

ADOLESCENT FEMALES AND PRIOR SEXUAL ABUSE;  
A DESCRIPTIVE STUDY

by

ANNAMARIE OLIVERIO

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APPROVAL

NAME: OLIVERIO, Annamarie  
DEGREE: Master of Arts (Criminology)  
TITLE OF THESIS: Adolescent Females and Prior Sexual Abuse: A Descriptive Study.

Examining Committee:

---

Senior Supervisor: Ronald Roesch  
Professor

---

Committee: Margaret Jackson  
Assistant Professor

External Examiner: Naida Hyde  
Director of Counselling Centre  
Simon Fraser University

Date Approved: November 19, 1987

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Annamarie Oliverio

(name)

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## Abstract

A sample of twenty adolescent females from an inpatient psychiatric facility in British Columbia voluntarily completed a variety of clinical survey measures, namely the SCL-90-R, the Teenage Behaviour Inventory and the Dissociation scale. The purpose was to evaluate the usefulness of these measures in providing information on psychological and behavioural distress associated with sexual victimization. Sexual abuse histories were located in the files for fifteen of the twenty females. It was originally intended that this study would compare individuals sexually abused with those not abused on psychological and/or behavioural measures. Because of the breakdown of abused (15) versus not abused (5) persons, comparative analyses were not appropriate. Instead, the psychological and behavioural profiles of the fifteen women who had reported histories of sexual abuse were described. Higher than normal levels of self-destructive behaviour, hostility, suicide attempts, phobic anxiety, depression, as well as alcohol and drug problems, were noted. The measures which were administered appeared to yield clinically-useful information. As well, routine administration of such measures could be potentially effective in identifying the particular treatment needs of the individuals; however, further investigation is needed before policy recommendations can be made.

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## I. INTRODUCTION

Over the past decade, child sexual abuse has been recognized by the public as a major social problem. While at one time public awareness about sexual abuse was furtive at best, today concern and interest are widespread amongst lay persons and professionals alike. Such an increase in public awareness has led to changes in public attitudes as well. In the recent past, child sexual abuse was considered to be a rare phenomenon, today we recognize sexual abuse as occurring frequently and as being associated with various negative psychological and physical outcomes for its victims. As well, our understanding of the victim's role and culpability have changed. At one time the victim was considered to be at least partially responsible for the abuse (Bender & Blau, 1937; Bender & Grugett, 1952; Demott, 1980; Freud, 1966; Henderson, 1983; Katan, 1973; Nelson, 1981; Rasmussen, 1934; Rascovsky & Rascovsky, 1950; Weiner, 1978). Our current understanding, however, is much more sensitive to the victim's oppression, placing the responsibility upon the abusing adult for his actions (Briere, 1984; deYoung, 1982; Gelinas, 1983; Halliday, 1982; Rush, 1976; Rush, 1980).<sup>1</sup>

These changes in public awareness and perceptions about sexual abuse have been affected and shaped by various sources such as the media, research and policy attention and, of course, the ongoing concerns that women have had about sexual

violence. In addition, although these dramatic changes appear to be sudden, they are based on years of research attempting to understand the sexual abuse phenomenon. In fact, many of our present beliefs have emerged in reaction to past research and the subsequent social misconceptions it produced. Thus, recent developments and reactions to sexual abuse are best understood within their historical context. What has led to our present perspectives can only be understood if we explore the various contributing factors to it. And, as our present notions about child sexual abuse appear almost diametrically opposed to what they have been historically, it is worthwhile to briefly describe the various aspects, such as media, policy research, and the women's movement which have influenced our present opinions and concerns. In this way, we may also better understand various broader social and political implications resulting from our present knowledge and changes in attitude about the child sexual abuse phenomenon.

#### Historical perceptions about sexual abuse

Until recently, incest and child sexual abuse was characterized as a rare occurrence (Henderson, 1975). The theory most commonly used to explain the context and incidence of sexual abuse was based on the Freudian notion of "child seduction". In Freud's essay on "Femininity", he wrote "...almost all my women patients told me that they had been seduced by their fathers. I was driven to recognize in the



end that these reports were untrue and so came to understand that the hysterical symptoms are derived from phantasies and not from real occurrences." (p. 584). He could not bring himself to believe that so many men in civilized Vienna were sexually abusing their daughters. Instead, he decided that these women who had trusted him with their most painful secrets were lying (Rush, 1980). Freud further claimed that whenever girls reported assault, they were actually revealing their innermost fantasies, expressing their true nature and that these expressions meant they wanted to be "seduced".

This theory, casting girls into the role of sex objects, aggressors, or "demon nymphettes" tended to dominate most of the past research and social perceptions of sexual abuse. As Rush (1980) has argued, such perceptions tended to define not only the child's body, but also her soul. In her book, The Best Kept Secret, Rush discusses the development and level of recognition given to this view of girls. She explains how Freud based his theory and built his practice on "Lolita"--the child seductress--and, every incest offender, of course, had one for a daughter or a sister (and so on).

As a consequence of this dominant view on sexual abuse, for many years victims of incest themselves were vulnerable to believing such definitions of reality and blamed themselves for their abuse (Masson, 1985). For example, Dostoyevsky in his novel Crime and Punishment describes a five year old child as a seductress:

There was something shameless and provocative in the childlike face; it was depravity, it was the face of a harlot...Now both eyes opened wide. They laughed... "What, at five years old, " muttered Svidrigailov in genuine horror. "What does it mean?" And now she turned to him, her little face aglow, holding out her arms...(1959: 537).

Freud's notion of the child seductress had obviously attained a certain prominence to be thus expressed in the literature of the time. Moreover, researchers tended to utilize these theories upon which they generated "empirical" findings to support them. While literature is often discounted as merely fictional in nature, as with Dostoyevsky's novel, scientific work which would present similar images of the child victim contributed to confirming these "fictional" assumptions as representative of reality (deYoung, 1982). Bender and Blau (1937), for example, produced a study on hospitalized sexually molested girls. Fifteen years later, Bender and Grugett (1952) conducted a follow-up study of the same sample. The authors concluded that "it was highly probable that the children had used their charm in the role of seducers rather than that they had been the innocent ones who had been seduced" (p. 826).

Since the Bender and Blau (1937) study, various researchers have attempted to confirm these sorts of assumptions about child victims (See Lukianowicz, 1972; Krieger et al., 1980; Henderson, 1975). Lukianowicz, for example, states that the "children were far from being innocent victims; on the contrary, they were willing partners and often

provocative seductresses (p. 309). Henderson (1975) believes that the daughters (in paternal incest) play a collusive role in most incestuous relationships. He asserts that "in father-daughter incest, the father is aided and abetted in his liaison by the conscious or unconscious seduction by his daughter...the daughters collude in the incest relationship and play active and even initiating roles in establishing the pattern" (p. 1533).

These theoretical propositions based on empirical research placing the responsibility (or at least part of it) on the child for her victimization can have obvious implications for the offending adult. It can be used not only to minimize their roles as offenders, but it can be used to incorrectly disparage the negative effects of incest (deYoung, 1982). In other words, if the child encourages the incest, then the encounter itself cannot be damaging to the child nor can the adult be held fully responsible for his actions. In fact, many professionals and researchers have maintained that such early sexual experiences with parents can be considered as truly beneficial to the child (DeMott, 1980; Nelson, 1981).

Since earlier studies on incest and child sexual abuse (Bender & Blau, 1937; Bender & Grugget, 1952; Rasmussen, 1934; Rascovsky & Rascovsky, 1950), research has been steadily increasing. New empirical findings increasingly questioned and challenged status quo perceptions and assumptions. Many researchers, such as deYoung (1982) have noted that the data

used to support past conclusions were not only isolated at best, but also upon careful consideration, the familial and social contexts in which the incest occurred were not included and/or explicated (p. 57). deYoung suggests four sources of data which were most likely responsible for assumptions of victim culpability: the incest offender's rationalizations (Freud's *Lolita*), the victim's passivity, pre-incest promiscuity and the victim's behaviour in therapy. She further notes that "when the familial and social context is fully appreciated, the culpability of the child diminishes" (p. 56). Hence, public and professional perceptions of sexual abuse have broadened considerably since the initial pioneer work in the area. Furthermore, various groups within society, such as women's groups became very involved in wanting to understand the phenomenon (Brickman, 1984). In fact, one of the goals of the women's movement involved informing public perceptions on the nature of sexual abuse--according to the victim's experience. The women's movement constituted one of the first and most positive means of action in increasing awareness of child sexual assault and in working to mobilize communities in its prevention.

#### The women's movement

The women's movement made several gains in both trying to understand as well as prevent the problem of sexual abuse over the past several years. Previous beliefs that incest and

sexual abuse were rare occurrences, or that children fantasized about being sexually assaulted (Freud, "child seduction theory") or that in the cases where it did occur either the child or the offender or both were deranged (see Rascovsky & Rascovsky, 1950; Weiner, 1962) were being questioned as more and more adult survivors recounted their experiences. Their experiences revealed a certain oppressive nature to the abuse experience which previously had not been recognized (James, 1977). Such new insights facilitated a disparaging of the previously assumed culpability of the child victim. Furthermore, this perspective has been viewed as empowering to both women and children not only in mobilizing public awareness about the reality of the problem, but also in developing effective prevention programs directed at helping and not alienating the victim (Hefland, 1985). At the same time, as Hefland and other feminists have argued, it has enabled women and children to become more informed about their personal rights and what constitutes violations to them.

Unlike the anti-rape movement, where it was much more difficult to convince the public that women were not responsible for their rape, the public clearly accepts the obvious dependence of children on adults and the relative power differentials. Thus, this movement against child sexual assault easily became widespread involving not only women and/or mothers, but anyone who cared about protecting children

and/or the threatened family unit.

While the women's movement has been most effective in developing an understanding of child sexual abuse and incest, their point of view has been considered biased and threatening. Their insistence and persistence in empowering children and adult survivors of sexual abuse has caused them to focus on the issue solely from the "women's experience". Thus, as the credibility of the victim's experience increased, so did the threat to men's authority and control in the family unit increase. As well, however, in depicting child sexual abuse as a major tool used to oppress women, the whole notion of the traditional family unit also came into question. The implications of some of the arguments maintained by feminists has thus led to various, supposedly counterbalancing responses. In fact, increasingly, much of the information being disseminated has been directed at mitigating the initial feminist claims and possible implications. Some authors, such as Hefland (1985) believe that these mitigating attempts have worked "against the gains made by feminists in understanding and preventing child sexual assault" (p. 14). One of the ways in which these mixed messages between feminist arguments about sexual abuse and restoring status quo assumptions about it have been known has been through the media. While the media has also contributed enormously to our present level of awareness and concern about sexual abuse, it has also led to a confusion in public perceptions. It is therefore also important to

briefly review the media's influence on the development and conceptualization of child sexual abuse.

### Media attention and influence

As this awareness of child sexual abuse increased, so did the media begin to focus its attention on this issue as a way to further increase public awareness. In fact, child sexual abuse events continue to receive enormous attention from newspapers and journals. Shocking revelations about abuse occurring in families, schools, daycare and other child-care facilities as well as horror stories on the fate of kidnapped or missing children have led to widespread confusion, fear and outcry. In short, the topic of child sexual abuse has appeared everywhere, from prime time television shows to national magazines in attempts to receive broad attention.

And yet, while such widespread media attention appears to be effectively informing the public, the content of the information reaching the public has been considered questionable. In other words, the media often times has delivered information which is somewhat distorted and ultimately counterproductive to understanding and preventing abuse (see, for example, Fritz & Altheide, forthcoming). Children, for example, are always portrayed as easily duped into their sexual victimization. They are always depicted as passive and vulnerable. While it has been necessary to show the relative powerlessness of child victims confronted by

abusing adults in emphasizing the credibility of the experiences of children and adult survivors, images of victim passivity can also be easily misconstrued. In other words, not all children are easily tricked, or react passively when confronted with someone they do not trust; yet their more aggressive behaviours are never portrayed (Lamb, 1986). Hefland (1985) argues that "it is crucial to make a distinction between innate characteristics and learned behaviour" (p. 9). She claims that women and children are taught to be passive and it is necessary to discredit such learned behaviour: "Many children resist, fight back, or see through tricks, yet this message which would contribute to empowering more children is seldom heard" (p. 9). Thus, current media images of children do little more than to reify their powerlessness and fear.

Furthermore, a disproportionate amount of media attention is given to child abuse offenders. The offender's experience is often the focus of movies, television talk shows, and magazine articles (See Newsweek, for example, May 14, 1984). The outcome of such media exposure featuring child molesters as "special guests" simply evokes sympathy for this "poor insane person." The offender, while seemingly accepting his responsibility for the abusive actions by publicly talking about them, is simultaneously admired for his remorse. In addition, the offender is given the opportunity to discuss the "real" reasons for his/her actions--the surrounding conditions



or circumstances. Mothers, for example, are often blamed for the abuse of their children by the father because "she works all the time" or "she is never home" or "she was cold sexually" (see Halliday, 1982; Hefland, 1985). The implication of such statements, of course, point to the breakdown of the traditional female role as wife and mother as the real factor responsible for such behaviour. For if the woman were home where she belonged, child sexual abuse would not occur--mother would take care of everyone's needs.

