

EFFECT OF INTRAFAMILIAL CHILD SEXUAL ABUSE
CHARACTERISTICS ON THE SELF-IMAGE OF
FEMALE VICTIMS, AGES 8-15

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ABSTRACT

Title of Dissertation: EFFECT OF INTRAFAMILIAL CHILD SEXUAL
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Nainan Thomas, Doctor of Philosophy, 1990

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This study was undertaken with two purposes: 1. to investigate the differences in self-image between girls who are victims of intrafamilial child sexual abuse and a control group of non-abused girls; 2. to examine the within group self-image differences of abused girls by age abuse began, relationship of the offender to the victim, type of sexual activity, use of violence, and mother support. Seventy one girls, 37 abused and 34 non-abused, ages 8 -15, matched on age, race, socioeconomic status and the single or two parent status of the families were administered two standardized measures, one measuring their self-image and another one measuring their perception of mother support. An abuse case information checklist completed by the abused girls' caseworker provided information on the abuse characteristics. Data were analyzed using ANOVAs and Correlational analysis. Five subscales of the self-image measure, body image, emotional tone, psychopathology, family relationships and vocational educational goals were selected as the final

outcome variables. Abused girls showed significantly poorer body image and marginally poorer emotional tone and psychopathology compared to non-abused girls. There were no significant interactional effects for age and mother support; however, among the abused girls, there was a significant negative correlation of age with mother support and family relationships, and this correlation was marginally different from the controls. Within group analysis of self-image differences of abused girls showed significantly better self-image on family relationships when the offenders were male relatives other than their biological fathers or stepfathers. Surprisingly, girls who experienced vaginal/ anal penetration showed significantly better self-image on family relationships and body image and marginal differences on psychopathology and emotional tone, compared to those who experienced fondling and kissing. Abused girls who had higher mother support had better self-image in family relationships and vocational educational goals. No difference in self-image was found by age abuse began, duration of abuse and use of violence. Findings, as they relate to and differ from the previous studies are discussed along with the implications of the findings for theory, practice and research.

Dedication

This dissertation is being dedicated as a tribute to my dear parents, Annamma and Ommen Nainan, whose sacrificial life, love, and affection challenged and motivated me to pursue and successfully complete the program of doctoral studies.

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Chapter 1

INTRODUCTION

Although over the past decade our understanding of the complex social problem of child sexual abuse has increased dramatically, our knowledge about the extent of its effects on the victims is still in its infancy. Available clinical reports and empirical studies indicate that it causes a wide variety of short-term and long-term psychological, behavioral, and sexual problems for the victims (Wyatt & Powell, 1989; Sirles, Smith & Kusama, 1989; McLeer, Deblinger, Atkins, Foa & Ralphe, 1988; Haugaard & Reppucci, 1988; DePanfilis, 1988; Asher, 1988; Browne & Finkelhor, 1986; Finkelhor, Araji, Baron, Browne, Peters, & Wyatt, 1986; Conte, 1986; Coons, 1986; Tufts, 1984). Also, it has been noted that empirical studies show more clearly than the clinical reports considerable variability in the magnitude of these problems (Wyatt & Powell, 1989; Haugaard & Reppucci, 1988; Finkelhor, 1987; Browne & Finkelhor, 1986; Adams-Tucker, 1982; Burton, 1968). In an effort to ascertain the sources of the variability, researchers have now begun to examine the possible differential effects of various abuse characteristics. (Haugaard & Emery, 1989; Haugaard & Reppucci, 1988; Asher, 1988; Finkelhor et al., 1986). However, to date, very few empirical studies have systematically conducted such examination using non-behavioral measures and adequate control groups. Specifically, there appears to be no

empirical study that has examined the effect of intrafamilial child sexual abuse characteristics on the victims on a standardized psychological measure of self-image by comparing the findings with that of a control group of non-abused children.

Statement of the Problem

The purpose of this study was to investigate the impact of intrafamilial child sexual abuse on the self-image of female victims, ages 8-15, and to examine the possible differential effect of selected abuse characteristics-- age of the victim when abuse began, relationship of the offender to the victim, type of sexual activity, duration of abuse, use of violence, and mother support -- on the victim's self-image. The specific research questions that guide this study are:

1. Does the self-image of girls who are victims of intrafamilial child sexual abuse differ from that of a control group of non-abused girls, and is there a difference by age and mother support?
2. Does age of the victim when abuse began have a differential effect on the victim's self-image?
3. How does the victim's self-image differ by the relationship of the offender to the victim?
4. Does the type of sexual activity have a differential effect on the victim's self-image?
5. Does the duration of abuse make a difference in

the victim's self-image?

6. Does the use of violence have a differential effect on the victim's self-image?
7. Does mother support make a difference in the victim's self-image?

Conceptual Definition

Conceptually it seems difficult to arrive at a definition of child sexual abuse which is broad enough to encompass the problem as a whole and sufficiently specific enough to avoid vagueness and ambiguity. Depending upon the source, context, and purpose of the definition, it has been defined in numerous ways. Consequently, definitions used by the legal system, professional helpers, and researchers are not identical in meaning (Haugaard & Reppucci, 1988; DePanfilis, 1988; Finkelhor et al., 1986; Finkelhor, 1984).

Legally, as per the Child Abuse Prevention and Treatment Act of 1974, as amended by U.S. Congress (1984), the term child sexual abuse means:

...(1) the employment, use, persuasion, enticement, or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct) for the purpose of producing any visual depiction of such conduct, or (11) the rape, molestation, prostitution, or other such form of sexual exploitation of children, or incest with children,

under circumstances which indicate that the child's health or welfare is harmed or threatened thereby

This Federal law conceptualizes sexual abuse as sexual acts including a wide range of body contact and non-body contact behaviors extending from fondling a child's genitals to intercourse, incest, forcible rape, sodomy, exhibitionism, and commercial exploitation through prostitution or production of pornographic materials committed to children under age 18 by a person "responsible for the child's welfare". Within the scope of this Federal law, the persons responsible for the child's welfare include individuals beyond the family. However, to be considered child sexual abuse, these acts have to be committed by persons responsible for the child's welfare such as a parent, stepparent or other relatives within the family or a unrelated individual outside the family such as a baby sitter, day care provider, or school teacher. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

While this Federal law sets a legal standard, it is not uniformly followed in individual states (DePanfilis, 1988). At the state level, a variety of civil and criminal laws, including incest laws, govern matters dealing with sexual abuse of children (Bulkley, 1981). The degree of specificity of legal definition of child sexual abuse in civil law differs from state to state (Bulkley, 1981). For instance, in

the civil law of Maryland (Annotated Code of Maryland, 1988) the revised definition of child sexual abuse reads as: an act or acts involving sexual molestation or exploitation, whether physical injuries are sustained or not, by a parent, adoptive parent, household or family member, including any step-parent, foster parent, guardian or custodian. In this law, the victim should be a minor under the age of eighteen. The State of Virginia's civil law (Virginia Code, 1988) defines child sexual abuse as instances where parents or other persons responsible for the child's care commits or allows to be committed any sexual act upon a child in violation of the law. "As we can see, while these definitions capture the substance of the definition in the Federal law, they vary from the Federal law in terms of their specificity. Like the civil laws, criminal statutory definitions are not uniform. There are wide variations from state to state in the penalty structures and in the upper age limit of the child victim (Kocen & Bulkley, 1981). Further, in some states, child abuse committed by a person outside the family may be handled quite differently from the same act committed by someone legally responsible for the child (MacFarlane, 1978). Also, most jurisdictions have both civil and criminal laws related to sex offenses involving children. While child protection and therapeutic intervention are the primary objectives of the civil laws, the criminal laws are designed to apprehend, try, and punish offenders. Because of these

differences in purpose legal definitions may vary widely between the two codes (Jones, Jenstrom & MacFarlane, 1980). In short, the legal definition of what constitutes sexual abuse of children remains largely a matter of jurisdictional interpretation (MacFarlane, 1978).

Professional conceptualizations of child sexual abuse create complexities similar to those resulting from the differences among legal definitions (Mrazek, 1981). Many professionals who define the problem in terms of sexual assault, child rape, child molestation, and incest focus on specific aspects of the problem and do not address the overall problem. For example, one definitional approach (Finkelhor, 1979) uses the term sexual victimization. "This approach emphasizes that the children are victimized because of their age, naivete, and relationship with the offender rather than being victimized by the aggressive intent of the abusive behavior. Another approach (Mrazek, 1980) emphasizes a clinical definition." This definition includes a description of what occurred, information about age and stage of development of the persons involved, an understanding of the nature of the relationship between those involved, a description of the attitudes, reactions and responses of other family members, and the prevailing cultural attitudes about sexuality in the community. Other professionals in the field (Jones et al., 1980) define childhood sexual abuse as any childhood sexual experience that is harmful and interferes

with or has potential for interfering with a child's normal development. Sgroi, Blick and Porter (1985) conceptualize child sexual abuse as an act imposed on a child who lacks emotional, maturational, and cognitive development.

In general, operationalization of the concept of child sexual abuse by researchers has often been too broad. As Peters, Wyatt and Finkelhor's (1986) review of prevalence studies points out, most studies differ to some extent according to what ages, acts, and types of relationship are included in their definitions of child sexual abuse. According to them, in a number of early studies, neither a definition of abuse nor an upper age limit to the concept of childhood was specified. They further note that even some of the recent studies used broad definitions combining intrafamilial and extrafamilial abuse, abuse involving body contact and non-body contact and numerous other situational factors.

Thus, it appears that there is no shared meaning of child sexual abuse. Our current knowledge about the incidence, prevalence and the effect of abuse on the victims seems to have been influenced by the diversity of definitions used by the legal system, professional helpers and researchers. Differences in philosophical approaches of responding to child sexual abuse appear to be the result of differences in definitions. "There is a basic dilemma about whether child sexual abuse should be regarded as a crime, a

form of mental illness, or, particularly in cases of incest, a major symptom of broader family dysfunction" (Bulkley, 1982).

Regarding the relationship of the offender to the child Jones et al (1980) differentiate four broad categories of child sexual abuse: (1) abuse by parent or parental figure; (2) abuse by other family members; (3) abuse by trusted adults; and (4) abuse by strangers. The first category consists of those cases in which a child is sexually abused by a parent or true parent figure (e.g., natural father, stepfather, adopted father, or mother's boyfriend). The second category consists of those cases in which the abuser is a family member other than a parent or parent figure (e.g., grandfather, siblings, uncles, or nephews). The third category includes those cases in which the abuser is not a relative but is a significant person in the child's life (e.g., neighbor, teacher, or baby sitter). The fourth category includes abuse by a stranger or remote acquaintance (e.g., strangers in park). Clearly, it would be inappropriate to develop a definition of child sexual abuse that is equally applicable to all these categories of abuse. A broad definition that includes all of the above categories would yield a heterogeneous group (intrafamilial and extrafamilial). While the use of too broad a definition incorporating all four categories dramatically increases the number of children who can be categorized as having been abused, it may be an

impediment to meaningful research. For example, in a study which uses a broad definition, any effect of a particular offender-victim relationship, nature of abuse, and other situational variable might become lost in the varying effect of other offender-victim relationship, nature of abuse, and situational variable (Haugaard & Reppucci, 1988).

In summary, to conduct meaningful research, careful description of specific categories of offender-victim relationships, nature of abuse and other abuse characteristics that might explain the differential effect on the victims are essential. Therefore, present study conceptually limits its area of investigation to intrafamilial child sexual abuse which incorporates Jones et al 's (1980) first two categories of offender-victim relationship: abuse by parent or true parental figure and abuse by other family members. Precisely, the nature of abuse conceptualized in this study is limited to sexual activities involving body contact between an adult male and female child who have a familial relationship. The intrafamilial abuse characteristics (independent variables) selected for the study are age abuse began, the relationship of the offender to the victim, the type of sexual activity, duration of abuse, use of violence, and mother support. The outcome variable (dependent variable) selected for the study is the victim's self-image. These independent and dependent variables and other important terms and concepts of the study are

operationally defined in Chapter III.

Scope of the Problem

Sexual abuse of children is neither a new phenomenon nor a rare occurrence. However, due to the recent surge of interest in this insidious problem, it is now understood to be a more common than originally believed. Incidence studies which attempt to estimate the number of new cases occurring in a given time period, usually a year, and prevalence studies which attempt to estimate the proportion of the population that are sexually abused during their childhood are the two main sources that have documented the extent of the problem and the family dynamics (Peters, Wyatt & Finkelhor, 1986).

Incidence Studies

Several major incidence studies have documented a dramatic increase in the number of child sexual abuse cases reported to Child Protective Services agencies across the nation over the past decade. One of such pioneer studies commissioned by the National Center on Child Abuse and Neglect (1981) to look at the national incidence of child abuse and neglect, extrapolating from 26 counties of the nation as a whole, estimated that 44,700 cases of sexual abuse, or .7 per 1,000 children, were known to professionals in the year 1980. In a review of this National Incidence Study, Finkelhor and Hotaling (1984) have noted the absence from this study's statistics the number of sexual abuse

incidents that were not reported and known only to victims, perpetrators, and perhaps only to a few family members and friends. The National Center on Child Abuse and Neglect's (1988) Second Study of National Incidence of Child Abuse and Neglect estimated sexual abuse of 155,900 or 2.5 children per 1,000 children known to professionals in the year 1986. This study noted a significant rise in the incidence of sexual abuse, with an increase of more than triple its original rate reported in 1980.

Since 1976, the American Humane Association has conducted an annual national analysis of official reports of child abuse and neglect incidence in the United States (Russell & Trainor, 1984). In one such analysis, the American Humane Association (1986) identified approximately thirteen percent of the cases of total child maltreatment in the year 1984 as sexual abuse. Extrapolating from this study, it is estimated that 110,878 children were reported as victims of sexual maltreatment in 1984. This represents an increase of 54 percent between 1983 and 1984. In another annual study of the American Humane Association (1988), approximately 15.7 percent of the cases of maltreatment were identified as sexual abuse. This study estimated that 132,000 children were reported as victims of sexual abuse in 1986. These statistics again represent an increase of about 27 percent in the estimated number of children who were reported as sexually abused in 1984.

There is reason to believe that child sexual abuse in day care settings and other commercial exploitation of children are becoming serious problems. For instance, a recent national study of all reports of sexual abuse in day care settings by non-parental caretakers between January 1983 and December, 1985, indicated that children in day care settings are not disproportionately at higher risk than are children in other settings (Finkelhor, Williams, Burrs & Kalihowski, 1988). This study estimated the incidence rate of sexual abuse in day care centers to be 5.5 per 10,000 children enrolled in such centers. These results confirm that a disturbing number of children are sexually abused in day care centers. Most estimates of incidence of child abuse do not include child victims of pornography. While the number of children involved in the production of pornographic materials is unknown, the commercial success of pornography as a multi-million dollar enterprise appears to validate the continuing threat of sexual exploitation and damage done by pedophilies to children (Baker, 1978).

Prevalence Studies

The prevalence studies were undertaken with the premise that most cases of sexual abuse were not reported and the best estimate of the full scope of the problem, both reported and unreported, can be obtained from community surveys of normal adults revealing their childhood experiences (Finkelhor, 1987). Herman (1981), in reviewing five studies

on the prevalence of sexual abuse in female children, found that one fifth to one third of women had some sort of sexual encounter with an adult male and four to 12 percent of women reported sexual experience with a relative. In addition, one percent of the women reported an incestuous relationship with a father or grandfather. In a recent comparison of nineteen such studies which used volunteers, college students, and random community samples, Peters et al (1986) found all studies reporting at least five percent of adults with some childhood sexual abuse experience. However, there are significant variations among the studies in the prevalence rates, ranging from six percent to 62 percent for females and from three percent to 31 percent for males.

One of the major prevalence studies, Kercher (1980) surveyed 2,000 people who were randomly selected from all possessing Texas driver's licenses. Of 1,054 respondents, twelve percent of females and three percent of the males admitted that they had been victims of sexual abuse as children. In another study of 796 New England College students, Finkelhor (1979) found 19.2 percent of the women and 8.6 percent of the men with histories of childhood sexual abuse. Of those who had been victimized, 43 percent of the females and 33 percent of the males had been abused by a family member. In a different study, Russell (1986) interviewed a random sample of 933 adult women in San Francisco and reported a significantly greater prevalence of

sexual abuse than Finkelhor's estimate. In Russell's study, 38 percent of the respondents had been sexually abused before the age of 18; sixteen percent of her respondents reported at least one sexual assault within the family before age eighteen, and twelve percent reported having experienced at least one such event before age fourteen. A national prevalence study (Timnick, 1985) with 2000 adults conducted by Los Angeles Times Poll also reported sexual abuse among 27 percent of the women and 16 percent of the men.

Family Dynamics

Incidence and prevalence studies and other clinical and empirical investigations are also sources of information about the various dynamics of abusive families. It appears that intrafamilial child sexual abuse has dominated most reports from child welfare systems. For instance, one analysis of official national reports of sexual abuse from child welfare agencies between 1976 and 1982 identified 56.5 percent of the abusers as natural parents, 20.9 percent as other parent figures (step, foster, adoptive), 16.3 as other relatives and only 6.3 percent as non-relatives (Russell & Trainor, 1984). According to this analysis, mother-son, mother-daughter, and father-son incest are believed to occur much less frequently than father-daughter incest. Finkelhor's (1987) review of cases reported to child welfare agencies also indicates an overwhelming representation of intrafamilial child sexual abuse involving fathers and stepfathers.

However, as noted by Weiner (1964) the types of cases reported may not reflect actual incidence rates. It is quite possible that other forms of incest, such as sibling incest, and incest involving other family members, occur as frequently or more frequently but are less likely to be reported.

Although all studies do not support a high percentage of abuse by family members, most researchers agree that the nonfamily (extrafamilial) abuser is usually known to the victim. For example, in a study of 583 sexually abused children, Conte and Berliner (1981) found that a relatively low percentage of the perpetrators were natural fathers; however, only eight percent of the offenders were strangers. In another study of 1,059 children with a chief complaint of sexual abuse, Coupli (1988) found that 58.1 percent of the perpetrators were known to the child, but they were not family members. Finkelhor's (1987) review of several prevalence studies (Russell, 1986; Bagley & Ramsey, 1986; Finkelhor, 1984; Wyatt, 1985; Keckley Market Research, 1985) also shows that most abusers, although not always family members, are usually known to the victim.

It appears that an overwhelming majority of abusers are men, and the victims are females. The American Humane Association's (1988) study suggests that males account for 82 percent of the perpetrators of reported child sexual abuse cases. Asher's (1988) review documents that 94 percent to 97

percent of the perpetrators of child sexual abuse are males and the vast majority of the victims are females. Also, almost all studies, incidence and prevalence, (National Center on Child Abuse and Neglect, 1988; Peters et al., 1986, Russell, 1986; Finkelhor, 1984; Kercher, 1980) agree that girls are at a higher risk of abuse than boys as victims. However, the estimated ratio ranges from two to ten times as often (Finkelhor & Baron, 1985).

Although the age of victims have been found to be as young as 4 months old, the average reported age is between 10 and 14 (Peters, 1973; Russell & Trainor, 1984). Regarding the age at which abuse begins, the prevalence studies show children's vulnerability between ages 9 and 12 and then declines somewhat during later adolescence (National Center on Child Abuse and Neglect, 1988; Finkelhor & Baron, 1985; Kendall-Tackett, 1988). Recent studies, however, indicate that these estimates may be a reflection of the cases that are recognized and reported, rather than a true account of age of the victims. In this respect, Finkelhor (1987) notes that the ages of abused children tend to be higher in reported cases since the reported cases record age at the time of disclosure rather than age at the time of actual onset of the abuse. Statistics from Children's Hospital National Medical Center (Rogers & Thomas, 1984) give support to Finkelhor's claim. Their data indicate that, during the period 1978-1981, among the cases that came to their

attention where abusers were parents or guardians, 41 percent of the victims were under the age of nine.

Regarding the type of sexual activity, Finkelhor's (1987) review of prevalence studies in general shows that 16 percent to 29 percent of the abuse involves intercourse or attempted intercourse. Another three to 11 percent of the activities involve attempted or completed oral or anal intercourse, and 13 percent to 33 percent manual touching of the genitals. The largest category of abuse involves fondling of children's bodies and genitals without penetration. It also noted longer lasting abuse associated to abuse within the family. Finkelhor's (1987) review of cases reported to child welfare agencies, in particular, noted abuse involving intercourse and other intrusive acts and abuse that goes on over an extended period of time associated with intrafamilial sexual abuse incidents. Similarly, Groth (1978), based on his clinical observations, noted that sexual abuse by family members is more likely to occur repeatedly and over an extended period of time, while abuse by strangers is usually a single incident.

Few researchers have studied the impact of changes in the structure of families on intrafamilial sexual abuse, such as the role of the stepfathers and absent parents. For instance, Russell (1984) analyzed the difference between the prevalence and seriousness of incest between children and stepfathers and children and biological fathers. This study

concluded that seventeen percent, or approximately one out of every six women, for whom the stepfather was the principal father figure in childhood, was sexually abused by him. The comparable figure for biological fathers was two percent, or one out of every forty women. Further when a distinction was made between "very serious sexual abuse" and other less serious forms, forty-seven percent of the cases of sexual abuse by step fathers were defined as "very serious," compared with 26 percent by biological fathers. Finkelhor and Baron's (1985) review identifies three other studies that found that a stepfather as principal father figure increased a girl's risk for all types of sexual abuse.

Several explanations regarding the etiology of intrafamilial child sexual abuse are seen in the literature. In an earlier study, Lustig, Dresser, Spellman & Murray (1966) identified five conditions that are often present in families where father-daughter incest occurs. They are: (1) the emergence of the daughter as the central female figure of the household; (2) the relative sexual incompatibility of the parents; (3) the unwillingness of the father to seek a partner outside the nuclear family; (4) pervasive fears of abandonment and family disintegration; and (5) unconscious sanction of the incest by the mother who condones or promotes the daughter's sexual role with her father.

Expanding the above list of conditions that exist in incestuous families, a recent analysis of research (Pecora &

Martin, press) examining risk factors associated with intra-familial sexual abuse identified the following conditions: (1) violence in the family, including the spouse as well as the children; (2) role reversal with the child; (3) substance abuse of the father or stepfather; (4) poor marital history, separation, or divorce; (5) presence of a stepfather; (6) absent, ill, or depressed mother; (7) parental history of childhood abuse; (8) rejection of daughter or poor relationship with daughter; (9) family isolation; (10) low socioeconomic status or unemployed father; (11) high school dropout mother; and (12) patriarchal family or family where father is the domineering figure. Many authorities believe that intrafamilial child sexual abuse may be more traumatic than those committed by someone outside the family and may cause more long-lasting negative effects (Wyatt & Powell, 1989; Finkelhor & Browne, 1988).

In summary, it is difficult to estimate the true extent of the problem and fully understand the family dynamics since most cases of sexual abuse do not come to the attention of any child welfare/law enforcement agency, professionals, or researchers. Also, there are reasons to believe that the reported cases of sexual abuse represent only the "tip of the iceberg." First, many parents, family members and others who are aware of the abuse incidents are reluctant to report to the authorities (National Center on Child Abuse and Neglect, 1981). Second, both traditionally and legally, the

sanctity and integrity of the family are supported by our society. For this reason, the families isolate themselves from public view and public censure due to the fact that revelation of the incidents would affect the sanctity and integrity of the family (Chandler, 1982). Third, children keep their sexual victimization a secret from their parents or significant others (Peters, 1976). Fourth, a high percentage of adults who have participated in retrospective studies report that they had never told anyone about the experience (Finkelhor, 1979). In light of this, most experts believe that most of the recent increase in the number of reported cases may be the result of intensified media and professional efforts at case detection, rather than a true account of the incidents (Finkelhor, 1987; Peters et al, 1986).

Theoretical Orientation of the Study

Terms such as self-concept, self-image, body-image, ego, identity, self-esteem etc. are used in the literature to denote individual's psychological perceptions of self (Putnam, 1987). There appears to be no theory that is widely accepted as providing a definitive view of how children's perception of self is developed as they grow old and what primary factors influence its high or low end. However, as a theoretical framework for the present study, some of the popular models that give useful explanations of the development of self-perception in children in general and the major hypothesis regarding the sources of differential self-

perception in sexually abused children are discussed here.

Developmentally, children's self-perceptions become increasingly abstract thing as they grow older. For example, Sheik and Beglis (1973) found that second graders describe themselves concretely e.g. "I am a boy, I live on Main Street." About fourth grade children frequently include remarks such as , I get good grades in spelling, "I have a lot of friends. " The latter statements indicate a growing sense of individuality. By sixth grade, many children include remarks about their future, their relationships with the opposite sex, and girls talk about physical appearance (Papalia & olds, 1975). There is almost universal agreement that adolescence is a stage of development noted for the profound physiological and psychological changes. During this period, major physical changes such as the development of secondary sex characteristics and the typical adolescent growth spurt get integrated into the repertoire of body images, while cognitive changes such as the development of Piagetian formal operations bring new levels of self-awareness (Putnam, 1987). According to Erikson (1950), this stage is dominated by a developmental crisis involving "identity versus role confusion." During this period, in Erikson's conceptualization, the individual may exhibit profound swings in his/her sense of self.

Most authorities point out socialization as the chief factor that shapes all forms of self-perception (Honess &

Yardley, 1987; van der Welde, 1985; Craig, 1979). While self-perceptions are internal, psychological experiences, it is assumed that they are primarily derived from one's perceptions of other's perceptions of one's self. To put it differently, they are largely social products arising out of experiences with other people - primarily parents, siblings, relatives, peers, teachers and the general community (Honeness & Yardley, 1987; Papalia & Olds, 1975; Dinkmeyer, 1965; Honeness & Yardley, 1987).

Trust and security appear to be major socialization factors that lead to the establishment of healthy self-perceptions. Coopersmith's (1967) widely cited studies on self-esteem in preadolescents indicate that self-concepts are rated based on a child's self-perceived degree of success in four areas: (1) significance in the way the child receives affection, love and approval from important people in his or her life; (2) competence in performing tasks that he or she feels are important; (3) virtue in their attainment of moral and ethical standards defined by significant others; and (4) power or mastery over the environment in knowing the extent to which they can influence their own life and the lives of others.

It is presumed that sexual abuse of children by adult family members, who are the primary agents of children's socialization and responsible for providing trust and security, interferes with the children's normal ego or

self-perception development. Experts in the field have advanced several major hypotheses regarding the sources of differential self-perceptions in sexual abuse victims. They can be categorized under the framework of cognitive learning, post-traumatic stress syndrome and emotional accommodation theories.

