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# Research & Advocacy Digest

*Linking Advocates & Researchers*

# Long-Term Effects of Childhood Sexual Abuse

## Letter From The Editor

Andrea Piper, Advocacy Specialist, WCSAP

The articles and featured interview in this issue explore long-term effects of childhood sexual abuse (CSA) to adult survivor well-being and functionality.

Upon filtering through the research and critically thinking about reported effects to survivor well-being and functionality, three challenges become quite apparent. These include,

1. designing comprehensive and representative CSA effect studies is intrinsically difficult;
2. there is a need for consistent terminology use between research and field and;
3. as an anti-rape movement we must reflect on the necessity and responsibility to appropriately integrate research findings rather than interpretations into our work.

A person is a culmination of their life experiences which have been shaped by cultural, physical and social mechanisms. How a person reacts to trauma is dependent on these experiences and other external variables that are filtered against their understanding of self and the world. This said, theoretically, for a long-term CSA study to be fully comprehensive it would need to account for all compounding variables (shaping variables) in a person's life, both, before and after an assault. Clearly, for a study, this level of comprehension is unattainable, subjective, and would lose comparative power. However, it is critical to acknowledge and account for survivors having individualized reactions as we examine CSA effects.

Two primary CSA study designs are *prospective* such as, Colman, R.A. and C.A. Widom (2004) or Loh, C. and C.A. Gidycz (2006) (reviewed within) and *retrospective* like McGregor. K. (2006) (reviewed within). Each study type has value and limitations. Consid-

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erations of design type include, but are not limited to, length of time, required monies, access of a representative sample and study goal. Most often, retrospective studies are undertaken because it is difficult to get a representative sample of CSA victims at the time of the abuse or to follow children early in life and monitor/compare those who were abused and their subsequent functioning. When longitudinal/prospective studies are employed they are typically based on documented abuse cases which are not representative of all CSA experiences.

Knowing the considerations of research designs supports our ability to critically review research findings. This is important because research trends and findings greatly impact our work in the anti-sexual assault movement. Findings not only guide treatment options and supportive services, but can affect how victim funds are designated and delivered to programs. This requires those of us providing services to communicate with researchers and to critically review and monitor research findings in an effort to minimize disconnect between research and the field, to ensure that survivor's voices are heard and to see that survivors aren't being adversely impacted. It also requires us as an anti-rape movement to responsibly apply research findings to our work and society as a whole.

Research has documented that CSA survivors are more prone to suffer from physical, social, emotional, cognitive, and behavioral problems than non-survivors. Difficulties include, but are not limited to, anxiety, depression, guilt, fear, sexual dysfunction, difficulty with interpersonal relationships, difficulty trusting, challenged boundary setting, lowered self-esteem, and dissociation.

Research has documented that CSA survivors are more prone to suffer from physical, social, emotional, cognitive, and behavioral problems than non-survivors. Difficulties include, but are not limited to, anxiety, depression, guilt, fear, sexual dysfunction, difficulty with interpersonal relationships, difficulty trusting, challenged boundary setting, lowered self-esteem, and dissociation. With such far-reaching effects, CSA can be viewed as a ***risk factor*** for a wide range of subsequent mental, physical, and social problems. The key phrase is ***risk-factor.*** The research does not demonstrate that CSA survivors are, "irreparably damaged," and we must be conscious that we don't inadvertently promote the idea of concrete outcomes for survivors by discussing effects as givens rather than possibilities.

*Damaged* is a strong word maintained by rape-mythologies. It infers that CSA survivors are 'less than' those who are not survivors, or that CSA survivors are destined to be afflicted with a host of issues that they will carry into their adulthood. For example, a child incest survivor, due to the nature of abuse incurred, may have difficulty forming and maintaining interpersonal relationships, but not necessarily. They may have had support and other foundational structures in place that allowed for navigation of trauma, resulting in an ability to form solid relationships. CSA survivors are statistically at higher risk for altered functioning, but again, it does not mean they will inevitably experience functioning difficulties in adulthood.

Certainly, CSA is a harmful experience that permanently impacts survivors' lives and this dialog does not negate the seriousness of the offense nor its impacts. It serves to promote consciousness so that we as a movement can acknowledge the importance of word choice and promote factual information, to support survivor well-being and accurately inform societal perceptions of survivors. The degree of impact CSA has on a person varies. Studies have demonstrated the following influencing factors: age of the child at abuse; duration of the abuse; relationship with the offender; number of offenders; frequency of the abuse; severity of the assault; and reactions to disclosure (see Ullman, 2003, featured herein).