Moreover, media attention on abuse occurring in day care centres further reinforces the public's view that women ought to stay home. And yet, it is consistently reported that between 75% - 80% of abuses occur by trusted friends, relatives, family members and even doctors, and ministers (Halliday, 1982; Hefland, 1985). Such information not only can cause us to totally misconstrue the context of sexual abuse but also it can misguide our preventive focus. In fact, if viewed within the parameters of mainstream media, any attempts at preventing or remedying the child sexual abuse problem can only be counterproductive to the gains made for victims. In other words, because the media focuses disproportionately on describing and analysing the offender's actions rather than the victim's experience, criminal justice and therapeutic efforts risk a similar disproportionate focus on the offender to the detriment of the victim.

In addition to the media "moral panic" production, there

has also been an increase in psychological, medical and social research. This increase in government and professional attention has also contributed to public awareness and concern about sexual abuse. The following section will briefly review some of the themes of the major government commission reports which have influenced the emergence and creation of the child sexual abuse issue.

#### Government sponsored research on child sexual abuse

Reports by the Badgley and Fraser commissions in Canada and the Meese commission in the United States have also provided dramatic evidence concerning the widespread incidence of sexual offences against children and youth. Furthermore, these reports have asserted that the pervasiveness of child sexual abuse is associated with the proliferation of prostitution and pornography. Additional and more recent survey research has estimated that one out of every four girls under the age of fourteen has undergone some form of sexual molestation (See Meese Commission Report, 1986).

The Badgley, Fraser and Meese reports on the pervasiveness of sexual abuse have also been widely disseminated through the mass media and, therefore, contribute to public opinion about sexual abuse. There are, however, critics who claim that these reports (along with the mass media representation) only further mislead and misinform the public about the context and nature of sexual abuse. The most common criticism is that much of the

reported research oversensationalizes and overgeneralizes limited empirical findings. The government reports, for example, include a substantial number of cases involving exhibitionism or flashing as a form of sexual abuse when it is not at all evident conceptually and clinically that the inclusion is appropriate. In effect, critics argue that while "flashing" is abnormal or gross behaviour it does not ipso facto constitute sexual abuse.

In addition to various methodological problems in the above government sponsored research, these reports have also been criticized for public images that arise from the ideological perspectives underlying the subsequent policy recommendations to deal with sexual abuse. These policies often appear to reflect a patriarchal and reactionary approach to the problems identified in the research. Some critics argue that such research can create a potentially negative impact with reference to proposed policies for women, homosexuals and in particular, young people. Regarding the latter group, Lowman et al. (1986) maintain these reports can be dangerous "in more insidious ways [to] all young people" (p. 255).

What appears to emerge from such controversial research and policies about sexual abuse is a climate of confusion and concern over the extent of its occurrence, the nature of the incidents, its aetiology and its effects. Accordingly, social

science and medical research in this area has increased dramatically in the interests of expanding our present understanding of the problem.

#### Present status of research on child sexual abuse

Studies conducted by various social scientists, particularly psychologists, have not only provided confirming evidence of the extensiveness of sexual abuse but also they have concluded that most women who were sexually abused as children suffer serious negative consequences, from psychological and social problems to medical problems (Bagley, 1985; Finkelhor, 1979; Hyde, 1984; Runtz & Briere, 1985; Sorrenti-Little, Bagley, Robertson, 1985). As documented by Bagley and Ramsey (1985), between fifteen and thirty percent of various female populations surveyed have reported a history of sexual abuse and about half of those who reported such histories indicated that the abuse occurred within the family or by a closely trusted person.

Much of the empirical work providing evidence on the effects of child sexual abuse has, however, also been considered biased and methodologically inadequate (Henderson, 1983; Toro, 1985). Criticisms have ranged from questionable designs and instrumentation (such as use of the MMPI which has been considered faulty in its ability to directly address psychological dysfunctions: see Conte, 1984), to small biased samples and poorly controlled studies. Although much of the

research is still in its formative phases of pilot testing, recent studies have improved somewhat upon former inadequacies. These studies have provided long-term follow-up work (Bagley and MacDonald, 1984), non-clinical, general population surveys (Badgely, 1984; Bagley, 1985; Briere, 1985; Finkelhor, 1979; Sorrenti-Little, Bagley, Robertson, 1984) and improved measures considered to address directly the association between sexual abuse and presenting psychological and behavioural distress (Conte, 1984; Runtz and Briere, 1985). As a result of such methodological improvements and extensions to research on sexual abuse, both professional and public attention and acknowledgement is increasingly being focussed on its adverse effects, continually testing and challenging previous beliefs and theories (Halliday, 1982; Oates, 1982; Rush, 1976).

Because of the tentative state of recent research on sexual abuse, further research is obviously necessary, especially with reference to overcoming validity concerns raised about designs and instrumentation employed. Nearly all measurement instruments to date have been validated on adult samples leaving open the issue of measuring the effect of sexual abuse on other populations such as adolescents. As a result of using older population samples, research to date has focused on measuring the long-term effects of sexual abuse. Further research, therefore, is necessary in order to address the initial and fundamental step of validly measuring the effects of sexual abuse as close as possible to the actual

occurrence(s) of sexual abuse. This step is critical in order to assess causal and other developmental issues regarding psychological harm associated with sexual abuse.

### Overview of the present study

The purpose of this thesis will be to focus on the key issue of how many, if any, psychological or behavioural problems may be identified amongst a group of adolescents who have reported histories of sexual abuse. A sample of adolescent females residing in a mental health facility voluntarily completed self-report measures of psychological and behavioural distress. Sexual abuse histories were located and verified through the file reports. It was anticipated that a clinical sample of adolescent women would have the greatest potential for identifying and describing the symptomatology resulting from sexual abuse. As well, various staff from this mental health facility indicated that a large proportion of the residents had reported sexual abuse histories, though exact figures were unknown. Accordingly, the design selected involved a combination of survey and interview methods. Several clinical and background measures which have been used in past sexual abuse studies, namely the SCL-90-R (Derogatis, Rickels & Rock, 1976), the Dissociation Scale (Briere & Runtz, 1985), and the Teenage Behaviour Inventory (Runtz & Briere, 1985) were administered to this population. The measures will be subsequently assessed as to their value in identifying and

explaining the psychological and behavioural problems of this institutionalized population of adolescents. In this way, generalizations may be made about the research value as well as the clinical utility of these measures for other similar populations.

Past studies have claimed that the above measures have been able to describe the connection between various types of psychological and behavioural problems and prior sexual abuse (Briere, 1984; Finkelhor, 1979; Runtz and Briere, 1985). However, these studies were conducted only on clinical and non-clinical adult female populations. As yet, these measures have not been administered to adolescents although adolescent norms for the measures are readily available. Thus, the measures to be used in this study have been chosen based on their claimed value of identifying associations between prior sexual abuse and presenting psychological and behavioural distress amongst adult females. In this study, the usefulness of these measures amongst adolescent females will be assessed.

Before turning to a more detailed description and analysis of the population in question, a review of the literature examining the prevalent theories and conceptualizations of sexual abuse and why it occurs will be presented. Chapter two will therefore deal with the task of defining sexual abuse as it has been defined in past studies as well as operationalizing the concept for the purposes of this study. Furthermore, a

presentation and analysis of the existing research on adults and, of course, on adolescents will provide the necessary theoretical perspective for the investigation of the theme of this study. Chapter three will include a description of the sample and design as well as outline the method and procedure used. Why certain methods and measures were selected will be explicated in light of past work supporting their use. As well, the strengths and limitations of the present study will be discussed. Chapter four will describe and explain the research findings in detail and chapter five will provide observations and discussion as suggested by my analysis of the findings. A brief summary and final remarks regarding suggestions for improvements to this study and/or for future studies in this area will conclude the thesis.



## Notes

<sup>1</sup>Because victims of sexual abuse are overwhelmingly female, and offenders male, it appears appropriate to use gender specific pronouns.

## II. LITERATURE REVIEW

Research interest in the problems associated with child sexual abuse and incest is somewhat recent. The literature, therefore, is not very extensive and, overall, is considered to be methodologically problematic (Toro, 1985). Furthermore, most empirical work on the effects of child sexual abuse has focused on its long-term consequences. Such research has for the most part utilized adult populations. Research examining the initial effects of child sexual abuse is even more uncommon than the long-term analyses and methodological limitations are even more pronounced. One of the major reasons for this is that to examine the initial effects of child sexual abuse, younger populations must be accessed. Because of the ethical considerations and questions associated with studying younger persons, attaining access and consent is much more difficult. And, even when access and consent are obtained, in studying pre-teen or teenage populations, questions arise about the reliability of their responses.

Yet, despite these difficulties associated with doing research in the area of child sexual abuse, there has been a steady increase in empirical work. This has occurred partly in response to the state of past research in attempts to improve methodological inadequacies and to refine theoretical propositions. Furthermore, studies on abusive and incestuous relationships which have argued that the effects of such

experiences have produced benign or even potentially positive self-actualization aftereffects (Nelson, 1981) have incited extensive controversy amongst social service providers and social scientists alike. As well, feminists have been adamant about exposing the short-comings of such research. Thus, most clinical research in recent years, has attempted to assess the import, if any, of assumptions claiming that abusive experiences can be benign or potentially positive. As well, recent work has been helpful in further understanding the role of the victim and the effects on the victim resulting from abuse. Negative behaviour such as running away, dropping out of school, bedwetting, drug and alcohol abuse, hysterical seizures, prostitution and suicide attempts have all been found to be associated with backgrounds of incest and/or sexual abuse (Bagley, 1984; Briere, 1984; Goodwin, Simms & Bergman, 1979; Herman, 1981; Ross, 1980; Runtz & Briere, 1985; Sedney & Brooks, 1984).

Such fundamental discrepancies in research findings, therefore, require a closer examination or review of the limited research. The purpose of this chapter will be to review the empirical literature on the effects of child sexual abuse. Studies on both long-term and initial effects will be reviewed in order to provide as comprehensive an examination as possible. While the empirical literature on the initial effects will be of specific relevance to the purpose of this thesis, an examination of the long-term effects will be

included for two major reasons. First, a greater number of studies have been conducted on adults than on adolescents, therefore the "long-term" effects of sexual abuse are more frequently tested and documented. Second, research on adults and long-term effects has stimulated research on younger counterparts and their immediate responses to sexual abuse experiences. Thus, discussing empirical research on long-term effects will be useful in providing the necessary context out of which research on adolescents and the immediate effects of sexual abuse has been inspired and developed.

#### Long-term effects of child sexual abuse

Research involving "long-term" effects have certain common characteristics. To begin with, sexual experiences always involve an older perpetrator and a younger victim, therefore, the age differential is the primary focus. This differential is important because the victim often experiences "subtle coercion", and is at a further disadvantage because the "ability to understand the situation is inherently unequal and is compounded by a serious difference in power . . ." (Finkelhor, 1979: 694-695). Accordingly, Hefland (1985) also states that:

an accurate view of incest recognizes the unequal relationship between father and child. By placing responsibility squarely with the man we see that, fundamentally he chose to hurt his child. Anger is totally justified as the response to the misuse of power and deliberate harm (p. 14).

Thus, age, knowledge and power differentials are considered to be crucial variables in assessing aftereffects of incest and/or sexual abuse. In contrast, abusive sexual experiences between peers are usually characterized by relatively similar levels of awareness (whether informed or uninformed) and by the absence of inherent power differentials. Another common characteristic is that samples consist predominantly of females. A few studies focus on male experiences but most of the psychological, behavioural and physical outcomes refer to females. Finally, all the adult-based studies have methodological shortcomings. These will be identified and critiqued in the summary section of the chapter. The review will begin by discussing the studies which report negative effects of child sexual abuse followed by an overview of the few studies suggesting positive effects from sexually abusive and/or incestuous encounters.

#### Negative effects of child sexual abuse

Studies on long-term effects of child sexual abuse document a range of problems from emotional responses such as guilt or depression to self-destructive behaviours to sexual dysfunctions. While some studies attempt to report and analyze this entire range of negative psychological and behavioural sequelae, others focus in on certain items. What eventually emerges from these studies is a definite overlap in their results indicating that persons who undergo such victimization

suffer chronic psychosocial difficulties throughout their lives. The following will constitute an overview of this research as it will allow for a greater understanding of the sort of psychological impact reflected in persons who may be presently undergoing such victimization. In other words, although the main focus of the review will be on adolescent psychological effects of abuse, forerunning studies on adults and long term effects enable us to understand the consequent chronic development and depth of the problems when they continue beyond the initial phases of psychological responses.

### Emotional/affective responses

#### **Depression**

Empirical studies utilizing both clinical and non-clinical samples have noted depression as the most common affective response of those who documented sexual abuse histories. Non-clinical sample studies have, however, been noted to demonstrate the distinctions amongst levels of depression better than clinical sample studies (Browne & Finkelhor, 1986). This is because within clinical populations it is difficult to select control groups that emotionally would not demonstrate depression regardless of sexual abuse history. The very need to seek out clinical assistance is indicative of the emotional and/or behavioural state of the entire clinical population. However, slight differences were noted in both Herman's (1981) and Meiselman's (1978) studies which were based on clinical

samples although neither finding may be considered as statistically significant. Herman noted that 60% of the abused victims in her study reported severe depression versus 55% of the non-abused comparison group who also reported depressive symptoms. In Meiselman's study the frequency of reported symptoms of depression was 35% amongst sexually abused versus 23% of the non-abused.

