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Validation: The missing link in recovery from childhood sexual abuse?

Jill Wollenzien-Daniels

DOCTOR OF PHILOSOPHY DISSERTATION

OF

JILL WOLLENZIEN-DANIELS

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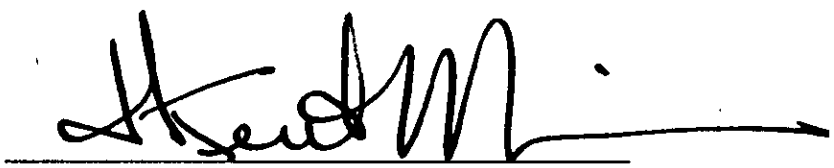

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Dr. Richard Waite, Committee Chair
Professional Psychology Faculty

Richard W. Waite
Signature

9-21-98
Date

Walden University

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Dr. William Wilson, Committee Member
Professional Psychology Faculty

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Jill Wollenzien-Daniels

and have found that it is complete and satisfactory in all respects.

Dr. Catherine James, Committee Member
Professional Psychology Faculty

Catherine E. James
Signature

9-22-98
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Walden University

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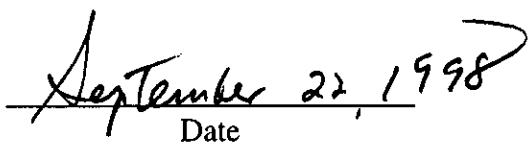

Date

Abstract

VALIDATION: THE MISSING LINK IN RECOVERY FROM CHILDHOOD SEXUAL ABUSE?

by

Jill Wollenzien-Daniels

M.S., University of Wisconsin-Milwaukee, 1976
M.S.W., University of Wisconsin-Milwaukee, 1982

Dissertation Proposal Submitted in Partial Fulfillment of
the Requirement for the Degree of
Doctor of Psychology
Psychology Department

Walden University
February, 1999

ABSTRACT

This study considered whether validation through corroborative evidence (an outside source affirming the abuse) is necessary for remediation of symptoms in women survivors of childhood sexual abuse (CSA) who have varying degrees of PTSD. It utilized multiple case studies, in a mixed qualitative-quantitative design, to gain a better understanding of the role of validation in the recovery process.

Two groups of adult female survivors with varying degrees of PTSD were compared: those who had validation of their abuse experiences through corroborative evidence (n=12), and those who did not (n=13). They were queried about their belief in the importance of validation through corroborative evidence and its possible impact on the remediation of their PTSD-like symptoms. This was operationalized by examining the differences in the frequency/intensity and quality of the following variables: dissociation, the current impact of their childhood sexual abuse(s), and their levels of self-esteem. These variables were assessed by using Bernstein and Putnam's *Dissociative Experiences Scale (DES-II)*, Horowitz and colleagues' *Impact of Event Scale (IES)*, Nugent and Thomas' *Self-Esteem Rating Scale (SERS)*, and a semistructured, personal interview.

A MANOVA was conducted on the data from the tests instruments (DES-II, IES, SERS), and no significance was found (a possible Type II error, with the sample being too small to detect an effect). Contrary to this, the data

from the personal interviews were quantified using descriptive statistics (frequency counts with percentages), and many substantial differences were discovered: Nonvalidated participants reported more dissociated/repressed and somatic memories; had a higher incidence of negative self-statements and beliefs (e.g., believed selves to be "crazy," "bad," "evil"); and currently had more intrusive PTSD symptoms than validated participants. This supports the theory that validation through corroborative evidence of CSA does make a difference in how survivors heal from their abuse. An unexpected and important finding was that mothers' support and validation was viewed by the survivors as being of great importance, and that for the majority of them, this validation was not given.

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DEDICATION

This dissertation is dedicated to the secret survivors of childhood sexual abuse(s), who are afraid to speak out because they believe they are "crazy" and fear that no one will believe them. And to those who have broken the silence, and given "voice" to their atrocities: Particularly to Barb C. a victim of childhood incest and multiple sexual abuses, who spoke up about the horrors she experienced at the hands of those who were suppose to love and protect her. She continues to struggle with feelings of being "crazy," "bad," and "evil," and is unable to trust what her body knows, because her mother (and family of origin) refuse to believe her. And to Barb's children, Lilly and Roy, who will grow to trust their perceptions, and feel good about themselves because *their* mother did believe them.

ACKNOWLEDGMENTS

Like most gardens, it started with a seed; a seed that was planted in the garden of my mind by Dr. Marc Weiss in an advanced workshop on "Ericksonian Methods of Psychotherapy and Hypnotherapy," back in 1993. *The seed was weak at first and did not take root until the next couple of years,* after I became the teacher and co-trainer ("When the student is ready, the teacher will emerge," Chinese Proverb-Anonymous). Through the positive feedback of this colleague, and the students we trained, the teacher in me gradually emerged and realized that she needed more knowledge and credibility. Then Walden University materialized to offer the opportunity to obtain these *(It was the fertilizer needed to enrich the soil).*

The seed was being watered and began to grow. . . . It was nurtured in the soil of my family by my step-son Dan Jr., a brilliant man and natural motivator, who was unaware of the impact of his simple words when he nonchalantly said: "I can see you being a doctor, mom." And nurtured even more by my loving husband Dan, who interrupted many of his desires and goals to give me the support I needed to achieve my goals. Without his gallant and steadfast efforts I could not have accomplished all that I have: He is the love of my life; *the sunshine in the garden that warms the seed and encourages it to take root, grow, emerge, and blossom.*

A doctoral degree would give me the validation I needed, to do what I needed to do—to fulfill my destiny. With this experiential knowledge as a background, it is no wonder that a Dissertation on the importance of "validity" eventually emerged in the foreground (validity with a much broader impact, however). Understanding the importance of validity for myself, was but a short step to investigating the importance of this for women who had suffered childhood sexual abuse. But the

emergence of an idea is a long-step from forming that idea into a 'doable' structure, particularly the structure of a research project as magnanimous as the Dissertation.

I am deeply appreciative of the professors and colleagues who have helped shape that fledgling idea-*the now firmly planted seed and nudged it to grow.* My practicum and internship supervisor Dr. Joan Kojis was one on my steadfast advocates. She assumed I had competence, and thus I did. She modeled all the qualities of an effective leader, and a kind and generous human being. She is someone I love and admire; She has a gentle power, and a "quiet way of knowing." *She is like the gentle wind that quietly whispers through the leaves, and scatters the seeds to their destination.*

I had thought that the Dissertation was like death: the end of a journey that one has to travel alone, but I was wrong. It was instead, the start of a journey with sojourners of like-mind. After selecting a committee of professionals whom I admired and felt comfortable with, I began to quickly realize what a truly encouraging "team" I had joined. I had anticipated that Dr. Will Wilson would be the task-master (the 'thorn' in my side), who would keep me on the 'straight and narrow' should I begin to stray—to my delight, he was not the thorn, but *the gentle rain that moistened the soil and allowed the seedling to expand,* and as he often said, to "go for it." He was wise enough to know what needed fixing, and what did not. He's an excellent motivator, who leads by example.

Dr. Catherine James shared her thoughts, and helped me shape mine. She got excited about my excitement, and best of all, she sent me many of her famous "hugs" when I needed them most. She is a brilliant lady, a nurturing human being,

and an effective role-model. She leads with her heart as well as her head. *She is the butterfly that quietly alights on the flower and encourages its petals to open.*

My chair, Dr. Richard Waite is a wise and kind leader. He was wise enough to let me struggle in order to learn more, and kind enough to gently guide me when I really needed it. He has a great understanding of people, and knows that I function best with "challenges," and independently. He wisely got out of my way and let me be as creative as the process would allow. His advice was logical, succinct, and encouraging. He respected my efforts and empowered me to give my best. I am forever grateful! *He is like the rich, fertile, soil that is always there waiting--inviting the seedling to take root and grow.*

A thank-you to my present intern supervisors: Dr. Robert Hirschman, and Dr. James Youngquist, who stimulated my passion for knowledge, and have "touched" my spirit with their minds. There is so much more that I have learned about people, systems, and myself from knowing them. *They are like the colorful foilage, varied and rare, that compliment the flower.*

My deepest appreciation is to the women survivors of childhood sexual abuse, who volunteered to share some of their most intimate "secrets" with me for the sake of others. Their stories were disturbing, but their resilience is amazing. They have touched my heart and soul and left an indelible imprint. *The seed has fully flowered now and is ready to drop its petals and re-seed (or recede). Let us hope that this will leave important nutrients for the 'soil' in the next planting cycle . . .*

TABLE OF CONTENTS

LIST OF TABLES

TABLES PAGE

CHAPTER 1: INTRODUCTION

Introduction to the Study

> *Her voice was small and tremulous, barely audible on the phone as she asked: "Do you work with sexual abuse issues?" I asked her to elaborate. She told her story: It was long and painful. She had excruciating vaginal pain that jabbed at her like a knife, and no logical explanation. She had haunting nightmares, with shameful sexual scenes that seemed disgustingly real; she had overwhelming episodes of sadness, intense fear, unexpected anger, and deep loneliness (despite her happy and close present family relationships). She felt "crazy" and "bad," like she had done something profoundly horrible. She had flashes of sexually degrading experiences, that randomly invaded her thoughts; times when she felt "frozen" and numb and could not feel at all. She had two young children who had been sexually abused by her father and brother. She had disconnected fragments, images, feelings, thoughts, sensations. She had the symptoms of an adult survivor of childhood sexual abuse (incest). She had all these loud and clear. What she did not have were memories; memories that could tie all these fragments together. She did not have validation. "What do you want from me?" I asked. "I want to know I'm not crazy," she answered. "How will you know that?" I asked. "When I know the truth. I want to know if I was sexually abused as a child," she replied. Can you help?"* (Paraphrased from the researcher's communications with an incest survivor)

This is the case that seeded the planting of the present study. It is planted in the "soil" of adult, female survivors of childhood sexual abuse, who, like the above client, have struggled to understand and overcome the disturbing, confusing symptoms that plague them. Working with sexual abuse survivors can be a most gratifying experience for the psychotherapist: An opportunity to help someone grow through major psychological trauma can be rewarding in that it can bestow optimism and a sense of meaning to one's work. There is a shadowy side to such endeavors, however. The acceptability of childhood sexual abuse and its consequences continues to be

challenged by social and political dynamics, as well as by a variety of legitimate scientific considerations. For more than a century and a half, the recognition of the effects of childhood sexual trauma on individuals and on society has been marked by controversies. Because these clients suffer from strange symptoms that are difficult to logically explain, they have always invited vehement disputes about the genuineness of their complaints, and have been suspected of malingering and of suffering from false memories or compensation neuroses (van der Kolk, McFarlane, & Weisaeth, 1996).

Memory and Recall of Childhood Sexual Abuse

The issue of memory has always been central to the study of trauma, particularly delayed memories of adults sexually abused as children. Many critics of recovered memories of childhood sexual abuse believe that memories involving amnesia are false creations of treatment (Frankel, 1995; Lindsay & Read, 1994; Loftus, 1993; Ofshe & Walters 1994; Simpson, 1995). They are portrayed as nothing more than an invention of the therapeutic situation fostered by the suggestibility of clients in intense distress and the power of therapists to influence beliefs through the effects of authority, use of suggestion, and selective reinforcement of thoughts and fantasy of sexual abuse (Frankel, 1995; Ofshe & Watters, 1994; Yapko, 1994). A recent study by Leavitt (1997), however, refutes the theory of high suggestibility in adult clients who have recovered memories of childhood sexual abuse. He measured suggestibility in adult patients who recovered memories of childhood abuse, and in a patient comparison group without a history of sexual trauma. The

results indicated that patients who recovered memories were remarkably less suggestible than the clinical field has been led to believe by advocates of false memory. As a group they scored low on suggestibility. Recovered memory patients yielded to suggested prompt an average of 6.7 times per case. This compared to an average of 10.6 in the psychiatric control group. Paradoxically, patients without a history of sexual abuse were more at risk for altering memory to suggestive prompts. A predisposition to low suggestibility makes sense, based on what is known about the effects of childhood sexual abuse. Children victimized by people in authority develop problems with trust and anger (Briere, 1984) that in turn may motivate them to rebel against direction from people in authority later in life. From this perspective, high suggestibility would *not* have been predicted.

There are extremes on both sides of the delayed memory controversy. On one extreme are those who believe that recovered memories nearly always represent "actual" traumatic experiences (e.g., Bass & Davis, 1988; Fredrickson, 1992), and that most psychopathological symptoms are rooted solely in childhood sexual abuse. On the other extreme are those who describe a growing epidemic of iatrogenic false memories of abuse that never occurred, fabricated primarily in the course of therapy (Loftus, 1993; Ofshe & Watters 1994; Yapko, 1994), or in the course of social service investigations (Gardner, 1992). The false-memory advocates believe that such false memories are easy to create and warn that patients who falsely come to

believe they were abused may cut off relationships with or sue family members.

Truth in Memories

Between these extremes are a growing number of scientists and clinicians better informed by the advances in memory and trauma research who argue that traumatization is sometimes associated with amnesia. According to the research studies of Briere and Conte (1993), Herman and Shatzow (1987), and van der Kolk et al. (1996), childhood sexual abuse seems to result in the highest proportion of people with total amnesia prior to memory retrieval, with figures ranging from 19% (Loftus, Polensky, & Fillilove, 1994) to 38% (Williams, 1994). Amnesias for emotional and cognitive material seem to be age-and dose-related. The younger a person was at the time of the trauma, and the more prolonged the trauma was, the greater the likelihood of significant amnesia (Briere & Conte, 1993; Herman & Shatzow, 1987; van der Kolk et al., 1996). These scientists and clinicians also concede that memories about traumatic experiences may contain accurate and inaccurate information, and that under certain conditions recovered memories may be total fabrications (Ceci & Loftus, 1994; Lindsay & Read, 1994; Terr, 1994).

Importance of the Therapist's Validation of the Survivor's Experience

There are instances when the client's disclosure of sexual abuse is disbelieved by the therapist (Sanderson, 1995). This tendency to deny that sexual abuse took place may occur when the client presents with histrionic or

borderline characteristics or behavior (e.g., those that are dramatic, sexualizing, or manipulative). In such instances, the therapist may assume that the abuse disclosure serves a secondary gain, intended primarily to accomplish increased credibility or greater attention, or that it reflects fantasy material or primary process thinking in a highly disturbed individual (Dolan, 1991; Freyd, 1996). However, this sort of clinical presentation has been empirically and clinically associated with a history of childhood victimization. Sexual abuse disclosures often precipitate or occur in the context of dissociation and other psychological defenses that allow the survivor to detach from or somehow alter the painful affect associated with replaying an abuse memory. Such coping techniques may result in either little visible emotional response (e.g., affective blunting or seemingly mechanical renditions) or inappropriate responses, such as laughter, inordinate casualness, or intellectualization. Also, the survivor's unconscious attempts to deal with the painful affect surrounding victimization experiences may have generated periods of amnesia or confusion regarding the specifics of the abuse and may be associated with conflicting memories and perceptions (Briere & Conte, 1993; Herman & Schatzow, 1987; Williams, 1995). The client's continuing attempt to avoid the abuse (and thus render it nonexistent or at least unimportant), unfortunately, may be all too successful in the short term, occasionally producing questions in the therapist's mind regarding the truth of the disclosure or the possibility of false memories.

Given this conundrum, the clinician may be left with the question: "How do I know what 'really' happened, and what didn't?"

Several researchers (Alpert, 1995; Bell-Gadsby & Siegenberg, 1996; Calof, 1993; Courtois, 1992; Kirshcner, Kirschner, & Rappaport, 1993) contend that there are many therapists who can and do irreparable damage to their clients by denying their memories and experiences of childhood sexual abuse. Orbach (1994) believes that a therapist who is not prepared to consider the possibility of childhood sexual abuse is doing his or her client a great disservice.

The therapist must question himself or herself as to why the exact, real facts are so important in treating adults who report childhood sexual abuse. In other areas of psychotherapy, it is often benignly assumed that clients' reports of past events although frequently distorted by defenses and previous experiences--have some intrinsic validity, and the client is rarely cross-examined as to the detailed aspects of his or her historical account. Reviere (1996) clarifies the truth of trauma in memory when she states:

> The therapeutic dialogue in combination with individual differences and myriad cognitive, emotional, and neurological processes preclude definitive conclusions about whether each detail of a given memory for trauma is absolutely "true" as such. The question of truth in psychotherapy may be directed most appropriately to considerations of integrity within the therapeutic relationship as well as within the individual therapist and individual client in terms of self-structure and life narrative. Mutuality in genuineness, honesty, and sincere collaborative striving for growth and healing create an openness to experience and understanding that, in its essence, can be relied upon to serve the best interests of the client and his or her search for truth. In such an environment, the question of truth may be answered most

> clearly by a subjective sense of fit and compatibility with the client's presentation and history. (p. 105)

Such a fit is perhaps manifested in what Curtis (1991) describes as a "quiet knowing" that emerges over time in both therapist and client (p. 5). Within this framework the life narrative is reconstructed in a way that enhances the emergence of the client's integrated, full self and provides a more sophisticated and complete knowing of the integrity of the client's truth and its function in ensuring integrity of the self.

Background

Prevalence of Childhood Sexual Abuse

The prevalence of childhood sexual abuse is difficult to estimate, since the various surveys differ greatly (Levitt & Pinell, 1995). Summarizing a series of recent surveys, Geffner (1992) estimates that between 20% and 35% of females and 10% to 18% of males will probably be sexually abused at least once by age 18. Loftus (1993) suggests a range of 10% to 50% without other specifications. Bloom (1994) claims that one female in three is sexually abused by age 18. She says further that "to claim that these numbers are highly controversial is just nonsense" (p. 472). Kluft (1990) refers to incest as "a commonplace event" (p. 3). Briere (1997) cites several recent studies which suggest "that approximately 35-70% of female mental health patients

(according to clinical setting), self-report a childhood history of sexual abuse, if asked" (p. 12). [1]

The most recent government report of the annual incidence of child sexual abuse (National Center for Child Abuse and Neglect, 1988) was 44,700. Assuming that incidence to be roughly constant for a 15-year period up to the current year, the prevalence of sexual abuse is approximately 667,500 cases. Estimating roughly an average population of 60 million persons under the age of 18, the prevalence of child sexual abuse is 1.1%. For the population between the ages of 5 and 18, the prevalence is 1.6%. These figures must be crudely modified by the fact that less than half of the accusations of child abuse are verified by child protective agencies (Eckenrode, Powers, Doris, Munsch, & Bolger, 1988). The critical term, *sexual abuse,* is not clearly defined in government reports, a shortcoming that they share with surveys.

Regardless of the true prevalence of childhood sexual abuse, sibling incest is far more prevalent than father-daughter incest. The ratio is 13:1, according to Finkelhor's (1990) research. Father-daughter incest appears to be the most damaging type of abuse that is most commonly reported (Levitt & Pinnell, 1995).

The Long-Term Effects of Childhood Sexual Abuse

[1] "Equivalent data on male mental health patients are largely unavailable at this time, although clinical experience suggests that the incidence of sexual and physical abuse is elevated in this group as well" (Briere, 1997, p. 12).

For those who have experienced sexual abuse, or have listened objectively to someone who has, there is little doubt that such experiences can be harmful. The long-term deleterious effects on victims of childhood sexual abuse are well documented (e.g., Briere, 1992; van der Kolk et al., 1996). Clinical symptoms frequently observed with this population include chronic depression, anxiety and panic disorders, significant relationship disturbances, sexual difficulties, suicidality, self-abusive behaviors, and psychosomatic disorders (Briere, 1989, 1992; Finkelhor, Hotaling, Lewis, & Smith, 1989; Russell, 1986). Feelings of guilt, self-blame, self-disgust, self-hatred, low self-esteem, powerlessness, mistrust of others, and a sense of hopelessness and despair are frequently cited as long-term effects of sexual abuse (Bagley Ramsay, 1986; Briere & Runtz, 1993; Browne & Finkelhor, 1986a; Herman, 1992; Jehu, 1991; McCann, Pearlman, Sackheim, & Arahamson, 1988).

Herman (1992) and van der Kolk (1993) have suggested that the distorted survival strategies that result from inescapable stress in humans include all of the above symptoms, as well as dissociative symptoms; compulsive reenactment; susceptibility to revictimization; intimacy and relationship disorders; and some personality adaptation in the borderline, narcissistic, antisocial, or schizoid realm.

Suedfeld (1990) proposes that children who are chronically traumatized by caretakers in an environment of endemic family stress (like sexual abuse), may have experiences similar to those of torture victims,

which include the creation of dependency, intimidation, disorientation, and isolation.

Childhood Sexual Abuse and Psychopathology in Adult Survivors

While the specific relationship between childhood sexual abuse and the later development of psychopathology in survivors is still under investigation (Levitt & Pinnell 1995; Rieker & Carmen 1986), it is believed that a host of symptoms are generally related to the complex of experiences surrounding childhood sexual abuse and incest. The symptoms of posttraumatic stress disorder (PTSD), for instance, have been positively correlated with childhood sexual abuse (Blake-White & Kline, 1985; Briere & Runtz, 1987,1993; Briggs & Joyce, 1997; Donaldson & Gardner, 1985; Lindberg & Distad, 1985; van der Kolk et al., 1996). Other symptoms include low self-esteem, anxiety disorders, chronic depression, eating disorders, drug and alcohol abuse, sexual dysfunction, and abusive marital or incestuous family relations. Kirshner et al. (1993) have noted that often survivors of incest present in therapy with a variety of cognitive, emotional, physical, and interpersonal difficulties, which they contend are interaction effects of incest which they have named "the incest syndrome." Hunter (1995) contends that "for child victims, even when the abuse stops, the cycle often does not, because the chronic, learned helplessness still renders them targets for further victimization throughout life" (p. 5).

Dissociation and Childhood Sexual Abuse

Over the last decade the role of dissociative symptoms in psychological disorders has gained in significance (Chu & Dill 1990; Coons, Bowman, Pellow, & Schneider, 1989). Dissociation is a way of compartmentalizing experience. It is a process that produces a discernible alteration in a person's thoughts, feelings, or actions so that for a period of time certain information is not associated or integrated with other information as it normally or logically would be (West, 1967). Dissociation has been implicated in traumas and childhood sexual abuse. In traumatized sexual abuse victims, dissociation often results in amnesia surrounding the traumatic event, in which the cognitive and affect systems become split and which may result in intense feelings of negative affect (e.g., uncontrollable self-destructive urges) without cognitive correlates. Elements of a trauma are not integrated into a unitary whole or an integrated sense of self. Although dissociation may be adaptive at the time of the trauma (a protective mechanism), the lack of integration of traumatic memories is thought to be the pathogenic agent leading to the development of complex biobehavioral changes, of which PTSD is the clinical manifestation (Carlson & Putnam, 1993). This observation was first made by Janet (1909), (long before the creation of PTSD as a diagnostic category), and has been confirmed by a subsequent century of clinical and research data.

More than 85 years ago Janet (as cited in Janet, 1925) claimed: "Forgetting the event which precipitated the emotion. . . has frequently been

found to accompany intense emotional experiences in the form of continuous and retrograde amnesia. [This is] an exaggerated form of a general disturbance of memory which is characteristic of all emotions" (p. 1607). He also noted that when people become too upset, memories cannot be transformed into a neutral narrative; a person is "unable to make the recital which we call narrative memory, and yet he remains confronted by [the] difficult situation" (Janet, 1919/1925, Vol. 1, p. 660). This results in "a phobia of memory" (Vol. 1, p. 661), which prevents the integration of traumatic events and splits off the traumatic memories from ordinary consciousness.

Statement of the Problem

Trauma theorists Alpert (1995), Kirschner et al. (1993), and Sanderson (1995), assert that it is counterproductive for the therapist to attempt to establish the "truth" of their clients' childhood sexual abuse experiences. What is more important, they contend, is for the therapist to focus on the survivor's truth as she or he believes it happened and to explore this. "It is the survivor's perception and the meaning the abuse has for her or him that must be the focus of the healing process, not corroboration or factual evidence" (Sanderson, 1995, p. 129).

If these trauma theorists' assumptions are true, then validation through corroborative evidence, and establishing the truth of the client's abuse experiences are not necessary factors in the healing process. But it is necessary to ascertain the accuracy of these assumptions. This study attempts to do this by answering the following question: Is validation

through corroborative evidence truly *not* necessary in how women experiencing posttraumatic states recover from childhood sexual abuse?

Purpose of the Study

Most human beings recognize that reality is not entirely historical or constructed, and that truth is not merely narrative. The real puzzle is to find some way to locate and define the elusive interplay of historical, constructed, and narrative truth. If therapists-researchers can allow themselves to explore this epistemological problem, informed both by the dilemma of the childhood abuse survivor, and by the rich, subjective data she or he can provide, as well as the plethora of objective trauma research, there is the potential to attain yet another new paradigm for trauma therapy.

The purpose of this study is to help complete this evolutionary movement in psychotherapy and psychological research, and contribute to the scholarly knowledge base, by using more qualitative, person-centered, methods to probe into the sensitive areas of childhood sexual abuse. This probe was done by allowing those most familiar with the issues of childhood sexual abuse to participate in the research: the female, survivors themselves. The survivor essentially became a co-researcher in the dissemination of relevant data.

Theoretical Orientation: The Interpretive-Constructivist Paradigm

Although quantitative measures were included in this study (e.g., objective tests used to measure dissociation, current impact of CSA, and self-esteem), creating an overall "mixed" qualitative-quantitative design, an interpretive-constructivist paradigm was the primary theoretical orientation, since the main purpose is to understand the participant's world, and learn from her.

