REPORTED PREVALENCE RATES OF CHILDHOOD SEXUAL EXPERIENCES AMONG CLIENTS IN A UNIVERSITY COUNSELING CENTER

by

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ABSTRACT

The present study found statistical support for the importance of querying clients in regard to childhood sexual abuse experiences to encourage clients to disclose this history. The literature suggests that the method of querying about sexual behaviors makes a significant difference in the percentage who report sexual abuse incidents. The present study, which used students who presented for personal counseling at a university counseling center, found no difference in paper-and-pencil or face-to-face interviewing methods of asking clients about sexual abuse incidents. Chi-square procedures did find a significant difference between (a) no formal method of querying and (b) asking clients about childhood sexual abuse either with pencil and paper or at the end of an intake interview after rapport had been established.

A series of one-way ANOVAs using self-esteem and depression (as measured by the Rosenberg Self-Esteem Scale and the Beck Depression Inventory, respectively) as dependent measures found no significant differences in sexual abuse survivors on independent variables of (a) relationship to the perpetrator, (b) age at onset of the abuse, (c) frequency of the abuse, (d) duration of the abuse, (e) whether force was utilized, and (f) whether previous counseling was received. Other exploratory analyses also failed to find significant differences (with the exception that those survivors who had been abused by more than one perpetrator reported significantly lower levels of self-esteem than those who were abused by only one person).

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CHAPTER I
INTRODUCTION

Childhood sexual abuse is a problem that has received much attention in the literature in the last few decades (e.g., Bass & Thornton, 1983; Burgess, Groth, Holmstrom, & Sgroi, 1978; Meiselman, 1990). In an early, frequently cited study, Weinberg (1955) estimated that sexual abuse had a one-in-a-million incidence rate. Although this estimate was obviously low, few professionals of the day had any idea that the rate would be significantly higher (Rosenfeld, 1979b). More recently, there has been an increasing awareness among mental health professionals that not only are children suffering in childhood from sexual victimization, but adults who survived the abuse also evidence long-term effects (Tsai & Wagner, l978). Those who are victims are more readily seeking intervention and treatment in childhood and adulthood, leading to an increase in the amount of research conducted in this area (Courtois & Watts, 1982).

Yet, there are still questions in the literature that have remained unanswered. These questions include ascertaining the most effective method to determine prevalence rate of childhood sexual abuse (so clinicians will be able to identify and treat these individuals) and determining how emotional characteristics of adults (such as self-esteem and depression) are affected by childhood sexual abuse. Areas of research that impact these issues will be briefly reviewed.

Professionals' Reactions

In today's treatment of sexual abuse victims and survivors, it is still not unusual for clinicians to avoid and deny incidents of molestation (Taubman, 1984). Underreporting by professionals can be traced back to psychoanalytic theory and Freud's hesitancy to accept childhood sexual experiences as reality (Rosenfeld, Nadelson, & Krieger, 1979; Sheldon, 1988). Professionals today are becoming more educated and knowledgeable about sexual abuse (Attias & Goodwin, 1985). Yet, just as there is a need for the public to become more educated about childhood sexual abuse and for more service to be

provided to those affected, there is also a need for professionals to become more educated (Briere & Runtz, 1988).

Definitions

Simply defining what constitutes childhood sexual abuse can be a major obstacle in studying this area. For example, when comparing four studies of sexual abuse, Sheldon (1988) found reported rates of occurrence of 4% in a clinical population where a sexual abuse history was not solicited and patients were only asked about paternal incest with daughters. However, an occurrence rate of 44% was reported in a clinical population when a broader definition of sexually arousing activities was used and patients were directly queried.

Behaviors Involved

Various studies have specified different behaviors as constituting sexual abuse of a child. For example, Sansonnet-Haydon, Haley, Marriage, and Fine (1987), when studying hospitalized adolescents, required that there be physical contact of the breast or genitals to consider a person to have been sexually abused. Legal definitions of incest and sexual abuse are also often very restrictive. Criminal definitions may include only cases of penetration in defining incest or sexual abuse (Wyatt & Peters, 1986a).

The choice of behaviors considered to constitute abuse obviously has implications for prevalence rates, effects on survivors, and recommended therapeutic interventions. It may be assumed that the child who has experienced more "severe" abuse (e.g., intercourse versus fondling) will suffer more severe consequences (de Young, 1985). The best solution for determining prevalence appears to be to collect data on all behaviors that may potentially be sexually abusive and to then use precise methodology to explore specific behaviors and consequences (Wyatt & Peters, 1986a). Several experts in the field state that for children and adolescents (those under the age of 18), the only sexual activity that is considered inappropriate to assess and report on as sexual abuse is consensual sexual contact between peers (Finkelhor, 1986; Finkelhor & Hotaling, 1984; Wyatt & Peters, 1986a).

Populations Studied

Clinical, Criminal, and General Populations

When reviewing the literature, authors have pointed out that using various populations has made a difference not only in the prevalence rate of sexual abuse reported but also in the symptomology reported. For example, research on clinical populations has found more pathology, and research on court-referred populations has uncovered more acting out behavior (de Young, 1985). In a clinical population there is also reporting of a longer duration of abuse, abuse that began at an earlier age, and more use of force and violence (Edwall, Hoffman, & Harrison, 1989).

Many studies on childhood sexual abuse have gathered subjects from clinical or criminal populations, making generalizability difficult (Kilpatrick, 1986). Briere and Runtz (1988) state that there is a paucity of data in the literature on non-clinical populations. Some studies on non-clinical populations have found few or no statistically significant results (e.g., Fromuth, 1986; Stinson, Hendrick, & Hendrick, 1990), whereas others have found a wealth of important findings (e.g., Briere & Runtz, 1988; Sedney & Brooks, 1984).

Regardless of the setting, the vast majority of researchers have concluded from their data that sexual abuse of children has long-term negative effects. Kilpatrick (1987) concludes that those studies that do not report negative effects are often scientifically questionable.

Intrafamilial versus Extrafamilial Sexual Abuse

Some studies have attempted to study the differential effects of intrafamilial and extrafamilial sexual abuse. The results of these studies have not been consistent. For example, Bryer, Nelson, Miller, and Krol (1987) found no difference on personality measures for persons whose sexual abuse had occurred with a family member versus with a non-family member. Yet, Sedney and Brooks (1984) and Ruch and Chandler (1982) reported higher symptoms of disturbance for those victimized within the family. In addition, more long-term effects for the victim have often been reported if the perpetrator was more closely related, such as a biological father rather than a grandfather or

uncle. This is believed due to the child's perception that the father should be someone who can be trusted and who should protect her (Blume, 1990; Courtois & Watts, 1982). Daie, Witztum, and Eleff (1989) have concluded from their small sample that if the relationship was an exploitive one, there is a higher chance that the victimized child will have difficulty establishing and maintaining healthy personal relationships. This may also be true for extrafamilial sexual abuse if the perpetrator is viewed as a close, trusted person (Blume, 1990). But for those abused by someone outside the family, the aftereffects may be more easily understood by considering other factors. For example, aftereffects are more severe if threats and violence are used, if injuries occur, and if a weapon is used by the perpetrator (Ruch & Chandler, 1982).

Prevalence Rates of Childhood Sexual Abuse

Studying the prevalence of childhood sexual abuse appears to have begun in earnest in the late 1970's, with scattered studies prior to this time. Although many of these studies use the term "incidence" (e.g., Rosenfeld, 1979b; Sheldon, 1988), which is defined as the number of new cases that occur each year, the majority focus on "prevalence," which is the percentage of persons who will experience sexual abuse anytime during their childhood. There has been a wide range of figures reported, with estimates as high as over 50% and as low as less than 10%. Much of the variation appears to depend on the population studied (Benward & Densen-Gerber, 1975; Haugaard & Emery, 1989) and the definition of childhood sexual abuse utilized (Wyatt & Peters, 1986a), as well as on the researchers' methodology (Wyatt & Peters, 1986b).

Population Differences

The population in which the data are collected makes a difference in the prevalence rates. In clinical populations, the prevalence of childhood sexual abuse is often high. For example, among drug abusers, the prevalence rate has been reported to be as high as 44% in a treatment population (Benward & Densen-Gerber, 1975). For an adolescent drug treatment program, 35% to 45% of the female patients

have a sexual abuse past (Edwall et al., 1989). Lower estimates in a clinical population include 19.7% for a drug abuse population (Ladwig & Andersen, 1989).

Criminal settings report various prevalence rates. For a juvenile shelter for runaways, almost 10% of the juveniles reported an incestuous history (Stiffman, 1989). Among mental health professionals, the rate of occurrence of childhood sexual abuse is high. In a study by Doughty and Schneider (1987), 21.6% of MA level psychologists and 22.6% of graduate students reported having been incestuously abused as children.

In an extensive study on a general population, Russell (1986) found that 16% of her female subjects reported a history of incest. When including any childhood victimization, the rate of occurrence rose to 31%. Herman (1983) reported that about one quarter of females in the general population are sexually molested by the time they reach age 18, while one tenth of females will be victimized by a family member. Those who go to college are emotionally and psychologically higher functioning than the general population. Therefore, studies that use college students as the subject pool are likely to underestimate the prevalence rate (Haugaard & Emery, 1989). Even so, in college populations Briere and Runtz (1988) reported a 15% prevalence rate of childhood sexual abuse, and Harter, Alexander, and Neimeyer (1988) reported a 13.4% familial and 10.0% non-familial sexual abuse rate. Using a questionnaire on childhood sexual abuse that is very similar to the one in the present study, the author and her colleagues found a 12% prevalence rate of childhood sexual abuse for females in a psychology subject pool at the same university from which data was gathered for the present study (Stinson et al., 1990).

Females report a higher rate of childhood sexual abuse than do males. For example, Sansonnet-Hayden et al. (1987) reported a 37.9% rate of occurrence for females and a 24% rate of occurrence for males when making direct inquiries of newly admitted patients on a psychiatric unit.

Other Factors Affecting Prevalence Rates

Reported rates of occurrence of childhood sexual abuse are affected by many factors. When comparing studies, Wyatt and Peters (1986b) concluded that personally conducted interviews lead to much higher rates of reported childhood sexual abuse than do self-administered questionnaires, in nonclinical populations. Also, asking several activity-specific questions leads to a higher rate of reported occurrence than does asking one or a few questions.

Prevalence rates will also be affected by the breadth of the definition used. If the definition is broader, the rate of reported occurrence will be higher. If the definition is narrow, the prevalence rate will be lower (Haugaard & Emery, 1989). With a broad definition, Kilpatrick (1986) found that 55% of her female sample reported that they had experienced sexual interactions as a child. But only 2% had experienced intercourse, with kissing and hugging in a sexual manner (37.1%) and exhibition (35.1% shown genitals of another and 22.9% showing own genitals to another) being the most reported forms of sexual contact (Kilpatrick, 1986).

Disclosure

It appears that adults seldom spontaneously disclose abusive pasts. There is fear in adulthood (as in childhood) that disclosing would indicate disloyalty to the family. Therefore, the victim continues to deny the activities in order to maintain the family system (Siegal & Romig, 1988). Even those in treatment, such as general psychiatric patients, often have never discussed with anyone their sexual abuse secrets (Bess & Janssen, 1982).

Survivors disclose that they have been victims of childhood sexual abuse for various reasons. For example, some who feel that they have suffered no adverse consequences may tell simply because it is something that has happened to them. Others, who feel deeply affected, may tell because they want to get rid of the pain they are feeling. Others only tell after a therapist has worked with them for a length of time and has coaxed them into admitting that there is a history of sexual abuse (Courtois & Watts, 1982).

Disclosure of a sexual abuse past is often expected by the clinician to happen spontaneously (Briere & Zaidi, 1989; Rosenfeld, 1979b). This is based on the assumption that sexual abuse that occurs will be reported, reflecting an accurate estimate of the rate of occurrence (Rosenfeld, 1979b). But there are vastly different rates of childhood sexual abuse reported when the patient is queried versus when reports of past abuse just "come up." For example, in a clinically important study by Briere and Zaidi (1989), a 6% prevalence rate was reported for non-psychotic females at an emergency room when patients were not queried about molestation, whereas a second phase of the study found a 70% rate of occurrence when patients were routinely asked about a sexual abuse history. In a study by Rosenfeld (1979b), only 16% of the patients spontaneously reported a sexual abuse history, whereas 33% reported such a past when queried. Therefore, clinicians are likely to overlook the possibility of sexual abuse unless they are told to ask directly about this topic. Many clients simply do not freely volunteer such information.

After finding several unreported cases of childhood sexual abuse in an inpatient hospital, Hart, Mader, and Griffith (1989) recommend that mental health professionals routinely ask about a sexually abusive past. Other professionals support this approach (e.g., Bryer et al., 1987; Ellenson, 1986; Kilpatrick,1983). Some professionals fail to query patients about sexual abuse because they do not know how to define sexual abuse (Sheldon, 1988) or they fear that false reports will be made (Rosenfeld, 1979b). The latter is an erroneous assumption since the majority of sexual abuse survivors wish the incidents had not occurred. It is more likely that survivors will fail to report the sexual incidents as well as the aftereffects, for fear of being viewed as crazy (Ellenson, 1985; Rosenfeld, 1979b; Shengold, 1963).

Effects for the Victim

Case example after case example in the literature details the negative effects that sexual abuse has on its victims (e.g., Bass & Thornton, 1983; Berliner & Conte, 1990; Ellenson, 1986; Lukianowicz, 1972; Meiselman, 1990; Root, 1989; Rowe & Savage; 1988). Most

authors and researchers maintain that childhood sexual abuse has some negative effects on the majority of its victims (de Young, 1985; Zilney, Nash & Hulsey, 1988). Yet, it is often difficult to distinguish between the effects that are a result of the sexual abuse and those that are the outgrowth of other familial situations such as physical abuse and neglect (which are so often coupled with the sexual abuse in a family) (Bess & Janssen, 1982; Hart et al., 1989; Yates, 1982). Yet, it is believed that sexual abuse is the most destructive form of abuse that a child can suffer (Freud, 1982).

Much of the research on aftereffects reviewed in the following sections will have been conducted primarily, if not completely, on female subjects. Much of what is reported in this literature review is on females (de Young, 1985). Yet, studies on males often find the same destructive short- and long-term effects (e.g., Adams-Tucker, 1982). It appears that males have the same issues of powerlessness and lack of control that are reported in the literature for females. Males also appear to have difficulties with self-esteem and depression (Singer,1989).

Long-Term Effects

The adult who was sexually abused by someone in childhood is commonly referred to in the literature as a "survivor" (e.g., Blume, 1990; Meiselman, 1990). This term is used because it denotes someone who has survival skills and is no longer a helpless victim. It in no way implies that the person's abuse was physically life-threatening (Becker, Skinner, Abel, & Cichon, 1986).

It is not surprising to find articles referring to the negative long-term effects of sexual abuse for survivors (e.g., Ellenson, 1985; Russell, 1986), since the victimization of the child is something that changes the child and affects him or her well into adulthood. Many of these effects are evident from the beginning of adulthood, whereas others may not be evident until the survivor has had time to develop relationships with a significant other or with his or her own children (de Young, 1985). As a survivor ages and attempts to more actively

make meaning of being sexually abused in childhood, more symptoms are experienced (Silver & Boon, 1983).

In general, women who have been incestuously abused rate lower on social adjustment scales, viewing themselves as significantly different from others (Harter et al., 1988). This is partially due to their inability to trust (Courtois & Watts, 1982; de Young, 1985; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983), the social isolation that results from the attempt to hide their secret (Bergart, 1986), and inadequate social skills (Tsai & Wagner, 1978). Some of the most well documented aftereffects for the sexual abuse survivor are chronic depression (Bergart, 1986; Briere & Runtz, 1988; Deighton & McPeek, 1985; Hartman, Finn, & Leon, 1987; Herman, 1981; Tsai & Wagner, 1978) and lower self-esteem because survivors tend to overvalue others and devalue their own worth (Blake-White & Kline, 1985; Courtois & Watts, 1982; de Young, 1985; Owens, 1984; Silver & Boon, 1983; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983).

Factors Affecting Long-Term Aftereffects

Those who are sexually abused by a family member often show signs of more long-term negative effects than do those abused by someone outside the family (as discussed earlier) (Sedney & Brooks, 1984), especially if the perpetrator is a father or stepfather (Herman, Russell, & Trocki, 1986; Scott & Flowers, 1988). Those abused within their families are more likely to experience anxiety and depression (Hartman et al., 1987).

Those who feel that the sexual relationship was exploitive are more likely to state that they had negative effects from their childhood sexual experiences. Of course, not all adults feel that the relationship was exploitive. This is especially true of peer-age sexual interactions (Nelson, 1986). Therefore, the amount of powerlessness that the participant felt may be a better indicator of aftereffects than are some other factors (Kilgore, 1988).

Age at which abuse occurs is an important consideration because there is some indication that greater frequency and a longer duration of abuse lead to more severe effects. Younger victims have more years

for the sexual abuse to occur (Kilgore, 1988; Zivney et al., 1988). Hartman et al. (1987) report that the child who is younger when sexually abused is more likely to show depression as an adult.

Unfortunately, many who are sexually abused as children are silent victims who do not receive any sort of treatment (Briere and Runtz, 1988). Even when the sexual abuse is discovered in childhood, the child victim often does not receive treatment (even when it is recommended) (Krener, 1985). Those who seek treatment as adults rate themselves as less well adjusted than those who seek no help (Feinauer, 1989). Seeking treatment is not necessarily an indicator of the type of abuse the victim endured or the factors involved, but rather a reflection of the person's adjustment to the abuse (Courtois, 1979).

Lack of Long-Term Effects

Some researchers have not found long-term effects for the sexual abuse survivor. For example, disclosure or lack of disclosure of a sexual abuse history to others appears to be unrelated to the severity of effects for survivors of childhood sexual abuse (Courtois, 1979).

Methodological factors may influence reported aftereffects. For example, too broad a definition, one that includes both contact and noncontact sexual abuse, may dilute apparent aftereffects (Fromuth & Burkhart, 1989; Haugaard & Emery, 1989). It also appears that using a young adult population that has not started to explore relationships may lead to a lack of significant results. Such individuals may consciously or unconsciously deny either that the abuse occurred or that it had any effects. As development continues, though, the survivor can no longer deny that the abuse happened. This is due to increasing side effects such as intrusive thoughts, hallucinations, and flashbacks (Ellenson, 1986).