Non-clinical sample studies have been more successful at reporting significant results indicating higher levels of depression amongst abused versus not abused respondents. For example, Briere and Runtz (1985), in their study of a sample of undergraduate women, noted distinctively higher levels of depression amongst abused women. Analysis of the presenting symptomatology was based on the Hopkins Symptom Checklist items which measure a range of psychological/emotional and behavioural dysfunctions. Abused subjects indicated higher levels of depression during the twelve months before the testing in comparison to non-abused subjects. Also utilizing a non-clinical sample of 301 college women, Sedney and Brooks (1984) found that those who had experienced sexual abuse as children had reported depression significantly more (65%) than those who had not been abused (43%).

Other studies successfully confirming the association between sexual abuse history and high levels of depression amongst non-clinical populations include Bagley and Ramsey's (1985) Calgary community study based on a random sample of 387

women, and Peters (1984) Los Angeles community study, also based on a random sample of 119 women. The Bagley and Ramsey (1985) study used two different measures of depression: The Centre for Environmental Studies Depression Scale (CES-D) as well as the Middlesex Hospital Questionnaire (MHQ). Using the CES-D, 17% of subjects with sexual abuse histories scored with symptoms of clinical depression compared to 9% of the non-abused group. The MHQ identified 15% of the abused with depressive symptoms versus 7% non-abused. Peters (1984) out of 119 interviews noted that sexual abuse, especially if physical contact was involved, was associated with a greater frequency of depression. Furthermore, both the Peters (1984) and the Sedney and Brooks (1984) studies noted that sexually abused subjects more often than non-abused subjects indicated that they had been hospitalized for their depressive symptoms (the result of 18% versus 4% was documented in the latter study).

### **Anxiety**

In addition to the higher levels of depression noted amongst both clinical and non-clinical populations with prior sexual abuse histories, higher levels of anxiety and tension or nervousness are noted. Briere (1984), in his clinical sample of 153 female walk-in patients, found that 54% of those sexually abused had anxiety attacks compared to 28% of the non-victims. These findings were further confirmed in his non-clinical sample study (Briere and Runtz, 1985) where sexual



abuse victims also scored higher than non-abused subjects.

Also, Sedney and Brooks noted that 59% of their subjects with sexual abuse histories experienced chronic anxiety overall and 41% experienced extreme forms of anxiety and nervousness. This compared with 29% of the comparison group who had indicated acute and chronic tension.

### Self-Image

Empirical data based on clinical samples have also noted that sexual abuse victims experience very poor self-image. They note feelings of stigmatization as well as isolation. For example, in Briere's clinical sample, 64% of the sexually abused women felt isolated and stigmatized compared to 49% in the control group. Herman (1981) noted that all the subjects in her study felt stigmatized. In fact, stigmatization was reported as one of the most consistently reported symptoms in her profile of incest victims.

Problems with self-esteem and stigmatization were also indicated in Courtois' (1979) community sample. Eighty-seven percent of the sample reported that their self-esteem had been negatively affected as a result of their sexual abuse histories. Seventy-three percent indicated feelings of isolation and/or alienation.

Amongst non-clinical populations, Bagley and Ramsey (1985), by using the Coopersmith Self-Esteem Inventory, found that 19% of their abused subjects reported "very poor" levels

of self-image as compared to 9% of the abused who had indicated "very good" levels. Although the overall levels reported are lower than in the above mentioned clinical studies, the findings reported by Bagley and Ramsey in their non-clinical sample are statistically consistent with those reported by Briere (1984), Sedney and Brooks (1984), Courtois (1979), and Herman (1981).

Along with these data indicating various long-term psychological/emotional problems associated to prior sexual abuse, long-term psychological behavioural problems ranging from sexual dysfunctions to suicide attempts have also been noted as more likely to manifest themselves amongst sexual abuse victims. The following section will briefly identify various empirical findings indicative of these problems.

### Psychological/behavioural problems

#### **Suicide and self-destructiveness**

Suicidal and self-destructive behaviours were noted in both clinical and non-clinical samples. Briere (1984) in his clinical sample found that 51% of the sexually abused subjects had a history of suicide attempts compared to 34% of the nonabused subjects. Self-destructive behaviour was reported by 31% of the sexually abused versus 19% of the nonabused. Other clinical studies such as Herman (1981) and Harrison, Lumry and Claypatch (1984) also revealed a link between childhood sexual abuse, suicide ideation, or self-destructive behaviours and

child sexual abuse history.

Accordingly, the non-clinical sample studies revealed similar associations between sexual abuse and suicidal and/or self-destructive actions. Bagley and Ramsey (1985), as well as Sedney and Brooks (1984) in their respective community and college student samples, found that suicide and/or self-harm ideation as well as deliberate self-harm was most prevalent amongst the childhood sexual abuse victims. Sedney and Brooks (1984) reported 39% versus 16% from the control group.

### **Somatic complaints**

Sleeping difficulties, nightmares, and somatic anxiety were also prevalent long-term symptoms noted in victims of sexual abuse. In the study by Sedney and Brooks (1984), 51% of the sexually abused subjects noted they had difficulty sleeping compared to 29% in the control group. Accordingly, the Bagley and Ramsey (1985) community sample reported 19% of their sexually abused subjects as having symptoms of somatic anxiety versus 9% of the nonabused subjects. Briere (1984) in his clinical sample also noted that female sexual abuse clients were more likely than nonabused clients to indicate higher levels of restless sleep and more frequent nightmares despite the number of years between the abuse incident, and the presenting symptoms. Briere's study showed that in most cases, even though at least thirteen years had passed since the actual abuse incidents, somatic problems were still highly evident.

## Sexuality and social functioning

Much clinical attention has been given to the later sexual functioning of childhood sexual abuse victims. Briere (1984), Meiselman (1978), Herman (1981), Langmade (1983), Tsai, Feldman-Summers and Edgar (1979) all found that women who had been sexually abused as children reported sexual difficulties as adults. Decreased sex drive, poor sexual self-esteem, sexual anxiety, sexual guilt as well as greater sexual dissatisfaction were all reported amongst the symptoms relating to sexual dysfunction and prior sexual abuse.

Fewer non-clinical studies have emphasized the association between sexual abuse and later sexual dysfunctions. Courtois (1979) found both an avoidance and/or abstention from sex in 80% of his former incest subjects. In his study on college students, Finkelhor's (1979) sexual self-esteem measure revealed lower levels of sexual esteem amongst sexual abuse victims.

Empirical work has also provided evidence showing that women with sexual abuse backgrounds have difficulty in their interpersonal relationships with respect to both men and women. DeYoung (1982), Meiselman (1978) and Herman (1981) all found that incest or abused victims felt hostility predominantly toward their mothers. DeYoung (1982) reported 79% of the sexually abused in her sample as being hostile toward the mother compared to 52% who felt hostility toward the abuser.

In Briere's (1984) study, he found that 48% of his clinical subjects who had been abused feared men as compared to 4% of the nonabused. These results logically support the contention that abused women generally have difficulty being in close relationships as was noted in both Courtois (1979) and Meiselman's (1978) samples. In both studies, most of the victims had problems relating to men (79% and 64% respectively) and a large percentage had never gotten married (40% and 39% respectively).

Also, the empirical literature appears to suggest that sexually abused women tend to be involved in abusive relationships later in life. Briere (1984) found that 49% of his clinical sexually abused subjects had been battered in their later adult relationships compared to 18% of the nonvictimized group. Also, a nonclinical sample study offered by Fromuth (1986) revealed revictimization experiences especially for women who been initially abused before the age of thirteen.

Sexual preference with respect to sexual abuse has found no empirical support so far. Gundlach, (1977), Bell and Weinberg (1981) all found that later sexual preference and early sexual abuse were not associated.

#### **Promiscuity, prostitution and substance abuse**

Increased promiscuity by victims of sexual abuse has been found by Courtois (1979), DeYoung (1982), Herman (1981) and

Meiselman (1978). Each of these authors noted an increase in sexual behaviour amongst the victims and attributed this to their way of gaining affection and attention. Fromuth (1983) on the other hand, in her nonclinical female college students found that promiscuity was related to the self-image of the victims more than it was related to their actual behaviour. In other words, victims would view themselves as being promiscuous even though they did not actually behave promiscuously.

However, studies by James and Meyerding (1977) as well as Silbert and Pines (1981) have found a connection between prostitution and child sexual abuse. Their findings (which also included adolescents, and will therefore be discussed later), however, have been disputed by Fields (1981) who matched a group of prostitutes with a group of non-prostitutes by age, race, and education. She did not find any significant difference in prevalence rates of early child sexual abuse between the groups (45% of the prostitutes compared to 37% of the non-prostitutes).

On the other hand, there is much empirical evidence with respect to clinical samples supporting the connection between child sexual abuse and later substance abuse--both alcohol and drugs (Briere, 1984; Herman, 1981; Peters, 1984). This finding, as well, has been questioned by nonclinical sample studies such as that by Sedney and Brooks (1984). Their college student sample revealed no significant differences

between abused and nonabused groups and levels of substance abuse.

Overall then, the empirical work on later psychological/behavioural problems of women who have sexual abuse histories suggests evidence of depression, anxiety, poor self-image and perception, feelings of stigmatization, sexual problems, difficulty in interpersonal relationships, as well as a tendency toward substance abuse. Some of these connections are provided by clinical samples and are either supported or disputed by nonclinical sample studies. It appears that further research is necessary in order to clearly establish such associations amongst the above mentioned variables and early sexual abuse, with consistency amongst both clinical and nonclinical populations. Before reviewing the existing empirical work on the initial effects of child sexual abuse, a brief overview of studies identifying positive adult-child sexual relationships will be presented.

#### Positive Adult-Child Sexual Relationships

A number of authors assert the perspective that adult-child sexual relationships, particularly incestuous ones, do not necessarily result in harmful consequences (Constantine, 1980; Demott, 1980; Nelson, 1981; Nobile, 1978; Pomeroy, 1978; Ramey, 1979; Rosenfeld, 1979). It is maintained that the incest "taboo" should be re-examined, since certain previous sexually "taboo" behaviour has become acceptable or at least

not viewed as destructive. Homosexuality and masturbation for example were at one time considered to be taboo activities. Currently, these sexual practices are even encouraged by some therapists who view them important for healthy sexual awareness and growth. Certain researchers similarly believe that the incest taboo should be weakened. They claim societal reactions to incest whether, sibling or adult-child, cause negative psychological effects and if the incest taboo were weakened, this sexual behaviour could provide a positive experience in the form of "a particular sense of the self" (Demott, 1977: 1).

These assertions are based on very limited and often very dated empirical research. In addition, the available data often include both peer and adult-child relationships implying that both types of relationships are equal in terms of the participants' understanding and consensus. This implication may be inappropriate as all differences appear to be crucial to understanding negative outcomes. There are a few studies indicating neutral to positive outcomes for early childhood sexual experiences with adults; however, not only are these studies few, but also negative sequelae are identified within the same populations. Nelson (1981), for example, conducted a study exploring various forms of family incest utilizing a population sample which she identified as predominantly of middle-class background. Subjects were recruited through advertisements. Out of the 100 respondents, and 137 incest experiences reported, 73 incidents were reported as positive,



54 as negative and 10 as uncertain. Although sibling incest was also reported in this study, the most common reported relationship was between father and daughter. A questionnaire was administered including demographic data and self-report questions about the incestuous relationship ranging from background to the effect of the incident as perceived by the subject. The responses were evaluated and rated by a professor, a social worker and an intern in a sexual abuse treatment program. Twenty-five percent of the reported positive experiences were between an adult and a child. Nelson notes that incestuous experiences can provide "self-actualization" within a "safe environment" (p. 163). However, in her conclusions, she also notes that the overall trend in her study was that incest between adult and child appeared to be more likely negative, "suggesting issues of power and freedom of choice..." (p. 174).

Rasmussen (1934) conducted a study on 54 children who were victims of assault including incest. The sample source was court records and all the children were in a hospital setting. With respect to the long-term effects, he concluded that 46 of the 54 children had made "normal adult adjustments." As Henderson (1983) notes, however, Rasmussen's assessments were based on "social parameters such as showing satisfactory citizenship and not being in difficulty with law enforcement agencies" (p. 38) rather than psychological criteria.

In defense of the beneficial effects of incest, Rascovsky and Rascovsky (1950) discuss in detail the sexual relations between a father and a daughter and indicate that the incestuous relationship prevented the daughter from becoming manic-depressive. In this case,

frustration in the infant-mother relationship and attempts at restoration from the basic depressive position led to a precocious transition to the oral search for the father. The real satisfaction afforded by incest led to a greater capacity for sublimation compensating for intense anxiety over failure to obtain an orgasm (Henderson, 1983: 38).

Weiner (1962) examined parental incest in families with prolonged incestuous relationships and he concluded that "the incest is often not found to be disrupting the family, but rather to be sustaining some kind of stable neurotic equilibrium" (pp.123-124). He found that when the relationship ended, psychological repercussions unfolded because of outside, societal pressures causing huge disruption in the family. He also notes that while "incestuous involvement with a parent is psychologically crippling for some children, others are found to not have suffered any pronounced adverse effects from such an experience" (p. 123).

For the most part, studies reporting positive effects on incestuous relations whether between adult and child or peers utilize data based on psychotherapists' opinions. As a result, although theoretical propositions and hypotheses on the potential beneficial effects of incest (DeMott, 1980;

Henderson, 1983; Ramey, 1979) may be persuasive, there is yet a lack of well designed empirical evidence to support these claims. For example, the "child seduction theory" as described by Freud (1924) which places the blame for sexual victimization on the child has yet to be validated. Not only are there little data available but also the social and familial contexts were not clearly explicated (see DeYoung, 1982). Studies by Bender and Blau (1937) and Bender and Grugett (1952), Krieger et.al., (1980) and Lukianowicz (1972) for example, in which this theory on "child seduction" has been suggested provided a speculative analysis based on a few scattered case studies. Such conclusions placing the responsibility on the child for his or her victimization have obvious implications for the offender. As deYoung (1982) suggests, "it not only minimizes their offensive roles but it incorrectly disparages the negative effects of incest" (pp. 56-59). After all, if the child encourages and initiates the incest, then the actual act in of itself cannot be damaging.