The cognitive learning hypothesis theorizes that the major cause of negative effects on the victim is the change in victim's self-concept. Summit, (1983), a major proponent of this theory, suggests that the major cause of negative effect on the victim is the changes that the child must undergo in her self-concept as a result of the atmosphere that surrounds most ongoing abuse. He suggests that if the sexual activity continues over a period of time, the perpetrator threatens the child to ensure that it is kept secret. On the other hand, if the victim should reveal the abuse, she is placed in the position of being responsible for the welfare of the family and its members. According to Summit, this inappropriate responsibility to protect those whom the child would normally be protected by places additional stress on the child. The child is thus confronted with the fact that she is engaged in an activity that is considered to be wrong, and she is powerless to stop it. Summit theorizes that in order to live with the ongoing situation, the victim then assimilates the abuse into her own life. In doing so, he argues, the victim accommodates

(modifies) her view of the world and self and begins to change her self-concept in the direction of being evil and helpless.

Several clinicians have hypothesized adults who are victims of childhood sexual abuse are prone to fall into Post-Traumatic Stress Disorder- PTSD (Courtois, 1986; Donaldson & Gardner, 1985). Some clinicians and researchers suggest that it can also affect children who experience stress due to incest. (Deblinger, McLeer, Atkins, Ralphe & Foa 1989; Patten, Gatz, Jones, & Thomas, 1989; McLeer et al., 1988; Horowitz, 1976). Prominent among them, Horowitz's (1976) formulation suggests that human cognition has an innate completion tendency by which experiences are repeatedly worked through in the mind until they can fit into a person's model of self and the world. According to him, the attempts to shield oneself from the memories reduce the chance of the mind to work on them. The result is the cyclical intrusion of such memories in one's life. This hypothesis, Horowitz argues, accounts for the poor self-image and some of the sexualized behaviors of the victims of child sexual abuse, as they attempt to work through and gain mastery over their abuse. Another intriguing explanation of PTSD phenomenon comes from Janoff-Bulman (1985). She traces the PTSD symptoms seen in victims of child sexual abuse to the fact that a traumatic event of abuse shatters the assumptions that victims have held about the operation of the world, assumptions such

as "I am safe", "I am good", and "the world is just, and bad things do not happen to good people."

Advancing an emotional accommodation hypothesis, as an alternative to PTSD formulations, Finkelhor & Browne (1985; Finkelhor & Browne, 1988) developed an eclectic model called Traumagenic Dynamics Model of Child Sexual Abuse. This model proposes four traumagenic dynamics which form the base for emotional, psychological injury to the child. They are: traumatic sexualization, betrayal, powerlessness, and stigmatization. Traumatic sexualization refers to the situation in sexual abuse under which children's sexuality is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion. This can occur in several ways. For example, this can occur when children are repeatedly rewarded by an offender for sexual behavior that is inappropriate to the children's level of development. It can also happen through the exchange of affection, attention, privileges, or gifts for sexual behavior, so the child learns sexual behavior as a strategy for manipulating others to get other developmentally appropriate needs met (Finkelhor & Browne, 1985; Finkelhor & Browne, 1988).

Betrayal in sexually abused children refers to the situation in which the children discover that someone on whom they were dependent has caused them harm and failed to protect them. This may occur in different ways in a molestation experience. For example, in the course of abuse

or its aftermath, children may come to the realization that the trusted person has manipulated them through lies about confusion or misconceptions of sexual behavior and moral standards. They may also come to realize that someone whom they loved or whose affection was important to them treated them with callous disregard. Children can also experience betrayal from nonabusing adult family members (usually the mothers) whom they trusted but who were unable or unwilling to protect or believe them, especially after the disclosure of the abuse (Finkelhor & Browne, 1985; Finkelhor & Browne, 1988).

Powerlessness in sexually abused children is caused when their will, wishes, and sense of efficacy are repeatedly overruled and frustrated and when they experience violence, the threat of injury, or annihilation. The most basic form of powerlessness is a child's vulnerability to repeated invasion of her body and the inability to stop it. Another core form of powerlessness is the experience of violence, coercion, and threat to the life and body that occur in some situations of sexual abuse. Ongoing vulnerability, entrapment, and the associated emotions of fear and anxiety also contribute to this dynamic (Finkelhor & Browne, 1985; Finkelhor and Browne, 1988). In this connection, Patten et al. (1989) note that issues of powerlessness are particularly crucial for adolescents, who normally are struggling developmentally with issues of dependency and identity, and for children, who are

vulnerable in any case.

Stigmatization refers to the negative connotation about self-evilness, worthlessness, shamefulness and guilt that are communicated to the children around the experience. These messages are communicated in several ways. They can come directly from the offender, who may blame the victim for the activity. When there is pressure for secrecy from the offender, this can convey powerful messages of shame and guilt. Stigmatization is also reinforced by attitudes that victims infer or hear from other persons in the family or community or out of the child's prior knowledge or sense that the activity is considered deviant and taboo. It is further reinforced if, after the disclosure, people react with shock or hysteria or blame the child for what has transpired. Thus, stigmatization can be caused by the offender, the victim's family, the community or even by the victim herself both during and after the abuse, and it can occur in varying degrees by the abuse characteristics. The psychological impact of stigmatization subsequently becomes incorporated into the child's self-image (Finkelhor & Browne, 1985; Finkelhor & Browne, 1988).

Sgroi's (1985) hypothesis of "damaged goods syndrome" among victims of child sexual abuse is another example of emotional accommodation hypothesis. According to Sgroi, fear of physical damage, societal response to the victim, experience of guilt and blame for participation in sexual

behavior, disclosure, and family disruption tend to undermine child sexual abuse victim's self-esteem. Low self-esteem combined with the feeling of somehow having *been spoiled or damaged tend to undermine the victim's self-confidence.

In sum, none of these theoretical models gives a conclusive view of the sources of differential self-perception among sexually abused children. However, the Traumagenic Dynamic Model developed by Finkelhor & Browne (1985, 1988), provides a very useful framework for the present study. In one of his most recent articles, Finkelhor (1989) postulated that each of the four traumagenic dynamics is an experience that "alters a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's self-concept, world view, or affective capacities" (p. 69). The result for the child, according to Finkelhor, is typically psychological injuries such as guilt or lowered self-esteem and a wide variety of emotional and behavioral problems. The Traumagenic Dynamics Model is an eclectic approach. It incorporates some elements of the PTSD, and thus includes both affective and cognitive distortion aspects of the child victim. It is also broad enough to explain the differential effect of sexual abuse on the victims based on the possibility that the degree of each of the traumagenic dynamics vary among victims.

Rationale for the Present Study

Child sexual abuse has become a complex, pervasive

social problem that cuts across all sectors of society. Much of what we know about the sequelae of child sexual abuse on the victims come from clinical reports and a few experimental studies. These investigations have reported a wide range of short-term and long-term negative emotional, behavioral, sexual and self-perception problems for the victims. Problems, noted in child and adolescent victims (short-term effects) include depression, anxiety, guilt, shame, fear, traumatic neurosis, blocked ego and self development, and poor self-esteem; learning disabilities, school problems, truancy, running away, isolation, delinquency, aggression, anger, hostility, self-mutilation, suicidal attempts, and impaired ability to trust; lack of sexual identity, drug abuse, re-victimization, prostitution, clinging and inappropriate sexual behavior; somatic complaints such as nightmares, hyper vigilance, eating and sleeping disorders, abdominal pain, vomiting; and post-traumatic stress disorders (Wyatt & Powell, 1989, Sirles, Smith & Kusama, 1989; Deblinger et al., 1989; Patten et al, 1989; McLeer et al., 1988; Zivney & Nash, 1988; Kilgore, 1988; Haugaard & Reppucci, 1988; DePanfilis, 1988; Livingston 1987; Finkelhor, 1987; Finkelhor et al. , 1986; Browne & Finkelhor, 1986; Conte, 1986, Coons, 1986).

Problems reported in adults who were victims of childhood sexual abuse (long-term effects) include depression; anxiety; relationship problems, particularly inability to trust and maintain intimacy with others, and

social isolation; identity problems, self-destructive behavior, including substance abuse and suicidal attempts; fear of sex, sexual dysfunctions, promiscuity and a tendency of re-victimization and prostitution; low self-esteem; fears; a profound sense of being stigmatized; pervasive feeling of helplessness; and extreme sense of guilt, shame and Post Traumatic Stress Disorders (Fromuth & Burkhart, 1989; Haugaard & Reppucci, 1988; Roth & Lebowitz, 1988; DePanfilis, 1988; Finkelhor, 1987; Finkelhor et al., 1986; Browne, & Finkelhor, 1986; Conte, 1986; Coons, 1986; Steele, 1986; Gelinas, 1984; Bagley, 1984; Greenberg, 1984; Gelinas, 1984; Herman, 1981).

Sequela commonly reported both in adolescents (short-term effects) and adults (long-term effects) who were victims of childhood sexual abuse include: (1) suicidal gestures and attempts; (2) personality problems, including guilt, anxiety, fears, depression, and permanent impairment of self-image; (3) serious personality dysfunction, including chronic psychosis, self-mutilation, induced obesity, anorexia nervosa, hysterical seizures, and a chronically self-punitive lifestyle that is a response to feelings of guilt and self-disgust; (4) running away from home, or removal by judicial and child welfare authorities unaware of, or indifferent to, the sexual abuse; (5) prostitution or sexually dominated or explicit lifestyle; (6) withdrawal, coldness, frigidity, or lack of trust in psychosexual

relationships; (7) aggression, aggressive personality disorders, and chronic delinquency; and (8) substance abuse leading to chronic addiction and health impairment (Wyatt & Powell, 1989; Asher, 1988; Finkelhor & Browne, 1988; Roth & Lebowitz, 1988; Bagley, 1984).

However, a comparison of clinical reports and the empirical studies in the areas of emotional, behavioral, sexual and self-perception problems for the victims, both short-term and long-term, indicate very few universal agreements in the findings. It appears impossible to predict with absolute certainty that every child who is sexually abused, even in cases of intrafamilial abuses, will experience the same consequences (Wyatt & Powell, 1989; Hangaard & Repucci, 1988; Wyatt, 1985). The limited number of empirical studies that have been completed to date show more clearly than clinical reports considerable variability in the magnitude of the negative effects experienced by both child and adult victims of childhood sexual abuse (Fromuth & Burkhart, 1989; Conte & Berlinger, 1988; Hangaard & Reppucci, 1988; Finkelhor, 1987; Browne & Finkelhor, 1986; Peters, et al., 1986; Adams Tucker, 1982; Burton, 1968). Some children appear quite seriously damaged by the experience while others are not so seriously damaged and some times not at all damaged. Many of the definitional and methodological problems, including measurement, and lack of adequate control group are said to be partially responsible for this

discrepancy in the findings of these empirical studies (Haugaard & Emery, 1989; Haugaard & Reppucci, 1988; Browne & Finkelhor, 1986; Peters & Wyatt, 1986).

Also, it is now assumed that a number of situational factors prior to, during and after the abuse may account for the differential effects on the victims (Asher, 1989; Finkelhor & Browne, 1988; Haugaard & Reppucci, 1988; Conte & Berlinger, 1988; DePanfilis, 1988). Consequently, researchers have begun to identify several such situational factors which need to be empirically examined for their possible differential effects. These factors include, the age of victim, victim's developmental status, age of offender, gender of offender, use of violence, the degree of shame or guilt invoked in the victim, the reaction of victim's non-abusing mother after the disclosure of the incident, reactions of other professionals involved, victim's removal from home, duration of abuse, type of abuse, the relationship of the abuser to the victim, number of offenders, and the number of problems exhibited by the victim's family (Asher, 1989; Haugaard & Reppucci, 1988; Browne & Finkelhor, 1988; Finkelhor et al., 1986; Conte, 1986; Tufts, 1984; Jones et al., 1980).

Although all of the above mentioned factors may influence the victim's reaction to a lesser or greater degree, in intrafamilial child sexual abuse situations, the abuse characteristics of age abuse began, relationship of the

offender to the victim, type of sexual activity, duration of abuse, use of violence, and mother support are the commonly identified variables that may account for differential outcome among victims. Further, impaired self-image/self-esteem is considered to be a primary cause of much of the emotional, behavioral, and sexual problems that are often seen reported among the victims of intrafamilial child sexual abuse. However, to date, no known empirical study investigating the short-term effects has systematically examined the differential effect of the above cited abuse characteristics among young adolescent victims of intrafamilial child sexual abuse using a standardized psychological measure of self-image and a control group of non-abused peers. The present study was designed to fill this gap.

Significance of the Study

The findings of this study are expected to have theoretical, empirical, and clinical significance.

Theoretical Significance

Currently, there is no theory that is generally accepted as providing a definitive view about the sources of differential consequences to victims. The major hypotheses that are available in the literature remain untested. The findings of this study are expected to validate the fundamental assumptions underlying the theoretical model outlined in this study in terms of the effect of child sexual

abuse on the victim's self-image and consequent emotional, behavioral and sexual problems. Validation of the findings of this study in similar studies in the future should help the development of an empirically tested theoretical model.

Empirical Significance

This is one of few empirical studies examining the possible differential short-term effects of intrafamilial child sexual abuse characteristics on the victim's self-image. The fact that this study's methodology is much more sophisticated than the previous empirical studies (e.g., limits its sample to intrafamilial child sexual abuse victims, includes only body contact abuse, clearly defines abuse characteristic variables, and uses a control group and a standardized psychological outcome measure) should help increase the validity of the findings. In addition, this study is expected to establish the need for more studies designed on this model to further validate the findings of this study using other standardized, non-behavioral outcome measures.

Clinical Significance

The results of this study are expected to have important implications for social service agencies (child protective services agencies) who investigate reports of child sexual abuse and clinicians who evaluate and treat victims. Because the interventions used with victims and their families should depend to a large degree on the hypothesized sources of the

effects, it is important that Child Protective Services agencies and other clinicians consider a wide range of possible sources that might predict which victims may react more negatively to sexual abuse. The findings of this study can be used to identify victims who may have greater or lesser chance of developing severe symptoms and to identify those who may be in need of more or less therapeutic intervention. Also, identification of meaningful relationships between the abuse characteristics and the degree of impairment of self-image on the victims would provide clinicians with valuable information about the directions for treatment and treatment strategies. This is particularly important since the success of intervention and treatment in families where child sexual abuse occurs depends to a large degree on how those intervening with the child and family view characteristics of abuse that are likely to cause negative consequences, rather than assuming that all victims, regardless of the abuse characteristics, suffer the same consequences.

Chapter II

REVIEW OF LITERATURE

The effects of sexual abuse on children and on adults victimized in their childhood have been an area of increased interest for mental health professionals lately. Many clinicians and researchers have described a wide range of negative short-term and long-term psychological, behavioral, and sexual problems for the victims. Short term effects, otherwise called "initial effects" are usually defined as those reactions occurring within two years of the termination of the abuse. Long term effects, on the other hand, are those consequences that last into adulthood (Browne & Finkelhor, 1986). This general review of the literature on the effects of child sexual abuse on the victims is organized in five sections: (1) short-term effects in clinical reports; (2) short-term effects in experimental studies; (3) long-term effects in clinical reports; (4) long-term effects in experimental studies; and (5) differential impact of abuse characteristic. The first four sections of this review separately focus on emotional and behavioral effects, sexual effects, and effects on the victim's self-perception. The final section focuses on the impact of abuse characteristics that are particularly relevant to the present study.

Short Term Effects in Clinical Reports

Much of the literature describing the short-term effects

of child sexual abuse consist of clinical reports in which the presumed effects are anecdotally presented, often in relatively small samples, without actual measurement of the effects reported (Conte & Schuerman, 1989). Such information about short-term effects on the victims typically involves descriptions of victims seen in clinical settings. Most of the clinical case studies simply document similarities in symptomatology among patients. Others describe a set of cases of children or adolescents presenting with a particular disturbance who later disclose recent or ongoing abuse. All clinical reports on short-term effects, however, document some degree of harm to the victim (Calahoun, 1983).

Emotional and Behavioral Effects

The clinical reports indicate a wide variety of emotional and behavioral disturbances in victims of child sexual abuse. Two, in particular, articles in the literature (McCowan, 1981; Roger & Thomas, 1981) based on the clinical case reviews list numerous possible emotional and behavioral indicators of sexual abuse that are representative of frequently mentioned symptoms. Symptoms identified in these articles include depression, somatic complaints, school problems, disruption in peer relationships, nervousness, aggression, hostility, running away, alcohol/drug abuse, aggressive behaviors, phobias, and suicidal ideation. In an earlier report, Lewis and Sarrel (1969) reviewed clinical cases from a residential treatment center and from a child

psychiatric clinic. They chose to distinguish child victims on the basis of age and listed emotional and behavioral symptoms separately for each age group. The primary reactions seen in infant victims were anxiety and impaired trust. Somatic problems and regressive behaviors were noted as likely manifestations of anxiety. They further found early childhood victims reacting with acute anxiety. Other observations noted include lying, stealing, and guilt. Somatic complaints, stealing, phobias, school difficulties, delinquency, borderline states and obsessional states were listed as symptoms occurring in middle childhood and were said to be more severe in ongoing abuse. Adolescents, who the authors felt to be particularly vulnerable to sexual abuse, reacted often with acute anxiety, depression, acting out, delinquency, and psychosomatic complaints. They further noted type and duration of abuse, and the quality of parent-child relationship related to pathological outcome.

In another clinical observation, MacVicar (1979) reported cases encountered in therapy distinguishing seven accidental victims from ten participating victims of incest. According to this author, latency age accident victims often experienced phobias, dramatic learning and behavioral problems, guilt, and increased interest in sex. Adolescent accidental victims reported depression and reluctance to return to school. Participating victims of latency age experienced an increased level of excitement and anxiety.

MacVicar reported aggressive impulse as one of the problems that most vividly demonstrated in therapy sessions. All developed learning disorders, and most of them showed severe behavior problems and phobias. All adolescent participating victims experienced depression. Other problems included uncontrolled hostility, borderline character pathology, drug use, suicide attempts and delinquency.

Simpson and Porter (1981) studied 20 self-mutilators under age 18 hospitalized in a psychiatric unit in a hospital. Nine of the 20 had been sexually abused. They had developed problems of guilt, anger, running away, suicidal ideation, heavy drug use and problems of psychosomatic nature. Anderson (1981) review of four case histories of suicidal adolescent girls who revealed incest with a father or step-father, found anxiety to be a major problem in all the girls and observed depression, guilt, and lowered self-esteem in some.

Livingston (1987) in a case review found significantly greater frequencies of psychotic symptoms, major depressive disorder, and somatic complaints in sexually abused children frequently hospitalized for psychiatric care compared to physically abused children. A more recent study (Sirles et al., 1989), which clinically assessed initial psychiatric profile of a large sample of sexually abused children who presented at an outpatient child psychiatry clinic, identified a wide diversity in victim response to incest. The

older the victim, the closer the relationship of the offender to the child, the greater the frequency of abuse incidents, the longer the duration of abuse, the offender having a history of alcohol abuse, and the victim being a victim of physical abuse as well as sexual abuse were all related to the presence of DSM-III Axis I clinical disorder. In another recent study, Patten et al., (1989) observed Post Traumatic Stress Disorders related to traumatic sexualization, stigmatization, betrayal and powerlessness in sexually abused children.

Fischer's, (1983) and Sturkie's, (1983) clinical studies of sexually victimized adolescents determined that the sense of guilt is felt more often by: (1) children who experience abuse over a long period of time; (2) children abused at an older age; and (3) children for whom natural physical responses or the increased attention and warmth from the abuser made the sexual activity pleasurable. Giarretto's (1981) clinical observation indicates that the guilt felt by a child whose report of incest causes a parent to be incarcerated is often heightened as other members of the family may blame the victim for the family's loss of financial support. The common denominator for feelings of guilt, however, appears to be the victim's sense of responsibility for the abuse or events occurring afterward (Haugaard & Reppucci, 1988).

In many victims the guilty feeling is accompanied by

anger or depression (Fischer, 1983; Gelinas 1983). Several clinicians report anger as an often pervasive emotional effect directed toward the abuser, other family members, and social service agencies with which the victim interacts (Lubell & Soong, 1982; Sturkie, 1983). Anxiety is another common emotional reaction; it is expressed in increased fearfulness, somatic complaints, changes in sleep patterns, and nightmares (Adams-Tucker, 1982; Byrne & Vldiserrir, 1982; Gelinas, 1983). Victims also experience a sense of powerlessness. This feeling can arise in response to the victims' inability to stop the repeated invasion of their bodies (Gelinas, 1983; Sturkie, 1983) and to their inability to control events once they begin to interact with social service, mental health and legal agencies (Lubell and soong, 1982).

Rogers and Terry (1984) in their clinical study of male victims of child sexual abuse found the development of aggressive behavior as a way of re-establishing their masculinity. This behavior often took the form of picking fights or bullying younger children and also chronic disobedience and antisocial acts. Bess and Janssen, (1982) found that incest and non-incest samples comprised of psychiatric patients were distinguished by a higher level of suicidal thoughts and actions in the incest group. High suicidal ideation and self-mutilation behaviors among sexually abused children have also been reported by other

investigators (Adams-Tucker, 1982; Dixon, Arnold and Calestro, 1978). Lindberg and Distad, (1985) found that of twenty-seven adolescents seen in therapy because of previous incest, sixteen had engaged in self-mutilation behaviors. Anderson (1981) also noted a high rate of both suicidal tendencies and self-mutilation behavior among sexually abused children.

There are some case reports which, however, conclude that sexual abuse causes minimal short-term damage. For instance, Yorukoglu and Kempf (1966) described two cases of parent-child incest with victims experiencing "no long-lasting symptoms" after one year. In fact they report that both victims, a girl and a boy, made a positive adjustment to previous experience after an initial difficult adjustment. They add, however, that the adolescents could encounter problems in later phases of their development.

Sexual Effects

There is clinical evidence of heightened sexual activity of children as a result of sexual abuse. DeYoung, (1984) reports on four children molested at young age who acted in sexually provocative ways toward older males. Similarly, Yates (1982) reports observing hypersexual behavior in several young, sexually abused children whom she describes as having been "eroticized" by their early sexual experiences. Fischer (1983) reports that 46 percent of the twenty-six sexually abused adolescent delinquents she saw engages in "sexually acting out behavior." James and Nasjleti, (1983)

and Borgman, (1984) report that common behavior of abuse victims in their samples included sexual acting out against adults and simulation of sexual activity with younger children. Kohan, Pothier and Norbeck, (1987) gathered data from 110 inpatient child psychiatric hospitals comparing the behaviors of sexually abused versus other patients. They found that over 80 percent of the hospitals reported that sexually abused children were involved in sexual play with others and were seductive with the staff more than other patients. Other case studies have reported a wide range of sexual problems observed in the victims including sexual self-consciousness or provocativeness, vulnerability to sexual approaches, promiscuity and regressive behavior, sex play, increased sexual activity, sexual fantasies, and homosexual activities, (McCowan, 1981; Thomas & Rogers, 1981; Pascoe & Duterte, 1981; MacVicar, 1979, Lewis and Sarrel, 1969).

Effect on Self-Perception

There are repeated clinical observations of disturbances of sense of self in physically and emotionally abused children. Martin & Beezley, (1977) found "very few abused children thought well of themselves" (p.374). Half of their sample showed "obvious low self-esteem" and often appeared unresponsive to praise. Green, (1978) likewise noted a high frequency of self-deprecation in his study of 20 physically and emotionally abused children. Humphrey, Ackerman,

Strickler, (1978) also report observing the tendency of abused children to incorporate negative parental attitudes and to believe that they deserve to be abused.

Disturbances in body image (feeling of permanent physical body impairment) have been repeatedly reported by clinicians working with sexually abused children (Sgroi, 1985; Burgess & Holmstrom, 1975; Kaufman, Peck & Tagiuri, 1954). Lewis and Sarrel's (1969) clinical review of cases revealed that sexually abused adolescents often reacted with lowered self-esteem. Finkelhor's (1989) review of clinical case studies noted problems in the area of self-esteem as one of the commonly documented symptoms. Several other clinicians noted a sense of loss in many victims of child sexual abuse. This includes loss of their family if they are placed in foster care, or if the family chooses to support the perpetrator rather than the victim, loss of their innocence, and loss of their "normalcy" (James, 1977, Lubell and Soong, 1982).

It is assumed that disturbances in self-esteem result in the development of self-destructive behaviors (self-injury, self-mutilation, suicide, and suicidal ideation) in sexually abused children. In this connection, DeYoung (1982) noticed 57.7 percent self-injurious behaviors in incest victims with a typical age of sexual abuse onset between 9.7 and 12.4 year. Kriechman (1987) and Volkmar, Poll and Lewis (1984) observed that conversion disorders, a manifestation of body

image disturbance, are strongly associated with histories of sexual trauma in children and adolescents. As Putnam (1987) observes, a number of interactive factors like learning and attentional problems (Kaufman et al., 1954; (Adams-Tucker, 1982), poor peer relationships (Green, 1978; Humphrey et al., 1978, Martin & Beezley, 1977) social withdrawal and isolation (Adams-tucker, 1982; Coons, 1986, Martin & Beezley, 1977; Green, 1978) depression (Blumberg, 1981; Coons, 1986; Kaufman, et al. 1954) and maladaptive behaviors such as aggression (George & Main, 1979; Hoffman- Plotkin & Twentyman, 1984) and oppositional behaviors (Adams-Tucker, 1982; Martin & Beezley, 1977) are likely to produce negative responses in peers and significant others leading to the downward spiral of self-esteem.

Porter, Blick and Sgroi (1985), based on their clinical experience, agree with the assumption of downward spiral of self-esteem. They observe that poor body image, societal response, guilt, shame, and blame for participation, disclosure, and disruption of family life all tend to undermine the victim's self-esteem. DeFrancis (1969) summarized data on 3,000 cases of reported sexual abuse of children ages 1-15 in New York. The author theorized that the child's ordeal of public cross-examination could cause more guilt, shame, embarrassment and anxiety than the event itself. DeFrancis also assumed that sexual abuse, in itself, could cause lowered self-esteem, and even perhaps psychosis.

Short Term Effects in Empirical Studies

Most of the findings described on the short-term effects of child sexual abuse on the victims are based on clinical impressions. To date very few empirical studies investigating short term effects have been conducted using standardized instruments, and even the limited number of empirical studies that have been completed used mostly behavioral measures, not psychological measures (Asher, 1988). While clinical reports and behavioral measures are useful in providing a context for discovery, without adequate psychological measures or control procedures they fail to demonstrate with any certainty what the actual psychological functioning of children is and what may actually account for such functioning (Conte & Schuerman, 1989).

Emotional and Behavioral Effects

A few empirical studies have given support to the clinical observations and reports of generally negative emotional and behavioral effects of child sexual abuse, (e.g., Bagley & Ramsey, 1986; Friedrich, Urquiza & Beilke, 1986; Gomes-Schwartz, Horowitz & Sauzier, 1985; Briere & Runtz, 1985; Tufts, 1984; Peters, 1984; Briere, 1984; Fromuth, 1983; Anderson, Bach & Griffith, 1981; Tufts, 1984; Seidner & Calhoun, 1983; DeFrancis, 1969). Some of their studies (e.g., Friedrich et al., 1986; Gomes-Schwartz et al., 1985; Tufts, 1984) used objective measures while others primarily used the judgment of the clinicians.

