. My friends were always a threat to you. Why? Come to think of it, just about everything concerning me is a threat to you. I think you are insecure, and because you are, it's my fault. That's what you want to believe. You don't trust yourself and so I know you don't trust me. Every time I want to go somewhere and you don't, you are always saying things to me about other guys and it doesn't fit in. Like I want to go to a BBQ and you told me to find some bed partner to go with. I don't see where that fits with what I wanted to do. I have always felt very suppressed in this marriage — always tense and I just want to let go and feel the freedom in our marriage. Sometimes I can hate you so easily and sometimes I can love you so easy. Where did all the romance go. It's as if when we married we didn't have to do that anymore. You know that I thrive on love and attention, so why cut me off so cold? Since we have been married you somehow always make me feel I owe you. What? I don't know. Sometimes you say things I want to agree with but I know if I did, you'd throw it back in my face at every chance you get. It's funny how things go in our marriage. You do something mean and I do it back to you. It's been a one for one too long, and I don't see any change in that — not now or in the future... What happened? I want to be happily married and you just come back with a saying that I want a fairy tale marriage. It seems everything I want you don't, and vice versa. So what are we going to do about it? What can we do about it? Most times we stay together for the kids and sometimes we find peace so long as it's impersonal stuff to go on. But when it comes to you and I — us — what happens? We just can't do it, we can't accept each other, why? We could before we were married. Where do we always go wrong? We are two different people, but at the same time we aren't so different. I am still drawing blanks when it comes to you. I love you sometimes, but I am not in love (head over heels).
with you. You have hurt me more than you will ever know, and I don’t seem to forget about all the ups and downs. You said to me the other day "where’s the Lisa that was funny" and so on. Or did you mean to say "where is my closet wife that I want so much". Or did I put myself in the closet but now you don’t know if you should let me open the door. You are scared of me coming out independent and you don’t like the idea at all. What are you so scared of? Do you think I won’t need you anymore or want you? So if that happens we’ll both have to accept that. (Our oldest son) can’t handle it anymore and why should he have to? What is best is best. So why can’t we decide what’s best. The past in our marriage won’t let us go on with the future. "Time" will go on for both of us, but I’m not sure I want to share that “time” that will go on with you. I feel I have to say I’m sorry. Maybe that’s just an excuse for the way I feel for you and our marriage. The best always, (Lisa)

I’m trying to understand why I feel like a victim when I’m in the presence of my ex. All the old feelings of hate and madness and I feel like saying “you asshole”. True feelings. I better be honest – I feel scared of him. Nervous, wondering what he is thinking of me. It’s like a rabbit caged with a wolf – the rabbit is wary and alert. Wondering what the wolf is going to do. This is my one last great obstacle. I’m feeling and thinking better in all areas of my life, except when I see him. Then I feel as if all my hard work over the past year has been futile and in vain. (Laura)

Some recognized that they remained in unhappy marriages through a kind of passive inertia – they were at least predictable, and the woman feared the alternatives more than she feared the status quo.

If I upset the apple cart with Bob (husband) what will happen is that I would leave him or get him out somehow. Up until now I have been totally avoiding anything at all. Like, I don’t try to make my marriage work, nor do I try to end it. What fears I have in ending it are that I would never find anyone else to go out with, I am too old and ugly. I also know I have no idea of Intimacy, or how to perform in it. So if I did find another relationship, I would only mess up anyway, or pick another abuser and continue the chain of a frozen life. I might also crawl in bed with a large amount of one night stands. When I did this I got nothing from it and it gave me even a worse self-image. My marriage might not give me anything, but it is predictable. And that predictability is secure as long as I know how to function in it, whereas I do not do good in new situations. Lastly, is that if I ended this marriage, then everyone would know I have failed twice, and that would be so humiliating and embarrassing. And I don’t have the strength to put up the impregnable front needed to handle it. My marriage is not good, but I do know how to function in it. (Alice)

A common theme for those few women in a relationship with a caring and reasonable man was one of fear and impending catastrophe – they could not believe that it could last.

Today is Wednesday and it’s been a very confusing day. One minute I feel alright and the next minute I’m crying. I don’t know what I’m crying about and that’s what’s pissing me off. Certain songs I’ve listened to today and goose bumps on my spine. I think of Tom and I when they come
I can't believe how I feel with this man. He turns me on something fierce. I miss him so much when he’s gone. I don't want to let go of him when we hug. I keep waiting for something to happen. It's like a dream come true and it's scary as hell. (Ellen)

**Relationship with family of origin**

As part of their working through, survivors needed to come to terms with their relationship with their birth family. For many individuals the parents (and siblings) remained a current factor in their lives, and were often provocative of more pain, distress and ambivalence. Survivors frequently continued to seek "fatherless", "motherless", "brotherless" and "sisterless" from individuals completely unable to provide such nurturing and appropriate relationships. The most extreme, and sometimes necessary, resolution to this is represented by Briere’s (1989) "parentectomy", wherein contact is permanently terminated. However, more often, the survivor needed to come to an objective place where she was able to gain a more realistic perspective regarding family members - as flawed, wounded humans who were unable to meet either their own or her needs. Members generally came to see themselves as the most healthy and powerful people in their families - as individuals capable of meeting their own needs for parenting and able to relinquish their attempts to get those needs met by their biological parents. Clearly there is real loss and consequent grieving involved in this process and individuals were assisted in recognizing the validity of this process.

Stuffed my face last Sunday, Monday, Tuesday, Wednesday. Why, because I didn’t want to admit my dad hasn’t changed. I took it for my own failing. How come? I explained how I felt growing up. He doesn’t understand. One of the hardest parts for me is letting go. Not trying to live up to the family. God damn that hurts. I went back to being that perfect little girl. Only perfect isn’t good enough. It’s amazing, how does someone with all that supposed wisdom have such a fucked up family. I’m tired of them running me down. (Anna)

Members often came to recognize their mothers as both victims of the father offender as well as abusers of the survivor herself. However, most left the door open for a relationship with mother , although they set up more appropriate limits and expectations.

It’s so hard to write about her (mom) because I really am having problems figuring out what to say about her. She is very much intimidated by George (the offending stepfather) but yet, on recalling my childhood, I know she can and is strong willed when she wants. Funny, I can’t recall her being happy or smiling much. Yet, I know at times she must have been. She worked hard keeping our house clean. I recall her canning food and baking. Basically, she yelled, screamed and snapped an awful lot. I used to hate her when she did that. Looking back, I guess she used to take
her anger and frustrations on us kids. She certainly couldn’t do that with George, he’d of killed her. She used to beat hell out of us with whatever was handy, usually the broom or a stick. She used to snap one up whenever she went outside because we kept hiding them on her all the time. But we always got it on the ass. Not like George. Mostly I remember her being busy all the time so you didn’t bother her too much or she got angry with you. I was away from home for two years (foster placement) and when I went back, Mom had changed as I had as well. We became more like friends then, which was never there before. She suddenly became supportive, encouraging, caring and fun! I lapped it up and even went back to school. For the first time in my life I got As and Bs, and I did it just for her. Eventually I got a job where she worked, and because our last names were different, they didn’t realize we were related and put me working right beside her. We had riots of fun and we grew closer. I tried to be supportive and encouraging of her as well, and we talked a lot about her leaving George. But she was too afraid of him to follow through. She was always tired... always. I used to wonder if she was sick, and then if she’d ever get better. I remember hating her when I was about 12 and it continued until I moved back home just before I was 17. All because of what George was doing to me. Always praying she would catch him and then everything would be okay again. Of course that never happened and I resented her immensely for that. When I was made a ward of the court she said “I hope you’re happy now, you’ve got what you want”. And she couldn’t have hurt me more if she’d killed me. I remember vowing to myself that nobody would ever get the opportunity to make me hurt that badly again, and so far no one has. She fears loneliness, and in aging seems to have become very materialistic and defeated. First by life, then a fight with cancer, and now recently, a stroke that has left her partially paralysed and with speech difficulties. I fear now she will really give up and wait for death... She is totally amazed at the change in me, the strength that is now dominant and unchecked by intimidation. I am hoping that some of this strength will rub off on her, and I refuse to give up on her. I will keep trying. Miracles do happen — look at me! I love my mom and really miss the closeness we had a few years back. Oh sure, we’re still close, but it’s diminishing and that makes me really sad and angry with her for just letting it happen. (Jean)

Sat back and watched my mother. She doesn’t give the kids any emotional attention — hands them their goodies and they scatter. She can get emotionally involved in her friends, but not anyone in the family. Somewhere in her past she must have been hurt. Sitting back watching really has its plusses. She walked around my house frowning at the various messes, came back into the kitchen and asked “where’s the washing machine?” I told her “under the pile of dirty clothes” with a chuckle. Insisted on seeing my books. Started to correct my spelling mistakes. I told her that’s why I’m back in school. (Anna)

Others came to realize the more indirect effects their unmet mothering needs could have — such as jealousy over their children’s relationship with grandmother.