Methodological Issues

Sampling Problems

Much of the research that has been done has been on clinical groups in treatment for childhood sexual abuse, which leads to problems with generalizability. However, some important studies have been conducted

on college populations (e.g., Fromuth, 1986; Kilpatrick, 1986). Finding statistically significant effects of abuse in a college population is an important contribution to the literature, since a college population would be a non-psychiatric population. It requires a higher minimal amount of psychological functioning to enter and complete college work than would be found in some treatment populations (Briere & Runtz, 1988).

Methodological Recommendations

Since there is no one instrument in the literature that is viewed as the best instrument to use to collect specific facts about childhood sexual experiences, there have been a variety of instruments used (e.g., Haugard & Emery, 1989; Josephson & Fong-Beyette, 1987; Wyatt, 1985). Such a wide collection of different instruments makes comparison of studies very difficult, if not impossible, since different definitions of childhood sexual abuse and different additional criteria are used.

Wyatt and Peters (1986a) recommend that the definition of sexual abuse be broad, including contact and non-contact behaviors and various perpetrators, so that more rich data may be collected. Precise methodology should also be used.

Wyatt and Peters (1986b) also recommend that the description of a given study be broader and more general in order to facilitate the subjects' willingness to participate. When interviews are conducted, they should be held in private and be somewhat lengthy so that rapport can be established with the subject. This will lead to more valid results. Personal contact appears to enhance compliance. The direct contact also allows the interviewer to answer any questions the subject may have.

Conclusions

The sexual abuse of children is a problem that has received much attention in the literature in the last few decades. Some solid research is beginning to be done in the area regarding the dynamics involved in incestuous families, studying various populations (e.g., clinical, criminal, and non-clinical/general), prevalence rates, and

short- and long-term effects for the survivors of sexual abuse. Professionals are becoming more aware of this problem for their clients. Researchers have also made some methodological progress in areas such as defining childhood sexual abuse and in using broader instruments.

Statement of the Problem

Although the literature to date indicates that gains have been made in the research area of childhood sexual abuse, there are still many gaps in this body of literature. In the area of prevalence, there are several important questions that have not been adequately addressed. For example, comparisons have been made that indicate that the reported rate of childhood sexual abuse is higher in a clinical or treatment setting if the subjects are directly questioned about such behaviors. Yet, these conclusions have been drawn based on comparisons between studies, not within one study. The one notable exception is that of Briere and Zaidi (1989), who studied female patients in a psychiatric emergency room. No such study has been conducted with a less impaired population (i.e., non-psychiatric setting).

The literature also indicates that the reported prevalence rate is affected by the manner in which the subjects are asked to disclose past childhood sexual experiences. It has been proposed that direct personal querying of a client about childhood sexual abuse (after rapport has been established) will result in a higher reporting rate than that of paper and pencil methods of collecting such information (Wyatt & Peters, 1986b). But, again, there are no studies that have directly explored this question by testing different data collection methods in one study. Only comparisons between studies have been made up to this point.

Finally, there has been much clinical and some empirical support for the hypotheses that levels of depression and levels of self-esteem are affected by childhood sexual experiences. Yet, there is still some question in regard to what situational factors (e.g., relationship of perpetrator, age at onset, frequency and length of abuse, threat of

force, disclosure to others, professional help received) are correlated with more severe aftereffects.

Hypotheses

With these problems in the literature in mind, several hypotheses are offered.

Hypothesis 1

Directly questioning clients about childhood sexual experiences will lead to higher reported prevalence rates. Therefore, clients directly questioned about childhood sexual abuse, either through an explicitly worded questionnaire or through direct inquiry by a therapist, will have a significantly higher prevalence rate than will clients for whom abuse is inferred from a client record or a therapist's recollections.

Hypothesis 2

Directly questioning clients about childhood sexual experiences face-to-face, after rapport has been established, will lead to higher reported prevalence rates than will simply inquiring on a pencil and paper measure.

Hypothesis 3

Those who have suffered more "severe" sexual abuse will have significantly higher levels of clinical depression and significantly lower levels of self-esteem than will less severely abused or nonabused persons. Therefore, non-abused subjects and those with more "mild" forms of sexual abuse will differ significantly on measures of depression and self-esteem from those who:

a. had a closer relationship with the perpetrator (e.g., relative);
b. were abused at an earlier age;
c. were abused more often (e.g., once a month or more often);
d. were abused for a longer period of time (e.g., one year or more);
e. had force or threat of force used; and

f. had previously received counseling for their childhood sexual abuse.

Hypothesis 4

Based on existing research, some situational factors do not have a significant influence on aftereffects for sexual abuse survivors. Therefore, there will be no significant differences in depression and self-esteem between:

a. those who have disclosed to others and those who have not disclosed to others.

CHAPTER II
METHOD

Sample

Subjects were recruited from the Texas Tech University Counseling Center, Lubbock, TX. Subjects were divided into three groups. Group I consisted of 100 former clients of the University Counseling Center whose files had been recently closed. This group formed the baseline for how many students spontaneously disclosed a childhood sexual abuse experience without being formally questioned about this topic either verbally or through written measures.

Groups II and III were formed from new students presenting for personal counseling at the University Counseling Center. Both of these latter groups completed a questionnaire battery. The difference between the groups was that the second group was administered a written questionnaire on childhood sexual experiences, whereas the third group was administered the questionnaire face-to-face.

Measures

The questionnaire packet contained four sections. These included a Background Information Sheet, the Rosenberg Self-Esteem Scale, the Beck Depression Inventory, and the Childhood Sexual Experiences Questionnaire.

Background Information Sheet

The Background Information Sheet was used to gather demographic data about each participant. Included in this section were questions about the participant's gender, ethnic heritage, age, size of geographic area in which raised, family income, number of siblings, and birth order.

Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale (RSES) (1965, 1989) is a 10-item instrument in a four-point Likert format that assesses a participant's general self-esteem. Reported reliability coefficients of .85 and .88

have been reported on college samples with a two-week test-retest interval (Rosenberg, 1989). The instrument has modest convergent validity with peer ratings (.32) (Demo, 1985). For this study, the instrument was used as a general measure of self-esteem and was found to have split-half reliability of .25 when the Spearman-Brown formula was applied (Anastasi, 1988).

Beck Depression Inventory

The Beck Depression Inventory (BDI) is designed to assess clinical depression (Beck, 1978). Reliability is quite high, with split-half reliability of .86 and Spearman-Brown correction for attenuation of .93. This instrument was used to assess the general level of depression of those presenting for therapy. Split-half reliability, using the Spearman-Brown formula (Anastasi, 1988), was .85.

Childhood Sexual Experiences Questionnaire

The Childhood Sexual Experiences Questionnaire (CSEQ) is an instrument designed for the current study to assess various aspects of sexual incidents that adults have experienced in childhood. It is based on questions used in Wyatt's (1985) study of Afro-American and White-American women in Los Angeles County. Wyatt reported a 62% prevalence rate among her subjects.

Wyatt used broad, yet behaviorally-specific questions that lend themselves to a paper and pencil or face-to-face collection of data with some modifications. Using Wyatt's broad questions, the CSEQ was developed by adding specific questions about sexual abuse situations (since Wyatt's questions were not in a fixed format). A fixed format (versus open ended questions) was necessary for the instrument to be used as a pencil and paper measure as well as a personal interview measure. Items selected for inclusion on the CSEQ to make it somewhat more comprehensive were predominantly from research previously conducted by the author and her colleagues (Stinson et al., 1990).[1]

Design and Procedure

The Center Director and Research Coordinator at Texas Tech University Counseling Center were contacted to arrange for data collection. After consulting with these administrators and the counseling staff in five meetings, permission was granted to collect data with the Counseling Center student population.

Data collection was conducted in two stages. The first stage consisted of gathering archival data on former student clients of the University Counseling Center. Randomly selected files of 100 recent former clients were examined individually to gather demographic data and to determine if the student indicated that he or she had been involved in any childhood sexual experiences. All files included standard intake forms and termination summaries but style and length of progress notes varied from counselor to counselor. The client's intake information sheet, where the presenting concerns are expressed, the counselor's progress notes, and the termination summary were the primary sources of information. All clients who had seen a counselor at least once were included in the sample.

The second stage consisted of gathering information from new student intakes at the University Counseling Center. As students came to the Center for services, they were asked on paper if they would be willing to take an extra 10 minutes to complete some additional information (see Appendices). If the student indicated in writing (by signing a release form) a willingness to participate, then she or he simply opened an envelope that was given to the student with routine intake papers. The envelope included the Background Information Sheet, the Rosenberg Self-Esteem Scale, and the Beck Depression Inventory. Half of the envelopes also included the Childhood Sexual Experiences Questionnaire.

Students who agreed to participate were divided into Groups II and III. Group assignment was accomplished by alternately giving any new student who requested personal counseling either a yellow envelope (Group II) or a manilla envelope (Group III). The yellow envelope (Group II) contained all questionnaires in the present study (Background Information Sheet, Rosenberg Self-Esteem Scale, Beck Depression

Inventory, and Childhood Sexual Experiences Questionnaire). The manilla envelope (Group III) contained all questionnaires except the Childhood Sexual Experiences Questionnaire. All questions in each envelope were to be completed on pencil and paper. Students were informed (through a signed release form) that the intake counselor might ask some additional questions at the end of the formal UCC intake interview. Students in Group II completed no additional information upon completing pencil and paper measures. If the student were part of Group III, after completing the personal interview part of the intake process (thus establishing rapport), the counselor asked the student if he or she was willing to answer some additional questions at this time (to ensure that the student's right to withdraw from the study at any time was protected). Then the Childhood Sexual Experiences Questionnaire was verbally administered to the student by the counselor.

Training

Prior to collecting data on new student clients, the UCC staff was trained. The support staff, who had initial contact with the second and third groups of students, was trained prior to collecting data in order to ensure that they understood the procedures. Training included giving written instructions to each staff person, going over the procedures, and responding to questions. Written instructions were also posted so that the support staff could refer to the procedures at any time (see Appendices for procedures). The staff was consulted throughout the collection to ensure clarity of procedures.

In a separate meeting, the counseling center senior staff and interns were trained to administer the Childhood Sexual Experiences Questionnaire in a standardized manner. Each counselor received a printed set of instructions (see Appendices) and practiced the procedure with another counselor. Of the counselors collecting the data, six had earned doctorates in psychology and four were currently working to complete doctorates in psychology. As data were collected, there were regular follow-up contacts (approximately two per month) by the researcher to ensure that data were being collected in a

standardized manner. It took seven months to complete data collection (October 1, 1990, to May 1, 1991).

Coding

Data on all questions except the Childhood Sexual Experiences Questionnaire were marked on a computer sheet by the subject as she or he completed the questionnaires. Data on the CSEQ was hand scored by the experimenter according to levels established on a code sheet (see Appendices). Some childhood sexual experiences were dropped from the study because (a) the incident occurred after the age of 17 or (b) the behavior would be considered consensual, sexual play due to age (age difference between participants of two years or less) or to description of the incident (e.g., "I had sex with my boyfriend").

Note

[1] Items selected for inclusion on the CSEQ to make it somewhat more comprehensive were predominantly from research previously conducted by the author and her colleagues (Stinson, Hendrick, & Hendrick, 1990), using the Sexual Victimization Questionnaire, an instrument developed by Hawley and Stinson (1987). By inclusion of a variety of questions (e.g., Who was the person involved? The age when this began was . . . ? How long did it last? The activity involved included . . . ? With what frequency did it occur? Other person who are aware of the situation, besides the ones involved, include . . . ? The way in which this has affected me . . . ? What kind of professional help have you received?), several significant results were found. For example, those who had been abused by father figures (natal fathers, step-fathers, and mother's lover) had a significantly lower level of self-esteem than those abused by others or not abused. Self-esteem was higher for controls and victims who had experienced abuse before age 10 than for those abused at age 10 or older. Also, when considering the type of incestuous sexual activity participated in, self-esteem was higher for control subjects and those who had experienced "milder" forms of abuse such as fondling than for those who had experienced intercourse or oral sex.

CHAPTER III
RESULTS

This chapter will present the results that are relevant to the proposed hypotheses, and some additional analyses. First, demographic data that describe the sample will be presented. Then, information concerning the method of collecting information on childhood sexual experiences and the percentage of those subjects who disclosed such experiences will be presented (Hypotheses I and II). The next section will present information concerning characteristics of childhood sexual experiences and self-esteem and depression (Hypotheses III and IV). Finally, additional information regarding self-esteem and depression will be presented.

Description of the Sample

Some 322 students participated in the study. Of these, ten (five males and five females) were dropped from Group II due to failure of the student to complete the Childhood Sexual Experiences Questionnaire. Twelve subjects (all females) were dropped from Group III due to the counselor's failure to administer the Childhood Sexual Experiences Questionnaire. Some 81 students refused to participate in the study. This included 30 males, 45 females, and 6 participants on whom gender information was not collected. The following results are based on the data from 300 students (100 in each group).

Of those who participated, 104 were male and 196 were female. Of these, 22 males and 50 females reported a childhood sexual abuse incident. Most of those who participated were White Non-Hispanic (83.0%). The sample included only 12.0% Hispanic and 2.0% Black students. About 20% of the sample were either age 18 or younger (9.7%) or 23-24 years of age (10.7%). The other students were fairly evenly divided among 19-20 years of age (28.0%), 21-22 years of age (25.3%), and 25 years of age or older (26.3%). The majority of students had one or two siblings (66.5%), and almost half (47.6%) were first-born. Of those students on whom data were available on other demographic variables (Groups II and III), the majority were from

cities with a population of 50,000 or more (66.0%) and from families who earned more than $35,000 last year (62.6%), placing them in the middle to upper-middle class in socioeconomic background.

Data Analysis

The results will be presented below first, presenting findings relevant to the hypotheses and second, presenting additional exploratory analyses based on background information and on questions on the Childhood Sexual Experiences Questionnaire. The first two hypotheses were examined by a chi-square procedure to assess if there were differences between groups on reporting of childhood sexual abuse. Hypotheses III and IV were assessed with a series of one-way ANOVAs to assess differences in self-esteem and depression for various characteristics of childhood sexual abuse experiences. Additional analyses assessed differences in self-esteem and depression for two background variables and six characteristics of childhood sexual abuse experiences, using a series of one-way ANOVAs.

Method of Data Collection

Hypothesis I predicted there would be a significantly higher rate of reporting childhood sexual abuse if the clients were directly questioned than if sexual abuse was inferred from a client record (archival data). Hypothesis II predicted that verbally questioning the client about childhood sexual experiences in an interview after rapport had been established would lead to higher rates of reporting than asking the client about such behaviors on paper prior to an intake interview. The results of the analyses of Hypothesis I and Hypothesis II are presented in Table 1.

A chi-square was performed on the three groups to assess Hypotheses I and II. Group I reported that 8% of the sample had been sexually abused as children, Group II reported that 35% had a sexual abuse history, and Group III reported that 29% had a sexual abuse history, X^2 (2, N = 300) = 22.04, $p < .05$. Partitioning using independent comparisons revealed there was a significant difference between Group I and the other two groups but no significant difference between Groups

II and III. Direct questioning, either by a written questionnaire or by an interview, resulted in a significantly higher reported sexual abuse rate than did inference of sexual abuse based on a client record. Thus Hypothesis I was supported, but Hypothesis II was not supported.

Characteristics of Childhood Sexual Abuse

Hypotheses III and IV examined specific situational factors related to the sexual abuse incidents. Hypothesis III predicted that those subjects with "more severe" sexual abuse characteristics [related to (a) relationship to the perpetrator, (b) age at onset of the abuse, (c) frequency of abuse, (d) duration of abuse, (e) force utilized, and (f) professional help received] would report lower levels of self-esteem and higher levels of depression than subjects with no sexual abuse history and subjects with "more mild" abusive characteristics. A series of one-way ANOVAs was conducted using levels of specific sexual abuse characteristics (as measured on the Childhood Sexual Experiences Questionnaire) as the independent variables, and measures of self-esteem and depression (as measured by the Rosenberg Self-Esteem Scale and Beck Depression Inventory, respectively) as the dependent variables. When frequencies in a level of a sexual abuse characteristic were too small for sufficient power to detect statistically significant differences, levels were sometimes collapsed (as indicated below). If collapsing would still not allow enough statistical power, no further analyses were conducted for that independent variable.

Analyses indicated that there were no statistically significant differences in self-esteem and depression for any of the sexual abuse characteristics examined in Hypothesis III. Those who had a closer relationship with the perpetrator, measured by social relationship (levels = relative / non-relative) or by how much the client reported he or she trusted the perpetrator prior to the sexual incident(s) (levels = no trust or mild trust / moderate to high trust) were not significantly different on self-esteem or depression. There were also no significant differences for those who (a) were abused at an earlier age (levels = eight years old or younger / nine years old or older), (b) were abused

more often (levels = once a month or more often / less than once a month), (c) were abused for a longer period of time (levels = less than six months / six months or longer) or (d) had force or threat of force used (levels = severe or very severe force or threats / mild to moderate force or threats / no force or threats). There were not enough subjects in levels for those who had received counseling for being sexually abused to continue analyses for effects on self-esteem or depression.

Based on the literature, Hypothesis IV predicted that there would be no significant difference between those who had previously disclosed their abusive history and those who had not disclosed a sexually abusive past prior to coming for counseling, on measures of self-esteem and depression. Results indicated that there was no significant difference in self-esteem or depression between those who had disclosed a sexual abuse history to no one and those who had disclosed their past to someone. So, Hypothesis IV was supported by the results. These results are shown in Table 2 (along with the results for Hypothesis III).

