An empirical study of the effects of sexual abuse on psychosocial development and distress

by Kevin E Wyse

A thesis submitted in partial fulfillment of the requirements for the degree Of Master of Education in Mental Health Counseling
Montana State University

Abstract:
The purpose of this study was to examine the differences in psychosocial development and reported distress levels between women in counseling who have experienced sexual abuse (N=20) and women in counseling who have not experienced sexual abuse (N=14). Psychosocial development was assessed using the Measures of Psychosocial Development (MPD), which measures resolution of Erik H. Erikson's eight psychosocial stages. Individuals' reported level of distress was measured by the Global Symptoms Index (GSI) on the Symptoms Checklist 90 Revised (SCL-90-R).

The sample consisted of Caucasian women at the Human Development Training and Research Clinic, the Montana State University Counseling and Psychological Services Center and selected clients of private counselors. All of these referral sources resided in the community of Bozeman, Montana. All participants were referred by their primary therapists to complete the assessments and an additional information form.

The data obtained from the MPD and the SCL-90-R was analyzed by comparing the means of each group through the use of t tests. At the $p = .05$ level, there was a significant difference between the two groups in all of Erikson's eight stages except the Intimacy versus Isolation stage. There was also a significant difference between the two groups on the GSI of the SCL-90-R ($p = .05$). Specifically, women who have experienced sexual abuse showed lower levels of resolution in seven of Erikson's eight psychosocial stages and higher levels of reported distress, as measured by the SCL-90-R. Descriptive data from the additional information form is reported in the study.

Recommendations resulting from this study include the use of the MPD and Erikson's theory in understanding and treating women in counseling who have experienced sexual abuse. Also, recommendations for further research include the investigation into the relationship between reported levels of distress and levels of psychosocial development.

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7/26/94
Date

Michael Wolfe
Chairperson, Graduate Committee

Approved for the Major Department

8/3/94
Date

Ellen Kreighbaum
Head, Major Department

Approved for the Major Department

8/8/94
Date

R L Bowen
Graduate Dean

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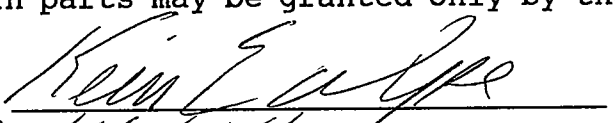
Signature 

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ABSTRACT

The purpose of this study was to examine the differences in psychosocial development and reported distress levels between women in counseling who have experienced sexual abuse (N=20) and women in counseling who have not experienced sexual abuse (N=14). Psychosocial development was assessed using the Measures of Psychosocial Development (MPD), which measures resolution of Erik H. Erikson's eight psychosocial stages. Individuals' reported level of distress was measured by the Global Symptoms Index (GSI) on the Symptoms Checklist 90 Revised
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CHAPTER 1

INTRODUCTION

I hear the cries of pain,
The silence that speaks of grief
And wonder,
Can they ever find relief?

I feel their disbelief and sadness
And see their lovelessness
And wonder
What is the answer to their pain?

To see this human havoc is pain enough.
To be that person must be terribly tough.
To know these brave survivors is to see their strength,
A shimmering diamond shining bright.

Jan Lincecum McLean
(Thorman, 1983)

As society is shedding the sheath of secrecy, it is becoming apparent that sexual abuse is much more prevalent than was ever imagined. Briere and Elliott (1992) reported that one out of every four children in this country experiences some form of child sexual abuse with 15% to 20% of the victims being boys. Reichert (1992) reported that 15 to 20% of females are abused as children, 50% of rape victims are teens, 25 to 66% of pregnant teens were sexually abused, and that 8 to 12 year old children are the most common victims of sexual abuse.

These statistics are particularly alarming given the impact sexual abuse may have on survivors' adjustment and

development. Several authors (Allers, Allers & Benjack, 1992; McFadden, 1987; Yates, 1991) reported the following problems which are associated with sexual abuse of children and adolescents: increased sexual and aggressive conduct; difficulties in meeting age appropriate behavior; an increase in drug and alcohol abuse; and an assortment of DSM-III-R diagnoses. Other authors (Briere, Evans, et al.; Browne & Finkelhor; Feinaur; Runtz & Runtz; cited in Ratican, 1992; Breire & Elliott, 1992; Johnson 1989) reported an array of problems which plague adults who have been sexually abused including increased incidence of depression, low self-esteem, guilt, anger, and anxiety. They also reported difficulties with dissociation, body image and somatic complaints.

There has been extensive speculation on how sexual abuse affects survivors. Thorman (1983) stated that most professionals who deal with sexual abuse survivors agree survivors suffer some type of emotional trauma. McFarlane (1978) believed that the abuse results in the production of a victim mentality which is extremely detrimental to the development of the survivor's personality. Gagliano (1987) reported that many children who have been sexually abused "fail to accomplish the normal developmental tasks of childhood and adolescence" (p. 103). McFadden (1987) also wrote in detail about the effects of sexual abuse on development, stating that "the effect of maltreatment is to arrest or freeze the developmental process" (p. 53). Johnson

(1989), Burgess (1985) and Byers (1990) believed that the effects of sexual abuse are similar to other traumas that impact people's lives. These authors have purported that sexual abuse negatively affects the normal development of children, adolescents and adults.

Though differences in developmental levels between women who have experienced sexual abuse and women who have not experienced sexual abuse have been reported by a number of authors, at the inception of this project, no empirical evidence had been identified which supported this assertion. It was the purpose of this study to assess whether or not there is a significant difference between the psychosocial developmental levels of adult women in counseling who have experienced sexual abuse and adult women in counseling who have not experienced sexual abuse.

Conceptual Framework

This study focused on the effects that sexual abuse has on psychosocial development. A conceptual framework for understanding psychosocial development has been suggested by Erik H. Erikson (Hergenhahn, 1990). Erikson postulated an eight stage developmental model. Hergenhahn (1990) explained that Erikson's theory "can be viewed as a description of how the ego gains or loses strength as a function of developmental experiences" (p. 150). Each developmental stage is characterized by a crisis, which can be defined as an

important turning point. The ego gains strength as the individual encounters a crisis and achieves a positive resolution of that stage. Likewise, the ego loses strength when there is negative resolution of a crisis. Sexual abuse may detract from the ego's ability to successfully resolve a crisis, negatively affecting the course of psychosocial development. For Erikson, each stage must result in the positive resolution of that stage because an unresolved crisis restricts the development of ego strength, which is necessary to deal with life's problems.

Erikson's first stage is Basic Trust versus Basic Mistrust and usually lasts from birth to the end of the first year. If there is positive resolution of this stage individuals will develop feelings of trust in other people and things, and a sense of belief that they can obtain what they desire in life. If there is negative resolution of this stage, individuals will exhibit apprehension and suspiciousness of others, and possibly of themselves. The second stage is Autonomy versus Shame and Doubt which lasts from about the end of the first year to end of the third year. If there is positive resolution in this stage, individuals can begin to decide for themselves if they will participate in something or not participate. Positive resolution is also characterized by an ability to understand cultural ideas of right and wrong. However, if there is negative resolution in the second stage,

individuals may become rigid, dogmatic and caustic (Hergenhahn, 1990).

The third stage described by Erikson is Initiative versus Guilt. It usually extends from the fourth year to the fifth year. If individuals successfully resolve this stage, they will be able to perceive future events, and their roles in these events. They will also develop an ability to try on different roles and decide which parts fit for them and which parts they would rather leave behind. If they are unsuccessful in resolving the third stage, individuals may demonstrate a lack of self-sufficiency and "will tend to live within the limits of others" (p. 155). The fourth stage is called Industry versus Inferiority and usually exists from the age of six to the age of eleven. Positive resolution in this stage is signified by the sense that there is pleasure in a job well done and confidence that they will have a place in society. Negative resolution of this stage can be characterized by individuals feeling as if they will not become useful members of society (Hergenhahn, 1990).