Allowing a word like "damaged" to define and shape the experiences of a CSA survivor is dangerous and as an adjective for a survivor is objectionable. It should not be synonymously interchanged with "effected." The word leaves no room for human resiliency, individuality, or supportive mechanisms that alleviate trauma symptoms and promote well-being.

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This issue of Research and Advocacy Digest explores articles that discuss effects of victimization as risk factors, rather than inevitable damage. I hope you find the articles and interview enlightening and that they provoke discussion amongst those of you doing the work. ■

# Interview with
# Lucy Berliner
## HARBORVIEW CENTER FOR SEXUAL ASSAULT AND TRAUMATIC STRESS

Interviewed by Andrea Piper, Advocacy Education Director, WCSAP

Lucy Berliner, M.S.W. is Director of the Harborview Center for Sexual Assault and Traumatic Stress. She is nationally recognized for her clinical work and research on sexual assault issues, notably child sexual abuse. She was instrumental in implementing the child sexual abuse protocols for Washington State and has conducted research on the impact of victimization and its treatment.

**WCSAP: Can you share with the readers a little bit about yourself and your work surrounding effects of child sexual assault?**

LB: I started in this field when it was barely a field, back in the early 70's. At that point we didn't even realize that child sexual assault was a significant problem; much less have research and knowledge to base our efforts on. I've had the good fortune to be part of the growing up of the field and to see an increase in children receiving specialized services. Currently, at our program (Harborview Center for Sexual Assault and Traumatic Stress) children represent about half of all sexual assault victims we see.

Over the last 30 years, there has been a wide body of research developed to help us in the field understand the immediate and long term effects of sexual assault experiences and from that we've developed some quality treatment practices for children and adults coping with the effects of child sexual abuse. While there is still work to be done, we have come long way in 30 years.

**WCSAP: We know that child sexual abuse can have long-term effects into adulthood. We also know that the degree of impact CSA has on a person individually varies. Can you share some of the influencing factors that shape responses?**

LB: The research about CSA effects has gotten increasingly sophisticated over the years. In the old days, researchers would simply take a group of people, usually women, who had not been sexually assaulted and compare them on some measure of psychological distress or functioning to a group of women who had been assaulted and draw conclusions from there. Today, researchers are much more conscious about research designs that address the complexities of victims' experiences.

What we have learned from older and current research is that most often there are measurable differences in psychological distress and functioning between the CSA survivors and non CSA survivors. However, there is also a significant overlap and varying ranges of effects among individuals in

the two groups. In other words, there are plenty of people who haven't been sexually assaulted who have experienced depression or who have had post traumatic stress for other reasons; some people have mild problems and others have significant ones. Simply knowing that overall there is a difference between groups with out focusing on the variables that produce individual variations tended to create an impression that all victims of childhood sexual assault would end up with significant problems later on. We now understand this is not accurate. In fact only a minority of all people who have childhood sexual assault experiences end up with significant and persistent psychological conditions.

One of the reasons for this is that the most common experience of child sexual abuse is a one or a few episodes involving an offender who is known but not related, like a neighbor, babysitter, or family friend. Survivors of this experience type are usually impacted, but would not be expected to have life-long serious psychological consequences. This is quite different from ongoing incest. Long-term incest was the type of child sexual abuse experience that used to comprise a majority of cases coming to clinical attention. Because of this, it shaped and defined what we knew about childhood sexual assault experiences, caused generalizations about other forms of CSA and created the perception that it is the most common CSA experience.

In reflection, our movement, in its efforts to overcome the historic tendency to dismiss or discount childhood experiences inadvertently perpetuated this misconception and overstated the case in terms of harm. We did so with good intentions; we were very interested in showing that these experiences were harmful and wanted to make sure that it was realized by the public. However, what we failed to communicate clearly was that although CSA is always wrong, can be very harmful and in many cases changes people's lives but it does not necessarily lead to psychiatric conditions that require formal clinical treatment or persist for years.

Nowadays, we recognize child sexual abuse is a risk factor for long-term impacts. These experiences will quite often cause distress and in about a third of cases it leads to persistent psychological conditions like post traumatic stress disorder or depression. We also understand that CSA can be related to other possible negative outcomes like substance abuse or health problems. Additionally, we recognize that risk for re-victimization goes up once someone has been assaulted in childhood. About half of all adult rape victims have a childhood sexual abuse history. Victims also tend to remain single or get divorced more than women who have not had sexual assault experience.