Specific Variables not Related to the Hypotheses

Data were collected on several other variables. Background variables (i.e., assigned group and gender) were examined to assess if there were differences in the sample that were unrelated to childhood sexual abuse. Additional questions on the Childhood Sexual Experiences Questionnaire (i.e., victim or not, type of abuse, age of the perpetrator, number of perpetrators, perceived severity of aftereffects by the survivor, belief that the sexual activity was abusive) that were not related to the proposed hypotheses (but were suspected to potentially affect levels of self-esteem and depression) were examined for exploratory purposes. A series of one-way ANOVAs was performed using these characteristics as the independent variables and self-esteem and depression as dependent variables. Results are reported for only 200 subjects since no measures for self-esteem or depression were available for the archival data group (Group I). Some analyses used fewer than 200 subjects when it was appropriate to use only those who were survivors of childhood sexual abuse (i.e., type of

abuse, number of perpetrators, perception of being abused). These results are presented in Table 3.

Two variables (group assignment and gender) not related to the proposed hypotheses or the Childhood Sexual Experiences Questionnaire were explored. For the two groups who were directly assessed concerning a history of sexual abuse (Groups II and III), there were no significant differences in self-esteem or depression. For gender, there was no difference on self-esteem, however, there was a gender difference on depression. For depression, the mean score for females was 15.40 (SD = 7.75), which was significantly higher than the mean score for males of 12.17 (SD = 6.59), $F(1, 198) = 8.93$, $p < .05$. An analysis of variance, using gender and history of sexual abuse as independent variables and level of self-esteem and depression as dependent variables, revealed that there was no significant interaction between gender and victim status for either depression or self-esteem (see Table 4).

Six additional variables were examined from data collected with the Childhood Sexual Experiences Questionnaire that were suspected to affect levels of self-esteem and depression. These variables were (a) victim (levels = yes / no), (b) type of abuse (levels = non-contact / mild contact / major contact), (c) age of the perpetrator (levels = 0 to 25 years of age / over 25 years of age), (d) number of perpetrators (levels = one / two or more), (e) perceived severity of aftereffects by the survivor (levels = none to mild aftereffects / moderate to severe aftereffects), and (f) belief that the sexual activity was abusive (levels = yes / no / don't know). For all but one of these variables, there were no significant differences found on either self-esteem or depression. For number of perpetrators, there was a significantly lower level of self-esteem for those who had been abused by more than one perpetrator than for those who had been abused by only one person. There were no significant differences for depression for number of perpetrators though.

Table 1

Chi-Square Analysis of Method of Data Collection

Variables	DF	Value
Group 1 versus 2 vs. 3	2	22.04*
Group 1 versus Groups 2 & 3	1	21.05*
Group 2 versus 3	1	.99

Note: Group 1 = archival data.
Group 2 = written measures to collect sexual information.
Group 3 = personal interview to collect sexual information.

* $p < .05$.

Table 2

Analysis of Variance of Self-Esteem and Depression as a Function of Sexual Abuse Characteristics

Independent Measures	N	Means	
Relationship to Perpetrator		Self-Esteem ($F<1$)	Depression ($F<1$)
Relative	37	13.13	14.84
Stranger /Acquaintance	27	13.07	14.52
Level of Trust		Self-Esteem ($F=1.44$)	Depression ($F<1$)
No Trust or Mild Trust	24	13.46	15.75
Moderate to High Trust	36	12.64	14.53
Age of Victim		Self-Esteem ($F<1$)	Depression ($F<1$)
0-8	34	12.82	13.88
9-17	30	13.43	15.63
Frequency of Abuse		Self-Esteem ($F<1$)	Depression ($F<1$)
< Monthly	43	13.09	15.53
Monthly or > Monthly	18	12.94	13.72
Duration of Abuse		Self-Esteem ($F<1$)	Depression ($F<1$)
< 6 Months	44	13.25	14.86
6 Months or longer	19	12.79	14.95

Table 2 (continued)

Threats or Force Used		Self-Esteem (F<1)	Depression (F=1.18)
None	31	13.39	13.17
Mild to Moderate	13	12.69	16.54
Severe to Very Severe	20	12.95	15.90
Disclosure (# of People Told)		**Self-Esteem (F<1)**	**Depression (F<1)**
0	26	12.88	15.62
1 or more persons	38	13.26	14.08

Note. * $p < .05$.

Table 3

Analysis of Variance of Self-Esteem and Depression as a Function of Specific Sexual Abuse Characteristics

Independent Measures	N	Means	
Group Number		Self-Esteem ($F<1$)	Depression ($F<1$)
II	100	13.51	14.20
III	100	13.58	14.28
Gender		Self-Esteem ($F=2.82$)	Depression ($F=8.93^{*}$)
Male	72	13.14	12.17
Female	128	13.77	15.41
Victim of Abuse (yes or no)		Self-Esteem ($F=2.71$)	Depression ($F<1$)
No	136	13.75	14.02
Yes	64	13.11	14.70
Type of Abuse		Self-Esteem ($F<1$)	Depression ($F<1$)
Non-contact	12	13.00	15.25
Mild Contact	35	13.31	14.83
Severe Contact	18	12.83	13.78
Age of Perpetrator		Self-Esteem ($F<1$)	Depression ($F<1$)
< 25 years of age	30	12.77	14.90
25 years of age or older	35	13.40	14.29

Table 3 (continued)

Number of Perpetrators		Self-Esteem (F=5.84*)	Depression (F=1.11)
One	40	13.70	13.90
Two or more	24	12.13	16.04
Perceived Aftereffects		**Self-Esteem (F<1)**	**Depression (F=2.15)**
None to Mild	35	13.34	13.20
Moderate to Severe	27	12.74	16.15
Believe Victim of Abuse		**Self-Esteem (F=1.14)**	**Depression (F=2.67)**
Yes	14	14.07	12.43
No	33	12.82	16.67
Don't Know	15	13.13	11.87

Note. * $p < .05$.

Table 4

Analysis of Variance of Self-Esteem and Depression as a Function of Gender and Victim Status

Independent Measures		N	Means	
Gender	Victim		Self-Esteem (F=2.37)	Depression (F=3.62*)
Male	No	53	13.47	12.64
Male	Yes	19	12.21	10.84
Female	No	83	13.93	14.90
Female	Yes	45	13.49	16.33

Source for Depression	DF	F
Gender	1	8.93*
Victim	1	.12
Gender by Victim	1	1.82

Note. * $p < .05$.

CHAPTER IV
DISCUSSION

This research explored how the method of gathering information about childhood sexual abuse affects the percentage of those who report such experiences. Also examined was how self-esteem and depression are affected by specific characteristics of the abuse, such as having a close relationship to the perpetrator, being abused at an earlier age, experiences happening often and for an extended period of time, having force or threats of force used, having received professional help, and having disclosed the incidents to others. This chapter will first discuss the hypotheses in the same order previously outlined and then discuss the relevance of additional exploratory analyses. Possible explanations for both significant and non-significant findings will be included.

Method of Data Collection

The first hypothesis was based on literature which states that questioning about childhood sexual abuse will lead to higher rates of reporting than will spontaneous reporting by the client of such incidents (e.g., Bryer et al., 1987; Ellenson, 1986; Hart et al., 1989; Kilpatrick,1983). Disclosure of a sexual abuse past is often expected by the clinician to happen spontaneously (Briere & Zaidi, 1989; Rosenfeld, 1979b), yet research in a psychiatric setting has shown as much as a 63% difference in reporting rates between those who are queried and those who report spontaneously (Briere and Zaidi, 1989).

Hypothesis I was supported by the data. Clients were significantly more likely to disclose childhood sexual experiences if queried in regard to this behavior. Disclosing of childhood sexual experiences was significantly more likely to occur if the client were directly queried on pencil and paper prior to being interviewed by an intake counselor or if questioned face-to-face after rapport had been established in an intake interview. Either of these methods led to higher reporting of childhood sexual abuse than did relying on the client to spontaneously reveal such history.

The second hypothesis was based on research that concluded if the client were asked about specific childhood sexual experiences in person, after rapport had been established, there would be a higher level of reporting such incidents than if data were gathered by some other method. In comparing studies, Wyatt and Peters (1986b) concluded that personally conducted interviews lead to much higher rates of reported childhood sexual abuse than do self-administered questionnaires in nonclinical populations. The current research found no such difference. In fact, although it was not statistically significant, a higher percentage of those who were questioned on pencil and paper reported childhood sexual experiences than did those who were questioned at the end of an intake interview. This research suggests that clients are equally likely to disclose a history of sexual abuse at intake whether asked by written or verbal measures, when the written or verbal measures are equally detailed.

Characteristics of Childhood Sexual Abuse

Hypotheses III and IV were based on literature that indicates that adults sexually abused as children suffer from lower levels of self-esteem (Blake-White & Kline, 1985; Courtois & Watts, 1982; de Young, 1985; Owens, 1984; Silver & Boon, 1983; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983) and higher levels of depression (Bergart, 1986; Briere & Runtz, 1988; Deighton & McPeek, 1985; Hartman et al., 1987; Herman, 1981; Tsai & Wagner, 1978) than do those who are not survivors of childhood sexual abuse. For example, in regard to relationships, the literature indicates that those sexually abused by a family member often show signs of more long-term negative effects than those abused by someone outside the family (Sedney & Brooks, 1984), especially if the perpetrator is a father or stepfather (Herman et al., 1986; Scott & Flowers, 1988). Also in regard to relationships, those survivors with difficulties in trusting, experience lower levels of self-esteem (Courtois & Watts, 1982; de Young, 1985; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983). However the current research did not support the proposition that the relationship of the victim to the perpetrator or the level of trust between the victim and

the perpetrator prior to the abuse affects levels of either self-esteem or depression for the victim.

Hartman et al. (1987) and Sedney and Brooks (1984) concluded that those who are sexually abused at an earlier age will evidence more negative aftereffects than those whose abuse began later. This conclusion was also not supported by this research.

Some research has concluded that those whose abuse occurred with greater frequency and for a longer duration evidence more severe effects (Kilgore, 1988; Zivney et al., 1988). In the present research, neither frequency nor duration of sexual abuse led to statistically significant results on either levels of self-esteem or depression.

Based on Courtois' (l979) and Feinauer's (1989) work, Hypothesis III also proposed that those who have received treatment for past sexual abuse are more likely to evidence lower levels of self-esteem and higher levels of depression due to their perception of being more affected by the abuse. However, the current research found no differences in self-esteem or depression, based on previous treatment.

Based on Courtois' (1979) work, Hypothesis IV predicted that whether the client had previously disclosed her or his abusive history would make no difference in levels of self-esteem or depression. The results of this research supported this hypothesis. Clients evidenced no differences in self-esteem or depression based on previous disclosure (prior to revealing abuse in this study).

Additional Analyses

Additional analyses of the data were conducted to determine if there were differences in levels of self-esteem or depression for Groups II and III for gender. There were no differences in self-esteem or depression for the two groups. There was also no difference in self-esteem for females and males. But, there was a significant difference between males and females on depression. Females reported a significantly higher level of depression than did males, but gender did not interact with sexual abuse status.

Other characteristics of sexual abuse from data on the Childhood Sexual Experiences Questionnaire (CSEQ) (that were not part of the

proposed hypotheses) were also examined to assess differences in self-esteem and depression. Items selected for inclusion on the CSEQ to make it somewhat more comprehensive were predominantly from research previously conducted by the author and her colleagues (Stinson et al., 1990). Additional variables examined were (a) whether the subject had been a childhood victim of sexual abuse, (b) the type of abuse experienced, (c) the age of the perpetrator, (d) the number of perpetrators, (e) the perceived severity of aftereffects by the survivor, and (f) whether the sexual activity was believed by the subject to be abusive. For all variables, there were no significant differences in either self-esteem or depression, except that having been sexually abused by more than one perpetrator did lead to lower levels of self-esteem.

Conclusions

Both clinicians and researchers have stated that it is important to ask clients if they have had childhood sexual experiences that were abusive. Otherwise, clients are likely to fail to inform the therapist of any such history (e.g., Bryer et al., 1987; Ellenson, 1986; Hart et al., 1989; Kilpatrick,1983). These conclusions have been drawn based on comparisons between studies, not within one study. The one notable exception is that of Briere and Zaidi (1989), who studied female patients in a psychiatric emergency room. No studies have been conducted with other populations. The present research on a less impaired population (college students at a university counseling center) supports Briere and Zaidi's results and confirms that it is important to ask clients if they were victims of sexual abuse.

Some literature concludes that the method of questioning the client about childhood sexual experiences affects the percentage of clients who are willing to disclose such incidents. For example, Wyatt and Peters (1986b) concluded that direct, verbal questioning about childhood sexual abuse experiences, after rapport with the interviewer had been established, leads to a higher percentage reporting these events. Wyatt and Peters' conclusions are drawn from comparing

studies instead of comparing data collected on different methods of questioning clients within one study.

The present study supports the concept that it is important to ask the client if he or she has been sexually abused as a child, but it does not matter what method of inquiry is used. This finding is not surprising in light of our society's taboo in discussing one's sexuality, especially deviant sexuality. Simply asking detailed questions about childhood sexual abuse in an accepting, non-accusatory, matter-of-fact manner (whether face-to-face or on pencil and paper) allows the survivor, perhaps for the first time, to disclose behaviors that he or she may have guarded for many years. To the client, giving permission to discuss childhood sexual abuse by asking detailed questions may be more important than how she or he is queried.

It is also possible that the method of inquiry makes no difference because clients who present for therapy expect to be asked personal questions. The client has come to the therapeutic setting with the expectation that she or he will be discussing personal matters. If the therapist, in any form, asks about personal, sexual information, the client may perceive that it is appropriate in the therapeutic context to discuss sensitive, sexual issues. Therefore, asking about a sexual abuse past on pencil and paper or verbally may lead the cooperative client to reveal childhood sexual abuse experiences because that is the therapeutic expectation.

Although many researchers have reported differences in levels of self-esteem and depression for clients who vary on specific situational characteristics related to childhood sexual abuse, the present study found few differences. One possible explanation for this finding is that the population from which the sample was taken (i.e., clients in a university counseling center) is different than those who present for treatment in other settings, such as mental health clinics or psychiatric settings. Although some research has found some differences in college populations in self-esteem (e.g., Stinson et al., 1990), clients at a university counseling center may report higher levels of self-esteem and lower levels of depression than other treatment populations. Also, the lack of significant findings in regard

to self-esteem could be related to the low internal consistency of the measure of self-esteem (i.e., Rosenberg Self-Esteem Scale).

The population in the present study is also different than students in a university undergraduate psychology subject pool (college non-treatment population). For example, Adler's (1989) student sample from the same university reported higher levels of self-esteem and Raciti's (1991) population from the same university reported lower levels of depression than the treatment population in the present study. Generally lower levels of self-esteem and higher levels of depression in the present population may make it more difficult to detect aftereffects related to self-esteem and depression due to childhood sexual abuse.

The present population also differed from a general psychology pool population in the percentage who reported a sexual abuse history. For example, one study at the same university, using a nearly identical instrument to gather data about childhood sexual abuse, found a 12% occurrence rate of sexual abuse for college females (Stinson et al., 1990) compared to the present study that found an occurrence rate of 35% for females. Prevalence rates depend on how and where data are collected. For counseling center clients, sexual abuse problems may be the most frequent "common denominator" in terms of problems.

The major significant finding of this study is that it is important to inquire about childhood sexual abuse incidents at intake by either a personal interview or pencil and paper method. Clinically, this finding is very important. As previously noted, it is still not unusual for professionals to avoid issues related to sexual abuse (Taubman, 1984). A formal method of gathering information on childhood sexual abuse will allow the therapist to assess this important area of the client's history.

Simply inquiring about sexual abuse, whether on pencil and paper or verbally at intake, allows the client to perceive that it is normal to report this information. Therefore, the client who is aware of a sexually abusive past, and willing to disclose this history, will reveal information about childhood sexual abuse regardless of the method of inquiry. It appears to make no difference if the therapist chooses to

ask the client on pencil and paper or verbally during the intake interview about childhood sexual abuse. The clinical implication is that it simply matters that the therapist does ask the client, giving the client the opportunity to reveal childhood sexual experiences.

Limitations of the Current Study

There are several possible limitations of this study. These include the nature of research on survivors of childhood sexual abuse and the generalizability of this study. Each of these possible limitations will be addressed below.

Because of the nature of childhood sexual abuse, it is difficult to gather accurate data at the time the abuse occurred and virtually impossible to conduct a longitudinal study to research aftereffects. Therefore, all studies of long-term effects have been retrospective, asking victims to recall what abuse happened to them years earlier and then attempting to assess the effect of these events on current functioning. Since survivors' memories are influenced by loss of memory and impression management, and there is typically no way to gather information from the perpetrator to verify the events, there is always some question in regard to validity (Kilpatrick, 1986). The same problems with validity reported in other research apply to the present study.

There is some difficulty in generalizing the results of this study to other populations for two reasons. The first reason is that these clients represent a select group of primarily young adults who are not representative of college students. Clients in university counseling centers appear to be different from the general college population. In addition, even though these students are presenting for therapy with important issues, it is not assumed that this population is equal to populations in other therapeutic settings or to the general population.

The second problem in generalization is that young adults who suffer from post-traumatic stress disorder (PTSD) may not remember that they were sexually abused as children (Donaldson & Gardner, 1985; Lindberg & Distad, 1985). Clients who tend to have suffered more severe forms of sexual abuse (and hence have more severe aftereffects)

may not be capable of disclosing their past until they are older and some life event or situation triggers a memory. Therefore, students who do not remember their abuse would be included with those who reported no experiences of childhood sexual abuse.

Directions for Future Research

The present study provided important clinical information on gathering information from new clients about sexual abuse histories. This research should be extended in the future to include older populations and broader settings to assess the effects of questioning clients in regard to childhood sexual abuse.

The body of literature on treatment of sexual abuse survivors would also be enhanced by further exploration of self-esteem and depression. The current research did not support previous research that concluded that these emotional factors are affected by childhood sexual abuse. However, because of the mixed research findings, future research should continue to explore childhood sexual abuse and the survivor's levels of self-esteem and depression.