In an early study of the effects of sexual abuse of 217 female children, including adolescents, DeFrancis (1969) reported that 66 percent of the victims were emotionally and behaviorally disturbed by the molestation, 52 percent mildly to moderately disturbed and 14 percent seriously disturbed. Only 24 percent were judged to be emotionally stable after the abuse. The sample of this study was drawn from court cases and subjects were primarily low income and multiple-problem families who were on public assistance. Therefore, these findings may have little generalizability. Investigating a different type of special population, Anderson et al., (1981) reviewed clinical charts of 155 female adolescent sexual abuse victims and reported psychosocial complications, including emotional and behavioral problems, in 63 percent of the sample. Reports of "internalized psycho-social sequela" such as sleep and eating disorders, phobias, depression, guilt, shame and anger were noted in 67 percent of female victims when the abuse was intrafamilial and 49 percent when the offender was not a family member. "Externalized sequela", including school problem and running away were noted in 66 percent of intrafamilial victims and 21 percent of extrafamilial victims. However, due to the fact that this study did not use any standardized measure, the judgments of these effects may be subjective.

In what is probably the best known empirical study to

date in this field, researchers affiliated with the Division of Psychiatry at the Tufts New England Medical Center (1984) gathered data on families involved in a treatment program restricted to those children who had been victimized or revealed their victimization in the prior six months. This study used standardized self-report measures such as the Louisville Behavior Checklist (LBC), The Piers-Harris Self-Concept Scale, the Purdue Self-Concept Scale, and the Dottschalk Glessner Content Analysis Scales (GGCA), with published norms and test validation data for the purpose of contrasting characteristics of sexually abused children with norms of general and psychiatric populations. Subjects ranged in age from infancy to 18 years and were divided into preschool, latency, and adolescence age groups. Data were collected on four areas: overt behavior, somatized reactions, internalized emotional states, and self-esteem.

In terms of the short term emotional and behavioral effects of the child sexual abuse, Tufts (1984) researchers found differences in the amount of pathology reported for different age groups. Seventeen percent of 4 to 6 year olds (N= 30) in the study met the criteria for "clinically significant pathology" and behavioral disturbances on 11 of the 18 test scales of LBC. This reflected more overall disturbance than a normal population but less than the norms for other children of the same age who were in psychiatric care. Sexually abused school age children (N = 58) presented

significantly more behavioral disturbance than non-abused children on all but two scales. School age abused children presented significantly less behavioral disturbance than school age children under psychiatric care on all scales of LBC except one scale. The highest incidence of psychopathology was found in the 7 to 13 year old age group, with 40 percent scoring in the seriously disturbed range. Interestingly, few of the adolescent victims exhibited severe psychopathology, except on a measure of neuroticism.

In another popular study, Friedrich et al. (1986) investigated emotional and behavioral effects of 85 sexually abused girls using a standardized measure. Subjects in this sample were abused within a 24-month period prior to the study. These researchers asked parents of the victims to complete the Achenbach Child Behavior Checklist (CBCL). This study reports that 46 percent of the subjects had significantly elevated scores on its Internalizing scale (includes items such as fearful, inhibited, depressed, and over controlled behaviors) and 39 percent had elevated scores on its Externalizing scale (aggressive, antisocial, and under controlled behaviors). This was compared with only two percent of the normative sample who would be expected to score in this range. Further, this study found that sexually abused girls were somewhat elevated on both internalizing and externalizing scales. For instance, 35 percent of the males and 46 percent of the females were elevated on the

internalizing scale, and 31 percent of the males and 44 percent of the females were elevated on externalizing scale. Overall, the younger children had more internalizing behavior, and the older children, ages 6 to 12, had more externalizing behavior.

A similar pattern of emotional and behavioral disturbance was noted by Gomes-Schwartz et al. (1985), who had the parents of 156 sexually abused children complete the LBC. In this study, norms for the general population and a clinical population were available for preschool and school-age children, and norms for clinical population were available for adolescents. All age groups of victims had lower frequency of adverse behaviors than the clinical norms, and the pre-school and school-age groups had a higher frequency of adverse behaviors than the general population norms. These researchers state that this intermediate level of behavioral outcome was due to the occurrence of relatively severe pathology in some victims, which brought the pathology of sexually abused group above that of the general population, and few signs of pathology in other victims, which kept the group pathology below that of the clinical population. This study, however, did not investigate which factors in the abuse situation might have caused the difference in pathology in sexually abused victims. This study also found that more school age children than pre-school children engaged in acting out behaviors.

Although fear is most commonly reported in empirical literature, the exact proportion of victims with this effect vary from high 83 percent reported by DeFrancis (1969) to 40 percent reported by Anderson et al. (1981). Tufts (1984) study found 45 percent of the 7-13 year olds with severe fears, compared with 13 percent of the 4-6 years old as measured on LBC. In this study on the adolescent version of the LBC, 36 percent of the 14-18 year olds had elevated scores on "ambivalent hostility" or the fear of being harmed. The Tufts (1984) researchers found that 45 percent to 50 percent of the 7-13 year-olds showed anger and hostility levels that were substantially elevated on measures of aggression and anti-social behavior (LBC) as did 35 percent on the measures of anger and hostility directed outward (GGCA). Thirteen percent to 18 percent of the 4 to 6 year olds scored above the norms on aggression and antisocial behavior (LBC), whereas 25 percent of the 4 to 6 year olds and 23 percent of the adolescents had elevated scores on anger and hostility directed outward (GGCA). In his study of court cases, DeFrancis(1969) noted that 55 percent of the children showed behavioral disturbances such as active defiance, disruptive behavior within the family, and quarreling or fighting with siblings or classmates. The findings of this study might have been considered biased because of the sample selection from court cases; however, his findings are not very different from the findings of the Tufts study for school age children.

Guilt, shame and depression are other frequently observed reactions in clinical literature. However, few empirical studies give clear percentages on these aspects. DeFrancis (1969) observed that 64 percent of his sample expressed guilt and shame, although this was more about the problems created by disclosure than about the molestation. Anderson et al. (1981) found guilt and shame reactions in 25 percent of victims. Depression is more often noted as a symptom with regard to adolescent victims than with younger victims. For example, Maisch (1972) reported that 28 percent of his adolescent sample was depressed and 4 of the 78 attempted suicide. Sixty percent of (N= 54) of DeYoung's (1982) adolescent sample attempted suicide at least once, with 27 making more than one attempt. The first attempt occurred either during the incest or within two years of its cessation.

Numerous other researchers have found support for clinical observations of generally negative emotional and behavioral effects as a result of child sexual abuse. For example, intrafamilial child sexual abuse victims have been found manifesting problems such as depression, anxiety, lack of sexual identity, confusion, fear of sex, traumatic neurosis, somatic complaints, and blocked ego development (Kilgore, 1988; Livingston, 1986; DeYoung, 1982). The victims are often isolated from the family members (DeYoung, 1982), and exhibit general signs of harm than peers in the general

population (Gomes-Schwartz, 1985). The victims may act out by running away, which is described as escape behavior, exhibit sleep disturbances, school problems, anti-social behaviors such as drug use, lying and stealing (Justice & Justice, 1979; Reich, & Gutierrez, 1979). There is evidence that some incest victims resort to self-injury (DeYoung, 1982). Also, three recent studies found a high rate of sexually abused children meeting DSM-III-R Post Traumatic Stress Disorder criteria (Sirles et al., 1989; Patten et al., 1989; Mcleer et al., 1988).

Developmentally, sexually abused children exhibit different emotional and behavioral symptoms at different age levels. Young children generally present with behavioral symptoms that are manifestations of anxiety. As children enter latency and early adolescence, aggressive and impulsive behavior begins to appear. Older children seem to be more disturbed emotionally and behaviorally by sexual victimization than are younger children. As children reach adolescence, acting out becomes more common as a way of expressing overwhelming feelings and also as a plea for help. Few sexually abused children of any age, however, are able to directly verbalize the emotional distress they are experiencing (Asher, 1988).

Sexual Effects

Reactions of inappropriate sexual effect in child victims of sexual abuse have been confirmed by several

empirical studies. For example, in an early study, Gagnon (1965) compared girls who had experienced ongoing abuse with those who had one "accidental" abuse contact with a stranger. He found that a similar pattern of peer sexual play before the abuse occurred and a higher level of homosexual peer sexual play by the girls experiencing ongoing abuse once it began. In Tufts (1984) study, 27 percent of 4 to 6 year old children scored significantly above clinical and general population norms on sexual behavior scale that included having had sexual relations, open masturbation, excessive sexual curiosity, and frequent exposure of the genitals. Thirty-six percent of 7 to 13 year olds also demonstrated high levels of disturbance on the sexual behavior measure when contrasted with norms for either general or clinical school-age populations. Similarly, Friedrich et al. (1986) using CBCL to evaluate 3 to 12 year olds found that 70 percent of the boys and 40 percent of the girls scored at least one standard deviation above a normal population of that age group on the scale measuring sexual problems. In a very recent study (Deblinger et al., 1989) found sexually abused children exhibiting significantly higher rates of inappropriate sexual behaviors than either the physically abused or non-abused children. Other researchers have found promiscuity, prostitution, pregnancy and revictimization as additional complications, especially, among adolescent victims (Romney, 1982; Maisch, 1972; Adams-Tucker, 1981).

Effect on Self-Perception

There is empirical evidence of impairment to self-esteem among physically abused children. Kinard (1982) found that physically abused children differed significantly from nonabused children on certain items of Piers-Harris Children's Self Concept Scale. More severe abuse was associated with a greater likelihood of having a negative self-image. Hjorth and Ostrov (1982) compared thirty physically abused adolescents with two control groups, one non-abused and another normal adolescents from similar background using Offer Self-Image Questionnaire. Results showed that physically abused adolescents feel worse in a number of areas when compared to non-abused. These areas include family relations, emotional stability, psychopathology, impulse control, coping skills, as well as poorer overall self-image.

Sexual abuse is frequently cited in clinical literature having an effect on self-esteem, but empirically it has not been tested enough to establish the claim. Fifty-eight percent of the victims in the DeFrancis (1969) study expressed feeling of inferiority or lack of worth as a result of having been victimized. However, this study did not use a control group. In a surprising finding, Tufts (1984) study, using Purdue Self-Concept Scale, found no evidence that sexually abused children in any age groups had consistently lower self-esteem than a normal population of children. However, it has to be noted that this study investigated the

overall effect of sexual abuse and did not look at specific characteristics of abuse that might have a differential effect on the self-esteem. Conte, Berlinger and Schuerman (1986) investigated the effects of sexual abuse on children using several behavioral measures developed by the researchers. On the Child Behavior Profile Checklist, completed by the parent, they found abused children with significantly low self-esteem on the self-esteem factor. They also found abused children with significant behavior problems on the clinical dimensions of body image/self-esteem. In this study on the self-esteem factors of the Self-Report Questionnaire, completed by the child, females indicated poorer self-esteem compared to males. However, since this study was primarily designed for measuring the behavioral problems, coupled with the fact that no standardized measure of self-esteem was included, make the findings of this study inconclusive.

In summary, while the clinical reports clearly indicate that sexually abused children suffer a variety of emotional, behavioral, sexual, and self-perception problems that can last for several years, the extent to which all victims experience the same reactions is not known. It is assumed that a wide range of emotional problems like guilt, anger, shame, depression, helplessness and lowered self-esteem cause the development of many adverse behaviors. Some victims internalize their distress, resulting in somatic complaints,

sleep disturbances, nightmares, and self-destructive behaviors. Others externalize their distress, which leads to aggressive behaviors, acting out, and sexual activity with both younger and older individuals. Previous sexual abuse appears to have detrimental effects on the sexuality of older adolescents and adults. However, a few studies have suggested that indications of negative effects do not occur in each case of sexual abuse. Empirical studies on short term effects of sexual abuse also suggest many of the short-term effects reported in the clinical literature, at least in some portion of the population. In particular, there appears to be strong evidence for the reactions of anxiety, depression, anger and hostility, and inappropriate sexual behavior. However, because many of these studies lack standardized measures and adequate comparison groups, it is not clear that these findings reflect the experience of all child victims of sexual abuse or are even representative of those children currently being seen in clinical settings. There appears to be a dearth of empirical studies investigating the effect on victims' self-esteem, on standardized measures and with comparison groups.

Long Term Effects in Clinical Reports

Much of the progress made in the field of child sexual abuse has been based on the information gathered from adults molested as children. Although limitations in recall of retrospective information have been noted, such information

has been helpful, specifically in identifying long-term effects of abuse upon later psychological functioning. Reports of long-term effects of child sexual abuse usually come from clinicians who treat adults in treatment for various disorders. These investigators usually center on the descriptions of an adult psychopathology and the identification of possible symptom clusters. The idea that sexual abuse in childhood can have serious long-term impact is generally accepted by clinicians who work with the phenomenon.

Emotional and Behavioral Effects

There are several reports of clinical case studies documenting a wide range of long-term emotional and behavioral effects. Peters (1976) discussed seven cases of adults from his private practice. All clients revealed histories of child sexual abuse. The reactions observed in these patients included phobias, anorexia, poor appetite, anxiety, guilt, hostility, and running away. Acute psychotic reactions developed at one time in three of Peters' seven cases; two of them became schizophrenic as adults, and one patient developed a major conversion hysteria.

Steel and Alexander (1981) presented three incest cases as examples illustrative of emotional and behavioral problems seen in adults sexually abused as children. The victims of father-daughter incest in this report experienced long-term responses of guilt, depression, suicidal ideation,

confused identity, a tendency to accept cruel and abusive partners and to abuse their own children. Of the two women involved as children in brother-sister incest, one experienced an immediate reaction of fear, and later became promiscuous and involved with an abusive man; the other avoided serious relationship with men. These clinicians further proposed that in addition to the above listed symptoms experienced by incest victims, sexually abused children in general may also develop symptoms of withdrawal, anxiety, delinquency, extreme anger, self-doubt characterized by an inability to trust their own judgment, inability to trust others, and to control their own lives.

Lukianowicz (1972) reviewed 26 cases of women in therapy who spontaneously revealed a history of father-daughter incest. Many victims became alcoholics, drug abusers, and delinquents. Eleven of the women were diagnosed as having character disorders. Three had symptoms of hysterical personality. Depression and suicide tendencies occurred in three. In contrast to the victims of father-daughter incest, 27 of 29 victims of other types of incest evidenced "no grave psychiatric sequela."

Summit and Kryso (1978) based on the review of their clinical and consulting experience concluded that childhood victims of sexual abuse were "harmed in predictable ways." According to these clinicians, possible behavioral and emotional effects for the victims include, guilt, drug

dependency, depression, suicidal ideation, and abuse of one's own children. Additionally they suggest that women abused as children would later "accept misogynous, imperious, or rapacious partners." Boekelheide (1978) discussed the functioning of college women in therapy who experienced incestuous relationships. Presenting complaints ranged from depression to anxiety neurosis. The revelation of incest in therapy often included guilt, depression, shame, and anxiety. Other adult problems included sleep disturbances, nightmares, anxiety, and alienation.

A recent report of emotional and behavioral trauma of seven women who experienced childhood sexual trauma (Roth & Lebowitz, 1988) is typical of the commonly reported problems. They include: (1) fear of overwhelming affect of the emotions associated with their trauma; (2) rage at their abuser or about the event; (3) helplessness in the sense that someone else had absolute power and control over them; (4) fear of the event and the consequences of reporting it; (5) a sense of loss, self-blame, and attempts to compensate for the effects of trauma; (6) alteration in schemes of self and about the world; (7) repetition of the elements of their sexual trauma sometimes leading to an abusive relationship; (8) unhelpful social responses; (9) isolation and alienation; and (10) feelings about the mother's support or lack of it.

Sexual Effects

Difficulties in adult sexual adjustment are frequently

reported in clinical literature on adult victims of childhood sexual abuse. Gundlach (1977) reported that ten of the eighteen women abused as girls by strangers and sixteen of the seventeen abused by family members had chosen a homosexual lifestyle. Along the same line, Bess and Janssen (1982) found that 70 percent of their sample of ten psychiatric patients who were abused as children, compared with 18 percent of twenty-two nonabused psychiatric patients, reported adult sexual impairment or variant sexual practices as an adult. Steel (1986), based on his long term clinical experience with victims of childhood sexual abuse, observed that individuals who were sexually abused as children continue to feel sexually exploited and have some tendency to exploit others. In his observation, males tend to feel much more ashamed, embarrassed and denigrated by their past experience, and girls feel degraded, dirty or spoiled. He further found that a significant number of such youngsters of either sex eventually get into prostitution and other types of sexual problems. In his opinion, true intimacy seems unattainable for many victims, and they develop a significant or even a complete aversion to sexual activity and maintain celibate, rather lonely and an hedonic lives without even developing significant relationships with the opposite gender. Such experiences, he maintains, may also contribute, in many cases, to the development of homosexual orientations and alternative lifestyles. Other clinicians also reported sexual

dysfunction, promiscuity, prostitution, broken marriages, masturbation, sexual preoccupation and pornographic modeling among a considerable percent of women sexually abused as children (Peters, 1976; Steele & Alexander, 1981; Lukianowicz, 1972; Summit & Kryso, 1978; Boekelheide, 1978).

Effect on Self-Perception

Similar to clinical reports of short term effects, almost all clinical reports of long-term effects on self-perception indicate lowered self-esteem among victims of childhood sexual abuse as one of the major effects. In his work with adults who were victims of childhood sexual abuse, Putnam (1987) repeatedly observed disturbances in person's self-perceptions. The forms of disturbances in self-perceptions that he observed include: self-concepts, self-image, self-esteem, body image and identity. He postulates that a number of symptoms commonly reported in adults who were victims of incest or other childhood sexual abuse (e.g. poor self-image and self-esteem, suicidal ideation and behavior, self-mutilation, disturbances in sexual identity and functioning, promiscuity, revictimization disassociation symptoms and multiple-personality disorders) can be interpreted as manifestations of major disturbances in the victims' sense of self.

Steel and Alexander (1981) noted self-doubt and low self-esteem in all three cases of incest cases that they presented as illustrative of problems seen in adults sexually

abused as children. Similarly, Summit and Kryso (1978) noted low self-esteem as one of the primary outcomes commonly observed among victims of childhood sexual abuse. James and Meyerding (1977) noted lowered self-esteem among women sexually abused as children. Steele (1986) observed that children, both girls and boys, inadequately protected by their mothers and have also been sexually abused by other family members seem to have an especially difficult time as they grow up and try to be part of the society. They have an especially low self-esteem and poor sense of identity which is particularly evident in the sphere of sexual identity.

Long-term Effects in Empirical Studies

The assumption that childhood sexual abuse almost certainly results in long-term mental health problems has been periodically attacked by skeptics who argue that the trauma is greatly overstated. Until recently, the argument for long-term impact was based primarily on less than rigorous clinical impressions. However, as evidence from clinical studies accumulates, it generally confirms the clinical impression that sexual abuse in childhood poses serious risk for long-term mental health. Compared to empirical studies of short-term effects, more empirical studies have been undertaken examining long-term effects, but very few of them actually compared childhood sexual abuse victims with nonvictims using standardized measures.

Emotional and Behavioral Effects

Retrospective studies which recruit subjects from clinical and general population limit the investigation of psychological damage to victims' self-reports of adult functioning, and they often demonstrate few long-term consequences. Several retrospective studies of child sexual abuse employed control groups for comparison among adults in psychotherapy. In one study, Meiselman (1978) investigated long-term effects of father-daughter incest, comparing 26 incest victims participating in therapy with 50 female controls from a psychotherapy clinic. This study found that the incest group presented with problems of depression, anxiety, suicidal ideation, hostility, phobias, and conflicts with children. Comparing women sexually abused as preteens with women victimized as adolescents, Meiselman found serious adult disturbances in 37 percent of the younger group and only 17 percent of the adolescents. In another retrospective study, Herman and Hirschman (1981) compared 40 women involved as children in father-daughter incest with 20 women whose fathers were seductive but did not initiate incest. Both groups attended outpatient psychotherapy clinics. Significant differences between groups included more problems of running away, teen-age pregnancy and attempted suicide in the incest group.

In contrast to the above studies of treatment populations, two studies of adults from the general

population who were sexually abused as children found few serious long-term effects from the experience. In an earlier study, Gagnon (1965) reviewed the adult reports of 33 women who had sexual contact before age 13 with an adult. An overall lack of negative effects was noted in this sample of mostly (71 percent) college educated women. Three-quarters of the sample reported their adjustment as fine with an additional 9 to 12 percent describing their as adequate. Four to seven per cent were labeled disturbed and five percent were severely damaged. Of the latter group of 18, only three women cited their early experience as a factor determining their present disturbance. The author related greater duration, the degree of coercion and the aggressive nature of the experience to negative outcome. Similarly, Brunold (1964) interviewed 62 adults (mean age 23 years) who as children experienced relatively serious sexual assaults. These victims' ages ranged from 5 to 14 at the time of offense. They were identified through court records. Brunold reported an almost complete lack of outcome after noting that the purpose of the negative investigation was not to uncover "positive proof of deeper psychic damage."

One study conducted by Tsai, Feldman-Summers and Edgar (1979) attempted to account for the various outcomes of previous studies by comparing victims from clinical and nonclinical populations. These researchers compared three groups of women on measures of psychosexual functioning and

on the MMPI: 30 women molested as children who sought therapy as adults, 30 women molested as children who never sought therapy, and 30 unmolested women who did not seek therapy. They found that clinical group adjusted in a significantly poorer fashion than the other groups, indicating that women who were molested as children may differ substantially from each other in terms of later adult adjustment. The clinical group in this study described a greater negative impact upon their lives than the nonclinical groups in various aspects of sexual functioning. On MMPI, the clinical group scored higher than other women on the following scales: Hypochondriasis, Depression, Psychopathic Deviate, Paranoia, Psychasthenia, and Social Introversion. These women additionally perceived themselves as significantly less well adjusted than the other groups. In contrast, the profiles of the molested women in the nonclinical group were 'normal' and did not differ significantly from the profiles of the matched control group. Women in the nonclinical group who experienced sexual abuse attributed their better adjustment to supportive family and friends and to sympathetic and understanding sexual partners. This investigation seems to reconcile the so-called contradictory findings of many studies of the long-term effects of child sexual abuse by documenting that one clinical group reporting such abuse was indeed less well adjusted than women from the nonclinical population who recalled similar experiences.

In another study, Gold (1986) contrasted the responses of 103 adult women who had been sexually abused as children and those of 88 women who were not abused. This study found many areas in which abused women appeared more disturbed. The abused women were more depressed as measured by the Beck Depression Inventory and had more psychiatric symptoms as measured by the Hopkin's Symptom Checklist. In clinical investigation reports, depression is the symptom most commonly reported among adults molested as children. One of the best known empirical survey studies (Bagley & Ramsey, 1986) seems to support this repeated clinical finding. This study, which surveyed 344 random sample of women in Calgary using measures such as the Middlesex Hospital Health Survey and Center for Environmental Studies' Depression Scale, found sexually abused women to be at generally twice the risk for depression, psychoneurosis, somatic anxiety, psychiatric hospitalization and suicidal gestures. This study also observed sexual abuse as the major risk factor for such outcomes after controlling for other negative developmental and family variables. However, severe levels of pathology were apparent in less than 25 percent of the sexual abuse victims. Another popular study (Peters, 1984), which surveyed a random sample of 250 women in Los Angeles, found a history of sexual abuse associated with increased risk for depression, as well as drug and alcohol abuse, when other variables were controlled.

There is some evidence indicating that both clinical and nonclinical samples that were used in experimental studies have shown self-destructive behaviors. Briere (1984) reported that 51 percent of the sexual abuse victims, versus 34 percent of nonabused clients, had a history of suicide attempts. Thirty one percent of victims, compared with 19 percent of the nonabused clients, exhibited a desire to hurt themselves. Bagley and Ramsey (1985) also in their study noted as association between childhood sexual abuse and suicidal ideation or deliberate attempts at self-harm. Similarly, Sedney and Brook (1984) in their study found that 39 percent of their college student sample with child sexual abuse reported having thoughts of hurting themselves compared to 16 percent of the control group.

Another reaction noted in clinical and nonclinical sample is the symptom of anxiety and tension. Briere (1984) reported that 54 percent of sexual abuse victims in his clinical sample experienced anxiety attacks as opposed to 28 percent of the nonvictims, and 54 percent reported nightmares, as opposed to 23 percent of the nonvictims, 72 percent had difficulty sleeping, as opposed to 55 of the nonvictims. Similarly, in their college sample, Sedney and Brooks (1984) found 95 percent with symptoms indicating nervousness and anxiety compared with 41 percent of the controls. Also in this study, 41 percent indicated extreme tension compared with 29 percent of controls, and 51 percent

had trouble sleeping compared with 29 percent of the controls.

The idea that sexual abuse victims continue to feel isolated and stigmatized as adults also has some support in the empirical studies which used clinical groups. Sixty four percent of victimized women in Briere's (1984) study reported feelings of isolation, compared with 49 percent of the controls. Herman (1981) reported that all women who had experienced father-daughter incest in her clinical sample had a sense of being branded, marked, or stigmatized by the victimization. Even in community samples of incest victims, Courtois (1979) found that 73 percent reported moderate to severe feelings of isolation and alienation.

Sexual Effects

Two disturbances uncovered by several empirical studies in the general population are sexual problems, including frigidity, vaginismus, flashbacks, and emotional problems related to sex and a much higher risk of subsequent sexual victimization (Wyatt, 1985); Fromuth, 1983; Herman, 1981). Two nonclinical studies (Courtois, 1979; Finkelhor, 1979) show effects on sexual functioning as well. In Courtois' study, 85 percent of the former incest victims reported an inability to relax and enjoy sexual activity, avoidance of or abstention from sex, or, conversely, a compulsive desire for sex. Finkelhor (1979), studying college students, developed a measure of sexual self-esteem and found that child sexual

abuse victims reported significantly lower levels of sexual self-esteem than their nonabused classmates. There is additional research suggesting a high percentage of prostitution among incest victims (James & Meyerding, 1977). A great frequency of sexual problems among the incest victims compared to that reported by controls was Meiselman's (1978) striking finding. Fritz, Stoll, and Wagner (1981) report that 23 percent of the molested women and ten percent of the molested men in their sample of college students were experiencing problems with sexual adjustment. Russell (1986) found that women abused as children appear to be more susceptible for later sexual violence than those who are not abused.

James and Meyerding (1977) compared early sexual histories of prostitutes with those of normal women and found that prostitutes had more incestuous experiences and reported more sexual advances by adults. The authors suggest that early, traumatic encounters were a factor influencing some women toward entrance into prostitution and other 'deviant' lifestyles. Benward and Den-Gerber (1975) found 52 percent of female residents (ages 13 to 42) in a female treatment program of victims of incest with a history of prostitution.