I just realized that since deciding and realizing the relationship with my mom is dead, I’ve been able to be more kind and loving to Sally and Jill (her 5 and 2 year old daughters). Also, I knew last night that I’d be going to see my mom at the hospital today. I almost blew-up at Sally again — I’m so glad I didn’t. Sally and my mom have a special relationship. So when I see my mom I’ll be cautious.
that this could happen. FUCK. I can’t believe what thought just jumped into my head – that maybe I’m jealous of the relationship that I see Sally and my mom have. Jesus, I can’t believe it. I just can’t believe it – that I could be jealous of my baby and my mom. But I think it’s true. I can’t believe my deep down thinking that if I can’t have it, then neither can Sally. My God, this is my own baby I’m talking about – I can’t believe it. It’s true I’ve just scratched away all the shit and I’ve found the raw core. The bare, exposed truth. I feel really free. (Karen)

Examination of the debilitating effects that their family interactions had had on them allowed members to give themselves permission to disengage without guilt.

I remember that one time I went to the top of her (mother’s) list for a while. I was about 18 and had been out working for about three years. For Christmas that year I bought her a new brown fur full length coat with matching scarf, gloves, shoes and purse. WELL, no one even came close. I was her favorite until the next one came along and bought her something. She bragged about that gift to all my brothers and sister. You know, I can still feel the feelings of superiority and smugness and the look on all of their faces. It is all so ugly now. That was how it was with us. we were all trying to buy the love and attention, and as brothers and sisters we all grew further and further apart. I understand that she is still like that today. I’m really relieved that I’m out of it all. (Joyce)

It’s really funny the way my thoughts have gone this week. I have been turning things over in my head and I’ve realized that my family had more of a hand in my lack of self-esteem than I first realized. I am angry at them. Even my mom staying with me has had a negative effect on me and my self-image. Somehow I feel that I’m a bad mother or an inadequate mother, that I’m lazy so she gets stuck more or less a slave to us. I don’t do that – she paints it to look that way. I always remember my mom telling me years ago that I better have no children because I sure had no patience with them. Now I wonder a lot whether I should have had them or not. Right now I remember things that each one of my family said or did to me that piece by piece destroyed my belief in myself and my own judgement. Yes, I’m angry at them too. And I’m glad that my mom is gone again. She was here five months and I feel free again. I don’t want to appear mean or anything but my privacy is important to me. I have always had a world of my own in my thoughts and I don’t want to feel that I have to share every thought with her. I’m relieved that she’s gone and I’m relieved that I don’t have to visit any of them. The way I feel right now is that I would rather not see or hear from them for a long time. I want to rebuild myself and my life in the fashion that I wish and not in the way they might sway me. I’m making some long term goals for my education and career right now and they may say something that would sway my confidence in my ability to accomplish these tasks. It won’t be easy but I’ll reach those goals. I’ll tell my family when I’m ready. (Judy)

Many members also came to the recognition that they had never experienced unconditional love until they became parents. This also opened up discussion around the issues of love and safety and power relationships.
My dad never loved me, my mom has never loved me — that's okay, now I don't like or love them. They never knew me. No one has ever known me and what I'm about. I'm just beginning to find out myself. I wanted someone to love me so bad. All of my life I wanted this. My grandpa loved me but he was gone. I've never known what it was like to have unconditional love, and yet I have given it so many times. It has hard for me to think of a relationship with anyone, all I can see is a lot of pain and failure. And yet, every once in a while I feel like it would be nice to have someone there, but it's not worth it for me. Unconditionally love my children, and I think that they love me (Oh, they do) but it's a safe area for me to love in. (Joyce)

Relationship with children

Members came to recognize their own abusive behavior toward their children, its impact on them, and the function it fulfilled — e.g., need for control, displaced anger, etc. They were then able to consciously and willingly substitute more appropriate ways of dealing with their children.

I've been trying to figure out why I get mad at Sandy (9 year old daughter) and others close to me. One thing I've realized is my strong need to control people and situations. Overpowering. I have such a strong will, I've just begin to realize. When Sandy acts her own feelings, I want her to act differently. I want to control her feelings. I feel I'm right and know best. Right now I'm trying to let her have own feelings and realize she is herself. When she is feeling bad, miserable feelings, all I am going to do is be kind, loving and gentle with her. (Laura)

The boys were fighting, hitting and kicking each other. I just went nuts and yelled (screamed) at them. Later, when I got control of myself I went and apologized and told them that they didn't deserve that kind of shit from me and that I still loved them and it wasn't their fault that I was upset over other things and would stop doing that kind of stuff to them. They were really good, understanding and hugged me. (Tina)

Called the kids to the table for supper and they came to the table arguing. I beat up my lifter on the sink. Then I looked at this mangled thing, looked at the kids, and said "this is not the right way to show anger". Then we sat down and talked about the right kind of behavior. I never realized the emotional damage that I myself gave to the kids. All that inadequacy — I had to make them feel bad too. I can sit back winging my hands when I have a week like this or I can think positive and take one thing at a time. (Anna)

Members were also asked to examine the strong bonds they had with their children, and the needs associated with them — a process which frequently revealed the ways in which they had been shamed for those bonds and actions arising from them.
Last week in group, Pat talked about (a group member’s) needs not being met and I immediately thought of Sally’s birth. Even though I was awake for the C-section delivery, I felt a strong need on the next morning to undress us both and lay naked with her. I felt ashamed for having such a need. But the need was overwhelming and I did it anyway. I tried to hide it from the staff when they came in. And when the doctor came in he nodded in an understanding way and reminded me to keep her covered. I just realized that was kind of a condescending remark. There wasn’t my warmness or better place for her on earth. I’m not ashamed of that now. I did not realize how powerful this feeling was until Jill was born. A vaginal birth. Immediately – still attached – she was put in my arms. I was sitting so I cradled her on my naked belly up under my breast. My needs and my baby’s needs were met. And although we find closeness and comfort in skin contact, it seems more natural, not a strong desire. (Karen)

Forging new role relationships

Survivors were encouraged to recognize the fear and risks involved in letting go of their old maladaptive roles in order to grow into a more authentic sense of themselves. They needed validation for the courage required in this process.

This role stuff is scary. Feel very scattered. Like my roles aren’t fitting so well anymore. Fell into my tough guy role last night. Afterwards I felt very ashamed and embarrassed. Wondering what those people thought of me. Even I thought I looked stupid. I feel bare, naked, alone, scared. Like, who is going to emerge from all of this... I feel like a woman standing in her closet madly trying on all the different clothes and nothing looks right. My roles don’t feel comfortable anymore. But I’m not comfortable as me, because I don’t know who I am. I’m so scared that no one will like me. I want reassurance from someone that I’m okay. (Helen)

As their healing proceeded a number of the members began to form new, healthier relationships with siblings and other relatives.

I had lunch with my younger brother. It was great. We had so much in common. He is one year younger than me. We got married within a year of each other. We broke up the same year. But we hardly saw each other over our married years. He has 2 kids and I have 2 kids close in age. We are both changing our lives. We are both single (without partners now). We are on the same thoughts. We are both learning to stop blaming other people for our lives. It’s really great. He understands me and I understand him. We hung around each other from childhood until I was 19 and then we were always friends until he got married and I got married. And now we can relate again. I was always hoping we could reunite our relationship. It’s now on a much better level. I think it could hold up next time he gets married or through a new marriage for me. Anyway, we are building our friendship and that feels good. (Susan)
Survivors were asked to examine their changing needs and expectations in friendships - most realized that they were more capable of bonding and of moving into non-abusive, equivalent, peer relationships.

I have become quite attached to the women in our group - like a mother who sees her baby take it's first step. Their accomplishments make me feel good, and their downs and pain touches my heart. I hope I don't embarrass anyone for saying this: I feel a real love, in a sort of distant way, for this group. I think I get a lot of strength from them. (Betty)

Close Friends: I still need them but don't need to tell them my troubles as much now. I feel more positive and want to be more free with them. I feel like I've learned to "lighten-up." I have many good strong friendships now. This makes me very grateful and happy. (Diane).

Something has occurred to me - that if someone does a kind act for me, I feel I should pay back, like with a gift or something. But as I get better I realize that doing so could jeopardize or diminish a friendship. I am still sceptical of kindness, especially from a man. I wonder what he wants, or why he might do a kind or helpful act. I have lots of work to do in this area. Especially with kindness without a price tag. I feel uneasy that someone might just like my company. Especially a man. And I think it's realistic to assume that most do want something in return. But there are kind ones who aren't calculating what I could or should be doing for them. (Karen)

It was important to help members clearly recognize how they were now dealing differently, non-abusively, and more appropriately, with interpersonal conflict and distress.