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APPENDIX A
EXTENDED LITERATURE REVIEW

Childhood Sexual Abuse Among Clients

Childhood sexual abuse has received much attention in the literature in the last few decades (e.g., Bass & Thornton, 1983; Burgess, et al., 1978; Meiselman, 1990). Research and theory have focused on both the initial consequences for the childhood victim of sexual abuse as well as the long-term effects for the adult survivor. Although initial journal articles on the topic tended to be theoretical, more recent articles have not only taken an empirical approach, but have become increasingly sophisticated in both methodology and analysis. Articles have focused on a variety of topics, such as dynamics of the abusive situation, prevalence rates, initial and long-term symptoms, and treatment (e.g., Browne & Finkelhor, 1986; de Young, 1985).

This review will explore the topic of childhood sexual abuse from several different perspectives. First, the act of childhood sexual abuse itself will be discussed. What is childhood sexual abuse, and who are its participants? Second, the much debated prevalence rate will be discussed, as will information on the disclosure of such events. Next, the effects on the victims of childhood sexual abuse will be examined. This section will briefly highlight short-term effects and then discuss in more depth long-term consequences for the adult survivor as well as treatment for these aftereffects. Then methodological issues in the study of childhood sexual abuse will be explored.

Childhood Sexual Abuse

In the l950's and l960's, the nation's attention turned toward child abuse (Rosenfeld, l979a), which can take on many forms, ranging from neglect of the child (omission) to purposefully trying to harm the child (commission) (Kaufman, Coury, Pickrel, & McCleery, 1989) . When an adult acts to purposely harm a child, a variety of behaviors may be involved, such as physical abuse, sexual abuse (Knox, 1988), and parents faking physical illness in their children so their children may receive unneeded medical treatment (Munchausen Syndrome by Proxy) (Rosenberg, 1987).

In an early, frequently cited study, Weinberg (1955) estimated that sexual abuse had a one-in-a-million incidence rate. Although this

estimate was obviously low, few professionals of the day had any idea that the rate would be significantly higher (Rosenfeld, 1979b). Today, some estimates are as high as an over 50% incidence rate (Wyatt & Peters, 1986a).

Although the female child is more often abused, the male child may also be sexually abused (Finkelhor, Hotaling, Lewis, & Smith, 1984). Abuse of males is underreported in both the literature and clinical settings due to fear, confusion, and embarassment. Also, as is true for females, a male may have repressed memories of the abuse and may not remember until something in adulthood triggers the recollection (Singer, 1989).

There has always been an interest in sexual abuse, especially incest, by authors, poets, and practitioners (Rist, 1979). But during recent decades, many changes in our society were taking place and the nation was becoming more aware of individuals' rights (Courtois & Watts, 1982). Sometime after this beginning, society began to admit that there was a problem with not only physical abuse and neglect, but also with sexual abuse of our children. Eventually, there was an increasing awareness among mental health professionals that not only were children suffering in childhood from this victimization, but many adults who were abused in childhood also evidenced long-term effects (Tsai & Wagner, l978).

The topic of childhood sexual abuse had been traditionally neglected because the initial focus was on prosecuting the male perpetrator and making sure that he paid for this heinous crime, as well as upholding the societal belief that sexual abuse of children was very rare, only occurring when a deranged male was on the loose (Tsai & Wagner, l978). Of course, today, mental health professionals realize that sexual abuse can occur in a family that evidences no other significant pathology (e.g., Scott & Stone, 1986), and may be perpetrated by a variety of persons, including males and females (de Young, 1985).

There are several social and scientific reasons why there is more research on childhood sexual abuse and its survivors now than previously. For instance, a more sexually permissive society has allowed more open discussion of topics previously considered

inappropriate. Many people openly talk about sexual topics and are also more accepting of other people discussing once forbidden areas. In addition, the social climate that allowed the women's movement created an atmosphere that focused on special issues for women. These included rape and wife battering, as well as the aftereffects of childhood sexual abuse, which is perceived as a women's issue. In addition, research on childhood sexual abuse has revealed that a significant amount of child abuse occurs. These factors, coupled with the fact that those who are victims are more readily seeking intervention and treatment in childhood and adulthood, has lead to an increase in the amount of research conducted in this area (Courtois & Watts, 1982).

Definitions

The definition used by the researcher and clinician to define what constitutes childhood sexual abuse is very important. Using different definitions has made the literature confusing. The confusion is evident when trying to understand research on prevalence rates and short- and long-term effects (de Young, 1985; Sheldon, 1988).

Simply defining what constitutes childhood sexual abuse can be a major obstacle to study in this area. Many studies are unclear as to what behaviors should be included as well as what methodology to use. Thus researchers may use vastly different criteria. For example, when comparing four studies of sexual abuse, Sheldon (1988) found reported rates of occurrence of 4% in a clinical population that did not solicit a sexual abuse history and only gathered data on paternal incest with daughters. However, an occurrence rate of 44% was reported in a clinical population when a broader definition of sexually arousing activities was used and patients were directly queried.

Another issue in the definition of childhood sexual abuse that makes the area difficult to research is that even though the child who has sexual interactions with an adult or older child is a "victim," the usual requirements for the definition of "victim" do not apply to children. For example, children may somewhat willingly become involved sexually with someone because of the power that the other

person has over them. But, children, unlike adults, are not cognitively capable of giving consent. Also, children do not have to be physically harmed to have been abused. The sexual abuse may have simply been fondling or verbal sexual abuse. Therefore, less serious forms of behavior may be abusive for a child but not fit traditional definitions of victim (Wyatt & Peters, 1986a).

To choose an appropriate definition, the researcher must look at the purposes of the research. For example, when looking for developmental influences of childhood sexual experiences, it might be appropriate to select a broader definition. But when looking for pathology, the researcher may want to select a more narrow definition since more severe abuse should be correlated with more severe aftereffects (Haugaard & Emery, 1989).

Breadth of definition. Although it is common for a researcher to use a restrictive definition when defining sexual abuse for children and for adolescents, there is no empirical rationale for this procedure. In fact, the effect of utilizing more narrow criteria may be to uphold a societal stereotype that blames the victim for their victimization. The victim may be considered a victim only if there is forceable rape (Wyatt & Peters, 1986a). This is an important issue since sometimes the victims themselves do not even realize that they were sexually abused as children. The child may have believed the adult who said that she or he was simply teaching the child about sex. Or the child, lacking a realistic gauge to measure appropriate adult/child interaction, may have believed that the sexual behaviors were normal forms of affection (Berliner & Conte, l990).

Some researchers and theorists have only considered contact abusive if it involved sexual intercourse with the child (Wyatt & Peters, 1986a). Also, some authors have debated whether a child consented to the sexual involvement (Benward & Densen-Gerber, l975). Others ignore the consent issue and look at the age of the child (e.g., Faller, 1989; Fromuth & Burkhart, 1989; Harter et al., 1988). They point out that if there is a minor child involved and there is a significant age difference between the persons involved (usually five

years), then the child is not capable of consenting due to the unequal power in the relationship (Finkelhor, 1984).

When the definition of childhood sexual experiences is defined broadly, including even mild situations such as hugging or kissing in a sexual way, the prevalence rate can be quite high. Haugaard and Emery (1989) point out, though, that using a broad definition of childhood sexual abuse may work to cover up the aftereffects for those who are severely abused, since it would include behaviors that are less likely to produce severe aftereffects. A broad definition may also raise concern for those with more benign experiences who are less likely to experience aftereffects.

Many of those who admit to some form of sexual involvement as children do not consider the interaction to be abusive. For example, 67% of Kilpatrick's (1986) college and community sample who said they had experienced some form of childhood sexual interaction indicated that they received little pressure to be sexually involved. It is not surprising that using a broad definition, Kilpatrick found no significant differences on measures of family relations, marital satisfaction, sexual satisfaction, depression, and self-esteem between those who had and those who had not had a childhood sexual experience. But those who had felt forced, were guilt-ridden, harmed, or pressured were significantly different from the other sexually abused subjects on several measures (e.g., depression, self-esteem).

A commonly used definition of incest (e.g., Courtois & Watts, 1982) is Benward and Densen-Gerber's (1975, p. 326) sociological definition which states that incest is " . . . sexual contact with a person who would be considered an ineligible partner because of his blood and/or social ties (e.g., "kin") to the subject or her family." This definition is embraced by clinicians and researchers because it includes "quasi-family" members. For example, sexual contact with a parent's lover, who is in a parental role and is perceived as trustworthy by the child, would be considered to be incestuous involvement with a child.

Sheldon's (1988) definition of childhood sexual abuse is broad, focusing on the victim's perception, both at the time of the abuse and later in life. If the survivor feels the incidents were abusive at any

time, it would be defined as abusive. Sheldon's definition allows all forms of contact and noncontact interactions to be considered.

Of course, a definition can become too inclusive to be practical for research. For example, Blume (1990) extends her definition of incest to include sexual contact with any perpetrator who would be considered a caregiver, including scout leaders, doctors, neighbors, and other non-relatives. To her, becoming a surrogate parent is the most important issue. This definition focuses on the emotional aspects of the relationship instead of the legal tie. For clinical purposes, this definition is helpful, but it may be unwieldy as a research tool without precise methodology to determine who the child considered a surrogate parent.

Many definitions stop at giving a conceptual definition of childhood sexual abuse within the family and by non-family members. Of course, for clear data collection, a more behaviorally-oriented, operational definition must be delineated. Although there have been attempts with more recent research to provide a clear, precise definition, there is still a wide range of definitions that are used by various experts and researchers.

Wyatt and Peters (1986a) believe that there is a simple solution to the debate of how to define childhood sexual abuse. They suggest reporting prevalence data for more narrow as well as more broad definitions of sexual abuse so that various studies in the literature can be compared with each other. This would lead to researchers reporting data on older adolescents, closer-aged perpetrators and less severe forms of abuse. Others prominent in the field also recommend using a broader definition. For example, Finkelhor (1979; 1984), who previously did not include age mates in his prevalence research, now recommends examining whether the relationship was abusive instead of simply setting age limits (Finkelhor & Hotaling, 1984; Wyatt & Peters, 1986a). Therefore, the only activity that is considered inappropriate to assess and report on is consensual sexual contact between peers (Finkelhor, 1986; Finkelhor & Hotaling, 1984; Wyatt & Peters, 1986a).

Behaviors involved. Various studies have specified different behaviors as constituting sexual abuse of a child. For example,

Sansonnet-Haydon et al. (1987), when studying hospitalized adolescents, required that there be physical contact of the breast or genitals to consider a person to have been sexually abused. Legal definitions of incest and sexual abuse are also often very restrictive. Criminal definitions may include only cases of penetration in defining incest or sexual abuse (Wyatt & Peters, 1986a).

Some studies broaden their definitions to include other forms of abuse besides sexual abuse. Some studies report prevalence and aftereffects for all types of abuse together, and some will break subjects into discriminant groups. For example, Stiffman (1989) studied sexual and physical abuse. She reported a 48% prevalence rate of physical and/or sexual abuse for runaways at a shelter. She also broke down her data to report a 9.6% prevalence rate of incest. In reporting the aftereffects, the physical and sexual abuse were not separated. This leaves the reader in doubt as to which aftereffects were correlated with the physical abuse and which were correlated with the sexual abuse.

The choice of behaviors has implications for prevalence rates, effects on survivors, and recommended therapeutic interventions. It may be assumed that the child who has experienced more "severe" abuse (e.g., intercourse versus fondling) will suffer more severe consequences (de Young, 1985). Again, as in breadth of definition, the best solution appears to be to collect data on all behaviors that may potentially be sexually abusive, then use precise methodology to explore specific behaviors and consequences (Wyatt & Peters, 1986a).

Perpetrator. Although father-daughter incest only has a 1% prevalence rate (Finkelhor, 1979; Knox, 1988), it is not uncommon for those who hear the word incest to think only of this form of sexual abuse (de Young, 1985). It appears that sibling incest is the most common form of sexual abuse and mother-child incest the most rare. There is much more in the literature on father/step-father and daughter incest than any other type of sexual abuse perpetrated on a child. But even for the supposed rare mother-child incest, there are many case examples in the literature, possibly due to the novelty of this type of sexual activity (de Young, 1985).

Legal definitions of incest tend to include only cases where the participants are blood relatives. When only blood relatives are included (excluding perpetrators such as step-fathers), the prevalence rate of intrafamilial sexual abuse becomes much smaller (Reinhart, 1987). Of course, including only blood relatives ignores the realities of today's society (Scanzoni, Polonko, Teachman, & Thompson, 1989) where a child may be sexually abused by a step-relative or a live-in lover. Often the child experiences the abuse as incestuous since they have a parental or close relative relationship with the perpetrator, although it may not be legally classified as such (de Young, 1985). Collecting this information makes the data more clinically rich and representative of reality.

Location. Sexual abuse of children may take place anywhere. In the case of intrafamilial abuse with a close blood relative with whom a child is living, the abuse usually occurs in the home, often in the child's own bed (Ellenson, 1985). With extrafamilial sexual abuse or with relatives with whom the child does not live, the sexual activity can take place anywhere, including schools, the outdoors, or the offender's home (Rivera, Seligman, & Liebman, 1984).

Dynamics of Abuse

Antecedents of Sexual Abuse

In an attempt to understand how and why sexual abuse, especially incest, occurs, several theories have been offered. For example, the feminist perspective looks at sexual abuse through a large frame that indicts society and its attempts to control and subjugate females. This is in contradiction to earlier work that viewed the mother in father-daughter incest as a co-perpetrator who indirectly encouraged the abuse (de Young, 1985). By not protecting her daughter, the mother was able to benefit from having the daughter take over the mother's role in the marriage, both in and out of the sexual arena (Justice & Justice, 1979; Maisch, 1972; Weinberg, 1955). A variation of this theory would state that the mother was assigned an inferior position in the family, could not withstand a controlling spouse, and was incapable of protecting her daughter (Herman, 1981).

From a psychosocial perspective, researchers have attempted to understand the "type" of family system in which incest occurs. Although a characterological perspective that viewed individuals in incestuous families as quite pathological was initially embraced by most scholars in the area, that perspective apparently is true in only a small portion of cases (Scott & Stone, 1986). In these molestations, the relative actually attempts to harm or rape the child. For many sexual abuse incidents, the outdated concept of typing families helps the clinician understand how sexual abuse events occurred. Yet, typing families does not explain all intrafamilial or any extrafamilial sexual abuse. So it is far too simplistic to use "typing" to explain the majority of sexual abuse cases. In fact, instead of helping the victim, typing a family may make the child more of a victim. For example, if the family is at fault, society sees the appropriate intervention as breaking up the family, thereby causing family financial problems which lead to more blame and guilt for the victim (Rosenfeld, 1979a).

A "mild" version of the pathological model was presented in the early work of Meiselman (1978). She classified some of the fathers of her clinical population as pathological in that they totally ignored the needs of their daughters in order to look only at their own needs. She attempted to understand the fathers and used other labels such as "endogamic" to explain the father who was dependent on the family to meet all his needs, and "pedophilic" to describe the father who sexually abused a variety of children.

Professionals have previously gravitated toward a pathological explanation because the adult does ignore the child's emotional needs and takes advantage of the child when he or she is incapable of giving consent. Therefore, the perpetrator "should" control him or herself. Also, the explanation is simple and easily embraced. Yet to simply label the individual or family as pathological is to ignore the dynamics that are going on inside the family (Rosenfeld, 1979a). For example, Scott and Stone (1986) studied intrafamilial sexual abuse in families with father-daughter or stepfather incest. They found that the fathers, stepfathers, and non-participating mothers did not elevate scales on the MMPI, but the daughters elevated the psychasthenia and

schizophrenia scales. From this they speculated that the incest did not begin as a result of psychopathology but led to the creation of psychopathology, which appears to be partially due to the parents using the child to meet their own emotional needs (Koch & Jarvis, 1987). Alcohol consumption by the perpetrator (Yeary, 1982) or by both parents (Bess & Janssen, 1982) may add to the unhealthy dynamics of the family.

When the perpetrator is an adult or older child, the relationship between the perpetrator and victim is one that abuses the power that an older person naturally has over a child, due to position and age. The older person should be one who can be trusted, but in reality the perpetrator betrays this role (Tsai & Wagner, 1978). Then all the family members do their part in some way to perpetuate this system that allows the abuse to continue (Rosenfeld, 1979a).

What may be a more helpful model of sexual abuse is that the parents, or other perpetrators, were victims of neglect or abuse themselves and have never learned to meet their needs without abusing children. Within the family, this is a generational perspective that attempts to understand the learned behavior that have been passed down from one generation to the next. There ". . . seems to be a multigenerational victim-to-victim relationship" (Rosenfeld, 1979a, p. 408).

When there is long-term sexual abuse, the perpetrator will go through a grooming process to socialize the child to accept the sexual involvement. The majority of children do not initially realize that sexual abuse is occurring. Berliner and Conte (1990) state there are three stages to this process which usually includes slowly sexualizing the relationship, offering some form of justification to the victim, and coercing the child to keep silent about the activities.

Consequences for the Family

Sexual abuse within the family has dramatic effects on the various members. Some of the effects are predictable by knowing who the participants are.

In the family where there is sexual abuse of the child by the opposite-sexed parent, for both male and female victims, there is role reversal between the child and the non-participating adult. The child becomes either the mother or father figure for the non-powerful, non-intervening, or absent same-sexed parent (de Young, 1982). The parent who is the abuser becomes the nurturer of the child victim, although in an unhealthy, sexual manner. The child is emotionally torn between the special attention received and the sexual behavior that is attached to that "gift" of special attention. The child may find both the physical activity and the attention pleasurable, which creates ambivalence for the child (Rosenfeld, 1979a).

In families where incest is known about by various family members, the relatives (e.g., mother, siblings) may become angry at the victim. For example, a daughter is supposed to have resisted the advances of the father, even in severe situations, such as when he beats her if she resists. Therefore, the victim is blamed for her victimization (Gordon, 1988).

From the little that is known about mother-daughter incest, when the mother enters into a sexual relationship with her daughter, it appears that there is a symbiotic relationship that excludes any males in the family. The mother sets up the family to make the daughter dependent on her and extends this enmeshed, emotional relationship to a sexual relationship (de Young, 1982; Meiselman, 1978).