**WCSAP: I've read that assault severity is an influencing response factor. This has been debated among service professionals, some of whom argue that no matter the degree of severity the effects are equally real and that any discussion of severity undermines survivor experiences. What are your thoughts?**

LB: I think that's a very good example of mixing up advocacy with scientific knowledge and clinical experience. It's just exactly the point I was making earlier that advocates have been very committed to making sure that we respect the experience of victims and acknowledge that regardless of the nature and the specifics of an assault; it can be incredibly distressing and harmful.

This is a perfectly legitimate position in one sense, but it doesn't represent the full range of victims'

experiences. Advocates themselves know this because each victim they see if affected differently, some are extremely severely affected, others have moderate and temporary distress and others are resilient.

In reality, if we are to really respect victims, we should respect what their experience is and not impose an expectation or an assumption that they will be irreparably harmed as a result of their sexual assault experience. Of course, that's not the intent of service professionals, but it is sometimes an unintended consequence. We need to make a distinction between being affected and being harmed and promote a hopeful message about recovery.
Severity of impact on an individual, in both research and clinical contexts, is ascertained by measurement of psychological symptoms or conditions (e.g., PTSD, depression, etc) and how well the child or adult is functioning. This is not the same thing as saying that the experience wasn't severe. An experience can be extremely severe and a particular victim might be unusually capable of coping and adapting.

**WCSAP: In this issue, we discuss negative social perceptions of CSA survivors as 'irreparably damaged'? Can you share your thoughts on this perception?**

LB: To some extent we are the cause of this perception. We in the sexual assault world have tried valiantly to change the social climate and bring to the social consciousness the recognition that sexual assault experiences are harmful. We didn't mean to say all victims are ruined. There is a difference between being affected and being harmed. A person can be affected, their life could be changed and how they look on the world might be altered in ways that you can't actually ever go back from, but that doesn't necessarily make the future less positive. We are all made up of our life experiences. Some are good and some are bad and that's just the nature of being a human being. So, we don't want to attach to an experience the idea that it is only possible for it to have a harmful effect. In fact, there is some current research coming out which shows that victims who are able to extract something positive, some meaning, some idea that it has some positive aspect, to their experience like, "I've learned how important life is" or "I've learned some lessons about my own safety," that those victims actually are doing quite well.

I believe to change this negative perception of 'irreparable damage' we must consciously make an adjustment to the way we speak of the distinction between being affected and being harmed. It's easy to see how the language of damaged/harmed has been integrated into our society. For example, in our civil legal system which is based on awarding money for damages, in essence the more harmed survivors are, the greater the settlement, i.e., the seriousness of the experience is defined primarily by the extent of long-term effects. For a sexual assault survivor this 'incentive' promotes not getting better during the course of the legal process. The dilemma this poses for survivors is evident.

Another complexity is created from for those CSA survivors who don't develop serious mental health problems or who do have difficulties but go on to get help and recover. This situation can lead people around them tend to think that the experience wasn't that big of a deal, or the survivor can lose social support. It is an unfair burden to place on a victim that his or her need for acknowledgement and support is dependant on having serious psychological problems.

**WCSAP: You touched on how this perception impacts survivors? What recommendations would you give to advocates working with a childhood sexual assault survivor who identifies themselves as being 'damaged'?**

LB: I would say that you want to try to help a survivor think about themselves in a way that doesn't involve being 'damaged' or ruined.

In a treatment environment, effective treatments for sexual assault victims are based on the cognitive behavioral theory for why people develop problems. One very important element of this theory is that how people think about their experiences and themselves has a major impact on their psychological condition. So, in the case of a survivor who is thinking "I am damaged," we would target that thought as one that is not accurate and is very unhelpful. We'd try to help a victim arrive at beliefs that are more accurate and more helpful. An example would be, "Yes, I am changed because of this experience, but I am not ruined. I have learned that I am capable of withstanding very difficult experience and emerging as a decent, caring and aware person." Cognitive behavioral treatment focuses very much on challenging and changing cognitions of victims that relate to self blame or shame.

An advocate should, in my view, take a similar position which is to distinguish between a person being affected and potentially harmed. I think advocates need to be very cautious about stepping out of their role, but if a victim were to express views that were clearly inaccurate and unhelpful I think it is a good idea for an advocate to gently suggest that maybe there is a better and different way of thinking about this.