The fifth stage, Identity versus Role Confusion, marks the transition between childhood and adulthood in a period Erikson called the psychological moratorium. Erikson explained that when individuals emerge from this stage with positive resolution, they will have a sense of who they are and an initial consideration for an overall plan for their lives. Furthermore, they will develop a doctrine which will help them

carry out this overall plan. However, without success, individuals will emerge with a negative identity or role confusion (Hergenhahn, 1990).

Hamachek (1988) listed the behaviors of people with a sense of role confusion or a negative identity:

> 1. They tend to have an unstable self-concept marked by ups and downs;
>
> 2. They tend to set short-term goals, but have trouble establishing long-range plans;
>
> 3. They are more susceptible to the shifting whims of peer pressure influences;
>
> 4. They tend to have rather low levels of self-acceptance;
>
> 5. They are apt to have trouble making decisions, fearing that they will be wrong;
>
> 6. They tend to have a somewhat cynical attitude about themselves, others and life generally;
>
> 7. They tend to believe that what happens to them is largely out of their hands, a matter of fate or breaks;
>
> 8. They are inclined to seek self-acceptance indirectly by being what they believe others want them to be;
>
> 9. They are inclined to have trouble being physically and emotionally close to another person without being either too dependent or too separate; and
>
> 10. They tend to be cognitively inflexible; their sense of self resides heavily on being right. (p. 359)

Erikson (1968) depicted a person with negative identity and role confusion as feeling as if "life and strength seem to exist only where one is not, while decay and danger threaten wherever one happens to be" (p. 173). Erikson also described

problems with intimacy, fear of success and failure, feelings of ambivalence about who one is, and an inability to commit oneself to an occupation. Many of these symptoms have been associated with survivors of sexual abuse.

At about 20 years of age, the identity process should be near completion and individuals can then move into the sixth stage of Intimacy versus Isolation. This stage usually lasts until the age of 24 and is identified by "young adults with a strong identity eagerly seek intimate relationships with others" (Hergenhahn, 1990, p. 159). Individuals should also have a sense of cultural expectations of caring and productive relationships. Negative resolution is indicated by individuals feeling a sense of detachment and separation from others. Stage seven, Generativity versus Stagnation, is depicted by the desire to pass on to others one's perception of what makes for a satisfying life. This stage usually occurs between the ages of 25 to 64. It is also the time where adults begin to pass on values of the culture to the next generation. If there is negative resolution of this stage, individuals will use their power for their own self-indulgent objectives. Erikson's final stage, Integrity versus Despair, occurs from about the age of 65 until individuals die. According to Erikson (Hergenhahn, 1990), "it is only the person who can look back on a rich, constructive, happy life who does not fear death. Such a person has a feeling of completion and fulfillment" (p. 161). Despair would be

denoted by individuals feeling desperate and hopeless about their lives (Hergenhahn, 1990).

Erikson postulated that this theory is epigenetic, meaning individuals must pass through these stages in order. He also indicated that each of the crisis resolutions is reversible. For example, if individuals were to leave the first stage with the resolution of trust, they may lose it. Likewise, individuals leaving this stage with mistrust, may at some point gain trust (Hergenhahn, 1990).

It is this principle of reversibility which could have important implications for survivors of sexual abuse. Specifically, does sexual abuse affect the psychosocial development principles described by Erikson? If there is a significant difference in the psychosocial development of women who have experienced sexual abuse, which stages are affected and to what degree are they impacted? If abuse does negatively impact psychosocial development, it is possible that a therapeutic intervention designed to reconstruct these developmental stages could allow sexual abuse survivors to move past the abuse or resolve developmental tasks.

Definitions

This section provides conceptual definitions of sexual abuse, human development, adjustment and counseling. Following each conceptual definition an operational

definition, used to measure each variable in this study, will be provided.

Sexual Abuse

Sgori (1982) defined child sexual abuse as:

> a sexual act imposed on a child who lacks emotional, maturational and/or cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance. (p. 7)

This is a comprehensive definition of child sexual abuse which points out that any of these circumstances, which could be present in an abusive relationship, involve more than the act of sex. Rather, it is the issue of power and dominance which is the foundation of the relationship between the victim and the perpetrator. Sgori also outlined what acts can produce negative effects of child sexual abuse. Behaviors such as the perpetrator being nude in front the victim, the perpetrator disrobing in front of the victim, exposure of the perpetrator's genitals, fondling by perpetrator of victim's genital area, any penetration of the vagina or anus by the perpetrator and even "dry intercourse" where the perpetrator ejaculates by rubbing his penis against the victim's vaginal or anal region can all be considered sexual abuse. Though this may seem obvious to some, it is important to acknowledge that each of these behaviors are important to consider for

this study and in the selection of the participants for this study.

For this study, incest was considered a form of sexual abuse. Poston and Lison (1989) defined sexual abuse using the definition put forth by the National Committee for the Prevention of Child Abuse; "sexual abuse consists of contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of that adult or of another person" (p. 21). They used the same definition for incest, but added that the perpetrator is a blood relative. They made no distinction between perpetrators who are blood relatives or relatives by marriage, for example a stepfather. They believed that either situation can have devastating effects on the victim. They added that the abuse often involves the dimensions of bribery, trickery or the use of force.

The final type of abuse which was denoted as sexual abuse in this study was sexual assault or rape. Katz and Mazur (1979) summarized their definition citing three criteria, "legally forcible rape is defined by three elements: (1) vaginal penetration, (2) use of force, and (3) non-consent of the victim" (p. 15). Sunday and Tobach (1985) added to this definition the concepts that rape is a crime of violence, rape is not committed for sex, but for domination and humiliation of the victim, rapists often use threats and weapons, and that rape is a violation of the victims civil rights. Finally,

Hursch (1977) reported that rape is not an act of affection or love "it is a way of degrading and debasing a woman" (p. 5).

Though these three acts of sexual abuse have components which differ, they have several elements in common. Powerlessness of the victim, violation of the victim by the perpetrator and use of force or coercion are all inherent in each of these acts. Therefore, it was appropriate to include all three types of sexual abuse survivors in this study.

These three types of sexual abuse were operationally defined as the clients reporting, or not reporting, one of these types of sexual abuse. The primary therapist then referred the individual to the study.

Human Development

Erik H. Erikson's psychosocial developmental model offers a conceptualization of development. As recounted above, Erikson described age appropriate developmental stages, indicated by resolution of crises and formation of ego.

For this study, psychosocial development of subjects was operationally defined as clients' scores on Gwen A. Hawely's Measures of Psychosocial Development (MPD). This assessment measures the resolution in each of Erikson's eight stages. An in-depth discussion of this assessment is offered in the Methods section of this study.

Adjustment

As reported earlier, sexual abuse survivors present to mental health professionals with varying levels of adjustment problems. To assess how levels of adjustment are related to surviving sexual abuse and resolution of Erikson's stages, it was necessary to assess the level of distress each participant was experiencing.

For this study, participants' level of distress was operationally defined as their scores on the Symptoms Check-list 90 Revised (SCL-90-R). This assessment measures an individual's level of distress over the last seven days on nine symptom indices and three global indices. An in-depth discussion of this assessment is offered in the Methods section of this study.