According to the interpretive-constructivist paradigm, human interaction is seen as relative, and there is no single, external, objective truth. Multiple realities exist, and the interactions between the investigator and participants creates the findings as the investigation unfolds. It is a reflexive process where information gathered from participants is fed back to them for verification of its accuracy (Denzin & Lincoln, 1994). This was done with the participants of this study during the personal interviews: The researcher would feed back many of the answers given by the participants for clarification and accuracy, and then made any necessary changes. "Thick description" (Geetz, 1973) was used "to bring the context and meaning of the participants' lives forward by presenting detail, emotion, and the webs of social relationships that join persons to one another" (Denzin, 1989, p. 83). The use of thick description allows readers to formulate their own interpretations of the results (Patton, 1990). The methods used in this research study are consistent with the interpretive-constructivist paradigm whose goal has been to allow the investigator to record the participant observations accurately and to uncover the meanings that participants

ascribe to their life experiences, particularly their childhood sexual abuse experiences and the impact that these have had on their lives today.

Assumptions of the Study

The study under inquiry is a gender-specific investigation of adult, female survivors of childhood sexual abuse and the relevance of validation through corroborative evidence of their experiences, in the remediation of their symptomatology. Case study was utilized as the method of study deemed appropriate for this type of research.

This study revealed personal experiences of women survivors of childhood sexual abuse, and assumed that individuals who were unable to discuss their experiences would not participate in this research.

That childhood sexual abuse, particularly incest, is a stressful life event which is disruptive to the developmental processes of the individual, and can result in long-lasting psychological injuries, is acknowledged. It is further assumed that there is a relationship between childhood sexual abuse and the development of "posttraumatic states" (as defined by Briere, 1997; and Herman, 1992) in the adult survivor.

The investigator assumed that the responses of the participants are honest and accurate representations of their experiences, and that the interpretations and insights were as accurate as the survivor's recollections and memories.

Scope of the Study

This study was directed to the issue of validation through corroborative evidence, and its relevance to remediation of symptomatology, as well as the current coping and adaptive strategies used by women who have been sexually abused as children and are experiencing varying degrees of PTSD or "posttraumatic states" (Briere, 1997; Herman, 1992). This was conveyed through case studies of their personal narratives. The scope of this study was limited to female survivors, because of their larger prevalence in psychotherapy; although it is acknowledged that male survivors also suffer many similar, devastating consequences of childhood sexual abuse (American Psychiatric Association Board of Trustees, 1994). A research study of Sigmon, Greene, Rohn, and Nichols (1996) has found, however, that females consistently demonstrated greater trauma-related distress than males on standardized measures.

Limitations

"The human factor is the great strength and the fundamental weakness of qualitative inquiry and analysis" (Patton, 1990, p. 372). The limitations of this study include all of those that are inherent in qualitative research, which include the following: it is subjective; it frequently produces more new questions than answers to old problems; despite triangulation, qualitative methods do not have widely agreed upon protocols or rigorous

tests of data; it is interpretive, holistic, naturalistic and uninterested in cause (Marshall & Rossman 1995; Stake, 1996).

The sample of this study is small (N=25), gender-specific (women only), and not totally random (20% of the sample were psychotherapy clients of the researcher). There were no controls for certain demographical variables such as education, race, or culture, which could have influenced the findings.

The researcher assisted two participants who had trouble concentrating, reading, or comprehending the test instruments (DES, IES, SERS) by reading the materials aloud to them, and checking off their answers. This could possibly add a bias to these assessment results. Also, five of the interviews were conducted by telephone for participants who lived at a distance. The test instruments were sent to them to fill out in advance of the interview, and then mailed back to the researcher. It is possible for these participants to have had someone else fill out these assessments, thus giving inaccurate data. Even though the interviews were audio-taped, it is possible for the researcher to have heard and recorded the participants' answers incorrectly, although the inclusion of three independent raters, who also listened to the individual tapes, substantially reduced this possibility.

All of the women in the study had symptoms (current or past) of varying degrees of posttraumatic states, and the question of comorbidity arises: the "which came first, the chicken or the egg?" analogy.

The limitations of delayed memory, dissociative states, and the lack of validation in the form of corroborative evidence of some of the survivors'

experiences of childhood sexual abuse are noted. Also acknowledged is the potential for distortions that may have arisen from the survivors' recollections and self-report of personal experiences that happened many years ago.

Definitions of Study-Specific Terminology

For purposes of this study, the following definitions were utilized:

Childhood Sexual Abuse

This term was used interchangeably with Sanderson's (1995) definition of incest (see under "incest," below), except that for this study, it also included sexual encounters imposed on a child by nonfamily members as well (e.g., boyfriend, friend, baby-sitter).

Comorbidity

Comorbidity occurs when two or more disorders are linked together and appear to be simultaneous (e.g., depression and substance abuse). "The association may reflect a causal relationship between one disorder and another or an underlying vulnerability to both disorders" (Edgerton, 1997, p. 44).

Coping

Coping has a variety of definitions and similar synonyms within the research. Terms such as adaptation, coping mechanisms, coping strategies, defense mechanisms, and coping styles (Lararus 1993; Monat & Lazarus, 1991), all appear in the literature. These terms are used interchangeably in this study. Coping is defined as a process of managing demands both external

and internal, "that are appraised as taxing or exceeding the resources of the person. . . . This definition implies a distinction between coping and automatic adaptive behavior" (Lazarus & Folkman, 1984, p. 141).

Delayed or Recalled Memories

In the context of this study, delayed or recalled memories are defined as the recollection after a period time, of forgotten memories of childhood sexual abuse (American Psychiatric Board of Trustees, 1994).

Dissociation

Dissociation is a process that produces a discernible alteration in a person's thoughts, feelings, or actions so that for a period of time certain information is not associated or integrated with other information as it normally or logically would be, and thus can produce amnesia for certain experiences (West, 1967). Dissociation is often linked with repression and may be part of a complex memory process (see Repression, below).

Incest

> Incest is defined as a sexual act imposed on a child or adolescent by any person within the family constellation who abuses their position of power and trust within the family. It includes all sexual encounters where there is a difference of age and power, and all types of sexual behaviors ranging from pornography, voyeurism, exhibitionism, fondling, masturbation, through penile penetration. (Sanderson, 1995, p. 15)

Memory Terminology

Stages of memory. The American Psychiatric Board of Trustees (1994) have succinctly summarized the stages of memory they state:

> Memory can be divided into four stages: *input, (encoding); storage, retrieval,* and *recounting* [italics added]. All of these processes can be influenced by a variety of factors, including developmental stage, expectations and knowledge base prior to an event; stress and bodily sensations experienced during an event; post-event questioning; and the experience and context of the recounting of the event. In addition, the retrieval and recounting of a memory can modify the form of the memory, which may influence the content and the conviction about the veracity of the memory in the future. Scientific knowledge is not yet precise enough to predict how a certain experience or factor will influence a memory in a given person.
>
> Explicit memory (also termed declarative memory), refers to the ability to consciously recall facts or events.
>
> Implicit memory (also termed procedural memory), refers to behavioral knowledge of an experience without conscious recall. A child who demonstrates knowledge of a skill (e.g., bicycle riding) without recalling how he-she learned it, or an adult who has an affective reaction to an event without understanding the basis for that reaction [e.g., a combat veteran who crouches in terror, when he hears the loud, backfiring of a car], are demonstrating implicit memories in the absence of explicit recall. This distinction between explicit and implicit memory is fundamental because they have been shown to be supported by different brain systems, and because their differentiation and identification may have important clinical implications. (p. 262)

PTSD: Posttraumatic States

This study defined posttraumatic stress disorder (PTSD) in an expanded way which included some or all of the following: (a) the definition of PTSD in DSM-IV (American Psychiatric Association, 1994, pp. 424-429); (b) and complex PTSD as proposed by Herman (1992), and defined by Briere (1997, pp. 34-36).

The essential features of PTSD as defined by the DSM-IV are that the person must have experienced an event outside the range of normal human experience and have had symptoms lasting for longer than 1 month in each of

the following categories: intrusive re-experiencing of the trauma; persistent avoidance of stimuli associated with the trauma, and/or numbing of general responsiveness; and persistent autonomic signs of anxiety, and/or hyperarousal-hypervigilance.

For this study, PTSD also included an expanded concept of the DSM-IV definition, which Herman (1992) has described as *complex PTSD,* and Briere (1997) has labeled *posttraumatic states.* These terms are synonymous and are used interchangeably throughout this study. They include trauma that is of an interpersonal nature (such as childhood sexual abuse), and is severe, prolonged and/or repeated. The term *complex PTSD* includes additional, and more clinically relevant symptoms such as dissociation, somatization, affective changes (i.e., increased anxiety, depression, anger, and affective instability), identity and boundary disturbance, affect regulation problems, chronic involvement in dysfunctional relationships, and self-injurious or self-defeating behaviors.

However, a strict adhesion to the DSM-IV, or Herman's-Briere's criteria was not necessary for subjects in this study to be identified as suffering from PTSD symptomatology: They had several, or only a few of the symptoms described above, and at varying degrees of intensity.

Reframing of Meaning

Remediation of symptoms might be demonstrated by a reframing of the abuse from a more negative event (e.g., "It was awful, I'll never get over

it"), to a more positive one (e.g., "It was a learning experience"—"It made me stronger"), thus changing its meaning for the survivor. Meaning has to do with the interpretation that the survivor has attributed to the trauma (e.g., "There's something terribly wrong with me, or this would never have happened"), and the impact she believes it has on her life in general. Caruth (1995) says that ". . .although the reality of extraordinary events is at the core of PTSD, the meaning that the victims attach to these events is as fundamental as the trauma itself" (p. 6).

Remediation of Symptoms

The terms *remediation of symptoms* and *recovery* are used interchangeable, and are defined as any lessening of the symptoms (intensity, frequency, and/or quality) described in *posttraumatic states*, or the presenting symptoms of the survivor (e.g., drug addiction, eating disorder, etc.). A lack of, or repudiation of the self-belief in being crazy, bad, evil, or being responsible for the abuse, also represented a remediation of symptoms, as well as a reporting of increased self-esteem, measured by both the Self-Esteem Rating Scale (Nugent & Thomas, 1993), and the personal interview. A lessening of the frequency, intensity, and/or quality of dissociation, as measured by the Dissociative Experiences Scale (DES-II--Carlson & Putnam, 1993) and personal interview, and the impact that the childhood sexual abuse(s) currently has on the survivor, as measured by the Impact of Event Scale (IES--Zilberg, Weiss, & Horowitz, 1982), and personal interview, are

likewise indicative of symptom remediation. Furthermore, any lessening (frequency, intensity, and/or quality) of complaints or issues linked to childhood sexual abuse by the survivor, and reported to be problematic from her perspective, represents a remediation of symptoms.

Repression

Repression is a construct that is thought to be the mechanism by which conscious material too difficult for the ego to assimilate is pushed from consciousness into unconsciousness, producing an amnesia, in an attempt to protect the ego from harm (Freud, 1920/1955). Researchers Beahrs (1982) and Erdelyi (1990) have theorized that repression and dissociation may be part of a complex memory process in which the various sensory, cognitive, and emotional associations are fragmented, with some components repressed (by way of one of several specific cognitive mechanisms), and others available in alternate states of consciousness (Singer & Sincoff, 1990).

Self-Esteem

Self-esteem is defined as one's perception (belief) about one's self, and feelings of self-love. High self-esteem indicates a positive self-perception, whereas a low self-esteem indicates a negative self-perception. The low self-esteem or poor self-concept has been described as one of the consequences of childhood sexual abuse (e.g., Briere, 1997; van der Kolk et al., 1996; Williams & Sommer, Jr., 1994). These researchers suggest that such a relatively mild term does not embody the true extent of self-degradation experienced by

many severely abused individuals, and that a more appropriate term might be "self-hatred."

Survivor

Survivor refers to any adult person who has experienced any form of traumatic, childhood sexual abuse and was not killed by it.

Validation

When validation is not used with corroborative evidence, it refers to the social support (e.g., family acceptance, support; other social support, acceptance) that is given a survivor following her disclosure of the abuse. Validation also refers to the acknowledgment and support given to the survivor by the therapist.

Validation Through Corroborative Evidence

This is defined specifically for this study as some kind of external attestation (confirmation) that the survivor's recollections of her childhood abuse(s) are accurate. Examples would include a perpetrator who admits the abuse, or another family, or non-family member, who knows about the abuse from either observing it directly, or indirectly from another source. Hospital records, and other external (outside the survivor) documents also exemplify validation, and do not need the same degree of evidence as required legally. It does *not* include a therapist's assessment that the abuse happened.

Research Questions

The overriding question of this study is, Does validation through corroborative evidence make a positive difference in how women experiencing posttraumatic states recover from childhood sexual abuse? Other questions which provide support follow.

1. How do women who have suffered childhood sexual abuse who have been validated (through corroborative evidence) differ from those who have not in their level of dissociation?

(a) Their frequency of dissociation?

(b) Their intensity of dissociation?

(c) Their quality of dissociation?

2. How do women who have been validated, and those who have not, differ in the belief that validation (through corroborative evidence) is necessary for them to heal from the abuse?

(a) How is this belief expressed?

(b) What is it they need to know about the abuse?

(c) From whom do they need to obtain this information (e.g., perpetrator, parent, court, therapist)?

3. In those who have been validated, how can their self-esteem and perceptions of self be described?

(a) How do these differ from those who have not been validated?

(b) Is there a difference in their perception of self as being *crazy, bad, evil*, or deserving of the abuse?

4. What impact has the abuse had on their adult lives? How do they differ in terms of

(a) Posttraumatic stress symptoms (e.g., flashbacks, intrusive images, intense affect, numbing of affect, regression to abuse, obsessing about the abuse, psychosomatic symptoms)?

(b) Psychologically distressing symptoms (e.g., depression, paranoia, anxiety, personality disorders)?

(c) Their ability to cope and come to terms (adapt) with the abuse?

5. In those who have been validated, how important are the following:

(a) Age of validation.

(b) Time of validation (e.g., upon self-disclosure, immediately after incident, years later).

(c) Who validated them (e. g, perpetrator, parent, friend, court).

Significance of the Study

In adulthood, it is not uncommon for victims of childhood sexual abuse to require services, resources, and financial contributions as a result of their victimization. Therefore, all members of society are traumatized directly or indirectly by childhood sexual abuse. The trauma of sexual abuse does not begin or end with a penis inserted in a mouth, vagina, or anus, followed by a disclosure. The crime of sexual abuse, particularly childhood sexual abuse

where the child by virtue of being a child, has no ability to consent, is not like the theft of one's jewels. Jewels can be replaced; a childhood cannot.

Until childhood sexual trauma is better understood, a prescription will not be provided for its healing. And until it is understood how to heal victims, all of society will continue to be damaged by the deeds of sexual offenders. A needed step, then, is to adequately understand the trauma of childhood sexual abuse from those who know it best: the adult survivors themselves.

Summary

Recent research findings of Briere (1996/1997), Finkelhor, Hotaling, Lewis, and Smith (1990), and Sanderson (1995), indicate that between one fifth to one third of all women have experienced sexual abuse in childhood. But because most abuse is done in private with few witnesses, and mingled with shame and guilt, it may be greatly underreported (Briere, 1997; Finkelhor, 1990). Therefore, the prevalence of childhood sexual abuse is difficult to ascertain.

Memories of childhood abuse by the adult survivor are likewise uncertain due to the mechanisms of repression, dissociation and strong defense mechanisms (e.g., denial, conversion reaction, etc.). Furthermore, many survivors of childhood sexual abuse come to therapy with symptoms that *seem* unrelated to this past abuse, and only later, after working with their current symptoms, do they begin to piece the fragmented memories together into an awareness of its relationship to their current

symptomatology. Researchers Briere and Conte (1993), Herman and Schatzow (1987), Leavitt (1997) and Williams, (1994) have found that many survivors have amnesia for some or all of their previous abuse. In these studies 38% to 59% of those who previously reported being sexually abused as children did not remember the abuse several years later, and therefore did not connect it with their current symptoms (psychopathology). Harvey (1996) and others (e.g., Chu & Dill, 1990; Smucker et al., 1996; Spiegel, 1990; Staton, 1990; van der Kolk & van der Hart, 1991a) believe that the lack of integration of memory with affect can be psychologically debilitating to survivors, particularly in their ability to trust themselves and their own perceptions.

The long-term deleterious effects of childhood sexual abuse are well documented (e.g., Sadeh et al. 1994; Shapiro & Dominiak, 1992; van der Kolk et al., 1996) and range from affective disorders, identity and dissociative disorders, to difficulties with intimacy and relationships. The most disturbing, enduring effects seem to be those that affect the self and self-image (Bagley & Ramsay, 1986; Briere & Runtz, 1993; Browne & Finkelhor, 1986; Herman, 1992).

Childhood sexual abuse is shrouded in secrecy, particularly when the abuse is between a child and a parent. Freyd (1996) has theorized that incest victims may develop a "motivated repression" to save them from knowing that someone they love and trust has betrayed them. Additionally, there is usually a great deal of shame and guilt associated with childhood sexual

abuse, thus making it extremely difficult to talk about. But when a survivor finally does disclose the abuse, it is important for her to be believed (Coffey, Leitenberg, Henning, Tonia, Turner, & Bennett, 1996; Sanderson, 1996). Many times these self-disclosures meet with denial and/or negative consequences (e.g., abandonment from family) and lead to further difficulties for the survivor (Browne & Findlehor, 1986; Waller, 1994). Validation, particularly from the survivor's social support system, can become a very important issue in the survivor's healing process (McNulty & Wardle, 1994; Pye, 1995).

The problem of validation can become a dilemma for both the therapist who was not there to witness the abuse, and the survivor of childhood sexual abuse, who desperately wants to know if what she remembers, or perhaps only instinctually senses, actually happened to her. The following question emerges: How important is validation through corroborative evidence (validation from an outside source) to the survivor's ability to heal from abuse? And further, how important is it for the survivor to have the therapist believe her? These are some of the difficult questions that this researcher in corroboration with the adult, female survivors, hoped to answer. As Shapiro and Dominiak (1992) state:

> We have learned much from listening to sexually traumatized patients. For example, the renewed and expanded understanding of dissociative processes and the enhanced appreciation for the importance of treatment relationships have added new dimensions to our clinical observations and conceptualizations of psychopathology in general. (p. xiii)

CHAPTER 2: LITERATURE REVIEW

Introduction

The purpose of this literature review is to explore current research on the effects of childhood sexual abuse on the adult, female survivor, including the issue of validation and its role in the remediation of trauma-related symptoms. This was accomplished by reviewing studies that address the following issues: (a) the controversy over the harmfulness of childhood sexual abuse; (b) the comorbidity of posttraumatic stress disorder (PTSD) and childhood sexual abuse; (c) the effects of childhood sexual abuse on adult functioning; (d) theories of traumatic memories and their impact on symptoms related to childhood sexual abuse; (e) dissociation-repression and their role in symptoms correlated with childhood sexual abuse; (f) the importance of validation and social support after disclosure of the abuse; (g) coping strategies of survivors of childhood sexual abuse; (h) current theories relating to childhood sexual abuse that are applicable to this study; (i) and a multidimensional theory of recovery from childhood sexual abuse.

Childhood Sexual Abuse: Controversy Over Negative Effects

There is a controversy among some authorities as to whether childhood sexual abuse produces negative effects. For instance, renowned sex researcher Kinsey and colleagues (1953) seem to minimize the negative consequences of sexual abuse: "It is difficult to understand why a child, except for its cultural conditioning, should be disturbed at having its

genitalia touched, or disturbed at seeing the genitalia of other persons, or disturbed at even more specific sex contacts" (Kinsey, Pomeroy, Martin, & Gebhard, 1953, p. 121). A noted psychiatrist, Henderson (1983), wrote: ". . . research is inconclusive as to the psychological harmfulness of incestuous behavior" (p. 34). More recently, another prominent psychiatrist questioned whether "a sexual encounter between an adult and a child--no matter how short, no matter how tender, loving, and non-painful--automatically and predictably must be psychologically traumatic to the child" (Gardner, 1992, p. 191). Spence (1994) notes that "although incest necessarily implies intercourse, child abuse does not necessarily imply incest" (p. 291). He contends that childhood sexual abuse is continually open to redefinition and that the most negative connotations of the spectrum tend to be projected onto it. Spence stresses that "we have no good evidence that its taboo nature is clearly apparent to the young child," (p. 291) and that the significance of this event changes over time. He further contends that some actions may have been experienced as either neutral or exciting or even pleasurable, with the attendant secrecy adding to the appeal, and that intention is disguised or misrepresented: "To the child, it is largely ambiguous and can be interpreted in a variety of ways, depending on the hopes and fears of the victim" (p. 291). Wakefield and Underwager (1994) have drawn a similar conclusion from their interpretation of a review article by Kendall-Trackett, Williams, and Finkelhor (1993), of reports on the effects of sexual abuse. They state: "The most recent review article on the effects of sexual abuse reports a consistent

finding that a substantial proportion of abuse victims show no symptoms" (p. 63). They further interpret this to mean that significant portions of persons abused later report their subjective experience to be neutral or positive, rather than traumatic.

Other researchers have suggested that many sexual abuse reports reflect false allegations, false memory syndrome, or some combination of therapist incompetence and client avarice in the context of wrongly prosecuted civil litigation (e.g., Loftus & Ketcham, 1994; Ofshe & Watter, 1994; Wakefield & Underwager, 1993).

But many other trauma researchers (e.g., Briere, 1992; Herman, 1992; van der Kolk et al., 1996, and Williams & Finklehor, 1993) take the position that is generally at odds with such notions, although they acknowledge the fact that both clients and therapists are vulnerable to human misconceptions (Briere, 1996/1997). Most published studies indicate that sexual abuse is commonly (although not inevitably) associated with significant psychological pain and suffering--trauma that may persist over the years unless specifically resolved. In one review of the literature, for example, Browne and Finkelhor (1986b) describe the findings of 52 studies on the impact of childhood sexual abuse and conclude that "empirical studies with adults confirm many of the long-term effects of sexual abuse mentioned in the clinical literature" (p. 72). They further note that "the risk of initial and long-term mental health impairment for victims of child sexual abuse should be taken very seriously"

(p. 72). Other more recent reviews offer similar conclusions (Briere & Runtz, 1993; Finkelhor, 1990; Neumann, Houskamp, Pollock, & Briere, 1996).

Wakefield and Underwager's Beliefs on Sexual Abuse

Despite their belief that childhood sexual abuse is not necessarily traumatic, Wakefield and Underwager (1994) acknowledge with Briere (1996/1997) and others that sexual abuse is always harmful, even though it may not be recognized as such by the individual, and though there may be no obvious psychological effects. In their book, Accusations of Child Sexual Abuse, Wakefield and Underwager (1988) state: "We do not agree that the effects of childhood sexual experiences with older partners are ever likely to be positive, as is sometimes claimed. Rather, the effects are apt to range from neutral to seriously damaging" (p. 352). They advanced an intimacy versus sex theory to explain why sexual contact between adults and children can never be positive. Their theory ascribes intimacy with another, over "genitalized sex" (a consequence of child sexual abuse), as being paramount to healthy development, and contend that

> Unity, wholeness, and the full intimacy of love that includes the expression of human sexuality requires an equality across all facets of humanity. . . .The greater the discrepancy in maturity and equality, the greater the emphasis will be on sex as sex alone if it is brought into the relationship. (p. 66)

And when this happens, they believe that the child learns genitalized sex which leads to the development of limited and partial comprehension of intimacy. The impact upon the capacity for wholeness, unity, and love is then

limiting and negative. For these reasons, they maintain that sexual contact between an adult and a child is always harmful in its impact on both parties.

Stress Versus Traumatic Stress

Historically, the field of traumatic stress has evolved independently from the preexisting domain of stress and coping. Despite attempts to articulate theoretical links between stress and traumatic stress research (e.g., Baum, 1990, Baum, Cohen, & Hall, 1993), there has been very little interaction between the two fields. van der Kolk et al. (1996) dispute the commonly held belief that traumatic stress, specifically PTSD, is a stress disorder, and an adaptive response to environmental changes. They contend that there is indeed a problematic conjunction between the two.

The core of stress theory consists of a homeostatic model of self-conservation and resource allocation in response to adversity (Cannon, 1932; Selye, 1956). Such responses usually occur under stress or in the immediate proximity of the stressor. The intermediate and long-term consequences of exposure, however, are beyond the scope of the model. In the classical example of the body's response to massive bleeding, Selye's (1956) model focuses on immediate coping responses, which adaptively attempt to reduce the effects of such bleeding on vital functions of the organism. It does not address the healing of the wound that has caused the bleeding to occur. Neither does it say anything about the recovery from eventual renal failure or brain damage, which may result from unsuccessful coping with the bleeding.

Traumatic Stress and PTSD

Stress, however, becomes traumatic precisely when psychological damage analogous to this type of physical damage occurs--that is, damage to a hypothetical stimulus barrier (Freud, 1920/1955) to the *self* (Laufer, 1988), to one's cognitive assumptions (Janoff-Bulman, 1985), to one's affect (Krystal, 1978), to neuronal mechanisms governing habituation and learning (Kolb, 1987), to one's memory network (Pitman, 1988), or to emotional learning pathways (LeDoux, Romanski, & Xagoraris, 1989).

Lazarus and Folkman's (1984) seminal work on stress theory (published 4 years after the DSM-III definition of PTSD) does not mention PTSD or any other Axis I disorder as a possible consequence of exposure to stress. These authors suggested that impaired social functioning, decreased morale, and poor somatic health are typical forms of negative outcome resulting from the failure to cope with stress.