In a family where sibling incest occurs, there appear to be three characteristics that correlate with this type of abuse. These families are sexually stimulating (Smith & Israel, 1987; Weinberg,1955), parents are unavailable emotionally and physically, resulting in a lack of supervision (Meiselman, 1978; Smith & Israel, 1987), and the family has a closed system that keeps secrets (Smith & Israel, 1987). Also, some families in which sibling incest occurs can be classified as enmeshed (Rosenfeld, 1979a). Paternal incest may have preceded the sibling incest (de Young, 1982; Meiselman, 1978). Often, when there is sexual abuse with a brother and sister, the male is an older, domineering child (de Young, 1982; de Young, 1985; Meiselman, 1978).

Regardless of who the participants are, children are affected by intrafamilial sexual abuse. For example, adults who were sexually abused within their families often see the parents negatively, viewing them as very controlling in their parenting style (Cole & Woolger, 1989).

Populations Studied

Clinical, Criminal, and General Populations

When reviewing the literature, authors have pointed out that using various populations has made a difference not only in the prevalence rate of sexual abuse reported but also in the symptomology reported. For example, research on clinical populations will find more pathology, and research on court-referred populations will uncover more acting out behavior (de Young, 1985). In a clinical population there is also a longer duration of abuse, abuse that began at an earlier age, as well as more use of force and violence (Edwall et al., 1989). Those adults entering therapy who as children were molested by a parent may present with more symptoms than those in therapy without a sexual abuse past (Meiselman, 1978). Many studies on childhood sexual abuse have gathered subjects from clinical or criminal populations, making generalizability difficult (Kilpatrick, 1986). Therefore, when conducting research, the researcher must keep in mind the study's purpose and the population to which the results will be applied.

Briere and Runtz (1988) state that there is a paucity of data in the literature on non-clinical populations. Some studies on non-clinical populations have found few or no statistically significant results (e.g., Fromuth, 1986; Stinson et al., 1990), whereas others have found a wealth of important findings. For example, in studying a college population, Briere and Runtz (1988) found that many victims suffered from symptoms that are linked to post-traumatic stress disorder (PTSD). In studying intrafamilial and extrafamilial sexual abuse, Sedney and Brooks (1984) found that college students evidenced more severe psychopathology when they had experienced intercourse as part of the abuse and had been sexually abused for a longer period of time. Rosenfeld (1979a) argues that using a clinical population may be

misleading in light of the number of well-adjusted survivors in college populations. But he defines well-adjusted as those who do not seek treatment. This may also be misleading.

Regardless of the population studied, the vast majority of researchers have concluded from their data that sexual abuse of children has long-term negative effects. Those studies that do not report negative effects are often scientifically questionable (Kilpatrick, 1987). For example, one study that reported on "non-damaging" incest was suspect because subjects were solicited from newspapers. Many who responded that the sexual activity was "not harmful" could perhaps have been perpetrators (Nelson, 1986).

Regardless of the setting, much of what is reported in this literature review is on females, since there has been so much more work done on female than on male victims (de Young, 1985). Yet, studies on males often find the same destructive short- and long-term effects (e.g., Adams-Tucker, 1982) plus the additional effect of males questioning their sexual orientation (Justice & Justice, 1979).

Intrafamilial versus Extrafamilial Sexual Abuse

Some studies have attempted to study the differential effects of intrafamilial and extrafamilial sexual abuse. The results of these studies have not been consistent. For example, Bryer et al. (1987) found no difference on personality measures for sexual abuse victims when abuse occurred between family members and non-family members. Yet, Sedney and Brooks (1984) and Ruch and Chandler (1982) reported higher symptoms of disturbance for those victimized within the family.

Intrafamilial sexual abuse. Hartman et al. (1987) make the point that the abusive situation is different depending on the relationship between the victim and the perpetrator. When the abuse occurs within the family, the abuse tends to begin earlier, uses less violence or threat of violence, is less likely to involve intercourse, occurs a higher number of times, and is less likely to be reported at the time of the abuse.

More long-term effects for the victim have often been reported if the perpetrator was more closely related, such as a biological father rather than a grandfather or uncle. As previously indicated, this is believed due to the child's perception that the father should be someone who can be trusted and who should protect his child (Blume, 1990; Courtois & Watts, 1982). Gordon (1989) reports that there is a qualitative lifestyle difference between families in which sexual abuse occurs when the perpetrator is a biological father rather than a stepfather. There are significantly more alcohol and drug abuse, marital problems, and low income in the home in which the natal father is the perpetrator.

Sibling incest. There has been little research on sibling incest (De Jong, 1989). The effects from sibling incest will depend somewhat on the nature of the relationship of the siblings. Daie et al. (1989) have concluded from their small sample that if the relationship was an exploitive one, there is a higher chance that the victimized child will have difficulty establishing and maintaining healthy personal relationships. There is an even greater threat to healthy sexual relationships. These problems are less likely to occur in a sibling relationship that would be considered nurturing.

Although they used no control group, Smith and Israel (l987) reported some interesting dynamics in families who had validated cases of sibling incest. For example, almost half (48%) of the children had witnessed their parents involved in some form of sexual activity, often without the parents being aware of the observation. Seventy-two percent of the families had a parent who was sexually abused as a child. The mothers tended to be extreme in their behavior toward their children in that 40% of the mothers were labeled by the researchers as "seductive" toward their children, while 32% were labeled as "rigid" and "puritanical" (not allowing sexual matters to be discussed or being negative about sexuality). In addition, an extramarital sexual relationship was going on outside of the family at the time of the sibling incest in 76% of the families, with the mother being involved in an extramarital relationship in all 20% of the cases where a female child was the perpetrator.

Other forms of intrafamilial sexual abuse. Other forms of incest besides paternal, maternal and sibling incest have not been well documented in the literature. This may be due to a lack of reporting, since a blood relative, such as an uncle or cousin who does not live with the family, can simply be excluded from further visits with the child. Also, a child who has had sexual interactions with a relative outside of the nuclear family may not have a significant emotional relationship with that family member. Therefore, the child would feel as if she or he had had interactions with a stranger, instead of a close, loving relative who should be able to be trusted (de Young, 1985).

The research that has been done on non-nuclear, intrafamilial incest indicates that the common belief that this form of incest is benign is not always accurate. When the relationship between the relatives is emotionally close (Meiselman, 1978) and the family is disorganized (Goodwin, Cormier, & Owen, 1983), there are more serious aftereffects for the child. An example of familial abuse that is downplayed is sexual abuse by a grandfather. This is often deemed to be just "foolish carrying on" by a dirty old man (de Young, 1985). The sexual interaction may not have significant effects on the child due to the non-threatening, gentle nature of the interaction (de Young, 1982), but such abuse may be related to behavioral or educational problems (Goodwin et al., 1983) and problems with heterosexual relationships in adulthood for the survivor (Meiselman, 1978).

Extrafamilial sexual abuse. For intrafamilial sexual abuse, the relationship to the perpetrator appears to make a difference in the reported effects on the survivor. This may also be true for extrafamilial sexual abuse if the perpetrator is viewed as a close, trusted person (Blume, 1990). But for those abused by someone outside the family, the aftereffects may be more easily understood by considering other factors. For example, aftereffects are more severe if threats and violence are used, if injuries occur, and if a weapon is used by the perpetrator (Ruch & Chandler, 1982).

When studying childhood sexual abuse, various populations may be targeted. For example, a clinical, criminal, or general/non-clinical population may be studied. Also, research may only look at incest, only

at extrafamilial sexual abuse, or may compare sexual abuse within and without the family. Whatever approach the researcher takes, assessing each of these populations will lead to somewhat different results.

Prevalence Rates of Childhood Sexual Abuse

Studying the prevalence of childhood sexual abuse appears to have begun in earnest in the late 1970's, with scattered studies prior to that time. Although many of these studies use the term "incidence" (e.g., Rosenfeld, 1979b; Sheldon, 1988), which is defined as the number of new cases that occur each year, the majority focus on "prevalence," which is the percentage of persons who will experience sexual abuse anytime during their childhood. There has been a wide range of figures reported, with estimates as high as over 50% and as low as less than 10%. Much of the variation appears to depend on the definition of childhood sexual abuse (Wyatt & Peters, 1986a) as well as on the researchers' methodology (Wyatt & Peters, 1986b).

Some individuals question reported prevalence rates because of the belief that children fabricate reports of sexual abuse. Although many allegations of sexual abuse are denied by the accused perpetrator, few false disclosures occur (Green, 1986; Rosenfeld, 1979b). When the incidents are fabricated, it is often the result of a child custody dispute in which one parent has coaxed the child to lie about the other parent (Green, 1986).

Factors Affecting Prevalence Rates

In reviewing the literature, it is clear that reported rates of occurrence of childhood sexual abuse are affected by many factors. On the other hand, some factors do not appear to impact reported rates.

Response rate. When gathering data on childhood sexual experiences, Haugaard and Emery (1989) found that an interesting phenomenon occurs. It appears that response rates have an effect on the resulting prevalence rates. If subject participation is high, the resulting prevalence rates may be an underestimation of the "true" prevalence rates. But, if the response rate is low, then it appears that there may be an overestimation of prevalence rates. These authors

conclude that the sexual abuse survivor is less likely to affirm that there has been past sexual activity when compared to a group where almost everyone cooperates (e.g., a college classroom where students fill out forms during class). But when there is a lower level of participation by others in the study (e.g., a college class that is allowed to take the questionnaire home and mail it back later), the person who has been involved in childhood sexual experiences is more likely than those not previously involved in sexual experiences to participate in the research and relate their experiences.

Methods. Using different methods often leads to varying degrees of reported abuse. When comparing studies, Wyatt and Peters (1986b) concluded that personally conducted interviews lead to much higher rates of reported childhood sexual abuse than do self-administered questionnaires in nonclinical populations. Also, asking several activity-specific questions leads to a higher rate of reported occurrence than does asking one or a few questions.

Prevalence rates will also be affected by the breadth of the definition used. If the definition is broader, the rate of reported occurrence will be higher. If the definition is narrow, the prevalence rate will be lower (Haugaard & Emery, 1989). With a broad definition, Kilpatrick (1986) found that 55% of her female sample reported that they had experienced sexual interactions as a child. But only 2% had experienced intercourse, with kissing and hugging in a sexual manner (37.1%) and exhibition (35.1% shown genitals of another and 22.9% showing own genitals to another) being the most reported forms of sexual contact. Only 33% felt that they had been forced into the sexual activity, while only 25% found the activity unpleasant. The subject's typical reaction was interest or curiosity. Although the literature has reported an increase in the incidence rate of childhood sexual abuse, some experts believe that the actual rate has not increased but that the definition has broadened, making it appear that there has been an increase. In fact, the overall rate of childhood sexual activity appears to have decreased over the last sixty years (Kilpatrick, 1986).

Some methodological issues appear to make no difference in response rates. Whether one employs a random sample makes no

difference in the results (Wyatt & Peters, 1986b). The order of questions also makes no difference in the prevalence rates obtained (Haugaard & Emery, 1989).

Population differences. The population in which the sample is collected makes a difference in the prevalence rates. In clinical populations, the prevalence of childhood sexual abuse is often high. For example, among drug abusers, the prevalence rate has been reported to be as high as 44% in a treatment population (Benward & Densen-Gerber, 1975). For an adolescent drug treatment program, 35% to 45% of the female patients have a sexual abuse past (Edwall et al., 1989). Lower estimates in a clinical population include 19.7% for a drug abuse population (Ladwig & Andersen, 1989).

Criminal settings report various prevalence rates. In a juvenile shelter for runaways, almost 10% of the juveniles reported an incestuous history (Stiffman, 1989). Among mental health professionals, the rate of occurrence of childhood sexual abuse is high. In a study by Doughty and Schneider (1987), 21.6% of MA level psychologists and 22.6% of graduate students reported having been incestuously abused as children. Unfortunately, what constituted incest in this study was not defined.

In an extensive study on a general population, Russell (1986) found that 16% of her female subjects reported a history of incest. When including any childhood victimization, the rate of occurrence rose to 31%. Herman (1983) reported that about one quarter of females in the general population are sexually molested by the time they reach age 18, while one tenth of females will be victimized by a family member. Those who go to college are higher functioning than the general population. Therefore, studies that use college students as the subject pool are likely to underestimate the prevalence rate (Haugaard & Emery, 1989). Even so, in college populations Briere and Runtz (1988) reported a 15% prevalence rate of childhood sexual abuse, and Harter et al. (1988) reported a 13.4% familial and 10.0% non-familial sexual abuse rate.

As previously indicated, females report a higher rate of childhood sexual abuse than do males. Earlier studies (e.g., Finkelhor, 1979) as

well as more recent studies report this difference. For example, Sansonnet-Hayden et al. (1987) reported a 37.9% rate of occurrence for females and a 24% rate of occurrence for males when making direct inquiries of newly admitted patients on a psychiatric unit.

Other factors. The prevalence rate of sexual abuse also depends on a variety of other factors contributing to whether a high or low rate of occurrence is reported. For example, when categorized by relationship to the perpetrator, incest committed by the biological father has a prevalence rate of approximately 1 to 2% (Kilpatrick, 1986; Knox, 1988). Sibling incest may be one of the most underreported types of incest, with most experts agreeing that it is the most common form of sexual abuse (de Young, 1985). Maternal incest has received little attention in the literature, with mother-daughter incest reported even less often than mother-son incest. Mother-daughter incest may not be reported as often in clinical populations because it does not occur as often or may not create as many negative effects for the victims (de Young, 1985).

There are several factors that appear to make no difference in the reported prevalence rate. For example, geographic areas of the United States make no difference in reported prevalence rates (Wyatt & Peters,1986b). Also, a stereotype exists that there is a high rate of occurrence of childhood sexual abuse in minority groups. But this is not supported by the literature (Kilpatrick, 1986; Wyatt & Peters, 1986b).

Disclosure

Determination of prevalence rates of childhood sexual abuse obviously depends on people's willingness to disclose facts about experienced abuse. Disclosure takes on different roles depending on the time at which disclosure occurs. The child who discloses sexual abuse is often doubted and questioned and is viewed with suspicion. The therapist will often regard the disclosure as fantasy (Masson, 1984; Rosenfeld et al., 1979). The adult who admits to a victimized past is believed, more often than not. Those who are made aware of the

incidents may tend to either exaggerate or minimize the effects, but the adult is generally believed (de Young, 1985).

Failure to disclose. Those who have been sexually victimized often fail to report the events to others. For the child, this is often due to the differential power of the adult and child that makes the child afraid to let others know of their secret (Conte & Berliner, 1981). It is often difficult for the child to disclose the abuse, and he or she will not even respond to direct questioning about the possibility. The clinician must be very skillful when inquiring, or erroneous conclusions and then, decisions may be reached (Sink, 1988).

Even when the child does disclose the abuse, as happened for approximately 25% of the female adolescent drug abusers in Benward and Densen-Gerber's (1975) study, the overwhelming majority of the mothers in this population did not believe their daughters. In addition, the disclosing child or adolescent also fails to receive treatment when he or she discloses. Instead, there is a paternalistic, protective response from the system that should protect the child from further abuse and advocate for the child (Rowe & Savage, 1988).

It appears that adults also seldom disclose abusive pasts. There is fear in adulthood (as in childhood) that disclosing would indicate disloyalty to the family. Therefore, the victim continues to deny the activities in order to maintain the family system (Siegal & Romig, 1988). General psychiatric patients often have never discussed with anyone their sexual abuse secrets (Bess & Janssen, 1982). Those with eating disorders are also likely to be reluctant to disclose a history of sexual abuse (Sloan & Leichner, 1986). Most adults who report that they have been sexually abused as children do not fake the reports. In fact, they wish it were fantasy (Shengold, 1963).

Kilpatrick (1983) found that women who had been raped as adults did not reveal previous sexual abuse because they did not see a connection between the abuse and their current functioning. Also, just as occurs for childhood sexual abuse victims (Morrow & Sorell, 1989), when rape victims had previously disclosed the abuse, they had received negative reactions such as blame and stigmatization (Kilpatrick, 1983).

Disclosing. Survivors disclose that they have been victims of childhood sexual abuse for various reasons. For example, some who feel that they have suffered no adverse consequences may tell simply because it is something that has happened to them. Others, who feel deeply affected, may tell because they want to get rid of the pain they are feeling. Others only tell after the therapist has worked with them for a length of time and has coaxed them into admitting that there is a history of sexual abuse (Courtois & Watts, 1982).

Disclosure of a sexual abuse past is often expected by the clinician to happen spontaneously (Briere & Zaidi, 1989; Rosenfeld, 1979b). This is based on the assumption that sexual abuse that occurs will be reported, thereby leading to expectations that reports which spontaneously occur reflect an accurate estimate of the rate of occurrence (Rosenfeld, 1979b). But there are vastly different rates of childhood sexual abuse reported when the patient is queried versus when reports of past abuse are expected to just "come up." For example, in a clinically important study by Briere and Zaidi (1989), a 6% prevalence rate was reported for non-psychotic females at an emergency room when patients were not queried about molestation, while a second phase of the study found a 70% rate of occurrence when patients were routinely asked about a sexual abuse history. In a study by Rosenfeld (1979b), only 16% of the patients spontaneously reported a sexual abuse history, whereas 33% reported such a past when queried. Therefore, clinicians are likely to overlook the possibility of sexual abuse unless they ask directly about this area. Many clients simply do not freely volunteer such information.

Sheldon (1988) believes there is underreporting also because of a lack of agreement on how to define sexual abuse. If the clinician is uncertain of what constitutes childhood sexual abuse, it is likely that there will be no inquiry into past victimization(s).

After finding several unreported cases of childhood sexual abuse in an inpatient hospital, Hart et al. (1989) recommend that mental health professionals routinely ask about a sexually abusive past. Other professionals support this approach (e.g., Bryer et al., 1987; Ellenson, 1986; Kilpatrick,1983). Some professionals fail to query patients

about sexual abuse because they fear that false reports will be made. For the patient who is viewed as compliant or highly suggestible, the indication that sexual abuse is a possibility may lead to false positives (Rosenfeld, 1979b). This is an erroneous assumption since the majority of sexual abuse survivors wish the incidents had not occurred. It is more likely that survivors will fail to report the sexual incidents as well as the aftereffects, for fear of being viewed as crazy (Ellenson, 1985; Rosenfeld, 1979b; Shengold, 1963).

