Sexual abuse treatment effects on borderline personality disorder symptoms
by Deborah Dianne Surratt

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
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Abstract:
The purpose of this study was to explore, from the client's perspective, the impact that treatment for sexual abuse has on the symptoms that are commonly associated with borderline personality disorder (BPD).

The confusion between the long-term effects of sexual abuse and BPD symptomatology, as well as the high incidence of sexual abuse in clients diagnosed with BPD, has been well documented. No attention, however, has been given to the sexually abused client's perception of the impact that treatment for sexual abuse has on the symptoms that are commonly associated with BPD.

Using a descriptive cross-sectional survey design, adults who were in treatment for sexual abuse were asked about their perceptions of the presence of BPD symptoms, about the change in symptoms commonly associated with BPD, and about the presence of abuse-related variables. Respondents completed questionnaires that were returned anonymously.

Data were analyzed using frequency distributions to describe the presence of BPD symptoms and change in those symptoms. Correlations and t tests were used to explore relationships between independent (demographic and abuse related) variables and dependent variables of reported symptoms and reported change in symptoms.

Seventy-three percent of the respondents answered affirmatively on the questionnaire for five or more of the diagnostic criteria for BPD. Every symptom of BPD was noted by at least some of the respondents as having improved. Reported BPD symptoms and reported change in BPD symptoms were not related to the variables of length of abuse, relationship to the abuser, involvement of intercourse, involvement of penetration, disclosure of abuse to families, length of time in therapy, or age. The use of force was positively related to a greater number of BPD symptoms; however, the involvement of force did not appear to affect reported change in BPD symptoms.

Findings from this study suggest that psychotherapeutic treatment specifically focused on sexual abuse for BPD clients who have a history of childhood sexual abuse may be warranted. Further study with a larger sample of sexually abused BPD clients is needed.

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by

Deborah Dianne Surratt

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APPROVAL

of a thesis submitted by

Deborah Dianne Surratt

This thesis has been read by each member of the graduate committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

April 11, 1994
Date

Kathleen Ann Long
Chairperson, Graduate Committee

Approved for the Major Department

April 11, 1994
Date

Kathleen Chaffey
Head, Major Department

Approved for the College of Graduate Studies

4/18/94
Date

R L Brown
Graduate Dean

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ABSTRACT

The purpose of this study was to explore, from the client's perspective, the impact that treatment for sexual abuse has on the symptoms that are commonly associated with borderline personality disorder (BPD).

The confusion between the long-term effects of sexual abuse and BPD symptomatology, as well as the high incidence of sexual abuse in clients diagnosed with BPD, has been well documented. No attention, however, has been given to the sexually abused client's perception of the impact that treatment for sexual abuse has on the symptoms that are commonly associated with BPD.

Using a descriptive cross-sectional survey design, adults who were in treatment for sexual abuse were asked about their perceptions of the presence of BPD symptoms, about the change in symptoms commonly associated with BPD, and about the presence of abuse-related variables. Respondents completed questionnaires that were returned anonymously.

Data were analyzed using frequency distributions to describe the presence of BPD symptoms and change in those symptoms. Correlations and *t* tests were used to explore relationships between independent (demographic and abuse related) variables and dependent variables of reported symptoms and reported change in symptoms.

Seventy-three percent of the respondents answered affirmatively on the questionnaire for five or more of the diagnostic criteria for BPD. Every symptom of BPD was noted by at least some of the respondents as having improved. Reported BPD symptoms and reported change in BPD symptoms were not related to the variables of length of abuse, relationship to the abuser, involvement of intercourse, involvement of penetration, disclosure of abuse to families, length of time in therapy, or age. The use of force was positively related to a greater number of BPD symptoms; however, the involvement of force did not appear to affect reported change in BPD symptoms.

Findings from this study suggest that psychotherapeutic treatment specifically focused on sexual abuse for BPD clients who have a history of childhood sexual abuse may be warranted. Further study with a larger sample of sexually abused BPD clients is needed.

CHAPTER 1

BACKGROUND

Problem Statement

Clients diagnosed with borderline personality disorder (BPD), a common psychiatric diagnosis, are widely recognized as difficult to treat and frequently have unsatisfactory outcomes (Turner, 1988; Herman, Perry, & van der Kolk, 1989). In fact, Kroll (1986) addresses this by stating, "In an informal sense, difficulty in treatment is practically diagnostic of borderline disorder." Briere and Runtz (1987) suggest that one possible explanation of the apparent low treatability of this population is a failure to recognize the impact of early sexual abuse which may have affected many persons diagnosed with BPD. The authors propose that optimal treatment for these clients might include aspects of treatment for post-traumatic stress.

Recent studies suggest the incidence of sexual abuse among BPD patients can be as high as 86% (Bryer, Nelson, Miller, & Krol, 1987). Clearly, it is an issue for many of these patients and one that is frequently not noted by the professionals working with them (Sheldon, 1988; Briere & Zaidi, 1989; Jacobson & Herald, 1990).

The similarity between long-term effects of sexual abuse and symptoms of BPD suggests the possibility of confusion of the two constellations. Briere and Runtz (1987) noted that adults who experienced severe childhood sexual abuse also have problems with substance abuse, self-destructiveness, chronic anger, fear of abandonment, and intense and unstable relationships. The authors suggest that this may cause victims of childhood sexual abuse to be inappropriately diagnosed as having a personality disorder, especially BPD. According to Shearer, Peters, Quaytman, and Ogden (1990), the DSM III-R criteria for BPD are identical to many of the long-term effects of childhood sexual abuse. The authors point out that both populations frequently exhibit impulsivity, substance abuse, self-destructive tendencies, identity disturbance, and chronic dysphoria. The high incidence of sexual abuse history among persons with BPD coupled with the striking similarities between the two symptom constellations raises the possibility that BPD is often misdiagnosed.

The confusion between the long-term effects of sexual abuse and BPD symptomatology, as well as the high incidence of sexual abuse in clients diagnosed with BPD, has been well documented. No attention, however, has been given to the sexually abused client's perception of the impact that treatment for sexual abuse has on the symptoms that are

commonly recognized as symptoms of BPD. Studies such as this one that examine the effects of such treatment are a logical step in exploring ways to improve treatment for clients who have symptoms of BPD.

Purpose

The purpose of this study was to explore, from the client's perspective, the impact that treatment for sexual abuse has on the symptoms that are commonly associated with borderline personality disorder.

Specific Aims

The specific aims of this study were to determine: (a) what symptoms consistent with borderline personality disorder (BPD) did clients who were in treatment for sexual abuse report, (b) to what degree have clients in treatment for sexual abuse noticed change in BPD symptoms, (c) were reported BPD symptoms related to prior sexual abuse or background demographic variables, and (d) was reported change in BPD symptoms related to prior sexual abuse or background demographic variables?