Psychotherapy

In this section, definitions for individual psychotherapy, family psychotherapy and group psychotherapy are provided. Psychotherapy, in general, is defined by Corsini (1989) as:

> A formal process of interaction between two parties, each party usually consisting of one person but with the possibility that there may be two or more people in each party, for the amelioration of distress in one of the two parties relative to any of the following areas of disability or malfunction: cognitive functions (disorders of thinking), affective functions (suffering or emotional discomforts) or behavioral functions (inadequacy of behavior), with the therapist having some theory of personality's origins, development, maintenance and change along with some method of treatment logically

> related to the theory and professional and legal approval to act as a therapist. (p. 1)

Individual psychotherapy was defined as one person seeking psychotherapy from a therapist. Family psychotherapy was defined as a group of individuals, who have kinship or previous emotional ties to each other, seeking psychotherapy from a therapist (Corsini, 1989). Group psychotherapy was defined as two or more individuals, who may or may not have previous emotional ties, meeting for the purpose of psychotherapy. These individuals must recognize that they belong to this group and have mutually agreed upon goals of the group (Gladding, 1991).

For the purpose of this study, psychotherapy was operationally defined as the individual participating in one or more of these types of psychotherapy. To be selected for this study, participants must have participated in psychotherapy for three sessions or more.

CHAPTER 2

LITERATURE REVIEW

The literature review explores the prevailing qualitative and quantitative research that pertains to the varied effects of sexual abuse. This chapter begins with an examination of evidence in the literature regarding the incidence of sexual abuse. Next, symptoms which are commonly experienced by survivors of sexual abuse are discussed, including Post-Traumatic Stress Disorder. Finally, the chapter discusses the literature addressing the underlying developmental dynamics of individuals who have experienced sexual abuse. The chapter ends with a summary of the literature and the statement of questions to be addressed in this study.

Incidence of Sexual Abuse

This section examines literature reporting the incidence of sexual abuse.

Byers (1990) characterized sexual abuse as a problem that has been around for many years. However, the extent of the problem is just now being realized by mental health professionals. Gelles and Conte (1990) reported "there has

been a 225% increase in reporting between 1976 and 1987" (p. 1046).

Byers (1990) found that different studies show that 8% to 28% of women have experienced some type of sexual abuse. One study of psychiatric settings cited by Byers indicated that 21% of the women had been sexually abused; a second reported that 19% of inpatient women and 38% of outpatient women were sexually abused. Byers reported that 80% of convicted sexual offenders had been sexually abused. Though Byers cites several renowned authors, she provides no empirical evidence for these figures. However, Craine, Henson, Colliver and Maclean (1988) found in their sample of 105 women that 54 of them had been sexually abused. Because these authors use a definition of sexual abuse which included behaviors other than sexual intercourse, they suggested that their results may display a higher percentage compared to studies where sexual intercourse was the only criteria recognized.

Briere (1992a) in a review of the literature found, "perhaps one third of the women and one sixth of the men in our culture have experienced sexual contact with someone substantially older by their mid-teens" (p.196). Briere and Elliot (1992) reported that one out of every four children in this country experiences some form of child sexual abuse with 15% to 20% of these being boys. Reichert (1992) stated that 15% to 20% of females are abused as children, 50% of rape victims are teens, 25% to 66% of pregnant teens were sexually

abused, and that 8 to 12 year old children are the most common victims of sexual abuse. Though all of these individual authors are experts in the field of the treatment of sexual abuse, they offer no empirical evidence for their figures.

Other studies also supported the contentions of these authors. Wyatt, Guthrie and Notgrass (1992) reported that, in a nonclinical population, 1 in 2.5 to 1 in 4 women experience sexual abuse by the age of eighteen. Wheeler and Walton (1987) reported that 4% to 12% of all women endure a sexual experience with a relative, and one percent of women have been sexually assaulted by their father or stepfather. Braver, Bumberry, Green and Rawson (1992) found that 35.7% of the college counseling center population they studied had been sexually abused. Allers, Allers and Benjack (1992) found in a study of 600 adolescent females, who were participating in inpatient treatment for substance abuse, that 35.2% admitted they had been sexually abused as children or adolescents.

The variations in reported sexual abuse would seem to warrant explanation. One possible reason for variations may be that different populations are researched in different studies. Patients in psychiatric hospitals, clients in outpatient mental health settings and individuals who have had no contact with mental health professionals may have different rates of abuse history. Variations in age, environment or presenting symptoms may also have an effect on the probability that an individual would have reported sexual abuse.

Different definitions of sexual abuse could also be another possibility for the variations.

Self-report measures, which were utilized by some of the above research, are also subject to limitations. Gotlib (1984) reported, because self-reports are a subjective report by an individual who may want help, individuals may tend to report in a negative light. According to Wessman, Prusoff, Thompson, Harding and Myer (1978), self-report measures may set up expectations that the individual should perform well on the assessment. This assumption lends itself to the possibility of an individual either over or under reporting the incidence of sexual abuse.

Another issue which is currently under investigation is the possibility of false memories. Persinger (1992) tested six subjects who had suddenly remembered experiences of child sexual abuse. Persinger (1992) found that individuals who were tested had a history of anxiety, EEG measurements which were epileptic-like and scores which were significantly high on the Hypnotic Induction Profile, implying high levels of suggestibility. Persinger suggested that this study supports the hypothesis that individuals with this profile may be prone to perceiving suggestions of sexual abuse as repressed memories. This may provide an interpretation for their feelings of unexplainable anxiety, providing even further reinforcement. Because of the small number of participants in this study ($n = 6$), the results of the study should be

questioned. Persinger (1992) also made several inferences which are not clearly explained, bringing into question the significance of the study.

False memories of sexual abuse may be produced to explain feelings of confusion or fear (Loftus, 1993). Sexual abuse may provide a logical answer to life-long struggles, when there actually was no experience of sexual abuse. Loftus also suggested that a therapist's suggestive probing may create false memories for clients who are struggling to understand painful feelings. Lotus offers no empirical evidence to support these suppositions.

Despite limitations of the studies, available data does suggest that sexual abuse of children is a reality in our society, raising questions about its effects on psychological adjustment and development.

Effects of Sexual Abuse

This section of the literature review considers the research on symptomatology and psychopathology associated with the experience of having been sexually abused.

McFadden (1987) reported several behaviors which may be present in children who have been sexually abused. In infants, eating problems, sleep disturbances and behaviors which demonstrate a lack of basic needs being met are manifested. Preschool children often demonstrate an increased need for love but an extreme problem communicating and

trusting adults. They may not feel guilty about the abuse but will often have a poor self-concept. Preschoolers usually do not understand sex or sexual abuse and deal with this confusion by repressing or denying any feelings about the abuse or the perpetrator. At this time too, children who have been sexually abused may begin to act out sexually with other children during times of play and may begin to have problems with enuresis or encopresis.

Gelles and Conte (1990), after reviewing the literature in the 1980's, stated:

> Specific differences in the functioning of sexually abused children have been observed in the research, and it is clear that such children display a variety of negative social, emotional, and physical sequelae in comparison with children who are not known to have been abused and those who are identified as having psychosocial problems. (p. 1053)

In a study with 15 children, Fagot, Hagan, Youngblade and Potter (1989) found that sexually abused children were more passive but were not more likely to exhibit behavior problems. They also found that passivity often leads to children interacting less with teachers and peers, leading to an increased incidence of depression and anxiety. The authors of these studies rely on clinical observation and offer no empirical evidence to support their inferences.

McFadden (1987) reported that as children reach school-age the effects of sexual abuse become more obvious. They may demonstrate negative feelings about their bodies and feel unworthy to associate with others unless there is some type of

physical encounter. They often illustrate both extreme difficulties with other children and feelings of shame in many of their peer and child-adult relationships. McFadden offers no empirical evidence to support the inferences in this study.