I realize I was in a prime mood for sabotaging myself by doing something I'd be sorry for later. My most usual method is being short-tempered, bitchy and nasty and cruel to those closest to me. Flying right off the handle. But I kept my patience with (her 9 year old daughter) and kept thinking "be kind to yourself and be kind to others". I got through the day without being unkind to anyone. (Laura)

Despite all these unfortunate happenings I have been able to keep my head above water. I seem to have found a comfortable space with my mom, as her phone calls and visits don't ruin my mood or depress me. I feel so much stronger now. I'm treating her as though she was a new acquaintance. I'm no longer linking her as the mother who let me down, the woman that was never a mother. It's as though she's not my mother at all - just an acquaintance. Right or wrong, it's a healthy approach, one that came all on its own. I'm caring for me now. I seem very important these days. I don't have to take any shit from anybody and it's easier than I thought. My brother's girlfriend has been a thorn in my side for three years. That's how she's put a damper on any visits we've had, birthday celebrations, Xmas, etc. This girl takes the cake, a bitch if there ever was one. Well, to make a long story short, she crossed the line with me last week. For the remainder of the day I was upset and angry, another stunt pulled by Denise. Enough was enough. I called my brother tonight.
and set the record straight. I told him he was welcome in my home any time, but that Denise was history for me. That I had worked hard to keep his gal happy over the past three years for the sake of him. But that the line had been crossed, and brother or not, I'd never do it again. What can I say? It felt dammed good to look after me and protect myself. It won't happen again, for I nipped it in the bud as the saying goes. I should have done it a long time ago. (Chris)

**IMPACT OF THE HEALING PROCESS**

**Emerging experience of happiness, well-being and agency**

For most, the experience of contentment and well-being as stable qualities, was a completely novel and thus, a much treasured (and somewhat feared) reward for their hard work in the service of their own healing.

Each day I seem to feel happier. Sometimes I feel happy and have a fleeting moment of memory that tells me I haven't been so deep down happy for many, many years – or never. (Karen)

I'm feeling really strong today and happier than I've been in a long time and does it ever feel good! I've accomplished a lot and decided I'm going to hold on to this for tomorrow too. (Jean)

I don't think I've ever felt so good – maybe since early childhood. Today in the car we had a children's tape playing. we were singing and I caught myself moving to the music like I don't ever remember before. My movement had a kind of freeness – like a bird soaring – but a starting-out, little soar. I know there’s more and greater things to come. I felt so free, but I'm feeling strange and cautious for having felt that way. (Karen)

They also recognized that they were much more effective in coping with problems from this new base-line. This novel experience was, necessarily, accompanied by a radical shift upward in their self-evaluations and self-esteem.

Tuesday: Another day, and no headache and no anacin. Could this possibly be because of my solid attempt for change. I'm really trying to put myself first and it's not as hard as I imagined. Mom called again today and there was no upset. It didn't spoil my day or ruin my attitude. I feel ready for her now. I'm ready to set her straight at any time and also ready to say no. What magic. I feel as though I could take on the world. I'm questioning how long it will last, wondering how long it will be before another headache. But one day at a time.

Wednesday: A busy day today, getting ready for (son's) birthday party tomorrow. I have enjoyed every moment of it. I seem to have come by some exciting mental energy. I don't feel
drained and have managed to handle every situation rationally. Including the spat Tom and I had tonight over the kids. I argued with him and was very angry. I left the kitchen and went into my bedroom. I could feel a headache starting. I came back into the kitchen and said "Tom, I'm in a no win situation here. I'm not able to please you and I'm not able to please the kids. Therefore I think it's time I pleased myself, the way I'm supposed to." I went into the living room and tuned into the movie I had rented. Guess what, the headache disappeared within moments and I was very proud of how I had looked after myself. (Chris)

Monday my carburetor ate a popsicle stick. The paperboy got it out. Left the car at the daycare until Wednesday. Guess what - no reverse. Pretty sure it's the transmission. I have a touch of the flu and the doctor says quit working so hard and reduce my stress. So why have I been in a good mood all week? I could sit back and moan at life's misfortunes, but it really is a lot funnier to look at the lighter side of things. Since Pat has made me realize just how much my reactions to other people and events center on how I make myself feel bad, I see how I have been doing it to myself. Nobody ever had to do it to me, I do it for myself. (Anna)

Everyday I can now see how happy I really am. I catch myself smiling all the time. I seem to have much more patience with the children. If they are fighting I let them sort it out without me flying off the handle anymore. This past week has opened my eyes to new feelings of being content. I found I took time off to relax and I didn't feel so bad about taking the time to relax. I find I have a lot of different feelings, but cannot pinpoint what they are. But I do know they are great feelings. I find I'm putting the kids first instead of the housework. I feel the difference in our communication. I'm starting to see the children as individuals instead of just being kids. The past two days since I got my haircut, I find when I look in the mirror and I can actually see beauty in myself and now I don't think I'm so ugly. I do feel like I'm being conceited though, but it's great at the same time. (Ellen)

**Risks involved in healing & the development of new coping strategies**

Members were asked to clearly identify their old ways of dealing with the world. Homework exercises such as "What are the payoffs for not being well", and "What are the risks in being well" helped to get at these issues.

**Payoff for not being well:**
1. I don't have to over stretch my limits  
2. Sympathy from myself and others  
3. Use sickness as an excuse not to do things  
4. Don't have to claim my own mistakes, can blame them on mom or (sisters), or (husband)  
5. Allows me to be lazy  
6. Since I never try I don't fail. (Betty)

When I'm sitting in group and I feel well integrated (body, mind and spirit all working together) I feel frightened. The first thought that jumps into my head is "I won't be allowed to come to group if I'm not sick". Irrational, I know. On looking at the question closer, I see that what I fear most in being
well is I'll become a different person. What will the ramifications be? I think: "If I'm a different person: (her husband) won't like me; my mother won't like me — but so what — I haven't got much to lose in that department. My relationship with Sara (her younger sister) will change. Right now it's one-sided. I do most of the phoning and visiting. Already I feel resentment building up that I'm not as important to her as she is to me. So I fear I will lose Sara because I'm moving to a space where I demand equality. If I was well I would have to take full responsibility for myself and my actions — I would not have any excuse for not being successful and happy. I'm afraid to be happy. Very, very afraid to be happy. (Betty)

I would like to be a happy person and let go of all my fears and insecurities, but at the same time it is very terrifying to me. Sometimes I'm determined to hold onto them because they're mine, and at other times I want nothing more than to send them all to hell. To be free from them would be like standing in an open space with no protection. What if people don't like me or talk to me anymore once they're gone. It's like a young child crying out for attention so they do something destructive, otherwise they feel like a nobody in the world. I don't want to need people or their attention, but I know that I do and hate it. I'm even ashamed to admit it. I suppose that's why I hang on to depression and the eating problem. I remember how, for years, I would lay in bed every night and daydream about having cancer or being hit by a car or something, just so people would notice me (I still do sometimes). If that's what it took, then I would make it happen. I just wanted love so bad and I still do. I have never felt that people would like me on my own without something being wrong with me. What qualities or type of personality or whatever it takes do I have for people to like me as I am. What if nobody liked me once I gained weight or if I was happy. I'm afraid to find out, yet I want to get rid of all this crap and live normally. I feel like I've programmed my mind for so long now. I'm standing on the edge ready to just go for it and then all this stuff holds me back into familiar territory again. Although it may be miserable, I know it and sort of learned to live with it. You never know what's going to happen on the other side — I can't see it — it's invisible. But then, how do I ever get better if I don't help myself. I don't want to choose this side of the door. (Paula)

Members were assisted to learn how to examine their responses to problems, sort through the issues confronting them, and then give themselves permission to come up with non-abusive and reasonable solutions.

(Journal entry after a down, feeling-victimized day) Much better today. I think I figured out what it was. I had my hopes up on something and had projected a great outcome. But after talking with my brother he informed me of it that it might not be a total possibility. So subconsciously I guess I'd become depressed, instead of looking at the situation in different angle. Now that i put my finger on it and have been able to look at it differently, I don't feel so sorry for myself... I'm very tired again tonight but I feel better, like a load has lifted. The girls were really good today. I'm sure they know my bad days and feel bad themselves. as on good days they seem to be much better. I am so grateful for my kids. (Susan)
STRESS: How I dealt with it and how I deal with it now: At home when things upset me – before I used to keep it inside. Now I write about it, then talk to people on how I’m feeling about something and listen to their ideas. I used to sleep too much sometimes as an escape from painful feelings. I used food sometimes to pacify what I was feeling. When I get that scared, panicky feeling, I take deep breaths and close my eyes. Walking is good for me. I need more exercise though. I am still lazy in that area. I still do not like people yelling at each other. I used to yell, but it’s not worth how I feel after. I rushed around in the mornings before I went to work, and this was when I felt dizzy and jittery. I do very little now – just shower and get ready. I write a lot of frustrations out. I don’t feel responsible for anyone except me. When I get behind in my housework, I ask for help. I ask for help with Sunday dinner clear up and they help me so I don’t have to feel resentful. Showers relax me. Swimming helps me when I feel wound up. I've started to ride my exercise bike for 10 minutes in the morning. I am trying to stay away from sugar foods as they really screw me up. I listen to nice music in the car and sing-a-long a lot. I feel strong and feel I am worth something and am able to let more people know how I feel. (Diane)