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Sexual Abuse

The incidence of sexual abuse among borderline patients has received significant attention in the literature. Gartner and Gartner (1988) cited various studies finding incidence ranging from 27-75%. Coons, Bowman, Pellow, and Schneider (1989) found that 31% of the patients in their study with a diagnosis of borderline personality disorder (BPD) reported that they had been sexually abused in childhood. It is not clear, however, whether this information was acquired from patients via questionnaires or through a clinical history. Incidence reported on questionnaires would likely be lower than that reported in a personal interview since many patients disclose sexual abuse only after they have determined it is safe to do so. Individuals often need to be asked two or three times before they disclose the abuse (Rohsenow, Corbett, & Devine, 1988). Herman et al. (1989) found that 67% of their subjects diagnosed with BPD had been sexually abused in childhood. Such high incidence of occurrence of childhood sexual abuse in BPD suggests the possibility that

addressing abuse issues in therapy may provide some degree of relief from BPD symptoms.

The literature on the long-term effects of child sexual abuse has been reviewed by Browne and Finkelhor (1986) and by Beitchman, Zucker, Hood, daCosta, Ackman, and Cassavia (1992). Both reviews suggested that child sexual abuse has serious long-term sequelae.

Browne and Finkelhor (1986) reviewed several empirical studies that associated depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, tendency toward revictimization, and substance abuse among adult women victimized as children. Difficulty in trusting others and impaired sexual functioning were also reported.

Similar associations were found by Beitchman et al. (1992). Additionally, associations between child sexual abuse and homosexual experiences in adolescence or adulthood were identified. However, the authors urged caution in interpreting results from many of the studies about long-term effects of sexual abuse. They noted nonrandom samples and lack of adequate control groups make isolation and identification of specific effects difficult. Furthermore, the authors reasoned that other variables related to, and often co-existing with, sexual abuse such as physical abuse and parental psychopathology are difficult to isolate and control. While certainly

desirable in terms of experimental design, tight control of the variables surrounding human behavior are usually not possible because of both ethical and reality based constraints.

Some abuse-related variables are more easily isolated and have been examined in terms of degree of impact or adjustment of the victims. Duration and frequency of abuse is one such variable, and in Browne and Finkelhor's review (1986) the relationship between the duration of abuse and the degree of trauma was not consistent. The authors suggested that this variable is closely related to other aspects of the abuse experience: (a) age at onset, (b) relationship to the offender, and (c) the nature of the sexual activity.

Age at onset of abuse was not consistently correlated with degree of trauma in either of the reviews (Browne & Finkelhor, 1986; Beitchman et al., 1992). Beitchman et al. (1992) suggested that when assessing for the effects of age, the associated variables of relationship to the offender and nature of the sexual activity be controlled. Additionally, it was recommended that the age at which the abuse stopped be controlled and that differentiation be made between prepubertal and postpubertal abuse.

Based on the literature, three variables are frequently associated with a greater degree of trauma. Abuse by a father or stepfather, sexual activity involving

penetration, and the use of force were all positively correlated with the degree of trauma experienced (Beitchman et al., 1992; Browne & Finkelhor, 1986).

Family functioning and parental response have also been examined in relation to degree of trauma and to adjustment of victims of child sexual abuse. Browne and Finkelhor (1986) concluded that the available evidence suggests that negative parental reactions aggravate trauma. Similarly, Beitchman et al. (1992) cited studies that correlated positive outcomes with supportive family relationships.

Borderline Personality Disorder

The diagnostic category of borderline personality disorder is well developed and clarified by the criteria in the DSM III-R (1987). Those criteria are:

1. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation
2. impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance use, shoplifting, reckless driving, binge eating
3. affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days
4. inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights
5. recurrent suicidal threats, gesture, or behavior, or self-mutilating behavior

6. marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values
7. chronic feelings of emptiness and boredom
8. frantic efforts to avoid real or imagined abandonment. (p. 347)

The similarity between these diagnostic criteria and the long-term effects of sexual abuse such as self-destructive behavior, poor self-esteem, anxiety, depression, substance abuse, and difficulty in trusting others is readily apparent.

Treatment of Sexual Abuse

Treatment of sexual abuse usually involves individual and/or group psychotherapy. Both treatment modalities, group and individual therapy, are relevant to this study.

Coons et al. (1989) asserted that victims of childhood abuse are able to regain control of a chaotic life with treatment. The lay literature also supports the idea that improvement is possible when women are treated for the effects of sexual abuse (Bass & Davis, 1988).

Group therapy has been suggested to be an effective treatment for incest victims. In a study by Alexander, Neimeyer, Follette, Moore, and Harter (1989) improvement in social adjustment, reduction in depression, and the alleviation of distress was apparent both during treatment and at a six months follow-up. Goodwin and Talwar (1989)

noted that after group treatment, members reported increased self-esteem and assertiveness and decreased guilt. Although sexual problems may continue, members reported increased intimacy. Tsai and Wagner (1978) reported women who participated in a four-week group therapy treatment program noticed improvement in their interpersonal relationships, a lessening of depression, and a greater acceptance of themselves.

Individual therapy is a recommended treatment for victims of childhood sexual abuse (Briere, 1989), especially in conjunction with group therapy. However, studies of the effectiveness of individual therapy are scarce. Most of the literature about individual psychotherapy for survivors of sexual abuse focuses on treatment issues rather than outcomes.

Borderline patients are a relatively high functioning population and are frequently able to be productive when not suffering an exacerbation of their illness. The cluster of symptoms revolving around difficulty with relationships, however, suggests difficulty in maintaining a productive lifestyle. Unsuccessful treatment perpetuates the problem. Herman et al. (1989) suggest further study to determine whether early recognition of a history of childhood sexual abuse, when it exists, might enhance treatment approaches for borderline patients. Borderline patients may not be offered therapy which facilitates the

exploration of feelings and eventual development of insight, however, this is a type of treatment that may be helpful for clients with a history of sexual abuse.

Conceptual Framework

The labeling perspective (Gove, 1975) provides the framework for this investigation. According to Gove, once a person is labeled deviant, they are stigmatized and others respond to them as deviant. They develop a deviant self-image based on how others react and have considerable difficulty shedding that label.

The labeling perspective is appropriate for this study in that victims of sexual abuse may be labeled with the diagnosis of borderline personality disorder (BPD). Since many therapists believe that in-depth psychotherapy is harmful to BPD clients (Gunderson & Chu, 1993) and avoid doing that type of work with their BPD patients, victims of sexual abuse who are labeled BPD often do not get a type of treatment that could be therapeutic for them. Furthermore, therapists rarely expect BPD clients to improve. When sexual abuse clients who are diagnosed BPD do not improve, it may be explained as part of the illness rather than a result of inappropriate treatment.