While it is plausible that incest is not always harmful, the evidence is not at all convincing. Thus the notion that "sexual reform in the family" is necessary if we are to purge the concept of its taboo implications must yet be re-evaluated and reassessed (Constantine, 1973; Oremland & Oremland, 1977; Pomeroy, 1978). In other words, the elimination of problems associated with incestuous behaviour as simply a matter of weakening its taboo references, appears to be an oversimplified

solution to a very complex societal as well as psychological phenomenon.

In reconciling such opposing claims with respect to the effects of child sexual abuse, further research is obviously necessary. Research on the initial reactions to sexual abuse amongst various adolescent populations is increasing in addition to the long-term studies as a further attempt to better inform our current understanding. Researchers have argued the importance of studying the psychological and behavioural responses as close to the abuse as possible. In this way, recollection of the experiences may be more accurate because less time has transpired between the abusive event and the psychological reactions to it. Preventive and/or therapeutic measures may be taken as soon as possible alleviating or perhaps preventing the more prolonged and potentially destructive effects. This next section will review the brief literature on the initial effects of child sexual abuse.

### Initial Effects of Sexual Abuse

Because the focus of this thesis is on describing the profiles of institutionalized adolescents and whether or not symptoms commonly associated with sexual abuse backgrounds appear amongst the population in question, a literature review of the empirical work on adolescents and/or the effects of child sexual abuse soon after and/or during the occurrences of

abuse is necessary. However, there are considerably fewer studies on adolescents mostly because of age-related ethical issues. The following section will constitute a brief overview of the empirical work available on the initial effects of sexual abuse. Studies which utilize adolescent populations to ascertain associations between various psychological, emotional and behavioural problems and sexual abuse will be reviewed.

### **Affective/emotional responses**

Empirical studies on adolescents generally demonstrate that negative affective/emotional responses are associated with childhood sexual abuse (Anderson, Bach and Griffith, 1981; Blumberg, 1981; DeFrancis, 1969; Gomes-Schwartz, Horowitz & Sauzier, 1985; Tufts, 1984). Two of these studies utilized standardized measures--Tufts (1984) and DeFrancis (1969). Emotional reactions reported in these studies include depression, anger, hostility, fear, guilt, phobias, shame as well as several neurotic disturbances. The Tufts (1984) study which is considered to be the best study on an adolescent population to date (Browne and Finkelhor, 1985) found differences in levels of pathology and types of disturbances amongst age groups. This finding is also supported by Gomes-Schwartz et. al. (1985) in their clinical study of 112 preschool, school-age and adolescent children who had all been sexually abused. Findings from the Gomes-Schwartz et. al (1985) study utilizing the Louisville Behaviour Checklist suggest that

as a group, children who had been sexually abused manifest more emotional as well as behavioural harm compared to children in the general population. Twenty-four percent showed clinically significant pathology on the neuroticism scale measuring anxiety, depression and obsessive concerns and 21% showed pathology on the dependent-inhibited scale which included a measure of lack of self-confidence. They conclude that emotional/psychological harm does not manifest itself in a single typical pattern. Each child's response to the stress of sexual victimization depends on his or her previous experiences and current developmental level.

The Tufts (1984) clinical study with a total of 156 subjects, 122 females, 34 males, reported that "clinically significant pathology was found in 17% of the preschool age group. The highest psychopathology score was found in the latency age group--40% scored as "seriously disturbed." Of specific interest to note and recall for later in this study is Tuft's finding that most of the adolescent victims did not exhibit severe psychopathology, although they did score highly on the measure of neuroticism. Also evident amongst the adolescent group were high scores on fear of being harmed ("ambivalent hostility" 36%) as well as outward hostility and anti-social behaviour (23%). The Tufts study, however, did not find any significant evidence of lower self-esteem across the age groups, (a symptom commonly associated with sexual abuse victims as noted in the studies of older populations), when

they were compared to the standardized scores of children in normal populations.

The DeFrancis (1969) study which also utilized a standardized objective measure is considered, however, to be more questionable methodologically (Browne and Finkelhor, 1985) than the Tuft's study because of from where her sample was drawn (court cases), thus limiting the generalizability of her results. Nevertheless, she reports that 66% of the victims reported emotional disturbances as a result of sexual molestation and 14% reported serious emotional disturbances. Her sample included a total of 250 subjects.

Anderson, Bach and Griffith (1981) found that 63% of the 155 female adolescent sexual assault victims from the Harbourview Medical Centre in Washington, manifested symptoms of psychosocial problems. Standardized measures were not used in this study, however. Frequencies ranged from 49% (non-family member offender) to 67% (family member offender) demonstrating what they referred to as "internalized psychosocial sequelae" (fear, phobias, depression, self-image, anger, somatic and eating problems and 21% (non-family abuse) to 66% (family member abuse who showed "externalized sequelae" problems (truancy, problems in school, running away).

### Behavioural consequences

A range of behavioural problems from eating disorders to

violent acting out have been evidenced in adolescents who have experienced sexual abuse. Runtz and Briere (1985) have noted a variety of "acting-out" behaviours which were commonly reported amongst the abused subjects in the sample. Out of 278 female undergraduates sampled, 39 were abused and 111 were not abused. On a 29-item Teenage Behaviour Inventory, the following behaviours were more likely to be associated with the abused subjects: problems with school, authority conflicts both with parents and the law, eating disorders and sexual disorders. Similarly, Sibert and Pines (1981) found many of the same behavioural problems as Runtz and Briere (1985) in their survey of 200 street prostitutes from San Francisco. Seventy percent of the sample was under 21 at the time of the survey and 96% reported being runaways as a result of sexual, physical or emotional abuse. Along with the finding that 60% of these subjects were victims of child sexual exploitation, the majority of the respondents felt that their prostitution was directly associated with their earlier sexual assault (See Browne and Finkelhor, 1986). Reich and Gutierrez (1979) found that sexually abused juvenile delinquents engage in more escape and antisocial behaviours. Their research provides a test to discount the theory that sexually abused juvenile delinquents are more aggressive than non-abused. A control group of non-abused delinquents demonstrated similar levels of aggression as the abused group. Frequency of escape infractions were more highly noted in the abused group.



Bagley (1984), in his review of all his empirical work identified the following behavioural problems as a result of early sexual abuse in adolescents: suicidal gestures, self-mutilation, induced obesity, anorexia, hysterical seizures, self-punitive lifestyle, running away from home, prostitution, frigidity, aggression and chronic delinquency.

A study by Ross (1980) demonstrates a link between child abuse and self mutilation. The sample involved female adolescent offenders from a correctional institution. Out of 120 girls interviewed, 80% had "carved" themselves at least once while in the institution and 58% had carved themselves more than once.

Suicidal behaviour amongst sexually abused adolescents has also been given empirical support by Byles (1980), Deykin, Alpert and McNamarra (1985), Goodwin, Simms and Bergman (1979) as well as Herman and Hirschman (1981). Hysterical seizures were especially notable in the Goodwin et al. (1979) study as a sequel to incestuous abuse. The six case-reports reviewed included adolescent patients who were referred for "psychotherapeutic exploration". In addition to hysterical seizures and suicidal attempts, Goodwin et al. (1979) also found their reports to contain incidents of running away and sexual problems.

Mannarino and Cohen (1986) also noted in their evaluation of 45 sexually abused children, 39 girls and 6 boys between the

ages of 3 and 16, (69%) displayed psychological behavioural symptoms such as bedwetting, nightmares, clinging behaviour, and inappropriate sexual behaviour. The shortcoming of this study is its lack of a systematic control group.

Herman and Hirschman's (1981) study which looked at 40 therapy patients who were victims of father-daughter incest were compared with 20 patients whose fathers were seductive but not overtly incestuous. Thirty-three percent of the incestuous group attempted running away compared to 5% in the seductive group. Also Meiselman (1978) noted that 50% of the incest victims in her sample left home before the age of 18 as compared to 20% of the nonvictimized female control group. Studies by Anderson et. al. (1981) and Peters (1976) both found that problems in school including truancy and/or dropping out was prevalent amongst the abused subjects in their respective samples.

#### Methodological Problems of Present Research and Summary

Whatever the outcome of studies on the effects of incest and/or sexual abuse, whether positive or negative, the quality of the research is still plagued with methodological inadequacies rendering whatever results to be questionable. For example, information has often been based on the varying opinions of psychotherapists. Samples are either too small or limited in terms of generalizability, control groups are lacking, instrumentation may be weak or of questionable

validity in measuring the phenomenon and long term follow-up work is still in the formative stages. Browne and Finkelhor (1986) indicated certain fundamental problems in the sampling alone, posing problems for empirical analyses and results. Such difficulties include the composition of samples, which are predominantly female, inconsistent definitional parameters, studies which include family member perpetrators and adult perpetrators only, excluding coercive sex between older adolescents and young children. These differences across studies, as indicated by Browne and Finkelhor (1986) are what "make comparisons among studies difficult" (p. 66). In addition to all these problems, with reference to adolescent populations, sampling is further fraught with ethical difficulties not only because of the obvious sensitive nature of the topic, but also because of the age of the subjects being tested. Research utilizing subjects who are legally defined as "underaged" are then questioned as to their capability or potential to participate in such studies. It is no wonder, then, that the obvious result of all this is the "inadequate samples" referred to and criticized by researchers and reviewers alike.

Insofar as instrumentation is concerned, recent studies have improved. Data based simply on clinicians' judgments are being replaced by results based on more objective measures, including the Minnesota Multiphasic Personality Inventory (MMPI) (Browne and Finkelhor, 1986), the Middlesex Hospital

Questionnaire (Bagley and Ramsey, 1985), and the Hopkins Symptom Checklist (Briere, 1984). However, researchers are for the most part still in the process of pilot testing various measures in trying to ascertain their validity and utility in explicating the incest and child sexual abuse phenomenon.

### III. DEFINITIONS, METHODS AND PROCEDURES

The focus of this chapter will be to describe the design, method and procedure used to investigate the psychological and behavioural problems of the adolescent residents. In addition, the choice of measures will be explained to justify why they are considered to be appropriate in providing both research information and advice for clinical assessments. To begin with, operationalizations for the terms "incest" and "child sexual abuse" are necessary.

#### Operational definitions

The operational definition for child sexual abuse to be used in this study is derived from definitions employed in previous major research such as Briere (1984), Bagley (1985), Finkelhor (1979), and a review by Gelinas (1983). A comprehensive as well as a consistent conceptualization of child sexual abuse is available from this research.

Child sexual abuse essentially denotes sex between an adult and a child. The concept clearly indicates a power differential between two persons--the adult being the one in control by virtue of age, stature and experience and the child subservient because of inherent vulnerability in knowledge, authority and physical status. The term "abusive" identifies the sexual experience as having been unwanted and coercive.

Because the measures used in this study replicate for the most part the measures used by Briere (1984, 1985) except that in the present study they were administered to an adolescent population rather than an adult population, the parameters of what will be considered as sexual abuse in this study will follow Briere's (1984) definition: "any sexual contact between someone under fifteen and anyone five or more years their senior who was at least sixteen" (p.4).

#### Description of the sample

The population surveyed in this study involved institutionalized adolescents between the ages of twelve to sixteen. The subjects were residents at a provincially funded psychiatric adolescent facility. The present population had been institutionalized for an average length of about eight months, at the time this study was conducted. Most of the residents have reported histories of sexual abuse. All the residents were contacted and their voluntary participation was solicited. Those choosing to participate signed a consent form (see appendix). Four residents refused to participate, resulting in a total sample size of 47 including 20 females and 27 males. The sample used for the data analyses in this study, however, consist only of the 20 females. The initial intention of the study was to compare the psychological and/or behavioural problems of sexually abused females with sexually abused males as well as comparing those sexually abused with

those who were not sexually abused. The actual breakdowns of sexually abused males and females did not allow for this (5 out of 27 males and 15 out of 20 females had sexual abuse histories). In addition, the breakdown between those sexually abused with those not sexually abused were not sufficient to conduct comparative analyses. Thus, because of these limitations of the sample, my discussion will include a description of the psychological profiles of only the abused females in the sample.

### Design

The research design chosen was clearly influenced by ethical considerations with reference to conducting research on an adolescent institutional population. It was necessary to protect the subjects from embarrassment as well as avoid violating the privacy of those who agreed to participate in this study. Furthermore, in order to enhance the validity of the study it was necessary to consider a design which would not be viewed as intrusive by the respondents. In this way, their responses could be as truthful as possible. It was not feasible, therefore, to utilize methods such as observational and/or interview in gathering information. While these approaches are considered to enhance the validity of one's data (Bailey, 1982), it was not unexpected that even a careful and sensitive inquiry of this nature was unattainable because it was not possible to obtain the appropriate consent. Consent had

to be obtained from four sources: the Ministry of Health and Welfare, the director/staff of the facility, the adolescents' parents and the adolescents themselves. In most cases, the adolescents' parents were impossible to locate. As indicated above, an intrusive method risked not only consent denial from the various parties, but also raised concerns about confidentiality, age of subject participation, and fallout problems.<sup>1</sup>

Given these considerations, it was necessary to use file data to obtain demographic data and prior sexual abuse history as well as related information. These data might not always be reliable. There were associated difficulties in extracting data from the files as these were not systematically recorded nor were they established, obviously, with the researcher's interests in mind: not an uncommon reality when accessing archival materials.