New day, new month. There have been so many changes in my life this year and there’s another 11 months left yet! It is nice to look at things in a positive way for once in my life. It feels strange – and to be honest, a little scary. I find myself waiting for something to go wrong. But at the same time knowing whatever does go wrong, I’ll handle it. Strange! (Jean)

Still feeling depressed. Social Services went to get check – they won’t give it. Previous reaction would be frustration, rage, crying, feeling hopeless and helpless. Went to shopping centre – my prescription not ready. This would have been the final straw – but I realized I felt real. I didn’t feel fragmented, unreal, in a daze. What a difference. On the way home I thought, I’m just plain mad at being given the runaround for a week. That’s a legitimate feeling. Can’t believe how the old feelings come and then pass away so quickly. (Laura)

I do not have to play the role of my mother. I can be happier in this shitty situation. I somehow thought if I wasn’t feeling lousy in a lousy situation, that it somehow didn’t go together. They can. And I’m okay and it makes it easier. That’s the black and white. It’s okay to be okay in a lousy situation. (Karen)
PHASE III: INTEGRATION & FOLLOW-UP

This phase is intended to integrate and consolidate the gains made by members during the previous months, and to help to prepare and equip the women to deal effectively with upcoming challenges. They also needed to recognize the magnitude and depth of the changes that had occurred within them and the impact of those changes on all levels of functioning.

SESSION STRUCTURE

Sessions 21-26

Session format continued as it did in the previous phase, with each member taking her turn reading out her journal work and engaging in brief interpretation and clarification of it with the therapist. The therapist then assigned the next week's homework for the member and moved on to the next participant. About 20-30 minutes were reserved at the end of the session for group discussion of the themes arising during session. As in the previous phase, the therapist took notes during the members' journal readings.

SESSION CONTENT

As shown in Table 20, four major themes were addressed throughout this phase: intrapersonal issues, interpersonal issues, anticipation of the challenges ahead, and the development of personal bills of rights. Issues around termination of the intensive portion of the therapy process also had to be addressed. This was not as traumatic as it would have been if session 26 had been the last contact. Instead, the schedule of follow-up sessions was agreed upon at ascending intervals - e.g., 2 weeks, 3 weeks, monthly, 6 weeks - with sessions booked for the 3 and 6 month follow-up points for administration of the test battery. After completion of session 26, group members also went on to form support groups which met weekly or biweekly in their homes. Most of these support groups were still in operation 12 to 18 months after termination of therapy and seemed to serve as healthy core support and social networks for survivors.
**INTRAPERSONAL ISSUES**

### Changing sources of satisfaction

As they healed, survivors had more of themselves and their energies available — they began to discover a wide range of emergent interests, creative abilities, and other forms of enjoyment previously unavailable to them.

Something interesting has been happening to me and my reactions to things. The things that used to give me great delight are now sliding down the scale. Things — like new things, new clothes, new haircut. All these kinds of things used to give me a sort of short-term sugar high. But I now see them only for what they are — things. More and more the kids and I are sharing really fun things. There’s an old Patsy Kline song "Back in baby's arms" — when It comes around on the tape, we turn it up and all belt it out and act silly. We are all really delighted with it, we really have fun. This is really the stuff that gauges my well being. (Karen)

My interests have changed and so has my ambition. I’m very curious to know what I’d really, and I stress really, like to do. For so long, I have moseled on through my life, never setting goals for myself or challenging my capabilities. As I mentioned, my job at ___ has become very boring — too routine. I really would like a change. I just can’t pinpoint what I’d like to do. A job change is definitely in the future for me. (Chris)

I’ve noticed all these wonderful changes in me. I really enjoy reading: papers, magazines, books. I love to sketch and I especially love to sing. I care what I look like, even just at home. I want to look nice. I care what I look like when I go to get the kids from school. I care what examples I’m setting for my children. (Barb)

### What she has to forgive herself for

Survivors were also asked to consider what they had to forgive themselves for — a necessary step toward giving up the sticks with which they had traditionally beaten themselves.

What I have to forgive myself for: I know the acceptable and appropriate things I could forgive myself for. But to say that and feel that are two entirely different things. I could say that I forgive myself for being angry and lashing out at my children, but I don’t think forgive is correct, In my mind. I can accept the fact that it is wrong, that I hate it, but hopefully learn from it. Even if it is just that I hate how it feels. (Karen)

List of things I have to forgive myself for:
- for not choosing sound and responsible men in relationships
- for not meeting my financial goals while raising my sons on my own
- for not completing goals I had set out for myself educationally — there’s still time to do it
- for being too easy with men
- for not being perfect
- for being a single parent
- for not knowing how to correct my low self-esteem or knowing how to protect myself (Judy)

I need to forgive myself for cutting myself down all the time. I need to forgive myself for putting thought in my mind which are negative. I need to forgive myself for hating my body so much, for holding back when I really wanted to laugh but was so dammed scared. I need to forgive myself for holding back the tears for so long because now I can’t stop. I need to be fair to myself. I have to forgive myself for not looking after my body. I feel dirty and scraggily-looking. I hate myself so much. Actually I love myself but my mind hates my body. I hate looking in the mirror. I need to stop blaming myself for what went on in the past. I need to forgive myself from thinking all men are alike. I need to forgive myself for having such low self-esteem about myself. I need to forgive myself for letting people use me. I need to forgive myself for being sick all the time. I need to tell myself that all this shit will be over with real soon then I will get my life back on track. I need to forgive myself for hating my body so much - actually not lying, just not knowing what they are. (Ellen)

Recognition of accomplishments

It was important for survivors to firmly situate themselves in terms of the internal and external changes they had made over the course of therapy. This was necessary, both in terms of recognizing the impact of their effort and risk-taking over the course of therapy, and as a means of empowering them to continue making gains.

What a glorious day. If I can hope to have days like this – well my life is great. Group in the morning and I can see everyone there improving so much – even with the setbacks. I see profound improvements. It’s like the people I met six months ago are not even the same people – they are not – they even look different. (Karen)

Members were asked to consider this issue using a range of strategies, such as "What have you done to feel good about?", "How is life different now?", "How do you feel about yourself and your family now?" A common theme was recognition that their improvements were closely allied with their ability to let go of the old illegitimate guilt and shame which had so crippled their functioning.

Things I have done to feel good about:
- I’m treating (her daughter) in a kinder, gentler way
- I’m letting go of my anger and rage
- I’m trying very hard every day to recover and to be emotionally healthy
- I’m seeing I have choices and what choices are good for my well being
- I’m willing to let go of all the feelings that aren’t good for me
- I'm not just thinking and talking about changes, I am actually doing them and in other areas still trying
- I'm not being so annoyed and touchy over little things. (Laura)

My relationship with John is growing closer everyday. I am no longer just a friend in a needing relationship. I now feel like a loving wife. The change is so extreme it's hard for me to find the words to explain it. I'm no longer frightened or shy when he touches me. Instead I'm anxious for it. I don't have panic attacks when he puts his arm around me, scared that he would make another move. Instead, I'm the first one to want a hug and it's wonderful. For the first time in my life I am no longer afraid to have sex. In fact, I love it. My children have seen the change in me and they're delighted to come into the room to find John and I hugging. I don't think I'm a different mom to them, just a mom whose outlook on so many things has changed. I feel so much stronger now, and have become very aware of what makes me happy, and as important, what makes me sad and depressed. I recognize now what those feelings are and I avoid them. It was a very sad girl that waited for her mom to call, or visit. In the last month I haven't given her a thought. I kept asking for the strength to get on with life, and I think I've found it. The strength has been in me, I just needed to take the right steps to find it. I recognize different feelings for my family now, I used to feel so sorry for (younger brother). I lived with it every waking day. That was because I felt so responsible for his abuse, that it was all my fault. That's gone now. What happened to (him) was mom's fault, not mine. I don't feel sorry for them anymore. She made her bed, now she has to lie in it. If she wants to be a part of my life, she has to play by my rules, no one else's. (Chris)

The way I used to feel about myself: Not smart enough. I wasn't good enough, not enough confidence, impatient, in a hurry, could never say no, worked hard, talked a lot. I was mean, drank too much, never listened. I wasn't pretty enough to catch the man I would like. I was nice, always right, a leader, perfect at what I could do, easy going, I took revenge, honest, didn't talk behind your back. Didn't very often take an uncalculated risk. I knew the answer before I asked the question. I always had a judgement.