CHAPTER 3

METHODS

Design

A descriptive cross-sectional survey design asked adults who were in treatment for sexual abuse about their perceptions of the presence of borderline personality disorder (BPD) symptoms and about the change in symptoms commonly associated with BPD. Based on the literature regarding psychological disturbance due to sexual abuse, information was gathered on the following variables so that subgroup analysis could occur. The variables were: (a) the length of time in treatment for sexual abuse, (b) length of abuse, (c) type of sexual abuse activity, (d) the relationship to the offender, (e) use of force, and (f) parental response.

The literature contains differing criteria for the definition of sexual abuse. Recently, the literature has begun to broaden the definition of sexual abuse to include a variety of incidents that do not always involve direct sexual contact (Bass & Davis, 1988). However, for the purpose of this study, sexual abuse was defined as any form of unwanted sexual contact, ranging from fondling to

intercourse, and/or any sexual contact that occurred before the age of 18 years and that was initiated by someone at least three years older.

Treatment of sexual abuse follows some general guidelines (Briere & Runtz, 1987; Tsai & Wagner, 1978; Gilbert, 1988; Goodwin & Talwar, 1989; Urbancic, 1989; Coons et al., 1989). These include (a) disclosure of the experience and emotional catharsis to a therapy group for survivors of sexual abuse or to an individual therapist, (b) some type of cognitive therapy to address the guilt, sense of responsibility, and low self-esteem, and (c) examination of interpersonal relationships, sexual functioning, and sexuality. For the purposes of this study, these were the guidelines used in determining that the clients were receiving treatment for sexual abuse.

Sample

The population of interest consisted of persons who had an identified history of sexual abuse (as defined in this proposal) and who had been in treatment for sexual abuse with a mental health professional for at least 14 sessions. A mental health professional could be a psychiatrist, master's degree prepared psychiatric nurse, master's degree prepared social worker, doctorally prepared psychologist, or licensed professional counselor.

Since it was unlikely that the population of sexually abused people who were in treatment in the study area would be large enough to allow for selection of a randomized sample of sufficient size, a convenience sample was utilized for this exploratory study. The target sample of at least 50 respondents was obtained through referral by mental health professionals practicing in outpatient or inpatient settings. In anticipation of a response rate considerably lower than 50% due to the nature of the population, 125 questionnaires were distributed. All questionnaires returned in useable form were included in data analysis.

Individuals were included in the study if they (a) had been sexually abused according to the previously identified criteria, (b) had been in individual or group treatment, as defined in this proposal, for sexual abuse for a minimum of 14 hours, and (c) were at least 18 years of age. In addition, the individuals must have had the ability to read and write the English language. Individuals were excluded if, in the opinion of the therapist, participation in the study would be detrimental to their treatment.

Procedure

Mental health professionals were contacted initially by a letter from the investigator, explaining the research project (see Appendix B). Therapists at one clinic were

also informed of the study at a staff meeting prior to receiving the letter. Interested professionals were asked to return an enclosed postcard indicating their interest and the most convenient time to be contacted personally. Follow-up phone calls to non-respondents were made two weeks following the mailing. The investigator met with interested professionals to explain the study, ascertain that the treatment offered met the criteria set in this proposal, and answer questions. Professionals who agreed to distribute the questionnaires were then given the questionnaires with a cover letter to clients. The cover letter explained the investigator's interest in learning about adult survivors of sexual abuse (see Appendix C).

The questionnaire was distributed at the beginning of a previously arranged therapy session by the therapist. The therapist was asked to assure clients that only the investigator would see the responses. A stamped envelope addressed to Montana State University College of Nursing was included with the questionnaire so that individuals could place the questionnaire in the envelope, seal it, and either mail it or return it to their therapist, based on their preference. Clients could return the questionnaire whether or not they completed it. In this manner the therapist did not know if the client completed the questionnaire, thus reducing any sense of coercion for clients. Returning a completed questionnaire was taken as

implied consent to participate in the study. Questionnaires were coded with an identification number for purposes of follow up with mental health professionals. The investigator maintained a list with corresponding therapists and identification numbers.

Instrument

The presence of symptoms and the effects of treatment on those symptoms from the client's perspective was measured using a 54 item, three-part questionnaire developed by the investigator. Based on an extensive review of the literature, no instruments measuring change in borderline personality disorder (BPD) symptomatology were available (Giese, Leibenluft, Filson, Zimmerman & Gardner, 1990). Client perception of improvement is a beginning step in determining the impact of a treatment. Keane and Sells (1990) identified that one advantage of self-reporting scales is sensitivity to change, which is useful is assessing treatment progress.

On Part I of the questionnaire, the Borderline Symptom Checklist, symptoms of BPD according to the DSM III-R (1987) were identified by the clients using a "true" or "false" response to statements. On Part II, the Symptom Improvement Scale, change in the identified symptoms as well as a general feeling of making progress was noted using a 5-point Likert type summated scale from "strongly

agree" (+2) to "strongly disagree" (-2) (see Appendix A). Included were items regarding the clients' perception of changes in (a) interpersonal relationships, (b) levels of depression, (c) mood changes, (d) intensity of anger, (e) suicidal or self-mutilating behavior, (f) compulsive behaviors, and (g) fear of abandonment. Part III of the questionnaire addressed information related to six sexual abuse background variables and demographic data. The format included fixed alternative and true/false answers.

Content validity of the instrument was established by submitting the instrument to a panel of experts (one skilled in measurement, and one skilled in clinical content) for examination for appropriate content and adequate clarity. Two editorial changes were made based on their opinions. Since Part I of the instrument was derived directly from the DSM III-R, an established and accepted diagnostic guide, it has inherent content validity. A representative from the client population was also asked to review the instrument for clarity. The questionnaire was pilot tested by administering it to three individuals who were receiving treatment for sexual abuse. Individuals were asked for written feedback regarding clarity of directions and questions. Respondents indicated that they felt overwhelmed with too many choices on the Symptom Improvement Scale which was originally constructed as a 7-point scale. Based on this feedback, responses to the

Symptom Improvement Scale were changed from a 7-point to a 5-point scale.

Data Analysis

The data were coded and each completed questionnaire assigned a number. Data analysis was accomplished using frequency distributions. For the entire sample, responses to each item on Part I, the Borderline Symptom Checklist, were summed to indicate frequency of each borderline personality disorder (BPD) symptom. Additionally, the mean of all BPD symptoms for the sample was calculated.