Survey instruments were chosen to apply the key measurements. In considering the priority of protecting the subjects, the various ethical constraints, and the exploratory purpose of testing and/or assessing the utility of various measures, the survey approach appeared to be the most efficient and acceptable choice.

### Instrumentation

The measures chosen for this study have been used in past empirical work on various adult female clinical and nonclinical



populations. Several clinical and background measures which have been used in past sexual abuse studies, the SCL-90-R, the Dissociation Scale and the Teenage Behaviour Inventory, were administered to this population. These measures will subsequently be assessed in terms of their utility in identifying and explaining the psychological and behavioural problems of this institutionalized population of adolescents. If validated in this study, generalizations about the clinical utility of these measures for other similar facilities can then be considered.

#### Description of the measures

Selection of the psychological scales was based on their brevity, ease of administration and subject completion, availability of adolescent norms and of course their popularity as valuable clinical/research measures and potential treatment outcome measures.

##### A. SCL-90-R

The first measure used was the SCL-90-R. It is an expanded version of the Hopkins Symptom Checklist (HSCL), the measure used by Briere (1984) in his study on the "post-sexual-abuse-syndrome". The SCL-90-R consists of ninety items. Each of the items is rated on a 5-point scale (0-4) of distress, ranging from "not at all" to "extremely". The items are scored and interpreted in terms of nine primary symptom dimensions and three global indices of distress.

## SYMPTOM DIMENSIONS:

1. Somatization - This dimension measures distress which may arise from perceptions of bodily dysfunctions. Various symptoms such as headaches, gastrointestinal problems, or general soreness of the body are all considered to be reflective components of this symptomatic dimension.

2. Obsessive-Compulsive - This symptomatic measure focuses on thoughts impulses and actions that the individual engages in, as an unwanted but also as an irresistible, unremitting behaviour. Cognitive experiences of this nature are also included.

3. Interpersonal Sensitivity - The focus of this dimension is to measure an individual's feelings of personal inadequacy or inferiority. How one feels in comparison to others, especially during interpersonal interactions such as discomfort or self-consciousness are all manifestations of this dimension.

4. Depression - Symptoms reflected in clinical depression are measured by this dimension. They include dysphoric mood and affect, lack of motivation, loss of energy, suicidal thoughts, various somatic equivalents, and signs of disinterest in life are all symptoms considered to comprise this dimension.

5. Anxiety - The symptoms related to this scale are associated with clinically high levels of anxiety. The characteristic manifestations include signs of nervousness, tension, trembling, panic attacks and feelings of terror.

6. Hostility - Aggression, irritability, rage and

resentment are all characteristic feelings and/or actions of this symptom dimension. Overall, this dimension is expected to tap into an individual's thoughts, feelings or actions that reflect a negative affect state of anger.

7. Phobic Anxiety - This dimension focuses on pathognomic and disruptive manifestations of phobic behaviour defined as persistent fear responses to specific persons, places, objects, situations. It is often irrational and disproportionate and can lead to avoidance behaviour.

8. Paranoid Ideation - Symptoms considered as representative of this dimension include projective thought, hostility, suspiciousness, grandiosity, centrality, fear of loss of autonomy, and delusions. This dimension, overall, measures a disordered mode of thinking.

9. Psychoticism - This scale provides a measure of the level of psychosis ranging from mild interpersonal alienation such as withdrawal or isolation to clear evidence of psychosis such as hallucinations or thought broadcasting. This scale is constructed to represent this symptomatic dimension as a continuous human experience.

#### ADDITIONAL ITEMS:

In addition to the items associated with measuring the nine symptom dimensions, there are seven extra items. These are part of the SCL-90-R, but they are not considered to be a part of the primary dimensions. Rather, the symptoms measured

by these items may be clinically important as "extras" to the several primary dimensions; they are not, however, univocal to any of them. Thus, these items contribute to the global scores. In other words, while they are not scored collectively as a dimension, they are summed into the global scores.

#### GLOBAL INDICES OF DISTRESS OF THE SCL-90-R:

The three global indices of distress are the Global Severity Index (GSI), the Positive Distress Index (PDSI) and the Positive Symptom Total (PST). Each of these indices measures the level or depth of the individual's psychopathology. Each focuses on different aspects of psychopathology. GSI, for example, measures intensity of distress; PDSI measures symptomatic distress; PST provides a count of the number of symptoms the patient reports. The GSI is the best single measure indicating the current depth of disorder. PDSI measures "response style" in that it indicates whether the individual is increasing or diminishing symptomatic distress by the way he/she reports the disorder. The PST, as it counts the number of "positive" symptoms reported, may be used configurally with the GSI score. This information is very useful for an overall clinical picture.

#### RELIABILITY AND VALIDITY OF THE SCL-90-R:

Two types of reliability measures were used to assess the consistency of the SCL-90-R (Derogatis, Rickels & Rock, 1976; Nunnally, 1976). Selected items representing each symptom construct were assessed in terms of their homogeneity and their

stability of measurement over time. Internal consistency measures homogeneity of the construct items in reflecting the underlying factor and test-retest reliability (Cook & Campbell, 1979) measures consistency with respect to stability and equivalency of the measures over time. The different dimensions assessed for their internal consistency were calculated from a study involving 219 "symptomatic volunteers" (Derogatis, Rickels & Rock, 1976). Coefficients ranging from .77 for Psychoticism to .90 for Depression were generated, indicating high consistency of measures. Most researchers consider test-retest reliability generated coefficients of between .80 and .90 to be an acceptable level for symptom construct measures. These coefficients were obtained from a sample of 94 heterogeneous psychiatric outpatients. They were assessed in an initial evaluation and reassessed a week later (Nunnally, 1976).

Validation of the SCL-90-R, given its popular use as a self-report symptom inventory, has involved a continual process of experiments with a key objective being the testing the generalizability of the construct. For example, the dimension scores for the 90 SCL-90-R items were contrasted with MMPI scores (Derogatis, Rickels & Rock, 1976). A high degree of convergent validity and factor structure was ascertained.

## **B. Dissociation scale**

In addition to the nine dimensions of distress in the SCL-90-R, Briere and Runtz (1985) devised items to provide a measure of dissociative symptoms. This is the second measure which was administered. Previous research had shown symptoms of dissociation to be prominent as part of the psychological trauma of sexual abuse. The five items: feeling outside of your body, not feeling like your real self, "spacing out", losing touch with reality, watching yourself from far away, are rated on the same scale as the SCL-90-R. The reliability of the Dissociation dimension was scored twice based on a sample of 278 female undergraduate students (Briere and Runtz, 1985) on the symptomatology associated with prior sexual abuse in a non-clinical sample. The first score referred to the "acute" condition (symptoms experienced in the last 7 days) and the second referred to the "chronic" condition (symptoms experienced in the last year). Both acute and chronic scoring resulting in Chronbach's alphas of .76 for all items indicating that the dissociation measures have substantial internal consistency. These results suggest that the SCL-90-R could provide useful clinical measures for analyzing the present sample of institutionalized adolescents.

## **C. The Teenage Behaviour Inventory**

The second measure, the Teenage Behaviour Inventory, is a 29-item inventory devised by Runtz and Briere (1985).

Respondents were asked to indicate on a scale of 1 to 5 the extent to which they had engaged in certain behaviours. Such behaviours include going to parties, running away from home, drinking alcoholic beverages--(see appendix). The TBI has been considered useful in comparing sexually abused and non-abused females. Runtz and Briere found that sexually abused females were more likely to skip school, lie to their parents, get in trouble with the law, undereat, do poorly in school, dress in clothes that made them look "sexy" and have homosexual contact.

Finally, basic background and demographic information, as well as clinical data were obtained from the residents' files (see appendix). Information on prior sexual abuse, criminal activity, physical abuse, abandonment, and suicide attempts were also coded and used to control for possible confounding variables threatening the validity of the measure (see Langbein, 1980) as well as for corroborative verification of the participants' reports.

There is research that indicates that the above measures have been able to connect various types of psychological and behavioural problems with prior sexual abuse (Briere, 1984; Finkelhor, 1979; Runtz and Briere, 1985). These studies, however, were conducted only on clinical and non-clinical adult female populations. It is clearly necessary that these measures be administered to adolescents in order to provide information on their clinical and/or research utility for this population. Fortunately adolescent norms for the measures are

available, therefore, it will be possible to compare the study sample scores on these measures to these norms. Again, the above measures have been chosen because of their hypothesized value of identifying an association between prior sexual abuse and various presenting psychological/behavioural problems in adults. Another reason these measures were selected for the study was that staff at this facility indicated that although residents consistently reported sexual abuse histories, staff felt unsure about the accuracy of the prevalence rate. In addition the staff wanted to begin to assess the effectiveness of their program in addressing the clinical needs of the residents. In order to provide this information, it would be first necessary to pilot test several clinical and background measures for their utility in providing profiles of the residents. If validated, these measures could then be employed as program/treatment assessment tools.

### Survey Procedure

The measures were administered at a psychiatric facility which is part of the British Columbia Juvenile Services Commission where the respondents were residing. Upon receiving consent, each participant completed the SCL-90-R, the Dissociation Scale and the Teenage Behaviour Inventory while at the institution. The questionnaires were administered in a private room and a researcher was available if any questions arose. The respondents took about fifteen to twenty minutes to



complete the measures. The instructions indicated that the information obtained would be used for group analyses only. As well, at any time during the completion of these measures, the respondent could choose to withdraw his/her responses if they considered the questions to be too intrusive (see appendix) and the questionnaire would be destroyed.

## Notes

<sup>1</sup>"Fallout" was a term used at the facility to simply refer to a relapse or a deterioration in the resident's condition. The staff claimed that such a relapse was usually caused by some sort of external influence.

#### IV. RESULTS

In this chapter, the sample of adolescent females will be described. Information on the results of the survey measures, the SCL-90-R, the Dissociation Scale and the Teenage Behaviour Inventory will be discussed only with reference to the females who had reported histories of sexual abuse. Describing these profiles will permit an initial consideration of the potential value and/or usefulness of the measures in addressing problems commonly associated with sexual abuse backgrounds (as identified in past empirical work) for this population.

##### Limits of the data and overview of analyses

Fifteen (75%) of the twenty females fell into the abused (11) or suspected abused (4) categories. Only five females did not report being sexually abused. Because of this uneven breakdown, comparisons between abused versus not abused and presenting psychological/behavioural problems for the females were inappropriate.<sup>1</sup> Furthermore, as mentioned in Chapter III because of the various ethical issues raised by both the staff and the directors about confidentiality, consent, age of subject participation, and fallout risks, data including abuse history, demographic and other background information were obtainable only from the files. Unfortunately, the files did not contain any information on the nature and/or frequency of abuse, therefore it will not be possible to determine associations between levels of abuse and intensity of

presenting psychological problems.

### Background information

#### **Demographics**

The average age for the females was slightly over 15, with a range of 13 to 17. Fifty-three percent of the females were caucasian; 40% Native Indian, and 7% East Indian. Given that the average age of this group was a little over 15, it is interesting to note that the average year of education completed was 7.9 years. Only 4 females were known to be in school at the time of admission to the institution. None of the females were employed prior to admission. Overall, this sample may be characterized as undereducated and unemployed. The institution where they were admitted emphasizes its school program to the residents. Clearly, it is a critical part of the residents' overall institutional program in that it may facilitate the residents' reentry into the school system upon discharge as well as improve their education while they are undergoing treatment.

#### **Institutional history**

Data on the residents' institutional history were also available from the files. Only four of the fifteen females were admitted to the institution from home. The rest were admitted from group homes, correctional facilities, or from other psychiatric inpatient facilities. The average time since admission was eight months, with a range of a few weeks to ten

months. All but one of these females had prior admissions to psychiatric facilities. Four had been previously arrested and their charges included: breaking and entering, public mischief, assault, and auto theft. It is evident from the data that this population of adolescent females is one which has been significantly involved with social and legal agencies.

### **Diagnostic information**

The most common diagnosis for this group of women was reflective of what the institution considered to be a "conduct disorder". This was the overall diagnosis for twelve (80%) of the fifteen females. A diagnosis of "thought disorder" was reported for three of the fifteen females. According to the facility, a diagnosis of conduct disorder meant that the individual tended to engage in "acting out" behaviours. Whereas, a diagnosis of thought disorder generally meant that individuals tended to have symptoms of depression, or phobic sensitivities.

### **Abuse history**

Out of the initial group of twenty females sampled, sexual abuse was overwhelmingly reported. Fifteen (75%) of the twenty had either reported (11) or were suspected (4) of having been sexually abused according to the information available in the case history files. Eight (40%) had been physically abused (5) or were suspected of physical abuse (3). Only one female was reported in the files as having been a sexual offender and only

one female had been identified as a physical abuse offender. Unfortunately, information on the nature, frequency and context of the sexual or physical abuse was not available in the files.