The way I feel about myself now: Happy, responsible, coping well. Some confidence, listening much better. Less talkative, not as judgmental. I can say no. Responsible for my own actions. Taking risks without knowing answers. Love myself, accept myself. Hungry to learn, less envious of others. Still not content that I am doing enough. I want a direction to work in. I need to find out what I will love to do and then work towards it. I feel I am smart enough to do anything that I would like to do now. Before I thought I couldn't do it even if I wanted to. I feel now I am less worried about my body than I ever was before. I also notice I don't have to look and compare myself to other women. (Susan)

I've got my love of life, my sense of humor. I slow down now, like I've never been able to. Things don't have to be in their proper places any more. My tunnel is getting wider. Going off a set routine doesn't throw me into a tizzy. I don't wake up in the middle of the night to clean house any more. What I want most in life is emotional support. Something I've never had much of. I do have people to give me the emotional support, but a lot of times I don't want to ask. I'm afraid it will dry
up... Can a person give themselves emotional support? I think I can sometimes. A lot of it is being able to trust my own judgement. (Anna)

Things I have to do to keep going in an upward way: The first thing that seems the most important is not to let other people overpower me. I have a right to my feelings and don’t have to be pleasing other people in my life at my expense, emotionally or physically. I must let other people choose their own way. I don’t know how to not feel for other people, but I do know I can’t afford to be pulled down by their pain anymore. I will miss our Friday sessions but know I can talk to someone when I have a need, or share with them when we have a chance. I feel different about myself and know I’m the only one I can really count on. I’m glad I’m not on Ativan and don’t get the extreme anxiety attacks. I don’t feel the need to write so much, but it still helps me sometimes as I don’t know what’s really going on until I write it down and read it over. I like the part about mothering myself. (Diane)

The following represents one of the group members assessments of changes she had made over the course of therapy on dimensions important to her:

<table>
<thead>
<tr>
<th></th>
<th>Then</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self confidence</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Patience</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Anxiety attacks</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Assertiveness</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Happiness</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Inner peace</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Outgoing</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Sociable</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Relaxed</td>
<td>2</td>
<td>7</td>
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Six months ago I was easily intimidated by people who I thought had power over me, especially men. It made me feel like when it came right down to it, I had no control. I also cried a hell of a lot, sometimes for little things. I was not even a fraction of how happy I am now. Six months ago I felt I couldn’t always act like myself, always felt like I was holding back some of my past stuff, Always knew I could be a better person and be happier but didn’t know how to go about it. I am a better parent now than I was before. I have more patience and have learnt different methods. Generally I feel a lot more confident in myself, although I feel I have not begun to reach my limits yet. (Kelly)

The following allegorical response to her progress was spontaneously produced by a woman with a grade 8 education level:

I’m absolutely 100% sure that I’ve planted a new seed. And it’s not planted in the sand in the middle of a deserted and lonely desert, where its roots will wither and die, and never know and feel life. But its planted in a valley in the richest soil beside a river of flowing water. And there her roots
grew deep and strong. I also see weeds growing about and around her. Their roots are trying to choke this little sprout with their deep and stronger roots. But this little plant has strong desires to live and grow. So she continues to grow stronger and stronger and deeper into her rich soil. The weeds soon wither and die for they cannot destroy her. And the years and seasons passed and the weeds are few around and about, until there are none left. But this little plant that has grown in abundance, multiplied and filled the valley. And the birds have nested their young in her strong branches and the animals have found refuge from time to time under her. And then one day the first little seed that was planted grew over that flowing river and she, oh so gently, dropped her seeds into it. And as they left and flowed down that river of life those seeds were planted in another valley of weeds and started to grow and new life began. (Barb)

Permission to fail

It was important for members to give themselves permission to "fail" — or, as it was reframed, to make the mistakes which are necessary for growth and learning. This issue was frequently brought up in group and individual discussion.

My fear is that I'm waiting for myself to screw up. Therapy really helped again today. Pat, you were right. Sure I screwed up, but not near as bad as I have in the past. I am making progress. I have to believe in myself because no one from my past does. (Helen)

Had an upset with John last night. Can't even remember why. Just a hard day with the kids and I lashed out at him. Not pleased with my performance — said and did all the wrong things. But I'm living with it today, that's a change. Not suffering and paying a price. I'm entitled to make a mistake. I apologized and so did he. That's important. (Chris)

Expectations

As a means of clarifying their future expectations and goals, members were asked to compare their past and present expectations and experience of themselves and others.

What I Want vs What I Had: (I want) a sense of humor, can laugh with me, not at me. Someone I can trust who can be honest with his emotions and give me support. Who can listen, then talk. Willing to try new experiences. Can let me have my own time without feeling threatened. No jealousy. Who likes children for what they are. Someone who is comfortable in a crowd or by himself, who can make their own fun. Someone who can admit to not being perfect. Someone who can get angry but doesn't have to yell or throw things to be able to talk about problems as they develop. Someone who can compromise. Someone who can see the good in people, not pick on people's faults. Someone who can accept me the way I am. Someone who can hug me just because I'm there. Now if only all my homework could be this easy, describing the perfect male. As far as the sexual side — if I'm comfortable with his emotional side all things would be possible. Variety is nice, so is doing the unexpected. No, it doesn't have to be the perfect male, more so someone I can be
comfortable with. Someone who's truthful. I want a man I could go up one side of and down the other, then he could hug me and say "what's really the matter?"

What I Had: No emotional support, no security, no compassion, no feelings for other people, no love for life. Someone always on the outside, never a joiner. He has gone through life expecting others to give. This is ridiculous, John has no qualities that I can admire. No, it's not ridiculous, I just got really jumpy having to write this down. His insecurity, no self-esteem. John never learned how to give anything. Looking back now is unreal. to think I was actually so attracted to him, even for the four months after I left shows me just how far I've learned. (Anna)

<table>
<thead>
<tr>
<th>Past Expectations</th>
<th>Now Expectations</th>
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<tbody>
<tr>
<td>-Never make a mistake</td>
<td>-That's okay, I'll learn</td>
</tr>
<tr>
<td>-If I fumble I'm a fool</td>
<td>-If I fumble, I giggle, I'm human</td>
</tr>
<tr>
<td>-I had to be the best</td>
<td>-Now I do my best</td>
</tr>
<tr>
<td>-Never wrong</td>
<td>-Able to admit being wrong without embarrassment</td>
</tr>
<tr>
<td>-Totally independent</td>
<td>-Now I do all I can but I ask for help when I need it</td>
</tr>
<tr>
<td>-Everyone has some good</td>
<td>-Now everyone still has some good - it doesn't mean I'll ever find it, nor would it probably be enough to make a difference</td>
</tr>
<tr>
<td>-Guys had to be exciting</td>
<td>-Now they have to be employed and treat me with respect and I have to like them not just them like me</td>
</tr>
<tr>
<td>-Guys could always make mistakes I'd have to forgive</td>
<td>-Now if they make a red flag appear, I listen. I make them accountable</td>
</tr>
<tr>
<td>-If someone asked me for something</td>
<td>-Now if something is asked I can say no or reply that the request is out of line (Judy)</td>
</tr>
<tr>
<td>-help or information - I had to comply regardless if it was right or not.</td>
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</table>

I want to be a wonderful mother and raise happy healthy children. I want always to have an honest open relationship with my daughter. I want to be with Ken (her husband) but I want him to work with me more. I want him to give me the kind of tenderness and caring he gives Jessie (their daughter). I want to have good friends that I know will be there for me in a clinic. I want to be active in Jessie's schooling, on a school board or something, so I know what's going on in her school. I want to be more confident in myself and feel happier with who I am. I'd like to be a social worker or counsellor some day. I want to: learn to play guitar; read music; do aerobics; take a pottery course; learn to draw better; learn to type; plant my own garden; decorate my house; learn to ride a horse; sew a lot better; get a part time job; never have to worry about money; bake a lot more; have time for everything. (Kelly)

I think my shame will disappear as I grow more caring for myself — more understanding of my own needs. That shame grows from being thought of as less than a worthy person. And I am worthy of love, of being loved by others and by myself — for wanting things just for myself, for showing my
needs and wants, my likes and dislikes, for being the person I am and not being ashamed of not being perfect. I am not perfect and need no shame for that. (Karen)

I have two girls, so I want them to be successful in life before they settle down with a family. I want them to be happy, have some fun every day, play lots. I also want them to be caring, kind and giving. I want them to love and enjoy people. I sure hope their childhood and adolescence is fun and learning. I want them to enjoy every day, not save all the good days for when they are older. I want them to be able to not have to want to leave home to have some say in their lives. I want to daily let them know I love them and that they have good ideals and they are perfect just the way they are. I do hope they finish school and go to college or university. I want them to feel good enough about themselves to choose what they want to do with their lives and then do whatever that is successfully. Whether it's being a mother and bringing up children with their time and their love and their learning, to do that job the best they can. Or if it's something more professional, I just want them to make their lives enjoyable for themselves and then everyone else will be happy. As I believe if you are happy with yourself, then life will be as good as it can be. I would like them to please other people only when they want to. Not to please and carry resentment. To be assertive and never be afraid to give of themselves. I'd like them to expect nothing from life, but receive lots. I want my children's relationships to be built on honesty of themselves and not on games or putting on certain faces for certain groups or men. As far as partners for them, I just like them to be a good, kind, honest person. I wouldn't worry about color, age or sex. as long as the person that makes them happy is their lover and their best friend. and that they can openly and honestly discuss anything without judgement and fights. I want them to have an open, honest and loving relationship with their kids. I really want them to know how important it is to be with their kids and be there for their kids anytime. Also, that while their kids are young they will be the most important people in their lives at that time. I feel they need their parents there for them the most from 0 to 6. Whether it be a full time mom or dad, they need the parent's influence in order to become another healthy, happy person... (Susan)