Effect on Self-Perception

Evidence of a negative self-concept is much stronger in empirical studies as a long-term effect. Bagley and Ramsey (1985) found that 19 percent of the child sexual abuse

victims in their random sample scored in the very poor category on the Coopersmith Self-esteem Inventory as compared with five percent of the control group. Similarly, nine percent of the victims demonstrated very good levels of self-esteem compared with 20 percent of controls. Women with very poor self-esteem were nearly four times as likely to report a history of child sexual abuse as were the other subjects. As might be expected, self-esteem problems among clinical samples of incest victims tended to be much greater. Eighty-seven percent of Courtois' (1979) community sample reported that their self had been moderately to severely affected by experiences of sexual abuse from a family member. Similarly, Herman (1981) noted that 60 percent of the incest victims in her clinical sample were reported to have a "predominantly negative self-image," as compared with ten percent of the comparison group with seductive but not incestuous fathers.

The Gold (1986) study found abused women with lower self-esteem in social situations as measured by the Texas Social Behavior Inventory. Finding fewer differences than Gold did, Orr and Dowes (1985) contrasted a group of twenty sexually abused female adolescents and a control group of actually ill female adolescents. This study found abused girls with lower scores on the subscales of "mastery of the external world" and "vocational-educational goals" on the Offer-Self Image Questionnaire than the ill girls, but they

showed no difference on several other subscales or on their overall adjustment. Since these two studies used different measures and different control groups, it is difficult to reconcile the differences in the results. However, it can be assumed that due to the fact that the Gold study involved adult women and showed greater effects than did the Orr and Dowes study, abuse experiences may have increasing dramatic effects on some individuals if not dealt with successfully soon after the abuse. Secondly, while the Gold study used "average" women as controls, Orr and Dowes used acutely ill adolescents. Gold's finding of more differences suggests the possibility that although the specific consequences of sexual abuse may be different from those of other traumas, the total impact of sexual abuse may be similar to that of other forms of childhood trauma such as acute illness.

In summary, the empirical studies of long-term effects, like clinical investigations of long-term effects, indicate various emotional, behavioral, sexual and self-perception problems for some portion of the victims. The implication of these findings is that a history of childhood sexual abuse is associated with greater risk for mental health and adjustment problems in adulthood. The empirical studies reveal that adult women victimized as children are more likely to manifest depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization, and substance abuse. Other

less consistent problems reported in empirical literature include difficulty in trusting others and sexual maladjustment in such areas as sexual dysphoria, sexual dysfunction, impaired sexual self-esteem, and avoidance of or abstention from sexual activity.

Whereas the clinical samples consisted almost exclusively of those suffering relatively serious negative effects, the empirical samples included some abuse victims who suffered no apparent consequences. It is assumed that, although the apparently unaffected victims may still experience negative consequences, certain abuse characteristics may cause fewer consequences, or certain victims may be able to deal with their experiences successfully. As observed by Browne and Finkelhor (1986), from studies of clinical and nonclinical populations, the findings concerning the trauma of child sexual abuse appear to be as follows: in the immediate aftermath of sexual abuse, from one-fifth to two-fifths of abused children seen by clinicians manifest pathological disturbances (Tufts, 1984). When studied as adults, victims as a group demonstrate impairment when compared with their nonvictimized counterparts, but under one fifth evidence serious psychopathology.

Differential Impact of Abuse Characteristics

In most studies conducted to date, it appears that some sexually abused children and some adults abused as children

will have major emotional, behavioral, sexual and self-perception problems while others will not. The knowledge that some victims of child sexual abuse suffer serious impairment whereas others do not has generated considerable speculation about what kinds of abuse are more or less traumagenic. In an effort to identify the source of this variability, researchers have recently begun to identify the need to systematically examine the possible differential effects of variables involved in the abuse situations. For example, Conte (1986) based on a review of clinical and empirical data, lists age of victim, age of offender, use of violence, frequency of abuse, duration of abuse, severity of abuse, relationship of offender to victim, number of offenders, and number of problems exhibited by victim's family, as possible sources of variability in effect. Groth (1978) based on clinical data, contended that the greatest trauma occurs in sexual abuse that continues for a longer period of time, occurs with a more closely related person, involves penetration and is accompanied by aggression. Although such speculations are fruitful directions for research, as Browne and Finkelhor (1986) note few studies have had enough cases and sophisticated methodology to empirically look at these questions. Unfortunately, the studies addressing these issues so far have reached little consensus in their findings. The following review is limited to the clinical and empirical

literature on the differential impact of the abuse characteristics selected as independent variables for the present study: age of the victim when abuse began, relationship to the offender, type of sexual activity, duration of abuse, use of violence, and mother support.

Age of the victim when abuse began

Age of the victim when abuse began probably has a significant influence on the type of symptoms that the victim suffers immediately, and it may well impact the long-term effects on the person as an adult. Some studies suggest that younger children are somewhat more vulnerable to trauma. Meiselman (1978), in her chart review of adults in treatment, found a larger percentage of seriously disturbed patients (37 percent) among those who had been sexually abused prior to puberty than among those abused after puberty (17 percent). Similarly, Courtois (1979), in her community sample, found that women abused before puberty had more difficulty with long-term relationships with men than did women molested after puberty. MacVicar's (1979) clinical review of cases encountered in therapy report that adolescents were better able to master the trauma of sexual abuse than latency-age victims. Gomes-Schwartz et al. (1985) study found that elementary school children were more affected than adolescents and preschool children, suggesting the possibility that children abused during the latency years may be the most affected. A more recent study (Zivney et

al.1988) examined Rorschach protocols of three groups of girls: 37 sexually abused before their ninth birthday; 43 sexually abused after their birthday, and a control group of 72 patients with no history of abuse. Five Rorschach variables were found to reliably differentiate early from late abuse onset groups. The pattern of group differences revealed that over half of early abused subjects manifested a preoedipal form of pathology characterized by disturbed cognition, damaged self, and preoccupation with themes of primitive supply and transactional relatedness. Only 12 percent of late abused subjects displayed this pattern. This suggests that abuse at younger ages tends to be most traumatic (Browne & Finkelhor, 1986).

Several empirical studies, however, have shown only small and statistically insignificant tendencies for young children to be more negatively affected by sexual abuse, suggesting few if any differences due to age (Alexander & Lupfer, 1987; Finkelhor, 1979; Russell, 1986; Tsai et al. 1979). The Tufts (1984) study, which gave particular attention to children's reactions to abuse at different ages, found no clear relationship between age of onset and outcome, but did find that latency age children were most disturbed. However, this finding appeared more related to the age at which the children were evaluated than the age at which they were first abused. They concluded that age at which abuse begins may be less important than the stages of development through which

the abuse persists. Other researchers have found that older children are more affected by abuse experiences (Sedney & Brooks, 1984; Adams-Tucker, 1982). In short, studies tend to show little clear relation between age of onset and trauma, especially when other factors are controlled. If there is any trend towards relationship, abuse at younger ages tends to be more traumatic. However, age interacts with other factors such as relationship to offender. Until more sophisticated analytical studies are done, it cannot be said that age has little independent effect or is simply still masked in complexity (Browne & Finkelhor, 1986).

Relationship of the Offender to the Victim

There is some empirical evidence that support the position that whether the perpetrator was a family member (intrafamilial) or a person outside (extrafamilial) did not have a significant effect on the trauma of the abuse (Finkelhor, 1979; Russell, 1984; Seidner & Calhoun, 1984; Tsai et al., 1979). Ruch and Chandler (1982), however, found that children in their study who experienced incest showed more trauma during their intake interview than did those experiencing nonincest abuse. Several other studies also found more trauma resulting from abuse by relatives (Landis, 1956; Anderson et al., 1981; Friedrich et al., 1986).

What has been consistently reported is greater trauma from experiences involving fathers and father figures compared with all other types of perpetrators. Adams-Tucker (1982),

Russell (1983) and Finkelhor (1979) found that abuse by the father or stepfather involved greater and significantly more trauma than did abuse by other family members or abuse by individuals outside the family. In contrast, the Tufts (1984) study found that abuse by the stepfather caused more trauma than abuse by the natural father. This result may be explained partially by Russell's (1983) findings that more serious abuse is perpetrated by stepfathers than by fathers. Other studies have found a small but nonsignificantly greater difference in impairment in women molested by fathers and stepfathers (Kendall-Tackett & Simon, 1987; Bagley & Ramsey, 1985).

Kendall-Tackett and Simon's (1987) study, which had 365 adults molested as children, gives additional data on the negative effect of abuse by parents, both biological fathers and stepfathers. In this study, 36 percent of the perpetrators were biological fathers, three percent were mothers, and 20 percent were stepfathers. The average time from the end of molestation to the time that adults sought therapy was seventeen years. This indicates the length of time incest can affect a victim. Thus, some empirical evidence, although not conclusive, is available in support of the popular and clinical assumption that sexual abuse by a close relative is more traumatic than abuse by someone outside the family.

Type of Sexual Activity

Reports of the relationship between the type of sexual activity and its effect on the victim yields contradictory results. Russell (1984) found that women who experienced some sort of vaginal or oral intercourse, fellatio, cunnilingus, anilingus, or anal intercourse as girls (59 percent) rated their experiences as being extremely traumatic, significantly more than did women who experienced only the touching of their unclothed breasts or genitals (36 percent), and of those who reported unwanted kissing or touching of a clothed part of the body (22 percent). Bagley and Ramsey's (1985) multivariate analysis confirming Russell's data found penetration to be the single most powerful variable explaining severity of mental health impairment. Tsai et al. (1979) state that their clinical group had experienced vaginal intercourse more frequently than their nonclinical, molested group. Landis (1956) found that 80 percent of his female subjects who had experienced attempted rape as girls and 50 percent of those who had been approached for intercourse stated their attitudes toward sexuality had been temporarily or permanently affected versus 28 percent of those who had been fondled and 23 percent who had been confronted by an exhibitionist. Three other studies (Peters, 1984; Seidner & Calhoun, 1984; Tufts, 1984) demonstrated that less serious forms of sexual contact are associated with less trauma.

However, the Tufts (1984) study using measures of children's anxiety, found children who had been fondled without penetration to be more anxious than those who actually suffered penetration. Other researchers (Finkelhor, 1979; Anderson et al., 1981; Fromuth, 1983) also found no consistent, significant differences in the amount of trauma reported due to the type of sexual activity. Thus, a number of studies agree that molestation involving more intimate contact is more traumatic than less intimate contact. However, there is disagreement about whether intercourse and penetration are significantly more serious than mere manual contact.

Duration of Sexual Abuse

Although it is generally assumed that long durations of abuse cause greater trauma for victims than short durations, there is no strong and consistent evidence in the literature for this hypothesis. In Russell's (1986) survey of adult women, 73 percent of sexual abuse lasted for more than five years was self-rated as extremely or considerably traumatic by victims, compared with 62 percent of abuse lasting one week to five years and 46 percent of abuse occurring only once. Tsai et al. (1979) found duration and frequency associated with greater negative effects. They found that abused women who reported themselves as still disturbed by their abuse had experienced abuse for a longer period of time (mean, 4.7 years) than did those who did not consider

themselves still disturbed by the abuse (mean, 2.5 years). Bagley and Ramsey (1985) found that the general mental health status of adult victims measured by a composite of indicators concerning depression, psychoneurosis, suicidal ideation, psychiatric consultation, and self-concept was worse for longer lasting experiences. Friedrich et al (1986) also found that duration predicted disturbances measured at CBCL. Two broadbased surveys of urban women (Wyatt, in press; Herman, Russell & Trocki, 1986) showed that longer duration of abuse related to lower scores of measures of general wellbeing and long lasting harms. However, several other studies (Finkelhor, 1979; Courtois, 1979; Langmade, 1983; Tufts, 1984; Adams-Tucker, 1982) found no relation between duration of abuse and negative effect on the victims. Thus the available studies reach quite contradictory conclusions about the relation between duration and trauma.

Use of Violence

There is general agreement that overt use of violence by perpetrator results in more short-term and long-term negative consequences to victim than occur when force is not used. For example, Finkelhor (1979) and Fromuth (1986), in their college sample, found that use of force explained the greatest amount of victims' negative reactions than any other variable. In Russell's (1986) study, 71 percent of the victims of force rated themselves as extremely or considerably traumatized, compared to 47 percent of other victims. Elwell and Ephros

(1987) within a small sample of sexually abused children found that those who experienced considerable force had a more negative initial reaction to the abuse than those who did not experience force. In Tufts (1984) study children subjected to coercive experiences showed greater hostility and were more fearful of aggressive behavior in others. Similarly, Friedrich et al. (1984) found the use of force to be strongly correlated with both internalizing and externalizing symptoms on CBCL. However, three other studies (Anderson et al., 1981; Seidner & Calhoun, 1984; Bagley & Ramsey, 1985), having found no significant relation between use of force and negative effects differ with the findings of the majority of other studies.

Mother Support

Adams-Tucker (1982) Schultz (1973), Rogers and Terry (1984), Simrel, Berg, and Thomas (1979) and MacFarlane, (1978) all found that parental response had a major effect on the trauma of the abuse. Conte and Schuerman (1987) report that the overall social support available to the child after the abuse and the child's having a supportive parent or sibling lessened the impact of the abuse. The Tufts (1984) study, although agreeing that negative responses by mothers tended to worsen the child's trauma, found that positive, supportive reactions did not ameliorate the trauma of the abuse. Specifically, the Tuft study found that when mothers reacted to disclosure with anger and punishment, children

manifested more behavioral disturbances, but the same study did not support the hypothesis that positive responses by mothers were systematically related to better adjustment. Anderson et al. (1981) also found similar results. They noted two and half times the number of symptoms in the children who had encountered negative reactions from their parents. Although only few studies have been done examining the effect of this variable, the findings of these studies suggest that parental reactions aggravate trauma in sexually abused children.

In summary, there are few unequivocal results in the various studies' attempt to find causes for the differential effects reported by victims of child sexual abuse. As Haugaard and Reppucci (1988) point out, at this time the extent of impact that results from the sexual activity, the atmosphere in which it occurs, or the reactions of others when it is discovered is less clear. There is still substantial work to be done before we fully understand the possible differential effects of situational variables on the victims. Although very few empirical studies conclusively support the various speculations concerning the differential effect of situational variables, certain trends are evident in the available findings. It has not been conclusively demonstrated that abuse at any particular age is more harmful. Similarly, long lasting abuse has not been clearly demonstrated as more traumagenic. Preponderance of evidence,

however, indicate that abuse by close relatives, especially by fathers and stepfathers, is consistently more traumatic. Also there appears to be evidence indicating that abuse involving force and genital contact including intercourse are more harmful. There is also tentative evidence to indicate that negative parental reaction to the victim, especially the nonabusive mother, result in more serious consequences to the victim. Thus the different aspects of the entire sexual abuse experience likely have varying psychological effects on the victims. Some victims apparently suffer no negative consequences for reasons that are unknown. The general lack of agreement on the findings, especially as they are evident in the empirical studies, may be a result of definitional and methodological differences, including heterogeneity in the nature of abuse sample, lack of adequate control groups, differences in the age of the subjects, and poor outcome measures (DePanfilis, 1986). Very few studies, however, to date have empirically investigated the effect of the characteristics of sexual abuse on the victims using standardized psychological measures and control group of nonabused peers. The present study is expected to fill the gap in this area.

Chapter III

METHODOLOGY

This study accessed a segment of the data which was collected for an ongoing, longitudinal study, investigating Psycho-biological Effects of Child Sexual Abuse (Female Growth and Development in Childhood and Adolescence), co-sponsored by the National Institute of Mental Health (NIMH) and the Chesapeake Institute, Wheaton, Maryland, a private non-profit organization that specializes in the treatment of child sexual abuse victims and their families. This investigator has been associated with the NIMH study as a graduate student, research assistant for the past three years.

Operational Definition of Terms and Concepts

The terms and concepts of the present study were operationally defined as follows:

Intrafamilial Child Sexual Abuse

In this study it was defined as any type of sexual activity involving body contact with a female child between the ages of 8 and 15, by a family member defined as biological father, step-father, and other male relatives.

Effect

In this study effect was defined as the psychological impact of intrafamilial child sexual abuse on the self-image of the victims.

Abuse Status

In this study abuse status was defined as the status of

the subjects as abused or nonabused. Abused subjects were girls who were victims of intrafamilial child sexual abuse, and non abused subjects were girls who were matched on age, race, socioeconomic status and single or two parent status of the family.

Victims

In this study the term victims meant girls between the ages of 8 and 15 who were subjected to intrafamilial child sexual abuse.

Self-Image

The definition of self-image in this study was adapted from the Self-image Questionnaire for Young Adolescents (Peterson, Schulenberg, Abramowitz, Offer, & Jarcho, 1984). It was defined as the phenomenological organization of individuals' experiences and ideas about themselves in various aspects of life, and it included impulse control, emotional tone, body image, mastery and coping, psycho-pathology, superior adjustment, peer relationships, family relationships, and vocational- educational goals.

Abuse Characteristics

In this study abuse situational variables including current age of the victim, age abuse began, relationship of the offender to the victim, type of sexual activity, duration of abuse, use of violence and mother support were defined as abuse characteristics.

Age

Age was defined as the chronological age of the subjects, 8 to 15, at the time they were seen in the study. Age was further grouped into three levels : 8 to 11; 11 to 13; and 13 to 15.

Age Abuse Began

Age abuse began was defined as the actual age of the child when the first incident of abuse took place, grouped as follows: 1 to 8; 8 to 12; and 12 to 15.

Relationship of the offender to the victim

Relationship of the offender to the victim was categorized as either biological father, step-father, or other male relatives. Child's mother's boyfriend was also included in the category of step-father. Other male relatives included child's siblings, cousins, uncles and grandfathers.

Type of Sexual Activity

Type of sexual activity included any sexual activity involving body contact. In this distinction was made between two types of sexual activities: (1) penetration which included vaginal or anal intercourse, and (2) fondling which included kissing, touching and oral-genital contact.

Duration of Abuse

Duration was divided into two categories: abuse that lasted less than 18 months and abuse that lasted more than 18 months.

Use of Violence

Use of violence was defined as intrafamilial child sexual abuse accompanied by physical force or threat of force.

Mother Support

The definition of mother support in this study was adapted from the Hill Intimacy Questionnaire (Blyth & Foster-Clark, 1987). It was defined as the degree of victim's closeness with the mother after the disclosure of the abuse incident as perceived by the victim.

Subjects

The subjects of this study were 72 girls, ages 8 through 15. The sexually abused group consisted of 37 girls, 51.39 % of the total sample, and the control group consisted of 35 girls, 48.61% of the total sample. A Histogram done on the SIQYA subscales revealed that one of the control subjects was an outlier on all of the subscales. Her scores were on the lower end of all subscales, pulling the SIQYA mean score of the control group remarkably down. This control subject's family consisted of an alcoholic father. She was physically and possibly sexually abused by her father. Consequently it was deemed appropriate to drop this subject from the control group. Hence the final control group count was 34 girls, and the total sample, 71 girls. The abused and control subjects were matched on age, race, single or two parent status of the family and family's socio-economic status (SES). The mean age

of the total sample was 12.86 years. Abused girls' mean age was 12.75, and the mean age of control group girls was 12.96. Racial breakdown of the total sample was 50.7% white, 42.3 % black and 7 % others. Among the abused group, 56.76 % were white, 35.14 % were black, and 8.10 % were others. Control group consisted of 44.12 % white, 50 % black, and 5.88% others.

Forty-five percent of the total sample in this study came from single parent families and 55 % were from two parent families. Among the abused subjects, 40% were from single parent families and the remaining 60 % were from two parent families. In control group, 51% came from single parent families, and the remaining 49 % were from two parent families.

Hollingshead's Two Factor Scale of Social Status (Hollingshead, 1975) was used to calculate the SES. According to Hollingshead formula, SES score of an individual or nuclear family unit is estimated by combining occupational and educational information. The SES score of a given individual is calculated by multiplying the scale value for occupation by a weight of five (5) and the scale value for education by a weight of three (3). When two parents work, their scores are averaged. The lowest possible combined SES score was 12 (menial service workers with 7th grade education) and the highest possible score was 66 (professionals with graduate degree). Socio-economic status (SES) score average on

the Hollingshead scale for the total sample was 36.10. The abused group's SES score was 36.42, and the control group had a SES score of 35.76. This represented the lower-middle class status of the families. As seen in Table 1, the demographic data showed no significant differences for age, race, socio-economic status and the single or two parent status of the families.

Table 1

Demographic Characteristics of Abused and Control Groups

| Item | Abused Group | Control Group | Total Sample |
|----------------------|--------------|---------------|--------------|
| Number of subjects | 37(52.11%) | 34(47.89%) | 71(100%) |
| Child's average age | 12.75 | 12.96 | 12.86 |
| Child's Race | | | |
| White | 21(56.76%) | 15(44.12%) | 36(50.70%) |
| Black | 13(35.14%) | 17(50%) | 30(42.30%) |
| Others | 3(8.10 %) | 2(5.88 %) | 5(7 %) |
| SES score average | 36.42 | 35.76 | 36.10 |
| Single parent family | 15(40%) | 17(51%) | 32(45%) |
| Two parent family | 22 (60% | 17(49%) | 39 (55%) |

Preliminary analysis of the abuse characteristics of the subjects provided the following descriptive data. The average age at the onset of abuse for the sample was found to be 9.64 years. Seven (21.5 %) of the 33 offenders were biological fathers, 15 (45.5%) were stepfathers, and the remaining 11 (33

%) were other male family members. Twenty abused subjects (61%) experienced vaginal and/or anal penetration, and the remaining 13 subjects (39 %) experienced fondling/touching behavior. Subjects who experienced penetration, vaginal or anal, did not have a longer duration of abuse compared to those who experienced fondling/ touching behavior. Mean duration of abuse was 25.53 months. Some kind of physical force or threat of force accompanied abuse of 28 % of the sample.

Preliminary analysis of the interrelationships of the subjects' abuse characteristics, age abuse began, relationship of the offender to the victim, type of sexual activity, duration of abuse, and use of violence (independent variables) were done utilizing analyses of variance (ANOVAs) and Chi-squares. First, the independent variable, relationship of the offender to the victim, which consisted of three categories (biological father, stepfather, and others), was analyzed by ANOVAs for duration of abuse and age abuse began. There were significant differences for duration of abuse ($F(2, 27) = 12.7, p < .01$) and age abuse began ($F(2, 30) = 6.1, p < .01$). These analyses revealed that the relationship of the offender to the victim was related to age abuse began and duration of the abuse. While the average age of child when abuse began was 9.64 years, the average age of the child was 8.29 years when the abuser was biological father; 11.27 years when the abuser was step-father; and 8.27 years when the

abuser was another family member. This shows that step-fathers began abusing their step-daughters at a later age than biological fathers and other male family members. Conversely, sexual abuse by biological father was found to be related to duration of abuse. Biological fathers abused their daughters for longer duration of time, an average of 58.43 months (5 1/2 years), compared to abuse by step-fathers, 10.40 months and other relatives, 25.13 months. As it can be seen in Table 2, Chi-square analysis revealed that whether or not violence accompanied sexual abuse was not significantly different by the relationship of the offender to the victim.

Table 2

Interrelationship of Offender, Duration of Abuse, Age Abuse Began, and Use of Violence

| Item | Relationship of Offender to the Victim | | |
|-------------------------------|--|-------------|-----------------|
| | Biological father | Step-father | Other relatives |
| Duration of abuse in months * | 58.43 | 10.40 | 25.13 |
| Age abuse began in years * | 8.29 | 11.27 | 8.27 * |
| Use of violence | | | |
| Violence occurred | 0 | 6 | 3 |
| No violence | 7 | 8 | 8 |
| n= 32 * p <.01 | | | |

Whether or not abuse accompanied violence was analyzed by ANOVAs for duration of abuse and age abuse began. As shown in Table 3, significant difference was found for duration of

abuse ($F(1,27) = 6.5, p < .05$). Those victims who did experience violence had a shorter duration of abuse (7.22 months) compared to those who did not experience violence (33.85 months). No significant difference was found whether or not violence occurred with age abuse began

Table 3

Interrelationship of Duration of Abuse, Age Abuse Began and Use of Violence

| | Use of Violence | |
|--------------------|-------------------|--------------|
| | Violence occurred | No violence |
| Duration of abuse* | 7.22 months | 33.85 months |
| Age abuse began | 10.22 years | 9.35 years |
| n= 33 * p. <.05 | | |

The independent variable, type of abuse (penetration and fondling) was analyzed utilizing ANOVAs by duration of abuse and age abuse began and by chi-square for violence and relationship of the offender. As Table 4 illustrates, there were no significant differences for duration of abuse, age abuse began, violence and relationship of the offender.

Table 4

Interrelationship of Type of Sexual Activity, Duration of Abuse, Age Abuse Began, Use of Violence and Relationship of the Offender to the Victim

| | Type of Sexual Activity | |
|------------------------------|-------------------------|--------------|
| | Fondling | Penetration |
| Duration of abuse | 27.91 months | 24.16 months |
| Age abuse began | 10.30 yrs. | 9.20 yrs. |
| Violence occurred | 3 | 6 |
| No violence | 10 | 13 |
| Relationship of the offender | | |
| biological father | 4 | 3 |
| stepfather | 5 | 10 |
| other | 4 | 7 |
| n= 33 | | |

Instruments

The present study used data collected on three measures:

1. The Self-Image Questionnaire for Young Adolescents (Peterson, Schulenberg, Abramowitz, Offer & Jarcho, 1984);
2. An Abuse Case Information Checklist developed by NIMH study;
- and 3. Hill Intimacy Questionnaire (Blyth & Foster-Clark, 1987).

1. The Self-Image Questionnaire for Young Adolescents (SIQYA)

SIQYA (Peterson et al. 1984) is a self-descriptive personality test which is used to measure levels of psychosocial adjustment in young adolescents. It is a downward extension of the widely used Offer Self-Image Questionnaire for Adolescents-OSIQA (Offer, Ostrov & Howard, 1982), and it uses nine subscales from that instrument which ascertain aspects of the self-image of young adolescents. Each subscale score represents an area of adjustment that is of particular relevance to the young adolescents' experience. This measure consists of 98 items that elicit responses on a 6-point Likert-type scale.

The subscales of SIQYA are emotional tone (11 items); impulse control (8 items); body image (11 items); peer relationships (10 items); family relationships (17 items); mastery and coping (10 items); vocational/ educational goals (10 items); psychopathology (11 items); and superior adjustment (10 items). This measure was originally designed for children ages, 11 to 15. However, it has been successfully used with children as young as 8 years (Susman, Nottelmean, Inoff, Dorn, Cutler & Loriaux, 1985). Reliability of this instrument was measured by Cronbach's coefficient alpha for inter-item consistency, which provides a good minimum estimate of reliability (Lord and Novick, 1986). The alpha coefficients for the sub-scale ranged from

.67 to .88 except for the subscale of superior adjustment which had an alpha of .54, indicating a high degree of internal consistency among the items. These reliabilites are well within the acceptable range for instruments of this type, especially considering the fact that alpha is responsive to the number of items in the subscale, which here is relatively low. The various domains of self-image appear to be adequately represented in the content of SIQYA. The contents of three subscales, peer relationships, family relationships, and vocational/ educational goals, focus on social contexts important in adolescence. The remaining subscales focus on individual aspects of the self-image. The validity of this instrument was established through factor analysis and through the association of the subscales with other measures of self-image (Peterson et al, 1984). This questionnaire was the outcome measure (dependent variable) in the present study (see Appendix A).