### Results of self-report measures

#### **SCL-90-R:**

For the SCL-90-R, scale scores were converted to standard (t) scores. The average score for the normative population corresponds to a t-score of 50. This t-score corresponds to a percentile rank of 50 which means that 50% of the normative samples scored above this level and 50% scored below. These norms are based on data of a sample of 806 male and female non-patient adolescents from two midwestern schools. Their ages ranged from 13 to 19. This population was almost exclusively white and middle-class. Forty to sixty percent of the sample was female. Separate norms were available for both males and females (Derogatis, 1977).

All average scores for the sample population of adolescent females were considerably higher than the averages for the normative sample (see Table 1, appendix). In general, what these scores indicate is that the sample of females reported considerably more symptoms than the normative population of adolescent females. Overall, the sampled females scored substantially on three scales: Phobic Anxiety (PHOB=61), Hostility (HOS=62), and Depression (DEP=60). All three of these scores were at or above a t-score of 60, corresponding to a percentile rank of 84. This means that 84% of the norm group

had scores below this level. Other scale scores such as Psychoticism (PSY=58), Somatization (SOM=56), Anxiety (ANX=57), and Paranoid Ideation (PAR=58) were also high in comparison to the scale scores of the normative population.

The "additional" SCL-90-R items, such as "poor appetite", "trouble falling asleep", "awakening in the early morning", "sleep that is restless or disturbed", "thoughts of death or dying" and "feelings of guilt" are neither considered to be part of the nine primary symptom dimensions, nor are they scored collectively as a dimension. Rather, they are summed into the global scores (Global Severity Index, Positive Distress Index, Positive Symptom Total). Derogatis (1977) explains that because these additional items are not univocal to any of the primary dimensions, they violate one of the statistical criteria for inclusion in the test; however they are considered to be clinically important, hence their inclusion in the Global Indices scores. For example, as Derogatis (1977) explains:

A high DEP score with 'early morning awakening' and 'poor appetite' may mean something quite different from a similar score with these symptoms absent. By the same token, the presence of conscious 'feelings of guilt' is an important clinical indicator, which communicates important information to the clinician (p. 11).

#### **Dissociative scale:**

Dissociative symptoms, as measured by the Dissociation Scale (Briere, 1984), generated a score of only .97. This

measure, like the SCL-90-R, was also a frequency of symptom scale ranging from zero to four. It is clear then, that this group of women scored quite low on this measure. Thus, dissociation does not appear to be a significant symptom dimension for this age group of females.

#### **Teenage Behaviour Inventory:**

The Teenage Behaviour Inventory (Briere and Runtz, 1985) elicited some very interesting results. The items in this measure were rated on a five-point scale of frequency ranging from "not at all" to "extremely often". The mean item scores are presented in Table 2 (see appendix). The mean scores for this particular sample were substantially high. For example, use of alcohol and drugs was reported as a fairly common activity (3.66 and 3.26, respectively). Suicide attempts were also numerous--12 of the 15 females (80%) indicated that they had made at least one suicide attempt. In the file data, nine had reported past suicide attempts. In addition, self-mutilation (Behaviour Inventory item #16) generated a relatively high mean score (3.80) indicating that these females tended to want to hurt themselves physically in order to punish themselves. Sexual activity also appears to be very common amongst this group. All of the females reported having had sexual intercourse at least once. Much of this activity may have been related to the abuse experiences, although the extent to which these two are related is unknown.

The Teenage Behaviour Inventory responses are very



consistent with the information obtained from the residents' files. Nearly three-fifths of the females were noted as having made suicide attempts in the past according to the file data. Self-mutilation, another common behaviour amongst this group of women according to the "Behaviour Inventory" was also reported in the files. Thirty percent had prior self-mutilation indicated in the files. Alcohol and drug problems were also frequently reported in the files for this sample.

## Notes

<sup>1</sup>Although the breakdowns were uneven and therefore comparative analyses were inappropriate, the differences in the mean scores between abused and not abused for the self-report measures were analysed. Only one item on the Behaviour Inventory ("visit a prostitute") emerged as significant at the .05 level (see Table 2, pp. 91-92). Another Behaviour Inventory item, "running away from home" resulted in a significance level of .09. While some may argue that statistical significance may be ascertained, it is disputable (see Fritz & Altheide, forthcoming).

## V. DISCUSSION AND CONCLUSION

The purpose of this thesis was to assess the usefulness of certain self-report measures (see appendix) which in past studies have been used to identify psychological and/or behavioural distress associated with sexual abuse. A sample of adolescent women residing in a mental health facility voluntarily were subjected to various measurement instruments for assessing psychological and behavioural distress. Sexual abuse histories were located and verified through the file reports. It was anticipated that a sample of adolescent women from a mental health facility claiming to have a high rate of residents with sexual abuse backgrounds would have the greatest potential for identifying and describing the symptomatology resulting from sexual abuse.

The measures administered to this population included the **SCL-90-R** the **Dissociation Scale** and the **Teenage Behaviour Inventory (TBI)**. Past studies have claimed that the above measures have been able to describe and/or identify a connection between various types of psychological and behavioural problems and prior sexual abuse (Briere, 1984; Finkelhor, 1979; Runtz and Briere, 1985). However, these studies were conducted only on clinical and non-clinical adult female populations. As yet, studies using these measures with adolescent sexually abused populations have not been conducted despite the availability of adolescent norms. The above

measures were, therefore, selected on the basis of their claimed value of identifying the association between prior sexual abuse and presenting psychological and behavioural distress.

The purpose of this chapter will be to discuss the findings of the study as presented in the previous chapter. In addition to providing observations suggested by the analysis of the data, suggestions for improvements to the present study as well as for future studies in this area will also be included.

### Prevalence of sexual abuse

The data presented in the thesis indicate that the incidence of sexual abuse is quite high amongst the female population of this local mental health facility. Along with findings published by Briere (1984) on the incidence rates of sexual abuse amongst adult female clinical groups, the present data strongly suggest that adolescent female clinical groups include a large proportion of sexual abuse victims. As Briere (1984) notes in his study on the post-sexual-abuse-syndrome, these data on prevalence rates simply indicate that abuse victims are generally "overrepresented" amongst "therapy-seeking groups of women" (pp. 7-8).

Findings by Finkelhor (1979), Russel (1983), Bagley (1985), Briere and Runtz, (1985) and others on the frequency of sexual abuse in North American society have also noted its common occurrence amongst "normal" populations. About one in

four women were found to have been sexually abused as children. Also, these studies have noted that approximately one in every five victims have experienced significant negative aftereffects.

The implications of victim prevalence rates, specifically with regard to their magnitude amongst clinical populations, are particularly important for mental health practitioners (Briere, 1984; Butler, 1978; Herman 1981). In the present investigation, which focused on institutionalized adolescent females and found that over half had sexual abuse histories, it appears to be useful for mental health professionals to consider specific treatment programs to treat current associated problems and therefore to possibly prevent the onset of more significant ones as well (See Briere, 1984). Butler (1978) and Herman (1981) have discussed in their studies how mental health practitioners would neither routinely ask about sexual abuse nor would they believe their clients' stories. In short, traditional psychotherapeutic approaches to client problems did not address sexual abuse. Today, mental health practitioners are much more sensitized to the sexual abuse problem; however, much more specific information is needed in order to better understand and treat the resulting negative effects. For example, much work still needs to be done on the sexual abuse of adolescents. This would allow for a better understanding of the "initial" presenting negative effects (See

Browne and Finkelhor, 1985).

In the present study, information on the extent and nature of prior sexual abuse experiences was not obtainable due to concerns about confidentiality and potential negative (fallout) effects on the residents. However, file information as it is presently recorded, does not provide sufficient detail about the nature and frequency of abuse. Given that the rate of sexual abuse is so high amongst the sample population for this study, and given the viable concerns for investigating and interviewing adolescent populations on the details of their abuse experiences, it would appear that more carefully recorded and detailed file information is needed. In this way, more sophisticated analyses may be conducted in providing a greater understanding about the context, levels of abuse and related "initial" psychological outcomes (See Briere and Runtz, 1985 and Browne and Finkelhor, 1985).

#### Psychological and behavioural problems

Past research on the long-term effects of sexual abuse on adult females has shown that these women experience a number of symptoms which distinguish them from other females (Briere, 1984). Such symptoms include dissociative experiences, anger, self-mutilation and destructiveness, substance abuse and changes in sexual functioning as well as higher than normal levels of fear, anxiety, depression and hostility (See Browne and Finkelhor, 1985 for a review of the research on the effects

of sexual abuse on psychological functioning and Chapter II of this thesis).

In the present study, certain self-report measures, the SCL-90-R, the Dissociative Scale and the Behaviour Inventory, all previously used in research on long-term problems associated with sexual abuse (Briere, 1984; Runtz and Briere, 1985) were administered to the sample population of adolescent females. The adolescents' responses to these measures yielded very similar results to past research on female adults and adolescents.

The SCL-90-R, for example, yielded some interesting and significant information regarding presenting symptoms in the sample. Three symptom dimensions in particular, Phobic Anxiety, Hostility and Depression were most pronounced in the sampled population. These findings support data published by Tufts (1984), DeFrancis (1969), and Gomes-Schwartz et. al (1985) also on adolescents. The Tufts study is, in fact, considered to be one of the best studies on child sexual abuse and adolescents to date. These studies also utilized standardized measures including aggression and antisocial behaviour (Louisville Behaviour Checklist), hostility (Gottschalk Glesser Content Analysis Scales), self-concept (Piers-Harris Self-Concept Scale, Purdue Self-Concept Scale). The emotional and/or psychological responses reported in these studies included depression, hostility, and phobias as three of the main neurotic disturbances. Other symptoms noted in these studies

were anger, fear, guilt, shame, low self-esteem and obsessive concerns. In the present study, anxiety, psychoticism, somatization and paranoid ideation also emerged as significant symptoms experienced by this population. Briere (1984), in his work on the long-term effects of sexual abuse, also found that his respondents reported higher than normal levels of restless sleep, nightmares, and anxiety attacks. Briere also utilized the initial version of the SCL-90-R called the Hopkins Symptom Checklist. It is of interest therefore to note that his study, which attempted to investigate the association between sexual abuse and later psychological symptomatology by comparing an abused group of women to a non abused group, yielded similar symptomatic results as the findings of this study which simply attempted to describe the profiles of a group of adolescent females. Although no causal associations may be made in this study, the high prevalence rate of sexual abuse amongst the total population would appear to suggest a similar association. Furthermore, the findings of this study along with the findings of Briere's work would appear to suggest that certain psychological problems may persist into adulthood and become chronic conditions. Thus, the implications for greater and more refined interventions and mental health services that can directly deal with the victimization experiences, especially before they become chronic problems later in life, appear to be particularly acute.



With regard to the usefulness of the SCL-90-R in measuring relevant clinical symptoms commonly associated to sexual abuse histories, it seems to be effective. Given the results of the present study as they compare to results of other studies in the area, the SCL-90-R yields useful information, especially in identifying individuals in need of certain specific treatment programs. As well, it has the advantage of being a brief and easy to administer measure. Moreover, if treatment programs were initiated, the SCL-90-R would be a good measure of change in symptoms from pre to post treatment.

The Teenage Behaviour Inventory appeared to be a reliable method of obtaining information about the frequency of selected behaviours. In fact, the TBI may also be useful in comparing sexually abused and non-abused females. Briere and Runtz (1985) found that sexually abused females were more likely to skip school, lie to their parents, get in trouble with the law, undereat, do poorly in school, dress in clothes that made them look "sexy" and have homosexual contact. The results for this sample on the TBI also showed high frequencies on the same items with the exception of "getting in trouble with the law". Suicide attempts, self-mutilation, substance abuse and sexual intercourse were the items which scored the highest and have the greatest implications in so far as treating and preventing such behaviour.

The high frequency rates of suicide and self-destructive behaviour have been noted to be especially high in victims of

sexual abuse. Briere, Runtz and Lightfoot (1985) discovered that suicidal attempts were considerably more common amongst the sexually abused clients in their sample as compared to the non-abused clients. In fact, they suggest that "sexual abuse victims, especially children and adolescents, are at greater risk for suicidality and suicide attempts than non-abused individuals" (p. 3). Self-destructiveness was also cited in their study as a common sequel behaviour to sexual abuse (see also, Runtz and Briere, 1985). Also, studies by Byles (1980), Deykin, Albert and McNamarra (1985), Goodwin, Simms and Bergman (1979) as well as Herman and Hirschman (1981) give further support to the finding of frequent suicide attempts amongst persons who have sexual abuse histories. A study by Ross (1980) shows a link between child sexual abuse and self mutilation, another finding which may be compared to the high rate of self mutilation found in this study.

Use of alcohol and drugs, also found to be quite a common behaviour amongst the sample population according to the results of the TBI, is supported by data published on both long-term and initial problems associated to sexual abuse (See Browne and Finkelhor, 1985). In particular, studies by Peters (1984), Herman (1981) and Briere (1984) which also utilized clinical populations, found a connection between child sexual abuse and later substance abuse. This finding on substance abuse and sexual abuse has, however, been disputed in studies

conducted on non-clinical populations (See Sedney and Brooks, 1984). While general population samples are often viewed as being more representative, they often do not reflect the problems experienced by the most traumatized groups of people. Thus, the finding of substance abuse amongst clinical populations in general, and specifically with reference to the adolescent sample in this study, has significant implications for mental health services and their treatment initiatives.

Dissociation was the only symptom which did not seem to emerge amongst this group. Dissociative processes have been noted in a few studies on long-term effects of sexual abuse, such as Briere (1984), Briere and Runtz (1985) and Blake-White and Kline (1985). Briere and Runtz (1985) consider dissociation to be one of the most intriguing and common symptoms of post abuse trauma. Thus, while dissociation was not a significant symptom in the age group sampled, it may be a more common behaviour amongst those who suffer from long term trauma. Accordingly, Briere and Runtz (1985) say: "dissociation may initially function as a coping strategy, later becoming an autonomous symptom" (pp. 11-12).