I was thinking about the day when I get my drivers licence and a car. To those people who drive, they seldom remember how much of a luxury it really is. I look forward to just getting in my car with my kids and going somewhere like a park or a movie, or go to a big shopping mall, or just drive in the country and look at the beautiful land we live on. To be able not to rely on someone else to get my daughter to the doctor or go shopping. I use my 10 speed a lot but I only can get so much on my back, I'll have more freedom. Just to be able to go by someone's house and say "let's go for coffee", or "I know of a great place to eat", or just pick them up and do a favor for them once. For the first time in my life I'm totally confident I'll succeed in doing this. I never thought I was smart enough to drive. I'm so excited with this goal. I get really giggly inside when I think about it. I'll be able to get involved in the activities I've always wanted to. (Barb)

Awareness of the broader context

Members were also encouraged to view their own abuse histories within the broader transgenerational and cultural context.
Through the therapy of the past 6 months I have travelled a great distance and still have far to go. But Pat is right, there is no going back. But along with all this consciousness and learning is a realization that so many others are so much in need of help and an awareness of just how much further I have to go. I realize how much the others that have screwed up my life need help and the insight into why they might be the way they are. It doesn't make my load any lighter. It's just the way it is. Right now I'm feeling very sad for Al (ex-husband). I think he is so hollow and empty, but he has glimpses of what might be. Maybe by seeing the kids and I, but he is so oblivious to so much. I'm also sad for the shallow lives my mom and dad live — I think they are even less aware or in touch. So I consider them sad and empty forever. I'm even sadder for myself because I'm the result of their shit two-fold. How could I possibly have won under those conditions. I do consider myself a winner now. I'm someone that realizes that deep down, happiness can be achieved, and I'm deserving of it for myself and my babies. I'm rising above all the shit that was thrown in my way, and the sad feeling that somehow I deserved it and did the best I could with it. I also realize that the sexual abuse was just one more piece — or pieces — of shit thrown my way, that resulted because of my misguided belief that I should do as I was told. Always consider the other person at my own expense and disregard what I know in my guts to be my reality. It was just part and parcel of the total package. (Karen)

I cried today, I guess I was feeling sorry for me and the kids. I didn't want my life to be so screwed up and I didn't want the kids' to be either. Why was I singled out. why was I so destroyed? For 30 years, that's a long time to be screwed up. I hate it. Mom and dad should have never had me. I hate them for what they did and didn't do for my life. They really screwed me up. Thanks guys. You know, the greatest part of all of this is that I've put an end to abuse in my family. I have no idea how far back it really goes. But I will start a whole generation upon generations upon generations to come of a totally different kind of family life. (Barb)

This weekend I found out to what extent John (her husband) was abused as a child. I knew he was before, but I didn't know how bad it really was. I really felt badly for him. It also kind of explains the way he is. What really gets to me about child abuse is not so much what happened to me, but the big scale of things. About 90% of the people I know were abused in one way or another. It's pretty scary! (Kelly)

It's hard for me to look back on the way I was because I was so dependent, on men, on female friends, depending on them for feelings of self worth. I've been through my supremely cynical phase and this song (poem) used to be sort of a theme song for me: Starlet, starlet on the screen, who will follow Norma Jean? Who do you have to fuck to get into this picture? Who do you have to lay to make your way/Hooray for Hollywood. What do you have to do to prove your worth? Who do you have to know to stay on earth? Who do you have to fuck to become important? How do you make a virtue into a vice? Who do you have to fuck to be treated nice? They lead you like an animal to slaughter: you're inspected, you're graded, you're stamped. Standard or prime, they hang you on a meat hook where you age. but female meat does not improve with time. they cut you up and take the part that's tender and when they're through all that's left of you is tough. The flesh is willing
but the spirit's growing weaker. And you wait for the phone to ring in a vine street motel. And you write your

about being in the movies is really, really swell! Well, if that's anyone's idea of heaven who do you have to fuck to get into hell? It doesn't do to become bitter and twisted. But sometimes it's hard not to. It's hard to wean oneself of the material world. I know that when I can free myself of the material world, I will have found freedom. I won't have to depend on anyone for myself for my happiness. I will claim myself. But the material world is so enticing, so exciting, so comfortable! (Betty)

INTERPERSONAL ISSUES

Coping with the legacies of the past

Very often group members were involved in abusive marriages featuring physical and verbal violence and, in a number of cases, sexual abuse of the children by father. Consequently, during the course of therapy many of the women had to cope with all the pragmatic and emotional problems of separation, disclosure, child protection, financial stressors, etc.

Tomorrow Al and I see the family court counsellor. I feel so nervous, like everything is hanging on what I'll say and his opinion of me. It's like being so afraid you'll drop an expensive ornament that you drop it and it smashes - just because you were so afraid of it. I realize I need to be as calm as possible so I can think clearly and be myself and be honest. I'm worried. Al can present himself very well when he wishes to. What a phoney he is. I don't think he even knows what he wants. ... (Next day): The Family Court Counsellor was not at all what I expected. We spent three and a half gruelling hours with only one short 10 minute break. The idea was that we were to decide with him as mediator and guide. During this time I was able to say many things to Al, even if I couldn't look at him face-to-face to say them. I told him he was abusive and that I would no longer live like that. He does not see it, and again denies that he choked me. I was able to say I was intimidated speaking in front of Al and explained that someone with my past chooses abusive men. It was the court counsellor who brought up the fact that I was in a room with two men fighting for what I know I must have. Al was wanting joint custody with prime residence with me and he was being really persistent - a great portion of our time was spent on this issue. I did not want this and was really feeling pressured. At one point I threw up my arms and said okay. But, thank God the counsellor was sensitive to the situation and asked me how I'd feel about such a decision once I left his office. He knew I was feeling pressured. At one point he even asked Al if he was holding out, figuring if we sat in his office long enough, that I'd change my mind. I consider myself very, very fortunate and lucky that this man was there to help. I feel very good about him. When we left his office I reached out to shake his hand with both my hands and he did the same. I felt he was letting me know he understood and was wishing me well. I feel I have come very far but have a long way to go. I am so grateful that on my journey I have had such caring, competent professionals to help me. I'm feeling very lucky. (Karen)
Sally asked me why Dawn was so sad. We had a private chat. I told her Dawn had a problem with a secret daddy wanted her to keep. But because it wasn't a nice secret Dawn knew it was all right to tell mom. (Anna)

Went out and got my own place. I'm really scared. Mom and dad are not very happy about it. I go back and forth, I don't know if I can do it. (Her boyfriend) and I had a really good talk about it. I realize that I always want someone else to make all the decisions for me. Always go to people looking for advice. Came home very excited – mom and dad very negative. (Helen)

Mother's day. a great day. Had some learning today. My (separated) husband called. Not to say happy mother's day, but to get my signature on a lot in _____. He wants all the money to start a business and later he will send me some. I say "okay, no problem". Then I get off the phone and I think that was crazy. Then I start thinking like I trust honest Sam will take care of me. So I called back collect and said no way – if he wants to sell that property I need half as soon as the deal goes through. (Susan)

**Moving forward as a parent**

Helping survivors to extricate themselves from the emeshed role-diffusion so frequently found in their maternal relationships was seen as an important issue. Members investigated this via such exercises as "what are the parallels between you and your child?", and "who is that person? – your child".