Stress research and traumatic stress literature differ in a number ways. Lindeman's (1944) "traumatic grief" and Horowitz's (1986) "stress response syndrome" are often cited as extensions of "classical stress theory" (e.g., Hobfoll, 1988, p. 6). These models, however, include a recovery or assimilation phase, which consists of a prolonged struggle with the results of exposure. Survivors often experience discomfort, distress, anxiety, and grief during this period. Confusingly, these reactions have been vaguely referred to as *stress* or *chronic stress*. Baum (1990), for example, has defined stress as a

"negative emotional experience accompanied by biochemical, physiological, and behavioral changes" (p. 654). Chronic stress, accordingly, is not limited to situations in which stressors persist for long periods of time. Responses may habituate before a stressor disappears, or may persist beyond the physical presence of the stressor. Theoretically, however, the use of the term *stress* for both acute and chronic responses is problematic. Recent neuroendocrinological studies by Yehuda et al. (1993) have shown reduced cortisol levels in PTSD (as opposed to elevated cortisol during acute stress), thereby supporting the distinction between acute stress and the prolonged states of posttraumatic morbidity.

Stress research and traumatic stress literature differ also in a number of methodological dimensions. Most of the research on traumatic stress has been focused on evaluating the relationship between a trauma and subsequent disorders thereby evaluating the traumatogenic nature of events rather than their stressfulness. New psychometric instruments, like the Impact of Event Scale (IES) (Horowitz et al., 1979) and the Mississippi Scale for Combat-Related PTSD (Keane, Caddell, & Taylor, 1988), have been created in order to assess these specific consequences of trauma. These instruments differ considerably from those used by stress researchers.

The stress literature is mostly experimental, using exploratory designs and controlled conditions. The traumatic literature, in contrast, is mostly naturalistic, retrospective, and observational. The stress researcher feels

more comfortable with continuous measures (e.g., blood pressure, urinary epinephrine excretion) than with predefined syndromes or categorical outcome measures (e.g., measures of the development of a disorder) (van der Kolk et al., 1996).

Hobofol (1988) has suggested a view that bridges the gap between stress and traumatic stress--namely, that massive stressors lead to a qualitatively different type of stress reactions, in which the primary concern is to conserve resources (playing dead). A similar view is held by Krystal (1978), who within psychoanalytic theory, has suggested that psychic surrender and freezing of affect (and subsequent loss of affective modulation and alexithymia) are central features of a traumatic response to extreme adversity. Other descriptions of extreme responses to massive stressors are dissociation: (e.g., Marmar et al., 1994; Spiegel et al., 1988), and disorganization (McFarlane, 1984).

Williams and Sommer, Jr. (1994) define traumatic stress by the nature of the stressors that impact on the individual. An important consideration in the assessment and treatment of childhood sexual abuse and comorbid posttraumatic states is whether the stressor producing this syndrome is Type I or Type II (Meichenbaum, 1994; Terr, 1991).

Traumatic Events

Type I Versus Type II Traumatic Events

Briefly, Type I trauma is an unexpected, isolated traumatic event of limited duration (e.g., a single incident of rape, physical assault, sniper

shooting, vehicle accident) from which a quicker recovery is more likely (Williams & Sommer, Jr., 1994).

By contrast, a Type II trauma is more long-standing in nature and involves a series of expected, repeated traumatic events (such as ongoing childhood sexual or physical abuse) that lead to a negatively altered schematic view of self and the world. Type II traumas frequently develop into a more complex and chronic PTSD response associated with other psychiatric conditions, including higher rates of substance abuse, eating disorders, mood disorders, chronic relationship problems, and long-standing characterological disturbances evidenced by emotional lability, self-abusive behaviors, and suicidality (North, Smith, & Spitznagel, 1994).

Comorbidity of PTSD and Childhood Sexual Abuse

One of the long-term effects associated with childhood sexual abuse is posttraumatic stress disorder (PTSD) (Blake-White & Kline, 1985; Briere & Runtz, 1987; Briggs & Joyce, 1997; Donaldson & Gardner, 1985; Lindberg & Distad, 1985; van der Kolk et al., 1996). The essential features of PTSD are that the person must have experienced an event outside the range of normal human experience and have had symptoms lasting for longer than 1 month in each of the following categories: intrusive re-experiencing of the trauma; persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness; and persistent autonomic signs of anxiety (DSM-IV, American Psychiatric Association, 1994). The symptoms of PTSD are divided into three clusters: (a) reexperiencing of the traumatic event, (b) avoidance of

trauma-relevant stimuli and (c) numbing of general responsiveness, and persistent hyperarousal.

Van der kolk et al. (1996), Briere (1997), and Herman (1992) extend the DSM-IV's criteria of PTSD for survivors of trauma that is of an interpersonal nature (such as childhood sexual abuse), and is severe, prolonged and/or repeated. They use the terms *complex PTSD* and *posttraumatic states*, which include additional, and more clinically relevant symptoms such as: intrusion, avoidance, and hyperarousal, but also dissociation, somatization, affective changes (i.e., increased anxiety, depression, anger, and affective instability), identity and boundary disturbance, affect regulation problems, chronic involvement in dysfunctional relationships, and self-injurious or self-defeating behaviors. Perhaps one of the more significant components of complex PTSD is its inclusion of symptoms and difficulties often associated with Axis II disorders. While acknowledging that it is unclear if all the symptoms found to relate to victimization experiences necessarily represent a unitary set of posttraumatic outcomes, Briere (1997) states:

> Nevertheless, the central message implicit in complex PTSD is important: It is unlikely that chronic interpersonal violence or maltreatment effects reside exclusively in PTSD or ASD (Acute Stress Disorder, added) or even solely on Axis I. Instead, prolonged trauma appears to lead to a variety of symptoms in a number of different areas. (p. 35)

There are current research studies (e.g., Briggs & Joyce, 1997; Goodwin, 1990; Herman, 1992) which contend that sexual abuse during

childhood, especially within the family, may produce posttraumatic symptoms, both immediately and later in life. These researchers purport that symptoms of PTSD are relatively universal in adult survivors. Others (Mcleer, Deblinger, Atkins, Foa & Ralphe, 1988; Resnick, Kilpatrick, Danshy, Saunders, & Besi, 1993) conclude that only a minority of survivors of childhood sexual abuse exhibit PTSD symptoms.

Using a nonstandardized PTSD diagnostics and a sample of 97 incest survivors and 65 matched controls, Albach and Everaerd (1992) reported a 62% PTSD rate in the incest group and a 0% PTSD rate in the control group. In a small subsample of inpatient participants with a diagnosis of borderline personality disorder, Saunders (1991) used the SCID (structured clinical interview for DSM-III disorders) to demonstrate higher PTSD intensity in a group of childhood sexual abuse survivors (n=12) than in controls (n=10). Two controlled studies of child sexual abuse survivors reported higher PTSD rates in sexually abused children than in nonabused children (McLeer, Callaghan, Henry & Wallen, 1994; Sadeh, Hayden, McGuire, Sachs, & Clivita, 1994).

Briggs and Joyce (1997) conducted a study to ascertain which childhood abuse experiences are associated with PTSD symptomatology for women survivors of childhood sexual abuse. Seventy-three women survivors of childhood sexual abuse participated. They completed a series of self-report questionnaires including a measure of PTSD symptoms, and an interview about their childhood abuse experiences. They were reassessed after 3 and 6 months. The study concluded that one of the long-term effects of child sexual

abuse is PTSD, and the women who reported multiple abusive episodes which involved sexual intercourse had increased symptoms of PTSD.

Rodriguez, Ryan, Vande Kemp, and Foy (1997) compared symptoms of PTSD in a group of 45 adult females in an outpatient treatment facility, and a group of 31 women who reported no childhood sexual abuse. The comparison group consisted of women in outpatient treatment for problems in their committed relationships with male partners. This research also investigated the traumatic impact of dual abuse (both childhood sexual and physical abuse). Standardized assessment instruments were used to measure PTSD (SCID--PTSD module), childhood sexual abuse and childhood physical abuse. Results indicated that 86.7% of the childhood sexual abuse group met criteria for current PTSD in accordance with the DSM-III (1987), compared with 19.4% of the relationship distress group, providing support for childhood sexual abuse as an etiological agent for PTSD. In addition, 89% of the childhood sexual abuse survivors reported childhood physical abuse (p. 53).

The Effects of Childhood Sexual Abuse on Adult Functioning

Other deleterious effects besides PTSD have been linked to childhood sexual abuse. Many recent studies have investigated the persistent, negative impact of childhood sexual abuse on later adult psychosomatic functioning and adjustment. Clinical symptoms frequently observed with this population include chronic depression, anxiety and panic disorders, significant relationship disturbances, sexual difficulties, suicidality, and self-destructive behavior (Briere, 1989, 1992; Finkelhor, Hotaling, Lewis, & Smith, 1989;

Russell, 1986; van der Kolk et al., 1996). Feelings of guilt, self-blame, self-disgust, self-hatred, low self-esteem, powerlessness, mistrust of others, and a sense of hopelessness and despair are frequently cited as long-term effects of sexual abuse (Briere & Runtz, 1993; Browne & Finkelhor, 1986b; Herman, 1992; Jehu, 1991; Jumper, 1995; Liem, O'Toole & James, 1996).

The Briere and Runtz study (1988) is particularly significant because they examined a relatively normal versus a clinical population, about the long-term effects of sexual abuse. Approximately 15% of 278 university women reported having had sexual contact with a significantly older person before age 15. On a modified version of the Hopkins Symptom Checklist, these women reported higher levels of dissociation, somatization, anxiety, and depression than did nonabused women. Abuse-related symptomatology was positively associated with the age of the abuser, the total number of abusers, use of force during victimization, parental incest, completed intercourse, and extended duration of time. These findings were especially significant since, as noted by Briere and Runtz, "the university screening process may require a certain minimal level of general functioning" (p. 54). To the extent that university samples therefore include a disproportionate number of more healthy subjects relative to the general population, the current data may provide a conservative estimate of sexual abuse effects on nonclinical individuals. More broadly, the nonclinical data suggest the presence of numerous silent abuse victims, who, despite their psychological symptoms, have not sought mental health services.

A number of authors have attributed these long-term deleterious effects of childhood sexual abuse to fundamental pathogenic beliefs about self, world, and relationships that became part of the abused child's cognitive schemata when the trauma(s) occurred. Janoff-Bulman (1985/1989) believes that much of the post-trauma pathology of childhood sexual abuse survivors can be attributed to a shattering of the victim's most fundamental assumptions concerning the benevolence and meaningfulness of the world, personal invulnerability, and self-worth. In a similar vein, Finkelhor and Browne (1985) have emphasized the tremendous impact which sexual abuse has on a child's self-concept and world view, and refer to the resultant schematic disruptions as traumagenic dynamics which contribute to post-abuse pathology. McCann and Perlman (1990) noted that disruptions in schemas are often pathogenic in core areas of safety, trust, power, esteem, intimacy, independence, and frame of reference. Jehu (1988) identified self-denigratory beliefs of worthlessness, badness, inadequacy, inferiority, stigmatization, difference from others, and subordination of rights. Briere (1989, 1992) cited negative self-evaluation, guilt, helplessness, hopelessness, and profound distrust of others as cognitive effects contributing to post-abuse pathology. Smucker and Niederee (1995) identified pathogenic abuse-related schemas of powerlessness, mistrust, abandonment, worthlessness, self-blame, inherent badness, and unloveability as being particularly prevalent with traumatized childhood sexual abuse survivors.

As the effects of traumagenic beliefs and schema disturbance in childhood sexual abuse victims receive increasing attention in the literature, clinical treatments designed to address this aspect of post-abuse psychopathology are becoming more prevalent as well (Briere, 1996; Dolan, 1991; Fallon & Coffman, 1991; Resick & Schnicke, 1992; Shapiro, 1996; Smucker, Dancu, Foa, & Niederee, 1995; Staton, 1990).

Women in Double Jeopardy of Sexual Abuse

Although it is acknowledged that male survivors suffer many of the same devastating consequences of childhood sexual abuse as female survivors (American Psychiatric Association Board of Trustees, 1994; Briere, Runtz, & Wall, 1988), the studies of Gidyca, Coble, Latham, and Layman (1993), Sigmon et al. (1996), and Wyatt, Guthrie, and Notgrass, (1992) have found that females consistently demonstrated greater trauma-related distress than males on standardized measures

Sigmon et al. (1996) concluded that "Overall, females demonstrated significantly higher levels of anxiety, depression, and trauma-related symptoms than their male counterparts" (p. 72). These researchers acknowledged the possibility that the gender differences in symptomatology may be due to the fact that females were significantly more likely than males to have been sexually abused both as children and again as adults. Nearly half of the women in the study (20 out of 59) reported being sexually re-victimized as adults (since the age of 18).

This confirms other studies which have found that women abused as children are at increased risk for later sexual victimization (Fromuth, 1986; Gidyca, Coble, Latham, & Layman, 1993; Koss & Dinero, 1989; Wyatt, Guthrie, & Notgrass, 1992). The Wyatt et al. study for instance, found that among women with a history of sexual abuse, the majority (65%) reported having been assaulted in both childhood and adulthood (1992). This then indicates that women survivors may have gender-specific issues and be in double jeopardy of being sexually abused, first as children and again as adults.

Theories of Traumatic Memories

Theories of Traumatic Forgetting and Delayed Recall

The issue of memory is important to childhood sexual abuse, particularly when the memories have been forgotten and there is delayed recall. Therefore an understanding of the mechanisms of memory is necessary in a study on childhood sexual abuse. Freyd (1996) reminds us that memory is far from being a monolithic system, separate from other mental operations. It is, rather, a component of a multitude of systems that serve other mental functions. The human brain is multifaceted, capable of many kinds of learning—for example, perceptual learning, motor learning, emotional learning. And for each kind of learning there is necessarily memory. Thus, there may be as many different memory systems as there are different capabilities of the human mind. Fuster (1995) states:

> Memory is a functional property, among others, of each and all of the areas of the cerebral cortex, and thus, of all cortical systems. . . .Furthermore, as the cortex engages in representing and acting on the world, memory in one form or another is an integral part of its operations. (p. 1)

There seems to be an agreement among modern memory theorists that memories are stored as electrical patterns in neurons in the brain, and that over time these patterns are translated into new neural circuitry in different brain areas, creating a record of events (van der Kolk, 1993). However, it is argued that in the presence of an intensely traumatic event in which there is high physiological and emotional arousal, the trauma becomes encoded into memory in fragments. As a result of increased physiological arousal and an upsurge of adrenaline, the neurophysiological processes in memory functioning may become disrupted to the extent that cognitive memory may become severed from the emotions being experienced (Staton, 1990).

Research of van der Kolk (1994) indicates that in the case of severe and chronic childhood trauma, the neurobiology of memory functioning, especially in relation to the limbic system which filters and integrates emotion, sensation, experience and memory, may become permanently damaged, preventing the integration of cognitive memory and emotional arousal. As van der Kolk states the "brain is so overwhelmed so many times by negative stimulation and arousal that it cannot accommodate and integrate all the information. This helps explain the phenomena of

flashbacks and body memories in the absence of conscious recollections" (p. 199).

The emotional sensations may be remembered differently on a non-verbal level either as visual images in the case of flashbacks and nightmares, or as bodily sensations, as a result of disrupted integration and storage. In subsequent states of high arousal these sensations and images may be triggered with no conscious experience or memory behind them, but with, nonetheless, the same intensity of feelings of fear and terror as when it was first experienced (Riviere, 1996).

Sanderson (1995) supports the view that the greater fragmentation observed in survivors who experienced a very early onset of abuse is due to the lack of integration of cognition and emotion for the above reasons, but can also be seen as a function of the child's developmentally limited cognitive capacity, whose unsophisticated and simplistic schemas are as yet unable to make sense or extract a full range of meaning from the experience. van der Kolk (1994) suggests that, due to limited cognitive functioning, there is no conscious recollection as the child was unable to make sense of the experience, but contends that there are memory traces of the emotional trauma and arousal.

Van der Kolk et al. (1996) summarize the current research on memory and trauma:

> Our research shows that in contrast with the way people seem to process ordinary information, traumatic experiences are initially imprinted as sensations or feeling states, and are not collated and

> transcribed into personal narratives. Our interviews with traumatized people, as well as our brain imaging studies of them, seem to confirm that traumatic memories come back as emotional and sensory states with little capacity for verbal representation. This failure to process information on a symbolic level, which is essential for proper categorization and integration with other experience, is at the core of the pathology of PTSD. (p. 296)

Summary of Theories of the Characteristics of Traumatic Memories

The research of trauma memory experts Staton, van der Kolk and van der hart (adapted from Smucker, 1997, pp. 2-9), Rossi (1993), and Smucker et al., (1996) is briefly summarized below:

1. The earliest memories of human experience are encoded in the sensorimotor system (ages 0-2). (Staton, 1990). They lack verbal narrative and context (van der Kolk & van der Hart, 1991b).

2. They are encoded in the form of vivid sensations and images (regardless of the victim's age), and cannot be accessed by linguistic means alone. van der Kolk and van der Hart (1991b) believe that in states of high sympathetic arousal, the linguistic encoding of memory is inactivated, and the central nervous system reverts to the sensory and iconic (visual) forms of memory that predominate in early life.

3. After age 2, memories are encoded primarily in images. Clinical researchers, Smucker, Dancu, Foa, and Niederee (1996) contend that unless therapy works with and transforms these images, they may be retained no matter how much "talk" occurs.

4. A child's linguistic system develops much later and is not fully developed until adolescence. Childhood abuse is encoded in a child's memory

primarily through the sensorimotor and visual modes of representations, rather than in auditory-linguistic terms, and therefore childhood abuse information is likely not available through linguistic-verbal means (van der Kolk & van der Hart, 1991b).

5. Traumatic memories are "state dependent," which means that memories are re-activated (amnesia reversal) when a person is exposed to a situation, or is in a somatic state (e.g., drug-induced) reminiscent of the one when the original memory was stored. Therefore, unless similar emotion or situation is experienced, the entire memory cannot be retrieved and the beliefs associated with the memory will be difficult to modify (van der Kolk & van der hart, 1991b; Smucker et al., 1996; Rossi, 1993).

6. Traumatic memories are difficult to assimilate or accommodate, which causes the traumatic memory to be stored differently and not be available for retrieval under ordinary conditions. Thus, the traumatic memory becomes dissociated from conscious awareness and voluntary control. Fragments of these unintegrated experiences may later manifest themselves through recollections or behavioral re-enactments. (van der Kolk & van der Hart, 1991b).

7. Traumatic memories remain fixed in the mind in their original form, and are not altered by the passage of time or by the intervention of subsequent experience. Thus traumatic flashbacks or nightmares may be re-experienced over and over without modification or change (van der kolk & Hart, 1991b).

van der Kolk et al., (1996) conclude that "Although trauma may leave an indelible imprint, once people start talking about these sensations and try to make meaning out of them, they are transcribed into ordinary memories--and, like all ordinary memories, they are then prone to distortion" (p. 296).

Dissociation and Childhood Sexual Abuse

Over the past decade there has been a plethora of research on dissociative symptoms in psychological disorders. High rates of dissociative symptoms have been found in a sample of subjects with PTSD (Branscomb, 1991; Brenner, Southwick, Brett, Fontana, Rosenheck, & Charney, 1992; Carlson & Rosser-Hogan, 1991; Kulka, Schlenger & Fairbank, 1988). The research studies of Holen (1993), Marmar et al. (1994), and Spiegel, (1990) have shown that having dissociative experiences at the moment of the trauma is the most important long-term predictor for the ultimate development of PTSD.

Studies by Bliss and Jeppsen (1985), Grave (1989), Ross (1991), and Ross, Anderson, Fleisher, and Norton (1991), have found high prevalence rates for dissociative identity disorders (DID) that range from 2.4 to 11.3 percent of inpatient psychiatric samples. And the research of Chu and Dill (1990), Coons, Bowman, Pellow and Schneider (1989), Coons, Cole, Pellow, and Milstein (1990), Goodwin, Cheeves, and Connell (1990), Herman, Perry, and van der Kolk (1989) revealed similar high prevalence rates for DID in subjects with histories of childhood abuse.

van der Kolk et al. (1996) note that the current utilization of dissociation refers to three distinct but related mental phenomena:

1. *Primary dissociation* is the inability to integrate the totality of what is happening into consciousness, which is a phenomenon commonly found in people confronted with overwhelming threat.

> Sensory and emotional elements of the event may not be integrated into personal memory and identity, and remain isolated from ordinary consciousness; the experience is split into its isolated somatosensory elements, without integration into personal narrative (van der Kolk & Fisler, 1995). This fragmentation is accompanied by ego states that are distinct from the normal state of consciousness. This condition is characteristic of PTSD, in which the most dramatic symptoms are expressions of dissociated traumatic memories--intensely upsetting intrusive recollections, nightmares, and flashbacks. (p. 307)

2. *Secondary dissociation* occurs once an individual is already in a dissociated state of mind, and further disintegration of the personal experience occurs.

> They report mentally leaving their bodies at the moment of trauma and observing what happens from a distance. Whereas primary dissociation limits people's cognitions regarding the reality of their traumatic experience, and enables them to go on temporarily as if nothing happened, secondary dissociation puts people out of touch with the feelings and emotions related to the trauma; it anesthetizes them. (p. 308)

3. *Tertiary dissociation* is the development of distinct ego states that contain the traumatic experience.

> Examples are the multiple dissociated identity (alter ego) fragments in dissociative identity disorder (DID), some of which experience different aspects of one or more traumatic incidents, while others stay unaware of these unbearable experiences. To the extent that their dissociative amnesia allows them to, these patients typically report chronic and

> intense sexual, physical, and psychological abuse that started at a very early age. (p. 308)

Validation of Memories Versus Validation of the Survivor

Many clients enter therapy without being aware that they have had a sexually abusive experience in childhood. According to reports in the clinical literature (e.g., Bass & Davis, 1988; Bell-Gadsby & Siegenberg, 1996; Calof, 1993; Courtois, 1992; Ederlyi, 1990; Fredrickson, 1992; Freyd, 1996; Terr, 1991; Williams, 1994) it is not uncommon for women who enter therapy because of depression, anxiety, self-destructive behavior and sexual problems, to have no recollection of early sexual abuse. Briere and Runtz (1988) found that only 39% of former abuse victims recognized their abuse experience prior to specific and direct questioning about their sexual history. Not only are these women unaware of their experiences but often the therapist does not recognize that there is a link between the presenting symptoms and childhood sexual abuse.

Many survivors are unable to remember their sexual abuse because of dissociation or denial. Several recent studies affirm this. For instance, a study by Briere and Conte (1993) investigated the incidences of repression of sexual abuse incidents in 450 adult clinical subjects with a history of childhood sexual abuse and found that 267 of them identified some period in their lives, before 18 yrs. of age, when they had no memory of their abuse. The results confirmed that variables most predictive of abuse-related amnesia (ARA) were greater current psychological symptoms, molestation at

an early age, extended abuse, and variables reflecting especially violent abuse (e.g., victimization by multiple perpetrators, having been physically injured as a result of the abuse, victim fears of death if she or he disclosed the abuse to others). In another study, Williams (1994) interviewed 129 women with previously documented histories of sexual victimization in childhood, about the details of their abuse histories, and their belief in whether people actually forget childhood sexual abuse. A large portion of the women (38%) did not recall the abuse that had been reported 17 years earlier. Women who were younger at the time of the abuse and those who were molested by someone they knew were more likely to have no recall of the abuse. The researcher concluded that long periods with no memory of abuse should *not* be regarded as evidence that the abuse did not occur. DiTomasso and Routh (1993) examined recalled abuse in relation to dissociation in a sample of 312 undergraduates (nonclinical sample), using several measures of sexual and physical abuse, and the dissociative experiences scale (Bernstein & Putnam, 1986) to measure dissociation. Significant correlations were found between the abuse variables and the dissociation variables for all measures except the hypnotizability scale. They concluded that there is a relationship between dissociative aspects of psychological functioning and recalled physical and sexual abuse. Because of this high level of dissociation and denial, among survivors of childhood abuse, uncovering the abuse can be extremely complex and difficult.

Nonetheless, some researchers in the clinical literature such as Alpert (1995), Freyd (1996), Hunter (1995), Rieviere (1996), and Sanderson (1995), believe that acknowledgment of the abuse experience is essential for the recovery of the client-survivor. Sanderson states:

> It is crucial that the counsellor validate and affirm the survivor by believing her. This means not only believing her abuse experiences, memories and pain, but also believing in her as a person who has the capacity to heal. (p. 128)

She warns that without information about sexual abuse having occurred in childhood, the therapist may focus treatment solely on the presenting symptom (e.g., depression) rather than the unresolved trauma. These trauma experts agree that to uncover abuse, it is essential that clinicians have some knowledge of the nature, impact, incidence, and long-term effects of childhood sexual abuse. Additionally, they say that clinicians must be knowledgeable about the mechanisms of traumatic memory and the defense mechanisms of repression, denial, and dissociation. They must also be aware of the possible links between presenting symptoms and sexual abuse, along with an awareness of clinically predictive indicators, in order to approach treatment knowledgeably and effectively (Alpert, 1995; Briere, 1997; Freyd, 1996; Hunter, 1995; Reviere, 1996; Sanderson, 1995).