When asked, the majority of adult survivors state that they wish that they had revealed the abuse earlier. It appears that the reason they do not report the abuse is that they have been coerced by the perpetrator to keep quiet (Berliner & Conte, 1990). As adults in treatment, clients indicate that they failed to report sexually abusive incidents because they were not ready to work through this area of their life and also because the clinician failed to inquire directly. When clients failed to continue to deal with this area of their life after it was revealed, the former clients indicated it was because of specific therapist characteristics such as lack of reassurance and validation (Josephson & Fong-Beyette, 1987). Therefore, for the client to continue to process an abusive past, the therapist must respond to the disclosure in a positive manner (Josephson & Fong-Beyette, 1987; Rosenfeld et al., 1979).

Effects on the Victim

Case example after case example in the literature details the negative effects that sexual abuse has on its victims (e.g., Bass & Thornton, 1983; Berliner & Conte, 1990; Ellenson, 1986; Lukianowicz, 1972; Meiselman, 1990; Root, 1989; Rowe & Savage; 1988). The majority of authors and researchers maintains that childhood sexual abuse has some negative effects on the majority of its victims (de Young, 1985; Zilney et al., 1988). Yet, it is often difficult to distinguish between the effects that are a result of the sexual abuse and those that are the outgrowth of other familial situations such as physical abuse and neglect (which are so often coupled with the sexual abuse in a family) (Bess & Janssen, 1982; Hart et al., 1989; Yates,

1982). Yet, it is believed that sexual abuse is the most destructive form of abuse that a child can suffer (Freud, 1982).

Male Victims

As mentioned, much of what we know about the aftereffects of incest has been learned only from females or from a female sample with a few males included. This is not because boys are not sexually abused. In fact, some scholars estimate that the rate of sexual abuse of boys is close to that of girls (de Young, 1985). There is a higher reporting rate for females. Therefore, when males are studied, the data often include results for males and females together, which may mask group differences (Rivera et al., 1988).

It appears that males are not studied because they are not viewed as victims. Since males in our society are expected to benefit from sexual interactions, they are not supposed to suffer negative effects. Also, males are not studied because much of the sexual abuse against male children is perpetrated by male relatives. Therefore, society views the incidents as homosexual acts instead of taboo incestuous acts. And of course, there is still much homophobia in our society that discourages the study of incest perpetrated on boys (de Young, 1985).

There is some solid research on males. For example, when comparing molested males and females who had been hospitalized, Reinhart (1987) found that there was a higher rate of sodomy (anal sex) for older males than for other groups and that males were more often abused by an adolescent than were females. In addition, in working with adult males who were victims of molestation by their mothers, Krug (1989) found that the survivors had problems in adulthood with emotional and sexual relationships. It also was not uncommon for them to show signs of depression and to be substance abusers.

An adult male may have received enjoyment from sexual stimulation by his father and may be very confused about his sexuality. A victim may not be aware of the source of sexual confusion until he reaches adulthood. For example, of 13 male clients in group therapy who had been sexually abused by their fathers, 5 had no recollection of the events until later in adulthood (Singer, 1989). It appears that the

males had the same issues of powerlessness and lack of control that are reported in the literature for females. Males also appear to have difficulties with self-esteem, depression, suicidal ideation, and personal relationships (Singer,1989).

The literature does note some differences between male and female sexual abuse victims. Tong, Oates, and McDowell (1987) found that females who had been sexually abused had significantly lower self-esteem compared to abused males. But there was no significant difference between abused males and their control group. Haugaard and Emery (1989), when comparing males to females, reported that males who had experienced childhood sexual experiences felt less guilt at the time of the experience, didn't feel that they had been pressured, and had positive reactions both during and after the experience. But differences between males and females disappeared when the definition of sexual abuse was more narrowly defined.

Much of the research reviewed in the following sections on aftereffects will have been conducted primarily, if not completely, on female subjects. But experts maintain that males and females suffer much the same effects from childhood sexual abuse.

Short-Term Effects

Not all children who are sexually abused experience clinically significant problems. It appears that some children adjust better, which may be due to individual children's abilities to adapt and to the nature of the sexual experiences (Tong et al., 1987).

The defining of childhood sexual abuse by the criminal system often makes a distinction between children and adolescents, only recognizing "lewd and lascivious acts" if done to a younger child, such as one 13 years of age or under. This supports a double standard between children and adolescents. This standard states that both young children and adolescents can be abused by intercourse, but older children, due to their maturity, are not really "victimized" by lesser forms of sexual activity (Wyatt & Peters, 1986a).

Yet, a variety of short-term effects, defined as those effects occurring within two years after the abuse (Edwall, Hoffman, &

Harrison, 1989), have been documented in the literature for both children and adolescents. These include emotional/ psychological problems such as psychosomatic complaints (Browning & Boatman, 1977; de Young, 1982; Gross, 1979; Yates, 1982), anxiety and fear (Browning & Boatman, 1977; de Young, 1982; Kolko, Moser, & Weldy, 1988; Yates, 1982), depression (de Young, 1982; Goldston, Turnquist, & Knutson, 1989; Justice & Justice, 1979; Sansonnet-Haydon et al., 1987), lower self-esteem (Justice & Justice, 1979; Tong et al., 1987), hallucinations (Sansonnet-Haydon et al., 1987), and nightmares (Schultz & Jones, 1983).

Also manifested in these victims are behavioral problems such as antisocial behaviors (e.g., being aggressive or running away) (Browning & Boatman, 1977; Goldston et al., 1989; Hart et al., 1989; Justice & Justice, 1979; Maisch, 1972; Schultz & Jones, 1983; Tong et al., 1987) and sexually acting out (Browning & Boatman, 1977; Goldston et al., 1989; Justice & Justice, 1979; Kolko et al., 1988; Maisch, 1972; Meiselman, 1978; Rosenfeld, 1977). There is also an increased prevalence of suicide attempts (Sansonnet-Haydon et al., 1987) and eating disorders (Hambidge, 1988). Some research has indicated that adolescent psychiatric patients who have been sexually abused will require longer hospitalization (Sansonnet-Haydon et al., 1987).

Sexually abused children may have more trouble making friends than non-abused children (Tong et al., 1987). Problems with interpersonal relationships may extend to adults (including therapists) since the child may have learned that to get attention they need to act in sensual ways. Sexualized behavior may make observers view the child as an initiator in the sexual activity. But professionals would argue that learning to act in seductive ways to receive attention has made the child even more of a victim (Rosenfeld, 1979).

Teachers also report changes in children who have experienced sexual abuse. For example, they evidence more behavior problems, deteriorate in their school work, and have to repeat a school grade more often than other students (Tong et al., 1987).

The reaction of the victim's parents makes an impact on the adolescent victim. For example, Morrow and Sorell (1989) found that

adolescent girls whose mothers responded negatively to the abuse were more depressed and had lower self-esteem. When the perpetrator had a negative reaction, the girls acted out more than did those girls whose abuser reacted less negatively. And, as previously indicated, there is a high occurrence of substance abuse among adolescent incest survivors whose mothers did not believe their disclosures (Benward & Densen-Gerber, 1975).

Long-Term Effects

The adult who was sexually abused by someone in childhood is commonly referred to in the literature as a "survivor" (e.g., Blume, 1990; Meiselman, 1990). This term is used because it denotes someone who has survival skills and is no longer a helpless victim. It in no way implies that the person's abuse was physically life-threatening (Becker et al., 1986). Adult survivors of childhood sexual abuse have also been called AMAC's, which is an acronym for Adults Molested as Children (Kendall-Tackett & Simon, 1988).

Although some researchers disagree (e.g., Henderson, 1983; Schultz, 1973), it is common in the literature to find articles referring to the negative long-term effects of sexual abuse (e.g., Ellenson, 1985; Russell, 1986). This is not surprising, since the victimization of the child is something that changes the child and affects him or her into adulthood. Many of these effects are evident from the beginning of adulthood, whereas others may not be evident until the survivor has had time to develop relationships with a significant other or with her or his own children (de Young, 1985). As the survivor ages and attempts to more actively make meaning of being sexually abused in childhood, more symptoms are experienced (Silver & Boon, 1983).

Some researchers have not found long-term effects for the sexual abuse survivor. One reason for this appears to be too broad a definition that includes both contact and noncontact sexual abuse (Fromuth & Burkhart, 1989; Haugaard & Emery, 1989). Another reason appears to be that the adult population typically assessed is too young and has not started to explore relationships. Such individuals may consciously or unconsciously deny either that the abuse occurred or that it had any

effects. As development continues, though, the survivor can no longer deny that the abuse happened. This is due to increasing side effects such as intrusive thoughts, hallucinations, and flashbacks (Ellenson, 1986). As specific long-term effects are discussed below, the reader will note that short-term and long-term effects frequently overlap.

Behavioral problems. Although it should not always be assumed that the sexual abuse was devastating (Courtois & Watts, 1982), the child who has been sexually abused is in fact at high risk for problems with adult functioning (Briere & Zaidi, 1989), often responding to the abuse by acting in destructive ways to deal with perceived "badness" (Bergart, 1986; Blake-White & Kline, 1985). The destruction may be turned inward or outward (de Young, 1985). When the behavior is inward, there will be evidence of problems such as substance abuse (Bergart, 1986; Herman, 1981; Root, 1989; Singer, Petchers, & Hussey, 1989; Yeary, 1982), self-mutilation (Carroll, Schaffer, Spensley, & Abramowitz, 1980; de Young, 1981; Singh & Maguire, 1989), eating disorders (Root, 1989; Sloan & Leichner, 1986), and psychosomatic complaints (Briere & Runtz, 1988; Courtois & Watts, 1982; Levitan, 1982).

The survivor may also act out toward society. For example, there is a high prevalence rate of incestuous victimization among prostitutes (Seng, 1989; Vitaliano, Boyer, & James, 1981) and property offenders (Vitaliano et al., 1981). Or the survivor may act out in rage toward others (Ellenson, 1989).

Psychological problems. Many studies have highlighted the psychological problems that are correlated with being an incest or sexual abuse survivor. The adult often feels out of control, exhibiting "victim behavior," with feelings of doom and despair (Blake-White & Kline, 1985; Courtois & Watts, 1982). The survivor may experience feelings of guilt (de Young, 1981; Ellenson, 1989; Tsai & Wagner, 1978), anger (Courtois & Watts, 1982; de Young, 1981; Owens, 1984), and feelings of fear and anxiety (Briere & Runtz, 1988; de Young, 1981). Some of the most well documented aftereffects for the sexual abuse survivor are chronic depression (Bergart, 1986; Briere & Runtz, 1988; Deighton & McPeek, 1985; Hartman et al., 1987; Herman, 1981; Tsai &

Wagner, 1978) and suicide or suicide ideation (Courtois & Watts, 1982; Deighton & McPeek, 1985; Herman, 1981). Survivors also often have lower self-esteem because they overvalue others and ignore their own good points (Blake-White & Kline, 1985; Courtois & Watts, 1982; de Young, 1985; Owens, 1984; Silver & Boon, 1983; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983).

Women may also face emotional dilemmas where they overvalue the opposite sex while at the same time resent their own sex. They devalue themselves and other women while acting in a very traditional manner, being overly nurturing and giving. This behavior pattern may set them up to be repeatedly victimized by those in their environment (Courtois & Watts, 1982; Herman, 1981; Herman & Hirschman, 1977; Tsai & Wagner, 1978). They also experience difficulty with a variety of interpersonal relationships (de Young, 1985; Owens, 1984; Tsai & Wagner, 1978) such as marital relationships (Courtois & Watts, 1982; Herman, 1981; Herman & Hirschman, 1977; Rosenfeld, 1979b) and parenting relationships (Courtois & Watts, 1982; Herman, 1981; Herman & Hirschman, 1977). In general, women who have been incestuously abused rate lower on social adjustment scales, viewing themselves as significantly different from others (Harter et al., 1988). This is partially due to their inability to trust (Courtois & Watts, 1982; de Young, 1985; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983), the social isolation that results from the attempt to hide their secret (Bergart, 1986), and inadequate social skills (Tsai & Wagner, 1978).

Sexual dysfunction is also commonly reported in the literature (e.g., Becker et al., 1986; Browne & Finkelhor, 1986; Courtois & Watts, 1982; Herman, 1981; Meiselman, 1980; Rosenfeld, 1979b). Sexual problems have been especially noted when the sexual abuse is committed by the father (Rowe & Savage, 1988). Although females may have doubts about their sexual identity, males especially question their sexual identity and often fear homosexuality, whether they have participated in homosexual acts or not (de Young, 1982).

Factors affecting long-term aftereffects. As is true for short-term effects, those who are sexually abused by a family member often show signs of more long-term negative effects than those abused

by someone outside the family (Sedney & Brooks, 1984), especially if the perpetrator is a father or stepfather (Herman et al., 1986; Scott & Flowers, 1988). Those abused within their families are more likely to experience anxiety and depression and also to attempt suicide or be hospitalized at some point (Hartman et al., 1987). It is also interesting that those who are abused by their fathers often learn to forgive the perpetrator, but have difficulty ever forgiving their mothers, feeling angry and resentful toward them (Meiselman, 1978; Scott & Flowers, 1988; Tsai & Wagner, 1978). This is especially true when the female survivor believes that her mother knew of the abuse. Those who believe that their mothers did not know appear to suffer less pathology (Scott & Flowers, 1988).

Those who feel that the sexual relationship was exploitive are more likely to state that they had negative effects from their childhood sexual experiences. Of course, not all adults feel that the relationship was exploitive. This is especially true of peer-age sexual interactions (Nelson, 1986). Therefore, the amount of powerlessness that the participant felt may be a better indicator of aftereffects than some other factors (Kilgore, 1988).

Some adult survivors never disclose that they were victims of childhood sexual abuse. Others tell one or many other persons. Disclosure or lack of disclosure of childhood sexual abuse prior to disclosure to a counselor appears to have no effect as to the severity of the short- or long-term effects for survivors of childhood sexual abuse (Courtois, 1979).

There is disagreement in the literature as to whether the age at which a child is sexually abused has an effect, and whether the survivor's functioning is more impaired if he or she is molested at an earlier or later age (Browne & Finkelhor, 1986). For example, Hartman et al. (1987) report that the child who is younger when sexually abused is more likely to show depression as an adult. Other research indicates that abuse that begins after puberty leads to more negative effects (e.g., Sedney & Brooks, 1984). Other authors argue that what is significant is not if a child sexually abused at an earlier or a later age has more severe aftereffects, but that the effects are qualitatively

different depending on the age at which the abuse occurs (Zilney et al., 1988).

Age is an important consideration because there is some indication that greater frequency and a longer duration of abuse leads to more severe effects. Younger victims have more years for the sexual abuse to occur (Kilgore, 1988; Zivney et al., 1988). The symptoms that the survivor evidences are one indicator of when the abuse occurred and its duration. For example, Kilgore (1988) concludes that aftereffects will be different for people who were abused at different ages, due to the developmental stage that they were in at the time of the abuse.

Although early research indicated that brother-sister sibling incest appeared harmless (e.g., de Young, 1985; Lukianowicz, 1972), more recent studies do not necessarily agree (de Young, 1985). A key question seems to be how much age difference there is between the siblings. The larger the gap, the more chance exists that the younger child, usually a female, will feel coerced and victimized. If the children are closer in age, the sexual activity may be viewed as collusive and may not have long-term negative effects (Finkelhor, 1980).

Post-Traumatic Stress Disorder

The diagnosis of Post-Traumatic Stress Disorder (PTSD) was first used as a formal diagnosis by mental health professionals in 1980. The diagnosis was predominantly applied to Vietnam veterans who suffered aftereffects from the war trauma they had endured. This theoretical framework is helpful to the survivor of childhood sexual abuse in that, as is true for veterans and rape victims, therapy focuses on the trauma the patient has experienced. This focus is viewed as more effective than traditional therapies such as insight-oriented therapy based on childhood, since the survivor is reacting normally to an abnormal event (Roth, Dye, & Lebowitz, 1988).

In clinical and non-clinical populations, it is not uncommon to find children (e.g., Adams-Tucker, 1982; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Krener, 1985) as well as adult survivors of childhood sexual abuse, with PTSD symptoms (e.g., Donaldson & Gardner, 1985;

Lindberg & Distad, 1985). They may have no memory of the abuse or its connection to any present symptoms. Symptoms include flashbacks, intrusive thoughts, illusions, visual and auditory hallucinations, dissociations, nightmares, obsessions, phobias, and somatization (Bergart, 1986; Briere & Runtz, 1988; Deighton & McPeek, 1985; Ellenson, 1985; Kilgore, 1988; Root, 1989). These symptoms are diagnostic of a survivor of sexual abuse. For example, sexually abused adolescents in a clinical population have significantly more hallucinations than non-abused adolescents (Sansonnet-Haydon et al., 1987).

There have been attempts to create questionnaires using PTSD symptoms applied to sexual abuse survivors. For example, Donaldson and Gardner (1985) created the Response to Childhood Incest Questionnaire (RCIQ) to assess Post-Traumatic Stress Disorder in incest survivors. There has been some preliminary psychometric work on the scale (Edwards & Donaldson, 1989).

Diagnoses

In one of the earlier reports on incestuously abused women, Meiselman (1978) reported that there is no one diagnosis that is given to those who have been sexually abused by their fathers and who present for treatment. These clients as well as those who present for treatment with no such past receive the same diagnoses. In her study, approximately half of each group had been diagnosed as neurotic, whereas the remainder was diagnosed either as an adjustment reaction or a personality disorder. Abused clients also did not show significantly different profiles on the Minnesota Multiphasic Personality Inventory (MMPI) from those of other clients (Meiselman, 1980).

In reviewing the literature, Rosenbaum and Weaver (1980) found that the majority of women who are treated for multiple personality disorder have an incestuous past. There have also been reports of males with multiple personality disorder that have an incestuous past. Although there is not a clear explanation of how this develops, the link appears to be there (Saltman & Solomon, 1982).