Sally and my parallels: Sally (5 year old daughter) is the first born as I was and I understand the incredible expectations of that. I fight very hard not to put her on display and ask her to perform. Although she does like attention, but prefers one-on-one with adults. She does not like to be the center of attention but likes her fair share of time. I thought it would be difficult to write about Sally, her own personality and to see her for who she is. As I thought about it this week, I wasn’t sure what was really her and what I inflicted or influenced in her. But her personality is there – her own identity and who she really is – I do know her for who she is... Sally was sexually abused at an early age and so was I. This has been really difficult to put on paper, but it’s true and I need to write it. I never ever thought it would also happen to a child of mine. An unbearable legacy but will hopefully change with Sally’s children. The unparallel is that Sally told me. But I too told in the best way I could – nightmares, incredibly scary nightmares, bedwetting, etc. I see Sally as herself but sometimes project other stuff onto her without considering her for who she is. She is very sociable. Has lots of friends and acquaintances and enjoys them – but not too many at once. She is very verbal and spends lots of time talking, sometimes about things she’s given great thought to. I think she expresses herself well. She is jealous of her sister sometimes and sometimes would like to be a baby again. She moves well and her muscles are well developed so she enjoys being outside and climbing. She is very sensitive to others’ feelings and shows compassion for their pain. Sometimes she is baffled by their reaction, but I too have such a problem, so we’ll work on it together. Sally has clear ideas about her likes and dislikes, but socially wants to fit in. (Karen)
Janet (her adult daughter) invited me out for brunch. We had a nice LONG talk about a lot of things. She is getting help for herself, needs to know some background info. - some of it painful and some of it okay. We went shopping, returned home late afternoon and we planted some flowers together. Feeling really close to her. She sure is a beautiful woman and she is my daughter. (Joyce)

Members also needed to validate their transition from old abusive patterns of parenting and to be aware of the risks of continuing to respond in old ways.

Another thing I notice when I get these mood swings is a lot of people offer me advice. For instance, when I was feeling good and strong I told my neighbor that I don’t hit my kids. As that was hard for me to change, I told her why she couldn’t change my mind on it. She tried to argue several reasons on different occasions, but nothing came close to changing my mind as it just never worked with my daughter Ashley. Anyway, I had mentioned to her the trouble I was having putting Ashley to bed at night and how I really would like to whack her, but haven’t because I don’t want to hit her and it never worked with her. What I’m getting at, is when I’m strong and feel I know what I’m saying about my parenting, no one disagrees. but as soon as I weaken a lot of other people want to guide me with the opposite ideals I have. And I was even thinking maybe she was right. But I didn’t spank her and my mood lifted and I’m glad I didn’t listen to her about that. That is just an example of many things that happen like that when I’m in my old mood. (Susan)

Now for my boys – what can I say that millions of others haven’t said already? I want my boys to respect, love and be happy. When I say respect, that goes for everything and everybody and it goes with love as well. It’s confusing for me because now I look back and try and figure out when I get mad at them. Is it for being kids or being males? Jamie is so independent and I more often than not fight him on that. I want to tell him or show him, and he wants to do it on his own. I should be thankful he wants to do things on his own. And Sean, I’m the opposite. I want him to do it on his own and most times he wants me to tell him or show him, or sometimes just do it. But I know as he becomes more independent I fight it tooth and nail. Am I just scared of losing my baby, so to speak? And if I am, why wouldn’t I want them to grow up a little each day. Am I scared I won’t have them if I let them go do their own thing. Jamie is going through another “why” thing. Why can’t I go to my friends, why do I have to clean my room, why, why, why? It wouldn’t take me any longer to explain why to him, than it does for me to yell at him and then threaten him. I can write it down, I can even talk about it. But why can’t I just do it? (Lisa)

Future relationships

Members were asked to consider what they wanted for their nuclear families in the years to come.

What I want my family to look like: I want a easygoing relationship with each person as an individual, and as a whole family. I want the kids to want things other than material things. To be
happy with the things we can do for them, not what they want bought for them. It is love and friendship and respect for each other that will count the most in the long run. To be able to be patient and understand the wants and needs from all of us so we can live easier with each other. I want the fun and laughter with a lot less crying and feelings of being mad and hurt. I don’t want anyone to feel they ever have to lie because of a lack of understanding. The four of us are a needy bunch and could fulfill each others’ needs if we opened our eyes to each other. When one needs love the other three should give it, not just one. A sharing family – that’s good. (Lisa)

They were also asked what characteristics they would be looking for in a future relationship with a man.

What I would like in a relationship: I would like someone who loves me for who I am and not for who they want me to be. Someone who respects my feelings and opinions. There has to be a lot of communication, otherwise things build up to a point of damaging the relationship. I would like someone who is honest with me and who can trust me. Someone who enjoys going out socially, but also just doing simple things like going for nice long walks. I would like someone who can think about other things beside sex – to know that we can just be alone to talk or hold one another without it having to lead to something all the time. I would like someone who is interested in what I have to say (my hopes, my dreams, my fears, my opinions). I need someone who isn’t serious all the time like I am – then maybe, perhaps I can even learn to laugh and smile a little more often. So, all in all, I would like a guy who is very rarely found and maybe doesn’t even exist. I hope one day to find someone who comes close though, because I really don’t want to be alone for the rest of my life. I can’t help but think sometimes that I will be, and that’s a scary thought. (Paula)

I’ve known my mom forever and (ex-husband) for 15 years, and there’s nothing there. I’m deep down saddened by that. I feel cheated and tricked. I’ve been really short changed. NEVER AGAIN. Never again will I allow myself to be so short changed. I will move cautiously and settle for nothing less than a wonderful, warm, caring, mutually beneficial and giving relationship with a man. If I can’t have, or find, that, I’ll take none. As for my mom – that’s gone. But I can reward myself by being kind to myself and my children. I’m really proud of myself. (Karen)

I will not tolerate being hit, pushed or handled roughly in any way. I will not stand being lied to. I won’t stand for being belittled in front of people. I won’t put up with anymore nights out without a phone call. I don’t want to be called names or yelled at in front of people. I won’t stand for being treated as anything less than your equal. I feel these things are things I cannot and should not have to give in on. I believe that (her husband) can be a better person if he wants too. (Kelly)

The qualities and characteristics of equivalent friendships were also investigated.

Friends: This is like starting over and very important to me. I have really only one friend left from my pre-therapy life. I will have to find time to meet and cultivate new friends. Going out
occasionally to functions, clubs, etc. where I can meet people will help open the door. I don't want to fall into the same traps as before. I want to choose my friend and who I trust in a more healthy thoughtful way. I don't want to be a pleaser, a placator, or pick friends on the basis I used to. (Tina)

**ANTICIPATION OF THE CHALLENGES AHEAD**

As part of the safety net, it was important to encourage group members to think ahead to the potential challenges facing them, and to prepare themselves to cope with them, and continue their growth.

Possible Pitfalls:

1. Jim getting out of jail and I meet up with him or he starts calling me
   Options: a. start seeing him again. Would be very risky because I'm very easily led by him. Also he's done some pretty mean things before and how do I know if he's changed or not. Could lead to another abusive relationship. b. Could just tell him I just want to be friends with him, but I'm not interested in going out with him anymore.

2. Start gaining weight
   a. Go back to laxatives and not eating - fall back into old pattern again. b. Accept weight gain and talk to friends when I get panicky so as to have some support while I'm going through the rough periods. Keep thinking of laxatives as my enemy and food as my friend.

3. Start going out with a guy and get panicky when he gets close to me.
   a. Talk to him about my fears and take the relationship real slow. b. Withdraw from him and push him away and finally break up with him - leaving me alone and angry with myself again.

4. See my dad and start feeling guilty again about not being a good Christian.
   a. Stop seeing my dad altogether because I really don't need him and him preaching in my life anymore. b. continue seeing my dad out of obligation and guilt.

5. Run into Ken
   a. Bring back all past memories and start dwelling on them and feeling guilty and depressed. b. Think positive about it and be thankful I got out of the relationship when I did or it would have resulted in an unhappy marriage. Think of it as another experience in my life that I have learned and grown from. (Paula)

The biggest problem I can foresee is not taking care of myself - not the outside self - the one that people see, because I can do that just fine - but the inside self. The one that makes a difference to me. I already have trouble taking time just for me, for writing, resting, and being alone. I need to be very conscious of that every day. I also need to make time for my children - for them not for just dressing and feeding - for the nurturing stuff. Again, it's easy to do the stuff that is outwardly visible - that's what I'm used to. I also need to be cautious in choosing men. First I need to get myself together and live with myself. But I'm aware that I need to allow time to get to know a man without jumping into bed and then trying to get to know him. I'm not interested right now, but I
know the day will come. The truth is that I know in my heart this kind of relationship I'd like to have, but it scares me to think that it might be possible. (Karen)

Members were also asked to explore their emerging capabilities and interests, as well as to think about their educational and vocational needs.