### Summary and conclusion

To the extent to which the present study can be generalized to other clinical adolescent groups, it appears as if sexual victimization in childhood may be a common occurrence for adolescent females in inpatient mental health facilities.

Also certain distinctive symptomatology appears to emerge amongst populations where sexual abuse histories are identified. This symptomatology consists of psychological as well as behavioural problems. Moreover, such symptoms likely persist into adulthood becoming chronic problems if they are not treated earlier. Clinicians and researchers alike ought to become particularly sensitive to learning more about the initial effects of sexual abuse in order to treat and perhaps prevent the onset of more significant problems.

In addition to the descriptive information and basic data obtainable from this research, this study provided useful information on the applicability of several potential measures for use with similar populations as the present one. These measures appear to provide very useful data which may be used in treatment planning which can directly address psychological and/or behavioural distress. Whether or not such distress emerges as a result of victimization experiences was not explored in this study. Thus, in order to investigate the issue of association between sexual victimization and resulting psychological and behavioural problems, further research and testing is necessary. Both clinical and non-clinical adolescent populations and the effects of sexual abuse must yet be examined. Studies conducted on clinical populations are often criticized for being biased or distorting our understanding of reality. While it is true that studies on clinical populations tend to overrepresent the extent of

pathology which may be caused by sexual victimization (see Browne & Finkelhor, 1986) compared to studies utilizing non-clinical populations (Bagley & Ramsay, 1985), further research on understanding the nature and causes for pathology still appears to be necessary.

Clinical populations are treatment seeking populations. Research must focus on understanding the problems of these people in order to treat them successfully. However, the problems suffered by persons who are institutionalized or who are treatment seeking ought not to extend to the general population. The selection bias must be addressed. For this reason, further research utilizing non-clinical samples is also important. As Browne and Finkelhor (1986) note: it is necessary "to expand the size and diversity...and particularly to study victims who have not sought treatment or been reported" (p. 75). In this way, the nature and extent of the effects of sexual abuse may be identified in a more realistic way for the population at large.

With respect to the results of this study, while it appears to be premature to recommend any routine administration of the measures used to any given clinical adolescent population, certain advantages may be considered. Both the SCL-90-R and the Teenage Behaviour Inventory are brief as well as easy to administer and complete. The information they yield appears to be clinically useful and may be easily

integrated into the treatment programs. Accordingly, if treatment programs were initiated, a measure such as the SCL-90-R may be useful in identifying change in symptoms from pre to post treatment.

In summary, this study provided some useful information on the applicability of several measures for identifying distress amongst institutionalized adolescents. It also provided some initial basic descriptive information on such a population. While larger and perhaps more diversified data bases are needed in order to further examine the issue of sexual abuse and its resulting effects, other measures should also be tested and assessed. It appears important, especially for therapy-seeking populations, that a routine battery of tests yielding clinically useful information on the needs of these people be routinely administered and collected. Psychological and behavioural problems were the selected units of examination in this study. These and other such measures can assist in program planning in understanding both the needs as well as the strengths of various groups.

**Appendices**

Appendix A: Tables



**Table 1**

**SCL-90-R: Raw Score Means and S.D.'s for the 9 Primary Symptom Dimensions and 3 Globals from Sample and Normative Cohorts**

Dimension/Global	(N = 15) Sample		(N = 806) Normative	
	$\bar{x}$	t-score	$\bar{x}$	t-score
1. Somatization	.91	56	.61	52
2. Obsessive-Compulsive	1.31	55	.91	50
3. Interpersonal Sensitivity	1.46	52	.99	50
4. Depression	1.63	60	.80	50
5. Anxiety	1.08	57	.66	51
6. Hostility	1.84	62	.88	52
7. Phobic Anxiety	.98	61	.39	52
8. Paranoid Ideation	1.53	58	.91	51
9. Psychoticism	1.14	58	.63	52
GSI	1.33	58	.76	50
PSDI	2.02	59	1.57	51
PST	54.80	49	39.81	48

Table 2  
Teenage Behaviour Inventory  
Mean Scores

Item	Score N=15
1. Go to parties	3.80
2. Go "steady"	3.00
3. Drink alcoholic beverages	3.66
4. Use drugs (other than marijuana)	3.26
5. Run away from home	3.93*    p < .1
6. Steal things from stores, etc.	2.66
7. Engage in sports	3.33
8. Attempt suicide	3.13
9. "Skip" school	3.40
10. Lie to your parents	3.42
11. Join clubs	2.40
12. Get in trouble with the law	2.00
13. Have sexual intercourse	3.80
14. Overeat	1.40
15. Undereat	3.00
16. Hurt yourself physically to 'punish' yourself	3.80
17. Visit a prostitute	2.13*    p < .05
18. Provide sex for money	2.21
19. Do poorly at school	2.86

Table 2 (cont.)

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Item	Score N=15
20. Discuss your home life with friends or peers	3.00
21. Play a musical instrument	2.40
22. Lie to your friends or peers	1.80
23. Have nightmares	2.80
24. Feel nervous about speaking in public	2.86
25. Cry in class or in public	1.40
26. Go to the hospital or doctor	2.80
27. Dress in clothes that made you look "sexy"	2.66
28. Dress in clothes that hid your body	2.53
29. Have homosexual contact	1.06

---

Note: The above items were rated on a five-point scale of frequency ranging from "not at all" to "extremely often".

Appendix B: Consent Form

CONSENT FORM

Name \_\_\_\_\_

The Maples program is conducting a study of selected questionnaires to determine their usefulness in treatment planning and evaluation. At this point, we are simply interested in evaluating their potential use. Thus, the questionnaires will not be made available to treatment staff and will not be placed in your file. Complete confidentiality will be maintained. You will not be personally identifiable in any reports of this study.

We appreciate your cooperation and will be glad to answer any questions you might have. You are free to withdraw from this study at any time; this will in no way affect your status in the Maples program.

Please sign below if you are willing to participate.

I understand that my involvement in the study will include the completion of questionnaires and a brief interview. I understand that reports of this study will contain information about groups only; no individual will be identifiable. Finally, I understand that participation in this study is voluntary and that I am free to withdraw at any time. This will in no way affect my status in the Maples program.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Appendix C: Maples Coding Form

CASE I.D. (M.H.S. number) [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

SUBSET [ ]

MAPLES CODING FORM  
Demographic Information and History

100. Sex (1=male, 2=female)  
..... [ ]
200. Date of Admission  
[ ] [ ]/[ ] [ ]/[ ] [ ] [ ]  
y y m m d d
300. Date of birth  
[ ] [ ]/[ ] [ ]/[ ] [ ] [ ]  
y y m m d d
400. Ethnic group (Code number)  
1. White  
2. Native Indian  
3. Black  
4. Oriental  
5. Other \_\_\_\_\_ [ ]
500. Education (Code last year completed)  
..... [ ] [ ]
600. Student status at time of admission (Code number)  
1. In school  
2. Out of school  
3. Other \_\_\_\_\_ [ ]
700. Employment at time of admission (Code number)  
1. Employed, full-time  
2. Employed, part-time  
3. Unemployed  
4. N/A (student)..... [ ]
800. Legal status at time of admission (Code number)  
1. Care of parent  
2. Care of guardian  
3. Ward of Human Resources  
4. Other \_\_\_\_\_ [ ] [ ]

900. Admitted from: (Code number)

1. Home
2. Foster home
3. Boarding home
4. Correctional Institute
5. M.H.S. Patient
6. Acute General Hospital
7. General Hospital--psychiatric
8. Other \_\_\_\_\_ [ ] [ ]

1000. Previous Psychiatric Care (Code 1 if applicable; blank otherwise)

1. None.....[ ]
2. This facility.....[ ]
3. M.H.S. outpatient.....[ ]
4. General Hospital -  
Psychiatric Unit.....[ ]
5. Private psychiatrist.....[ ]
7. Other \_\_\_\_\_ [ ] [ ]

1100. Agencies Involved - past and present (Code 1 if applicable; blank otherwise)

1. Mental health services  
(E.C.).....[ ]
2. Public health.....[ ]
3. Correctional agencies.....[ ]
4. Social agencies.....[ ]
5. School.....[ ]
6. Private psychiatrist.....[ ]
7. Physician .....[ ]
8. M.H.R.....[ ]
9. Family Court.....[ ]
10. Other.....[ ] [ ]

1200. Prior living arrangements (Code number)

1. Natural parents
2. Father alone
3. Step-father
4. Mother alone
5. Adoptive parent(s)
6. Foster parents
7. Grand parents
8. Other family members
9. Friend's home
10. Boarding or group home
11. Institution
12. Transient
13. Other \_\_\_\_\_ [ ] [ ]



Personal History

1300. Delivery and post-natal (Code 1 if applicable; blank  
development otherwise)

- 1. Normal.....[ ]
- 2. Breech.....[ ]
- 3. C-section.....[ ]
- 4. Forceps used.....[ ]
- 5. Premature delivery.....[ ]
- 6. Other complications  
.....[ ] [ ]

1400. Alcohol Problem

- 1. No
- 2. Yes
- 3. Unknown.....[ ]

1500. Drug Problem

- 1. No
- 2. Yes
- 3. Unknown.....[ ]

1600. Suicide attempts

- 1. None
- 2. Past
- 3. In maples
- 4. Past and in Maples
- 5. Unknown.....[ ]

1700. Self-mutilation

- 1. None
- 2. Past
- 3. In Maples
- 4. Past and in Maples
- 5. Unknown.....[ ]

1800. Employment status (father)

- 1. Employed full-time.....[ ]
- 2. Employed part-time.....[ ]
- 3. Unemployed.....[ ]
- 4. Student.....[ ]

1900. Employment status (mother)

- 1. Employed full-time.....[ ]
- 2. Employed part-time.....[ ]
- 3. Unemployed.....[ ]
- 4. Other.....[ ]

2000. Prior Arrests

- 1. Yes
- 2. No

3. Unknown.....[    ]

If "Yes" list offences in order of seriousness:

_____	[    ]	[    ]
_____	[    ]	[    ]
_____	[    ]	[    ]

2100. Prostitution

- 1. Yes
- 2. No

3. Unknown.....[    ]

2200. Sexual Abuse as victim

- 1. Yes
- 2. Suspected

3. Unknown.....[    ]

2300. Physical Abuse as victim

- 1. Yes
- 2. Suspected

3. Unknown.....[    ]

2400. Relationship of victim to offender (Code 1 if applicable; blank otherwise)

- 1. Mother.....[    ]
- 2. Father.....[    ]
- 3. Step-mother.....[    ]
- 4. Step-father.....[    ]
- 5. Brother.....[    ]
- 6. Step-brother.....[    ]
- 7. Sister.....[    ]
- 8. Step-sister.....[    ]
- 9. Foster-brother.....[    ]
- 10. Foster-sister.....[    ]
- 11. Other relative.....[    ]
- 12. Friend.....[    ]
- 13. Neighbour.....[    ]
- 14. Stranger.....[    ]
- 15. Foster parent.....[    ]
- 16. Other.....[    ] [    ]

2500. Sexual Abuse as offender

- 1. Yes
- 2. Suspected

3. Unknown.....[    ]

2600. Physical Abuse as offender

- 1. Yes
- 2. Suspected

3. Unknown.....[    ]

2700. Relationship of offender to victim (Code 1 if applicable; blank otherwise)

- 1. Brother.....[ ]
- 2. Step-brother.....[ ]
- 3. Sister.....[ ]
- 4. Step-sister.....[ ]
- 5. Foster-brother.....[ ]
- 6. Foster-sister.....[ ]
- 7. Other relative.....[ ]
- 8. Friend.....[ ]
- 9. Neighbour.....[ ]
- 10. Stranger.....[ ]
- 11. Foster parent.....[ ]
- 12. Other.....[ ] [ ]

DSM III  
DIAGNOSTIC INFORMATION

Forensic Psychiatric Services Commission  
of British Columbia

101 Axis I (Clinical Scales) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_. [ ] [ ] [ ] [ ] [ ]  
(If more than one diagnosis) . . . . . [ ] [ ] [ ] [ ] [ ]  
. . . . . [ ] [ ] [ ] [ ] [ ]

102 Axis II (Personality Disorders) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_. [ ] [ ] [ ] [ ] [ ]  
(If more than one diagnosis) . . . . . [ ] [ ] [ ] [ ] [ ]  
. . . . . [ ] [ ] [ ] [ ] [ ]

103 Axis III (Physical Disorders & Conditions)

\_\_\_\_\_  
\_\_\_\_\_. [ ] [ ] [ ] [ ] [ ]  
(If more than one diagnosis) . . . . . [ ] [ ] [ ] [ ] [ ]  
. . . . . [ ] [ ] [ ] [ ] [ ]

104 Axis IV (Severity of Psychosocial Stressors)

\_\_\_\_\_  
\_\_\_\_\_ . . . . .

105 Axis V (Highest Level of Adaptive Functioning,  
Past Year) \_\_\_\_\_

\_\_\_\_\_ . . . . .