The Importance of Therapist Validation of the Abuse

Despite the logical and intuitive sense of the importance of validating a survivor's childhood sexual abuse experiences, it is impossible for a therapist to absolutely validate the truth of memories she or he did not

witness. However, there is often strong, circumstantial evidence that the abuse occurred, which the therapist can help the survivor acknowledge. Such evidence for example, might include pointing out a pattern of abuse that has occurred when other family members have also been abused. The knowledgeable therapist can validate the survivor's feelings, and symptoms, and relate what is known about childhood sexual abuse, its effect upon adult functioning, and the latest research on traumatic memory, and how it works. Pye (1995) clarifies the therapist's role in the validation of memories, when she states:

> In therapies where there is tremendous pressure about "delayed memories," the issue is usually that the patient is trapped in a persecutory paradigm. The patient feels persecuted by his or her memories and hopes or expects that the therapist can protect the patient omnipotently by being able to decipher what did or did not occur at times when the therapist was not present. If instead, the therapist helps the patient to enter an agenic (action [word added]) paradigm, it gradually becomes possible for the patient to reflect on memories, to allow them to be ambiguous, to cohere, and to differentiate. The pressure to make memory into something definitive and univocal subsides. (p. 182)

A recent study by Coffey, Leitenberg, Henning, Tonia, Turner, and Bennett (1997) attests to the importance of validation of the survivor's experiences, in regard to her or his mental health and self-esteem. And a study by McNulty and Wardle (1994) found that validation is particularly necessary after the survivor has disclosed the abuse..

Research on Validation and Support After Disclosure of Abuse

Jehu (1988) has suggested that disclosure by the survivor has a direct bearing on later psychological well-being. In particular, adverse reactions to

disclosure (e.g., blaming or ignoring the victim, disbelief, and punishment) are likely to be detrimental to psychological functioning (Browne & Finkelhor, 1986a; Waller, 1994). A perceived adverse response to attempted disclosure might serve to reinforce perceptions of self-blame for the specific event. In addition, such a response could lead to more general self-denigratory beliefs becoming established, including feelings of general worthlessness, inferiority, and stigmatization (Jehu, 1988, pp. 77-81). Research by Elliot (1991) affirmed this. She surveyed 2,963 high-functioning professional women to obtain information regarding the history and characteristics of childhood sexual abuse, and aspects of the childhood family environment. An analysis of the results indicated that 29% had experienced sexual molestation prior to the age of 16 (ranging from fondling to intercourse), and a history of sexual abuse was predictive of most aspects of adult adjustment measured (e.g., PTSD, sexual problems, impairment in the capacity for object relatedness). She concluded that among other things, negative responses from others upon disclosure of the abuse may result in a form of revicitimzation, increasing the impairment in adult adjustment. Kaldveer (1992) studied somatic symptomatology in 50 female survivors of childhood sexual assault, and 37 controls (no childhood sexual abuse history). The findings indicated a higher incidence of somatic symptomalogy in the survivors, and more chronic symptoms than briefly experienced symptoms. Post hoc Mann-Whitney U analysis revealed that the survivors who disclosed their abuse before 18 with positive reactions, had fewer symptoms than

women disclosing after 18 with negative reactions. Numerous other studies have shown that the degree of support a person receives from parents and others following the disclosure of sexual abuse can moderate the negative long-term effects (e.g., Bagley & Ramsey, 1986; Testa, Miller, Downs, & Panek, 1992; Wyatt & Mickey, 1987), and perhaps even mediate them (Roesler & Wind, 1994). Although these studies affirm the importance of validation and social support of the survivor's childhood sexual abuse experiences (particularly from the abuser and/or parental figures), the tragedy is that this is not usually forthcoming.

Support from the Therapist after Disclosure

Inadequate and possibly harmful responses to the disclosure of abuse have also been noted among professional groups working with survivors. Frenken and Van Stolk (1990) reviewed the experiences of 50 adult women who were victimized as children and those of 150 professionals involved in cases of disclosure. They observed that while many of their subjects received adequate professional support, over half (39) of the women went on to consult another professional following their first consultation. On initial consultation 61% of the professionals "did not delve further into what was being told them" (p. 259). A figure that dropped to 38% over four subsequent (new) professional involvements. Dissatisfaction with professional support was reflected in the subjects ratings of their experiences, with 38% describing themselves as very dissatisfied with their first professional contact. In common with the findings of these studies, many of the survivors

encountered disbelief, ridicule, and blame. Alarmingly, five subjects encountered direct sexual advances from their professional confidants.

Sanderson (1995) summarizes the role of the therapist in validation of the survivor. She notes that

> The role of the therapist is always crucial to the therapeutic dyad, but in the case of survivors of child sexual abuse the therapist needs to be even more sensitive to the client's needs and areas of conflict by validating her voice, a voice which may never previously have been heard. (p. 235)

Remediation of Symptoms: Recovery

Coping Strategies

Coping has to do with how people recover from trauma. Lazarus and Folkman (1984) defined coping as a process, and state that there are "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 41). van der Kolk et al. (1996) suggest that successful coping, rather than any particular coping strategy, may ultimately moderate the effects of stress, and the remediation of stress-related symptoms (including those associated with childhood sexual abuse). Effective coping results in relief of personal distress, maintenance of a sense of personal worth, conservation of one's ability to form rewarding social contacts, and sustained capability to meet the requirements of the task (Pearlin & Schooler, 1978).

Categories of Coping: Problem-Focused and Emotion-Focused

Lazarus (1966) and Solomon, Mikulincer and Avitzur (1988) divided coping into two general categories: (a) problem-focused coping (channeling resources to solve the stress-creating problem), and (b) emotion-focused coping (easing the tension aroused by the threat through intrapsychic activity, such as denying or changing one's attitude toward the threatening circumstances). Of these two coping styles, problem-focused coping would on the surface, appear to be superior. And indeed, it is associated with lower rates of PTSD in combat soldiers (Solomon, Mikulincer, & Arad, 1991).

However, different styles of coping can be useful under different conditions. Although being assertive often helps people escape from danger, it may be dangerous when a child is being physically or sexually abused. There are some situations in which people are simply caught in inescapable trauma. In the context of child abuse, rape, or torture, active resistance is likely to provoke retaliation from the perpetrator. In such cases, passive coping is not maladaptive; sometimes spacing out (dissociating) and disengaging can help people survive. Unfortunately, the negative consequences of using these coping mechanisms is that they tend to become ingrained, and used in other situations where there is no danger (e.g., during consensual sex with a lover); they then become maladaptive.

Meaning as a Coping Mechanism

Meaning can be both a maladaptive and adaptive coping mechanism. The meaning that sexually abused individuals make out of the present

depends on their prior experience and on the many subtle and indirect ways that their personal past has been incorporated into their current attitudes and beliefs. This can lead to a range of maladaptive responses in their current lives, with some neurotically responding as if they were reliving the past (stuck in the past). But meaning that stems from adversity can also be very positive, as Viktor Frankl (1984, 1988), noted psychotherapist and Holocaust survivor, attests. He contends that an existential technique which utilizes the discovery of a meaning in life motivates people to be strong enough to survive. Frankl believes the uniqueness of each person's meaning is as individual as each person. Even a tragic or unavoidable circumstance can be turned into a personal learning experience and can produce human achievement by discovering the meaning of the lesson.

Dissociation as a Coping Strategy

Dissociation is likely one of the primary ways in which a child avoids abuse-related stress (particularly the stress of childhood sexual abuse--Horowitz, 1986). Beyond its impacts on attachment (Bowlby, 1988), dissociation during early abuse is thought to reduce opportunities for learning how to tolerate painful affect without avoidance. It is likely to preclude the need to develop other more complex and conscious affect regulation skills. It has been suggested that this forced reliance on dissociation during childhood motivates the continued need for dissociation and other primitive avoidance strategies later in life (Briere, 1997).

Social Support as a Coping Mechanism

Social support can be defined in terms of family, friends, or a social system in general (e.g., one's circle of friends). It is the real or perceived ability to receive encouragement and help when needed. Trauma therapists believe that support from therapists is an important element in the survivor's ability to cope with the consequences of his or her trauma.

> It is likely that without external guidance and support from caregivers, the result of early trauma will be pathological intensification or mental disorder. Thus the impact of trauma can be measured only by assessing both event and context (i.e., the presence or absence of nurturing and support from the caregivers). (Hunter, 1995, p. 2)

A study by Schreurs and de Ridder (1997) showed positive correlations between social-support variables and successful coping strategies. They have shown that social support generally contributes to more adaptive coping strategies such as problem-focused ones. Although there is mounting evidence in the coping literature that the function of social support as a coping resource may be a very important one, it is frequently not available to the survivor of childhood sexual abuse, particularly from family members. Several studies cited previously (e.g., Jehu, 1988; Roesler et al., 1994) have revealed that the majority of survivors who disclosed the abuse to their parents prior to age 18 were likely to be met with disbelief or blame, rather than with support, validation, and protection.

Avoidance and Acceptance: Alternative Coping Strategies

Sigmon, Stanton, and Snyder (1995) discussed two alternative coping strategies of avoidance and acceptance. Although many researchers generally

view avoidance as a relatively ineffective coping strategy (e.g., Carver, Scheier & Weintraub, 1989), using avoidant strategies may be more adaptive, at least temporarily, in relatively uncontrollable situations, such as subjection to chronic sexual abuse as a child. But in the long run coping by approaching the problems is more adaptive (Schreurs & de Ridder, 1997).

In this study, past use of coping strategies in response to the childhood sexual abuse, and present use in response to their current, distressful symptoms (assumed to be consequences, at least in part, of the earlier abuse), were examined in adult survivors of childhood sexual abuse.

Theories of Child Sexual Abuse Applicable to This Study

Childhood sexual abuse is a multidimensional problem with many complex and intricate variables, which, like tentacles, reach out to grab others to them. For instance, it is difficult to separate childhood sexual abuse problems from symptoms of posttraumatic stress. The multifaceted and interwoven structure of this phenomena necessitate equally multifaceted theories of explanation. Therefore this study describes three theories which address the various components that are believed to be involved in childhood sexual abuse: information processing models of PTSD; attachment theory; and an ecological-interactional theory of traumatic abuse.

Information Processing Models

There is research and clinical literature which indicate that PTSD is very much part of the clinical profile presented by adults who have been sexually abused in childhood (e.g., Blake-White & Kline, 1985; Briere, 1997;

Briere & Runtz, 1987; Briggs & Joyce, 1997; Donaldson & Gardner, 1985; Lindberg & Distad, 1985; Terr, 1991; van der Kolk et al., 1996). As the conceptualization of PTSD has developed in recent years, information-processing models which emphasize the role of emotional networks (Shapiro, 1996) have gained considerable support as explanations of PTSD symptomatology. There is currently widespread agreement among information processing theorists that posttraumatic stress symptomatology develops as a result of inadequate emotional processing of the traumatic event(s), and that PTSD symptoms abate once adequate or successful emotional processing has occurred (e.g., Horowitz, 1986; Rothbaum & Foa, 1992; Resick & Schnicke, 1993; Smucker, Dancu, Foa, & Niederee, 1995). Consensus has not yet been reached, however, on what constitutes "adequate emotional processing of traumatic material," or what specific interventions can best facilitate such processing in adult survivors of childhood sexual abuse.

In his theory of emotional processing of fear, Rachman (1980) proposed that successful emotional processing could "be gauged from the person's ability to talk about, see, listen to or be reminded of the emotional events without experiencing distress or disruptions" (pp. 51-52). Horowitz (1986) contended that the processing of traumatic material is complete once the cognitive schemata have been altered to successfully incorporate and integrate the new information. Until such processing occurs, a completion tendency causes unintegrated material (e.g., flashbacks and nightmares) to

emerge repetitively. Successful processing of traumatic material is thus frequently delayed or prevented by means of denial or numbing which, according to Horowitz (1986), are defense maneuvers designed to protect the victim from information overload.

Lang (1979, 1986) developed a theory of emotional processing in which traumatic, fear-inducing memories are thought to be encoded in a neural network consisting of stimuli, responses, and the subjective meaning assigned to the stimulus and response data. Lang contended that vivid response imagery and affective involvement must be present both in accessing and altering a fear memory.

Foa and Kozak (1986) who expanded Lang's theory by placing greater emphasis on the cognitive meaning of the trauma, define emotional processing as the modification of memory structures that underlie emotions. From their work with adult rape victims, they concluded that recovery from PTSD requires activation of the entire fear network--along with the associated painful affect--and incorporation of corrective information that is incompatible with traumatic elements of the fear structure. The authors advocate the use of prolonged imaginal exposure both to activate the fear stimuli, and to change the meaning of the fear memory by facilitating physiological habituation, a process which is incompatible with the belief that anxiety decreases only through escape and avoidance.

Although prolonged imaginal exposure has yielded positive results in alleviating PTSD symptomatology with adult rape victims (Rothbaum & Foa, 1992), Resick and Schnicke (1993) argue that exposure alone "does not provide direct corrective information regarding misattributions or other maladaptive beliefs" (p. 17). The approach Resick and Schnicke recommend for treating rape victims is *cognitive processing therapy*, which employs verbal cognitive techniques to directly challenge and modify trauma-related attributions and beliefs when the traumatic memory is activated. However, while cognitive processing therapy has shown some positive results with adult female rape victims who have the capacity to linguistically process their abuse, adult survivors of childhood sexual abuse who have not experienced or processed their traumas linguistically are not likely to possess such verbal facility and recall. There is evidence that those who do not have the capacity to linguistically process their traumas may instead benefit from imaginal methods, such as "imagery rescripting" (Smucker & Niederee, 1994), and hypnotherapy (Bell-Gadsby & Siegenberg, 1996; Dolan, 1991; Rossi, 1993). In a similar vein, Smucker et al. (1995) note that "the meanings which victims ascribe to their childhood sexual traumas greatly exceed the relationship between perceived danger and physiological reactivity" (p. 7). The authors suggest expanding the definition of "meaning elements" to account for the meanings experienced by adult survivors of childhood sexual abuse with PTSD.

It is important to note that rape is considered to be a Type I trauma from which quick recovery is more likely, whereas incest and childhood sexual abuse generally fall under the category of a Type II trauma (more long-standing in nature) from which recovery is much poorer (Meichenbaum, 1994; Terr, 1991).

According to theories of emotional processing (Foa & Kozak, 1986; Lang, 1979), state-dependent recall (Bower, 1981) and schema theory (Young, 1994), abuse-related beliefs and schemas can most readily be accessed, challenged, and modified when the individual is in an affective state similar to when the abuse was experienced; that is, when the greatest number of elements of the traumatic experience are accessed (Smucker et al., 1995).

Betrayal Trauma Theory and Childhood Sexual Abuse

Betrayal trauma theory is a relatively new theory developed by Jennifer Freyd (1996), and based on Bowlby's attachment theory (1988). It posits that the victim of childhood sexual abuse unconsciously creates information blockages of the abuse to be able to survive within an essential relationship--that of parent and dependent child, for instance.

Betrayal is the violation of implicit or explicit trust. The closer and more necessary the relationship, the greater the degree of betrayal. The theory contends that extensive betrayal is traumatic, and that much of what is traumatic to human beings involves some degree of betrayal (Bowlby, 1988).

The theory posits that under certain conditions, betrayals necessitate a "betrayal blindness" in which the betrayed person does not have conscious awareness, or memory, of the betrayal. Betrayal trauma is a theory of psychological response to trauma. It builds from the belief that the degree to which a trauma involving betrayal by another person, significantly influences the traumatized individual's cognitive encoding of the experience of trauma, the accessibility of the event to awareness, and the psychological as well as behavioral responses. These beliefs are verified by several past and recent studies. For example, Williams (1994) studied repression in 129 women with previously documented histories of childhood sexual abuse and incest, and found that a large percentage of the women (38%) did not recall the abuse that they had reported 17 years earlier. The researcher concluded that women who were younger at the time of the abuse, and those who were abused by someone they knew, were more likely to have no recall of the abuse. Briere and Conte (1993) studied 450 adult, clinical subjects who reported childhood sexual abuse, and 267 identified some period in their lives, before 18 years of age, when they had no memory of their abuse. Martinez-Taboas (1996) reported the cases of 2 female patients (ages 28 and 36 years respectively) with the diagnosis of dissociative identity disorder, whose experiences of childhood sexual abuse, of which they had no conscious memory, were independently verified.

As a rule, when people are able to freely choose social relationships, they would normally want to establish trustworthy ones and avoid those who

had previously betrayed them. Cosmides (1989) suggests that humans have an internal *cheater detector* that provides them with information necessary to establish trustworthy social alliances. In certain kinds of abusive betrayals of children (like incest), however, escape is not usually a viable option. Freyd (1996) suggests that the ability to detect betrayal may need to be stifled for the greater goal of survival. A child who distrusts his or her parents risks alienating the parents further, and thus becomes subject to more abuse and less love or care. This is exemplified in a study by Everson, Hunter, Runyon, Edelshon, and Coulter (1990). They found that the lack of maternal support to children following the disclosure of incest was associated with increased foster placement and increased psychological scores in clinical assessments (e.g., higher psychopathology). In a review of the research studies on the aftermath of disclosure of childhood sexual abuse and incest, McNulty and Wardle (1994) concluded that disclosure of sexual abuse may be a primary cause of psychological distress, resulting in the dissolution of social support systems and increasing the individual's vulnerability to psychiatric disorders. In situations like these, it may be more advantageous to be blind to the betrayal (Freyd, 1996).

There are situations in which it is actually dangerous to respond in any usual way to betrayal (e.g., consciously acknowledging it; mistrusting, avoiding, the betrayer; disclosing the abuse). These situations occur when the person doing the betraying is someone the victim cannot afford not to trust. If

the betrayed person followed the usual response pattern and did not trust the betrayer, he or she would only make the situation worse, or so it would seem. A sad consequence of betrayal trauma is that sometimes (perhaps often) the victim could afford to know about the betrayal but does not know that such awareness is safe (Freyd, 1996).

Betrayal trauma theory does not directly address the issue of veracity of recovered memories of abuse or trauma. Instead, it indirectly addresses this by questioning what we would logically expect to happen to that information, when a child is abused and betrayed? From a logical analysis of developmental pressures and cognitive architecture, one can expect cognitive information blockage under certain conditions (like sexual abuse by a parent), which will create various types of betrayal blindness and "traumatic amnesia" (Freyd, 1996). As one client-survivor commented to the researcher of this study after recalling her childhood sexual abuse experiences: "It's so hard to know that he (father-added) did those awful things to me. I think sometimes I really didn't want to know" (Bonnie D.).

The Ecological-Interactional Theory of Trauma

The ecological theory of trauma is a relatively new theory proposed by Mary Harvey (1996). It is similar to the earlier work of Wilson (1989), who proposed a person-environmental interactional paradigm of traumatic stress reactions. These two models together offer a holistic, and more integrated theory of trauma, which will be combined and described simultaneously.

A person-environmental interactional paradigm "assumes that there is a dynamic interaction between the characteristics of the person and the dimensions of the environmental situation in which a traumatic event occurs"(Williams & Sommer, Jr., 1994, p. 5). Summarized, this theory purports that the nature of the interaction between the person and the environment by which a traumatic event occurs sets up a complex process that includes individual and/or collective responses that determine forms of stress response syndromes and posttraumatic adaptation (Wilson, 1994).

Ecology is defined as the science concerned with the interrelationship of organisms and their environments (Webster's Ninth New Collegiate Dictionary, 1985). The ecological view of psychological trauma (Harvey, 1996) assumes that individually varied posttraumatic response and recovery patterns are multidetermined by complexly interacting response and recovery patterns of person, event, and environmental factors. Williams and Sommer, Jr. (1994) explain these factors:

> The person inputs to the model include all dimensions of personality processes, such as traits, needs, cognitive style, values, and genetic propensities to stressful experiences. The environmental inputs to the processing of trauma include four major categories: (1) the dimensions of the trauma, (2) the experience of the trauma, (3) the structure of the trauma, and (4) the post-traumatic milieu. The features of the person and the environmental dimensions of the trauma codetermine the individual's subjective responses to the stressors, of which there are five categories: (1) emotional reactivity, (2) cognitive processes, (3) motivation, (4) neurophysiology, and (5) coping patterns. These five dimensions occur simultaneously within a person at different levels of awareness and ultimately determine the post-traumatic pattern of adaptation, which ranges from severe psychopathology and diminution

> of humanness to self-actualizing transcendence, positive character change, and altruism toward others. (p. 18)

A Multidimensional Definition of Recovery

Recovery from psychological trauma is understood as a multidimensional phenomenon by the ecological model (Harvey, 1996), with the following outcome criteria:

> *Authority over the remembering process.* Trauma survivors are often plagued both by the absence of salient information about their experience and by traumatic intrusions which disable and terrify even as they elude meaningful appraisal (van der Hart, Steele, Boon, & Brown, 1993). A primary sign of recovery from psychological trauma (and therefore a primary aim of trauma treatment) is that of new or renewed authority over the remembering process. (p. 11)

> *Integration of memory and affect.* In the wake of one or of a prolonged series of traumatic experiences, some individuals will have clear and continuous memories of these experiences, yet feel little, or nothing as they recall them. Others will feel waves of terror, anxiety or rage in response to specific stimuli, yet be unable to draw meaningful associations to past or present precipitants to these affects (Harvey & Herman, 1994). In both cases, memory and affect are separate and psychological impairment is a result of the separation. In recovery, memory and affect are joined. (p. 12)

> *Affect tolerance.* Recovery implies that the affects associated with traumatic events no longer overwhelm or threaten to overwhelm. . . . . Feelings can be felt and named and endured without overwhelming arousal, without defensive numbing and without dissociation. In recovery. . . affects are differentiated from one another and are experienced in varying degrees of intensity, reflecting a more measured response to traumatic recall and a greater capacity to manage contemporary stressors. (p. 12)

> *Symptom mastery.* In recovery, particularly persistent symptoms have abated or become more manageable . . . .The recovered trauma survivor may continue to experience symptomatic arousal, but she-he has mastered and practices healthful coping routines to reduce arousal and manage stress. (p. 12)

> *Self-esteem and self-cohesion.* Early, prolonged and repeated victimization is associated with severe identity disturbances and with a discontinuous and fragmented self-experience (Herman, 1992). . . . .Recovery from psychological trauma thus entails repair and mastery in the domain of self-esteem and self-cohesion. (pp. 12-13)
>
> *Safe attachment.* Traumatic events involving interpersonal violence and the betrayal of trust can sorely compromise the individual's ability to pursue, negotiate and sustain safe and supportive relationships (van der Kolk, 1987). Recovery from psychological trauma thus entails the development or the repair and restoration of a survivor's relational capacities. . . . It almost always involves a self-directed expansion of the trauma survivor's social support network. (p. 13)
>
> *Meaning-making.* Making meaning out of trauma is a deeply personal and highly idiosyncratic process, particularly when the trauma has entailed interpersonal violence and direct encounter with the human capacity to commit atrocity. . . .Whatever the process, the recovered survivor will have named and mourned the traumatic past and imbued it somehow with meaning that is both life-affirming and self-affirming. (p. 13)

Conclusions

While the combined interactional (Wilson, 1994), ecological (Harvey, 1996), theories make up a paradigm which is the most inclusive of all the theories investigated in this study, none of the theories presented are mutually exclusive. And although the models enhance our understanding of trauma, and the specific trauma of childhood sexual abuse, they are nonetheless essentially descriptive frameworks that incorporate a range of dissonant theories and observed clinical data. As such, in their present forms, they cannot be viewed as true theories until they are tested empirically, in particular in their application to treatment and intervention. Knowledge about child sexual abuse, its effect on the child, and the long-term effects on

adults, is still limited, especially in formulations of effective treatment and intervention models. It is the hope of this study that more of these unknowns can be learned from the real experts on childhood sexual abuse: the adult, female survivors.

CHAPTER 3: METHODOLOGY

Rationale for the Use of Qualitative Paradigm

In the last 2 decades, psychology has clearly witnessed a move away from the dominance of the laboratory experiment, to a more naturalistic psychology where more real-world studies are conducted (Smith, 1996). This move operates at a number of levels. First, psychology has become more open to research on a range of previously neglected areas which are central to the psychology of everyday life, illustrated, for example, by the explosion of work on the Self (e.g., Honess & Yardley, 1987; Markus & Wurf, 1987; Shotter & Gergen, 1989). Secondly, there is a great openness to different types of data collection, for example field experiments, and self-reports. Thirdly, more studies are attempting to include more appropriate participant groups, moving beyond the student population which has overwhelmingly provided the subjects for experimental psychology (Smith, Harre, & Van Langenhove, 1996).

Combining Case Studies with Quantitative Measures

This study is a scholarly inquiry into the relevance of validation through corroborative evidence, in the remediation of symptoms in women who display varying degrees of posttraumatic states (Briere, 1997), and a history of childhood sexual abuse. It utilized multiple case studies, with "thick descriptive" (Geetz, 1973) narratives by the survivors themselves, and was "grounded in the data" (Marshall & Rossman, 1995) that was presented. Patton (1990) suggests that case study assists in "investigating a

phenomenon in order to get at the nature of reality with regard to that phenomenon. The basic (researcher's) purpose is to understand and explain" (p. 152). The researcher used progressive focusing in the clinical setting, and observed the workings of the cases to record objectively, while simultaneously examining the meanings and redirects of observation, to refine or substantiate the meanings. The opportunity to learn from the participants themselves, was of primary importance in this exploratory, phenomenological study.