All subjects (71) completed this measure. Five of the nine subscales of this measure which were conceptually related to the study and representative of the social and personal aspects of adolescents's self-image were selected as the final outcome variables for the purpose of this study, and the remaining subscales were dropped. The selected subscales were body image, emotional tone, psychopathology, family relationships, and vocational educational goals. Reliability analysis revealed Cronbach's coefficient alpha above .70 for

three of these subscales, family relationships, emotional tone and vocational educational goals. Psychopathology and body image subscales had Cronbach's alpha coefficient above or equal to .68, but with the removal of one item each from these subscales alpha levels were increased to .70 or above. Table 5 provides and reliabilites of all SIQYA subscales, and Tables 6 and 7 respectively provide correlations and standard deviations of the five selected subscales.

Table 5

SIQYA Subscale Reliabilities

| SIQYA subscales | items(+,-) | alpha coef. (N=71) | alpha 1 item removed (N=71) |
|--|---------------|--------------------------|--------------------------------------|
| * Family relationships | 17 (7+/6-) | .85 | |
| * Voc. educ. goals | 10 (6+/4-) | .75 | |
| * Emotional tone | 11 (3+/8-) | .71 | |
| * Psychopathology | 11 (11-) | .68 | .70 |
| * Body image | 11 (5+/6-) | .68 | .72 |
| Peer relationship | 10 (4+/6-) | .63 | |
| Mastery and coping | 10 (5+/5-) | .64 | |
| Superior adjustment | 10 (9+/1-) | .63 | |
| Impulse control | 8 (4+/4-) | .62 | |
| * Subscales selected for the present study | | | |

Table 6

Selected SIQYA Subscale Correlations

| SIQYA | 1 | 2 | 3 | 4 | 5 |
|-------------------------|------|------|-------|------|------|
| 1. Emotional tone | 1.00 | .52* | .73* | .42* | .35* |
| 2. Body image | | 1.00 | .42 * | .32* | .34* |
| 3. Psychopathology | | | 1.00 | .40* | .44* |
| 4. Voc. edu. goals | | | | 1.00 | .54* |
| 5. Family relationships | | | | | 1.00 |
| N= 71 * p <.01 | | | | | |

Table 7

Selected SIQYA Subscales: Means and Standard Deviations for the Total Sample

| SIQYA subscales | Abused group (= 37) | | Control group (n=34) | | Total sample (N=71) | |
|------------------|------------------------|-----------|-------------------------|-----------|------------------------|-----------|
| | <u>M</u> | <u>SD</u> | <u>M</u> | <u>SD</u> | <u>M</u> | <u>SD</u> |
| Emotional tone | 49.97 | 8.60 | 53.30 | 8.01 | 51.56 | 7.94 |
| Body image | 42.08 | 8.98 | 46.06 | 8.01 | 43.96 | 8.71 |
| Psychopathology | 42.87 | 8.26 | 46.06 | 7.36 | 44.39 | 7.95 |
| Family relat. * | 76.81 | 14.41 | 75.65 | 14.65 | 76.25 | 14.43 |
| Voc. educ. goals | 49.73 | 6.69 | 49.23 | 7.65 | 49.49 | 7.11 |

M = Mean SD = standard deviation

2. Abuse Case Information Checklist

This questionnaire, developed by the NIMH study, was used to collect information from the abuse case record through the family's Child Protective Service caseworker. It has 11 categories of questions. Information that were relevant to the present study included age abuse began, relationship of the offender to the victim, type of sexual activity, duration of abuse, and use of violence (see Appendix B). Of the 37 abused girls, abuse case information was available only on 33 girls for the purpose of analysis.

3. Hill Intimacy Questionnaire

Hill Intimacy Questionnaire (Blyth Foster-Clark, 1987) is a 16 item measure which contains 8 questions each on victim's perception of closeness with the mother and father, rated on one of the three levels: 1 = "not at all", 2 = "a little", and 3 = "a lot". An over all high score or low score on the first eight items is considered to be a measure of the degree of higher or lower mother support to the victim after the disclosure of the abuse. Only the child's rating on the mother support scale was used in the present study (see Appendix C). Data were available on this measure from 63 subjects, 32 abused and 31 control. The internal consistency and reliability of mother support subscale of the Hill Intimacy Questionnaire was tested. It was found to be a highly reliable instrument with a Cronbach's alpha of .76.

Procedures

The abused subjects in this study were recruited from the metropolitan Washington area Child Protective Service agencies, including Prince George's, Montgomery, Charles, and Washington counties in Maryland, Fairfax and Manassas Counties in Virginia, and the Department of Human Services of the District of Columbia. There were several eligibility criteria for referral of abused subjects to the study. They were: (1) the child victim should be a female between 8 and 15 years of age; (2) the initial or most recent disclosure of the sexual abuse should have occurred within six months of referral; (3) the sexual abuse should have involved body contact including genital contact and/or penetration; (4) the identified perpetrator should be a family member broadly defined as father, stepfather, or other male relatives; and (5) a nonabusing parent or the child's legal guardian should be available and willing to participate in the study (see Appendix D & E).

Subjects were referred to the study by the family's Child Protective Service caseworker. The worker during his/her regularly scheduled home visit presented the printed information about the study to the child's legal guardian and obtained written permission to refer the child to the study (see Appendix F & G). Once written permissions for referral were obtained, the referral forms were mailed to the data collection center at the Chesapeake Institute. Subsequently,

the families were contacted by phone giving more information about the study and appointments were made for the subjects to come to the data collection center (see Appendix H). The control subjects of non-abused girls were recruited through advertisements through news papers (see Appendix I). Those who responded to the advertisement were given more information over the phone (see Appendix J) and were told that they would be screened to match with the specific demographic variables of the abused subjects (see Appendix J). Subsequently, control subjects were also contacted by phone to schedule appointments to come to the data collection center.

All subjects, abused and control, came to the data collection center at Chesapeake Institute on the scheduled appointment dates accompanied by their legal guardians. The measures reported in this study were administered as part of the larger data collection of the NIMH study in two sessions which took place approximately 1 week apart. A tester and an interviewer, two trained graduate research assistants of the NIMH study, a male and a female respectively, administered these measures. This process took place as follows: At the first session when the child and legal guardian would arrive, the tester would introduce himself and the interviewer to the child and the legal guardian. Then the tester would obtain separate informed written consents from the child and the legal guardian for their participation in the study (see Appendix K & L). Once these consent forms were signed, the

tester would take the child to a comfortably furnished testing room, to administer SIQYA. Meanwhile, the interviewer would take the child's legal guardian, usually the non-abusive mother, to a different room to obtain the demographic information.

Once in the testing room, the tester would sit down at the testing table across the room from child and tell the child (while pointing to magic markers and paper on table) that she could draw a picture if she wanted before she started and that she could draw on the table or on the floor or anywhere she liked. The tester would then write down the subject number on SIQYA while engaging in a "warm up" conversation with the child for up to 8 minutes. Usual topics for the conversation would be school, weather, sports, and the picture being drawn. Examples of questions would include, "What is your favorite subject in school?", "Do you have a favorite sport?", "What do you think of the weather today?", "Could you tell me a story about the picture?"

At the close of the warm up session, the tester would administer SIQYA to the child. If the child would appear to have difficulty understanding the instructions on the front page of SIQYA (this would be ascertained by asking the child), the tester would explain the instructions to the child. At the second session this procedure with the tester would be repeated for The Hill Intimacy Questionnaire. Also at the second session, written permission would be obtained from the

abused child's guardian to collect abuse case information from the child's abuse case record (see Appendix M). Subsequently, the Abuse Case Information Checklist would be mailed to the caseworker along with the child's guardian's written consent to release the information. The case worker would then complete this form and return it to the data collection center. In order to assure confidentiality, the data were stored on a personal computer by subject number only, and nowhere in the storage file would the data be identified by the subject name.

Data Analysis

The data were analyzed in two phases. The first phase included a series of preliminary analyses of the demographic data, and interrelationships of abuse characteristics (independent variables) using chi-squares and analyses of variance (ANOVAs). During this phase, the internal consistency and reliabilites of the mother support subscale of Hill Intimacy Questionnaire (another independent variable) and SIQYA subscales were also tested through a series of reliability analyses. Findings of the first phase of the analyses were reported earlier in this Chapter. The second phase of analysis had two parts. The first part addressed the first research question pertaining to the self-image difference between abused and non-abused girls and the interactional effect of abuse status with age and mother support. For this, simple analyses of variance (ANOVAs) and

a 2 x 3 (group x age) and 2 x 2 (group x mother support) design ANOVAs and correlational analyses were done. The second part of the analysis addressed research questions 2 to 7 which were designed to investigate the self-image differences within the abused group by the abuse characteristics. For questions 2 - 6, analyses of variance (ANOVAs) were repeated. For question number 7, correlational analyses and ANOVAs were done. Results of the second phase of the analysis are reported in Chapter IV.

Chapter IV

RESULTS

Results of the second phase of the data analysis pertaining to the research questions are reported here in two parts, following the order of the questions and the sequence of the analysis. All results with $p < .05$ are reported as statistically significant, and $p < .1$ are reported as marginal.

Part I : Between Group Analysis

Research Question I: Does the self-image of girls who are victims of intrafamilial child sexual abuse differ from that of a control group of non-abused girls, and is there a difference by age and mother support?

First, to determine if there is a group difference in self-image between the abused and nonabused girls, analyses of variance (ANOVAs) were performed using abuse status as independent variables and the five SIQYA subscales as the dependent variables. These analyses revealed main effect for abuse status for the subscale of body image ($F(1,69) = 3.96$, $p < .05$) and marginal effects for the subscales of psychopathology ($F(1,69) = 2.94$ $p < .1$) and emotional tone ($F(1,69) = 3.19$ $p < .1$), with abused girls demonstrating poorer self-image in all three components compared to nonabused girls (see Table 8 & Graphs 1, 2, & 3). No differences were found between the groups for the subscales of family relationships and vocational-educational goals.

Table 8

Self-Image Difference Between Abused and Control Groups on
SIOYA Subscales: Results of ANOVAs

| | Abused Group (n=37) <u>M</u> | Control Group (n=34) <u>M</u> | <u>F</u> | Sign. level of <u>F</u> |
|-----------------------------|---------------------------------------|--|----------|----------------------------------|
| Dep. Var.: Body image | | | | |
| Abuse status | 42.03 | 46.06 | 3.96 | .05 |
| Dep. Var.: Emotional tone | | | | |
| Abuse status | 49.97 | 53.29 | 3.19 | .07 |
| Dep. Var.: Psychopathology | | | | |
| Abuse status | 42.86 | 46.06 | 2.94 | .09 |
| Dep. Var.: Family relat. | | | | |
| Abuse status | 76.81 | 75.65 | .14 | ns |
| Dep. Var.: Voc. educ. goals | | | | |
| Abuse status | 49.73 | 49.24 | .08 | ns |

Abuse status = abused vs. control groups); N= 71

Secondly, for the purpose of examining whether abuse status has a different effect on self-image, depending on the age group of victims (interactional effect) 2 x 3 ANOVAs (2 = abused and control groups; 3 = three levels of age) were done. In these analyses, the three levels of ages were 8 -11; 11-13; and 13-15. No significant interactional effect was found, but a significant main effect was noted for age on the vocational educational goals ($F(2,65) = 3.25, p < .05$), with

older girls in the control group showing better self-image on this subscale. Similarly, separate 2 x 2 ANOVAs were done (2 = abused and control groups; 2 = high or low mother support) to examine the two way interactional effect of abuse status by mother support. These analyses also did not reveal any significant interactional effect (see Table 9).

Table 9

Interactional Effects of Age and Mother Support with Abuse Status on SIOYA Subscales : Results of 2 Way ANOVAs

| | Abused Group (n=37) <u>M</u> | Control Group (n=34) <u>M</u> | <u>F</u> | Sign. level of <u>F</u> |
|----------------------------------|---------------------------------------|--|----------|----------------------------------|
| Dep. Var.: Body image | | | | |
| Age x abuse status | (A) 45.25 (B) 40.54 (C) 41.63 | 47.17 49.27 43.59 | 1.26 | ns |
| Mother support x abuse status | (L) 43.09 (H) 44.50 | 43.05 48.00 | .62 | ns |
| Dep. Var.: Emotional tone | | | | |
| Age x abuse status | (A) 45.25 (B) 45.23 (C) 44.81 | 51.83 49.36 46.53 | .53 | ns |
| Mother support x abuse status | (L) 50.91 (H) 50.95 | 51.67 54.36 | .43 | ns |
| Dep. Var.: Psychopathology | | | | |
| Age x abuse status | (A) 42.50 (B) 43.15 (C) 42.81 | 47.00 47.55 44.76 | .21 | ns |
| Mother support x abuse status | (L) 43.73 (H) 43.15 | 45.89 44.71 | .02 | ns |
| Dep. Var.: Family rel. | | | | |
| Age x abuse status | (A) 83.13 (B) 75.92 (C) 74.38 | 78.00 77.27 73.76 | .21 | ns |
| Mother support x abuse status | (L) 68.09 (H) 83.20 | 71.61 79.29 | 1.17 | ns |
| Dep. Voc. educ. goals: | | | | |
| Age x abuse status | (A) 51.00 (B) 46.08 (C) 52.06 | 49.33 47.18 50.53 | .29 | ns |
| Mother support x abuse status | (L) 47.82 (H) 50.30 | 47.50 50.50 | .02 | ns |

Abuse status = abused vs. control group; N= 71; A = ages 8-11; B= 11-13; C= 13-15; L= low mother support; H= high mother support

Further, to determine whether there were different patterns of relationship of age with mother support and with SIQYA subscales in the abused and non-abused groups, correlational analyses of child's age, mother support and SIQYA subscales were run separately for the two groups. In the abused group, child's age was negatively correlated with family relationships ($r = -.32, p < .05$) and mother support ($r = -.28, p < .07$). This finding indicated that the older girls in the abused group were worse on family relationships and mother support. In the control group, as seen in the previous analysis, age was found correlated with vocational educational goals ($r = .24, p < .09$). See Table 10. There was a marginal difference in the correlational pattern of age with family relationships and mother support between the two groups. Older girls in the abused group showed poorer self-image in family relationships ($z = 1.48, p = .07$) and mother support ($z = 1.34, p = .09$) compared to the nonabused group.

Table 10

Correlations of Child's Age with Mother Support and SIOYA Subscales for Abused and Control Groups

| Items | N= 71 | |
|--|-------------------------|-------------------------|
| | Abused Group (n= 37) | Control Group (n=34) |
| Body image | -.11 | -.15 |
| Emotional tone | .03 | -.15 |
| Psychopathology | .06 | -.05 |
| Family relat. | -.32 * | .03 |
| Voc. edu. goals | .10 | .24 * * |
| Mother Support + | -.28* * | .07 |
| * * p <. 05 * p <.09 + n for mother support in abused group = 31 ; n for mother support in control group = 32 | | |

Part II : Within Group Analysis

Research Question 2: Does age of the victim when abuse began have a differential effect on the victim's self-image?

As shown in Table 11, analyses of variance (ANOVAs) done within the abused group using three categories of age when abuse began, less than 8 (less than 96 months); 8 to 12 (97 to 144 months), and 12 to 15 (145 to 180 months) as independent variables and the subscales of SIQYA as dependent variables did not reveal any significant difference on any of the self-image subscale.

Table 11

Self-Image Difference by Age Abuse Began on SIQYA Subscales

| SIQYA subscales | Age Abuse Began (n=33) | | | F | Sign. level of F |
|------------------|---------------------------|----------------|----------------|------|------------------------|
| | LT8 (n=12) | 8-12 (n=16) | 12-15 (n=5) | | |
| | <u>M</u> | <u>M</u> | <u>M</u> | | |
| Body image | 48.08 | 42.63 | 49.20 | 1.69 | ns |
| Emotional tone | 49.42 | 50.81 | 50.80 | 1.08 | ns |
| Psychopathology | 45.17 | 45.75 | 46.00 | .11 | ns |
| Family relat. | 80.00 | 71.88 | 75.60 | 1.09 | ns |
| Voc. educ. goals | 48.33 | 47.94 | 54.80 | 2.31 | ns |

Research Question 3: How does the victim's self-image differ by the relationship of the offender to the victim?

Analyses of variance (ANOVAs) done within the abused group using three categories of the relationship of the offender to the victim (biological father, stepfather, and other male relatives) as independent variables and SIQYA subscales as dependent variables did reveal significant difference on the family relationships subscale ($F(2,30) = 5.07$ $p < .01$). Girls who were sexually abused by male relatives other than biological fathers and step-fathers showed better self-image in the family relationships subscale (mean = 85.45), compared to those who were abused by biological fathers (mean = 68.89) and step-fathers (Mean = 71.07). See Graph 4. There were no other significant differences in any of the other self-image subscales.

Table 12

Self-Image Difference by Relationship of the Offender to the Victim on SIOYA Subscales

| SIOYA subscales | Relationship of the Offender (n=33) | | | | |
|------------------|--|-------------------|----------------------|-----------|------------------------|
| | Biol.F. (n= 7) | Step.F. (n=15) | Other M.R. (n=11) | M.R. F | Sign. level of F |
| | <u>M</u> | <u>M</u> | <u>M</u> | | <u>F</u> |
| Body image | 41.71 | 47.33 | 45.73 | .86 | ns |
| Emotional tone | 47.29 | 51.40 | 50.73 | .63 | ns |
| Psychopathology | 45.57 | 46.67 | 45.55 | .06 | ns |
| Family relat. | 68.89 | 71.07 | 85.45 | 5.07 | .01 * |
| Voc. educ. goals | 46.14 | 49.40 | 50.64 | .99 | .ns |

Biol. F= Biological father; Step F. = Step father;
other M.R.= other male relatives

Research Question 4: Does the type of sexual activity have a differential effect on the victim's self-image?

Analyses of variance (ANOVAs) done within the abused group using the two types of sexual activity (penetration and fondling) as independent variables and self-image subscales as dependent variables revealed significant main effects for type of sexual activity on body image ($F(1,31) = 4.44, p < .05$) and family relationships subscales ($F(1,31) = 8.8, p < .01$) and marginal effects on psychopathology ($F(1,31) = 3.83, p < .06$) and emotional tone subscales ($F(1,31) = 3.96, p < .06$). See Graphs 5, 6, 7 & 8. These findings showed that those who

experienced vaginal/ anal penetration had scored higher on body image, family relationships, emotional tone and psychopathology subscales compared to those who experienced fondling and touching behavior (see Table 13). Type of sexual activity was found to have no effect on the subscale of vocational- educational goals.

Table 13

Self-Image Difference by Type of Sexual Activity on SIQYA Subscales

| SIQYA subscales | Types of Sex. Activity | | | Sign. level of F |
|----------------------|-------------------------|------------------------------------|------|------------------------|
| | fondling (n=13) M | (n=33) penetrat. (n=20) M | F | |
| Body image | 37.77 | 44.35 | 4.44 | .043 |
| Emotional tone | 47.00 | 52.45 | 3.96 | .056 |
| Psychopathology | 39.08 | 44.55 | 3.83 | .059 |
| Family relat. | 67.08 | 80.80 | 8.81 | .006 |
| Voc. educ. goals | 47.23 | 50.35 | 1.75 | .ns |
| ns = non significant | | | | |

Research Question 5: Does the duration of abuse make a difference in the victim's self-image?

Analyses of variance (ANOVAs) done within abused group using two categories of duration, less than 18 months and more than 18 months, as independent variables and SIQYA subscales as dependent variables did not reveal significant effects for duration of abuse on any of the SIQYA subscales (see Table

14). Correlational analyses were also run, using duration of abuse as a continuous variable, but they were not significant either.

Table 14

Self-Image Difference by Duration of Abuse on SIQYA Subscales

| SIQYA subscales | Duration of Abuse (n=30) | | | Sign. level of F |
|---|-----------------------------|----------------------|----------|------------------------|
| | < 18 months (n=14) | >18 months (n=16) | | |
| | <u>M</u> | <u>M</u> | <u>F</u> | |
| Body image | 43.07 | 40.94 | .39 | ns |
| Emotional tone | 45.36 | 45.06 | .01 | ns |
| Psychopathology | 42.79 | 41.56 | .16 | ns |
| Family relat. | 73.14 | 76.25 | .31 | ns |
| Voc. educ. goals | 49.14 | 48.94 | .01 | ns |
| <18 = duration of abuse less than 18 months | | | | |
| >18 = duration of abuse more than 18 months | | | | |

Research Question 6: Does the use of violence have a differential effect on the victim's self-image?

As shown in Table 15, analyses of variance (ANOVAs) done using two categories of violence (violence or threat of violence and no violence or threat of violence) as independent variables and SIQYA subscales as dependent variables did not reveal significant effects on any of the SIQYA subscales.

Table 15**Self-Image Difference by Use of Violence on SIQYA Subscales**

| SIQYA subscales | Use of Violence (n=32) | | | Sign. level of F |
|------------------|---------------------------|-------------------------|----------|------------------------|
| | Violence (n=9) | No. Violence (n= 23) | | |
| | <u>M</u> | <u>M</u> | <u>F</u> | |
| Body image | 48.00 | 44.30 | 1.01 | ns |
| Emotional tone | 50.22 | 50.17 | .00 | ns |
| Psychopathology | 44.00 | 46.65 | .59 | ns |
| Family relat. | 74.11 | 75.83 | .08 | ns |
| Voc. educ. goals | 49.33 | 48.74 | .05 | ns |

Research Question 7: Does mother support make a difference in the victim's self-image?

Univariate correlation of mother support with SIQYA subscales within the abused group found significant correlation of mother support with family relationships ($r = .56$, $p < .000$), and vocational educational goals ($r = .31$, $p < .05$). In the abused group, girls who had higher mother support had better self-image on family relationships and vocational educational goals subscales (see Table 16). In order to graphically represent this, analyses of variance (ANOVAs) using mother support in two categories (high/low) as independent variables and SIQYA subscales as dependent variables were done. Girls who had high mother support showed significantly better self-image in family relationships ($F(1, 29) = 8.48$, $p < .01$) compared to girls who had low mother

support (see Graph 9). Although it did not reach the level of significance, girls who had high mother support also showed better self-image in vocational-educational goals, compared to girls who had low mother support (see Graph 10).

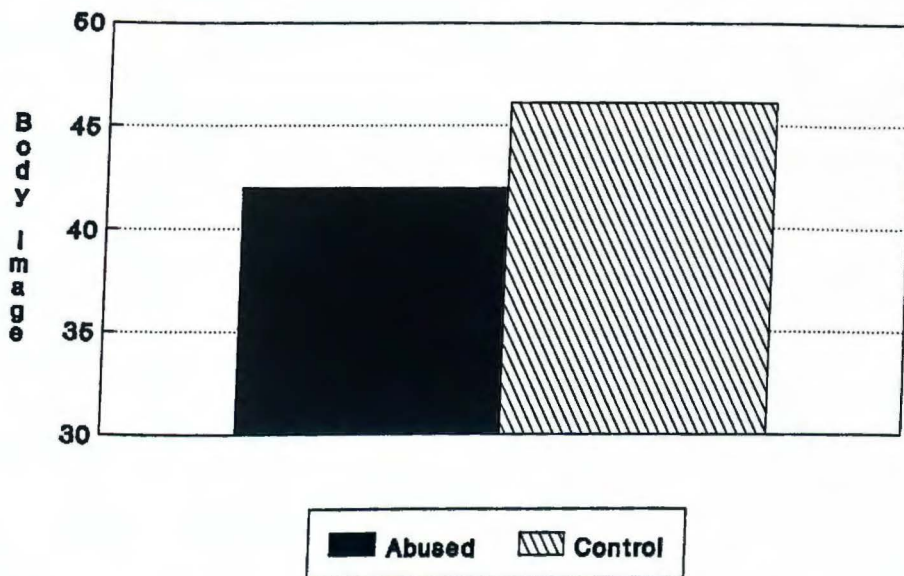
Table 16

Correlation of Mother Support with SIOYA Subscales within Abused Group

| SIOYA subscales | Abused Group (n=31) | Sign.level of p |
|--------------------|------------------------|--------------------|
| Body image | -.01 | .47 |
| Emotional tone | .02 | .44 |
| Psychopathology | -.01 | .47 |
| Family relat. | .56 * | .00 |
| Voc. educ. goals | .31 ** | .04 |
| ----- | | |
| * p <.000 ** p<.05 | | |

Graph 1

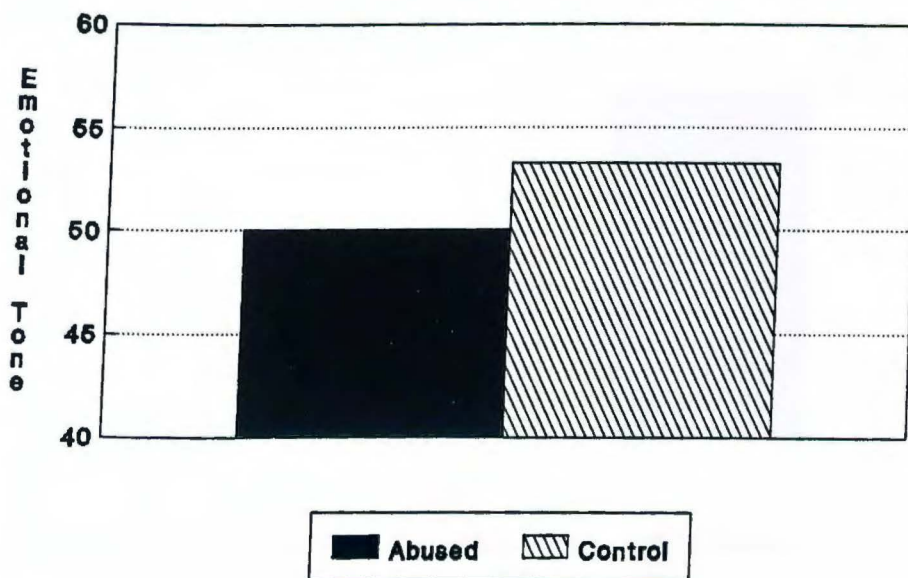
Body Image in Abused and Control Girls

 $p = .05$

Body image scores indicate mean scores for groups.