**WCSAP: Thinking about child sexual abuse research, do you believe this perception of being permanently and negatively effected is being perpetuated? Please explain why or why not.**

LB: I don't think the research has ever perpetuated or taken that point of view. Research presents results; the interpretation of the results is where the problems tend to come in. Sometimes researchers overstate results or overemphasize certain aspects of their findings without putting them in context. This can happen both in the direction of overstating harmful effects and in the direction of understating or minimizing them.

A classic example of understating is the infamous Rind et al [1] controversy. The authors published a meta-analysis of various long term outcome studies demonstrating that there were hardly any long-term effects of CSA. There were methodological problems with the analysis they did, but they weren't totally off base in their point that it was a significant exaggeration to claim that the majority of victims were severely harmed by these experiences. Where they went wrong was in their discussion and interpretation. For example, they went to an extreme of saying that we shouldn't even call it abuse unless it could clearly shown that the acts were unwanted and that there was harm; It should be called some neutral term like "adult-child sex" and perhaps then we should revisit penalties. Of course, that created quite a furor as it should have.

The research itself has basically said the same thing all along. There are group differences between survivors and non-sexual assault victims, but within groups there is variation. Some people are not

noticeably harmed in ways that can be measured, others are. Some people are severely harmed, but most survivors are in the modest range of negative effects. It is interpretations and how people use research results in other environments where I believe problems arise.

**WCSAP: I appreciate the conversation about interpretation versus findings. Why is it that we as a movement may have focused on interpretations?**

LB: It's human nature to want to rely on research that tends to support positions that we already have and to be skeptical or discounting of research that doesn't. The key is to really pay attention to what the research actually says. Is it a good study? How did they measure variables? When we overstate the case we don't actually help victims. Not only by presenting the message to a victim, him or herself, that they are horribly harmed, but as well in stating positions to the general public, where people say "well, that doesn't make sense with my experience."

**WCSAP: When researchers create a study that looks at the effects of child sexual abuse on adult functioning there is obviously a plethora of variables to consider. What key components do you feel researchers should focus on when designing such a study? Why?**

LB: The most important variable is who is in the sample. Samples that are representative of the general population tell us the most about the general population and are highly valuable in giving us the big picture. Studies like the Rape in America study or the National Violence against Women study are excellent exemplars of nationally representative samples. We conducted a study for OCVA on The Prevalence and Impact of Sexual Assault Experiences on Washington State Women that provided similar information for our state. For example, all of these studies had similar findings. They found that the majority of all sexual assault experiences occur in childhood. The Rape in America study and the Washington State study both found that about third of the women developed PTSD or depression. These results show that sexual assault in childhood is associated with significant impact for some women but not for all.

In contrast, studies that only include victims who have reported to someone, are involved in the system or who are in treatment provide a different picture. These are the victims that we see in our programs or practices. But they represent a minority of all victims since most sexual assault is not reported at the time. And it is important to distinguish between children who are being seen because of recent experiences and adult survivors who are seeking treatment. In the child samples, there will be children with a range of impact from no apparent consequences to moderate to severe. In many cases victims will not even need treatment because they will recover with natural supports or will respond to treatment and go on to function well. On the other hand, by definition, adult survivors who are seeking treatment are those who continue to have significant psychological effects many years later.

Those of us who are in community advocacy and counseling programs or even the criminal justice system need to be aware that the victims we see represent a certain group of all victims. It's not that what we see isn't true, of course it's true, but it's not necessarily the whole story.

In other research design considerations, we already know a lot about the variables associated with greater harm. For example, certain aspects of the experiences are correlated with more serious outcomes, such as the length of time over which it went on, perceived life threat or shame about the experience. We know that having prior trauma or other life problems makes the impact of abuse worse. Negative reactions by others also make a difference. What we need now are studies that go beyond these consistent findings and give us new insights into how to help victims. For example, it would be very helpful to know more about factors that can be changed in improving victims' recovery since what has already happened cannot be undone. It would be useful to learn more about protective factors that could be built on in advice to parents, in counseling or in our system responses so that those of us who work with victims could do more to reduce the likelihood of long-term harm. All of us working with victims want them to have the best life they can and to be able to make a positive difference toward that end. ■

All of us working with victims want them to have the best life they can and to be able to make a positive difference toward that end.