As previously stated, it appears that the clinician who does not directly inquire about a client's sexually abusive past may inaccurately diagnose. For example, the patient in treatment will often be misdiagnosed as borderline (Briere & Zaide, 1989; Sheldon, 1988). In a drug treatment program, Benward and Densen-Gerber (1975) found that adolescents with a sexual abuse history were more likely to be diagnosed as neurotic, depressive type and less likely to be diagnosed as personality disordered than were others in the program. With a higher number of perpetrators and with increased severity of the abuse, the patient is also more likely to receive a significantly higher number of diagnostic labels (Briere & Zaide, 1989).

Professionals' Reactions

The professional who is confronted with a client who is suspected of having a sexual abuse history may have various reactions. Freud initially believed female clients who reported a history of sexual abuse. Therefore, he developed his famous "Seduction Theory." After only a short period of time, however, he withdrew his theory and said that those patients who were reporting sexual abuse were merely fantasizing and wishing that they could have a sexual experience with the perpetrator (Masson, 1984). Of course, in child custody dispute cases, it may be true that the reported sexual abuse is a false allegation (Rosenfeld et al., 1979). But this does not negate the fact that the literature indicates that most children who report sexual abuse are telling the truth (Conte & Berliner, 1981).

In today's treatment of sexual abuse victims and survivors, it is still not unusual for clinicians to avoid and deny incidents of molestation (Taubman, 1984). Underreporting by professionals can be traced back to psychoanalytic theory and Freud's hesitancy to accept childhood sexual experiences as reality (Rosenfeld et al., 1979; Sheldon, 1988). Countertransference reactions can make the therapist ineffectual in working with the client. This may be due to the client's current functioning as well as to his or her past. For example, it is not unusual for a young sexual abuse victim to be openly seductive while in treatment (Krieger, Rosenfeld, Gordon, & Bennett, 1980). The therapist

can have a wide variety of reactions including disbelief, attraction, revulsion, rage, concern and confusion (Ganzarain & Buchele, 1986; Krieger et al., 1980).

Some researchers and therapists have concluded that sexual abuse does not have negative effects for the average child (Henderson, 1983), and that what is most harmful is the reaction of professionals when the sexual activity is disclosed (Schultz, 1973). Of course, a legal system that intervenes and mishandles the case may truly make the situation more difficult for the child and family (de Young, 1985).

Professionals today are becoming more educated and knowledgeable about sexual abuse (Attias & Goodwin, 1985), with most realizing that a child should not be removed from the home at the first mention of sexual abuse (Finkelhor, 1984). Yet, just as there is a need for the public to become more educated about childhood sexual abuse and for more service to be provided to those affected, there is also a need for professionals to become better educated (Briere & Runtz, 1988).

Treatment

The majority of incest survivors state that they were upset by their experiences (Herman et al., 1986). But as recently as a decade ago, authors were writing that there was a paucity of materials written about the treatment of sexual abuse survivors (Rist, 1979). It has not been uncommon for professionals to approach treatment as if the perpetrator were deranged. This has led to trying to control and punish the perpetrator instead of treating the victim and family. To help the victim, however, psychotherapeutic intervention should be a first measure instead of a last resort (Rosenfeld, 1979a).

Who Receives Treatment

Unfortunately, many who are sexually abused as children are silent victims who do not receive any sort of treatment. For example, in a study by Briere and Runtz (1988), only 2 of the 41 females who reported previous sexual abuse had ever received any type of treatment. Even when the sexual abuse is discovered in childhood, the child victim often does not receive treatment (even when it is recommended). This

may be due to economics, procedural problems, etc. (Krener, 1985). This is unfortunate since some research indicates that treatment is successful when a multimodal approach that treats the entire family is utilized (Taylor, 1986). Mandated reporting of child abuse may not be necessary for the abuse to stop or even for the family to engage in some form of intervention. In fact, reporting of the sexual abuse may even exacerbate the situation instead of improving it, since it may lower family cooperation because of the fear of legal reprisal. Reporting and having social services in charge may also interfere with the therapist's professional responsibility (Rosenfeld, 1979a).

When gathering data from a community sample, it is clear that the vast majority of white, middle-class persons who voluntarily admit that they were sexually abused as children do not receive any sort of intervention from any type of criminal or social service organizations. In fact, Cole and Woolger (1989) found that only 6.3% of their sample received such intervention from police or social service agencies as children, and only 47.4% had ever received any therapy, even as adults.

Some survivors of childhood sexual abuse do not seek treatment because they do not perceive that they need help. What is more important than the specific abusive situation is the perception that the survivor has of the family and the sexual abuse (Feinauer, 1989; Harter, Alexander, & Neimeyer, 1988). But those who seek treatment rate themselves as less well adjusted than those who seek no help (Feinauer, 1989). Adults who do seek treatment for childhood sexual abuse seem to wait until they have established relationships. For example, one nonclinical study found that for the women who did seek treatment, the average age was 31 years of age. About 10% of these attended less than ten therapy sessions, whereas about 17% were in therapy for two years or more (Feinauer, 1989).

It appears that those whose abuse began earlier and lasted for more than one year are more likely to seek treatment (Kendall-Tackett & Simon, 1988). For those who endured abuse longer, there is a more diligent effort to make some sense of the abuse (Silver & Boon, 1983).

Many survivors of incest spend the rest of their adult lives trying to adjust and make meaning out of the victimization that they

experienced. Some never come to terms with their abusive past, while others come to some understanding of it. This may occur either through the survivor understanding how incest happens in a family, realizing that their fathers had mental health problems, or by seeing that there were some positive results from the abuse (such as receiving special attention) (Silver & Boon, 1983). Research indicates that about half of incest survivors recover well from their abuse (Herman et al., 1986). It is not surprising that those who seek treatment in adulthood to deal with the aftereffects of incest report more serious effects than those who seek no such help. Seeking treatment is not necessarily an indicator of the type of abuse the victim endured or the factors involved, but rather a reflection of the person's adjustment to the abuse (Courtois, 1979).

Yet, it is important to look at the specific abuse that was suffered by the victim. For example, those seeking treatment are more actively trying to make sense of the incidents that happened and have typically had more forceful, intrusive, and prolonged sexual abuse (Herman et al., 1986).

Type of Treatment

Today, there is a wealth of materials designed to help the therapist provide treatment for the sexual abuse survivor. Some materials are designed to be read by the survivor, such as "The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse" (Bass & Davis, 1988). Others are geared toward the professional who works with the survivor (e.g., Blake-White & Kline, 1985; Courtois, 1988; Meiselman, 1990).

There are many kinds of treatment that may be effective. For example, letter writing, guided imagery, and divorce ritual (Courtois & Watts, 1982). It appears that goals are more important than methodology. For example, the treatment will need to focus on different goals if the abuse was perceived as rape (i.e., forced) as opposed to the survivor feeling that he or she was compliant (Rowe & Savage, 1988).

Group treatment. According to the literature, group therapy is often the primary treatment of choice for sexual abuse for both

adolescents (Furniss, Bingley-Miller, & Van Elburg, 1988; Gagliano, 1987) and adult survivors (e.g., Sharma & Cheatham, 1986; Tsai & Wagner, 1978). No single goal is right for all groups, so it is important that the group members agree on their goals (Courtois & Watts, 1982). The therapist must socialize the members to the group process (Phelan, 1987). The group process allows survivors who have never been able to express pain to describe the abuse to others who will understand. The group members are able to relate to each other better than with most therapists, who have never had a similar experience (Roth et al., 1988). For adolescents, group therapy may even be preventive, working to lessen the depression that would have been experienced in adulthood, due to feelings of guilt (Gagliano, 1987).

The group process also breaks down the walls of secrecy that have surrounded victims from the time when the abuse began to the present. For survivors, this identification with others that makes them not so unusual or "special" seems to be a curative factor (Tsai & Wagner, 1978; Yalom, 1985). A survivor is ready for healing during group treatment when she or he is between the phase of denying that the sexual abuse occurred and the phase of being overwhelmed by intrusive thoughts and other symptoms (Cole & Barney, 1987). The client must value the outcome in order to endure the stress that will be brought on by reliving the sexual trauma (Roth et al., 1988).

PTSD approach. A PTSD format may be beneficial in group treatment (Cole & Barney, 1987). The group members must be allowed to reconstruct what has happened to them in order to process symptoms and create a more healthy way of functioning (Ellenson, 1986).

Length of treatment. Tsai and Wagner (1978) report that short-term group therapy that lasts for as few as four sessions can be helpful to the survivor. Although participants have stated that four sessions is not enough, this time limited approach has the benefit of requiring that the participant focus on relevant problems from the beginning.

More therapists recommend long-term treatment, with six months or a year suggested as a minimum amount of time (Bergart, 1986).

Singer (1989) believes that long-term therapy is required to determine the emotional and behavioral symptoms that are a result of the molestation. It is also important that the actual trauma is the focus of treatment, although the client often comes to therapy reporting relationship problems, somatic complaints, etc. In time, by examining the trauma, the dynamics of existing relationships that replicate the earlier abuse can be altered to allow functioning in a more healthy way (Siegel & Romig, 1988). Therefore, similar techniques may be used for different clients, but the nature of that specific client's abuse must always be kept in mind (Rowe & Savage, 1988).

The therapeutic process is often slow and is very demanding for the therapist (Courtois & Watts, 1982). The therapist must deal with the feeling that the client's trauma creates in her or him (Bonney, Randall, & Cleveland, 1986). Often a combination of individual and group therapy is recommended for the sexual abuse survivor, male (Singer, 1989) or female (Blake-White & Kline, 1985).

Methodological Issues

There are many problems with the sexual abuse literature. Such problems include the definition of terms (Kilpatrick, 1987; Roland, Zelhart, & Dubes, 1989; Wyatt & Peters, 1986a), sampling problems (Kilpatrick, 1987), and the measurement of consequences of abuse (often due to a lack of empirical instruments) (Kilpatrick, 1987; Roland et al., 1989). Some researchers have criticized studies for lack of a control group and for comparing groups that are incomparable (Evenson, 1987). Many studies have been descriptive, necessitating qualitative rather than quantitative conclusions (Kilpatrick, 1986).

Because of the nature of childhood sexual abuse, it is difficult to gather accurate data and virtually impossible to conduct a longitudinal study to research aftereffects. Therefore, all studies of long-term effects have been retrospective, asking victims to recall what abuse happened to them years earlier and then attempting to correlate these events with current functioning. Validity is jeapordized since survivors' memories are influenced by loss of memory and impression

management. Also, there is no possibility of comparing the survivor's story with that of the alleged perpetrator (Kilpatrick, 1986).

Sampling Problems

Much of the research that has been done has been on clinical groups in treatment for childhood sexual abuse, which leads to problems with generalizability. However, some important studies have been conducted on college populations (e.g., Fromuth, 1986; Kilpatrick, 1986). Finding statistically significant effects of abuse in a college population is an important contribution to the literature, since a college population is higher functioning than a general population. It requires a higher minimal amount of functioning to enter and complete college work (Briere & Runtz, 1988).

To gather non-clinical samples of sexual abuse survivors, a variety of methods has been used, which makes it difficult to compare studies. For example, some researchers have advertised in media (Cole & Woolger, 1989; Josephson & Fong-Beyette, 1987), used informal networks (Josephson & Fong-Beyette; 1987, Kilpatrick, 1986), surveyed college social science classes, and advertised in dormitories ("study of long-term consequences of certain childhood experiences") (Sedney & Brooks, 1984). Some have paid their subjects with money or course credit (e.g., Sedney & Brooks, 1984).

Instruments Employed

Since there is no one instrument in the literature that is viewed as the best instrument to use to collect specific facts about childhood sexual experiences, there have been a variety of instruments used (e.g., Haugarrd & Emery, 1989; Josephson & Fong-Beyette, 1987; Wyatt, 1985). Such a wide collection of different instruments makes comparison of studies very difficult, if not impossible, since different definitions of childhood sexual abuse and different additional criteria are used.

Methodological Recommendations

Although there are many points to consider when conducting research on childhood sexual abuse, there are some pertinent recommendations made in the literature. For example, Wyatt and Peters (1986b) recommend that the description of the study be more broad and general in order to facilitate the subjects' willingness to participate. They also suggest that when interviews are conducted, they should be held in private and be somewhat lengthy so that rapport can be established with the subject. This will lead to more valid results. Personal contact appears to enhance compliance. The direct contact also allows the interviewer to answer any questions the subject may have.

In determining the effects of incest, de Young (1985) indicates that one should consider activity involved, frequency, duration, family system, and personality of the victim prior to the abuse. Mrazek (1980) indicates that a clinical definition of incest should include the behaviors involved, frequency, and threat of force or actual force used. Yet, other research indicates that the effects of incest cannot be predicted by knowing information such as duration, frequency, relationship to the perpetrator, use of coercion, and whether the victim told others of the abuse (Courtois, 1979). Therefore, all scholars do not agree on what factors are helpful in assessing long-term effects (e.g., Courtois & Watts, 1982).

Although it is important to include contact and non-contact sexual abuse so that data can be compared between studies (Wyatt & Peters, 1986a), including non-contact abuse may lead to non-significant results. Briere and Runtz (1988) postulate that this is why they found an array of statistically significant results in aftereffects for survivors in a college population, but Fromuth (1986) found no such results using a broad definition that included non-contact sexual interactions. There are problems in looking at the age of onset and trying to determine if there are more significant effects for younger or older victims. This is due to the fact that those who are abused beginning at an earlier age are, as a group, abused for a longer period of time (Zivney et al., 1988). Faller (1989) recommends including the age

at onset so that the mean age at which abuse began may be compared for the entire sample.

These are just some of the factors that should be considered when conducting research on the sexual experiences of children. It is extremely important to take into consideration the purpose of the research (Haugaard & Emery, 1989).

Conclusions

The sexual abuse of children is a problem that has received much attention in the literature in the last few decades. Some solid research is beginning to be done in the area in regard to the dynamics involved in incestuous families, studying various populations (e.g., clinical, criminal, and non-clinical/general), prevalence rates, and short- and long-term effects for the survivors of sexual abuse. Strides have also been made in treatment of former victims, and professionals are becoming more aware of this problem for their clients. Researchers have also made some methodological progress in areas such as defining childhood sexual abuse and in using broader instruments.

APPENDIX B

CONSENT FORM

VOLUNTARY CONSENT FORM

Enclosed in the attached envelope is a set of questions on information that the University Counseling Center believes would be helpful to know about the average student who comes to the Counseling Center. The purpose of this study, which is being conducted by Marilyn Stinson under the supervision of Dr. Susan Hendrick (742-3737), is to gain knowledge about specific childhood experiences of college students who use the services of a University Counseling Center.

If you agree to participate, open the envelope and take five minutes to fill out the questions. Then, at the end of your intake interview, your counselor may ask you a few more questions. All the responses will be held in confidence and will only be identified through coded numbers. Any participation is completely voluntary and will not influence the services that you receive at the Counseling Center. Some of the questions are very sensitive in nature. You are free to not participate at all or to quit at any time without any effects on the services you receive from the Center. The purpose of gathering the information is to gain knowledge about the average student, not any one specific student, and to eventually improve services at this center and other centers.

Dr. Susan S. Hendrick, Room 201, Psychology Building, Texas Tech University, Lubbock, TX, 79409 (742-3737), has agreed to answer any questions you may have and you may contact the Texas Tech University Institutional Review Board for the Protection of Human Subjects by writing them in care of the Office of Research Services, Texas Tech University, Lubbock, TX, 79409, or by calling 742-3884.

If this were a project that would cause any physical injury to the participants, treatment is not necessarily available at Texas Tech University or the Student Health Center, nor is there necessarily any insurance carried by the University or the personnel applicable to cover any injury. Financial compensation for any such injury must be provided through a student's own insurance program. Further information about these matters may be obtained from Dr. Robert Sweazy (742-3884), Vice Provost for Research, Holden Hall, Texas Tech University, Lubbock, TX, 79409.

DIRECTIONS:

(1) IF YOU ARE WILLING TO PARTICIPATE: If you understand all the above information and are willing to help with this project, please sign and date this form below. Then proceed by opening the envelope, reading the brief instructions, and taking about five minutes to answer the questions. Later, at the end of your intake interview, your intake counselor may ask you a set of questions that will take only about five more minutes.

Signature _____ Date _____

Investigator _____ Date _____

(2) IF YOU PREFER NOT TO PARTICIPATE: Simply return the unopened envelope to the receptionist who will arrange for your intake counselor to see you.

APPENDIX C
COUNSELOR TRAINING

INSTRUCTIONS TO INTAKE COUNSELORS FOR RESEARCH

Marilyn Stinson
Fall 1990

To gather data for a research project that will eventually help the UCC provide better service to the students who seek counseling, it is very important that those who do the intake interviews *say the same thing* to each student who agrees to participate. Therefore, the following guidelines have been set up to aid you.

I. WHO RECEIVES ENVELOPES: Only those students who have an intake interview with a senior staff person or an intern (none will be given to students whose intakes are done by practicum students since these counselors will not be trained to participate in the study).

II. WHEN DO THE STUDENTS GET THE ENVELOPES and WHAT IS SAID TO THE STUDENT: After arriving for an intake interview and after completing *all* intake paperwork, the student will be asked to read the front page attached to the envelope. The person at the front desk would say to the student,

> *"The Counseling Center is collecting information to provide better services to students. Would you look this over after you complete these other sheets?"*

III. AFTER THE STUDENT GETS THE ENVELOPE:

IF THE FORM IS SIGNED, depending on the color of the envelope, the front desk will do one of two things:

(a) If the envelope is manilla (brownish-yellow): It will be put inside the student's file folder *before* the counselor sees the student. (This is a cue to the counselor to know that the Childhood Sexual Experiences Questionnaire (CSEQ) should be administered to this student).

(b) If the envelope is white: It will be placed in Marilyn's box (the student was in the group that received the CSEQ on paper) and you will not receive it. You will not administer the CSEQ to this student.

IF THE FORM IS *NOT* SIGNED: Some student will choose not to participate (which is fine). You will be able to tell that they do not want to participate because they will not have signed the form on the front of the envelope. Therefore, before administering the CSEQ, check the front page and put any unsigned envelope that slipped through in Marilyn's box.