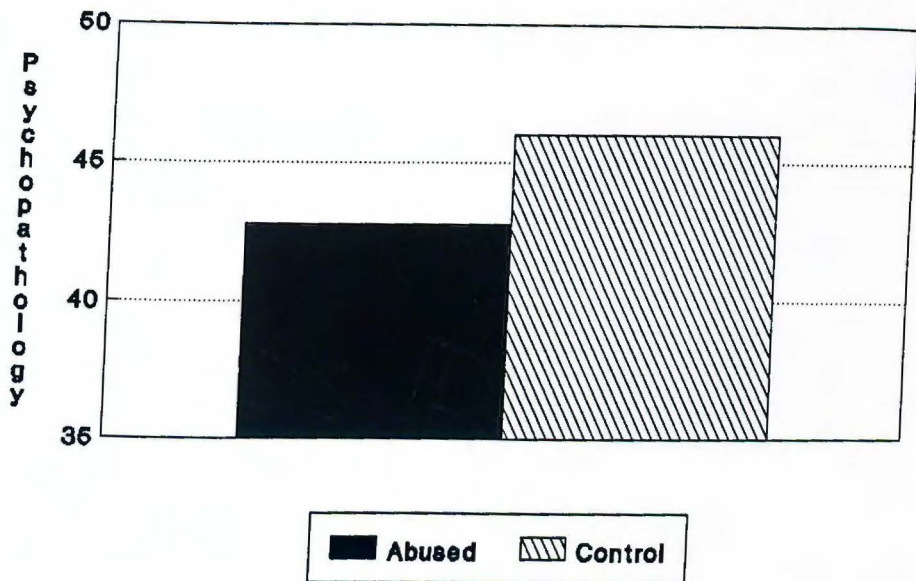
Graph 2

Emotional Tone in Abused and Control Girls

 $p < .08$

Emotional tone scores indicate mean scores for groups.

Psychopathology in Abused and Control Girls

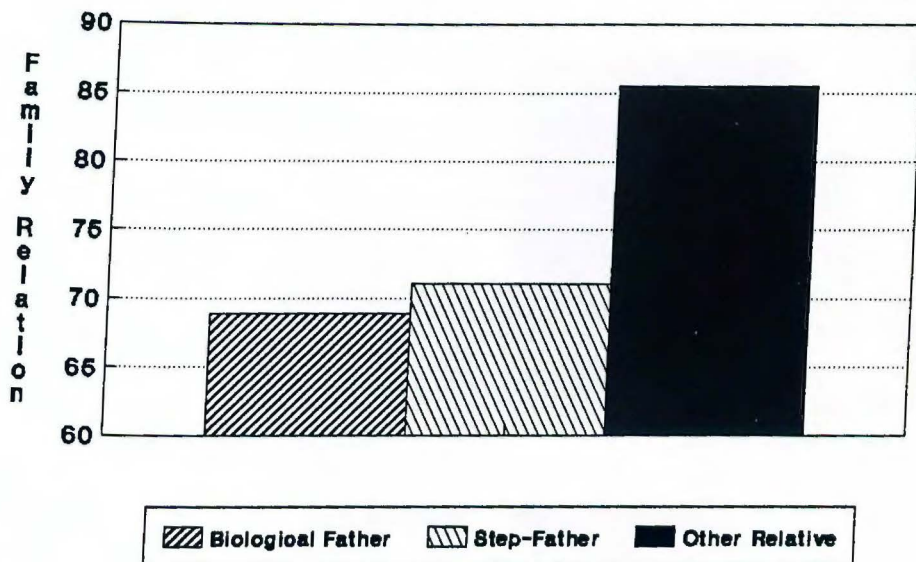


$p < .1$

Psychopathology scores indicate mean scores for groups.

Graph 4

Relationship of the Offender and Family Relationships

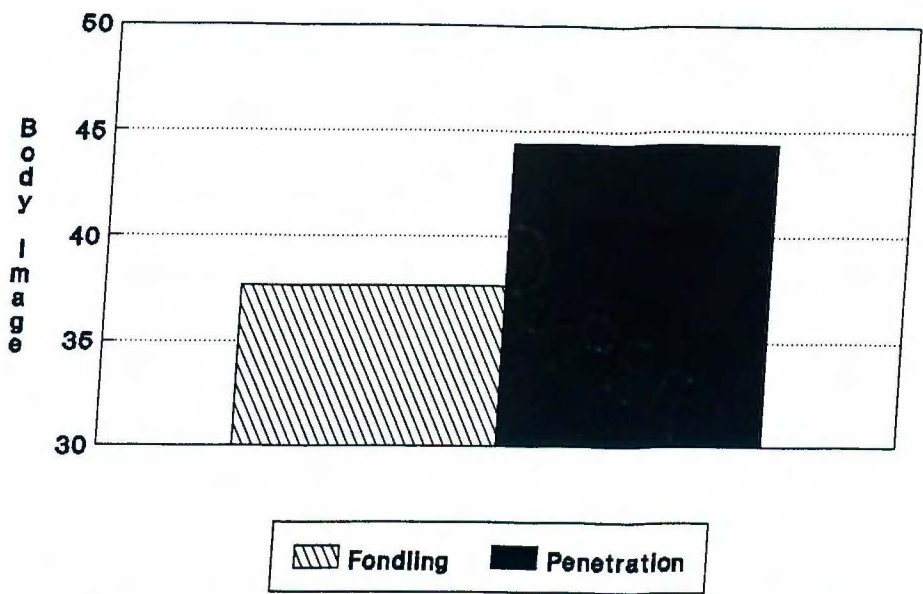


$p < .01$

Family relationships scores indicate mean score for relationship of the offender to the victim.

Graph 5

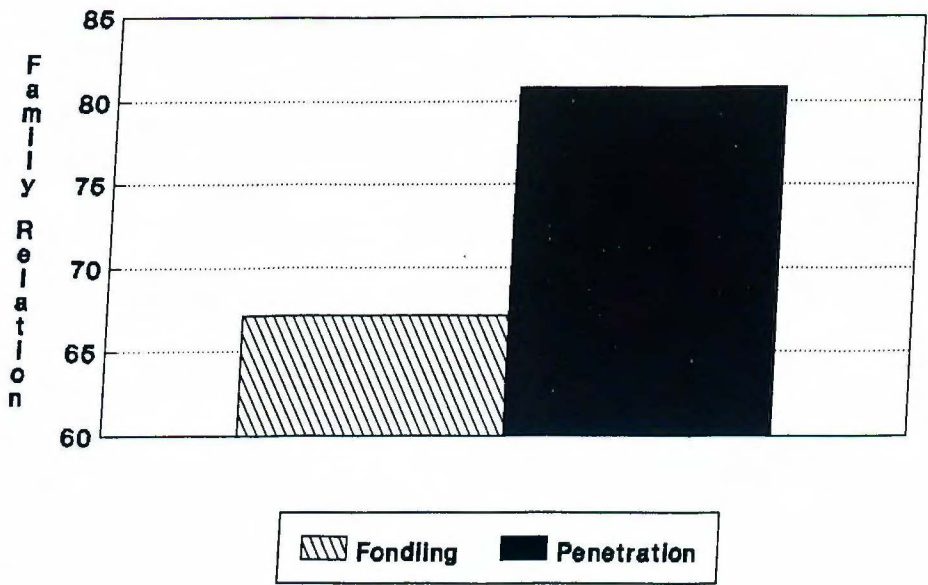
Type of Sexual Activity and Body Image



$p < .05$ Body image scores indicate mean scores for type of sexual activity.

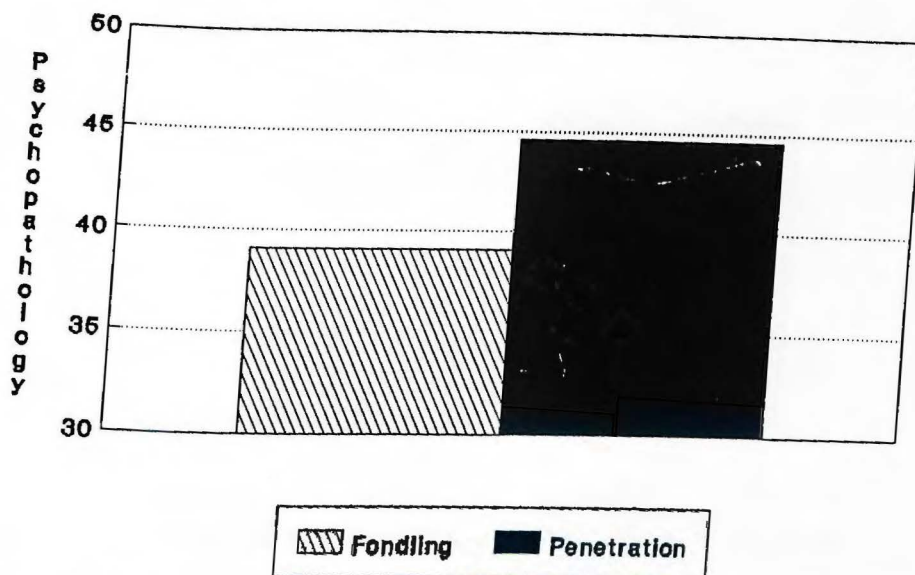
Graph 6

Type of Sexual Activity and Family Relationships



$p < .01$ Family relationships scores indicate mean score for type of sexual activity.

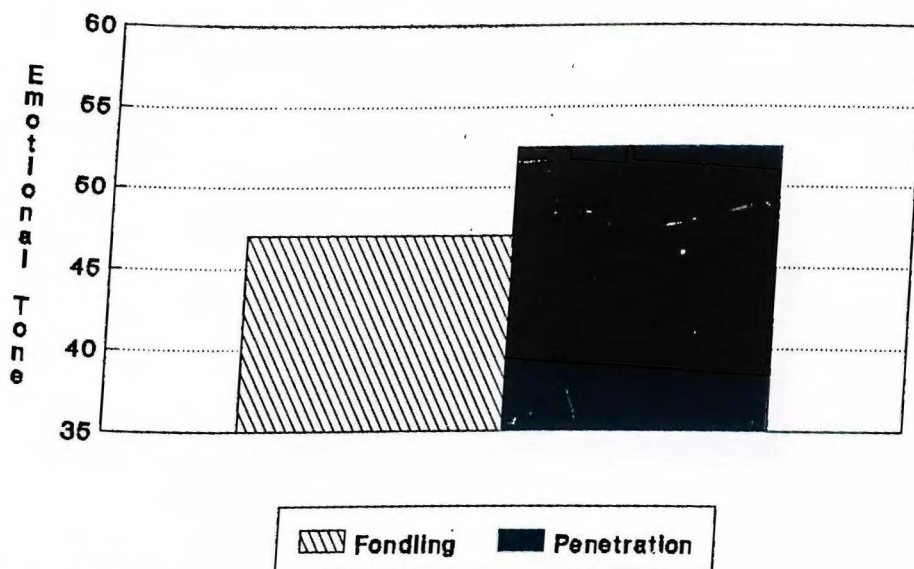
Type of Sexual Activity and Psychopathology



$p < .06$ Psychopathology scores indicate mean scores for type of sexual activity.

Graph 8

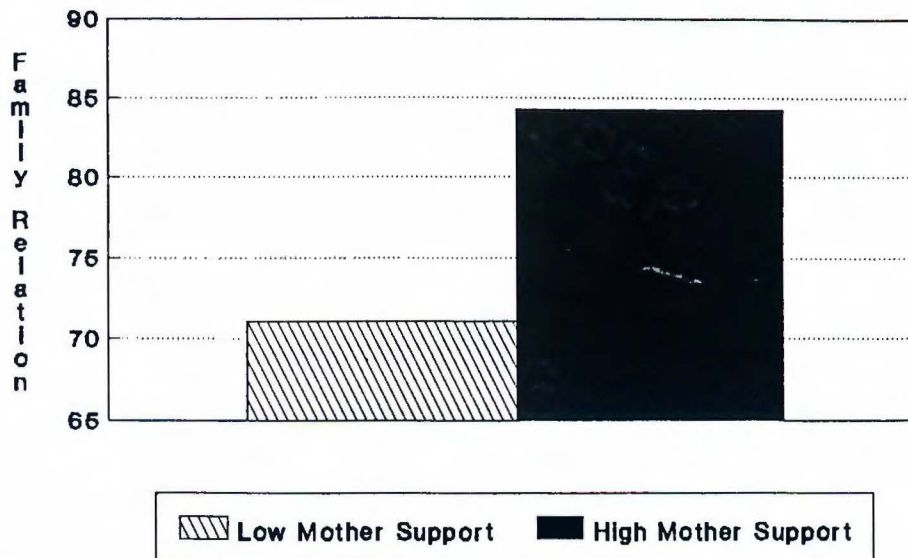
Type of Sexual Activity and Emotional Tone



$p < .06$ Emotional tone scores indicate mean scores for type of sexual activity.

Graph 9

High/Low Mother Support and Family Relationships

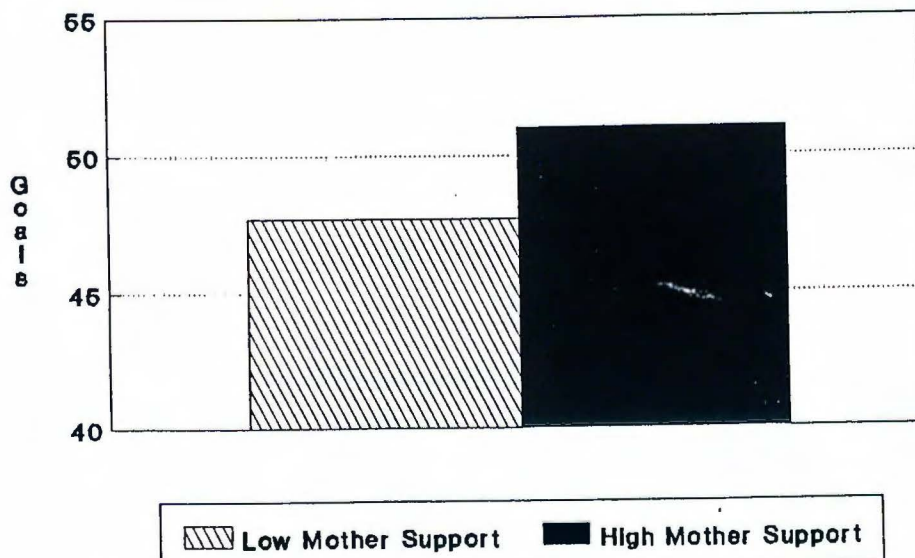


$p < .01$

Family relationships scores indicate mean scores for mother support.

Graph 10

High/Low Mother Support and Vocational-Educational Goals



Vocational -educational goals scores indicate mean scores for mother support.

Chapter V

SUMMARY, CONCLUSIONS AND DISCUSSION

Summary of the Study

This study was conducted with two purposes: (1) to examine the difference in self-image between girls who are victims of intrafamilial child sexual abuse and their non-abused peers; and (2) to examine the within group differential effect of abuse characteristics on the self-image of abused girls. Seven research questions guided the study. The first question dealt with self-image differences by the subjects' abuse status (abused or non-abused) and the interaction of age and mother support with abuse status. The remaining six questions sought to identify possible self-image differences between girls within the abused group by age of the child when abuse began, relationship of the offender to the victim, type of sexual activity, duration of abuse, use of violence, and mother support.

This study accessed part of the data collected for a currently undergoing longitudinal study investigating the psychobiological effect of child sexual abuse. The total number of subjects of this study consisted of 71 girls, ages 8-15. The abused group consisted of 37 girls who were victims of intrafamilial child sexual abuse, and the control group included 34 girls who were matched on age, race, socioeconomic status, and single or two parent status of the families. The abused girls were recruited through the

Washington metropolitan area Child Protective Service agencies. The control group girls were recruited through advertisements in news papers.

This study used data collected on three instruments. All subjects completed two of the three instruments, one dealing with self-image (dependent variable) and the other dealing with mother support (independent variable). The third instrument, completed by the abused girls' protective service caseworker provided information on the abuse characteristics (independent variables). The data were coded and statistically analyzed using SPSS-PC program. The statistical techniques used for data analysis included Chi-square, reliability analysis, analysis of variance (ANOVA) and correlation.

Findings indicated significant difference in self-image between abused and nonabused girls on the subscale of body image and marginal differences on the subscales of emotional tone and psychopathology, with abused girls showing poorer self-image compared to nonabused girls in all three components. No significant interactional effects were found for age and mother support with the abused/ nonabused status of the subjects. Correlational analysis, however, indicated a negative correlation of age with mother support and family relationships within the abused group. This correlation was marginally different from the correlation pattern of age with mother support and family relationships in the nonabused group, with older girls in the abused group showing poorer

self-image on both subscales compared to the older girls in nonabused group. Additionally, in the control group age was found significantly correlated with vocational-educational goals, with older girls showing better self-image in this subscale compared to older girls in the abused group.

Within group examination of the differential effect of relationship of the offender to the victim showed significantly better self-image in family relationships subscale when offenders were male relatives other than biological fathers or step-fathers. Within group examination also showed differences in self-image by type of sexual activity. Girls who experienced vaginal/ anal penetration surprisingly showed significantly better self-image in family relationships and body image and marginally better self-image in psychopathology and emotional tone, compared to those who experienced fondling and kissing. Further, in the abused group, girls who had higher mother support had significantly better self-image on the subscales of family relationships and vocational educational goals. No difference in self-image was found by age abuse began, duration of abuse, and use of violence.

Conclusions

The following conclusions were drawn from the findings as they relate to the seven research questions.

Research Question 1: Does the self-image of girls who are victims of intrafamilial child sexual abuse differ from that

of a control group of non-abused girls, and is there a difference by age and mother support?

It is concluded that this study findings support that self-image of girls who are victims of intrafamilial child sexual abuse differs from that of non-abused girls in body-image, psychopathology, and emotional tone, with the abused girls showing poorer self-image in all three areas. The findings, however, do not suggest any significant interactional effect of age or mother support with abuse status on the self-image. Based on the existence of a negative correlation of age with mother support and SIQYA subscales in the abused group, and a different pattern in the nonabused group, it is concluded that older girls in the abused group have lower mother support and poorer family relationships compared to the older girls in the nonabused group. Further, it is concluded that older girls in the nonabused group are better on vocational educational goals compared to the older girls in the abused group.

Research Question 2: Does age of the victim when abuse began have a differential effect on the victim's self-image?

It is concluded that the findings of this study do not support that age of the victim when abuse began has a differential effect on the victim's self-image.

Research Question 3: How does the victim's self-image differ by the relationship of the offender to the victim?

It is concluded that the findings of this study support

that girls who are victims of intrafamilial child sexual abuse maintain better self-image on the family relationships when their offenders are male relatives other than their biological fathers or step-fathers. The mean score differences of girls who were abused by biological fathers, stepfathers, and other relatives, on the family relationships subscale probably also suggest that the closer the relationship between the child and the offender, the worse the damage to self-image in family relationships. Conversely, it may also suggest that the more distant the relationship between the offender and the victim, the better the victim's self-image in family relationships.

Research Question 4: Does the type of sexual activity have a differential effect on the victim's self-image?

It is concluded that the findings of this study support that the type of sexual activity in which the victims are involved in intrafamilial child sexual abuse has a differential impact on the victim's self-image in the areas of body image, family relationships, psychopathology and emotional tone. Surprisingly, based on the findings, it is concluded that girls who have experienced penetration (anal/vaginal) tend to have better self-image compared to girls who experienced mere fondling behaviors (kissing, touching, and fondling).

Research Question 5: Does the duration of abuse make a difference in the victim's self-image?

It is concluded that the findings of this study do not support that duration of abuse, neither linear nor non-linear, has a differential effect on the victim's self-image. **Research Question 6: Does the use of violence have a differential effect on the victim's self-image?**

It is concluded that findings of this study do not support that intrafamilial child sexual abuse accompanied by violence has a differential impact on the victims' self-image. **Research Question 7: Does mother support make a difference in the victim's self image?**

It is concluded that the findings of this study support that abused group girls who have higher mother support are likely to have better self-image in family relationships and vocational educational goals.

Discussion

As mentioned in Chapter I and made clear through the review of literature in Chapter II, both clinical reports and empirical studies on the short-term and long-term effects of child sexual abuse for the victims, suggest that victims of child sexual abuse face a wide variety of emotional, behavioral, sexual and self-perception problems. In this connection, it was pointed out that previous empirical studies, although few in number, revealed more clearly than the clinical reports considerable variability in the magnitude of the problems the victims face. It was also noted that in an effort to ascertain the sources of this

variability, researchers have recently begun to examine the possible differential effects of abuse characteristics and that the findings of such studies to date have been inconsistent (Mannarino, Cohen, Smith, & Moore-Motily, 1990; Conte et.al, 1986; Browne & Finkelhor, 1986). Further it was noted that in the past, most of the empirical studies mixed the sample population of intrafamilial and extrafamilial abuse victims, and very few of these studies systematically ventured to investigate the differential impact of abuse characteristics on the victim's self-image, using non-behavioral, standardized psychological measures and control groups of nonabused girls. The present study was planned on a sound theoretical basis using standardized psychological measures and a control group of nonabused girls. Nevertheless, due to the minimum amount of previous studies in this direction and the use of a sample population consisting only victims of intrafamilial child sexual abuse, this researcher was unsure of what this study would reveal. The object of the following discussion is to relate the study findings and conclusions pertaining to each of the research questions to the existing literature, to offer explanations for unusual results, and to make recommendations regarding areas of future research.

Research Question 1: Does the self-image of girls who are victims of intrafamilial child sexual abuse differ from that of a control group of non-abused girls, and is there a

difference by age and mother support?

This study found significant difference in self-image between abused and non-abused girls in the area of body-image and marginal difference in emotional tone and psychopathology. The abused girls showed poorer self-image in all these areas compared to nonabused girls. Also, there was a negative correlation of age with mother support and family relationships, with older abused girls showing marginally lower mother support and poorer self-image in family relationships compared to nonabused girls. Further in vocational educational goals, abused girls had poorer self-image compared to nonabused girls. These findings can be better understood within the context of the study population's developmental stage, prior clinical reports and empirical studies.

First, it appears important to view these findings in the context of the victim's developmental stage. There is almost universal agreement that adolescence is a stage of profound physical and psychological changes. At this stage, the development of secondary sex characteristics and the typical adolescent growth spurt are expected to be integrated into the repertoire of body-images, while cognitive changes such as the development of Piagetian formal operations bring new levels of self-awareness (Putnam, 1987). Erikson (1950) described it as a stage of "identity versus role confusion" where the individual may exhibit profound swings in his /her

sense of self. Terms such as self-image, self-concept, self-esteem, body-image, identity, which are often used interchangeably, are particularly important concepts for adolescents at this stage of development. It is assumed that sexual abuse and betrayal of trust in adolescents by a trusted family member, who is charged with the responsibility of providing trust, security, protection, care and nurturing interferes with the adolescents' normal development and psychological well-being.

Secondly, the study finding of negative self-image among sexually abused girls give strong support to a wide range of prior clinical reports claiming that child sexual abuse is traumatic to the victims and has a very definite effect on their self-image. Self-image problems in adults who were sexually victimized in childhood have been reported in virtually all clinical reports of long-term effects (e.g., Steel & Alexander, 1981; James and also Meyerding, 1977; Summit and Kryso, 1978). Short term effect of disturbances in body image have also been repeatedly reported by several clinicians working with sexually abused children (e.g., Sgroi, 1985; Burgess & Holmstrom, 1975; Lewis & Sarrel, 1969). Of special relevance to the present study, Porter, Blick and Sgroi (1985) based on their clinical exploration of the causes of damaged self-image in victims of child-sexual abuse identified poor body-image, societal response, guilt, shame, blame for participation, disclosure, and disruption of the

family as some of the factors that undermine the victim's self-esteem. As previously noted in Chapter II, several other self-image related emotional and psychopathological problems have been frequently noted in clinical literature (DePanfilis, 1989; Haugaard and Repucci, 1988). Further, the findings in the study that sexually abused older girls have poorer relation with their mothers and poorer self-image in family relationships, marginally different from that of the older nonabused girls, support the clinical data in this direction (Haugaard and Reppucci, 1988; DePanfilis, 1988).

Thirdly, it may be noted that while support for self-image differences between abused and nonabused girls has been very strong in studies of long-term effects (Bagley & Ramsey, 1985; Courtois, 1979; Herman, 1981), such clear findings have not been consistently available from studies of short term effects. In a surprising finding, Tufts study (1984), using Purdue Self-Concept Scale, found no evidence that sexually abused children in any age group had consistently lower self-esteem than a normal population of children. However, Conte, Berlinger and Schuerman (1986) investigating the effects of sexual abuse on children using several behavioral measures completed by parents and social workers noted significantly low body- image/ self-esteem among sexually abused children. Also, in this study, on the self-esteem factors of the Self-Report Questionnaire completed by the child, females indicated poorer self-esteem compared to

males. Orr and Doves (1985) contrasted a group of twenty sexually abused female adolescents and a control group of actually ill female adolescents. This study found abused girls with lower scores on the subscales of "mastery of the external world" and "vocational-educational goals" on the Offer-Self Image Questionnaire. Several other empirical studies on short term effects have also reported that their group of sexually abused children demonstrated significantly greater psychopathology on the parent form of the Child Behavior Checklist (CBCL) than a normal control (Mannarino et al, 1990; Friedrich, Beilke, & Urquiza, 1987). The present study adds to the body of empirical literature that has found self-image differences between abused and non-abused girls. The findings of the present study, however, need further validation through replication of the study with a much larger sample.

Research Question 2. Does age of the victim when abuse began have a differential effect on the victim's self-image?

The findings of the present study that age of the victim when abuse began does not account for any significant difference in self-image confirm previous empirical findings in this direction. While some clinical reports suggest that younger children (often latency age) are somewhat more vulnerable to trauma than older children (Miselman, 1978, Courtois 1979; MacVicar, 1979; Gomes-Schwartz et al., 1985; Zivney et al, 1988), empirical studies have shown only small and statistically insignificant tendencies in this direction

(Alexander & Lupfer, 1987; Finkelhor, 1979; Russell, 1986; Tsai et al., 1979). The Tufts study (1984) which highlighted victim reaction to abuse at different ages also found no clear relationship between age of onset and outcome, but it did find that the latency age children were more disturbed. Although not significant, the present study also gave indication that latency age children may be more disturbed. This trend was somewhat reflected in the mean score difference of different age groups on the body image subscale. The mean score on the body-image subscale of girls whose abuse started during latency age (8-12) was the lowest in the present study compared to girls whose abuse began prior to age 8 and between ages 12-15. It is, however, not clear whether this trend is related to the age at which the girls completed the questionnaire rather than the age at which their abuse began. It may be quite possible that age at which abuse began may be less important than the stages of development through which the abuse persists. There is also the possibility that age is masked in complexity and interacts with other factors like the child's relationship to the offender, frequency of abuse, duration of abuse and type of abuse. These areas warrant future investigation.

Research Question 3: How does the victim's self-image differ by the relationship of the offender to the victim?

In this study relationship of the offender to the victim was found accounting for significantly better self-image in

family relationships subscale. Several empirical studies in the past found that whether the perpetrator was a family member or a person outside the family did not have a significant effect on the trauma of the abuse (Finkelhor, 1979; Russell, 1984; Seidner & Calhoun, 1984; Tsai et al., 1979). Other studies reported that abuse by relatives causes more trauma than abuse by non-relatives (Landis, 1956; Anderson et al., 1981). There were also studies which reported that abuse involving biological fathers and stepfather figures were more traumatic compared with all other types of perpetrators (Adams-Tucker, 1982; Russell, 1983; Finkelhor, 1979; Tufts, 1984).