Secondary to the self-reports of the participants are the methods of data analyses. It is necessary to have a succinct way of analyzing the participants' words and meanings, and reporting how these relate to the research questions, so their importance is not lost. This was addressed by combining the case studies in a quantitative way (using cluster analysis and frequency counts), in a mixed, dominant-less dominant design: primarily a qualitative design with quantitative methods employed for data analysis and triangulation purposes. In addition, three objective tests were given to measure the current frequency and intensity of dissociation; impact of the childhood sexual abuse(s); and self-esteem variables. This combining of methods was done for all the reasons that Creswell (1994) and others (e.g., Greene, Caracelli, & Graham, 1989; Swanson, 1992) have suggested: (a) for purposes of triangulation (a method used in qualitative research to help build validity); (b) to compliment the dominant paradigm, using overlapping, so

that different facets of a phenomenon may emerge (e.g., like chipping through the different layers of a rock and getting to its core); (c) to aid in the developmental process where the first method is used to sequentially inform the second method (e.g., the case studies-first method, formed the percentages-second method, which together told the larger 'story'); (d) for the purpose of noting contradictions and forming fresh perspectives (e.g., some of the quantified data [objective tests-MANOVA] contradicted other data [case studies]); and (e) to add scope and breadth to the study (the quantification of the test scores indicated that a larger sample may be necessary for the findings to be significant. Likewise, the findings of the case study indicated that objective tests may be insufficient for this particular research subject or sample).

Purpose of the Study

The purpose of this study is to complete the evolutionary movement in psychological research, and contribute to the scholarly knowledge base, by using more qualitative, person-centered, methods to probe into the sensitive areas of childhood sexual abuse. This probe was done by allowing those most familiar with the issues of childhood sexual abuse to participate in the research: the female survivors themselves. The survivor essentially became a co-researcher in the dissemination of relevant data.

Demographics of the Survivor Population

The actual numbers of adults sexually abused as children are unsubstantiated for the myriad of reasons stated previously (e.g., government underreporting, delayed recall, repression-dissociation of memories, etc.). Other reasons for under reporting are because this kind of activity is usually done in private with people of unequal power, and because of the social stigma, as well as the shame and guilt that this activity produces in its victims. But it is a denial to say that childhood sexual abuse is rare. According to a plethora of recent trauma literature, child sexual abuse is not rare (e.g., Alpert, 1995; Briere, 1997; Finklehor, 1990; Hunter, 1995; Reviere, 1996; van der Kolk et al., 1996).

Also, patients in general, do not usually make up abuse stories. In fact, trauma experts report that they usually do the opposite. They try to hide them (Bell-Gadsby & Siegenberg, 1996; Freyd, 1996; Riviere, 1996; Sanderson, 1995). Sometimes people enter therapy without any memories of abuse, but nevertheless, know that they have been abused—what Curtis (1991) calls a "quiet knowing." In some cases, the abuse memories explicitly return; in others they remain only disconnected fragments (Staton, 1990; van der Kolk, 1994). This study included these participants: women who self-reported being sexually abused as children, some who had explicit memories of their abuse, and some who did not. It also included women survivors who had their abuse(s) validated with corroborative evidence, and those who did not.

Description of the Sample

A gender-specific population was utilized in this study because of the high prevalence of female, childhood sexual abuse survivors seeking therapy for abuse-related issues, and their consequent availability as research participants. The twenty five (N=25) female survivors selected for this study were adults (over 18), and mentally able to give their consent for participation (see Appendix C). They all engaged in some form of psychotherapy, or survivors' support group, for at least 6 months, or had previously been in treatment for at least 6 months, where their childhood sexual abuse issues were addressed. This was to ensure they had a therapist or treatment methods available to them, so that any traumatic memories and feelings that surfaced as a result of their participation could be addressed within a supportive, therapeutic context. Any type of self-reported sexual experience before the age of 16 which was imposed on them by someone older or in a position of power and/or trust was defined as sexual abuse. Studies by Rodriguez, Ryan, Vande Kemp, and Foy (1997), and Peters, Wyatt, and Finkelhor (1986) have used similar samples and definitions (except that they defined *older* as a 5-year age difference between the victim and perpetrator).

Two groups of participants were targeted: those who had validation through corroborative evidence of their childhood abuse (n=12), and those who did not (n=13).

Although memory per se was not a focus of this study, it is acknowledged that some of the women had explicit, intact memories of their abuse, some had delayed, recalled memories, and others had only implicit, somatic, or fragmented memories of their abuse(s). Regardless of their varying levels of recall, all the women believed and self-reported that they were sexually abused as children. Additionally, all of the women in this study self-reported varying degrees of PTSD symptoms (per DSM-IV, 1994) and/or symptoms synonymous with *posttraumatic states* (Briere, 1997; Herman, 1992).

Criteria for Sample Selection and Setting

The women targeted for this study came from various sources: 20% were clients of the researcher; 20% were doctoral students in psychology from the researcher's university and 60% were referred from the previous two groups of participants and/or other therapists known to the researcher. They ranged in ages from 29 to 62 years with a median age of 46 (Sd=9.33), and all but one (Asian-American) were of Anglo-American origin. Most of the participants were interviewed in-person in the researcher's outpatient, mental health clinic, with five (20%) being interviewed by telephone. Two were interviewed in their home, and 2 were interviewed in a school setting, with the participant's preference and convenience being the determining factor in the setting selection. They were a nonrandom, convenience sample, and were *not* recruited by age, race, culture or severity-type of symptoms.

Further Criteria for Sample Selection

Further criteria used for this study are as follows:

1. Participants must have been willing to discuss their childhood sexual experiences and other sensitive material related to these experiences with the interviewer, and have their discussions audiotaped.

2. Participants must have agreed to willingly fill out several assessment instruments, and participate in an in-depth interview regarding their childhood sexual abuse experiences.

3. They must have signed all the appropriate consent forms (see Appendix C).

Design of the Study

A dominant-less dominant design (Creswell, 1994) was used in this study, which employed multiple methods of data collection and analysis, and combined both qualitative and quantitative approaches. The design is primarily qualitative, using a multiple case studies format. A component of the design included the quantification of three objective assessment instruments (DES, IES, SERS), as well as the semistructured interview, including a cluster analyses and quantification of all the qualitative data.

Instrumentation

The validity and reliability of these qualitative case studies was assured through several methods of *triangulation* (Denzin, 1978), which included the following:

1. *Data source triangulation* is a manipulation of circumstances in an effort to see if what the researcher is observing-reporting carries the same meaning when found under different circumstances. This was accomplished in the present study by conducting interviews in various settings, using multiple case studies, and conducting a pilot study. The pilot study attested to the validity of the semistructured interview instrument by making sure it measured what it was suppose to measure. Additionally, interrater reliability was established by having three independent reviewers code, cluster, analyze, and interpret the pilot study. This then became a training for the raters in how to do this for the larger study. A worksheet was created by the researcher for the raters to use in categorizing the data from the individual taped interviews, named "Raters' Instructions and Categorizing Sheets for Interview Data" (see Appendix I). They were instructed in the use of these forms in two ways: through the clear, written, instructions printed on the sheets themselves (see Appendix I), and the verbal instructions of the researcher. The raters did not have any problems understanding and using these sheets. A 66% agreement between raters was the minimum requirement for inclusion of variables in the study. Reliability of coding was determined by using the following formula: Reliability equals the number of agreements divided by the total number of agreements plus disagreements (Miles & Huberman, 1994).

2. *Investigator triangulation and theory triangulation* refer to the extent to which other researchers agree with the primary researcher's observations and interpretations of the data, as well as the extent to which they describe the phenomena with similar detail. This study utilized three independent researchers (raters) to review and analyze the following data interpretations: (a) the semistructured interview instrument; (b) the clustering of data, and factor analysis of the interview, and statistical analyses of the assessments; and (c) the interpretation-analyses of the data. The raters included one master's level counselor, from Lindsey-Wilson College in Columbia, Ky. and two clinical psychology doctoral students from Walden University and UW-Milwaukee, respectively. A statistician (statistical instructor from UW-Milwaukee) was also employed to run the quantitative tests (MANOVA) on the test instruments (DES, IES, and SERS), and descriptive statistics of the quantified, personal interview data. The raters and statistician were independent of the research project, and unaware of the full purpose of the study: The raters were blind to which participants had validation through corroborative evidence. This was done to helped reduce potential experimental bias.

3. *Methodological triangulation* is obtained by the use of multiple approaches within a single study. This was accomplished by the use of multiple qualitative case studies, using a semistructured interview instrument and *focused observation* methods, combined with the use of three

objective, quantitative measures: the Dissociative Experiences Scale (DES-II) (Bernstein & Putnam, 1986); Impact of Event Scale (IES) (Horowitz, Wilner, & Alvarez, 1979); and Self-Esteem Rating Scale (SERS) (Nugent & Thomas, 1993).

Dissociative Experiences Scale (DES-II)

This is a brief, 28-item self-report instrument designed by Bernstein and Putnam (1986) to measure dissociation, which is the lack of normal integration of thoughts, experiences, and feelings into the stream of consciousness and memory. Dissociation is viewed not only as a problem in and of itself, but is related to a number of other psychiatric disorders. The DES is based on the assumption that dissociation lies along a continuum from minor dissociations of everyday life to major psychopathology. The DES was developed by using data from interviews with people meeting DSM-III criteria for dissociative disorders and consultations with clinical experts. Items identifying dissociation of moods and impulses were excluded so that experiences of dissociation would not be confused with alterations in mood and impulse related to affective disorders. This study used the DES-II scale, which is an updated version of the DES (Appendix D). It has the same properties, and comparable validity and reliability scores as the original DES, except that it is easier to score. The response scale has been changed from a visual scale to a format of numbers from 0 to 100 (by 10s).

The DES-II is viewed as an excellent research and clinical measure of dissociation (Fischer & Corcoran, 1994).

Reliability

The DES-II has very good split-half reliability, with coefficients for the eight groups ranging from .71 to .96, and with six of these being .90 or above (in Carlson & Putnam, 1993). The DES also have very good stability, with a 4-8 week test-retest reliability coefficient of .84 (Fischer & Corcoran, 1994).

Validity

The validity of the DES has been established by studies which collected data relevant to the construct validity and criterion validity of the scale (Carlson & Putnam, 1993).

Construct validity refers to an instrument's ability to accurately measure a construct, in this case dissociation. The most obvious evidence of the construct validity of the DES is the fact that those who are expected to score high on the test do score high and those who are expected to score low do score low. The DES shows that those with PTSD, DDNOS, and DID score very high on the scale. It is appropriate that the highest scores on the DES would be earned by subjects with dissociative disorders. The high scores of PTSD subjects are consistent with previous descriptions in the literature of high dissociative symptomatology in this population (Blank, 1985; Kolb, 1985).

Criterion validity is an index of how well a measure agrees with some criterion related to the construct being used. In the case of the DES, criterion validity would be established by providing evidence that DES scores agree with the criteria of DSM dissociative disorder diagnoses. Carlson and

Putnam (1993) reported many studies that attested to the high criterion validity of the DES. The concurrent validity (or predictive capacity) of the DES was also studied to further establish its criterion validity. Concurrent validity compares the results of the measure to some other criterion measured at the same time. In a large multicenter study (N=1,051), Carlson et al. (1993) found that despite sources of error (errors introduced into the results because of inconsistency in diagnosing dissociative disorders, like MPD), the analysis of data yielded a sensitivity rate (proportion of MPD subjects correctly identified) of 74% and a specificity rate (proportion of not-MPD subjects correctly identified) of 80%. Two other studies of the DES have produced similar results (Frischoltz et al., 1990; Steinberg, Rounsaville, & Cicchetti, 1991). These findings indicate that the scale has good concurrent and criterion validity.

The DES-II is widely used by researchers and clinicians, and may be reproduced without specific permission (Carlson & Putnam, 1993, p. 22).

Impact of Event Scale (IES)

The Impact of Event Scale is a brief, 15-item instrument designed by Horowitz (Horowitz, Wilner, & Alvarez, 1979) to measure stress associated with traumatic events (Appendix E). It assesses the experience of posttraumatic stress for any specific life event and its context, such as an experience of rape, or the loss of a loved one. The instructions intentionally do not define the traumatic event. This is to be done by the researcher and respondent during the assessment. The IES is a relatively direct measure of

the stress associated with a traumatic event. The IES measures two categories of experience in response to stressful events: intrusive experience, such as ideas, feelings, or bad dreams; and avoidance, the recognized avoidance of certain ideas, feelings, and situations. Because the IES has been shown to be sensitive to change, it is a useful clinical tool that is appropriate for monitoring clients' progress in treatment (Fischer & Corcoran, 1994).

Reliability

Based on two samples, Fischer and Corcoran (1994) found that the subscales of the IES show very good internal consistency, with coefficients ranging from .79 to .92, with an average of .86 for the intrusive subscale and 90 for the avoidance subscale. Zilberg, Weiss, and Horowitz (1982) also found that outpatients with stress response syndromes, scored significantly higher on all but two IES items compared with new medical students, and that the IES was sensitive to clinical change in the outpatients. Stability data, however, were not reported.

Validity

Horowitz et al. (1979) reported a moderate correlation (.42) between the intrusion and avoidance subscales, which indicates that these subscales are measuring related, but somewhat independent, dimensions of response to stress. Two subsequent studies (Zilberg, Weiss, & Horowitz, 1982; Schwarzwald, Solomon, Weisenberg, & Mikulincer, 1987) used factor analysis to confirm that the IES measures the two different dimensions suggested originally by the authors. Furthermore, the subscales indicate the IES is

sensitive to change as scores changed over the course of the treatment (Fischer & Corcoran, 1994).

Self-Esteem Rating Scale (SERS)

The SERS is a 40-item instrument designed by Nugent and Thomas (1993), to measure self-esteem (Appendix F). It was developed to provide a clinical measure of self-esteem that can indicate not only problems in self-esteem but also positive or nonproblematic levels. The items were written to tap into a range of areas of self-evaluation including overall self-worth, social competence, problem-solving ability, intellectual ability, self-competence, and worth relative to other people. The SERS is a very useful instrument for measuring both positive and negative aspects of self-esteem in clinical practice.

Reliability

The SERS has excellent internal consistency, with an alpha of .97. The standard error of measurement was 5.67. Data on stability were not reported (Nugent & Thomas, 1993).

Validity

The SERS was reported as having good content and factorial validity (.83-.56 range). The SERS has good construct validity, with significant correlations with the Index of Self-Esteem and the Generalized Contentment Scale (a measure of depression), .94-90 respectively, and generally low correlations with a variety of demographic variables, as predicted (Fischer & Corcoran, 1994; Nugent, 1993; Nugent & Thomas, 1993).

Semistructured Interview

Rationale for the Use of a Semistructured Interview

There is an assumption in qualitative research that the participant's perspective on the phenomenon of interest should unfold as the participant views it, not as the researcher views it (Marshall & Rossman, 1995). In this study, the researcher is attempting to understand the importance of certain factors (e.g., validation through corroborative evidence, in the remediation of symptoms) that are related to childhood sexual abuse, from the expert's point of view: the female survivor of childhood sexual abuse. It is an attempt to gain a detailed picture of the survivor's beliefs, perceptions, or accounts of this particular area of inquiry. And since the respondent's point of view is of paramount importance, instruments used to elicit her viewpoints must be sensitive and flexible enough to accomplish this task. One such instrument is the semistructured interview, which allows the researcher to be able to follow up on particularly interesting avenues that emerge in the interview, as well as allowing the participant to give a fuller picture of the phenomena of interest. This approach is what Giorgi (1995) calls a phenomenological perspective. From this perspective, the semistructured interview approach is an attempt to capture the richness of the themes emerging from the participant's talk rather than reduce the responses to quantitative categories as might be done with the use of a structured interview. It is an in-depth interview, which Kahn and Cannell (1957) describe as "a conversation with a purpose" (p. 149).

Semistructured Versus Structured Interview

The advantages of the structured interview format are control, reliability, and speed, giving the researcher maximum control over what takes place in the interview. But there are disadvantages which arise from the constraints put on the respondent and the situation. It deliberately limits what the respondent can talk about—this having been decided in advance by the investigator. Thus the interview may well miss out on a novel aspect of the subject, an area considered important by the respondent but not predicted or prioritized by the researcher. Moreover, the topics which are included are approached in a way which makes it unlikely that it will allow the unveiling of complexity or ambiguity in the participant's position.

With the semistructured interview, the researcher will have a set of questions on an interview schedule (structure), but the interview will be guided by the schedule rather than dictated by it. Interviews are facilitated to provide a mechanism for the survivor to bear witness to what is remembered. The researcher's goal is to stimulate conversation, with little direction, in an effort to bring the survivor's oral history to life.

In using the semistructured interview instrument, the researcher followed the general recommendations of Smith (1996), Marshall and Rossman (1995), Lincoln and Guba (1985), and other qualitative researchers by using the following process:

1. Established a trustworthy rapport with the participant.

2. Used more open-ended, rather than closed (yes-no) questions.

3. The category of questions was important (e.g., questions about the abuse; questions about memory; about validation; meaning; coping styles), but the order (sequence) was not.

4. The researcher deviated from the schedule, and freely probed interesting areas when they arose—following the participant's interests or concerns.

5. The researcher attempted to frame the questions in a way that felt familiar and comfortable to the participant. The use of research or psychological *jargon* was avoided as much as possible.

6. The technique of *funneling* (Smith, 1996) was utilized when necessary to address the research questions. Funneling is an interview approach that starts with the most general possible question (open-ended), and moves progressively, like a funnel, to ever more specific questions (more closed). The pilot study (N=4) determined that more specific, detailed questions needed to be added to the interview instrument, and this was done with subsequent participants.

7. The use of probe questions—questions that attempted to elicit expansion of an answer, such as "Can you tell me more about that,?" or "Is there anything more you'd like to add?" were interspersed throughout the interview.

The Personal Questionnaire

A personal questionnaire was administered by the researcher before the semistructured interview. It is a brief form that asked participants about certain demographics such as age, cultural heritage, income level, and so forth (see Appendix A).

The Interview Procedure

Most of the interviews were conducted in person (20 of 25). Five, however, were conducted by telephone for the convenience of those participants living at a distance. The same semistructured format was used with both of them (see Appendix B).

The interviews were tape-recorded for the reasons succinctly stated by researchers Smith, Harre, and van Langenhove (1996):

> Obviously a tape-recording allows a much fuller record than notes taken during the interview. It also means that the interviewer can concentrate on how the interview is proceeding and where to go next rather than laboriously writing down what the respondent is saying. (p. 18)

The tapes were destroyed by the researcher upon completion of this study.

Data Collection and Other Procedures

All of the data for this study were physically administered and collected by the researcher. For the 20 in-person interviewees, the personal questionnaire (demographic data) and the three objective tests (DES, IES, SERS) were administered just before the personal interview was conducted. For four of the five participants who were interviewed by telephone, the objective test instruments and personal questionnaires were mailed to them

in advance of the interview. They then filled them out privately and mailed them back to the researcher before the interview. Three of the interviewees (two in person, one telephone) had their objective tests read to them by the researcher who then marked their answers on the test instruments. This was done to expedite the process due to time constraints, and also to give them a better understanding of the questions (this alteration in test administration however, also had the potential to bias the study results).

The data consist of multiple case studies from 25 women survivors of childhood sexual abuse (developed from individual personal interviews with each participant, whose words were clustered into categories and quantified using descriptive statistics), and the results from three objective test instruments: the Dissociative Experiences Scale (DES-II); the Impact of Events Scale (IES); and the Self-Esteem Rating Scale (SERS) (see Appendixes D, E, F).

The Case Study Format

The research under study was investigated in an effort to illuminate societal concern, by forming a comprehensive understanding of the knowledge surrounding the impact of childhood sexual abuse on the adult, female survivor. This will then contribute to the scholarly knowledge base, which Patton (1990) believes is the purpose of qualitative research. Merriam (1988) has suggested that a descriptive case study is utilized when the prevailing goal is to create a detailed account of the phenomenon relating to a specific event or occurrence. In Merriam's viewpoint, descriptive case studies

provide the database for future theory building, as well as comparison and contrast of theory. Taylor and Bogdan (1984) believe that qualitative phenomenological case studies are not only descriptive, but also allow the researcher to acquire the perspective of reality from the participant's point of view. This naturalistic, holistic approach is unobtrusive and sensitive to the participants, while the research develops concepts, insights, and understanding from patterns in the data (Taylor & Bogdan, 1984).

Understanding the implications of women living with the shame, guilt, secrecy, and confusing fragmented memories and images that often surround childhood sexual abuse is unimaginable to those who have not personally experienced these traumas. The raw descriptions, the memory fragments, the unconnected pieces, the horrifying stories, the betrayal of the innocent and the testimonies which defy the human mind's perception of reality barely touch the surface of what was experienced by many survivors. Researchers and clinicians search to understand what is perhaps not comprehensible to the human mind. Their scars, though hidden from others, are noticeable to the themselves, as one survivor of childhood incest stated to the researcher: "There're a lot of feelings. They're background feelings, you don't necessarily connect them to the incest but I've connected them to my self-worth."

Use of a Pilot Study

A test pilot study was conducted with a sample of four survivors (N=4), preceding the full study. This was done in order to assess the validity and usefulness of the semistructured interview before it was administered to the

full sample population of this study. Additionally, it was used as a method of training the research assistants (the three independent raters) in how to reliably code, classify, and analyze the data and stimulated the creation of a form for the raters to do this (see Appendix I: *Raters' Instructions and Categorizing Sheets for Interview Data*). This added credence to the study's inter-rater reliability.

The information gathering portion of this inquiry was accomplished by use of either telephone or in-person interviews which attempted to solicit open-ended responses in order to gather relevant information related to the research questions: description and memory of the abuse(s); validation of the abuse (presence or not of corroborative evidence); survivor's belief about the importance of corroborative evidence; survivor's belief about the importance of the psychotherapist's validation of her abuse experience(s); meaning of the abuse; current symptoms of the abuse and coping strategies used during the abuse and currently. These general categories were used in all the interviews to assure consistency within the interview process (Appendix B).

The participants were made aware that they would be asked to talk about their childhood sexual abuse experience(s) for the purposes of conducting research to better understand the impact of childhood sexual abuse on women survivors, and to understand the coping mechanisms they used then and now. Each participant, however, was blind to the inquiry which focused on the significance of validation through corroborative

evidence in the remediation of their trauma-related symptoms of dissociation, low self-esteem, and belief in being crazy, bad, or evil.

The intent of the in-person and telephone interviews was to elicit personal narratives as they relate specifically to the importance of validation through corroborative evidence in the remediation of their symptoms, and the other research questions. Information was added to the interview which assisted in data verification, establishing rapport, and gathering a meaningful overview of the background of the participant (see Appendix B). Facilitation of gathering information from the survivor during the interview involved open-ended structuring of questions from the researcher, such as, "Tell me more about that." The goal of the open-ended format is to allow the survivor the opportunity to tell her story from her own, personal perspective.

Data Analysis Procedures

Cluster Analysis

"Factor analysis is widely used but. . . an alternative method of exploring underlying structure which may be more supportable with the data psychologists often handle is termed *cluster analysis"* (Breakwell, Hammond, & Fife-Schaw, 1995, p. 377).

The heart of data analysis consists of identifying categories, recurrent themes, ideas or language, and belief systems that are shared across research participants and settings (Marshall & Rossman, 1995). Huberman and Miles (1994) suggest the utilization of clustering as a means of

inductively forming categories to discover patterns or themes within a population or phenomena under investigation. Cluster analysis was used in this study to create an overview or a means of segregating the data to discover the familiarities and patterns. This process involves what is called segmenting the information (Tech, 1990), developing coding categories (Bogdan & Biklen, 1992), and generating categories, themes, or patterns (Marshall & Rossman, 1995). Huberman and Miles (1994) suggest that clustering analysis assists the researcher by moving to higher levels of abstraction to create families within a matrix.

The researcher coded and recorded the incidence and occurrence of the relevant information reported by the survivors in their tape-recorded interviews onto clustering sheets (Appendix G). Additionally, three independent researchers coded, clustered, and analyzed the data to assure validity and reliability of the results through utilization of triangulation procedures.

Furthermore, a layered clustering sheet was utilized to separate the data into smaller categories (subgroupings) as a means of eliciting patterns or repeated themes (Appendix H). Tesch (1990) calls this process *de-contextualiztion and re-contextualization.* This process results in a higher level analysis: "While much work in the analysis process consists of 'taking apart' (for instance, into smaller pieces), the final goal is the emergence of a larger, consolidated picture" (Tesch, 1990, p. 97). Subgroups were established

as another method of clustering the responses to analyze the results as they related to this study.

The clustering sheets included the following categories: frequency of beliefs about validation and recovery; frequency of impact of the abuse on symptomatology (e.g., PTSD); frequency-intensity of belief in being *crazy, bad,* or *evil;* frequency-intensity of negative self-appraisal (self-esteem); negative meaning attributed to the abuse: negative (e.g., "I'll never be able to get over it"), or positive (e.g., "It's made me a stronger person"); and coping strategies, which included dissociation; meaning; social support; denial; avoidance and acceptance (Appendixes G, H). However, since this is participant-based, exploratory research, the researcher remained open to the possibility of new categories that might have emerged from the survivors' testimonies. One such category that did emerge was the "Reaction Received after Disclosure," which was then included in Appendix I: the *Raters' Instructional Categorizing Sheets for Interview Data.*

The data results from the taped interviews were transcribed onto the clustering sheets, coded, categorized by words, counted for the incidence of the subgrouping terms, and then ranked from the highest to lowest incidence of occurrence. This was be done so that statistical tests could be performed in order to determine possible correlations and the effect and importance of validation through corroborative evidence on the remediation of PTSD-like symptoms in women survivors of childhood sexual abuse.