I'm scared. I don't know what I want. Do I want to go back to work? I've been looking into schooling – it's scary. That's why I liked religion and being married. It was so structured and controlling. I never had to think. What do I really want? Who the hell knows? I used to think all I wanted was to be a mom and have 6 kids. That's the only area of my life I feel competent in. I think that's while I feel so defensive around my family as that's my job and they're not going to make me feel incapable. Although I am afraid that I hang on so tight to (her 3 year old son). Following the pattern of being a needy parent. (Helen)

I think anything is possible if I really want it. I have no pipe dreams, just a need to make some minor changes. After all, the biggest change has been in me, Anything else is secondary. I believe I have the energy now to find out what it is I'd really like to do in my job. How I would like to spend quiet time, what hobbies I might enjoy doing and what type of person I could befriend. I don't think I've ever got to know the person I am and what would make her happy. I've only been going through the motions of life. Now's a good time to stop and get to know her. This week I have had all sorts of questions running through my mind. What makes me happy? Am I really happy doing what I do now? Would I have made other choices had I not been a victim – such as marriage, career, family? (Chris)

One of the challenges up ahead for me will be to find "the" job for my future. I would like to work at a job that has contact with people, is long-term employment and good wages with a good pension plan. At this point this is a BIG challenge for me. My old tapes begin to play and I feel insecure, inadequate and afraid as well as incompetent. I must replace these tapes and keep telling myself that I can do anything that I really want to and that "the" job is out there for me. I have to try real hard to project self-confidence so that when "the" job comes along I will get it. More than projecting, I have to feel it inside and know that it's true. I must replace that fear (False Evidence Appearing Real) with self-confidence and self-worth, competence, security and adequacy. (Joyce)

**PERSONAL BILL OF RIGHTS**

Members were asked to prepare a personal bill of rights for the last session (#26).

I know I have rights and the main one is to feel and be free to be me (this is not corny). I have the right to be happy and sane, to feel and express my feelings. Regardless of anyone and their choices, I will not be pulled down again. I do care for a lot of people, but my responsibility is to me. I
have read stories about people in slavery who had no rights and I feel I let myself be a slave to other people’s demands. I also wanted to possess people and feel great about letting them go. They have rights to do it their way too! If (daughter) and (son-in-law) move away, I’ll miss them but it will be okay. I don’t feel upset at all. I have the right to have any friend I want to. Go where I want to. Do things I enjoy. I have responsibilities to my family but not control of them. My main responsibility is to myself – to be as healthy as I can be. To work on weight loss, but not be possessed by it. Being an example, instead of analyzing everything and everybody, lets me be free. I will not let anyone make me responsible for their actions. But I am responsible for mine... My friends are not my responsibility. I want to be there when they want me, but not to be a rescuer. It’s too tough of a job. They have rights to be who they are... I am going to keep on staying on track and do what’s best for me. I don’t have to be fulfilled by other people. I will mother me and be kind and not abusive to me. I feel a lot more kinder towards myself and a lot stronger towards others. Ta-da! I really am an okay lady and feel excited about tomorrow. (Diane)

Bill of Rights:
1. I have the right to live in a loving and peaceful environment
2. I have the right to help if I should need it, choose, or desire it.
3. I have the right to a pleasant home that doesn’t take most of my income.
4. I have the right to happiness in and out of my home.
5. I have a right to my feelings whether they be sad, happy or otherwise.
6. I have a right to provide a loving, kind and nurturing home for my children.
7. I have a right to my children’s love, just as they do mine
8. I have a right to accept love and kindness from others in the world.
9. I have a right to my opinion, thoughts and feelings – they are my own.
10. I have a right to space, solitude, and privacy. (Karen)

Bill of Rights:
1. I am an important person who does not deserve to be hurt or mistreated
2. I do not have to try to please people who do not matter in my life
3. I can look after myself and do all that makes me happy.
4. I do not have to impress people
5. I do not have to look after my mother. She can look after herself
6. I do not have to feel sorry for (her brother)
7. I do not have to help a relationship between my brothers and my mother
8. I don’t have to be a perfect mother, just a good one. (Chris)

Bill of Rights:
1. First and number one, I have a right to be a equal human being
2. Second, I have a right to my own opinions, thoughts and feelings
3. Third, I have the right to make my own way in life the way I see best for me
4. Fourth, I want the right for my actions, and not to have to answer to anyone but myself
5. I want the right to love and be loved with no conditions (Lisa)
Bill of Rights:
- The right to eat without fear or guilt
- The right to say YES or NO
- The right to my own opinions
- The right to make my own decisions
- The right to my own religious beliefs
- The right to be treated as an equal
- The right to be treated with respect
- The right to be angry
- The right to love and be loved
- The right to ask for help when I need it and not feel guilty
- The right to feel happy
- The right to live without guilt that is not mine
- The right to laugh and have fun
- The right to not be abused in any way (Paula)
APPENDIX A
INFORMATION SHEET

Name: ____________________________
Age: ________ Date of First Contact: __________ Date of Testing: __________
Intake Source: ______________________ Medications: ______________________
Previous Therapy: Y N Recurrent Depressions: Y N Starting: _______________
Previous Suicide Attempts: Y N Most Recent Date: ______________
Education Level: ________________ Marital Status: ______________________
Children: Y N Ages ________________ Self Supporting: Y N Employed: Y N
Income Level: ________________ Work History: ______________________

Presenting Problems: ______________________________________________________

Overt Abuse History:
Childhood Physical Abuse: Y N Abuser(s): ______________________
   Age of Abuse Onset: __________ Duration of Abuse: ______________
Adult Physical Abuse: Y N Abuser(s): ______________________
   Age of Abuse Onset: __________ Duration of Abuse: ______________
Childhood Sexual Abuse: Y N Abuser(s): ______________________
   Age of Abuse Onset: __________ Duration of Abuse: ______________
Adult Sexual Abuse: Y N Abuser(s): ______________________
   Age of Abuse Onset: __________ Duration of Abuse: ______________

Notes: __________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
APPENDIX B

RESEARCH CONSENT FORM

I, ____________________________ of, ____________________________
(print full name) (address)
understand that I will be taking part in an experimental group therapy program for adult
survivors of childhood sexual abuse. The active therapy portion of the program will cover an
initial six (6) month period during which the participants will meet on a weekly basis. The
subsequent six (6) months will minimally include two (2) follow-up group sessions at the three
(3) and six (6) months points. Additional individual appointments will be provided as needed. I
understand that I may terminate my participation in the program at any time and that best efforts
would then be made to provide me with alternate therapy choices.

I understand that any and all test and written materials completed by me for, and during, the
therapy program may be used for research purposes. Such research guarantees that any
information and/or material provided by me will remain confidential and will in no way be
identified, or identifiable, as arising from me. I understand that only the primary
therapist/researcher, Pat Fisher, shall have access to the original material provided by me.

I hereby consent to participate in the above described research program under the terms and
conditions noted above.

_________________________  ____________________________
(signature)                  (witness)

Dated the _________________ day of ________________________, 19 ____. 
APPENDIX C

COMPLETING THE PERSONAL PROJECTS MATRIX (PPM)

The PPM asks you to think about and evaluate those things that have been going on in your life over the past week. We ask you to answer the questions as you see them, not as someone else might see them. The following set of directions provide the sequence in which the form should be completed.

1. Fill in your name and date at the top of the page.
2. Consider the four sets of scales under your name and date. The first asks you how physically healthy you feel right now, please circle the number (from 1-10) that best describes how you feel. The other three scales ask you: how satisfied you feel with your life; how depressed or happy you feel; and how close you feel to the important people you are living with. As with the first scale, please circle the appropriate number.
3. Now we ask you to change gears and think about what has been going on in your life over the past week. What have you been thinking or worrying about? What have you been involved in? Now, just start listing these things down in the left hand column. They don’t have to be written out so that we understand them, just one or two words so that you know what you are referring to will do. There is room for up to 14 of these "projects", so keep on listing until you run out.
4. Now we would like you to evaluate each of these projects in terms of the 7 scales running from left to right. Again, we ask you to rate each of your projects as you see them, not as someone else might see them. Please complete each column down first before moving to the next scale (e.g., first rate all your projects on Importance, then rate them all on Difficulty, then on Enjoyment, etc.).

- Importance: On a scale of 1 to 10 how important was each of your projects to you over the past week? (10 = very important, 1 = not at all important).
- Difficulty: On a scale of 1 to 10 how difficult did you find each of your projects over the past week? (10 = very difficult, 1 = very easy).
- Enjoyment: On a scale of 1 to 10 how much did you enjoy each of your projects over the past week? (10 = very enjoyable, 1 = very unpleasant)
Appendix C: Completing the Personal Projects Matrix

**Importance to Quality of Life (QOL):** On a scale of 1 to 10 how important was each of your projects to your long term quality of life? (10 = very important, 1 = not at all important).

**Actual Time:** On a percent basis, how much time have you spent on each of your projects? (e.g., how much of your time has it been on your mind, or have you been involved in it). Note that one or more projects may seem to have been on your mind all the time, or 100%.

**Desired Time:** On a percent basis, how much time do you wish you had spent on each of your projects? This value is compared with the actual time you just assigned.

**Project Domain:** Now we ask you to decide which area of your life each one of the projects falls into. Note the list of 10 life domain areas on the left of the form, about one-third of the way down the page. We ask you to choose the appropriate domain for each project and fill in the number that goes with that domain. It is important to remember that if you have strong feelings about any of your projects they become "emotional concern" (#9) projects, rather then the other types of projects they might seem to be.

**Emotional Status of Projects:** In this last column we ask you to describe in one or two words how you feel about each of your projects.

5. Last of all, please use the comments section at the bottom of the page to tell us about anything that has been going on for you over the week.
REFERENCES


References


References


References