McFadden (1987) found that school-age children may be sexually over-aroused. In a review of the research, Browne and Finkelhor (1986) cited two researchers who have studied sexual behavior in children who have been sexually abused. Tufts (cited in Browne & Finkelhor, 1992) found that 27% of children four to six years old who were sexually abused scored significantly higher on a sexual behavior scale compared to clinical and general control populations. The behavior scale which was utilized included "having had sexual relations, open masturbation, excessive sexual curiosity and frequent exposure of the genitals" (p.68). Though overt sexual behavior is not an indicator of sexual abuse, this study suggested that it may be a difficulty that some children who have been sexually abused experience. It is important to note that neither Browne and Finkelhor nor McFadden described the instruments or the limitations of these studies.

Friedrich, Urquiza and Beilke (cited in Browne and Finkelhor, 1986) found in a study of sexually abused children that 70% of boys and 44% of girls scored one standard deviation above the mean for a normal population on a scale measuring sexual difficulties. During times of sexual arousal, children may dissociate from their experience, have

feelings of fear or revulsion, or seek further gratification which is uncommon in non-abused children of this age (McFadden, 1987). It is important to note that neither Browne and Finkelhor nor McFadden described the instruments or the limitations of these studies.

Based on her clinical experience, MacFarlane (1978) reported that sexual abuse instills within its victims a reference of self which leaves them feeling they are victims, not only in the context of the abuse, but also in the greater context of their lives. She suggests that this may be the most long lasting effect of sexual abuse and leads to a life of self-deprecation and poor self-concept.

Burgess (1985) stated that sexual abuse denotes an ego-shattering experience for adolescents. In adolescence, any type of anxiety may cause individuals who have been sexually abused to damage their health through self-mutilation or the development of sleeping or eating disorders. Adolescents may also disassociate from body sensations during times of stress to protect themselves from a perceived threat. Chronic feelings of worthlessness or failure may result in the individual presenting with clinical depression, including suicidal ideation (McFadden, 1987). Burgess and McFadden based their findings on clinical experience.

Adolescents who are currently being sexually abused, or have been abused in the past, may have trouble looking past the present and into the future. Their behavior is often

promiscuous, leaving them open to future abuse, sexually transmitted diseases and pregnancy in their teenage years (McFadden, 1987). Byers (1990) supported this observation by reporting that adolescent survivors of sexual abuse often use sex as a tool to control or manipulate others. McFadden and Byers offered no empirical evidence to support their inferences.

Tufts (cited in Browne and Finkelhor, 1986) found that 45% to 50% of a sexually abused adolescent sample scored high, when compared to a norm sample on an aggression and antisocial behavior measure. DeFrancis (cited in Browne & Finkelhor, 1986) reported that 64% of his sexually abused adolescent sample expressed extreme guilt. Again, this is not to suggest that guilt, aggression or antisocial behavior are unique to survivors of sexual abuse, only that these may be difficulties experienced by sexually abused adolescents. Browne and Finkelhor (1986) acknowledged that there are few studies which assess the constructs of aggression, antisocial behavior and guilt, making it difficult to obtain a more accurate measure of these constructs.

Adults, too, may suffer from the effects of sexual abuse which occurred when they were children and adolescents. Ratican (1992) reported on the effects that childhood sexual abuse may have had on adults. Potential effects can be summarized as follows:

1. a higher incidence of depression, including suicidal ideation, eating disorders and sleeping disorders;

2. low self-esteem, including lack of self-confidence, feelings of hopelessness or shame, self-abusive behavior, impulsive behavior and procrastination;

3. inappropriate guilt, including feelings of over-responsibility for others and events beyond one's control or perfectionism;

4. increased levels of anger, often exhibited by irritability, explosiveness, fits of rage for no apparent reason and overly passive or aggressive behavior;

5. higher frequency of anxiety related problems, including panic attacks, insomnia or phobias;

6. somatization diagnoses including pelvic pain, genital or urinary problems, gastrointestinal problems or difficulty swallowing;

7. relationship problems, including being sexually, emotionally or physically abused or abusive, being overly passive or hostile, a poor sense of personal boundaries or an extreme fear of intimacy;

8. difficulties in sexuality, including sexualizing most relationships, being inappropriately seductive, sexual compulsiveness or promiscuousness, lack of sexual desire, flashbacks of abuse during sex or fear of being touched;

9. negative body image, including obesity, obsessed with body appearance, poor or perfectionistic grooming or self-mutilation;

10. denial of abuse, including amnesia of parts of childhood, down-playing of effects of abuse or discounting the pain experienced by other survivors; and

11. increased levels of dissociation, including omissions of periods of time, feeling cut-off from body, learning problems, hearing voices or multiple personalities. (p. 37)

Ratican's conclusions stem from clinical observations and other researchers, not through empirical evidence.

Browne and Finkelhor (1986) reported in their review of sexual abuse literature that depression is the most frequent symptom reported by survivors of sexual abuse. They cited several authors (Bagley & Ramsay; Briere & Runtz; Peters; Sedney & Brooks) who, through empirical research, found significant differences between abused and non-abused populations. In a study of 153 women in a clinical population, Briere (cited in Browne & Finkelhor, 1986) found that 51% of the sexually abused population was suicidal. This compares to 34% of the non-abused population. Browne and Finkelhor suggested that this is a significant difference.

Briere, (cited in Browne and Finkelhor, 1986) describing a clinical sample, reported that 54% of abuse survivors reported anxiety attacks, as compared to only 28% of non-abused persons reporting such attacks. Fifty-four percent of sexual abuse survivors, compared to 23% of non-abused persons, reported intrusive nightmares. Seventy-two percent of sexual abuse survivors, compared to 55% of non-abused persons, had sleeping difficulties. Briere also found that social isolation was a problem for 64% of the sexually abused population, while only 49% of a non-abused clinical population experienced social isolation. Other studies (Bagley & Ramsay; Courtouis; Herman; Sedney & Brooks) mentioned by Browne and Finkelhor (1986) all found similar results.

Browne and Finkelhor (1986) summarized the observations of other authors who compared sexual abuse survivors to non-abused individuals. These authors found that the survivors showed significantly poorer self-concepts, self-esteem, interpersonal relationships, sexual adjustment difficulties and higher levels of prostitution, drug abuse, and alcohol addiction. All of these studies were conducted on a variety of individuals with a number of different instruments. Browne and Finkelhor did not mention the limitations of these studies.

Some authors have suggested that women who have been sexually abused are at risk of re-victimization because they do not understand the effect the first experience of abuse had on them (Wyatt, Gutherie & Notgrass, 1992). De Young (1984) explains:

> These children, in other words, actually sought out and engaged in the very activity that caused anxiety in the first place. In their effort to master the anxiety [created by the initial trauma of sexual abuse], they became "participant victims," initiating and maintaining sexual relationships with exploitative adults, in which each encounter reduced their level of anxiety and strengthened their existing defenses against the residual anxiety. (p. 336)

DeYoung suggested that children often develop a counterphobic response to the trauma of sexual abuse. DeYoung based her conclusions on her clinical observations.

Russell (1986; cited in Browne & Finkelhor, 1986) found in a population of 930 women, 33% to 68% of the women who had been sexually abused were sexually assaulted at a later date.

This compared to 17% of the non-abused population. Russell also found that between 38% to 48% of sexually abused women married physically abusive husbands. This compared to 17% of women who had not been sexually abused. Forty percent to 62% were later abused by their husbands, compared to 21% of women who had not been abused. Browne and Finkelhor (1986) offered no explanation for the variation of the figures for the abused population. They reported that there was a variety of sexual abuse which women in the sample experienced. They also reported that several authors (Briere; Fromuth; and Miller et al.) reported similar findings.