Statistical Analysis

Since this study is primarily qualitative and exploratory, concerned more with process (asking "how," and "in what ways") than with known entities and cause, technically no hypotheses or null hypotheses are required. Rather, there are hypothetical research questions, with possible societal implications, which need to be answered about the differences between two groups of survivors of childhood sexual abuse: those who have validation through corroborative evidence of their abuse, and those who do not. Specifically, these questions ask how these two groups differ in the following areas: their levels (frequency, intensity, and quality) of dissociation; the impact that the abuse has on them presently; and their self-perceptions and self-esteem (high-low). In addition to having these questions probed qualitatively in a semistructured interview, participants were given three assessments to measure these variables quantitatively as well: the Dissociative Experiences Scale (DES-II); the Impact of Event Scale (IES); and the Self-Esteem Rating Scale (SERS).

After the assessments (test instruments) had been scored, descriptive statistics were employed to summarize the raw scores, determine averages, standard deviation, frequencies, and variances.

A multivariate analysis of variance (MANOVA) was performed in which the means of the two groups (those who have validation through corroborative evidence, and those who do not) were compared. This was done to help determine how much of the dependent variable's (e.g., level of self-

esteem, PTSD symptoms, etc.), variance could be accounted for by variation of the independent variable (validation through corroborative evidence). An outside statistician was employed (a statistical instructor at UW-Milwaukee) to assist in performing these statistical tests, using the SPSS computer package.

The assessment results and their significance are reported in Chapter 4. The interpretation of results, presenting discussion, conclusions, and implications for further research, are reported in Chapter 5. The conclusions are based on the data from both the written and verbal testimonies of the study participants: the voices of the women survivors of childhood sexual abuse

Summary: Sample, Methods, Instruments, and Data Analysis

In summary, the participants of this study included 25 adult females who self-reported having been victims of childhood sexual abuse and presently have, or have had, varying degrees of posttraumatic stress symptoms related to their abuse(s). Twelve of the 25 participants had validation through corroborative evidence of their abuse (an outside source verified the abuse), and 13 did not. All of the participants volunteered to freely share their abuse experiences with the researcher in a personal semistructured interview, either in person or over the phone, as verified by their signing the research consent form (Appendix C). Additionally, all of the participants filled-out a personal questionnaire describing certain demographics, as well as three brief, test instruments (the DES-II; IES;

SERS). The completion time of these procedures varied with each individual participant, with the average being approximately 90 minutes per session. The researcher observed that 11 of the participants had strong, emotional reactions, and 6 had dissociative experiences (as further verified by the participants themselves) when relaying their stories. The researcher, who is a psychotherapist specializing in trauma intervention, then paused to respond to them, working therapeutically with them, until they felt ready to continue (as agreed upon in the "Research Consent Form"-Appendix C). This then increased the time of these sessions by approximately 30 minutes.

The participants were recruited in various ways: by direct verbal request of the researcher to clients, colleagues, and psychotherapists who have experienced or worked with sexual abuse clients-issues, and through one email posting on the Walden University psychology student list-serve (see Appendix N). A letter explaining the research project and criteria for participants was sent to psychotherapists (Appendix O), and/or potential participants who requested it (Appendix P).

The data were collected by the researcher and analyzed by three independent assistants (one master's degree counselor, and two clinical psychology interns). The data from the interviews were coded and recorded in categories. They were then clustered and subclustered according to the various variables (e.g., belief that corroborative evidence is necessary for the remediation of symptoms; self-perceptions; meaning of abuse; coping strategies, etc.), analyzed by three independent "raters" (assistant

researchers), quantified, and put into tables. The quantitative data (three objective tests) from the two groups (survivors who have validation through corroborative evidence of their abuse, and those who do not) were compared using a MANOVA, and there significance was reported in Chapter 4. Finally, all of the qualitative data were synthesized and reported in tables, as well as descriptively. The final results of the research study are discussed in detail in Chapter 4. The discussion of the research and implications for future studies is reported in Chapter 5.

CHAPTER 4: RESULTS

Introduction

> *I was 4. . . . It was my stepfather. . . . He started by putting his 'thing' (penis) in my mouth and doing all different kinds of other sexual stuff. . . . At 5 or 6 years old I was bleeding because of what he did, and I was afraid. . . but I never told anybody because I thought I was going to get killed. . . . Then when my mother found out that this was happening; she blamed me. . .because I was developing. . .it was my fault how I looked. . . . I tried to commit suicide in 9th grade from the way I was being treated. . . . I started beating myself on the head with a hammer because I just couldn't take any more. . . . What stopped me. . .was an 'inner voice' that said "it's not right." It was just like a spirit kind of a thing. Maybe it was my guardian angel, I don't know.* (From an interview with Rose N., a survivor of childhood sexual abuse)

This chapter reports the results of this study. The findings of this research are of two types. One type is the statistical findings of the assessment instruments (DES; IES; SERS), resulting from a comparison of two groups of Women survivors of childhood sexual abuse (CSA): those who have validation of that abuse through corroborative evidence (as defined in chapter 1), and those who do not. A second set of findings comes from statistical and non statistical analyses of the personal interview (Appendix B). Since this study is primarily qualitative and descriptive, the case studies of the participants (25 women survivors of childhood sexual abuse), are reported and their 'voices' analyzed. "For the most part, the cases of interest in. . .social service are people. . . .We seek to understand them. We would like to hear their stories" (Stake, 1995, p. 1). Variables of the case studies have been clustered into categories, quantified, and displayed in tables.

Pilot Study Results

This was the initial study which consisted of four female survivors (n=4) of childhood sexual abuse, whose ages ranged from 36 to 61 (Mean=50.25, Sd=10.53). Two of the participants had validation through corroborative evidence of their abuse(s), and 2 did not. Due to the low power (small number of subjects) of the pilot study sample, the results of the quantitative tests-assessments were tabulated in with the total participants, and a MANOVA was conducted which was found not to be significant [F=.476, p=.849]. The interview questionnaire variables were combined with the total participants, and are reported in the tables below each research question. The qualitative data for the various research questions have been quantified as percentages and reported in tables. They have been narratively described in the individual case studies as well (see Appendix L).

The purpose of the pilot study was to assess the validity and reliability of the study instruments and make any appropriate revisions. The following changes were made as a result of this study: A revision of the personal interview (Appendix B) was done to include more "funneled" questions, directly related to the research questions, with specific questions about "coping" also added. Inclusion in the Personal Questionnaire (Appendix A) of the category "other" and "not applicable" was done. Appendix I, *Raters' Instructions and Categorizing Sheets for Interview Data,* was created as a way for the raters to categorize the information from the personal interview tapes.

A *Raters' Interview Category Comparison Worksheet* (Appendix J) was also created to score the agreement between the three raters. In addition, Appendix K, *The Data Quantification Worksheet,* was devised as a way of recording both the quantitative data (the assessment instruments), and the qualitative data (the Personal Questionnaire and the personal interview), which were put into quantifiable form (frequency tables and displayed as percentages).

Statistical Data on Demographics of Study Participants

There were 25 female survivors of childhood sexual abuse who participated in this study. They were a nonrandom, convenience sample consisting of the following: 20% were clients of the researcher; 20% were doctoral students in psychology from the researcher's university; 60% were referred from the previous two groups of participants, and/or other therapists known to the researcher. They ranged in ages from 29 to 62 years (mean=45.92, Sd=9.33). The percentages of demographic variables for the participants, are listed according to their group (validated participants versus nonvalidated participants), and displayed in Table 1. Some notable findings follow: The majority from both groups are married (50% validated; 69.2% nonvalidated); the majority from both groups are of European-American heritage (100% validated; 9.33% nonvalidated); half of the validated group are Catholic, and slightly more than half of the nonvalidated group are "spiritual" (53.8%); the majority from both groups are college

educated or above (58.3% validated; 69.3% nonvalidated); the majority from both groups are *not* on prescribed medication (58.3% validated; 53.8% nonvalidated), but of those who are, the highest percentage are on anti-depressants (25% validated; 23.1% nonvalidated), with nonvalidated being equally on a combination of antidepressants and anti-anxiety medication (23.1%).

Statistical Findings of the DES, IES, and SERS

A multivariate analysis of variance (MANOVA) was conducted on the data generated from the Dissociative Experiences Scale (DES II), the Impact of Event Scale (IES), and the Self-Esteem Rating Scale (SERS), comparing two groups of participants: those who had validation through corroborative evidence of their childhood sexual abuse (n=12), and those who did not (n=13). These tests found *no* significant differences between the groups [F (8)=.476, p=.849]. For exploratory purposes univariate tests were performed to see if there were any reliable differences worthy of future investigation. None was found.

This was a likely artifact of the study's limited power (too small a sample for the amount of variables), which was unable to detect any effect (a possible Type II error). This is suspected because these results differ from the descriptive statistical information gleaned from the quantification of the personal interview, which analyzed the narratives of the participants, using the same dependent variables: dissociation; impact of the CSA (current

symptoms); and self-esteem. Important percentage differences where found, between the two groups on many of these variables. These results are reported both descriptively, and in tables, under each research question.

Results of the Full Study

Inter-Rater Reliability

There were three raters (described in Chapter 3: Methods) who listened to the individual audio tapes of the participants, and categorized their narratives using the "Rater's Instructions and Categorizing Worksheet for Interview Data" (Appendix I). The researcher then tallied up their answers using the "Rater's Interview Category Comparison Worksheet" (Appendix J). As a result, the only variables included in the tables for this study have a minimum 66%, and maximum 100% inter-rater agreement.

Research Question 1

How do women who have suffered childhood sexual abuse who have been validated (through corroborative evidence) differ from those who have not in their level of dissociation?

a) Their frequency of dissociation:

b) Their intensity of dissociation:

c) Their quality of dissociation:

Table 1

Demographic Variables for Validated and Nonvalidated.

	Validated	Nonvalidated
Marital Status		
Single, Never Married	25%	7.7%
Married	50%	69.2%
Separated/Divorced	25%	23.1%
Ethnicity		
Asian American	0%	7.7%
European American	100%	92.3%
Religion		
Catholic	50.0%	15.4%
Protestant	33.3%	15.4%
Spiritual	16.7%	53.8%
Fundamentalist	0%	7.7%
New Age	0%	7.7%
Educational Level		
High School	16.7%	15.4%
Some College	25.0%	15.4%
College Graduate	25.0%	30.8%
Graduate Degree	8.3%	7.7%
Post Graduate	25.0%	30.8%

(Table 1 continues)

	Validated	Nonvalidated
Career/Job		
Nonprofessional	8.3%	0%
Homemaker	0%	7.7%
Business	8.3%	15.4%
Helping Profession	66.7%	61.5%
Student	8.3%	7.7%
Other	8.3%	7.7%
Income Level		
< $10,000	16.7%	7.7%
$10-15,000	8.3%	15.4%
$16-35,000	16.7%	38.5%
$36-60,000	41.7%	30.8%
> $60,000	16.7%	7.7%
Drug/Alcohol Abuse		
Yes	8.3%	0%
No	91.7%	100%
Others' Opinion of Use		
Problem	8.3%	0%
Not a Problem	83.3%	100%

(Table 1 continues)

	Validated	Nonvalidated
AODA Treatment		
No	8.3%	0%
Not Applicable	91.7%	100%
Prescribed Medications		
Yes	41.7%	46.2%
No	58.3%	53.8%
Type of Prescribed Medication		
Anti-anxiety	8.3%	0%
Anti-depressant	25.0%	23.1%
Sleep Disorder	8.3%	0%
Combination	0%	23.1%
Not Applicable	58.3%	53.8%

(Table 1 continues)

There were no significant statistical differences found in the frequency and/or level of dissociation between the two groups as measured by the DES.

The differences in the *quality* (experience) of dissociation between the groups was gleaned from the quantified memory variables of the personal interview which are described in percentages (Table 2), and summarized narratively in the individual case studies.

These instruments do show differences in dissociation: validated participants had much higher incidences of clear, declarative memories, and a lower percentage of dissociated, fragmented memories of their CSA than nonvalidated participants; nonvalidated participants had a much higher incidence of body memories (somatic memories-dissociated from consciousness), than validated, who had no incidences of body memories.

Summary

Although statistically no significant differences in Dissociation were found between the validated versus nonvalidated groups, using the DES measure (perhaps due to limited power), there were percentage differences that indicate at least a "qualitative" difference between these groups, with the nonvalidated group having more dissociated memories (including body memories), than the validated group (see Table 2). Also, further qualitative differences are demonstrated in the narratives of the case studies, with nonvalidated participants describing body memories and dissociated memories in more detail, than validated participants (see summary for each case study; and detailed case studies in Appendixes L, M).

Research Question 2

How do women who have been validated, and those who have not, differ in the belief that validation (through corroborative evidence), is necessary for them to heal from the abuse?

a) How is this belief expressed?

b) What is it they need to know about the abuse?

c) From whom do they need to obtain this information? (e.g., perpetrator, parent, court, therapist).

These questions are answered by the quantification of the personal interview data, displayed in Table 3 (Validation Variables for Validated and Nonvalidated), and the narratives of the case studies.

Summary

Question 2a (How is that belief expressed), and 2c (From whom do they need to obtain this information? . . .) are linked, as 2a is answered by reading the narrative case studies, as well as the results of question 2c, listed in Table 3.

Some interesting differences that were found are: The majority from both groups highly agreed that validation through corroborative evidence was important (75% validated, versus 77% nonvalidated), and that validation from the perpetrator was also important, although the validated group expressed this more frequently than the nonvalidated group (58.3% versus 38.5%). And 83.4% of those validated versus 53.8% nonvalidated, believed that it was important for *mom* to validate them. There was a high agreement in the two groups' belief that validation from the therapist was important (91.7% validated-92.3%. nonvalidated).

Table 2

Memory Variables for Validated and Nonvalidated

	Validated	Nonvalidated
Clear Declarative		
Yes	75%	38.5%
No	25%	61.5%
Dissociative/Fragmented		
Yes	25%	38.5%
No	75%	61.5%
Repressed		
Yes	25%	53.8%
No	75%	46.2%
Body Memories		
Yes	0%	38.5%
No	100%	61.5%
Time Sequence		
Always Remembered	58.3%	53.8%
Delayed Memories	16.7%	23.1%
Mixed Memories	25.0%	23.1%
Circumstances of Recall		
Not in Therapy	58.3%	46.2%
In Therapy for CSA	8.4%	7.6%
In Therapy for Other	33.3%	46.2%

The answers to question 2b): What do they need to know about the abuse?, are found in the narrative case studies (Appendix M). These narratives can be summarized by saying that each group wanted to have the validation in order to either affirm (nonvalidated group), or reaffirm (validated group) their own perceptions about what happened to them (the CSA) and assuage their self-doubts and self-blame. They also expressed a belief in varying degrees, that this would help relieve negative symptoms related to their abuse(s), particularly guilt and self-blame.

Research Question 3

In those who have been validated, how can their self-esteem and perceptions of self be described?

a) How do these differ from those who have not been validated?

b) Is there a difference in their perception of self as being crazy, bad, evil, or deserving of the abuse?

These questions are answered by the statistical measurement of the SERS (MANOVA results); the quantification of the personal interview data, displayed in Table 4 (Negative and Positive Self-Beliefs for Validated and Nonvalidated); and the narratives of the case studies (Appendixes L, M).

Summary

The answer to question 3a is twofold: One, there were *no* significant statistical differences in self-esteem between the two groups as measured by the SERS. Two, their narrative reporting of self-esteem variables listed in

Table 3
Validation Variables for Validated and Nonvalidated.

	Validated	Nonvalidated
Age of Validation		
0-5	0%	N/A
6-12	33.3%	N/A
13-17	8.3%	N/A
18-29	8.4%	N/A
30-49	50.0%	N/A
50 and up	0%	N/A
Not Validated	0%	100%
Time of Validation		
During the Abuse or Shortly After	50.0%	N/A
Upon Disclosure As a Child	16.7%	N/A
Upon Disclosure As an Adult	25.0%	N/A
Years Later	8.3%	N/A
Never Validated	0%	100%
Validation Important	75.0%	77.0%
Validation from Whom		
Perpetrator		
Important	58.3%	38.5%
Not Important	16.7%	46.2%
Not Reported	25.0%	15.4%

(Table 3 Continues)

	Validated	Nonvalidated
Mom		
Important	83.4%	53.8%
Not Important	8.3%	30.8%
Not Reported	8.3%	15.4%
Dad		
Important	25.0%	23.1%
Not Important	25.0%	23.1%
Not Reported	50.0%	53.8%
Sibling		
Important	50.0%	30.8%
Not Important	8.3%	15.4%
Not Reported	41.7%	53.8%
Other Relative		
Important	25.0%	7.7%
Not Important	0%	15.4%
Not Reported	75.0%	76.9%
Child		
Important	0%	0%
Not Important	0%	23.1%
Not Reported	100%	76.9%

(Table 3 continues)

	Validated	Nonvalidated
Authority		
Important	0%	7.7%
Not Important	0%	15.4%
Not Reported	100%	76.9%
Medical		
Important	0%	0%
Not Important	0%	15.4%
Not Reported	100%	84.6%
Other Adult		
Important	25.0%	7.7%
Not Important	0%	7.7%
Not Reported	75.0%	84.6%
Therapist		
Important	91.7%	92.3%
Not Important	0%	7.7%
Not Reported	8.3%	0%
Other		
Important	16.7%	23.1%
Not Important	8.3%	7.7%
Not Reported	75%	69.2%

(Table 3 continues)

Table 4, does show differences in negative self beliefs and self-appraisals between the validated and nonvalidated group, with the nonvalidated group being consistently higher on all measures but shame (75% validated versus 69.2% nonvalidated). And although the nonvalidated group reported much higher negative self-statements than the validated group (84.6% nonvalidated versus 66.7% validated), the nonvalidated group also expressed much higher positive self-statements than the validated group (15.4% nonvalidated versus 8.3% validated).

Table 4

Negative and Positive Self-Beliefs for Validated and Nonvalidated.

	Validated	Nonvalidated
Negative Self-Beliefs		
Crazy/Bad/Evil	41.7%	46.2%
Other Negative Words	41.7%	53.8%
Deserved It	25.0%	61.5%
Guilt	50.0%	61.5%
Shame	75.0%	69.2%
Self-Appraisal		
Negative Self-Statements	66.7%	84.6%
Positive Self-Statements	8.3%	15.4%
Self Not to Blame	66.7%	46.2%

Question 3b is answered by the quantification of the self-statement variables of the personal interview, reported in Table 4. There is a difference

between the two groups, in their perception of self as being crazy, bad, evil, or deserving of the abuse, with the nonvalidated group being higher in these beliefs than those who were validated: (46.2% of nonvalidated participants believed they were crazy, bad, evil, and 61.5% of this group believed they deserved the abuse, versus, 41.7% of validated who believed they were crazy, bad, evil, and 25% of validated who believed they deserved the abuse).

Research Question 4

What impact has the abuse had on their adult lives? How do they differ in terms of:

a) Posttraumatic stress symptoms (e.g., flashbacks, intrusive images, intense affect, numbing of affect, regression to abuse, obsessing about the abuse, psychosomatic symptoms).

b) Psychologically distressing symptoms (e.g., depression, paranoia, anxiety, personality disorders).

c) Their ability to cope and come to terms (adapt) with the abuse?

This question is partially answered by the MANOVA results, which found no statistical significant differences between the two groups as measured by the Impact of Event Scale (IES).

Question 4a and 4b are answered in Tables 5, 6 and 7, which show the percentages of current symptoms for validated and nonvalidated participants, quantified from the personal interview data. It is also answered in the narratives of the individual case studies (Appendixes L, M). The

notable differences found are the following: the nonvalidated group had more intrusive PTSD symptoms than the validated group (76.9% versus 58.3%), more avoidance/numbing PTSD symptoms (53.8% versus 41.7%), but *less* increased arousal-hypervigilance (38.5% versus 58.3% for validated). With affective-behavioral symptoms, the nonvalidated group reported substantially higher incidences of depression (69.2% versus 58.3%) and eating disorders (69.2% versus 41.7%). The validated group reported higher incidences of addictions (58.3% versus 46.2%) and substantially higher reports of obsessive/compulsive behaviors (25%), with the nonvalidated group reporting no incidences (0%). Under somatizations, there were notable differences in two areas: multiple health problems (nonvalidated 15.4% versus 0% validated); and sexual dysfunction (46.2% nonvalidated versus 33.3% validated). And there were substantial, notable differences in obesity-weight with the nonvalidated group reporting a much larger percentage in this category than the validated group (76.9% versus 33.3%). The most notable differences between the two groups under the "Personality" category was dependency, with nonvalidated reporting a much higher percentage of this (30.8% versus 16.7%).

Question 4c which asks how the two groups differ in their ability to cope and come to terms (adapt) with the CSA, is answered in Table 8. Essentially, the two groups are fairly equal in their use of emotion-focused and problem-focused coping strategies. They both reported high percentages

(over 50%) in the following areas: Dissociation/Repression; Negative Social Support; Avoidance; Positive meaning; Positive Social Support; Logical methods; and Helping others/Affiliation. However, there are some notable differences: in the Spirituality/Transcendence category, with the validated group reporting 50%, and nonvalidated only 38.5%. Another large and interesting difference is with Acceptance, with the validated group reporting a much higher percentage (41.7%) than the nonvalidated group (7.7%).

Table 5

Current Symptoms and Affect for Validated and Nonvalidated

	Validated	Nonvalidated
Current Symptoms		
Intrusive Symptoms	58.3%	76.9%
Avoidance/Numbing	41.7%	53.8%
Increased Arousal	58.3%	38.5%
Other	0%	0%
Affective		
Depression	58.3%	69.2%
Anxiety/Fears	50.0%	53.8%
Addictions	58.3%	46.2%
Obsessive/Compulsive	25.0%	0%
Eating Disorders	41.7%	69.2%
Other	8.3%	0%

Table 6

Somatizations and Behaviors for Validated and Nonvalidated

	Validated	Nonvalidated
Somatizations		
Psychosomatic	33.3%	30.8%
Pain	0%	7.7%
Multiple Health Problems	0%	15.4%
Obesity/Weight	33.3%	76.9%
Negative Body Image	58.3%	53.8%
Sexual Dysfunction	33.3%	46.2%
Other	0%	0%
Behavioral Issues		
Promiscuity	16.7%	23.1%
Relationship/Intimacy Problems	75.0%	76.9%
Self Destructive/ Mutilation	0%	7.7%

Table 7

Personality Variables for Validated and Nonvalidated

	Validated	Nonvalidated
Personality		
Identity/Boundary	33.3%	23.1%
Overly Dependent	16.7%	30.8%
Avoidance/Isolation	33.3%	30.8%
Confused Thoughts	0%	0%
Antisocial/ Sexual Acting Out	8.3%	15.4%
Other	58.3%	46.2%

Summary

The nonvalidated group reported a higher percent of the intrusive and numbing symptoms associated with acute PTSD (76.9% and 53.8% respectively, versus 58.3% and 41.7% respectively, for the validated group) and less of the increased arousal symptoms which are associated more with chronic PTSD.

The nonvalidated group has higher percentages in affective symptoms (e.g., depression, anxiety), than the validated group, with the exception of obsessive/compulsive symptoms, which they scored zero (0) on, compared to the validated group who have a 25% rate.

The nonvalidated group also has a higher percentage of eating disorders (69.2% versus 41.7%), pain, multiple heath problems, sexual dysfunction, promiscuity, self destruction/mutilation (7.7% versus 0%), and a large difference with obesity/weight problems (76.9% versus 33.3%). There are similar percentages for both groups in regard to negative body image, with validated being a bit higher (58.3% validated-53.8% nonvalidated). Relationship/intimacy problems, showed the highest percentages for both groups, with the nonvalidated group being only slightly higher (nonvalidated, 76.9% versus validated, 75%).

Coping Summary

There did not appear to be large differences in the coping strategies of the two groups except for the following: denial, which was used much more by the validated than the nonvalidated group (16.7% versus 7.7%), and acceptance, which was used much more by the validated than the nonvalidated group (41.7% versus 7.7%). The validated group was appreciably higher in using spirituality-transcendence than the nonvalidated group (50% versus 38.5%). Both groups scored higher percentages in the use of positive social support (91.7% validated; 84.6% nonvalidated), and logical methods (83.3% validated; 76.9% nonvalidated) and generally higher in the use of problem-solving coping versus emotion-focused coping. The validated group did have much higher percentages than the nonvalidated group, in the "other" (coping strategies not specified in the study) category.

Table 8

Coping Strategies for Validated and Nonvalidated

	Validated	Nonvalidated
Emotion-Focused Coping		
Negative Meaning	41.7%	38.5%
Dissociation/Repression	58.3%	53.8%
Negative Social Support	66.7%	69.2%
Denial	16.7%	7.7%
Distraction	16.7%	15.4%
Avoidance	58.3%	61.5%
Other	33.3%	15.4%
Problem-Solving Coping		
Positive Meaning	58.3%	61.5%
Positive Social Support	91.7%	84.6%
Logical Methods	83.3%	76.9%
Acceptance	41.7%	7.7%
Helping Others/Affiliation	58.3%	61.5%
Spirituality/Transcendence	50.0%	38.5%
Other	50.0%	15.4%

Research Question 5

In those who have been validated, how important are the following:

a) Age of validation.

b) Time of validation (e.g., upon self-disclosure, immediately after incident, years later).

c) Who validated them (e.g., perpetrator, parent, friend, court).