For the entire sample, mean scores and standard deviations were calculated for each item on Part II, the Symptom Improvement Scale (SIS), and for the SIS overall. This reflected change among the client group in relation to specific symptoms as well as change in overall BPD symptomatology.

Subgroups were developed using responses to Part III, the Variable Checklist. The following subgroups were developed: (a) length of abuse (items 1 and 4), (b) relationship of abuser (item 2), (c) involvement of intercourse (item 5), (d) involvement of penetration (item 6), (e) involvement of force (item 7), (f) presence of family support (items 9 and 10), (g) length of time in therapy (item 8), (h) age (item 11), and (i) gender (item 12). Means and standards deviations for the identified

subgroups were also calculated for both the Borderline Symptom Checklist and the SIS.

Correlations were used to explore relationships between the independent variables of age, length of abuse and length of time in therapy, and the dependent variables, namely reported symptoms and change in reported symptoms. Relationships of the other independent variables to reported symptoms and reported change in symptoms were explored using a *t* test. Differences in scores were considered significant at the $p<.05$ level, in keeping with the exploratory nature of the study.

Protection of Human Subject Rights

Individuals were asked to complete a three-part questionnaire consisting of a total of 54 items, requiring no more than 20 minutes of time to complete. Confidentiality of clients was protected based on the method of questionnaire distribution. Identification numbers only were used on questionnaires. Data were kept in a locked file cabinet accessible only to the researcher. Individuals were informed of this process.

Since some clients had the diagnosis of and/or were aware of the symptoms of borderline personality disorder (BPD), clients were not informed of the BPD aspect of the study in order to avoid bias in response. Therapists, however, were informed since their knowledge of that aspect

was not likely to effect validity. In fact, it was postulated that therapists would be more interested in the study and therefore helpful with data collection if they were informed of the investigator's interest in sexual abuse and BPD.

The investigator maintained a list specifying which questionnaires, identified by number only, were given to each mental health professional for purposes of follow up with mental health professionals. If several questionnaires were not returned from a given therapist, the investigator contacted the therapist to determine if the questionnaires were given to respondents. Mental health professionals and respondents were assured that only the investigator had access to the list, and that only group data would be reported. No comparisons between therapists were reported. The investigator offered to share a compilation of the data at the conclusion of the study to any respondent or therapist who desired it.

A proposal was submitted to the human subjects committee of Montana State University College of Nursing and to the internal review board of any participating agency contacted if requested.

Risks associated with this study included anxiety, triggered memories of abuse, and/or a mild exacerbation of symptoms due to response to some of the items on the questionnaire. Individuals were told they may choose not

to answer some items, or could decide against participation in the study at any time. The suggested timing of the data collection before a therapy session provided additional support for any client who may have felt anxious.

Therapists may have felt anxious wondering how their clients responded and if this was indicative of their value as a therapist. Clients may also have felt anxious about reporting a lack of improvement if this was the case.

A potential benefit of participation in this study was an increase in awareness of the effects of abuse in an individual's life. Memories of abuse could also have been triggered, making this material available for therapeutic intervention. The results of this study may benefit the population of sexually abused people with a diagnosis of BPD by suggesting helpful therapies.

CHAPTER 4

FINDINGS

Sample

The convenience sample consisted of 36 respondents ranging in age from 20 to 64 years with a mean of 33.7 and a standard deviation of 9.2. All but one were female. The actual sample size was smaller than the target sample of 50 respondents. In addition to the originally planned method of data collection, some of the mental health professionals contacted by letter referred the investigator to other professionals who otherwise would not have been contacted. These professionals were contacted personally and agreed to distribute several questionnaires. In this manner, a total of 36 respondents were recruited. This sample size was considered adequate for an exploratory study and permitted the study to be completed within a reasonable time frame. All 36 respondents provided answers to all items with the following exceptions: (a) item #20 of the Borderline Symptom Checklist (n=1), (b) items gathering data for the variables of penetration (n=2), length of abuse (n=5), use of force (n=1), and involvement of intercourse (n=2). Responses from all 36 respondents were analyzed, and

missing item information is noted in reporting the findings.

Reliability for the instruments was assessed using Cronbach's alpha. The alpha coefficient for the Symptom Improvement Scale (SIS) was .71, indicating an acceptable level of internal consistency especially for a new instrument. However, the Borderline Symptom Checklist had an alpha coefficient of only .46, raising concern about findings from this instrument. These concerns are addressed below.

Borderline Personality Disorder Symptoms

The first aim of the study was to determine what symptoms consistent with borderline personality disorder (BPD) were reported by clients who were in treatment for sexual abuse. In order to address this aim, responses to each item on the Borderline Symptom Checklist were summed and results of these responses are given in Table 1. All items were scored so that a response indicating a problem behavior equaled 1, and a response indicating absence of such behavior equaled 0. The possible range of scores on the instrument was from 0 to 20.

Items represented specific behaviors that were a part of a specific BPD symptom. Each of the items was responded to in a way indicative of problem behavior by at least 5 respondents. Items were grouped according to the symptom

Table 1. Reported borderline personality disorder symptoms.

Symptom	Item	Number Reporting
Boredom	Often bored and cannot decide what to do	16
Abandonment	Ending a relationship with someone close is scary	34
Abandonment	Like to be alone much of the time *	13
Identity disturbance	Employed in many different types of jobs	21
Identity disturbance	Not sure about what values are important	14
Identity disturbance	Friends have been in life for several years *	15
Identity disturbance	Cannot decide on career	18
Intense interpersonal relationships	Sometimes people get too involved	19
Constant or inappropriate anger	Angry a great deal of the time	23
Impulsiveness	Eat everything in sight	22
Impulsiveness	Always take medication as prescribed *	13
Impulsiveness	Drinking more alcohol	6
Impulsiveness	Never use illegal drugs *	5
Impulsiveness	Sometimes use medications in ways not prescribed	12
Impulsiveness	Often go on shopping sprees	17
Impulsiveness	Had casual sex many times	11

Table 1. Continued.

Symptom	Item	Number Reporting
Affective instability	Moods change quickly	28
Affective instability	Often felt depressed	32
Recurrent suicidal threats	Want to hurt self at times	19
Recurrent suicidal threats	Rarely have suicidal thoughts *	24

* Item reverse coded.

(diagnostic criterion) they presumably addressed, and positive responses to each symptom were summed. Responses by ten individuals indicated four or fewer BPD symptoms. Responses by the remaining 26 respondents (73%) indicated five or more BPD symptoms. According to the DSM III-R (1987), a diagnosis of BPD may be made when a person has at least five symptoms from the diagnostic criteria as rated by a clinician.