[1] **Rind, B., Tromovitch, P. & Bauserman, R. (1998).** A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin,* 124, 22 - 53.

# Childhood Abuse and Neglect and Adult Intimate Relationships: A Prospective Study

Colman, R.A., & Widom, C.S. (2004). Childhood abuse and neglect and adult intimate relationships: a prospective study. *Child Abuse and Neglect,* 28 (11), 1133-51.

This article examines long-term effects of early childhood sexual assault, physical abuse, and neglect on adult intimate relationships and relationship functioning. The research goal was to compare how long-term effects of child physical abuse and child neglect compare to childhood sexual assault victimization effects on relationship longevity and perceived quality of adult intimate relationships for both men and women.

This study was conducted from 1967-1995 and encompassed a sample size of 1196 individuals (676 abused and neglected children and 520 controls). It was controlled for and aided by a comprehensive design and utilization of logistic and multiple regression analyses.

Abused participants (aged 11 and under) were selected from substantiated court cases of child abuse and neglect during 1967-1971. Non-abused participants were selected at the same time and from the same geographical area and matched in gender, age, race, and approximate family class to the abused and neglected sample. Both sets were followed prospectively into young adulthood. Participants were intentionally not informed that they had been selected to participate in the study so their engagement in and interpretations of relationships would not be biased. In 1989-1995, the selected participants (now adults) were invited to participate

by taking part in a 2 hour in-person interview which included a psychiatric assessment. Standardized rating scales were utilized to generate measurable data about participant family background (marital and economic status of natural parents); involvement in intimate relationships (cohabitation/marriage habits); and relationship functioning (fidelity and trust).

The results found statistically significant parallels in intimate relationship structure between neglected and physically abused children to sexually abused children. It indicated that all types of maltreated children were prone to higher levels of relationship dissatisfaction, difficulty in maintaining intimate relationships, and were less satisfied with their relationships than their non-abused counterparts. Relationship difficulties were not significantly greater in one victimization type, economic status, race, or age group. The most significant reported difference was in how abused males and females viewed relationships.

Both male and female abuse victims were found to have higher levels of relationship difficulty than non-abused persons, with abused females having greater relationship dissatisfaction than abused men. According to the report, "Abused and neglected women were at risk of experiencing intimacy-related difficulties (dissatisfaction, sexual unfaithfulness, and infidelity) within their on-going romantic relationships; abused and neglected males were not. Thus, early childhood experiences of childhood abuse and neglect may impact more heavily upon the expectations and social behavior of female) victim childhood maltreatment (pg.1147)."

Data further indicated that:

- Childhood victimization did not reduce the likelihood of marriage for males or females.
- Of the three abuse types evaluated, neglected children were more likely than physically and sexually abused children to cohabitate with intimates rather than marry.
- Male victims of neglect were less likely to be involved in committed relationships.
- Males and females who were abused and neglected experienced more dysfunction in their marital relationships than non-abused individuals.
- Physical abuse, sexual abuse, and neglect all increased the risk for divorce, with the likelihood of divorce being the highest among sexually abused males.
- Married abused females were more likely than non-abused females to commit infidelity with multiple partners.
- Abused males rated the quality of their relationships higher than their non-abused counterparts.
- Abused females rated the quality of their relationships lower than their non-abused counterparts.

The finding indicating that abuse early in life can disrupt capacity to form and maintain healthy relationships is consistent with other long-term abuse studies concerned with social functioning. However, the bulk of previous abuse research has focused on effects of female childhood sexual assault victimization, thus making this study more inclusive with the consideration of males and other forms of child maltreatment.

This study is statistically sound and allows for an expanded dialog about long-term effects of child maltreatment however, it is not a definitive work and cannot be universally applied. Despite being conducted over a long period of time and considerate of multiple variables, it is limited by its original design. The authors themselves highlight, "Our findings may not be generalized to all cases of childhood and neglect (before age 12). Our findings may not generalize to individuals with underreported or unsubstantiated cases of child abuse and neglect or to individuals abused and neglected in adolescence. Likewise, maltreating families

who come to the attention of official agencies typically are all on the lower end of the socio-economic spectrum making it hard to determine where the abused and neglected individuals from middle or upper class homes would demonstrate the same pattern of relations of those found in our sample (pg.1148)." The authors also highlight that institutional response and verification of abuse cases has changed over time and may affect the reliability of their findings. ■

-Andrea Piper

# The Process of Coping with Domestic Violence in Adult Survivors of Childhood Sexual Assault

Griffing, S., Lewis, C.S., Chu, M., Sage, R., Jospitre, T., Madry, L., & Primm, B. (2006). The Process of Coping with Domestic Violence in Adult Survivors of Childhood Sexual Assault. *Journal of Child Sexual Abuse,* 15 (2), 23-41.