This question is answered by perusing the percentages listed under "Validated" in Table 3 for the following categories: Age of Validation; Time of Validation; and Validation from Whom. Additionally, Table 9 describes who validated them, as well as the narratives of the individual case studies (Appendixes L, M).

Question 5c (In those who have been validated, how important are the following: Who validated them?. . .) can be answered not only by looking at the percentages in Tables 3 and 9, but also by comparing this data to Table 10 under the categories of: "Disclosure to Whom," and "Reactions to Disclosure."

Summary

The validated sample consisted of 12 of 25 participants. Fifty percent (50%) were not validated until they were middle-aged adults (between 30-50 years), with 33.3% validated between the ages of 6-12, and 0% between birth and 5 years of age (note: 24% of the participants were sexually abused beginning at age 5 or under). Half of them were validated during the abuse or

shortly afterward (50%); 25% were validated upon disclosure as an adult, and only 16% upon disclosure as a child, with the smallest percent being validated years later (8.3%).

Nine (9) of the 12 validated participants (75%) were validated by a sibling (8 of 9 were sisters), who was also sexually abused by the same perpetrator. Four of the 12 were validated by the perpetrator (33.3%), and two of the four perpetrators were the dad (see Table 9 below).

Table 9

Validating Person: Relationship to Survivor.

Case Study # Name	Perpetrator	Mom	Dad	Sibling(s)	Other Relative	Other abused child	Medical
#1 Geraldine N.				√=Sister		√	
#3 Rose N.				√=Sister		√	
#8 Bonnie D.	√=Dad		√=Perpetrator	√=Sister		√	
#12 Kristie P.		√		√=Brother		√	√=Doctor
#13 Jean-Marie B.				√=Sister		√	
#17 Diane B						√=Boy	√=Doctor
#18 Lecia H.		√				√=Friends	
#20 Louise D.	√=Brother	√	√	√=Sister	√=Nieces	√=Sister	
#21 Catherine D.	√=Janitor	√	√	√=Sister			
#22 Gail S.				√=Sis/Bro		√=Sister	
#23 Marlene S.		√					
#25 Sharon D.	√=Dad		√=Perpetrator	√=Sister	√=Aunt	√=Sister	

Table 10

Disclosure Variables for Validated and Nonvalidated.

	Validated	Nonvalidated
Age of Disclosure		
0-5	0%	7.7%
6-12	33.3%	7.7%
13-17	25%	23.1%
18-29	8.4%	0%
30-49	33.3%	53.8%
50 and up	0%	7.7%
Disclosure to Whom		
Mom	83.3%	61.5%
Dad	41.7%	38.5%
Sibling	75.0%	61.5%
Other Relative	25.0%	23.1%
Child	25.0%	23.1%
Authority	25.0%	15.4%
Medical	16.7%	15.4%
Other Adult	58.3%	61.5%
Therapist	100%	100%
Other	16.7%	38.5%

(Table 10 continues)

	Validated	Nonvalidated
Reactions to Disclosure		
Mom		
Positive	16.7%	7.7%
Negative	75.0%	69.2%
Unknown	8.3%	23.1%
Dad		
Positive	16.7%	0%
Negative	41.7%	38.5%
Mixed	0%	7.7%
Unknown	41.6%	53.8%
Sibling		
Positive	50.0%	30.8%
Negative	16.7%	30.8%
Mixed	16.7%	0%
Unknown	16.6%	38.4%
Other Relative		
Positive	16.7%	0%
Negative	25.0%	15.4%
Mixed	0%	7.7%
Neutral	0%	7.7%
Unknown	58.3%	69.2%

(Table 10 continues)

	Validated	Nonvalidated
Child		
Positive	0%	7.7%
Negative	33.3%	15.4%
Neutral	0%	7.7%
Unknown	66.7%	69.2%
Authority		
Positive	16.7%	7.7%
Negative	25.0%	15.4%
Unknown	58.3%	76.9%
Medical		
Positive	25.0%	0%
Negative	16.7%	15.4%
Unknown	58.3%	84.6%
Other Adult		
Positive	50.0%	69.2%
Mixed	8.3%	7.7%
Unknown	41.7%	23.1%
Therapist		
Positive	83.3%	100%
Unknown	16.7%	0%

(Table 10 continues)

	Validated	Nonvalidated
Other		
Positive	16.7%	30.8%
Negative	25.0%	7.7%
Mixed	0%	7.7%
Unknown	58.3%	53.8%

(Table 10 continues)

Unexpected Validation/Disclosure Variables

An interesting, unexpected finding is that five (5) of the 12 participants (41.6%--data gleaned from the case studies), did not disclose and/or work with the negative consequences of their CSA until after the perpetrator died (see case studies: 1, 3, 8, 17, and 18). And although 83.3% believed that it was important for mom to validate them, and 83.3% disclosed their abuse to mom, only 16.7% reported positive reactions from her upon disclosure, while 75% reported negative reactions from mom upon disclosure of the abuse (see Table 10).

Case Studies

The variables are described in detail, in the individual case studies (Appendix M), using the participants' narratives, which have been categorized according to the research questions and the cluster sheet categories (Appendixes G, H, and I).

Additionally, a brief summary of the childhood sexual abuse (CSA) variables and their relationship to the research questions is given for each case study below:

Case Number 1: Story of Geraldine N.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  7 until 13/14 years old.

- Abused by (whom/relationship):
  Her uncle by marriage (mother's sister's husband). Started with "digital penetration," and progressed into sexual intercourse when she was 12.

- Singular/multiple abuse(s):
  Multiple abuses; single abuser.

- Research Question #1 (Dissociation/memory variables):
  Two memories are very *clear:* the one at 7 years old when her uncle "fondled" her and "fingered" her genitals, and the one at 12, when he had intercourse with her. Many of the other memories of the CSA are *sketchy, fragmented,* and *dissociated*, with delayed recall. The memories did not begin to fully surface until she was 35 years old. They surfaced out of therapy, during psychosomatic illnesses and PTSD episodes.

- Research Question #2 (Belief about link between validation and healing):
  Believes that validation is important from the *therapist.* Has *mixed* feelings about validation from her *sister* (who was also a victim of CSA by the same perpetrator): glad to be validated, and yet angry that her sister had not told her earlier, so she would not have had to go through all the debilitating PTSD symptoms and emotional "pain."

- Research Question #3 (Self-esteem variables):
  Geraldine has many negative beliefs about herself that she feels are connected to the CSA: ". . .I have no value; not good enough; no worth. I'm *crazy, bad*. . .felt shame and guilt and that my badness was *inherited* (genetic)." She also reported feeling *unclean.* She claims to have less of these beliefs since being in therapy for herself, as well as from working with other women survivors as a therapist.

- Research Question #4 (Impact of CSA on her adult life):
  ". . .I had this intense anger toward my mother and grandmother (as a child and an adult), and then towards my husband. . . ." which she now recognizes was about the CSA. She had intrusive PTSD symptoms, with intense affect and psychosomatic migraine headaches for many years. Currently, she has a "mild" eating disorder (never feels thin enough even when she is); a negative body image; hypervigilance; obsessive-compulsive cleaning; sexual dysfunction: ". . .Sex is *not* enjoyable, it's an obligation."

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated. When she disclosed her PTSD-like symptoms to her sister at 35/40 years old, her sister revealed that she too had been sexually abused by as a child by the same uncle

  Geraldine tried to disclose the abuse to her mother and grandmother as a child, but they dismissed it as a bad dream. She disclosed to her mother as an adult, after the uncle's death, and mother again refused to believe her She also revealed the abuse to her daughter's therapist because she suspects that her daughter may also have been sexually abused by the same uncle. Sister, husband, and daughter have been supportive of her.

Case Number 2: Story of Jean W.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  15 until 17 years old.

- Abused by (whom/relationship):
  Brother-in-law (sister's husband-10 years older).

- Singular/multiple abuse(s):
  Multiple abuses; single abuser.

- Research Question #1 (Dissociation/memory variables):
  Jean has *clear, declarative* memories of the CSA.

- Research Question #2 (Belief about link between validation and healing):
  She does *not* think that validation from the *perpetrator* would help her heal, because she feels that the issues about it are *hers* not his (self-blame, has taken responsibility for the abuse).

- Research Question #3 (Self-esteem variables):
  Jean has some very negative beliefs about herself even today, she says: ". . .I'm a *rotten* person, and I *hate* myself, and in general I *don't* think I'm a good person."

- Research Question #4 (Impact of CSA on her adult life):
  Jean "suffers" from major depression which is alleviated through medication. She also has a negative body-image and eating disorder. She struggles with her weight (overweight) and says: ". . .I'm aware that I keep myself overweight so that I'm not attractive to men, because I think if I feel if I am attractive, I'll do it again. I don't trust myself." She still has *guilt* and *shame* over the abuse, and cannot forgive herself for the betrayal of her sister (who never found out about it).

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. Although her brother-in-law did not deny his sexual involvement with her, he also never admitted that it his fault, or that it was sexual abuse (even though she was a child and he was 10 years her senior). Jean has never disclosed this abuse to anyone but her therapist (not even to her husband who is very emotionally supportive of her).

Case Number 3: Story of Rose N.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  4 until 16 years old.

- Abused by (whom/relationship):
  Step-father and adult, male roomer.

- Singular/multiple abuse(s):
  Multiple abuses from multiple abusers.

- Research Question #1 (Dissociation/memory variables):
  Clear, declarative memories of the CSA.

- Research Question #2 (Belief about link between validation and healing):
  Rose believes that validation from the *therapist* is important for her to heal from the abuse. She did not directly address the issue of the importance of validation from the perpetrator, parents or others. But she did *imply* that validation from *mother* would have been very healing.

- Research Question #3 (Self-esteem variables):
  Rose has low self-confidence, and many times believes the *introjects* of her parents: ". . .I just think that everybody else is better than me, and I don't have anything to offer. . . everybody else is kind of smarter than I am. . .I was told that I was dumb and stupid and ignorant all my life."
  Despite this she also says: ". . .I think I'm a good person." Rose has *unlovable* and *unworthy* schemas.

- Research Question #4 (Impact of CSA on her adult life):
  Abandonment and betrayal are central issues in Rose's present life. The abuse has made it difficult to allow herself to trust and be intimate with others, particularly men, and thus she has trouble forming close, intimate, relationships. She is dependent on alcohol, and uses it to self-medicate her anxiety so she can sleep at night. She has many fears, and is hyper-alert (which is why she has difficulty sleeping through the night), and experiences many intrusive PTSD symptoms as well. Rose also has a negative body image, is overweight, and also suffers from depression.

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated. Rose's sister walked in on her when step-father was sexually abusing her. A couple of sisters have disclosed that they too were sexually abused as a child by the same perpetrator. Rose tried to tell her mother, but her mother refused to believe that it happened. Other people (her sister, friends of the family, relative) tried to tell Rose's mother that the step-father was abusing her, but she wouldn't believe them. Rose disclosed the abuse to her foster parents when she was 16, and they believed her and protected her. She disclosed to many of her siblings (who were also abused by the father), and some of them are supportive of her.

Case Number 4: Story of Rosanne K.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  5 until 7 years old.

- Abused by (whom/relationship):
  Male baby-sitter (friend of the family), who was in his late teens (over 10 years older than Rosanne).

- Singular/multiple abuse(s):
  Multiple abuses; single abuser.

- Research Question #1 (Dissociation/memory variables):
  Rosanne seems to have used 'motivated forgetting' and *repression* in her childhood sexual abuse memories. Many of the memories are very *clear*, but she says: ". . .I don't want to remember. But I know it happened." Rose reports that she slips into *dissociation* and regression automatically, particularly when she is in pain or something stressful is occurring that she wants to escape from.

- Research Question #2 (Belief about link between validation and healing):
  She believes that validation from her *parents* and/or the *perpetrator* would have helped her back then, when it occurred, but she does not believe that it would be of any help now. She feels very strongly that it is important for the *therapist* to believe her; and that this is necessary for her healing.

- Research Question #3 (Self-esteem variables):
  Rosanne has a strong, *unlovable* schema, she says: ". . .I can't understand why anyone would love me, I have a problem with that. . ."

- Research Question #4 (Impact of CSA on her adult life):
  Rosanne feels she has trouble being overly submissive, passive and dependent, particularly with men. She states: ". . .I feel like I can't be in control of myself-I was forced to do things I didn't want to do, feel like I have to. I have this feeling I need to be loved and that I have to really work at that, and do whatever someone else (a man) wants in order to get that. . .I must be very, very, good to be loved. . ." She is still filled with *guilt* and *shame* over the CSA because the boy told her he loved her and she believed him (even though she was only 4-7 years old). She can regress into PTSD symptoms (traumatic states), when she is tired, in pain, or stressed. She has major depression and is on medication which helps control this. She also has some psychosomatic illnesses and multiple health problems. She struggles with weight (obesity) and a negative body image.

- Research Question #5 (Importance of validation factors: age; time; who):
  Non-valildated. The only witness to the CSA was her little girl friend (the perpetrator's sister) who was abused with her. But she was only about 5 at the time, and did not reveal the abuse to anyone.

  Rosanne attempted to disclose the abuse to her mother when it occurred, but she refused to believe her, and continued to leave her with this baby-sitter until her family moved to another state (2 years later). She again attempted to disclose the abuse to mother as an adult, but mother continues to deny that it happened. She has disclosed to her husband and therapist, and both have been very supportive of her.

Case Number 5: Story of Julia K.

Summary of CSA Variables and Relationship to the Research Questions:

- Age of abuse(s):
  4/ 5 years old until about 12, and 16 years old, until 17.

- Abused by (by whom/relationship):
  Dad (at 4/5); 32 y. o. man (at 16).

- Singular/Multiple abuse(s):
  Multiple abuses; two abusers at different times.

- Research Question #1: (Dissociation/memory variables):
  Dissociated, delayed, *somatic* memories of the CSA at 4/5 from dad. Dissociated as coping and continues to automatically dissociate when working with the CSA. *Clearly* remembers most of the abuse(s) at 16.

- Research Question #2 (Belief about link between validation and healing):
  Believes it would have helped back *then* (during the abuse), but not now. Believes that she *now* needs to validate herself, and strongly feels *therapist's* validation is currently important.

- Research Question #3 (Self-esteem variables):
  Still feels *unclean*, *crazy*, *evil*, and *bad* about herself and *not good enough*. Strong feelings of unworthiness and unlovability.

- Research Question #4 (Impact of CSA on her adult life):
  "Suffers" from intrusive PTSD symptoms and hypervigilance , along with: dissociation; depression; obsessive-compulsive behaviors (e.g., compulsive cutting of self; overworking; obsessive worrying); addictions (overeating/overworking/recovering drug abuse); and negative body image.

- Research Question #5 (Importance of age; time; by whom):
  Nonvalidated. No witnesses to abuse with dad. She tried to tell mom, but mom would not allow her to talk about it as a child, and did not believe her when she disclosed as an adult.

Case Number 6: Story of Barbara (Barb) C.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  Younger than 5, believes she was a toddler or younger.

- Abused by (whom/relationship):
  Oldest brother most consistently; dad; other brothers and their friends.

- Singular/Multiple abuse(s):
  Multiple abuses and multiple abusers, with older brother being the primary, most consistent and frequent, abuser (included intercourse and *possible* pregnancy in teens).

- Research Question #1 (Dissociation/memory variables):
  Had completely dissociated memories of her own CSA until early thirties when she discovered that her children (ages 2 ½ and 8 then) were sexually abused by some of the same perpetrators (her brothers and dad). Has delayed, dissociated, *body memories*.

- Research Question #2 (Belief about link between validation and healing):
  Barb strongly believes that validation from her brother (one perpetrator), mother and family of origin is *necessary* for her healing, as well as for her children's (they were sexually abused by these same perpetrators).

- Research Question #3 (Self-esteem variables):
  Thinks of herself as being *crazy, evil,* and *bad.* She believes that these beliefs stem from her childhood sexual abuses, and not being validated by the perpetrators or other family members who knew about them. Reveals *unworthy, not good enough* schemas.

- Research Question #4 (Impact of CSA on her adult life):
  Intrusive PTSD symptoms (nightmares; flashbacks; flooding of affect; somatizations; spontaneous regression to abuse incidences; intense fears, etc.); depression; anxiety and profound loneliness. Re-traumatization of herself through her children. Difficulty trusting her own perceptions of people and situations.

- Research Question #5 (Importance of validation factors: age; time; by whom):
  Nonvalidated. One sister admitted she too was sexually abused as child by the same perpetrator, but recanted her story due to family pressure. Family of origin denies the abuses and says she was *dreaming.*

Case Number 7: Story of Kate V.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  12/13 years old (uncle); 15 years old (step-dad); and raped 18.

- Abused by (whom/relationship):
  26 year old uncle by marriage (mother's sister's husband), and
  Step-father.

- Singular/Multiple abuse(s):
  Multiple abuses; two CSA abusers (another sexual abuse/rape at 18).

- Research Question #1: c, (Dissociation/memory variables):
  She *suppressed,* but *did not* dissociate the CSA memories.
  Uses *fantasy* rather than dissociation.

- Research Question #2 (Belief about link between validation and healing):
  Does not think that validation from uncle is important, but *does feel* that validation from *mother* is most important in her healing.

- Research Question #3 (Self-esteem variables):
  Reports *not* liking herself or her body; reveals an *unlovable* schema.

- Research Question #4 (Impact of CSA on her adult life):
  Depression; unresolved anger felt and acted upon, towards mother and her only brother; eating disorder (obesity); relationship problems; former promiscuity; current sexual dysfunction (low desire-inhibitions about being touched). Was re-traumatized when she was raped at 18 y. o.

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. No witnesses, neither uncle nor dad ever confessed.

Case Number 8: Story of Bonnie G.

- Age of abuse(s):
  About 7 or 8 until 16 years old.

- Abused by (whom/relationship):
  Dad.

- Singular/multiple abuse(s):
  One abuser, multiple abuses (included intercourse). She was manipulated through 'love,' and favoritism, rather than violent coercion.

- Research Question #1 (Dissociation/memory variables):
  Did *not* dissociate from the abuse, but did forget and/or suppress some details of the memories. Did *not* use dissociation as a coping mechanism.

- Research Question #2 (Belief about link between validation and healing):
  She reported belief that validation *is* important, particularly from the family of origin and *mother*. Interestingly, she did not disclose the abuse to mother until *after* her dad's (perpetrator's) death, although she believes that if he were alive today, he *would* admit what he did (validate her).

- Research Question #3 (Self-esteem variables):
  Still feels some guilt and shame over the CSA, because she can't understand why she let it go on for so long. Also has trouble with feeling *worthy,* and with boundaries, as she says she puts everybody else's needs before her own.

- Research Question #4 (Impact of CSA on her adult life):
  Hypervigilance and panic symptoms are current, with sporadic periods of depression, and relationship/intimacy problems.

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated at age 36 (sixteen years after dad's death). She was validated upon disclosure by her younger sister, who revealed that she too was a victim of dad's sexual abuse. Dad inappropriately admitted one time to the CSA, but did not admit that it was abuse, wrong, or his fault.

Case Number 9: Story of Pat K.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  0-5 years old.

- Abused by (whom/relationship):
  Dad, and a group of men.

- Singular/multiple abuse(s):
  Multiple abuse and abusers.

- Research Question #1 (Dissociation/memory variables):
  Has sensory-motor memories *(Body memories)* with delayed-recall (recalled after a *re-birthing* process at 49-50 years of age). Continues to dissociate currently: ". . .I dissociate a lot (leave my body). . ."

- Research Question #2 (Belief about link between validation and healing):
  Feels strongly that validation is important from the therapist: ". . .*repeated* validation. . .because so often I don't believe myself." She would "love it" (validation) from her mom/family of origin, but does *not* believe she'll ever get it.

- Research Question #3 (Self-esteem variables):
  Reports lots of shame, guilt; feels it was her fault. Feels she is a *damaged* person because of the abuse.

- Research Question #4 (Impact of CSA on her adult life):
  Depressed/sad; phobic reaction to penis; dissociates frequently.

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. No witnesses to the CSA.

Case Number 10: Story of Eileen O.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  14 years old.

- Abused by (whom/relationship):
  Unknown male rapist (from behind her-unable to identify).

- Singular/multiple abuse(s):
  Singular abuse (intercourse involved).

- Research Question #1 (Dissociation/memory variables):
  Always remembered but "blocked" it out (supression/denial). Does *not* dissociate, rather is hyper-alert *(Hypervigilant).*

- Research Question #2 (Belief about link between validation and healing):
  Does *not* feel that validation is relevant to her situation as she *knows* (remembers) it happened and her problem was with her family of origin finding out and making too much of it (faulting or belittling *her*).

- Research Question #3 (Self-esteem variables):
  Eileen has negative beliefs about the *world* (and other people) rather than herself (e.g. "The world is *scary* place; life is not fair/just; you can't trust others; people are not dependable," etc.).

- Research Question #4 (Impact of CSA on her adult life):
  Has great difficulty trusting others and sharing her feelings; sexual/intimacy problems; isolates self from others and becomes dependent on one relationship; phobic-like fears of being alone, and of the dark. Has high anxiety; panic-attacks and unusual body symptoms that are possibly psychosomatic.

- Research Question #5 (Importance of validation factors: age; time; who):
  Not validated; no witness to her rape.

Case Number 11: Story of Kathy P.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  10 to 11/12 years old.

- Abused by (whom/relationship):
  Brother who was 3 years older.

- Singular/multiple abuse(s):
  Multiple, with sexual intercourse involved. Only 1 abuser.

- Research Question #1 (Dissociation/memory variables):
  Clear, declarative memories (never forgot except for some details).

- Research Question #2 (Belief about link between validation and healing):
  Ambivalent about whether validation from perpetrator and/or therapist would help in her healing. Definitely feels that validation from *mother* would help.

- Research Question #3 (Self-esteem variables):
  Stopped short of calling herself evil or bad, but did report feeling like a *"fake"*: ". . .I'm not as good as they think I am." Kathy says she plays the *martyr* role (pleases others at expense of self), and that her ". . .self-esteem is next to nothing."

- Research Question #4 (Impact of CSA on her adult life):
  "I've battle with weight all my life" (overweight); obsession with body weight; negative body image; sexual dysfunction; depression;

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. No witnesses to the abuse; perpetrator discounted its importance and said: " . . .it was no big thing."

Case Number 12: Story of Kristie P.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  8 years old until 13 (male, cousin); 13 years old until 18 (brother).

- Abused by (whom/relationship):
  Cousin, who was 5 years older (13 at onset; 18 at end)-abused her and her younger brother (2 years younger than her), alone and together. She and her brother then became mutual abusers to each other from ages 13 until 18 (after the cousin left for military service).

- Singular/multiple abuse(s):
  Multiple abusers cousin; brother; other boys.
  Multiple abuses which included intercourse and two pregnancies (by brother) and two births. One baby girl was adopted immediately after birth, and Kristie never saw her again. The other baby boy she kept, but he died after 7 weeks from genetic defects attributed to incest.

- Research Question #1 (Dissociation/memory variables):
  Most memories were clear, declarative, she says: ". . .I never really forgot. I like to try to block them out." Uses *fantasy* rather than dissociation.

- Research Question #2 (Belief about link between validation and healing):
  She *does* believe that validation has been important in her healing. In therapy, her brother and her were able to admit what they had done and make amends to each other. She felt that this was powerful, and healing. However, she and her cousin (the first perpetrator who probably set the scene for future abuses) have never discussed the abuse. While Kristie believes that validation from the cousin would be important, she also believes that positive reactions from *mother* upon her discovery of the sexual activity between her and her brother, would have had the most healing effect.

- Research Question #3 (Self-esteem variables):
  She feels that she is a *bad* person, and "not good enough." She sees herself as "nutty" (crazy) and not able to "fit in" with systems, other people. She says: ". . .The consequences of this whole sexual abuse stuff, is that I don't feel that I can do anything right. My whole life has been where I've failed at things. . ." She also reports feeling *unclean* and *guilty,* with a great deal of *shame* over the CSA.

- Research Question #4 (Impact of CSA on her adult life):
  She had been diagnosed with a mental disability and is unable to work, stay in school, or drive a car. She "suffers" from: psychotic episodes; depression; phobias; anxiety; obsessive-compulsive disorder (picks skin excessively); body jerking, 'tics;' psychosomatic illnesses; and physical disabilities related to physical abuses from her father.

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated at age 8 and beyond, by her younger brother who was witness to the abuses of the cousin, as he was also abused with her.
  Mother also discovered the sexual activity between Kristie and her brother (after Kristie got pregnant from him at 16). She blamed Kristie and did not talk to her, or instruct either of them about their sexuality, or any of the issues related to their sexual activities.

Case Number 13: Story of Jean-Marie (Jeanne) B.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  9/10 to 16/17; and 12 years old.

- Abused by (whom/relationship):
  Father's best friend (a 40 year old man); and an adult man (the dad of the children she was baby-sitting for).

- Singular/multiple abuse(s):
  Multiple abuses from the 40 year old friend of father; one incident with the dad of children she was baby-sitting for. Molestations with *no* intercourse involved.

- Research Question #1 (Dissociation/memory variables):
  Clear, declarative memories. Numbing of body: ". . .I just froze."
  Does *not* report dissociative episodes.

- Research Question #2 (Belief about link between validation and healing):
  Believes that validation is important in healing from CSA.
  Believes that it would have helped her tremendously if her *parents* had been more effective-would have stopped the further abuses.
  Believes that validation from her *sister* was important (he abused her too).
  Assumes validation from the *therapist,* and views it as essential.
  Does *not* feel that validation from the perpetrator is important now.