Gagliano (1987) found that survivors of sexual abuse often experience fear of the dark, fear of strangers, have increased levels of substance abuse, and poor attendance at school or work. Fallon and Coffman (1991) reported increased levels of substance abuse, promiscuity and prostitution, suicide attempts, feelings of poor self-esteem and an array of other symptoms similar to those cited above. Sexual abuse survivors also have been reported to exhibit extreme problems in social adjustment, perceive themselves as different from people close to them, and are less connected to their families of origin. Children who experience abuse that involves a parent or intercourse, show higher levels than other survivors in the areas of social maladjustment and perceived isolation (Harter, Alexander & Neimeyer, 1988).

Wheeler and Walton (1987) reported that sexual abuse survivors who took the Minnesota Multiphasic Personality Inventory were most likely to demonstrate elevation on the Psychopathic Deviance scale, the Schizophrenia scale and the Depression scale. They also reported that results from the Leary Interpersonal Checklist, the Gambrill-Richey Assertion Inventory, the Parental Attributes Questionnaire and the Rorschach Projective Test suggest that survivors of sexual abuse are unassertive, have poor self-esteem, have problems developing intimate relationships and problems expressing anger. Braver, Bumberry, Green and Rawson (1992), in a study of a university counseling center population, found clients reporting sexual abuse experienced more psychological problems than non-abused clients according to scores on the Personal Information Questionnaire, the Brief Symptom Inventory, the Beck Depression Inventory and the Millon Clinical Multiaxial Inventory.

Knight (1990), in observations of sexual abuse groups, reported that survivors often struggle with feeling isolated, dirty, guilty, unable to protect themselves and distrustful of others, and that they experience flashbacks, nightmares and hopelessness. In a study of 98 female psychiatric inpatients, who were predominantly white and middle class, 36% reported a history of child sexual abuse. Seventy-seven percent of this population scored significantly higher than the median on the Dissociative Experiences Scale. Allers, Allers and Benjack

(1992) have investigated the high incidents of chronic depression and dementia in older adults (over 65) and have found a correlation between these symptoms and child sexual abuse.

Briere (1988) compared the mean scores on the Crisis Symptoms Checklist of 195 abused and non-abused female clients, and found significant differences in the results. The results of this study are listed in Table 1. Though the p values vary for the different variables, Briere stated, "the results of the current investigation, as do those of other recent studies, offer strong support for the notion that sexual abuse in childhood produces long-term psychological problems" (p. 331).

The trauma of sexual abuse has also been compared to other forms of trauma (Sprei & Goodwin, 1983). Byers (1990) described the effects of trauma as chronic traumatic neuroses. She explains, "the sexual abuse experienced as a child is a trauma and the aftereffects are similar to those of survivors of other traumas" (p. 26). Kilgore (1988), in an article describing the symptoms of child sexual abuse, presented his argument "many researchers espouse the adaptive-survival concept for symptom formation, diagnostically labeled post-traumatic stress disorder" (p. 228). In his book, Trauma in the Lives of Children, Johnson (1989) also placed reactions to child sexual abuse into the DSM-III-R diagnostic category of Post-Traumatic Stress Disorder (PTSD). Behaviors such as

hypervigilance, nightmares, flashbacks, dissociation and sleep disturbances are all symptoms of PTSD that are exhibited by the sexual abuse survivor (Briere & Elliott, 1992).

Craine, Henson, Colliver and MacLean (1988) stated that many of the sexually abused psychiatric patients which they observed demonstrated symptoms congruent with PTSD.

Table 1. Mean Scores on the Crisis Symptoms Checklist.

Variables	Abused (n=133)	Non-abused (n=61)	p <
Dissociation	.53	.29	.0001
Sleep Problems	.76	.60	.0007
Sex Problems	.65	.40	.0001
Anger	.49	.32	.0008
Alcoholism	.28	.03	.0001
Drug Addiction	.32	.08	.0002
Sexual Assault	.43	.13	.0001
Self-Mut	.08	.00	.0197
Suic. Ideation	1.11	.42	.0001
			p.330

Nevertheless, many of these patients had not been given this diagnosis. In 1980, the American Psychiatric Association reported that the cluster of symptoms which may be experienced by sexual abuse survivors is comparable to the symptoms associated with PTSD (Fallon and Coffman, 1991). Patten, Gatz, Jones and Thomas (1989) reported that all of the symptoms which are present in PTSD are present in many

survivors of sexual abuse. These authors suggested that sexual abuse creates disruptions and symptoms in peoples lives which are similar to those seen in veterans of war or victims of natural disasters.

As mentioned earlier in the consideration of the incidence of sexual abuse, it is necessary to recognize differences in populations, difficulties in self-report assessments, and the potential that reports of abuse are based on false memories.

Gelles and Conte (1990) also reported that while there is evidence of cognitive, emotional and social difficulties in children who have been sexually abused, there are no retrospective studies which measure these elements before the abuse. The inability to measure pre-abuse psychological levels is something that is not mentioned in the majority of the literature. If an individual is experiencing pre-abuse difficulties, research and documentation of the effects of sexual abuse may be inappropriately skewed, adding to the assumption that sexual abuse was the cause of the symptoms reported by survivors. It is also possible that if there were pre-abuse psychological conditions present, they may have contributed to subject's vulnerability to abuse.

Developmental Effects of Sexual Abuse

This section of the literature review considers research which explores the effect sexual abuse may have on survivors psychological development.

As children move through the formative years of their lives, they usually begin to accomplish developmental tasks such as changing their relationship with parents, cultivating a sense of who they are in relation to others, learning respect for authority and acquiring necessary socialization skills. Children who have been sexually abused may have trouble with assertiveness and self-sufficiency, respecting persons who are authority figures, and managing their anger. This often leaves children isolated and unable to encounter the experiences necessary to accomplish developmental tasks (Gagliano, 1987). Though Gagliano suggested sexual abuse prevents children from achieving developmental milestones, he provides no systematically gathered, empirical evidence.

Burgess (1985) explained that "the major task for the adolescent is gaining a sense of identity" (p. 12). He suggested that sexual assault or abuse is an ego shattering experience for both the female and male adolescent. Byers (1990) used Erikson's model of development to explain the reactions that adolescents have due to sexual abuse. The author reported that sexually abused adolescents are struggling with many developmental tasks including the development of a sexual identity. As survivors of sexual

abuse, they often learn to use sex as a tool for protection. They may also identify sex as something which is disgusting and to be avoided. Both of these attitudes may have detrimental effects on identity formation as the child moves from adolescence to adulthood and becomes aware of the wrongness of the sexual abuse.

Survivors of sexual abuse usually seek help for symptoms such as depression, poor self-esteem or substance abuse. These symptoms may be viewed as difficulties in achieving developmental milestones. Interpersonal relationships are also affected by developmental deficits. Survivors often mature with relationship imbalances and will tend to recreate these relationships throughout their lives (Byers, 1990). Though Byers offered ample anecdotal evidence to support her suppositions, she offered no systematically gathered empirical evidence.

McFadden (1987) reported on the importance of creating a safe environment for children who have been sexually abused. McFadden suggested that sexual abuse arrests the normal development of childrens' personalities and it is necessary to create a safe environment within the counseling relationship to move their development forward. McFadden suggested that arrested development is due to years of abuse and it is necessary to consider the differences between the developmental stage and the chronological age of a sexual abuse survivor. Developmental stages are sequential and

cannot be skipped. Therefore, survivors may need to re-experience earlier stages in order to move past the effects of the abuse. Though these contentions seem to have face validity from clinical observations, Mcfadden offered no systematically gathered empirical evidence.