Clearly, the present study neither duplicates any of the previous finding nor challenges it; rather, it adds a new dimension to the already inconsistent pool of findings. Contrary to the expectation, in this study girls who were sexually abused by biological fathers, stepfathers and other male relatives did not show any significant difference in self-image for body image, psychopathology and emotional tone. On the other hand, the findings suggest that girls who were sexually abused by male relatives other than biological fathers and step-fathers maintain significantly higher self-image in family relationships. Another noteworthy aspect of this finding, although not significant, was the pattern of mean score difference among the three categories of relationship of the offender to victim on the family

relationships subscale. The mean score for family relationships was the lowest when the offenders were biological fathers, followed by step-fathers and other male relatives.

This finding, perhaps not striking at first, may be very meaningful when understood within the context of the family situation after the disclosure of the secret of intrafamilial child sexual abuse. Obviously this study finding doesn't reach the level of significance in support of the position that the closer the relationship of the offender to the victim, the worse the trauma on the victim. The finding rather appears to be significant in support of the position that the farther the relationship of the offender to the victim, the better the self-image in family relationships.

Several explanations can be offered for this finding in the context of the present study population of intrafamilial child sexual abuse victims. First, lack of an approximately equal number of subjects in the three categories of relationship of offender to victim may have affected the finding. In fact, there were only 7 girls who were sexually abused by biological fathers, as against 15 by step-fathers and 11 by other male relatives. Secondly, the victim's step-father and mother's boy-friend, whether live-in or not, were included in the category of step-father. Third, it is not known above and beyond the nominal relationships as biological father, step-father and other male relatives, how many of

these offenders maintained an overall quality relationship with the victim which could have an impact on the extent of trauma. Fourth, the finding may be an indication that the child who is abused by an extended family member would more than likely receive better support, reassurance and comfort from close, more significant family members, including both parents in a nuclear family. Fifth, there could be other variables such as coercive tactics used to engage the child into sexual activity that may increase or decrease the intensity of the impact regardless of the relationship of the offender to the victim. It is reasonable to speculate that one or more of these variables in combination may account for variation in trauma, not just relationship of the offender. Future studies may find it an interesting area for investigation.

Research Question 4: Does the type of sexual activity have a differential effect on the victim's self-image?

Perhaps, the most surprising findings of this study have been the differential effect on self-image by the type of sexual activity. One would expect penetration to be a more genuine and serious form of abuse and, therefore, more traumatic, in comparison to fondling behavior. However, this study findings did not validate this assumption. In this study, girls who experienced fondling behavior indicated significantly poorer self-image on the subscales of body image and family relationships and marginally poorer self-image on

psychopathology and emotional tone, compared to those who experienced vaginal or anal penetration. Interestingly enough, empirical evidence of the relationship between the type of sexual activity and victim reaction in the literature has been inconsistent (Haugaard & Reppucci, 1988). Several investigators have reported that vaginal or anal penetration experience is significantly more traumatic than fondling of the breasts or genitals (Russell, 1984; Bagley and Ramsey, 1985; Tsai et al, 1979; Landis, 1956 ; Peters, 1984). However, other studies have negated this finding. Tufts' study (1984) which used more rigorous and standardized measures found children who had been fondled without penetration to be more anxious than those who actually suffered penetration. Other researchers (Finkelhor, 1979; Anderson et al., 1981; Fromuth, 1983) also found no consistent, significant difference in the amount of trauma reported due to the type of sexual activity. In view of the lack of consistency in empirical findings in this area, several explanations can be offered for the findings of the current study.

First, one of the important factors that needs consideration here is the possibility that the type of abuse may be a crucial factor in determining whether a child is readily believed, supported, comforted and reassured by the non-offending family members and other involved agencies and professionals. It is well known that disclosure of sexual abuse could disrupt the normal family life for a long time,

and it may also lead to family breakdowns. Family disruption and breakdown are often costly, usually for the non-offending mother, who could be deprived of financial stability and security of herself and the family. For this reason, the non-offending parents are often unwilling to believe the allegation of abuse at least in the initial stage. However, the chances of their believing and taking steps to protect the child are much higher regardless of the cost to the family, if the allegations are of a serious nature such as vaginal or anal intercourse/ penetration. Professional experiences have shown that such allegations are more likely to be readily believed by the child's non-offending parent/s, other family members, the agencies mandated to investigate reports of abuse, and other professionals who treat victims. The chances of the non-offending family members and other professionals taking immediate steps to comfort and protect the child are very high in those circumstances. This may in turn help to minimize the trauma of serious abuse and help stabilize or boost the child's self-image. On the other hand, it is possible that the non-offending parent may take an allegation of kissing and fondling by a family member rather skeptically, blame the child and even refuse to believe the child for a long time to avoid risking family breakdowns. This situation may lead to continued victimization of the child and lack of support and help. Therefore, it seems possible that victims in such predicament, even if they experienced

only lesser forms of abuse, maintain poor self-image and feel themselves bad, evil, not worthy of belief, and no one to turn for help.

A second factor to be considered as an alternate explanation for the present finding is the issue of immediate versus long term effects for type of abuse. Recognizing that the data of the present study were collected soon after the disclosure of the abuse (not more than six months after the disclosure), it is possible that the abused girls in this study were still in a period of denial and the full trauma of more serious type of abuse was not yet apparent to them. Perhaps the findings on repeated measures over a period of time may vary as a function of increasing trauma as a long term effect. Indeed this possibility was documented in a recent study (Mannarino, et. al. 1990) which found that girls who were subjected to sexual intercourse reported significantly more depressive symptoms, state and trait anxiety, and self-esteem problems at twelve month follow up than those who had experienced fondling. For these subjects such significant symptomatology was not related to intercourse experience at the initial assessment or at six months follow up. Mannarino et al (1990) findings indicate the possibility of an initial " sleeper effect" for type of abuse that may become evident over time. It is possible that in the current study, typical adolescent pseudo-maturity and the desire to overcompensate for the shame, hurt feeling, and insult to the

body caused the victims to deny and underreport the full impact of more serious type of sexual activity immediately. Perhaps, a change in perception of the impact of more serious sexual activity in the long-term may result in significant findings of self-image damage in the same victims. Replication of the findings of the current study and more follow up studies investigating long term effects are needed before any definitive conclusion about this issue can be drawn.

A third issue of consideration in explaining the current findings should be the controversy surrounding the inconsistencies in findings between the child self-report measures and parent reported measures. On standardized self-report measures, sexually abused children have not been found to identify more psychological symptoms than control samples (Einbender and Friedrich, 1989). Mannarino, Cohen & Gregor (1989) initially found no significant differences on self-report measures of depression, trait anxiety, and self-concept between sexually abused, clinical and normal control groups. At 6 and 12 months follow up of the psychological symptomatology of sexually abused girls too, Mannarino et. al (1990) noted all findings on the child self-report measures to be nonsignificant, except the findings on the Piers-Harris Self-Concept Scale at twelve month follow up. However, on the parent reported measures of Child Behavior Checklist (CBCL), the sexually abused girls were significantly more pathological than the controls at both follow up periods. It

is possible that on self-report measures adolescents underreport the extent of the trauma. This assumption is especially relevant in the present study because this study did not include parent report measures to make a comparison.

Fourthly, as alternate explanations, it seems logical to attribute the causes of the current findings to the design of the study. By design, the subjects of this study were strictly intrafamilial child sexual abuse victims who lived at home after the disclosure of the abuse and did not include abused girls who live in hostile families and in foster care. When the subjects were seen for the study, nearly all of them were still living at home under the primary care, and protection of the non-offending parents, usually the mothers, or other extended family members, while the offenders were out of their homes. The study also required consent from at least one of the parents, usually the mother, along with the consent from the child. The non-offending parent, usually the mother, was also required to accompany the child to the data collection center. Therefore, by the very design of the study the child was expected to be living within a supportive family environment after the disclosure of the abuse incident. It is thus possible that supportive family environment may be a mediating factor in neutralizing the effect of more serious type of sexual activity.

On the other hand, due to the study requirement of parental consent for participation in the study, girls who

were victims of intrafamilial child sexual abuse and live in families that are angry with agencies such as child protective service, the police and the courts for interfering in what the families consider to be their "private matter" were noticeably absent from the study. If a family is angry with the system and does not seek voluntary help from agencies that provide services to children and families for the recovery and rehabilitation, and rather resists the involvement of these agencies, chances are that the victims who live in such a family are subjected to certain degree of blame and resentment from the family members. This may exacerbate the negative effects on the victim. It was not possible to obtain parental consent for the participation of girls who live in such families for their participation in this study. Therefore, this study findings do not reflect the possible full trauma faced by child victims living in resistant and hostile families.

Similarity, it is a known fact that children are removed from their families and placed in foster care only when the family environment is unsupportive and unstable for their care and well-being. Families that lack such caretakers and support systems are usually multi-problem and pathologically dysfunctional families. It is likely that children who are sexually abused in such families and placed in out-of home settings following the abuse disclosure may be more troubled and traumatized than children who stay home under the

protection and care of their non-offending family members. Girls who are in such predicament were also not part of this study due to the legal complications of obtaining double consent from the foster care system and the natural parent/s. Therefore, it is possible that this study findings do not reflect the full negative impact of more serious type of sexual activity, especially of girls who live in hostile families and in foster homes.

Research Question 5: Does the duration of abuse make a difference in the victim's self-image?

The findings of this study did not contribute any new knowledge pertaining to differential effect on self-image as a function of the duration of abuse. Rather, the findings are in agreement with much of the previous empirical investigations which did not find significant differences for trauma by duration of abuse alone. Despite the clinical assumption that long duration of abuse causes greater trauma for victims than short duration, there is no strong and consistent evidence in the literature for this hypothesis. While some studies found duration and frequency associated with greater negative effects (Tsai et al., 1979; Bagley and Ramsey, 1985; Friedrich et al, 1986), several other studies (Finkelhor, 1979; Courtois, 1979; Langmade, 1983; Tufts, 1984; Adams-Tucker, 1982) found no relationship between duration of abuse and negative effect on the victims. Thus the available studies reach quite contradictory conclusions

about the relationship between duration and trauma. The present finding, however, has to be viewed with caution. Duration of abuse is a relative variable. Several other variables, such as type of sexual activity, frequency of sexual activity, the relationship of the offender, and the tactics used to engage the child in sexual activity may be inevitably connected with the duration of abuse in making it a less or more traumatic experience.

Research Question 6: Does the use of violence have a differential effect on the victim's self-image?

This study finding that violence accompanying abuse made no difference in victim's self-image does not fall in line with the findings of the majority of empirical studies on this issue. Most studies have found that overt use of violence by perpetrators results in more short term and long-term negative consequences to victims than abuse when force is not used (Finkelhor, 1979 ; Fromuth, 1986; Russell, 1986; Ewell & Ephros, 1987; Tufts, 1984 ; Friedrich et al., 1984). However, three other studies found no significant relationship between the use of violence and negative effects (Anderson et al., 1981; Seidner & Calhoun, 1984; Bagley & Ramsey, 1985). In light of the overwhelming evidence for the negative effect of violence, the generalizability of the finding of the current study is questionable for several reasons. In the present study, violence was defined less rigorously compared to the definitions of previous studies. While most of the previous

studies defined violence as an overt use of physical force, this study added to the definition threat of any kind due to the fact that some form of physical force occurred in only three cases. Also, including the three cases of actual use of physical force, there were only nine cases where either physical force or threat of force accompanied sexual abuse. It is recommended that future studies with larger samples define use of physical force and threat separately in an effort to precisely examine the effect of violence.

Research Question 7: Does mother support make a difference in the victim's self-image?

In this study, within the abused group, mother support was found accounting for significantly better self-image in the victim's family relationships and vocational educational goals. This finding clearly supports several other previous studies which found that having a supportive, non-abusive parent to the child after the disclosure has a positive effect in reducing the trauma of abuse (Adams- Tucker, 1982; Schultz, 1973; Rogers & Terry, 1984; Simrel, Berg, & Thomas, 1979; MacFarlane, 1978; Conte & Schuerman, 1987). Although only a few studies have examined the role of mother support in minimizing the trauma of child sexual abuse, there appears to be a strong indication that mother support is crucial for the child's self-image as it relates to family relationships and less traumatic adjustment after the disclosure of abuse.

Implications of the Study

The findings of this study have implications for theory, practice, and empirical literature

First of all, the findings of this study have clear theoretical implications. In Chapter I, three theoretical hypotheses were discussed as the framework for the study : the cognitive learning hypothesis (Summit, 1983); post traumatic stress disorder hypothesis (Horowitz 1976); and emotional accommodation hypothesis (Finkelhor & Browne, 1988). According to the cognitive learning hypothesis, the major cause of negative effects on the victim of child sexual abuse is the change in the victim's self-concept as a result of the atmosphere that surrounds the abuse. Summit, (1983) the leading advocate of this model, theorized that in order to cope with an ongoing abuse situation, where an adult who is expected to protect the child betrays trust and abuses the child, the child assimilates (modifies) her view of the world and self and begins to change her self-concept in the direction of being evil and helpless. Giving a post-traumatic stress disorder explanation, Horowitz (1976) postulates that the child victim's attempts to shield herself from the memories of the abuse reduces the chance for the mind to work through them, and this, in turn, results in a cyclical intrusion of such memories in her life. In Horowitz's formulation, this cyclical intrusion process accounts for the poor self-image, and related emotional and behavioral problems

seen in the victims. The advocates of the emotional accommodation model (Finkelhor & Browne, 1988) claim that four traumagenic dynamics of abuse, traumatic sexualization, betrayal, powerlessness, and stigmatization, which the child victim experiences in connection with the abuse incident, form the basis for emotional and psychological injury to the child and become incorporated into the child's self-image. Having seen clear differences in self-image between abused and nonabused girls, and further among abused girls by several abuse characteristics, the findings appear to support and give credibility to the underlying assumptions of all three models. It is quite possible that self-image damage is a cognitive process, a result of post-traumatic stress disorder, an emotional accommodation, or even an eclectic process, which incorporates all three. These models, however, need further validation through future empirical research using larger sample and multiple measures, which would ideally combine child self-report and parent report measures in order to acquire the status of a fully developed, comprehensive theory accounting for the trauma of child sexual abuse.

Second, the results of this study have important implications for practice. In this connection, it has to be recognized that in the present study the outcome of sexual abuse experience is only in part assessed in psychological damage to the self-image. Several behavioral aspects which may also be affected and may have practical implications were not

examined in this study. However, in a very general way the current findings support the professional notion that child sexual abuse is a traumatic experience for the victims. This has been evident in the findings of group difference in self-image between abused and non-abused girls in some of the important components of self-image for adolescents, body image, emotional tone and psychopathology. These findings give further credibility to child protective service agencies' and mental health practitioners' claim that some level of therapeutic intervention is needed to help minimize the trauma to the victim.

Additionally, the study's findings of differential trauma as a possible function of abuse characteristics are very useful information for child protective service agencies and mental health practitioners who evaluate, recommend and treat victims. The findings of this study caution us against universal effect. It appears that the effects of sexual abuse vary. Some victims may appear more seriously affected by the experience than others; for some victims, the effects may not be apparent until later in life; and some may not be affected at all. In this study, the findings of differential effect on self-image by the relationship of the offender to the victim, type of sexual activity and mother support seem to imply that all victims of child sexual abuse do not need the same level of intervention and treatment services, and that in planning intervention it is important that mental health practitioners

consider a wide range of variables which might predict which victims may react more negatively to sexual abuse and which would find it relatively easier to recuperate. Also, the findings of this study have implications for identifying victims who may be at greater or lesser risk of developing severe symptoms. This, in turn, may help to determine the need for more or less therapeutic intervention, the direction and strategies for such intervention.

It should be noted that unlike most other empirical studies which choose mixed samples from both victims of intrafamilial and extrafamilial child sexual abuse, this study limited its sample to victims of intrafamilial child sexual abuse. Therefore, the findings of this study have specific implications for dealing with intrafamilial child sexual abuse. Within the context of intrafamilial child sexual abuse, mother support and other supportive family relationships seem to have strong implications for better psychological adjustment of the victims and recovery from trauma. A related implication of these findings raises concern about the professional intervention practices, most often initiated through social services agencies. Removal of the child victim from her home after the disclosure of the abuse often deprives her contact with the possible supportive environment. If the inferences derived from the findings of the current study are correct, clearly some children live in homes and supportive environments which can be linked to reducing the impact of

sexual abuse. When this is the case, removal of the child from that supportive home environment may deprive the child of factors associated with better functioning and may worsen the trauma. Therefore, the findings imply that removal should be considered only after thorough assessment of the effectiveness of the available family support system.

Finally, there are several implications of this study for research. For instance, the study findings expand the empirical body of literature pertaining to the self-image of sexually abused girls providing support to a number of prior findings and adding new knowledge. The study reconfirmed self-image difference between abused and nonabused girls in body-image, psychopathology, and emotional tone with abused girls exhibiting poorer self-image in all these areas. Further, the study found a negative correlation of age with mother support and family relationships within abused group, indicating a marginally differential pattern from that of the non-abused girls. Additionally, the study findings provide some new insight on the dynamics of intrafamilial child sexual abuse, specifically self-image difference of victims by relationship of the offender to the victim, type of sexual activity and mother support, for future researchers to further validate and build on.

The generalizability of the findings of this study, however, is limited by the sample size, the amount of missing data, level of sophistication of the analysis used, and the

reliability of the measurements. The sample size has been less than ideal. Although the recruitment of a sample for a study like this is not an easy task considering that it took three years to collect a sample of 71 girls, 37 abused and 34 matching controls for this study, future studies are recommended with a sample size of at least one hundred subjects, especially in view of the number of variables involved for a comparable study and the possibility of missing variables. While data on SIQYA measure was available for all 71 subjects, only 63 subjects completed the Hill Intimacy Questionnaire. Similarly, of the 37 abused girls, information on the five abuse characteristics collected through the Abuse Case Information Checklist, which was crucial for most of the analysis, was available only on 33 subjects. Even those subjects for whom abuse case information was available had missing data on several important variables like age abuse began, duration of abuse and use of violence.

A multiple regression analysis would have been ideal and a more sophisticated analysis to give precise account of the differential impact of abuse characteristics on self-image. Such an analysis would have examined how much of the variance in self-image is accounted for by each one of the abuse characteristics over and above the previous one entered in the equation. However, as discussed above, the small sample size, missing data on several relevant variables, and the consequent statistical power problems restricted the usefulness of such

an analysis in the present study. Therefore, ANOVAs and correlational analyses were chosen as the next best alternatives. It is recommended that future studies with larger sample use more sophisticated analysis for the purpose of further validating the present findings.

It is also recommended that future studies select or develop measures which are more sensitive to the population of sexually abused girls. The SIQYA measure used in this study is a measure designed for normal population. It is not clear whether this measure has been sensitive enough to measure the full scope of self-image in the subjects who have been sexually abused. Special mention has to be made of the fact that only three of the nine subscales of this measure were found to have alpha .70 or above when administered to this population before increasing the alpha level of two more subscales by removing one item each from them. Further, it is recommended that future studies use a combination of child self-report measures and parent report measures for comparison purposes and for the purpose of obtaining a more accurate and balanced picture of the trauma.

ID# _____

SELF-IMAGE QUESTIONNAIRE FOR YOUNG ADOLESCENTS

AFTER CAREFULLY READING EACH OF THE STATEMENTS ON THE FOLLOWING PAGES, PLEASE CIRCLE THE NUMBER WHICH INDICATES HOW WELL THE STATEMENT DESCRIBES YOU. EACH NUMBER GOES WITH A CATEGORY TELLING WHETHER IT DESCRIBES YOU VERY WELL (1), WELL, (2), FAIRLY WELL (3), NOT QUITE (4), HARDLY (5), NOT ALL (6). THERE ARE 98 STATEMENTS. PLEASE RESPOND TO ALL OF THEM. REMEMBER, THERE ARE NO RIGHT OR WRONG ANSWERS.

EXAMPLE

STATEMENT: I LIKE ICE CREAM.

CHOICE OF ANSWERS:

- | | |
|----------------------------|-------------------------------|
| 1-DESCRIBES ME VERY WELL | 2-DESCRIBES WELL |
| 3-DESCRIBES ME FAIRLY WELL | 4-DOES NOT QUITE DESCRIBE ME |
| 5-HARDLY DESCRIBES ME | 6-DOES NOT DESCRIBE ME AT ALL |

IF YOU LIKE ICE CREAM A WHOLE LOT, YOU WOULD CIRCLE 1. IF YOU DON'T LIKE ICE CREAM AT ALL, YOU WOULD CIRCLE 6. IF YOU LIKE ICE CREAM A LITTLE, YOU WOULD CIRCLE 3. IF YOU ONLY OCCASIONALLY LIKE ICE CREAM, YOU MIGHT CIRCLE 4.

- 1-DESCRIBES ME VERY WELL 2-DESCRIBES ME WELL
 3-DESCRIBES ME FAIRLY WELL 4-DOES NOT QUITE DESCRIBE ME
 5-HARDLY DESCRIBES ME 6-DOES NOT DESCRIBE ME AT ALL

1. FOR ME, GOOD SPORTSMANSHIP IS AS
 IMPORTANT AS WILLING THE GAME.....1 2 3 4 5 6
2. WHEN I AM WITH PEOPLE I AM AFRAID THAT
 SOMEONE WILL MAKE FUN OF ME1 2 3 4 5 6
3. I AM NOT SATISFIED WITH MY WEIGHT.....1 2 3 4 5 6
4. I "LOSE MY HEAD" EASILY1 2 3 4 5 6
5. MY PARENTS ARE ALMOST ALWAYS ON THE
 SIDE OF SOMEONE ELSE, SUCH AS MY
 BROTHER OR SISTER 1 2 3 4 5 6
6. BOYS FIND ME A BORE1 2 3 4 5 6
7. I FEEL NERVOUS MOST OF THE TIME1 2 3 4 5 6
8. I USUALLY FEEL OUT OF PLACE AT
 PICNICS AND PARTIES1 2 3 4 5 6
9. I FEEL THAT WORKING IS TOO MUCH
 RESPONSIBILITY FOR ME1 2 3 4 5 6
10. MY PARENTS WILL BE DISAPPOINTED IN ME
 IN THE FUTURE1 2 3 4 5 6
11. AT TIMES I HAVE FITS OF CRYING OR
 LAUGHING THAT I SEEM UNABLE TO
 CONTROL.....1 2 3 4 5 6
12. MOST OF THE TIME I AM HAPPY WITH THE
 WAY I LOOK1 2 3 4 5 6
13. IF I PUT MY MIND TO IT, I CAN LEARN
 ALMOST ANYTHING 1 2 3 4 5 6
14. I LOOK FORWARD TO THE COURSES
 AVAILABLE IN HIGH SCHOOL1 2 3 4 5 6
15. VERY OFTEN I FEEL THAT MY FATHER IS
16. I AM CONFUSED MOST OF THE TIME..... 1 2 3 4 5 6

- 1-DESCRIBES ME VERY WELL 2-DESCRIBES ME WELL
 3-DESCRIBES ME FAIRLY WELL 4-DOES NOT QUITE DESCRIBE ME
 5-HARDLY DESCRIBES ME 6-DOES NOT DESCRIBE ME AT ALL

17. I FEEL THAT I AM NOT AS GOOD AS MOST
 PEOPLE I KNOW1 2 3 4 5 6
18. MY PARENTS ARE DIFFICULT TO UNDER-
 STAND1 2 3 4 5 6
19. I CAN COUNT ON MY PARENTS MOST OF
 THE TIME1 2 3 4 5 6
20. IN THE PAST YEAR I HAVE BEEN VERY
 WORRIED ABOUT MY HEALTH1 2 3 4 5 6
21. I OFTEN BLAME MYSELF EVEN WHEN I AM
 NOT AT FAULT.1 2 3 4 5 6
22. MOST OF THE TIME I AM HAPPY.1 2 3 4 5 6
23. I WISH THAT I WERE IN BETTER
 PHYSICAL CONDITION1 2 3 4 5 6
24. MY WORK, IN GENERAL, IS AT LEAST AS
 GOOD AS THE WORK OF MOST OTHERS1 2 3 4 5 6
25. SOMETIMES I FEEL SO ASHAMED OF
 MYSELF THAT I JUST WANT TO HIDE
 IN A CORNER AND CRY1 2 3 4 5 6
26. I AM SURE THAT I WILL BE PROUD ABOUT
 MY FUTURE JOB1 2 3 4 5 6
27. MY FEELINGS ARE EASILY HURT1 2 3 4 5 6
28. WHEN A TRAGEDY OCCURS TO ONE OF MY
 FRIENDS, I FEEL SAD TOO1 2 3 4 5 6
29. THE PICTURE I HAVE OF MYSELF IN THE
 FUTURE SATISFIES ME1 2 3 4 5 6
30. I AM A SUPERIOR STUDENT IN SCHOOL. . . .1 2 3 4 5 6
31. I FEEL RELAXED UNDER NORMAL
 CIRCUMSTANCES.1 2 3 4 5 6
32. I FEEL EMPTY EMOTIONALLY MOST OF THE
 TIME1 2 3 4 5 6

- 1-DESCRIBES ME VERY WELL 2-DESCRIBES ME WELL
 3-DESCRIBES ME FAIRLY WELL 4-DOES NOT QUITE DESCRIBE ME
 5-HARDLY DESCRIBES ME 6-DOES NOT DESCRIBE ME AT ALL

33. I WOULD RATHER SIT AROUND AND LOAF
 THAN WORK.....1 2 3 4 5 6
34. I AM UNCOMFORTABLE WITH THE WAY MY
 BODY IS DEVELOPING1 2 3 4 5 6
35. I AM NOT AFRAID OF COMPETING TO
 SUCCEED.....1 2 3 4 5 6
36. I BECOME VIOLENT IF I DON'T GET MY
 WAY.....1 2 3 4 5 6
- 37 MOST OF THE TIME MY PARENTS GET
 ALONG WELL WITH EACH OTHER1 2 3 4 5 6
38. I THINK THAT OTHER PEOPLE JUST DO
 NOT LIKE ME1 2 3 4 5 6
39. I FIND IT VERY DIFFICULT TO
 ESTABLISH NEW FRIENDSHIPS.....1 2 3 4 5 6
40. I AM SO VERY NERVOUS1 2 3 4 5 6
41. WHEN MY PARENTS ARE STRICT, I FEEL
 THAT THEY ARE RIGHT EVEN IF I
 GET ANGRY.....1 2 3 4 5 6
42. I AM PROUD OF MY BODY.....1 2 3 4 5 6
- 43 AT TIMES I THINK ABOUT WHAT KIND
 OF WORK I WILL DO IN THE FUTURE1 2 3 4 5 6
44. EVEN UNDER PRESSURE I MANAGE TO
 REMAIN CALM1 2 3 4 5 6
45. WHEN I GROW UP AND HAVE A FAMILY,
 IT WILL BE IN AT LEAST A FEW WAYS
 SIMILAR TO MY OWN1 2 3 4 5 6
46. I OFTEN FEEL THAT I WOULD RATHER DIE
 THAN GO ON LIVING1 2 3 4 5 6
47. I FIND IT EXTREMELY HARD TO MAKE
 FRIENDS.....1 2 3 4 5 6
48. I WOULD RATHER BE SUPPORTED FOR
 THE REST OF MY LIFE1 2 3 4 5 6