Child sexual assault and domestic violence survivors employ a variety of coping mechanisms to make sense of the victimization and to process incurred trauma. These mechanisms may include, but are not limited to, denial, minimization, dissociation, self-blame, self-harm, social withdrawal, wishful thinking, emotional expression, and support seeking. Types of coping mechanisms have been classified by researchers as engaged or disengaged.

*"The engagement dimension reflects efforts to engage in an active and ongoing negation with the stressor, whereas the disengagement dimension consists of strategies focused on avoiding thought or feelings about the situation (pg. 25)."*

This article reports what previous research has demonstrated; disengaged coping techniques such as withdraw, denial, self-criticism, and wishful thinking are associated with higher levels of general, depressive, and/or trauma-related symptomatology. It also indicates that domestic violence and child sexual assault survivors (CSA) employ disengaged coping at high rates. It hypothesizes that survivors of CSA who are exposed to subsequent episodes of violence are more likely use disengaged coping strategies placing them at a higher risk for psychological symptomatology.

The study reviewed the relationship between coping, depression, and self-esteem in order to 1) determine if there is a difference in psychological functioning and the type of coping mechanisms employed by CSA who have also experienced recent domestic violence over those who do not have a CSA history and 2) assess if the rates vary among an ethnically diverse sample.

The sample consisted of 219 female residents at an urban domestic violence (DV) shelter. The demographic profile of the study group included African-American (58.9%), Latino (32.9%), Caucasian (3.2%), and other ethnicities (5%). Of the participants, 39.3% had a self-identified history of CSA. The average participant age was 26.77 years. The study used a variety of screening and recording tools and statistically valued data through t-tests and regression formulae.

The study found that CSA survivors recently exposed to DV had higher rates of disengaged coping with an emphasis on wishful thinking, self-criticism, and social withdrawal than non -CSA DV survivors. It also indicated that CSA survivors exhibited a higher level of depression and lower self-esteem. No statistically significant differences in coping or psychological

functioning were correlated to ethnicity.

The researchers highlight that although the rate for disengaged coping was higher in CSA survivors, disengagement was also the most common technique employed by non-CSA DV survivors. The study concluded that due to the high utilization of disengaged coping CSA survivors are statistically at more risk for impaired psychological functioning (higher rates of PTSD, depression) but the degree is unknown and warrants further investigation.

As highlighted by the authors, there are intrinsic methodological limitations to this study. The women were exclusively DV victims and resident at a DV shelter. The fact that they had sought shelter exhibited previous use of engagement strategies, and reporting bias may have existed due to in-person interview and social desirability factors. They argue however, that "despite these limitations, the relationships between CSA, disengaged coping and psychological functioning among DV survivors have important clinical implications (pg.38)." What is implied is that knowing the assault history can support introduction of engaged adaptive coping strategies that reduce self-blame, solicit supports, and reframe victimization contexts. ■

-Andrea Piper

# Social Reactions to Abuse Disclosures: A Critical Review

Ullman, S.E. (2003). Social Reactions to Abuse Disclosures: A Critical Review. *Journal of Child Sexual Abuse,* 12 (6) 89-121.

Negative reactions to disclosures of child sexual abuse (CSA) are harmful to survivors' well-being. This research review looked at how many survivors disclose, who is told, the length of time until disclosure, the reactions to the disclosure, and the consequences of these factors for survivors' health.

While studies indicate that some survivors disclose CSA in childhood, many wait years or until adulthood. About one-third of female survivors never disclose. Survivors of "more severe abuse experiences of longer in duration by known offenders" are less likely to disclose. These survivors are also more likely to experience more negative psychological symptoms.

While non-disclosure may be harmful, disclosure by itself may not alleviate symptoms. Studies indicate that survivors do not disclose out of fear of negative reactions, embarrassment, the desire to protect others, and offender threats. On the other hand, survivors choose to disclose because they can no longer tolerate the abuse or symptoms, due to educational programming or in response to others' disclosures.