The symptoms most frequently reported were: (a) fear of abandonment (n=34), (c) affective instability (n=28), and (d) suicidal thoughts (n=24). The lowest scores were for the two items addressing the symptom of impulsiveness, (a) illegal drug abuse (n=5) and (b) alcohol abuse (n=6). The mean score on the Borderline Symptom Checklist for the entire sample was 10.2 with a standard deviation of 2.73.

Low internal consistency reliability on the Borderline Symptom Checklist appeared to result from lack of clarity and specificity in wording. Additionally, the tool assessed all possible BPD symptoms when in reality, individuals with BPD would be expected to have only some of the behaviors and symptoms. This circumstance in and of itself tends to lower internal consistency reliability. In addition, responses in this study indicated some items in need of clearer, more precise wording. For example, spending more money, one of the items designed to measure impulsiveness, may have been inadequate. Several respondents indicated that although they were, in fact, spending more money, they were spending it on therapy and medication. For future studies, the meaning of this item should be clarified to convey impulsive spending. In further development of the Borderline Symptom Checklist, it will be important to do factor analysis to determine how well each item is addressing the intended symptom.

Changes in Borderline Personality Disorder Symptoms

The second aim of the study was to determine to what degree clients in treatment for sexual abuse have noticed change in borderline personality disorder (BPD) symptoms. This was accomplished by calculating mean scores and standard deviations for each item on the Symptom Improvement Scale (SIS) (see Table 2). This instrument

Table 2. Borderline personality disorder symptom improvement scores.

Symptom	Item	Mean Improvement Score[1]	Standard Deviation
Boredom	Still have tendency to be bored	3.11	1.21
Fear of abandonment	Look forward to being alone	3.88	1.11
Fear of abandonment	Less afraid of losing therapist	3.47	1.27
Fear of abandonment	Spend less time alone	3.16	1.10
Fear of abandonment	Less fear of losing significant other	2.86	1.29
Identity disturbance	Set and partially attained goals	4.22	.87
Identity disturbance	More clear about values	4.02	.81
Intense interpersonal relationships	More comfortable with relationships	3.61	1.20
Intense interpersonal relationships	Do not change friends as often	3.41	.87
Constant or inappropriate anger	Angry as often now as before	3.36	1.20
Impulsiveness	Spending more money	3.33	1.40
Impulsiveness	Binge eating more	3.33	1.23

Table 2. Continued.

Symptom	Item	Mean Improvement Score	Standard Deviation
Impulsiveness	Not abusing alcohol or drugs as much	3.94	1.26
Impulsiveness	Continue to have casual sex	4.72	.70
Affective instability	Mood changes more quickly	3.33	1.15
Affective instability	Mood unlikely to change	2.52	1.18
Affective instability	Feel less depressed	3.88	1.19
Suicidal threats	Fewer self-mutilating attempts	3.66	1.09
Suicidal threats	Closer to attempting suicide more often	4.05	1.28
Suicidal threats	More difficulty controlling self-mutilating desires	3.83	1.16
Suicidal threats	Suicidal thoughts less frequent	3.72	1.16
	Can see many positive changes	4.50	.65
	Making satisfactory progress in treatment	4.08	.94

[1] Range 1-5, with higher score indicating greater improvement.

contained 23 items. Scores on each item were converted from the -2 to +2 point Likert range to a 1-5 point range to afford greater ease of calculation. Two items asked respondents about overall progress in treatment; all other items addressed change in specific symptoms. Responses to items that represented a worsening of symptoms were recoded so that, for every item, a high score indicated improvement and a low score indicated a lack of improvement or regression. Possible total scores on the instrument ranged from 23-115.

Mean improvement scores on each item could range from 1 to 5, with 5 indicating greatest improvement. Mean improvement scores for the items addressing change in the most commonly reported symptoms on the Borderline Symptom Checklist, fear of abandonment, affective instability, and suicidal threats, were: (a) fear of abandonment by therapist (3.47), (b) fear of abandonment by significant other (2.86), (c) feel less depressed (3.88), (d) mood changes more quickly (3.33), and (e) fewer suicide attempts (4.05). Scores indicating marked improvement were found on the following six items: (a) continue to have casual sex since being treated for sexual abuse (4.72), (b) can see many positive changes since beginning therapy for sexual abuse (4.5), (c) have set and partially attained goals since being treated for sexual abuse (4.22), (d) feeling of making satisfactory progress in treatment (4.10), (e) have

come closer to attempting suicide more often since being treated for sexual abuse (4.05), and (f) more clear about what values are important than before sexual abuse treatment (4.03). Total scores on the SIS ranged from 66 to 103 with a mean of 84.25 and a standard deviation of 9.5.

Items were also grouped according to the symptom (diagnostic criterion) they presumably addressed, and item scores for each symptom were averaged. The average improvement scores for each symptom are as follows: (a) identity disturbance (4.12), (b) suicidal threats (3.84), (c) impulsiveness (3.83), (d) intense interpersonal relationships (3.51), (e) constant or inappropriate anger (3.36), (f) fear of abandonment (3.34), (g) affective instability (3.24), and (h) boredom (3.11).

Overall, respondents reported some degree of improvement in all symptoms. The score for the symptom of boredom had the least improvement reported (3.11), and the scores for symptoms of identity disturbance (4.12) and suicidal threats (3.84) showed the most improvement. Respondents also indicated that they felt satisfied with the overall progress in their treatment (4.08) and felt they were making many positive changes as a result of treatment (4.5).

Relationship to Demographic or Abuse Variables

The third and fourth aims of the study were to determine if reported borderline personality disorder (BPD) symptoms and change in BPD symptoms were related to prior sexual abuse or background demographic variables. This was accomplished by examining data from subgroups based on the following variables: (a) relationship of abuser, (b) involvement of intercourse, (c) involvement of penetration, (d) involvement of forces, and (f) presence of family support. Mean scores and standard deviations for both the Borderline Symptom Checklist and the Symptom Improvement Scale (SIS) were calculated for all subgroups, and differences in scores among the dichotomous variable subgroups were assessed using *t* tests. Relationships between the variables of length of abuse, length of time in therapy, and age and the dependent variables, reported symptoms and change in reported symptoms, were explored with correlations.

Length of abuse ranged from less than one year to 30 years with a mean of 11.38 years, and a standard deviation of 8.57. Thirty respondents provided information about length of abuse. There was no relationship between length of abuse and number of reported BPD symptoms (correlation coefficient, .16) or change in BPD symptoms (correlation coefficient, -.31).