## BIBLIOGRAPHY

- Anderson, S.C., Bach, C.M. & Griffith, S. (1981, April). Psychosocial sequelae in intrafamilial victims of sexual assault and abuse. Paper presented at the Third International Conference on Child Sexual Abuse and Neglect, Amsterdam, Netherlands.
- Badgely, R. (1984). Sexual offences against children. Ottawa: Ministry of Justice Report.
- Bagley, C. (1984). Mental health and the in-family sexual abuse of children and adolescents. Canada's Mental Health, June, 17-23.
- Bagley, C., & McDonald, M. (1984). Adult mental health sequels of child sexual abuse, physical abuse and neglect in maternally separated children. Canadian Journal of Community Mental Health, 3, 15-26.
- ✓ Bagley, C., & Ramsay, R. (1985, February). Disrupted childhood and vulnerability to sexual assault: Long-term sequels with implications for counselling. Paper presented at the meeting of the Conference on Counselling the Sexual Abuse Survivor, Winnipeg, Manitoba.
- Bagley, C., & Ramsay, R. (in press). Sexual abuse in childhood: Psychosocial outcomes and implications for social work practice. Journal of Social Work and Human Sexuality.
- Bailey, K.D. (1982). Methods of social research. New York: The Free Press.
- Bell, A., & Weinberg, M. (1981). Sexual preference: Its development among men and women. Bloomington: Indiana University Press.
- Bender, L., & Blau, A. (1937). The reaction of children to sexual relationships with adults. American Journal of Orthopsychiatry, 7, 500-518.
- Bender, L., & Grugett, A.E. (1952). A follow-up on children who had atypical sexual experience. American Journal of Orthopsychiatry, 12, 825-837.
- Blake-White, J. & Kline, C.M. (1985). Treating the dissociative process in adult victims of childhood incest. Social Casework: The Journal of Contemporary Social Work, September, 394-402.

- Blumberg, M.L. (1981). Depression in abused and neglected children. American Journal of Psychotherapy, 35, 342-355.
- Borgman, R. (1984). Problems of sexually abused girls and their treatment. Social Casework: The Journal of Contemporary Social Work, 5, 182-186.
- Brickman, J. (1984). Feminist, nonsexist and traditional models of therapy: Implications for working with incest. Women and Therapy, 3(1), 49-67.
- Briere, J. (1984, April). The effects of childhood sexual abuse on later psychological functioning: Defining a post-sexual-abuse-syndrome. Paper presented at the Third National Conference on Sexual Victimization of Children, Children's Hospital National Medical Centre, Washington, D.C.
- Briere, J., & Runtz, M. (1985, August). Symptomatology associated with prior sexual abuse in a non-clinical sample. Paper presented at the annual meeting of the American Psychological Association. Los Angeles, California.
- Briere, J., Runtz, M., & Lightfoot, A. (1985, April). Suicidality in former sexual abuse victims. Paper presented at the American Association of Suicidology, Toronto, Ontario, Canada.
- Browne, A. & Finkelhor, D. (1986). Impact of child sexual abuse: a review of the research. Psychological Bulletin, 99(1), 66-77.
- Butler, S. (1978). Conspriacy of silence: The trauma of incest. San Francisco: Volcano Press.
- Byles, J.A. (1980). Adolescent girls in need of protection. American Journal of Orthopsychiatry, 50(2), 264-278.
- Constantine, L. & Constantine, J.M. (1973). Group marriage. New York: Macmillan.
- Constantine, L. (1980). Effects of early sexual experience: A review and synthesis of research. In L. Constantine & F.M. Martinson (Eds.), Children and sex (pp. 217-244). Boston, Little, Brown.

- Conte, J.R. (1984, November). The effects of sexual abuse on children: A critique and suggestions for further research. Paper presented at the Third International Institute on Victimology, Lisbon, Portugal.
- Cook, T.D., & Campbell, D.T. (1979). Quasi-experimentation: Design and analysis issues for field settings. Boston: Houghton Mifflin Company.
- Courtois, C. (1979). The incest experience and its aftermath. Victimology: A International Journal, 4, 337-347.
- DeFrancis, V. (1969). Protecting the child victim of sex crimes committed by adults. Denver CO: American Humane Association.
- Demott, B. (1980). The pro-incest lobby. Psychology Today, 13, 11-16.
- Derogatis, L.R. (1977). SCL-90-R: Administration, scoring & procedures manual-II. Clinical Psychometric Research.
- Derogatis, L.R., Rickels, K., & Rock, A. (1976). The SCL-90-R and the MMPI: A step in the validation of a new self-report scale. British Journal of Psychiatry, 128, 280-289.
- Deykin, E.Y., Alpert, J.J., & McNamarra, J.J. (1985). A pilot study of exposure to child abuse or neglect on adolescent suicidal behavior. American Journal of Psychiatry, 142, 1299-1303.
- deYoung, M. (1982). Innocent seducer or innocently seduced? The role of the child incest victim. Journal of Clinical Child Psychology, 11(1), 56-60.
- Dostoyevsky, F. (1959). Crime and punishment. New York: Laurel Free Press.
- Fields, P.J. (1981, November). Parent-child relationships, childhood sexual abuse, and adult interpersonal behavior in female prostitutes. Dissertation Abstracts International, 42, 2053B (microfilm).
- Finkelhor, D. (1979). Sexually victimized children. New York: The Free Press.
- Fraser, P. (1985, April). The report of the special committee on pornography and prostitution. Ottawa: Department of Justice, Canada.

- Freud, S. (1966). The complete introductory lectures of psychoanalysis. New York: Norton.
- Fritz, N.J. & Altheide, D.L. (forthcoming). The mass media and the social construction of the missing children problem.
- Fromuth, M.E. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. Child Abuse and Neglect, 10, 5-15.
- Gelinas, D.J. (1983). The persisting negative effects of incest. Psychiatry, 46, 312-332.
- Gomes-Schwartz, G., Horowitz, J.M., & Sauzier, M. (1985). Severity of emotional distress among sexually abused preschool, school-age, and adolescent children. Hospital and Community Psychiatry, 36(5), 503-508.
- Goodwin, J., Simms, M., & Bergman, R. (1979). Hysterical seizures: A sequel to incest. American Journal of Orthopsychiatry, 49, 698-703.
- Gundlach, R. (1977). Sexual molestation and rape reported by homosexual and heterosexual women. Journal of Homosexuality, 2, 367-384.
- Halliday, L. (1982). The silent scream. Campbell River, B.C.: Linda Halliday.
- Harrison, P.A., Lumry, A.E., & Claypatch, C. (1984, August). Female sexual abuse victims: Perspectives on family dysfunction, substance use and psychiatric disorders. Paper presented at the Second National Conference for Family Violence Researchers, Durham, N.H.
- Hefland, J. (1985, January). Media attention to child sexual assault: A good thing? Off Our Backs, 9, 14.
- Henderson, J. (1975). Incest. In A.M. Freedman, H.I. Kaplan, & B.J. Sadock, (Eds.), Comprehensive textbook of psychiatry--II. Baltimore: Williams and Wilkins.
- Henderson, J. (1983). Is incest harmful? Canadian Journal of Psychiatry, 28, 34-39.
- Herman, J.L. (1981). Father-daughter incest. Cambridge, M.A.: Harvard University Press.



- Herman, J.L. & Hirschman, L. (1981). Families at risk for father-daughter incest. American Journal of Psychiatry, 138(7), 967-969.
- Hyde, N. (1984). Long term effects of childhood sexual abuse. The British Columbia Medical Journal, 27(7), 448-450.
- James, J., & Meyerding, J. (1977). Early sexual experiences and prostitution. American Journal of Psychiatry, 134, 1381-1385.
- James, K. (1977). Incest: The teenagers perspective. Psychotherapy, Theory, Research, and Practice, 14(2), 146-155.
- Jehu, D., & Gazan, M. (1983). Psychosocial adjustment of women who were sexually victimized in childhood or adolescence. Canadian Journal of Community Mental Health, 2, 71-82.
- Katan, A. (1973). Children who were raped. Psychoanalytic Study of the Child, 28, 208-224.
- Krieger, M.J., Rosenfeld, A.A., Gordon, A., & Bennett, M. (1980). Problems in the psychotherapy of children with histories of incest. American Journal of Psychotherapy, 1, 81- 88.
- Lamb, S. (1986). Treating sexually abused children: Issues of blame and responsibility. American Journal of Orthopsychiatry, 56(2), 303-307.
- Langbein, L.I. (1980). Discovering whether programs work. Palo Alto: Goodyear.
- Langmade, C.J. (1983). The impact of pre-and postpubertal onset of incest experiences in adult women as measures by sex anxiety, sex guilt, sexual atisfaction and sexual behavior. Dissertation Abstracts International, 44, 917B (microfilm).
- Lowman, J. Jackson, M.A., Palys, T.S., & Gavigan, S. (Eds.). (1986). Regulating sex: An anthology of Commentaries on the findings and recommendations of the Badgley and Fraser reports. Burnaby, B.C.: School of Criminology, Simon Fraser University.
- Luckianowicz, N. (1972). Incest. British Journal of Psychiatry, 120, 301-313.

- MacFarlane, K. (1982). Sexual abuse of children, In J.R. Chapman & M. Gates (Eds.), The victimization of women. Beverly Hills, California: Sage.
- Mannarino, A.P., & Cohen, J.A. (1986). A clinical-demographic study of sexually abused children. Child Abuse and Neglect, 10, 17-23.
- Masson, J.M. (1985). How honest was Freud? New York: Penguin Books.
- ✓ Meese, E. (1986, July). Attorney General's Commission on Pornography: Final Report. Department of Justice, Washington, D.C., U.S.A.
- Meiselman, K.C. (1978). Incest: A psychological study of causes and effects with treatment recommendations. San Francisco: Jossey-Bass.
- Nelson, J. (1981). The impact of incest: Factors in self-evaluation. In L. Constantine & F.M. Martinson, (Eds.), Children and sex, (pp. 163-174). Boston: Little, Brown, 70-95.
- Nobile, P. (1978, January). Incest: The last taboo. Penthouse, 117.
- Nunnally, J. (1970). Introduction to psychological measurement. New York: McGraw-Hill.
- Oates, K. (1982). Child abuse: A community concern. New York: Brunner.
- O'Hare, J., & Taylor, K. (1983). The reality of incest. Women and Therapy, 2(2/3), 215-229.
- Oremland, E., & Oremland, J. (1977). The sexual and gender development of young children: The role of education. Cambridge, Mass.: Ballinger.
- Peters, S.D. (1984). The relationship between childhood sexual victimization and adult depression among Afro-American and white women. Unpublished doctoral dissertation, University of California, Los Angeles, C.A.
- Pomeroy, W. (1978). A new look at incest. The best of forum, 92-97.
- Ramey, J. (1979). Dealing with the last taboo. SIECUS, 7, 1-2, 6-7.

- Rascovsky, M., & Rascovsky, A. (1950). On consummated incest. International Journal of Psychoanalysis, 31, 42-47.
- Rasmussen, A. (1934). The importance of sexual attacks on children less than fourteen years of age for the development of disease and character anomalies. Acta Psychiatrica Neurology, 9, 351-434.
- Reich, J.W., & Gutierrez, S.C. (1979). Escape/aggression incidence in sexually abused juvenile delinquents. Criminal Justice and Behavior, 6, 239-243.
- Rosenfeld, A.A. (1979). Incidence of a history of incest among 18 female psychiatric patients. American Journal of Psychiatry, 136(6), 791-795.
- Ross, R.R. (1980). Violence in, violence out: Child abuse and self-mutilation in adolescent offenders. Canadian Journal of Criminology, 22, 273-287.
- Runtz, M., & Briere, J. (In press). Adolescent "acting out" and childhood history of sexual abuse. Journal of Interpersonal Violence.
- Rush, F. (1976). The Freudian cover-up. Chrysalis. 1(1), 31-45.
- Rush, F. (1980). The best kept secret: Sexual abuse of children. New Jersey: Prentice-Hall, Inc.
- Sedney, M.A., & Brooks, B. (1984). Factors associated with a history of childhood sexual experience in a nonclinical female population. Journal of the American Academy of Child Psychiatry, 23, 215, 218.
- Silbert, M.H., & Pines, A.M. (1981). Sexual child abuse as an antecedent to prostitution. Child Abuse and Neglect, 5, 407-411.
- Sloane, P., & Karpinski, E. (1942). Effects of incest on the participants. American Journal of Orthopsychiatry, 12, 666- 673.
- Sorrenti-Little, L., Bagley, C., & Robertson, S. (1984). An operational definition of the long-term harmfulness of sexual relations with peers and adults by young children. Canadian Children, 9, 46-57.

- Special Report: Sexual abuse, the growing outcry over child molesting. Children and the court: A case study of incest. (May 14, 1984). Newsweek, 30-38.
- Summit, R., & Kryso, J. (1978). Sexual abuse of children: A clinical spectrum. American Journal of Orthopsychiatry, 48, 237-251.
- Tsai, M., Feldman-Summers, S., & Edgar, M. (1979). Childhood molestation: Variables related to differential impacts on psychosexual functioning in adult women. Journal of Abnormal Psychology, 88, 407-417.
- Tsai, M., & Wagner, N.N. (1979). Therapy groups for women sexually molested as children. Archives of Sexual Behaviour, 7, 417-427.
- Tufts' New England medical Centre, Division of Child Psychiatry (1984). Sexually exploited children: Service and research project. Final report for the Office of Juvenile Justice and Delinquency Prevention. Washington, C.C.: U.S. Department of Justice.
- Weiner, I.B. (1978). A clinical perspective on incest. American Journal of Disturbed Children, 132, 123-124.