The process of disclosure appears to have many stages, but more research is needed in this area. Among survivors who choose to disclose abuse, both children and adults are more likely to tell an informal source first, and those who have told an informal source are more likely to follow through with formal disclosures. Positive reaction to disclosure is related to positive outcomes for children, but the relationship is unclear for adults.

A more detailed understanding of the "who" and "when" of disclosure is particularly important as we seek to understand the relationship between disclosure to informal sources (friends, family) versus formal source (advocates, law enforcement or other service providers) and what that means in terms of our service provision. ■

-Toby Shulruff

# Therapy for child sexual abuse: women talk about helpful and unhelpful therapy experiences.

McGregor, K., Thomas, D.R., & Read, J.(2006). Therapy for child sexual abuse: women talk about helpful and unhelpful therapy experiences. *J Child Sex Abuse,* 15(4), 35-59.

The authors of this article suggest that the treatment of the long-term effects of CSA requires tailored and specialized therapy because survivors generally have experienced a particular form of interpersonal betrayal that often leads to fear of another person, shame, secrecy, confusion and physical pain. For these reasons, working with survivors of CSA can be complex and challenging. In addition, over time, generalized and deeply embedded childhood trauma can make this group particularly vulnerable to therapy errors.

The purpose of this study was to describe some key abuse-focused therapy strategies and experiences that a selected sample of CSA clients in New Zealand reported as being either helpful or unhelpful. The criteria for inclusion in the study were that participants should be women with histories of CSA who (1) were over the age of 20; (2) had at least five sessions of therapy; and (3) were not currently in a therapy relationship.

Participants self volunteered for the study by responding to various media solicitations for participants. They were mailed a questionnaire, and from the 191 returned surveys that fit the study criteria, an interview subsample of 20 participants was selected. Members of this group ranged in age from 26 to 57 years. Thirteen identified as New Zealand Europeans, six were Maori, and one was Samoan. The authors acknowledge that while 20 interviews is a relatively small sample size, research on this topic is scarce and a study of even this size is nonetheless representational and useful for the therapeutic community.

From interviews with the CSA survivors, three specific areas of therapy were targeted for focus: (1) establishing a therapeutic relationship; (2) talking about experiences and effects of CSA; and (3) dealing with errors in therapy.

For these survivors, helpful therapeutic relationships included the following: being given information about the process and expectations of therapy, including their rights and responsibilities; experiencing equality in the therapeutic relationship; experiences of rapport and being listened to; and effective assessment. Because participants had experienced disempowerment as children, they reported the need for therapists to actively work towards encouraging them to feel equal. Study participants rejected therapists who did not encourage this equality and who had difficulty building rapport and did not listen to them. Survivor/clients valued therapists who were able to fully assess the effects of CSA and then help them work through the effects. When these aspects of therapy were absent, a number of participants reported dissatisfaction with therapy.

When talking about experiences and effects of CSA, study participants suggested that it was preferable that therapists were knowledgeable about abuse-focused therapy, were able to normalize the effects of CSA, were able to listen to accounts of CSA, and provided client-directed therapy. A theme that became apparent was that, in order to do this work, it was vital that therapists were knowledgeable about the dynamics and effects of CSA. One participant said she considered it "essential" that a therapist working with the effects of CSA be "someone who has professional knowledge base, someone

who really knows as much as possible about the effects of CSA, the consequences of it, how it can impact our lives as teenagers, middle age, and different stages."

Therapists who reassured participants they were not "crazy" but were experiencing common effects of CSA were highly valued. Finding such therapists was reported as rare, and when one was found the relief experienced was described as "profound." Feeling safe enough to talk about the details of CSA was also described as a relief. Several participants reported how much they appreciated therapists who listened closely to what they wanted in terms of the pace and focus of therapy, as well as what they wanted to achieve. Some of the women in the study reported that some therapists did not respond with such careful listening and respect for their stated therapy goals, which often reinforced old feelings of being disrespected, unimportant, powerless, humiliated and angry.

Interview themes described therapeutic "errors" along a continuum from distancing to intrusion, including therapists who were passive, who exaggerated their objectivity, who misinterpreted meaning and who were angry. Several participants described feeling frustrated by non-involved, passive, or non-responsive therapists. Several more complained of therapists acting as though they were "blank screens" and refusing to act within the bounds of everyday social interactions. This failure to interact socially caused some participants to feel insulted, humiliated, hurt and angry. A few participants reported that some of their therapists seemed angry and unable to contain their feelings and personal issues. These therapy "errors" caused participants to feel hurt, abandoned, blamed, angry, and often to abandon therapy (sometimes forever).