Respondents' relationship to the abuser was examined in terms of whether or not the abuser was a father or stepfather. Twenty-one of the respondents were abused by a father or stepfather, 14 were abused by someone other than a father or stepfather, and one indicated she could not remember who the abuser was. The mean score on the Borderline Symptom Checklist for the 21 respondents who were abused by a father or stepfather was 10.23 (SD,2.4). For the 14 who were abused by someone other than a father or stepfather the Borderline Symptom Checklist Score was 10.14 (SD,3.2). Mean scores on the SIS were 82.76 (SD,9.34) for the group who was abused by a father or stepfather, and 86.33 (SD,9.61) for the group who was not. There was no statistical significance ($p \leq .05$) between the groups on the scores for the Borderline Symptom Checklist or the SIS scale. Thus, relationship to the abuser did not appear to affect the number of BPD symptoms reported or the degree of change in those symptoms.

The variable "involvement of intercourse" indicated whether or not the abuse involved intercourse. Seventeen respondents indicated that intercourse had occurred, and 16 respondents indicated that it had not. Three respondents stated they could not remember whether or not intercourse had occurred. The mean score on the Borderline Symptom Checklist for those with intercourse involvement was 10.23 (SD,2.75); the score was 9.93 (SD,2.79) for those without.

SIS scores were 85.05 (SD,11.81) for the group with intercourse, and 83.93 (SD,6.9) for the group without. The differences between the groups in scores on both instruments was not statistically significant at the .05 level. Thus, there appeared to be no relationship between involvement of intercourse and number of BPD symptoms or change in those symptoms.

The variable "penetration" indicated whether or not the abuse involved penetration of any body part with any object. Twenty-one respondents indicated that penetration was involved, 12 indicated that it was not, and three stated they could not remember whether or not any penetration had occurred. The group that had involvement of penetration scored 9.85 (SD,2.79) on the Borderline Symptom Checklist; the group without penetration scored 10.5 (SD,2.68). SIS scores were 86.38 (SD,8.3) for the group with penetration and 81.53 (SD,11.32) for the group without. The differences between the groups on scores for both instruments were not statistically significant at the .05 level. The involvement of penetration did not appear to affect the number of BPD symptoms or change in those symptoms.

The variable "force" indicated whether or not the use of force was involved in the abuse. Twenty-three respondents reported that force was involved, eleven reported that it was not, and two indicated they could not

remember whether or not force was used. The mean score on the Borderline Symptom Checklist for the group where force was involved was 10.73 (SD,2.83); the group without the involvement of force scored 8.72 (SD,1.79). This difference was significant (p=.02). Mean scores on the SIS were 83.37 (SD,9.96) for the group where force was involved, and 86.63 (SD,8.72) for the group without force. This difference was not statistically significant at the .05 level. Respondents who had force involved in the abuse reported a greater number of BPD symptoms than those who did not experience the use of force. However, there was no apparent relationship between the involvement of force and reported change in BPD symptoms.

Presence of family support was examined by asking clients if they disclosed the abuse to their family, and, if so, if they perceived that the family responded in a helpful way. Only nine respondents disclosed the abuse to their family; 26 did not. The mean scores on the Borderline Symptom Checklist for these two groups were 9.8 (SD,2.62) for those who did not disclose, and 11.33 (SD,2.87) for those who did disclose. Mean scores on the SIS were 83.77 (SD,7.98) for those who disclosed, and 84.40 (SD,10.08) for those who did not. There were no statistically significant differences. Disclosing the abuse to families did not appear to affect the number of BPD symptoms reported or change in those symptoms.

Of the nine respondents who disclosed the abuse to their families, three perceived that their families responded in a helpful manner. Mean scores for this group were 11.66 (SD,4.16) on the Borderline Symptom Checklist, and 86 (SD,3.6) on the SIS. The other six respondents who disclosed to their families but did not perceive a helpful response had a mean score of 11.33 (SD,2.42) on the Borderline Symptom Checklist and 82.66 (SD,9.6) on the SIS. The number of respondents was too small to allow for meaningful statistical analysis.

The range of time respondents had been in therapy was from 1 to 12 years with a mean of 3.53. There was no apparent relationship between length of time in therapy and number of BPD symptoms (correlation coefficient, .27) or reported change in those symptoms (correlation coefficient, -.20).

Respondents' ages ranged from 20 to 55 with a mean of 33.77 (SD,9.16). No relationship was established between present age and number of BPD symptoms reported (correlation coefficient, -.01) or change in those symptoms (correlation coefficient -.29).

Reported BPD symptoms and reported change in BPD symptoms were not related to the variables of (a) length of abuse, (b) relationship to the abuser, (c) involvement of intercourse, (d) involvement of penetration, (e) disclosure of abuse to families, (f) length of time in therapy, or

(g) age. Findings from this study did suggest a relationship between the variable of force and number of BPD symptoms. Those respondents who indicated that force had been used in sexual abuse reported more BPD symptoms than those who indicated force had not been used. However, the involvement of force did not appear to affect reported change in BPD symptoms.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Borderline Personality Disorder Symptoms

Respondents were individuals in treatment for sexual abuse. Seventy-three percent of the respondents answered affirmatively for five or more of the criteria for borderline personality disorder (BPD) on the Borderline Symptom Checklist. Thus, using the criteria in the DSM III-R (1987), these individuals would have been diagnosed with BPD. However, several therapists who referred respondents indicated that they avoided using a BPD diagnosis because they felt it was quite stigmatizing and not useful. Possibly the concern raised in this study that the diagnostic label of BPD may keep some individuals from receiving a type of therapy that could be helpful is already being addressed informally by therapists.

Improvement in Borderline Personality Disorder Symptoms

Every symptom of borderline personality disorder (BPD) was noted by at least some respondents as having improved. Due to the limitations of sample size and type, these findings cannot be generalized to persons receiving

treatment for childhood sexual abuse. The findings do suggest that further study of improvement in BPD symptoms using a larger, randomized sample of sexually abused people is indicated.

Respondents reported the greatest improvement in the symptom of identity disturbance; they indicated that they had been able to set goals and gain some clarity about values. These reported changes are a reasonable outcome of therapy and suggest that treatment for sexual abuse may be helpful in relieving this symptom of BPD.

The symptoms of suicidal threats (including self-mutilating behavior) and impulsiveness also showed substantial improvement. Paradoxically, these were the areas identified by some (Kroll, 1986) as ones that may become problematic when doing in-depth psychotherapy with BPD patients. Findings from this study suggest the opposite may be true; psychotherapeutic treatment for sexual abuse may actually be helpful in reducing suicidal threats and impulsiveness.