Brown and Finkelhor (1986) reported one of the long-term effects of sexual abuse may be difficulties in psychological development. Gagliano (1987) reported that many children who experience sexual abuse "fail to accomplish the normal developmental tasks of childhood and adolescence" (p. 103). She continued to explain that experiencing an adult sexual relationship is more than the child's psyche can manage. Briere (1992a) reported that when an investigator conducts research with survivors of sexual abuse, it is important to consider developmental issues when explaining variability in results. Though these authors seem to have gathered data from their clinical observations, they offer no empirical evidence.

Briere (1992b) in his book, which is one of four in the Interpersonal Violence Series, states:

> Abuse-focused therapy suggests that the client is not mentally ill or suffering from a defect, but rather is an individual whose life has been shaped, in part, by ongoing adaptation to a toxic environment. Thus the goal of therapy is less the survivors recovery than his or her continued growth and development. (p.82)

Briere would seem to have suggested that sexual abuse does negatively affect development. He goes on to mention that sexual abuse trauma often causes normal development to diverge

from the norm. Nevertheless, he offered no systematically gathered empirical evidence which would substantiate this inference.

Mcfarlane (1978) reported that it is hard to determine the effects of sexual abuse. She explained that there are many factors which may determine the reaction to the abuse by the child. They include:

> Age and developmental status, the relationship of the abuser to the child, the amount of force or violence used by the abuser, the degree of shame or guilt evoked in the child for her participation, and, perhaps most importantly, the reaction of the child's parents and those professionals who become involved in the case (p. 61).

Though Mcfarlane believed these factors influence the degree of severity in response to sexual abuse, she suggested that sexual abuse leads to the formation of a "victim mentality" (p. 55), as survivors' personalities develop. The victim mentality often transcends any efforts to help survivors eliminate a negative self-image. King (1983) reported that sexual abuse often leads to an abusive sexual self-identity which affects development. King added that lack of self-identity may lead to further victimization. Though this evidence would seem logical, these authors offered no empirical evidence which would purport this to be true.

Cole and Putman (1992) examined the effects of sexual abuse from a Self Psychology perspective. Self Psychology postulates that the development of the internal sense of self and the external social self begins in infancy and continues

through childhood, adolescence and adulthood. As individuals mature throughout their lives, they encounter developmental transitions which usually result in a redefinition of their internal and social selves. Through this process, individuals develop the ability to regulate their behavior and affect in a manner which seems congruent with the social situation. Cole and Putman observed the behaviors of sexual abuse survivors and concluded that sexual abuse severely impacts this process.

For example, Cole and Putman (1992) suggested that while abused toddlers and preschoolers may not have a sense of social taboos against incest, there seems to be a lack of development of the self as separate from others. The trauma of the penetration of a child's body by a caretaker's finger or penis results in developmental difficulties in trust or a sense of not being able to control threatening events. In later childhood, ages seven to nine, the more common experiences of development would allow the child to increase social exploration and gain competence in the world beyond the home. However, the sexually abused child often is isolated and, coming to realize the implications of abuse, is filled with guilt and shame. At this stage of development, sexual abuse seems to interrupt the "integration of positive and negative aspects of self and realistic self-appraisal" (p.178). Unable to integrate the experience of the abuse, the

child often reverts to either denial or dissociation in order to deal with the overwhelming events.

Cole and Putman (1992) suggested the lack of completion of developmental tasks continues as the child moves into adolescence. A sexualized relationship with a parent or someone who is much older becomes even more socially inappropriate. This leads to confusion and disorder during the critical development of the sexual self. Adolescents are also trying to consolidate many different aspects of the internal and social self. Sexual abuse, again, creates unusual experiences that are difficult to integrate. Cole and Putman (1992) suggested that as the adolescent moves into adulthood, social expectations create situations and expectations which become even more disrupting to the disorganized self. Problems in intimacy, decision making, communication, sexuality and regulations of personal boundaries become apparent. Though comparison of behaviors which are apparent in sexual abuse survivors and developmental deficits defined by Self Psychology seem to correlate, Cole and Putman offered no empirical data to substantiate these inferences. They offered no instruments which would allow for systematic measurement of Self Psychology developmental delays of sexual abuse survivors.

Alexander (1992a), in an introductory article for a special issue about adult survivors of sexual abuse in the Journal of Consulting and Clinical Psychology stated "sexual

abuse occurs within the context of normal developmental changes in a child and therefore is bound to interact with other events and developmental processes" (p. 165). Alexander (1992b) studied the effects of sexual abuse, specifically incest, according to the principles of Attachment Developmental Theory. Attachment Developmental Theory postulates that infants and children have a biological attachment to their primary caregiver. This attachment at first may be for protection but later it serves the purpose of developing expectations of the individuals' and others' roles in relationships. This can lead to either the development of trust and worthiness or mistrust and unworthiness.

Alexander (1992b) observed that victims of incest often are rejected by one or both of their primary caregivers except in incidence of sexual contact. This leads to interpersonal difficulties, a negative self-image and problems in control of affect, leading to periods of depression and anxiety. Again, Alexander relied on clinical observations of behavior rather than systematically gathered, empirical evidence. However, Socarides (1983) reported that children who suffer rejection and sexual abuse from parents often develop the defense mechanism of splitting the personality into different parts. This would suggest that the lack of attachment through rejection or sexual abuse results in severe disturbances of human development. Symptoms which demonstrate the lack of attachment seem to fit with symptoms seen in survivors of

sexual abuse. However, these authors offered no empirical evidence which substantiates this supposition, nor did they offer any instruments which would allow for the investigation of developmental levels of attachment of sexual abuse survivors.

As mentioned earlier, symptoms associated with the diagnosis of PTSD have been linked to both survivors of trauma and sexual abuse (Briere & Elliott, 1992; Byers, 1990; Fallon & Coffman, 1991; Johnson, 1989; Kilgore, 1988; Patten, Gatz, Jones & Thomas, 1989; Sprei & Goodwin, 1983). Everly (1993), in his work with survivors of trauma, utilized Abraham Maslow's theory of human development to explain PTSD symptoms. Maslow developed a hierarchy of needs which are necessary for a person to reach full psychological potential. This hierarchy begins with needs such as food and water. After these most basic needs are met, individuals can then begin to address other needs such as safety, a sense of belonging and being loved by others. With these needs met, individuals may then turn to satisfying the needs of self-esteem and finally, self-actualization (Hergenhahn, 1991). However, these needs may not be met when traumatic experiences are encountered.

Everly (1993) reported that trauma violates individuals' ability to keep themselves safe. This results in the development of individuals returning to the stage of safety and remaining there until the need for safety is met. This may result in hypervigilance or intrusive thoughts; two

symptoms which are often seen in clients with PTSD and in survivors of sexual abuse. Like others, Everly (1993) offered no systematic method or assessment by which Maslow's developmental theory can be empirically established.

Hall, Kassees and Hoffman (1986) seem to have supported this contention when they compared victims of sexual abuse to other victims of serious trauma. They suggested that sexual abuse trauma "results in an arrest of socioemotional development" (p. 86). They continued to explain that when the abuse stops, children often do not return from their sexual adult role to a typical developmental level. Therefore, it is important to consider developmental remediation as an integral part of therapy. Braver, Bumberry, Green and Rawson (1992) reported that arrests in development often result in difficulties trusting and becoming intimate with others. Poston and Lison (1989) reported that trust is the foundation for the development of a healthy personality. They cited Erik Erikson's Basic Trust as the principle component needed for children to gain self-acceptance and feel accepted by others. They reported that sexual abuse betrays the sense of trust at a most fundamental level, leaving the child unable to develop a healthy sense of self. Furthermore, Hall, Kassees and Hoffman (1986) suggested that if basic trust is not acquired in childhood, it is difficult to attain in adulthood. Though a trauma, such as sexual abuse, would seem to disrupt trust of

the world and of others, these authors offered no empirical evidence to support their conclusions.