IV. DURING THE INTAKE INTERVIEW: If the student has signed the form and you have received the envelope in the intake file, you should administer the CSEQ at the very *end* of the intake session. A transition statement has been written at the top of the CSEQ to help you and the student change gears. Please stick as closely to it as possible. For research purposes, it is important that the interviews be conducted in the same manner.

At the end of the questionnaire, if the student appears to have no questions or concerns, just end the session as you normally would (for example, you will write up the intake information and they can call tomorrow to find out who their counselor will be and to set an appointment). But, if the student appears to have concerns about the questions just asked, go ahead and help the student with these concerns and, if appropriate, ask them if they would like this information included in the intake information for their counselor to know.

Once the student has left your office, open the envelope they have signed and slip the CSEQ inside with the other questionnaires. Then place the envelope in Marilyn's box.

V. OTHER ISSUES:

(a) In collecting data, remember that if you act like it is normal to collect information that is personal in a counseling setting, the student will be more at ease. Help the student relax by using your clinical skills. Obviously, some students will have had some sexual experiences that will be uncomfortable to talk about. Try to balance the tasks of (1) gathering as accurate of information as possible for the Center and (2) allowing the student who does not want to continue with the study to discontinue and still feel comfortable receiving services for other issues. A general rule of thumb would be to continue as long as the student raises no objections. On the other hand, if the student is giving strong verbal cues that they no longer want to participate, it is ok to say, *"Is it all right if I go to the next question?"* Remember that discomfort over being asking questions about a taboo topic is somewhat natural. Therefore, do not encourage students to discontinue answering questions, but do not ignore their needs either.

(b) Some students may want to ask about the research study.

-If a student asks about the study, just tell them *"We are collecting information to improve services."* It is especially important to not say much about the research before the data is collected so the results will not be biased. The purpose and uses will have been explained to the student on the consent form.

-If a student asks who will see their answers from the questionnaire they filled out in the front office, realize that the inside instructions have told them that the counselor will not see their questionnaire (and you should not open up the envelope and read their answers). You may explain that we are collecting data on students who come to the UCC and only those who run statistics on the data will have access to the answers and they will not put individual names with questionnaires, code numbers will be used.

If you have other questions as we collect the data, please let me know.
THANKS FOR YOUR HELP WITH THIS PROJECT!

APPENDIX D
SUPPORT STAFF TRAINING

INSTRUCTIONS TO FRONT OFFICE ON HANDING OUT ENVELOPES

Marilyn Stinson
Fall 1990

To gather data for a research project that will eventually help the UCC provide better service to the students who seek counseling, it is very important that those who work at the front desk help give out envelopes and *say the same thing* to each student who receives an envelope. Therefore, the following guidelines have been set up to aid you.

I. WHO RECEIVES ENVELOPES: Only those students who have an intake interview with a senior staff person or an intern (none will be given to students whose intakes are done by practicum students since these counselors will not be trained to participate in the study).

II. WHEN DO THE STUDENTS GET THE ENVELOPES and WHAT IS SAID TO THE STUDENT: After arriving for an intake interview and after completing *all* intake paperwork, the student will be asked to read the front page attached to the envelope.

Examples:

(a) If a student fills out intake paperwork at the same time they come in for the personal interview, they will receive an envelope at that time. The person at the front desk would say to the student,

"The Counseling Center is collecting information to provide better services to students. Would you look this over after you complete these other sheets?"

(b) If a student fills out intake paperwork on a different day, they will not receive an envelope at that time but will receive one when they come back for the actual interview. The person at the front desk would say to the student,

"The Counseling Center is collecting information to provide better services to students. Would you look this over before you see your counselor?"

III. HANDING OUT ENVELOPES: There will be a stack of envelopes at the front desk. There will be two different colors of envelopes that will be alternated. Simply hand the student the top envelope.

IV. TAKING BACK ENVELOPES: When the student hands the envelope back to the front desk (which the instructions on the envelope will tell them to do), simply say,

"Thank you. Your counselor will be with you in a minute."

Once the student gives the envelope back, look at the front to see if they signed the form.

IF THE FORM IS SIGNED, depending on the color of the envelope, you will do one of two things:

(a) If the envelope is manilla (brownish-yellow): Put it inside the student's file folder *before* the counselor sees them. (This is a cue to the counselor to know what to do so the counselor *must* have it before seeing the student).

(b) If the envelope is white: Place it in Marilyn's box.

IF THE FORM IS *NOT* SIGNED: Some student will choose not to participate (which is fine). You will be able to tell that they do not want to participate because they will not have signed the form on the front of the envelope. Simply put the entire unused envelope in Marilyn's box.

V. OTHER ISSUES: Some students may want to ask you about the research study. To get the best information to help the students, it is important that all students receive the same information. Therefore, to the best of your ability, say only what is written on this sheet.

If a student asks about the study, just tell them *"We are collecting information to improve services."* (I know you've already said it but some students may not hear it.)

If a student asks about who will see their answers, realize that the inside instructions have told them that the counselor will not see their questionnaire (and the counselor won't). Therefore, if the student seems to have a concern over a question(s), instruct them, *"You can talk to Marilyn Stinson who is collecting all the information for the Counseling Center or you can bring up any concerns you have to your intake counselor."* If it seems appropriate (for example, its a question on why are we doing the research or how is the information to be used), arrange for Marilyn to talk to them as soon as possible. It is more likely that they will have a counseling issue that they will want to mention to the intake counselor.

Overall, say as little as possible to the student to help collect data in a consistent fashion. THANKS FOR YOUR HELP WITH THIS PROJECT!

APPENDIX E
INTRODUCTORY LETTERS

PLEASE READ CAREFULLY

Dear Student,

Thank you for your willingness to answer the questions in this envelope and let your intake counselor ask you some questions later. Please remember as you go through the questions that we are interested in the responses of all the students who participate in this research. Your answers will not be used individually but will become part of a group of answers. You may end your participation at any time. At the same time, though, it is important you attempt to answer every question so that your questionnaire can be used to understand specific childhood experiences of students who use the services of the University Counseling Center.

On questions 1 to 39, answer only on the opscan computer sheet. Do not write on the questionnaire. It should take you five to ten minutes to fill out the entire questionnaire. After answering all the questions, simply put all sheets back into the envelope, re-close the metal clasp, and hand it to the receptionist.

At the end of your intake interview, your intake counselor may ask you another set of questions which will take only about five minutes. If you have any further questions about this study, please feel free to ask to speak to Marilyn H. Stinson, who is conducting this research. Remember that all your responses are confidential and will be used for research purposes only (your counselor will not see your questionnaire).

THANK YOU VERY MUCH FOR YOUR COOPERATION

APPENDIX F
BACKGROUND INFORMATION SHEET

On the enclosed computer sheet, please fill in the responses that are the most accurate for you. **Answer only on the computer sheet.**

1. I am a: [A] Male [B] Female

2. My ethnic heritage is: [A] Black [B] White-non-Hispanic [C] White Hispanic [D] Oriental [E] Other

3. My age is:
   [A] 18 or younger [B] 19-20 [C] 21-22 [D] 23-24 [E] 25 or older

4. I was raised in an area that was:
   [A] Farm or small village [B] Town of 10,000 or less
   [C] Town of 10,000 to 50,000 [D] City of 50,000 to 200,000
   [E] City of 200,000 or more

5. My family's total income last year was:
   [A] $10,000 or less [B] $10,001 to $20,000 [C] $20,001 to $35,000 [D] $35,001 to $50,000 [E] $50,001 - up

6. I have the following number of sisters and brothers:
   [A] None - only child [B] One [C] Two [D] three [E] Four or more

7. I am: [A] First born (or only child) [B] Second born [C] Third born [D] Fourth born [E] Fifth or later born

APPENDIX G
ROSENBERG SELF-ESTEEM SCALE

After reading the following sentences below, mark whether you:

[A] strongly agree
[B] agree
[C] disagree
[D] strongly disagree

8. On the whole, I am satisfied with myself.
9. At times I think I am no good at all.
10. I feel that I have a number of good qualities.
11. I am able to do things as well as most other people.
12. I feel I do not have much to be proud of.
13. I certainly feel useless at times.
14. I feel that I'm a person of worth, at least on an equal plane with others.
15. I wish I could have more respect for myself.
16. All in all, I am inclined to feel that I am a failure.
17. I take a positive attitude toward myself.

APPENDIX H
BECK DEPRESSION INVENTORY

This section consists of groups of statements. After reading each group of statements carefully, mark on your computer sheet the one statement in each group which **best** describes the way you have been feeling in the **past week, including today. Be sure to read all the statements in each group before making your choice.**

18. A. I do not feel sad.
B. I feel sad.
C. I am sad all the time and I can't snap out of it.
D. I am so sad or unhappy that I can't stand it.

19. A. I am not particularly discouraged about the future.
B. I feel discouraged about the future.
C. I feel I have nothing to look forward to.
D. I feel that the future is hopeless and that things cannot improve.

20. A. I do not feel like a failure.
B. I feel I have failed more than the average person.
C. As I look back on my life, all I can see is a lot of failures.
D. I feel I am a complete failure as a person.

21. A. I get as much satisfaction out of things as I used to.
B. I don't enjoy things the way I used to.
C. I don't get real satisfaction out of anything anymore.
D. I am dissatisfied or bored with everything.

22. A. I don't feel particularly guilty.
B. I feel guilty a good part of the time.
C. I feel quite guilty most of the time.
D. I feel guilty all of the time.

23. A. I don't feel I am being punished.
B. I feel I may be punished.
C. I expect to be punished.
D. I feel I am being punished.

24. A. I don't feel disappointed in myself.
B. I am disappointed in myself.
C. I am disgusted with myself.
D. I hate myself.

25. A. I don't feel I am any worse than anybody else.
B. I am critical of myself for my weaknesses or mistakes.
C. I blame myself all the time for my faults.
D. I blame myself for everything bad that happens.

26. A. I don't have any thoughts of killing myself.
B. I have thoughts of killing myself, but I would not carry them out.
C. I would like to kill myself.
D. I would kill myself if I had the chance.

27. A. I don't cry any more than usual.
B. I cry more than I used to.
C. I cry all the time now.
D. I used to be able to cry, but now I can't cry even though I want to.

28. A. I am no more irritated now than I ever am.
B. I get annoyed or irritated more easily than I used to.
C. I feel irritated all the time now.
D. I don't get irritated at all by the things that used to irritate me.

29. A. I have not lost interest in other people.
B. I am less interested in other people than I used to be.
C. I have lost most of my interest in other people.
D. I have lost all of my interest in other people.

30. A. I make decisions about as well as I ever could.
B. I put off making decisions more than I used to.
C. I have greater difficulty in making decisions than before.
D. I can't make decisions at all anymore.

31. A. I don't feel I look any worse than I used to.
B. I am worried that I am looking old or unattractive.
C. I feel that there are permanent changes in my appearance that make me look unattractive.
D. I believe that I look ugly.

32. A. I can work about as well as before.
B. It takes an extra effort to get started at doing something.
C. I have to push myself very hard to do anything.
D. I can't do any work at all.

33. A. I can sleep as well as usual.
B. I don't sleep as well as I used to.
C. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
D. I wake up several hours earlier than I used to and cannot get back to sleep.

34. A. I don't get more tired than usual.
B. I get tired more easily than I used to.
C. I get tired from doing almost anything.
D. I am too tired to do anything.

35. A. My appetite is no worse than usual.
B. My appetite is not as good as it used to be.
C. My appetite is much worse now.
D. I have no appetite at all anymore.

36. A. I haven't lost much weight, if any, lately.
B. I have lost more than 5 pounds.
C. I have lost more than 10 pounds.
D. I have lost more than 15 pounds.

37. I am purposely trying to lose weight by eating less.
A. Yes
B. No

38. A. I am no more worried about my health than usual.
B. I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
C. I am very worried about physical problems and it's hard to think of much else.
D. I am so worried about my physical problems that I cannot think about anything else.

39. A. I have not noticed any recent change in my interest in sex.
B. I am less interested in sex than I used to be.
C. I am much less interested in sex now.
D. I have lost interest in sex completely.

APPENDIX J
CHILDHOOD SEXUAL EXPERIENCES QUESTIONNAIRE

It is now generally realized that many young men and women, while they were children or adolescents, have had a sexual experience with an adult or someone older than themselves. By sexual, we mean behaviors ranging from someone exposing themselves (their genitals) to you, to someone having intercourse with you. These experiences may have involved a relative, a friend of the family, or a stranger. Some experiences are very upsetting and painful, while others are not, and some may have occurred without consent.

Now, we'd like you to think back to your childhood and adolescence and remember if you had any sexual experiences with a relative, family friend, or stranger. Describe each experience completely and separately by answering the questions below it. There may be more than one incident in each question (for example, a cousin one time and a neighbor another time). If so, please make mention of each one.

Answer the rest of the questions (questions 40-50) **on this paper** . (*Do not answer on the computer sheet.*)

(40) During childhood or adolescence, did anyone ever expose themselves (their sexual organs) to you? Yes ____ No ____

(if **no** go to question 41; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(41) During childhood or adolescence, did anyone masturbate in front of you? Yes _____ No _____
(if **no** go to question 42; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(42) Did a relative, family friend, or stranger ever touch or fondle your body, including your breast or genitals, or attempt to arouse you sexually? Yes _____ No _____
(if **no** go to question 43; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(43) During childhood or adolescence, did anyone try to have *you* arouse them, or touch *their* body in a sexual way?
Yes _____ No _____
(if **no** go to question 44; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(44) Did anyone rub their genitals against your body in a sexual way? Yes _____ No _____
(if **no** go to question 45; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(45) Did anyone have oral sex with you? Yes _____ No _____
(if **no** go to question 46; if **yes**, please answer the following section)
Was the oral sex with the other person

i) _____ putting *their* mouth to *your* genitals
ii) _____ putting *your* mouth to *their* genitals
iii _____ *both* oral sex on you and on them

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(46) During childhood or adolescence, did anyone *attempt* to have vaginal intercourse with you? Yes _____ No _____

(if **no** go to question 47; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(47) Did anyone *have* vaginal intercourse with you?
Yes ____ **No** _____ (if **no** go to question 48; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(48) Did anyone have anal sex with you? Yes ____ **No** _____
(if **no** go to question 49; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(49) Did you have any other sexual experiences involving anyone? Yes _____ No _____

(if **no** go to question 50; if **yes**, please answer the following section)

(a) What was their *specific* relationship to you? (if relative: specify relationship such as father, step-father, cousin, etc.)

_____

(b) How much did you trust this person before this happened?

_____

(c) What age were you when this began?

_____

(d) What age was the other person?

_____

(e) With what frequency (how often) did it occur?

_____

(f) How long did it continue (for example: it only happened once or happened over a number of months or years)?

_____

(g) What kind of force or threats were used?

_____

(h) What other persons are aware of this situation?

_____

(i) In what ways has this incident affected you?

_____

(j) What kind of professional help have you received in regard to this situation?_____

(k) Briefly describe the incident(s).

_____

_____

_____

(50) Were you ever a victim of childhood sexual abuse?
Yes_____ No_____ I'm not sure _____

APPENDIX K
CHILDHOOD SEXUAL EXPERIENCES
QUESTIONNAIRE CODE SHEET

(40) During childhood or adolescence, did anyone ever expose themselves (their sexual organs) to you?
A = Yes
B = No
C = No to all questions on questionnaire (no more coding for subject)

(a) What was their *specific* relationship to you?
A = Relatives
B = Aquaintance (of self or family) or stranger

(b) How much did you trust this person before this happened?
A = None or very little to moderate amount (or similar response)
B = Much to very much (or similar response)

(c) What age were you when this began?
A = 0 to eight years old
B = nine to seventeen years old

(d) What age was the other person?
A = 0 to less than twenty-five years old
B = over twenty-five years old

(e) With what frequency (how often) did it occur?
A = less than once a month
B = once a month or more often

(f) How long did it continue (duration)?
A = up to six months
B = more than six months

(g) What kind of force or threats were used?
A = none
B = mild to moderate (verbal persuasion or coersion, no physical force)
C = severe to very severe (threats of severe consequences or violence, physical force)

(h) What other persons are aware of this situation (disclosure)?
A = no one
B = one or more persons

(i) In what ways has this incident affected you?
A = not at all to mild aftereffects
C = moderate to severe aftereffects

(j) What kind of professional help have you received in regard to this situation?
A = none
B = individual or group counseling

(41) During childhood or adolescence, did anyone masturbate in front of you? Yes _____ No _____
* Questions 41a-j are coded the same as Questions 40a-j.

(42) Did a relative, family friend, or stranger ever touch or fondle your body, including your breast or genitals, or attempt to arouse you sexually? Yes _____ No _____
* Questions 42a-j are coded the same as Questions 40a-j.

(43) During childhood or adolescence, did anyone try to have *you* arouse them, or touch *their* body in a sexual way? Yes _____ No _____
* Questions 43a-j are coded the same as Questions 40a-j.

(44) Did anyone rub their genitals against your body in a sexual way? Yes _____ No _____
* Questions 44a-j are coded the same as Questions 40a-j.

(45) Did anyone have oral sex with you? Yes _____ No _____
* Questions 45a-j are coded the same as Questions 40a-j.

(46) During childhood or adolescence, did anyone *attempt* to have vaginal intercourse with you? Yes _____ No _____
* Questions 46a-j are coded the same as Questions 40a-j.

(47) Did anyone *have* vaginal intercourse with you? Yes _____ No _____
* Questions 47a-j are coded the same as Questions 40a-j.

(48) Did anyone have anal sex with you? Yes _____ No _____
* Questions 48a-j are coded the same as Questions 40a-j.

(49) Did you have any other sexual experiences involving anyone? Yes _____ No _____ **
(** note: all these responses will be "**No**" since any reported behavior that was under 18 years old was recoded into the appropriate previous question)

(50) Were you ever a victim of childhood sexual abuse?
Yes_____ No_____ I'm not sure _____

(51) Number of perpetrators:
A = one
B = two or more

Note. For analysis purposes, incidents were divided into:
Category 1 = no sexual contact (questions 40, 41)
Category 2 = mild sexual contact (questions 42, 43, 44)
Category 3 = major sexual contact (questions 45,46,47,48)