Only a few therapists were reported as committing serious "errors", and in spite of less than optimal therapy experiences with some therapists, a number of participants were forgiving and understanding of therapy errors. In their overall assessment of therapy, many reported therapy for CSA as life enhancing and several reporting it as "life saving." ■

-Nj Progar-Hayes

# A Prospective Analysis of the Relationship between Childhood Sexual Victimization and Perpetration of Dating Violence and Sexual Assault in Adulthood

Loh, C. & Gidycz, C.A. (2006). A Prospective Analysis of the Relationship between Childhood Sexual Victimization and Perpetration of Dating Violence and Sexual Assault in Adulthood. *Journal of Interpersonal Violence,* 21, 732–749.

Much of what we know about the link between childhood trauma and future perpetration of sexual assault or domestic violence comes from research on incarcerated men using a retrospective study design. Also, there is a lack of research on the effects of child sexual assault on sexual functioning and attitudes in men. The purpose of this study is to examine the effects of CSA including assessment of future and sexual assault perpetration, using a prospective design. The authors hypothesized that "sexual abuse would have negative effects on sexuality issues, dating conflict strategies, alcohol use, and perpetration of sexual assault (pg. 732)".

The study included baseline and 3-month assessment of 325 undergraduate men from a Midwestern university. The majority of participants were Caucasian, heterosexual, and between 18 and 19 years old. Specific measures included: the Sexual Experiences Survey which identifies perpetrators of sexual assault; the Conflict Tactic Scales which assesses intrafamilial and dating conflict; the Child Sexual Victimization Questionnaire which assesses sexual victimization before age 14; the Drinking Habits Questionnaire which assesses the type, amount and frequency of alcohol consumption; and the Multidimensional Sexuality Questionnaire (MSQ) which measures 12 aspects of human sexuality. Approximately 80% of participants completed the 3-month assessment. Of those who did not return there was not a significant difference on history of perpetration or CSA from the participants who completed the follow up.

CSA was collapsed into 3 categories: none, noncontact (involves requests for sexual activities and exposure but no physical contact), and contact (involves physical contact with perpetrator). Five percent of the participants experienced either noncontact or contact CSA. The study showed CSA to be related to perpetration of sexual assault after age 14 but before enrollment in the study. At baseline, 40% of participants with noncontact CSA perpetrated sexual assault while 80% of those with physical contact CSA perpetrated sexual assault. At follow-up there was no relationship between CSA and subsequent perpetration of sexual assault. There was no relationship between CSA and alcohol use or dating conflict. The likely explanation for no relationship between CSA and alcohol use could be the high percentage of heavy drinking among participants.

The results from the MSQ show a relationship between history of CSA and sexual preoccupation, sexual anxiety, sexual depression, and external sexual control. Compared to participants with no history of CSA, participants with a history of noncontact CSA experienced more unhappiness and greater tension or discomfort about the sexual aspects of their life. They also believed to a greater degree that sexuality is determined by external or environmental force when compared to the other 2 groups of participants. This was a surprising result to the authors who discussed that possible explanations could be that men who experience CSA with physical contact are more likely to label the experience as abuse and therefore have the opportunity and support to psychologically adjust.

History of sexual perpetration at baseline was best predicted by a statistical model composed of CSA, mother-child conflict resolution strategies, and dating conflict resolution strategies. This was interesting finding because dating conflict was not related to CSA in this study. Results indicate that although men who experience CSA are at a greater risk for sexual assault perpetration, the relationship is more complex and likely involves other factors.

At the 3-month follow up the best model that predicts sexual assault perpetration includes: history of sexual assault perpetration, father-child and mother-child conflict resolution strategies, and dating conflict resolution strategies. Interestingly, it does not include a history of CSA. These results support other research that suggests negative consequences of CSA are mediated by other factors like family discord.

The limitations of this study includes the inability to generalize the results to a larger population, the short time span between baseline and follow up, and a relatively small sample size. ■

-Katherine Gechter

# Opportunity for Input

Did you read or author an article you'd like to contribute for review in the Research and Advocacy Digest?

If so contact the editor, Andrea Piper, for more information about guideline submissions.

What topics would you like to see covered in upcoming issues of Research and Advocacy Digest?

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