Johnson (1989), who compared the symptoms of sexual abuse to PTSD, viewed Erickson's model of human development as an important concept when understanding the effects of sexual abuse. He described Erikson's theory as it pertains to sexual abuse:

> Development, then, is a process of transformation through stages characterized by specific demands, opportunities, and vulnerabilities. As Erikson suggests, adverse conditions may affect development in stage specific ways. This disruption affects not only the stage during which the event occurred but also resolution of tasks in subsequent stages. (p. 56)

He concluded by stating the importance of exploring developmental deficits in children who have experienced sexual abuse.

Murdy (1986), in his work with survivors, reported that each stage of Erikson's theory is often unresolved for sexual abuse survivors. For the child who is being sexually abused, trust is often replaced with secrecy, deceit or reversal of roles; autonomy is often replaced with powerlessness; initiative is often replaced with a feelings of inadequacy as the child tries to fulfill adult responsibilities; industry is often replaced with trying to meet the needs of others, especially sexual needs; identity is often replaced with a sense of oneself as a victim; intimacy is often replaced with only feeling close to another when one is being sexual. These

authors suggested, through observational evidence, that developmental stages in Erikson's theory are affected by sexual abuse. However, they did not offer any systematically gathered empirical evidence which would support this supposition.

Though the literature cited above clearly suggests that sexual abuse affects the psychological development of survivors, at the inception of the current study there is no empirical evidence which measures the degree or breadth of developmental delays in sexual abuse survivors. There is also no literature which describes the use of an instrument to measure developmental levels in sexual abuse survivors, regardless of the theoretical framework.

Summary of the Literature Review

The literature cited above indicates that reports of sexual abuse are increasing and that sexual abuse is a violation which many women and men experience in our society. The effects of sexual abuse are explored in the literature. The effects cited are wide ranging and in many cases, severe and life long. Many authors cited a variety of DSM-III-R diagnoses which have been observed in survivors of sexual abuse. There is also speculation in the literature that there is a connection between sexual abuse and arrests in psychological development. Several authors have tried to explain observed symptoms in sexual abuse survivors by using

a variety of psychological developmental theories. However, there is no empirical evidence which documents psychological developmental levels among survivors of sexual abuse. The purpose of this study was to explore the question, do women in counseling who have experienced sexual abuse show a significant difference in their psychosocial development in comparison to women who are not known to have experienced sexual abuse?

CHAPTER 3

METHODS AND PROCEDURES

In this chapter, the methods and procedures for the study will be outlined. The chapter begins with a statement of the hypothesis which was tested (stated in both the null and alternative hypothesis format) then proceeds to a discussion of the design of the study, the sample, a description of the assessments, and procedures for data collection and analysis.

Hypotheses

The null hypotheses stated:

Ho_1: A t test analysis will reveal no significant difference between subjects' experience of sexual abuse and their level of development on the Trust versus Mistrust scale (R1), as measured by the Measures of Psychosocial Development (MPD).

Ho_2: A t test analysis will reveal no significant difference between subjects' experience of sexual abuse and their level of development on the Autonomy versus Shame and Doubt scale (R2), as measured by the Measures of Psychosocial Development (MPD).

Ho_3: A t test analysis will reveal no significant difference between subjects' experience of sexual abuse and their level of development on the Initiative versus Guilt scale (R3), as measured by the Measures of Psychosocial Development (MPD).

Ho_4: A t test analysis will reveal no significant difference between subjects' experience of sexual abuse and their level of development on the Industry versus Inferiority scale (R4), as measured by the Measures of Psychosocial Development (MPD).

Ho_5: A t test analysis will reveal no significant difference between subjects' experience of sexual abuse and their level of development on the Identity versus Role Confusion scale (R5), as measured by the Measures of Psychosocial Development (MPD).

Ho_6: A t test analysis will reveal no significant difference between subjects' experience of sexual abuse and their level of development on the Intimacy versus Isolation scale (R6), as measured by the Measures of Psychosocial Development (MPD).

Ho_7: A t test analysis will reveal no significant difference between subjects' experience of sexual

abuse and their level of development on the Generativity versus Stagnation scale (R7), as measured by the Measures of Psychosocial Development (MPD).

Ho_8: A t test analysis will reveal no significant difference between subjects' experience of sexual abuse and their level of development on the Integrity versus Despair scale (R8), as measured by the Measures of Psychosocial Development (MPD).

Ho_9: A t test analysis will reveal no significant difference between subjects' experience of sexual abuse and their reported level of distress on the Global Symptoms Index (GSI), as measured by the Symptoms Checklist 90 Revised (SCL-90-R).

The alternative hypotheses stated:

H_1: A t test analysis will reveal a significant difference between subjects' experience of sexual abuse and their level of development on the Trust versus Mistrust scale (R1), as measured by the Measures of Psychosocial Development (MPD).

H_2: A t test analysis will reveal a significant difference between subjects' experience of sexual

abuse and their level of development on the Autonomy versus Shame and Doubt scale (R2), as measured by the Measures of Psychosocial Development (MPD).

H_3: A t test analysis will reveal a significant difference between subjects' experience of sexual abuse and their level of development on the Initiative versus Guilt scale (R3), as measured by the Measures of Psychosocial Development (MPD).

H_4: A t test analysis will reveal a significant difference between subjects' experience of sexual abuse and their level of development on the Industry versus Inferiority scale (R4), as measured by the Measures of Psychosocial Development (MPD).

H_5: A t test analysis will reveal a significant difference between subjects' experience of sexual abuse and their level of development on the Identity versus Role Confusion scale (R5), as measured by the Measures of Psychosocial Development (MPD).

H_6: A t test analysis will reveal a significant difference between subjects' experience of sexual abuse and their level of development on the Intimacy

versus Isolation scale (R6), as measured by the Measures of Psychosocial Development (MPD).

H_7: A t test analysis will reveal a significant difference between subjects' experience of sexual abuse and their level of development on the Generativity versus Stagnation scale (R7), as measured by the Measures of Psychosocial Development (MPD).

H_8: A t test analysis will reveal a significant difference between subjects' experience of sexual abuse and their level of development on the Integrity versus Despair scale (R8), as measured by the Measures of Psychosocial Development (MPD).

H_9: A t test analysis will reveal a significant difference between subjects' experience of sexual abuse and their reported level of distress on the Global Symptoms Index (GSI), as measured by the Symptoms Checklist 90 Revised (SCL-90-R).

Design Statement

In this section the type of research design which was employed in this study is discussed.

A correlational research design was employed in this study. Gay (1992) characterizes a correlational study as a research method which utilizes quantitative data to demonstrate the degree of the relationship between two or more variables. The strength of this relationship can be depicted by a t test comparing the level of development and level of reported distress between women who have experienced sexual abuse and women who have not experienced sexual abuse.

Gay (1992) reported "the t test is used to determine whether two means are significantly different at a selected probability level" (p. 436). The means of each of the two groups, women who have experienced sexual abuse and women who have not experienced sexual abuse, were compared in each of the MPD's stages and the GSI of the SCL-90-R. The t test determines if the difference between the two means happened by chance. This is accomplished through establishing a probability level. If the probability level calculated by the t test is less than or equal to the probability level which was established by the investigator, the difference between the two means is significant. If the two means are determined to be significant, it can be assumed that they did not occur by chance. This would indicate that different levels of development and distress on one variable are associated with experience (or no experience) of sexual abuse. The probability level for this study was established at $p = .05$,

meaning there is only a five percent chance that the differences between the two groups happened by chance.