The symptoms fear of abandonment, affective instability, constant or inappropriate anger, and boredom had the least reported improvement. Respondents indicated that they still had some fear of losing their significant other, a logical outcome of the disturbed intimate relationships that occur with sexual abuse. Assessing constant or inappropriate anger may be difficult or even

inappropriate with this population. Frequently, survivors of sexual abuse are encouraged to explore and express anger toward the perpetrator that may have been repressed. Accordingly, in this population, expression of anger could be a sign of improvement rather than a sign of illness or regression. The symptom of boredom had the least reported improvement. Since the DSM III-R (1987) criterion for BPD includes chronic feelings of emptiness as well as boredom, items addressing emptiness should be included in the Borderline Symptom Checklist in the future to allow for more complete information regarding their symptom complex.

Findings from this study suggest that treatment for identified sexual abuse which includes emotional catharsis, some type of cognitive therapy, and examination of interpersonal relationships may be helpful in relieving numerous symptoms commonly associated with BPD. Clinicians who have clients with a diagnosis of BPD should carefully assess for the possibility of a previous history of sexual abuse. Specific psychotherapeutic treatment for sexual abuse may be warranted.

The findings of this study suggest that further research in the area of BPD symptom improvement is indicated. A longitudinal, experimental design to follow clients diagnosed with BPD who are receiving psychotherapeutic treatment for a prior history of sexual

abuse and a matched control group who are not is recommended.

Related Variables

The relationship of prior sexual abuse and background demographic variables to reported borderline personality disorder (BPD) symptoms and reported change in BPD symptoms was examined. Based on the literature regarding psychological disturbance due to sexual abuse and adjustment of the victims, information was gathered on the following variables: (a) length of abuse, (b) relationship of abuser, (c) involvement of intercourse, (d) involvement of penetration, (e) involvement of force, (f) presence of family support, (g) length of time in treatment, and (h) age.

A relationship between length of abuse and number of reported BPD symptoms or reported change in BPD symptoms was not established. This finding was consistent with Browne and Finkelhor's review (1986) of several empirical studies on the long-term effects of child sexual abuse in which the relationship between duration of abuse and degree of trauma was not consistent. The authors suggested that the variable, length of abuse, is confounded by other aspects of the abuse experience; (a) age at onset, (b) relationship to the offender, and (c) the nature of the sexual activity.

The findings of this study support previous findings that the use of force is positively related to a greater degree of trauma (Beitchman et al., 1992; Browne & Finkelhor, 1986). Respondents in the present study who reported force as a part of their abuse indicated a greater number of symptoms than those who did not.

The literature correlates a greater degree of trauma with negative parental response (Browne & Finkelhor, 1986). In this study, the number of respondents who disclosed the abuse to their families was too small to examine the relationship with BPD symptoms reported or change in BPD symptoms. The fact that such a small percentage of the sample sought assistance from their families may be suggestive of additional family dysfunction.

The finding that the length of time in treatment had no apparent relationship to the number of BPD symptoms or reported symptom improvement is interesting in light of the recent trend toward time limited therapy and the need for cost containment. Further study of this finding is warranted.

Nursing Implications

Findings from this study indicate that nursing care for borderline personality disorder (BPD) clients should include a careful nursing assessment to screen for a past history of sexual abuse. At the baccalaureate level,

nursing education should include content related to personality disorders as well as long-term effects of childhood sexual abuse. Students should be prepared to intervene in a caring, non-judgmental fashion with the behaviors common to BPD and sexual abuse survivors. The importance of screening for and being alert to indicators of past sexual abuse should be emphasized in nursing curricula. Students need opportunities to assess the physiological and psychological symptoms of sexual abuse that may be manifested by patients of various ages and in a wide variety of settings. Baccalaureate level nurses should be able to provide emotional support and appropriate referral for sexually abused patients and to adapt other nursing interventions in order to be sensitive to the patient's history of sexual abuse.

Nurses with advanced preparation in psychiatric/mental health nursing need, as part of their educational preparation, a thorough understanding of the psychopathology of personality disorders as well as, and as it relates to, long-term effects of sexual abuse. Additionally, they need to be prepared to thoroughly and accurately assess for a previous history of sexual abuse in medical as well as psychiatric settings and to offer psychotherapeutic intervention for clients who have been sexually abused. Furthermore, additional nursing research

focused on effective nursing interventions for BPD and sexually abused clients is needed.

Summary

The purpose of this study was to explore, from the client's perspective, the impact that treatment for sexual abuse has on the symptoms that are commonly associated with borderline personality disorder (BPD). Clients who had been sexually abused reported that they, in fact, did have many symptoms associated with a diagnosis of BPD. They also reported that treatment for sexual abuse provided some degree of relief for most of these symptoms. These findings suggest that treatment specifically focused on sexual abuse for BPD clients who have a history of childhood sexual abuse may be warranted. Further study with a larger sample of sexually abused BPD clients is needed.

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APPENDICES

APPENDIX A

DATA COLLECTION INSTRUMENT

Part I

Borderline Symptom Checklist

Read each statement below and indicate your agreement or disagreement by writing T (true) or F (false) in the space in front of each statement.

____ 1) I am often bored and cannot decide what to do.

____ 2) Ending a relationship with someone close to me is very scary.

____ 3) I have been employed in many different types of jobs since I was old enough to work.

____ 4) Sometimes people get too involved in my life.

____ 5) I am not sure what values are important to me.

____ 6) During the past year or so it seems I am angry a great deal of the time.

____ 7) Most of my friends have been in my life for several years.

____ 8) Sometimes it seems I eat everything in sight.

____ 9) I have felt depressed often in the past year or two.

____10) Sometimes I want to hurt myself.

____11) I cannot decide what type of career I would like to pursue.

____12) I always take my medication as my doctor instructs me.

____13) My feelings or moods have been likely to change quickly during the past year or two.

____14) During the past year or so I have been drinking alcohol more than I would like to.

____15) I have rarely, if ever, had thoughts of wanting to kill myself.

____16) I never use any illegal drugs.

____17) Sometimes I use medications in ways they were not prescribed.

____18) I often go on shopping sprees and spend more money than I can afford.

____19) Many times I have had sex with someone I knew casually.

____20) I like to be alone much of the time.

Part II

Symptom Improvement Scale

Read each statement below and indicate your agreement or disagreement by circling the appropriate number below each statement. If a statement does not apply to you, please circle 0.

2) Strongly agree
1) Agree somewhat
0) No strong feelings either way
-1) Somewhat disagree
-2) Strongly disagree

1) Since I have been treated for sexual abuse, I have come closer to attempting suicide more often than usual.

2 1 0 -1 -2

2) I feel I am making satisfactory progress in my treatment.

2 1 0 -1 -2

3) I am more comfortable with my relationships with my friends than I was before I was treated for sexual abuse.

2 1 0 -1 -2

4) My mood is unlikely to change quickly.

2 1 0 -1 -2

5) I feel less depressed now than I did before I was treated for sexual abuse.