- 1-DESCRIBES ME VERY WELL 2-DESCRIBES ME WELL
- 3-DESCRIBES ME FAIRLY WELL 4-DOES NOT QUITE DESCRIBE ME
- 5-HARDLY DESCRIBES ME 6-DOES NOT DESCRIBE ME AT ALL
49. I FEEL THAT I HAVE A PART IN
MAKING FAMILY DECISIONS1 2 3 4 5 6
50. I FEEL SO VERY LONELY1 2 3 4 5 6
51. I ENJOY LIFE.....1 2 3 4 5 6
52. I KEEP AN EVEN TEMPER MOST OF THE
TIME1 2 3 4 5 6
53. A JOB WELL DONE GIVES ME PLEASURE....1 2 3 4 5 6
54. MY PARENTS ARE USUALLY PATIENT WITH
ME.....1 2 3 4 5 6
55. I AM SATISFIED WITH MY HEIGHT.....1 2 3 4 5 6
56. I WOULD RATHER BE ALONE THAN WITH
KIDS MY AGE.....1 2 3 4 5 6
57. WHEN I DECIDE TO DO SOMETHING, I DO
IT1 2 3 4 5 6
58. I THINK THAT BOYS FIND ME ATTRACTIVE 1 2 3 4 5 6
59. I FEEL THAT THERE IS PLENTY I CAN
LEARN FROM OTHERS1 2 3 4 5 6
60. I FEAR SOMETHING CONSTANTLY1 2 3 4 5 6
61. VERY OFTEN I THINK THAT I AM NOT AT
ALL THE PERSON I WOULD LIKE TO BE ..1 2 3 4 5 6
62. IF I KNOW THAT I WILL HAVE TO FACE
A NEW SITUATION, I WILL TRY IN
ADVANCE TO FIND OUT AS MUCH AS
POSSIBLE ABOUT IT.....1 2 3 4 5 6
63. USUALLY I FEEL THAT I AM A BOTHER
AT HOME1 2 3 4 5 6
64. IF OTHERS DISAPPROVE OF ME I GET
TERRIBLY UPSET.....1 2 3 4 5 6
65. I LIKE ONE OF MY PARENTS MUCH BETTER
THAN THE OTHER1 2 3 4 5 6

- 1-DESCRIBES ME VERY WELL 2-DESCRIBES ME WELL
 3-DESCRIBES ME FAIRLY WELL 4-DOES NOT QUITE DESCRIBE ME
 5-HARDLY DESCRIBES ME 6-DOES NOT DESCRIBE ME AT ALL

66. BEING TOGETHER WITH OTHER PEOPLE
 GIVES ME A GOOD FEELING1 2 3 4 5 6
67. WHENEVER I FAIL IN SOMETHING,
 I TRY TO FIND OUT WHAT I CAN DO
 IN ORDER TO AVOID ANOTHER
 FAILURE.....1 2 3 4 5 6
68. I FREQUENTLY FEEL UGLY AND
 UNATTRACTIVE1 2 3 4 5 6
69. EVEN THOUGH I AM CONTINUOUSLY ON
 THE GO, I SEEM UNABLE TO GET
 THINGS DONE.....1 2 3 4 5 6
70. WHEN OTHERS LOOK AT ME THEY MUST
 THINK THAT I AM POORLY DEVELOPED1 2 3 4 5 6
71. MY PARENTS ARE ASHAMED OF ME1 2 3 4 5 6
72. MY BODY IS GROWING ABOUT AS
 QUICKLY AS I WOULD LIKE1 2 3 4 5 6
73. I FEEL STRONG AND HEALTHY.....1 2 3 4 5 6
74. I AM A CALM PERSON1 2 3 4 5 6
75. NEW SITUATIONS ARE OFTEN DIFFICULT
 FOR ME TO COPE WITH1 2 3 4 5 6
76. I TRY TO STAY AWAY FROM HOME MOST OF
 THE TIME.....1 2 3 4 5 6
77. I FIND LIFE AN ENDLESS SERIES OF
 PROBLEMS WITHOUT SOLUTION IN SIGHT...1 2 3 4 5 6
78. I FEEL THAT I AM ABLE TO MAKE
 DECISIONS.....1 2 3 4 5 6
79. I HAVE BEEN CARRYING A GRUDGE
 AGAINST MY PARENTS1 2 3 4 5 6
80. I AM WORRIED THAT I WILL NOT BE
 ABLE TO ASSUME RESPONSIBILITIES
 FOR MYSELF IN THE FUTURE1 2 3 4 5 6

- 1-DESCRIBES ME VERY WELL 2-DESCRIBES ME WELL
 3-DESCRIBES ME FAIRLY WELL 4-DOES NOT QUITE DESCRIBE ME
 5-HARDLY DESCRIBES ME 6-DOES NOT DESCRIBE ME AT ALL

81. WHEN I ENTER A NEW ROOM I HAVE A
 STRANGE AND FUNNY FEELING.....1 2 3 4 5 6
82. I FEEL THAT I HAVE NO TALENT
 WHATSOEVER1 2 3 4 5 6
83. WHEN I AM WITH PEOPLE I AM BOTHERED
 BY HEARING STRANGE NOISES.....1 2 3 4 5 6
84. MOST OF THE TIME MY PARENTS ARE
 SATISFIED WITH ME1 2 3 4 5 6
85. I DO NOT HAVE A PARTICULARLY
 DIFFICULT TIME MAKING FRIENDS.....1 2 3 4 5 6
86. SCHOOL AND STUDYING MEAN VERY LITTLE
 TO ME1 2 3 4 5 6
87. VERY OFTEN I FEEL THAT MY MOTHER IS
 NO GOOD1 2 3 4 5 6
88. I AM LOOKING FORWARD TO THE YEARS
 HEAD.....1 2 3 4 5 6
89. USUALLY I CONTROL MYSELF1 2 3 4 5 6
90. I ENJOY MOST PARTIES I GO TO.....1 2 3 4 5 6
91. I AM FEARFUL OF GROWING UP1 2 3 4 5 6
92. I FREQUENTLY FEEL SAD1 2 3 4 5 6
93. THERE ARE PEOPLE THAT I WILL NEVER
 FORGIVE FOR THINGS THEY HAVE DONE ...1 2 3 4 5 6
94. I ENJOY LEARNING NEW THINGS1 2 3 4 5 6
95. I FEEL THAT I CANNOT COPE WITH
 DIFFICULT SITUATIONS1 2 3 4 5 6
96. I AM A LEADER IN SCHOOL1 2 3 4 5 6
97. SOMETIMES I DO THINGS THAT I KNOW I
 SHOULDN'T BUT I CAN'T STOP MYSELF....1 2 3 4 5 6
98. I AM POPULAR AT SCHOOL1 2 3 4 5 6

Appendix B

ABUSE CASE INFORMATION CHECKLIST

_____ (birthdate: _____) is participating in the research project cosponsored by NIMH and the Chesapeake Institute concerning the physical and psychological development of female sexual abuse victims. The parent has given permission for us to obtain the following information from protective services (see attached form.) Thank you. Your help is very much appreciated.

1. Relationship of offender to child:

- _____ 1. Biological parent
- _____ 2. Step-parent
- _____ 3. Mother's live-in boyfriend
- _____ 4. Sibling
- _____ 5. Other relative - specify: _____
- _____ 6. Other - specify: _____

(Please indicate gender of offender if not obvious.)

2. Age of child when abuse began: _____

3. Duration of abuse: _____ (in years & months if known.

4. Frequency of abuse: Which of the following best describes the frequency.

- _____ 1. One time only
- _____ 2. Sporadically (less than once a month.)
- _____ 3. Once a month
- _____ 4. Once a week
- _____ 5. Daily

If none of the above categories describes the frequency well or if the abuse stopped and started again, please describe below:

5. Type of abuse (check all that apply):

- ☐ Kissing the child in a lingering and intimate way
- ☐ Fondling of child's body and/or breasts and genitals
- ☐ Adult masturbates self while child observes
- ☐ Child masturbates adult
- ☐ Mutual masturbation of one another
- ☐ Child's mouth in contact with offender's genitals
- ☐ Offender's mouth in contact with child's genitals
- ☐ Penetration of vagina or rectum by offender's finger or object
- ☐ Anal intercourse
- ☐ Vaginal intercourse

6. a. Has the child been exposed to pornographic materials (videos, written materials, etc.)? ☐ 1. Yes ☐ 2. No

b. Has the child observed adult sexual activity?

☐ 1. Yes ☐ 2. No

7. Was this child sexually victimized at any other time or if yes, please give details:

8. Was the abuse accompanied by violence or threat of

violence? ____ 1. Yes ____ 2. No

If yes, please give details:

9. Has the child also experienced physical abuse separate from that accompany the sexual abuse? ____ 1. Yes ____ 2. No.

If yes, please describe the nature of the abuse and relationship of the abuser to the child:

10. Is the child currently in treatment for mental health problems? ____ 1. Yes ____ 2. No If yes please provide the following information:

a. Is the treatment related to this sexual abuse situation? ____ 1. Yes ____ 2. No. If yes, please specify:

b. What type of treatment is being received (e.g., individual, group, or family therapy, etc.,)? Are other family members involved? If so, who? _____

c. How long has the treatment been going on? With what

frequency?

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11. a. Have criminal charges been filed against the offender?

_____ 1. Yes _____ 2. No. If yes, what is the current
status of the charge? _____

b. Has a Child In Need of Assistance Petition been filed?

_____ 1. Yes _____ 2. No. If yes, what is the current
status?

c. Has the child been required to testify in either of
these proceedings? _____ 1. Yes _____ 2. No. If yes,
please give details.

12. a. Is the child currently in therapy? _____ 1. Yes
_____ 2. No.

b. If yes, what type of therapy? Individual _____
Group _____ Dyad _____ Family _____

c. How did the child disclosure the abuse. 1.
_____ Voluntarily 2. _____ Involuntarily

Appendix C

Hill Intimacy Questionnaire

Now I'm going to ask you some questions about you and your mother.

Please answer each question with "Not at all," "A Little," or "A Lot."

Code 0 if parent dead/no contact

| | <u>NOT AT ALL</u> | <u>A LITTLE</u> | <u>A LOT</u> |
|---|-------------------|-----------------|--------------|
| | 1 | 2 | 3 |
| 1. How much do you go to your mother for advice/support? | _____ | | _____ |
| 2. How much do you want to be like your mother? | | | _____ |
| 3. How much does your mother accept you no matter what you do? | | | _____ |
| 4. How much does your mother understand what you're really like? | | | _____ |
| 5. How much do you share your inner feelings with your mother? | | | _____ |
| 6. How much does your mother come to you for advice/support? | | | _____ |
| 7. How important is your mother to you? | | | _____ |
| 8. How satisfied are you with the relationship you have with your mother? | | | _____ |

Now I'm going to ask you some questions about you and your father. As before, please answer with "Not at all," "A Little," or "A Lot."

Code 0 if parent dead/no contact.

| | <u>NOT AT ALL</u> | <u>A LITTLE</u> | <u>A LOT</u> |
|--|-------------------|-----------------|--------------|
| | 1 | 2 | 3 |
| 1. How much do you go to your father for advice/support? | _____ | | _____ |
| 2. How much do you want to be like your father? | | | _____ |

3. How much does your father
accept you no matter what you do? _____
4. How much does your father under-
stand what you're really like? _____
5. How much do you share your inner
feelings with your father? _____
6. How much does your father come
to you for advice/support? _____
7. How important is your father to you? _____
8. How satisfied are you with the
relationship you have with your father? _____

GENERAL INFORMATION ABOUT NIMH STUDY
(The present study used data from NIMH study)

The Psychobiological Effects of Child Sexual Abuse

The longitudinal study from which data for the present study was collected is jointly sponsored by the laboratory of Developmental Psychology, National Institute of Mental Health, and the Chesapeake Institute. It is a multi-disciplinary project focusing on both the psychological and biological effects of sexual abuse on females. The design combines cross-sectional and longitudinal components and assesses both immediate and long-term impact. It has a developmental focus - one of the major research questions concerns how passage through puberty may mediate the impact of sexual abuse. The multi-method approach includes standard psychological tests of social, emotional, and cognitive development, psychiatric screening, staging of pubertal development, assessment of blood hormonal levels, assessment of school functioning, and structured observation of the child and of child-adult interaction. The sample consists of girls, 8-15 years of age who have been sexually abused by a family member. A non-abusing caretaker also participates. The comparison group is matched on age and race of the child and social class of the family.

Note: The investigator of the present study has been associated with the NIMH/ Chesapeake study as a graduate student research assistant.

Appendix E

INFORMATION FOR CHILD PROTECTIVE SERVICE WORKERS

The Psychobiological Effects of Child Sexual Abuse

The National Institute of Mental Health and the Chesapeake Institute are cosponsoring the first controlled, longitudinal study of the psychological and biological effects of child sexual abuse. This research focuses on the physical, social, and emotional development of sexually abused girls between the ages of 8 and 15 with a focus on how the passage through puberty may mediate the effects of the abuse. The study uses a multimethod approach (interviews, standardized questionnaires, and structured observation) to obtain information about the child's cognitive and social competence, behavior problems, and psychiatric symptomatology. Additionally, a brief health screening will be conducted by a registered nurse, during which a blood sample will be taken to measure hormone levels and ascertain pubertal level. Dissociative capacity will also be screened. A non-abusing parent or guardian will provide additional information about the child and family. Feedback on the child's development will be provided to the parent and, with the parent's permission, to the referring agency.

The health screening and the psychological measures will be administered during two sessions at our project offices at the Chesapeake Institute in Wheaton, Maryland. Both adult and child will be paid for their participation on a hourly basis. The total per family for the two sessions will be approximately \$130.00. Transportation costs are also provided. Families will then be contacted at yearly intervals for two years for follow-up visits.

To be eligible for this study, the families need to meet the following criteria:

1. The child victim is currently between 8 and 15 years of age.
2. The initial or most recent disclosure of the sexual abuse occurred within the last 6 months.
3. The abuse included genital contact and/or penetration.
4. The identified perpetrator is a family member broadly defined (parent, step-parent, sibling, uncle, live-in boyfriend, etc.)
5. A non-abusing parent or guardian is available and willing to participate in the project.

For more information or if you have any questions about whether a particular family meets these criteria, please call 949-5000.

Appendix F

Dear Parent:

When families experience the types of problems which have brought you to the Department of Social Services, there is often concern and worry about the effects on the children involved. The National Institute of Mental Health and the Chesapeake Institute of Wheaton, Maryland, are co-sponsoring a project designed to learn more about the effects of these problems on girls physical and psychological development.

Participation in this project will involve a total of about 5 or 6 hours of your child's and your time in two meetings about one week apart. The child will do some tasks and games with a psychologist. While this is going on you will provide some information on your child's development to an interviewer, and fill out some forms. Later your child will have a brief health screening by a registered nurse. Feedback on your child's development will be provided to you.

Protection of your rights

If you agree to let us contact you, at that time we will explain more about the project, the types of questions we will ask, and give you a chance to ask questions. If you decide to participate in the project, you will have the right to refuse to answer any questions at any time. You will not be identified by name in any reports on this project.

Payment for your time

All participants (the adult and the child) will be paid for their time. Altogether the family will receive approximately \$130.00 for the two visits. Transportation costs will also be paid (up to \$22.00) per visit.

Thank you very much for considering this request.

Permission

Project title: Psychobiological Effects of Child Sexual Abuse

Project personnel may contact me so that I can get more information in order to decide whether I wish to participate.

Adult's name- please print

Adult's signature

Relationship to child

Child's name and age

Address

Phone number
(day/evening)

Caseworker's name and phone number

INFORMATION FOR POTENTIAL PARTICIPANTS - ABUSE

During first contact on telephone, explain that this study (project) is concerned with the impact of girl's development of sexual abuse (or "the kinds of experiences _____ has had -if a euphemism seems needed.)

Say we will be giving measures to the child that deal with such things as self esteem, cognitive development, relationships with friends, mental health problems and will be doing a health screening. Our interest here is in what stage of puberty the child is in. We have an experienced and friendly registered nurse who does the screening. The child will need to disrobe for assessment of secondary sex characteristics (e.g. amount of breast development) but there is no internal exam.

Also a blood sample will be taken. If the mother suggests the child would be reluctant to have blood drawn, say we hope they'll participate anyway and we won't force the child if she doesn't want it. In fact, if there are any parts of the project either she or the child is reluctant to do or any question they don't want to answer they just have to say so. The mother can be present in the room if she or the child desires. We do not ask the child any questions specifically about the abuse experience.

While the child is doing these things, the mother will be interviewed about what the child's early years were like and some other information about the family. After the two visits we will give the mother some feedback about the child's psychological and physical development.

We do whatever we can to make it an interesting and pleasant experience for both mother and child. The families who have taken part so far have enjoyed it. Both mother and child will be paid by the hour for participating. This comes to about \$50 per person. The payment comes in a check to each person about a month or six weeks after we see them. Also there's an extra payment to the mother to compensate for transportation costs.

Appendix I**PAID VOLUNTEERS WANTED**

Mother's and daughters wanted to take part
in a project on

**FEMALE GROWTH AND DEVELOPMENT IN
CHILDHOOD AND ADOLESCENCE**

sponsored by

**THE LABORATORY OF DEVELOPMENTAL PSYCHOLOGY
NATIONAL INSTITUTE OF MENTAL HEALTH
and
THE CHESAPEAKE INSTITUTE**

Girls must be between the ages of 6 and 15
Parent and child will make two visits to the project
offices in Wheaton, Maryland (near Wheaton Plaza) for
interviewing by project staff. The child will receive a
free health screening given by a registered nurse.

Both child and parent will
be paid on an hourly basis for
the time spent on the project. The
total amount paid per family is \$130.00

*Child's father or other guardian knowledgeable about the
child's "growing up years" may participate in place of
the child's mother.

TRANSPORTATION COSTS PROVIDED

For more information CALL 949-5000.

Appendix J

INFORMATION FOR POTENTIAL PARTICIPANTS - CONTROL

During first contact on telephone, explain that this study (project) is concerned with the psychological and physical development of girls and especially how the passage through puberty affects this development. And so we are interested in seeing girls who haven't yet entered puberty, girls who are "in the midst" and girls past puberty. Besides seeing regular ("normal") families such as yours, we are also seeing families with some particular problems which we will tell you more about when we see you. (Could say, "Have you heard of medical research that has "normal control groups"? That's essentially what your family would be a part of.")

Say we will be giving measures to the child that deal such things as with self esteem, cognitive development, relationships with friends, and mental health problems and will be doing a health screening. Our interest here is in what stage of puberty the child is in. We have an experienced and warm registered nurse who does the screening. To assess stage of puberty, the nurse looks at how advanced secondary sex characteristics (e.g. amount of breast development) are. The nurse presents this in a very educational way, so the child learns something about what puberty is, what the different stages are, when it is usually occurs, etc.

Also a blood sample will be taken. If the mother suggests the child would be reluctant to have blood drawn, say we hope they'll participate anyway and we won't force the child if she doesn't want it. In fact, if there are any parts of the project either she or the child is reluctant to do or any question they don't want to answer they just have to say so. The mother can be presented in the room if she or the child desires.

While the child is doing these things, the mother will be interviewed about what the child's early years were like and some other information about the family. After the two visits we will give the mother some feedback about the child's psychological and physical development.

We do whatever we can to make it an interesting and pleasant experience for both mother and child. The families who have taken part so far have enjoyed it. Both mother and child will be paid by the hour for participating. This comes to about \$50 per person. The payment comes in a check to each person about a month or six weeks after we see them. Also there's an extra payment to the mother to compensate for transportation costs.

Appendix K

MEDICAL RECORD: CONSENT TO PARTICIPATE IN A CLINICAL
RESEARCH STUDY

*Adult Patient or *Parent, for Minor Patient

INSTITUTE: National Institute of Mental Health

STUDY NUMBER: 87-M-14

STUDY TITLE: Psychobiological Effects of Child Sexual Abuse

We invite you (or your child) to take part in a research study at the National Institutes of Health. It is important that you read and understand several general principles that apply to all who take part in our studies: (a) taking part in the study is entirely voluntary; (b) personal benefit may not result from taking part in the study, but knowledge may be gained that will benefit others; (c) you will withdraw from the study at any time without penalty or loss of any benefits to which you are otherwise entitled. The nature of the study, the risks, inconveniences, discomforts, and other pertinent information about the study are discussed below. You are urged to discuss any questions you have about this study with the staff members who explain it to you.

This study is concerned with the relationships between physical growth and development and psychological changes which occur as girls pass through childhood and enter adolescence. Participation in the study will take approximately a total of 5 hours on two different days at our offices once a year for three years.

During each session you fill out checklists and questionnaires about you and your child's health and medical or other problems you or your child may have had. Your child will have a physical examination by a doctor or nurse to find out where she is in terms of pubertal growth. Approximately 3 tablespoons of your child's blood will be drawn. When the blood is drawn, the needle will hurt for a moment, just like getting a shot. Sometimes a small bruise forms where the needle enters the vein. Your child will be given some measures of social and emotional development and asked to fill out questionnaires about friends and family. Part of this session will be videotaped. Both parent and child measures have been completed by many adults and children who usually find them to be interesting and enjoyable. We will also be asking you to sign a release of information form so that we may contact your child's teacher at school to get information about her academic work and behavior in school. Information from your case record at _____ will be requested from your caseworker or therapist, who will also fill out a questionnaire about your child's behavior.

MEDICAL RECORD: CONTINUATION SHEET for either: NIH 2414-1
or NIH-2514-2

STUDY NUMBER: 87-M-14 page 2 of 2 pages.

We would like to measure your child's ability to be hypnotized, since this ability appears to change as children grow older. Many researches in hypnosis believe that children frequently go in and out of hypnotic trances spontaneously. This test involves giving your child a standard set of suggestions, e.g. "Your arm feels very light, as if it were floating. Now you feel it start to rise up on its own" and then measuring if the arm moves. Hypnosis is very safe. A trained hypnotist will be administering this test and will only do so if he/she believes that your child will be able to participate without any ill effects.

Risks and Discomforts

Sometimes people who have been hypnotized describe feeling light-headed or sleepy afterwards. Occasionally they may have a mild, transient headache. If these symptoms should occur, they will disappear on their own in a short time. On rare occasion, hypnosis will cause people to remember painful or frightening experiences that have happened to them. If this should occur, the doctor doing the hypnosis will help your child process this experience and we will discuss this with you. The only discomfort in this study is when the blood is drawn, the needle will hurt for a moment, just like getting a shot. Sometimes when blood is drawn a small bruise forms where the needle enters the vein.

Confidentiality:

Many of the findings from this research may be used for publication. However, you and your child's identity will be kept in strict confidence, known only to the investigators. The only exception to this would involve that information which we are required by law to report. In this event, this information would be discussed with your caseworker or therapist.

I have read the above, and any questions about the study have been answered. I understand the purposes of the study. I also understand the agreement to participate does not obligate me to participate in further studies. I consent to participate in the study as described. I understand that I may interrupt the procedures or withdraw from the study at any time.

Signature of Parent of Minor: _____ Date: _____
Signature of Investigator: _____ Date: _____

MEDICAL RECORD: MINOR PATIENT'S ASSENT TO PARTICIPATE IN A
CLINICAL RESEARCH STUDY

* Attach to NIH 2514-1, Consent to
Participate in A Clinical Research Study

INSTITUTE: National Institute of Mental Health
STUDY NUMBER: 87-M-14

STUDY TITLE: Psychobiological Effects of Child Sexual Abuse

You are invited to take part in a research study being conducted by the National Institute of Mental Health. The following principles apply to all people who take part in our studies: (1) The decision to take part is entirely up to you - you should take part only if you want to. (2) Knowledge may be gained from the study that will help others. (3) You are completely free to drop out of the study at any time. Your doctors believe that you have a right to do this and will not hold it against you. (4) Whatever information is obtained from you during the study is completely confidential.

The purpose, risks, discomforts, and other details of the study are discussed below. Please feel free to ask any questions you may have about the study.

We are interested in how you think and feel as you grow and develop. We want to find out how you feel and behave as your body changes both inside and outside. Here are the things you will be asked to do if you decide to be in the study:

1. A doctor or nurse will examine you, just as your doctor examines you when you go for a check-up. The exam will tell us about your physical growth.

2. You will give the doctor or nurse about 3 tablespoons of your blood once every year. A needle will be put in a vein in your arm and some blood will be taken out. The needle will hurt just for a moment and then it will stop. Sometimes a small bruise forms where the needle enters the vein, but it goes away in about a week. The blood will tell us how your body is changing inside.

MEDICAL RECORD MINOR PATIENT'S ASSENT TO PARTICIPATE
IN A CLINICAL RESEARCH STUDY

Continuation Page 2 of 2

STUDY NUMBER: 87-M-14

3. You will talk to a doctor, nurse or their helper about the times when you were ill or other things that have made you worry about yourself.

4. You will be asked to work on tests like the ones you take in school. You will not get a grade on the tests. You will be asked to name things or you will mark whether the sentence is like you or not like you. The study will take about five hours of your time once a year for three years. You will get paid for helping us. You may stop being in the study at any time, and no one will be angry with you.

5. You will be asked to take a test that measures your ability to be hypnotized. the doctor will ask you to close your eyes and he will give you some suggestions, such as your arm feels very light and is beginning to float up by itself, and feel how easy it is for you to do the things that he suggests. Hypnosis is very safe, but before you take this test, the doctor will ask you some questions to make sure that it is alright for you to do this. A few people have a mild headache, sleepiness or feel light-headed after being hypnotized. If you should have these feelings they will disappear on their own after a short time. Sometimes people who are hypnotized remember things that they have forgotten, including things that have frightened them when they were younger. If this should happen with you, the doctor can help you understand and talk about this experience.

I have read what was written (or it was read to me) and I understand the things that I will be doing here. I will be in the study knowing that I can stop if I want to. I know that the information about me will be put together with the information about others in the study and my name will not be used in any papers written about the study.

I have had this study explained to me in a way that I understand, and I have had the chance to ask questions. I agree to take part in this study.

Signature of Minor Patient: _____ Date: _____

Signature of Investigator: _____ Date: _____

Appendix M

PERMISSION TO RELEASE INFORMATION

I give permission to _____ to release information about the events that brought my child to the attention of protective services to the Laboratory of Developmental Psychology, National Institutes of Mental Health. I understand that this information will be used only for the purposes of the research study (NIMH Protocol # 87-M-14) and will be kept confidential.

Parent/guardian's name

Signature

Child's name and age

Date

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