Sample

This section discusses sample selection and the limitations of generalizing to other populations.

Women for this study were selected from clients at the Human Development Training and Research Clinic, the Montana State University Counseling and Psychological Services and selected counselors in the community of Bozeman, Montana.

The Human Development Training and Research Clinic serves a population which consists of residents of Bozeman, Montana and the greater Gallatin County, Montana, area. This population is mostly caucasian but includes several minorities, in particular Native Americans. The population of the clinic could generally be described as lower to middle socioeconomic class. The clinic also serves Montana State University staff as a part of the Employees' Assistance Program. The staff at the clinic are graduate students who are obtaining their masters degrees in Mental Health Counseling, Marriage and Family Therapy or School Counseling.

The Montana State University Counseling and Psychological Services Center serves the campus population at Montana State University. Though the majority of students at the University are from the State of Montana, the University also serves students from other states throughout the United States. The

population is mostly caucasian but the center does serve a variety of individuals from a variety of cultures, including students from foreign countries. Clients at the center come from a variety of socio-economic classes. The staff of this center is comprised of clinical and counseling psychologists, a psychiatrist, a social worker, pre-doctoral interns and masters level practicum students.

Counselors in the community of Bozeman, Montana, serve clients similar to the population served by the Human Development Training and Research Clinic. However, clients served by counselors in the community would generally come from a higher socioeconomic level.

This study involved women between the ages of 18 and 60 years. All participants were involved in individual, family or group counseling. Participants were referred by their primary therapist to the study after the client reported the presence or absence of abuse. Participants who had experienced sexual abuse remembered the sexual abuse or had other evidence that it occurred (i.e. report by parent to participant or authorities). They also were willing to disclose in writing their age, their level of education, the age at which they were abused, the duration of the abuse, the amount of time they have spent in therapy and the concerns addressed in therapy.

Participants who had not experienced sexual abuse agreed to disclose their age, level of education and duration of

therapy. Both groups signed a subject consent form for participation in human research (see Appendix B). The sample size of 20 participants who had experienced sexual abuse and 14 participants who had not experienced sexual abuse were utilized. Of the 14 women who had not experienced sexual abuse, six were referred from the Human Development Training and Research Clinic, four were referred from the Montana State University Counseling and Psychological Services Center and four were referred from counselors in the community of Bozeman, Montana. Of the women who had experienced sexual abuse, 11 were referred from the Human Development Training and Research Clinic, seven were referred from the Montana State University Counseling and Psychological Services Center and two were referred from counselors in the community of Bozeman, Montana.

Demographic information concerning the participants was as follows: of the 34 women who participated, 14 (41.2%) had experienced no sexual abuse and 20 (58.8%) had experienced sexual abuse. Of the participants who experienced sexual abuse 15 (75%) were abused before the age of 12, 12 (60%) had experienced sexual abuse by a blood relative or step-parent, 3 (15%) were abused as children by someone other than a relative, 7 (35%) experienced some combination of incest and non-incest child sexual abuse and 5 (25%) were sexually assaulted after the age of 12. The mean age of the group which had not experienced sexual abuse was 34 years old

(standard deviation of 8.081) and the mean age of the group which had experienced sexual abuse was 35.8 years old (standard deviation of 6.521).

The concerns addressed in therapy for the women who experienced sexual abuse included sexual abuse, self-esteem, depression, sexuality issues, feelings of worthlessness, substance abuse issues, dissociation, unexplainable fears, an inability to trust others, over-weight issues, PTSD, and interpersonal problems. The concerns addressed in therapy by women who had not experienced sexual abuse included stress, self-esteem, depression, loneliness, communication skills, feelings of worthlessness, substance abuse, self-growth and interpersonal problems.

Level of education for the group which had experienced sexual abuse was 1 (5%) less than high school diploma, 3 (15%) with a high school diploma, 11 (55%) currently in college and 5 (25%) with college degrees. For the group which had not experienced sexual abuse the level of education was 7 (50%) currently in college and 3 (21%) with a college degree and 4 (29%) with more than a college degree.

Limitations of the results for generalizing to other populations include: the limited number of participants; the lack of ethnic diversity of the sample; and the specific geographic setting.

Instruments

This section reviews the two specific instruments which were used to measure the variables. It also includes the validity and reliability measures, norms and prior use of each of the assessments and the method by which the data were collected and compiled.

Measures of Psychosocial Development

The first instrument discussed is the Measures of Psychosocial Development which was developed by Gwen A. Hawley in 1980, then revised in 1984 and 1988. The Measures of Psychosocial Development (MPD) measures positive, negative and overall resolution of psychosocial developmental according to Erik Erikson's theory. It is a 112 item, self-report instrument which asks individuals to respond to each item according to a five-level, Likert scale, as follows: (A) Not at all like me, (B) Not much like me, (C) Somewhat like me, (D) Like me, and (E) Very much like me. Each individual rates each item according to this scale. Items are arranged in seven sections in the test booklet.

As the MPD was developed, the first criteria was to write items which adhere as closely as possible to Erikson's theory. For example, the instrument provides a score for an individual's level of Trust, a score for an individual's level of Mistrust and a score of the level of resolution between

Trust and Mistrust. The level of resolution is conveyed as either positive conflict resolution, a higher level of Trust than Mistrust, or negative conflict resolution, a higher level of Mistrust than Trust. The instrument addresses each of the separate attitudes which result in conflict resolution, not in opposition to each other, but rather as dualities which individuals struggle with concurrently throughout life (Hawley, 1988). For example, at any time in a person's life it is possible to have both Trust and Mistrust playing a role in situations which a person encounters. The MPD measures which of these constructs dominates in a majority of situations, considering the age of the individual at the time of the assessment.

Hawley (1988) also hypothesized that it would be confusing and complicating, rendering the assessment unusable for gathering data, to write items which would follow Erikson's epigenetic principle. Therefore, each item was written to represent attitudes that relate only to a specific stage construct. Again using the stage of Trust versus Mistrust as an example, the MPD measures the level of Trust in items 1, 17, 33, 49, 65, 81 and 97. It measures the level of Mistrust in items 9, 25, 41, 57, 73, 89 and 105. To follow Erikson's epigenetic principle, the items which measure Trust would have to be included in the items which measure Autonomy, the items which measure Trust and Autonomy would have to be included in the items which measure Initiative, and the items which

measures Trust, Autonomy and Initiative would have to be included in the items which measure Industry. This would have to continue until each item which measured a previous stage was included in that stage. The same principle would hold true for all negative levels of resolution.

The MPD is designed for administration to caucasian individuals and is not recommended for use with non-caucasian individuals unless local norms have been established. Any individual taking the MPD must be able to read at a sixth grade level. The normative population consisted of 2,480 individuals, ages 13 to 86, 62% women and 38% men. T scores ranging on any of the MPD scales from 40 to 59 are considered normal. Scores between 30 to 39 are considered low and scores 60 to 69 are considered high. Scores above 70 and below 30 only occurred 4% of the time in the norm population. Separate age profiles exist for the age classifications 13 to 17, 18 to 24, 25 to 49 and over 50 years. Separate age profiles exist for males and females (Hawley, 1988).

Reliability Coefficients for the MPD

Hawley (1988) reported the test-retest reliability coefficient of overall conflict resolution from .91 to .75 (Table 2). Test-Retest reliability suggests that scores for a person will remain relatively stable over time intervals, one indication that the measure is assessing real rather than error variance. The time intervals for the MPD ranged from 2 to 13 weeks. Hawley (1988) reported that the test-retest