2 1 0 -1 -2

6) I am spending considerably more money than I was before I was treated for sexual abuse.

2 1 0 -1 -2

7) I do not change friends now as often as I did before I was in treatment for sexual abuse.

2 1 0 -1 -2

8) My mood changes more quickly than it did before I was treated for sexual abuse.

2 1 0 -1 -2

9) I am binge eating now considerably more than I did before I was treated for sexual abuse.

2 1 0 -1 -2

10) I look forward to being alone at times since I have been treated for sexual abuse.

2 1 0 -1 -2

11) Since I have been treated for sexual abuse, I have thought of suicide <u>less</u> than usual.

2 1 0 -1 -2

12) I can see many positive changes in myself since I began therapy for sexual abuse.

2 1 0 -1 -2

13) I am less afraid that my therapist will stop seeing me than I was when I began treatment for sexual abuse.

2 1 0 -1 -2

14) Since I have been treated for sexual abuse, I have had more difficulty controlling the desire to physically injure myself.

2 1 0 -1 -2

15) Since I have been treated for sexual abuse, I have not drank or abused drugs (including prescription) as much as I have in the past.

2 1 0 -1 -2

16) I spend less time alone than I did before I was treated for sexual abuse.

2 1 0 -1 -2

17) I am angry as often now as I was before I was treated for sexual abuse.

2 1 0 -1 -2

18) I have less fear that my spouse or significant person will leave me than I did before I was treated for sexual abuse.

2 1 0 -1 -2

19) The number of times I have attempted to physically injure myself has declined since I have been in treatment for sexual abuse.

2 1 0 -1 -2

20) Since I have been treated for sexual abuse, I have set goals for myself and been able to at least partially attain some of them.

2 1 0 -1 -2

21) Treatment for sexual abuse has not changed my tendency to be bored.

2 1 0 -1 -2

22) I am more clear now about what values are important to me than I was before I was treated for sexual abuse.

2 1 0 -1 -2

23) I continue to have sex with people I know casually since I have received treatment for sexual abuse.

2 1 0 -1 -2

Variable Checklist

Please answer the following questions about your situation as accurately as you can.

1) At what age did your abuse first occur?_____

2) Was the abuser your father or stepfather?
   ____ Yes
   ____ No

4) At what age did your abuse stop?_____

5) Did the abuse involve intercourse?
   ____ Yes
   ____ No

6) Did the abuse involve penetration of any body part with any object?
   ____ Yes
   ____ No

7) Was force used as part of the abuse?
   ____ Yes
   ____ No

8) How long have you been seeing a counselor or therapist?
   ____years ____months

9) Did you tell your parents about the abuse when you were still a child (under the age of 18)?
   ____ Yes
   ____ No

10) <u>If</u> you told your parents, did they respond in a way that you perceived to be helpful?
   ____ Yes
   ____ No

These last few questions are about you.

11) ____ Age

12) ____ Sex

APPENDIX B

LETTER TO MENTAL HEALTH PROFESSIONALS

Dear ,

As a psychiatric nurse and graduate student of Montana State University College of Nursing, I am particularly interested in studying clients who have a history of sexual abuse. In fact, this is the topic of my thesis. The literature suggests some similarities between the long-term effects of sexual abuse and borderline personality disorder (BPD) symptomatology. Specifically, I will be looking at what effect treatment for sexual abuse may have on those symptoms commonly attributed to BPD. This will be accomplished by asking clients who have a history of sexual abuse about their perceptions of the impact treatment has on symptoms commonly associated with BPD via a questionnaire. Client anonymity will be strictly protected as the questionnaire will be distributed by you and completed questionnaires mailed to the MSU College of Nursing by the client, or returned to you if the client prefers. A summary of the results of all completed questionnaires can be given to you at the conclusion of the study if you request one.

If you have clients with a history of sexual abuse, and you address the abuse issue in therapy, I would very much like to schedule a short meeting with you. Please return the enclosed postcard as soon as possible and I will contact you to set up a mutually convenient appointment.

Sincerely,

Deborah D. Surratt BSN, RNC

APPENDIX C

INFORMED CONSENT LETTER TO PROSPECTIVE PARTICIPANTS

Dear Client,

Because you and your therapist deal with issues related to sexual abuse in your therapy, your therapist has given you this questionnaire. He/she is the only person who knows that you have received the questionnaire. I do not and will not ever know who you are.

Sexual abuse is a widespread problem, and it is important that we understand how it impacts survivors' lives as well as whether or not treatment is helpful. You are perhaps in the best position to provide this information. The results of this study may benefit other sexually abused people by suggesting helpful therapies.

I am a graduate student, focusing my study on psychiatric nursing at Montana State University, and hope to finish my master's degree in nursing this year. I have worked with psychiatric patients for nine years, and have worked specifically with survivors of sexual abuse for the last four years. Because of my interest in the treatment of sexual abuse, I have decided to do my thesis on this topic. In order to gather the most accurate information possible, I have developed a questionnaire for survivors of sexual abuse. I would truly appreciate your careful and thoughtful responses to these questions.

Each questionnaire has a number written in the right-hand corner that helps me know how many questionnaires were returned and the diagnosis of the person answering the questions, but this does not identify you in any way. No one, including your therapist, will know whether or not you answered the questionnaire unless you tell them. The completed questionnaires will be kept in a locked file, and I will be the only person who has a key to the file. After the information from the questionnaires has been entered on to the computer, the questionnaires will be destroyed.

You are free to respond to the questions or not. Answering all of the questions will take ten to twenty minutes of time. If you decide to answer the questionnaire, please write in your answers, place the questionnaire in the enclosed envelope, <u>seal it</u>, and mail it or give the envelope to your therapist. Your therapist will return the sealed envelope to me. If you decide you do not want to answer the questionnaire, please place the blank questionnaire in the enclosed envelope, <u>seal it</u>, and mail it or give the envelope to your therapist.

Answering the questions may cause you to feel somewhat anxious or uncomfortable. You may stop answering the questions at any time. Although you do not need to tell your therapist whether or not you answered the questions, you may wish to talk to him/her about the feelings you had. Reading the questions could increase your awareness of the

ways sexual abuse has affected you, and could possibly trigger memories of abuse, making these issues available for discussion in your therapy. Since this is one of the ways healing from sexual abuse can occur, please feel free to seek support from your therapist.

The information from all of the questionnaires will be compiled, and a report will be available to you if you request it. No questionnaire will be reported in any way that identifies anyone. No names of people responding will be known to anyone.

Your views are crucial in developing treatment methods that are helpful. Thank you for giving this very important matter your time and attention.

Sincerely,

Deborah D. Surratt, BSN RNC

HOUCHEN
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