- Research Question #3 (Self-esteem variables):
  Had a belief the ". . .*I just don't count,*" because after disclosing the abuse as a child, the parents said they would take care of it, and the abuse continued, leading her to believe that she wasn't important enough for them to do anything about it. After disclosing to her sister, as an adult in her 30s, she found out that her parents actually did confront the man and threaten him harm if he continued to abuse Jean-Marie. This revelation changed her negative thinking about herself.

- Research Question #4 (Impact of CSA on her adult life):
  Sexual dysfunction (inorgasmic with men); intimacy/relationship problems. Re-victimized (sexually molested) as a young woman (20s).

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated by her younger sister after Jeanne-Marie disclosed her abuse as an adult (early 30s). The sister admitted that she too was sexually abused by this same man.
  Disclosure issues: Jeanne believes that if her parents had communicated more openly with her about what they meant when they said "We'll handle it," the abuse could have been stopped from going any further.

Case Number 14: Story of Shann M.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  8 years old; and "preverbal."
- Abused by (whom/relationship):
  Adult uncle (at 8); and her father (preverbal).

- Singular/multiple abuse(s):
  Abused one time by uncle (". . .fondling me in my underpants"); multiple times by father (as infant).

- Research Question #1 (Dissociation/memory variables):
  Memory of uncle, is clear, declarative. Memories of CSA from father are *dissociated,* and *state-dependent* (only come when in an intense, affective state reminiscent of the abuse circumstances).

- Research Question #2 (Belief about link between validation and healing):
  Believes that validation from the *therapist* is very important in her healing.

  Does *not* believe that mother's discovering the abuse would have helped, as mother was *powerless* next to Shann's dominant father. *Does* believe that sisters' validation is important.

- Research Question #3 (Self-esteem variables):
  Shann had more negative feelings/thoughts about the *world* and *other people* rather then herself. She has a strong belief that: ". . .I'm not safe," and views the world in a frightened way. She also reports having poor boundaries, particularly with men, and not being able to say "No." She implied a poor sense of self as separate from others, and a belief in feeling *unworthy.*

- Research Question #4 (Impact of CSA on her adult life):
  Hypervigilance is a dominant issue, as well as the following: depression; anxiety including panic attacks, fears, phobias; sexual dysfunction; weight problems (overweight); and relationship/intimacy issues. Also has difficulties with her boundaries with men.

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. No witnesses to any of the abuses. She never verbally revealed the abuse(s) in childhood, but thinks that her behaviors spoke loudly, though no one noticed: ". . .I had behaviors that. . .I remember rubbing my genitals in public and they're thinking I'm tired. . .when we see our children rubbing themselves, or things like that we usually notice that something's up."

  Her sisters believed her upon disclosure as an adult (age 42/44).

Case Number 15: Story of Cori Y.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  10 years old.

- Abused by (whom/relationship):
  Adult, brother-in-law.

- Singular/multiple abuse(s):
  One abuser; singular physical, sexual episode; multiple *seductive* behaviors. Molestation with *no* intercourse involved.

- Research Question #1 (Dissociation/memory variables):
  Forgot the abuse until her mid 20s-used *repression*, but *not* dissociation.

- Research Question #2 (Belief about link between validation and healing):
  Does *not* believe that validation from her brother-in-law would be useful. *Does* believe that acknowledgment from her family *(mother, father, siblings)* is important: ". . .acknowledgment. . .that it happened and that I was damaged by it. . I keep holding on to the wish that someone will come and at least say they were sorry. . .That might be one of the things that keeps me from healing completely. . ."Also believes that the *therapist's* validation is extremely important: ". . .it was incredibly important to have the therapist validate me."

- Research Question #3 (Self-esteem variables):
  Cory saw herself in childhood, as having very low self-esteem (although she does *not* see herself this way today—since therapy). She says: ". . .I think that the incredible fear and shame that came from that incident pretty much killed any potential that I had of having healthy self-esteem as a child.

- Research Question #4 (Impact of CSA on her adult life):
  Cory said: ". . .it has damaged my life in almost every area. I started drinking at 10. I was an active alcoholic for 30 years. . .I'm on my fourth marriage. I believe that I married an alcoholic each time. All three of my marriages were physical and sexual abusers; this one is not. . ."
  Although she now has a happy marriage, relationships and intimacy issues have mostly been problematic, as was her addiction to alcohol.

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. There was no witness to the CSA. She disclosed the abuse to her mother when she was 48 years old. She did not reveal it earlier because, as she said to her mother: ". . .You wouldn't have been there for me," which her mother "sort of admitted was true." Her present husband and daughters know about the abuse and are supportive.

Case Number 16: Story of Sandi M.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  4/5 until 16; 13/14 for about 6 months; 15/16 in high school.

- Abused by (whom/relationship):
  Main abuser was step-father (from about 4 to about 13/14); Friend's father (at 13/14 years old); and a high school teacher (at 15/16 years old).

- Singular/multiple abuse(s):
  Multiple abuses by step-father that included sexual intercourse and pregnancy when she was 12 ½, which continued after the birth of the baby (without intercourse), until she left home at 16.

  Multiple abusers including her friend's father when she was around 13/14, which lasted for about 6 months; sexual intercourse was involved. A high school teacher also fondled and propositioned her, one time.

- Research Question #1 (Dissociation/memory variables):
  Most of the CSAs are pretty clear, but she says: ". . .There were 'blocks' of time that I don't remember. . ." (These' blocks' of time are probably when she *dissociated.)* She says: ". . .I really did go through some heavy *dissociation* during the actual abuse. . ."

- Research Question #2 (Belief about link between validation and healing):
  Sandi believes that validation from the *perpetrator* is important for healing, she says: ". . .it would have helped for him to admit that he had done it, and that it was wrong. I think it would have helped it go by quicker, smoother."

  She also believes that validation from the *therapist* was very instrumental in her healing.

- Research Question #3 (Self-esteem variables):
  From the time Sandi left home (16 years old) until she finally disclosed to a therapist (around 40), she reports having had very low self-esteem and a poor self-image. ". . .I thought I was a *bad* person. . .I believed that I deserved everything that I got. I absolutely took *guilt* for everything that happened. . .it was his idea initially, but I thought I could have stopped it . . .it wasn't unpleasant. . .and even though I dreaded it, I didn't feel real bad that it happened, so I figured 'there must be something wrong with me'.. . I was a very passive person; a different person than I am today. It's almost like talking about a different lifetime."

- Research Question #4 (Impact of CSA on her adult life):
  Sandi reported having had serious problems related to the CSA. like: intrusive PTSD (flashbacks, etc.). She's had multiple marriages and was unfaithful in them and promiscuous. In her 20s during stressful times, she'd *dissociate* (mentally leave). She still uses eating as a stress reliever and struggles with weight (overeating). Currently, she is in a "wonderful relationship" with her present husband and has few of her previous symptoms.

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. No witnesses although she feels that her mother knew. She says: ". . .I don't know how she just couldn't know. . .I just know that there had to have been signs that she knew, but she never said anything and she never acted like she knew. . ."
  Sandi did not disclose the CSA until she was an adult (36 y. o.), after her mother had died: ". . .I think it was my mother's passing that released something in me that said, 'now I can take care of myself.'" She first disclosed to a roommate and then to a therapist, and both were very supportive.

Case Number 17: Story of Diane B.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  Early grade-school, around 7/8 until 13 (when the perpetrator died).

- Abused by (whom/relationship):
  Adult neighbor, father of her male friend (who was also sexually abused by this man).

- Singular/multiple abuse(s):
  Multiple abuses by the same perpetrator. Sexual intercourse was involved. The man sexually abused Diane and her friend (his son) separately and together. Violent threats, coercion, and cruelty were used.

- Research Question #1 (Dissociation/memory variables):
  Repressed and *dissociated* memories of the CSA, with delayed-recall.

- Research Question #2 (Belief about link between validation and healing):
  Diane believes that validation from the *perpetrator* and his son is important in healing. She says that she has a "fantasy" that she will be able to talk to the son about what happened to her/them, and he would affirm that his father did this, and that it was wrong.

- Research Question #3 (Self-esteem variables):
  Diane had some very negative beliefs about herself for a long time: She believed she was *crazy* and was on a "psychotic edge." She indicates that she no longer feels that way today.

- Research Question #4 (Impact of CSA on her adult life):
  Currently she has some sleep disturbances; negative body image; eating disorder (obesity); food addictions; shame and guilt over the abuse, her genitals, and enjoyment of sex; major depression; intimacy/relationship issues.

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated. The son (fellow victim and witness) did *affirm* that it happened, but he did *not* affirm that it was his father's fault. Instead he *assumed* that she had initiated the sexual activity and liked it. Medical findings also indicated that she had "suffered" early, forced, sexual abuse.

Case Number 18: Story of Lecia H.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  6 or 7 until about 30 years old.

- Abused by (whom/relationship):
  Older brothers (5 and 7, and 20 years her senior).

- Singular/multiple abuse(s):
  Multiple abuses by brothers, with one brother continuing to sexually abuse her after she was married with two children (to age 30). Sexual intercourse was involved as well as coercion and violent threats.

- Research Question #1 (Dissociation/memory variables):
  Dissociated, repressed, memories, with delayed recall. Some memories are vivid (at 6 or 7 years old), others are *fragmented.* She began to remember and disclose recently in therapy (38 years old) which she began because of problems with her mother, that were thought to be unrelated to the CSA.

- Research Question #2 (Belief about link between validation and healing):
  Does *not* believe validation from perpetrator or her family would help her now because she believes that they might possibly hurt her and/or her present family and has no hope of validation from them. She *does* believe

that validation from the *therapist* is important in her healing: ". . .It's very important because it's made me feel a whole lot better since we've been talking about it in therapy." Lecia also values the validation she has gotten from her *husband.* (He believes her and is supportive.)

- Research Question #3 (Self-esteem variables):
  She said she felt *crazy, bad, evil* and a *sinner.* Lecia has excepted the *introjects* of her family of origin and believes that ". . .I'm nobody and . . .it was my fault." She has an *unworthy* schema.

- Research Question #4 (Impact of CSA on her adult life):
  Lecia has intrusive PTSD symptoms (reoccurring nightmares of the abuses; flashbacks; regression), and wakes up finding herself beating on her husband and knocking him out of bed (as if he were the brother abusing her right there and then). She also dissociates frequently and has *state-dependent* regressive periods; high anxiety, guilt and shame.

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated. Her little friends and cousins were witnesses to the CSA when it first was initiated by the brothers. Mother also was also aware of it, and blames Lecia for it: ". . .well you let this happen to you with your brother and you could've kept this from happening, and you're better than that; you were taught better than that. . ."
  Lecia has only *disclosed* recently to her therapist and husband; both are very supportive.

Case Number 19: Story of Elaine K.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  9; 10; 11; and 12 years old.

- Abused by (whom/relationship):
  Elderly man (stranger in a movie theater) when she was about 9; older brothers (13, 14, 15 years old) of girlfriend when she was 10; teen-age boy on school grounds when she was about 11; and 14 year old neighbor boy when she was between 10 and 12 years old. Intercourse was involved with the latter.

- Singular/multiple abuse(s):
  Multiple abusers; multiple abuses.

- Research Question #1 (Dissociation/memory variables):
  She says that she always remembered the memories of the CSA but compartmentalized them which implies more of a *repression* than a dissociation. But she did remember times when she was a child, and in a dissociated state, she says: ". . .I remember just living like in a fog, not being cognizant of anything. . ."

- Research Question #2 (Belief about link between validation and healing):
  ". . .It would have absolutely made a difference in my healing, if my *mother* had validated me. . .if she would have believed me. . .if she had protected me."

- Research Question #3 (Self-esteem variables):
  Elaine believed that she was *evil, bad, rotten to the core,* and *deserved* the abuse. She thought: ". . .I'm no good; I'm evil; I'm a whore; I must be attracting these boys to me." She currently knows that that thinking was inaccurate, and does *not* take the blame for the abuses done to her. ". . .I was a child, I deserved protection. . .this should never have happened to me, and I didn't deserve it; there is no black core within me. . .I'm real clear on that. . ."

- Research Question #4 (Impact of CSA on her adult life):
  Elaine has used food to cover up her hurt feelings, and now continues to have a 'mild' eating disorder (weight problems/ gorging). She was re-victimized as a child by older boys, and as an adult through the sexual abuses of her children.

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. There were no witnesses to her CSA. Mother was in the theater when the older man put his hands down her pants and masturbated her, but did not appear to notice.

  Elaine has never disclosed to her father or mother. She disclosed to her husband and sons (who themselves were sexually abused by a male, baby-sitter) when she was 54 years old, after the birth of her granddaughters. She also disclosed to her sisters. They are all very supportive of her.

Case Number 20: Story of Louise D.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  10 years old.

- Abused by (whom/relationship):
  20 year old brother.

- Singular/multiple abuse(s):
  Multiple abuses; singular abuser. Sexual intercourse *was* involved.

- Research Question #1 (Dissociation/memory variables):
  Louise *dissociated* during much of the abuse, she says: ". . .I wasn't always there during the abuse. There were times when I could feel myself go away. . .I could put it away and *dissociate* from it, and be able to function and not have to think about it. . .I think I always remembered the abuse, but the dates and times are *fuzzy*."

- Research Question #2 (Belief about link between validation and healing):
  Louise strongly believes that *mother's* validation and actions toward the perpetrator were extremely important and stopped the abuse from continuing. She also believes that it is of ". . .utmost importance that the *therapist* believes the client's account of the abuse. . .", and that this is necessary for the client to heal from it.

- Research Question #3 (Self-esteem variables):
  ". . .every once in awhile that still surfaces (feelings of being *unlovable),* because of what happened with my brother. . .I felt *used.* And when people are *used* in my mind it's probably the greatest degradation. Then people become objects, and aren't lovable because they're *things.* . ."

- Research Question #4 (Impact of CSA on her adult life):
  Louise still has problems with a negative body image; and intimate/sexual relationship. She is in the ministry and has sworn a life of chastity that she admits she may have chosen because of the childhood sexual abuses. Louise was re-traumatized recently and had severe depression and guilt after discovering that her brother had also sexually abused her nieces (his daughters). She had suspected abuse, but could not find any evidence of it, at the time. She states: ". . .I felt I had failed. I made an attempt to see if the kids were O.K., and I had failed at it. . ."

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated. Sister disclosed as a child to *mother,* who immediately believed her and Louise. Mother confronted the brother and made him move out (go into military service). Louise also recently confronted her brother (the perpetrator) after it was disclosed that he had been sexually abusing his daughters. He confessed, and asked for forgiveness.

Case Number 21: Story of Catherine D.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  6 and 15 years old.

- Abused by (whom/relationship):
  Older neighbor man when she was 6; High school janitor (20s) when she was 15. Sexual molestation, with *no* intercourse.

- Singular/multiple abuse(s):
  Multiple abusers; two abuse experiences.

- Research Question #1 (Dissociation/memory variables):
  Clear, declarative memories of the CSA.

- Research Question #2 (Belief about link between validation and healing):
  Believes that her *parents'* validation and the *therapist's* validation are very important in the healing process. ". . .My parents validation was very important, the fact that they didn't blame me. . .and my therapist. She has really been important. . ."

- Research Question #3 (Self-esteem variables):
  Catherine did feel *guilty* for the abuses, but does not now. She did *not* express any negative self-statements.

- Research Question #4 (Impact of CSA on her adult life):
  She had PTSD symptoms (nightmares, fears related to the abuse) in childhood, but not as an adult. Had an eating disorder (ate to cover up her body), and currently continues to struggle with weight; and a negative body image.

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated. Catherine was validated at 6 y. o. by her 8 y. o. sister who witnessed the abuse. She was also validated during the second abuse, by the janitor (second perpetrator) who admitted the abuse while he was doing it, and stopped himself from going any further.

  Catherine's sister disclosed the abuse to their parents and they acted on it immediately and protected her from further abuse. Catherine also told her mother about the abuse by the Janitor and mother again believed her and took action to alleviate any further abuse by him.

Case Number 22: Story of Gail S.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  6 until 16; and 11-12 years old.

- Abused by (whom/relationship):
  Father at ages 6 to 16; roomer (dad's friend) at age 11 or 12.

- Singular/multiple abuse(s):
  Multiple abuses by father and roomer, with sexual intercourse involved. Coercive, threatening, violent abuse.

- Research Question #1 (Dissociation/memory variables):
  Never forgot: *clear, declarative* memories. .

- Research Question #2 (Belief about link between validation and healing):
  Gail believes that validation is very important in her healing, from her *sister*, her *husband* and children, and her *therapist.*

- Research Question #3 (Self-esteem variables):
  Gail used to hate herself and think she was *bad, evil,* and *unclean.* She also had consuming guilt and shame because she didn't try to stop the abusers, but currently claims to really love herself. She says: ". . .*I really like, love me!*. . .and I don't believe it was my fault, any of it. Probably because I know it happened to my sister, and my brother, and maybe even two other sisters. . ."

- Research Question #4 (Impact of CSA on her adult life):
  Has had intrusive PTSD symptoms (flashbacks, nightmares, etc.) in the past, but not recently. Recovering from alcohol dependency; still has some sleep problems (related to feeling unsafe-the abuses happened at night); and "battles" with weight (overweight).

- Research Question #5 (Importance of validation factors: age; time; who):
  Validated. She was validated as an adult, by her sister and brother (who were also victims of father's sexual abuses).

  Gail tried to tell her mother about the abuse (as a child), but mother denied it, and told Gail that she was dreaming. She disclosed to her husband and siblings as an adult and they believed her and are supportive.

Case Number 23: Story of Marlene S.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  13 years old, to adulthood (early 30s).

- Abused by (whom/relationship):
  Boyfriend, who was 6 years her senior.

- Singular/multiple abuse(s):
  Multiple abuses; singular abuser. Sexual intercourse *was* involved, with threats, coercion and violence.

- Research Question #1 (Dissociation/memory variables):
  Clear, declarative memories. ". . .I always remembered it, but I have forgotten some of it, only because my life has turned around for me, and I no long *need* to remember it." *No* dissociation was talked about.

- Research Question #2 (Belief about link between validation and healing):
  Marlene does *not* believe that validation from the *perpetrator* is important in her healing. She *does* however believe that *protection* by her *mother* and *father* could have prevented the abuse and consequent symptoms.

- Research Question #3 (Self-esteem variables):
  Marlene felt extreme *guilt*; *unlovability* and *unworthiness* related to the abusive relationship with the perpetrator (who subsequently became her husband and father of her 5 children). After she divorced him and remarried, she began to change her feelings about herself and increased her self-esteem. She says: ". . .I like myself and love myself now."

- Research Question #4 (Impact of CSA on her adult life):
  During the abuse which started in childhood (13 years old) and ended when she was a young adult (30s), Marlene had *boundary* issues with the perpetrator. She was overly sympathetic with him despite the fact that she was depressed, anxious and "terrified" of him (his moods/violent behaviors). She developed severe eczema (psychosomatic symptoms) which she was hospitalized for numerous times, that dramatically cleared up after she divorced him. Marlene does not report any current psychological symptoms that she believes are related to her CSA. She attributes this in part to her present happy marriage (of 18 years), and supportive relationships.

- Research Question #5 (Importance of validation factors: age; time; who): *Validated.* Her mother found her "panties" after she had had sexual intercourse with the perpetrator, and confronted her about it. Marlene's parents began to witness the perpetrator's violent temper, and made some very weak attempts to separate them, but were too embroiled in their own bitter divorce to pay much attention to what was happening to their daughter. Marlene was terrified of this man, but felt very sorry and responsible for him. She ended up getting pregnant at 15 and married him. Marlene was finally able to divorce him in her early 30s, with the help of supportive fiends. She disclosed the abuse to her current husband who has been very loving and supportive of her.

Case Number 24: Story of Gina N.

Summary of Information and Relationship to the Research Questions:

- Age of abuse(s):
  8 until 16; and 13 until 16 years old.

- Abused by (whom/relationship):
  Brother, three years older; boyfriend, 4 years older.

- Singular/multiple abuse(s):
  Multiple abuses by brother and boyfriend. Included *sexual intercourse* with brother, and *rape* by boyfriend. Emotional manipulation and flattery used by brother; force, coercion, and violence used by boyfriend.

- Research Question #1 (Dissociation/memory variables):
  Gina remembers that it happened, and on a pretty regular basis, so most memories were *clear, declarative.* But she also says that: ". . .I've completely blocked out certain memories of certain times that it happened." There was likely some *repression* rather than dissociation that occurred.

- Research Question #2 (Belief about link between validation and healing):
  Gina believes that validation from the *perpetrator* is of central importance in her ability to heal from her CSA. She states: ". . .yes, it would help a great deal! I feel if we could ever sit in a room and have tears, and he would say: 'Gina I'm so sorry, I don't know why I did that.'. ."Oh, absolutely, that would make me feel validated, because who else could validate those feelings other than the person who hurt you?. . ."

- Research Question #3 (Self-esteem variables):
  Gina says that she felt *ashamed* of herself, and *dirty*. She still "struggles" with many of these feelings. She says that she has had problems with low self-esteem and feelings of unlovability most of her life.

- Research Question #4 (Impact of CSA on her adult life):
  Gina has difficulties in her sexual relationship with her husband which she attributes to the CSA. She has a phobic reaction to having her breasts touched. She also reports having difficulties with depression; anxiety, including panic attacks and hypervigilance. Boundary, dependency issues are prevalent and she "battles" with weight problems (obesity); and a negative body image.

- Research Question #5 (Importance of validation factors: age; time; who):
  Nonvalidated. There were no witnesses to the sexual abuses with her brother or the rape by her boyfriend (when she was 14/15). She says: ". . .No one ever witnessed the abuse, or even suspected what we were doing." She did reveal the abuse to her *mother* when she was 16, but her mother, thinking that she was protecting her son and daughter, told her daughter not to tell her step-dad. The perpetrator was never confronted and nothing was ever done about the abuse. Gina struggles with herself over whether she should reveal the abuse since her brother now has a young daughter and she worries about his abusing her.

Case Number 25: Sharon D.

Summary of Information and Relationship to the Research Questions

- Age of abuse(s):
  Doesn't remember exact age. Thinks she must have been very young, but does know that it lasted until she was 15 or 16 years old.

- Abused by (whom/relationship):
  Father.

- Singular/multiple abuse(s):
  Multiple abuses; singular abuser. Sharon did not want to go into the detail of the abuse or if intercourse was involved, but did imply that it was, when she states:". . . I was hospitalized twice over 30 days. . .because the memories of the abuse were so horrible and overwhelming that I needed to be in a hospital. I guess the abuse was rather violent. . .

- Research Question #1 (Dissociation/memory variables):
  Sharon reported having *dissociated* memories, with delayed-recall. She was 18-19 when she began to recover the memories through nightmares, and flashbacks. She began to remember the early abuse after being hospitalized for severe depression and suicide attempts. She said she had been diagnosed with a severe Dissociative Disorder.

- Research Question #2 (Belief about link between validation and healing):
  Sharon does *not* feel that validation from the *perpetrator* is important in her healing. She states:". . .My dad did admit it. I called him from the hospital and he did admit it. He's apologized more than once for what he did. But it didn't help. It didn't matter. I think the only thing that would have helped is if it hadn't happened at all. . .that it happened once was enough, it still affects me. . ." She also states that she got her validation from outside the family ". . .I had validation from school, that's where I put all my energy, into school and into any extracurricular activities I learned. I became a high achiever."

- Research Question #3 (Self-esteem variables):
  Sharon was not specific about how her self-esteem was affected by the abuse, but she did state: ". . .I totally dissociated the abuse, so I don't remember if I had any negative beliefs about myself during that time. Once I remembered the abuse, I never thought I deserved it, but I was very *ashamed, angry* that it happened to me. . .It was just *crazy.* I think I knew it was his fault and not mine, but it still affected me, the things he told me still hurt. . .I don't think I had a lot of negative beliefs about myself because I was very popular at school, always at the head of my class, in charge of everything. Any kind of activity, if I competed I always won. . ."

- Research Question #4 (Impact of CSA on her adult life):
  Sharon reported having extremely intrusive PTSD symptoms and extreme dissociation, depression and suicide attempts. She was hospitalized twice for 30 days because of the memories of the abuse where so "horrible" and "overwhelming." She says that the abuse had affected her sexuality. She totally avoided sex, hated it and felt it was *dirty* and *painful.* It continues to affect her relationship with her husband, who is very angry at her father and prefers that she not talk to her dad, or ever see him. She says: ". . .My husband's still very hurt over what he did to me. That's his right to be hurt over it, but I have a right to work through it, and decide what kind of relationship I want to have with my father now. . . Today I'm *not* still angry at him. But it's affected my relationship with my sister very much. . ."

- Research Question #5 (Importance of validation factors: age; time; who): *Validated.* ". . .My dad did admit it. . .mom did walk in on it once, but I kind of covered up for him...when I told my sister, she told me 'Well yeah, of course.' She always remembered the abuse. . .she confirmed it all. But once I started having the flashbacks, I knew about the abuse and didn't need my sister to validate it, because I knew it happened. . .my aunt (father's sister-words added) said 'yes, it happened, because all of us had the same abuser, my *father*."

Summary of the Results

The MANOVA Findings

No significant differences were found between the two groups: (validated versus nonvalidated) conducting a MANOVA on the data gathered from the DES, IES, and SERS [F (8)-.476, p=.849], probably due to limited power (a possible Type II error: failing to obtain an effect when one is present). This is contrary to many of the results of the other research instruments (personal interview and case study narratives), which do indicate percentage differences between the two groups.

The Findings of the Personal Interview and Case Studies

The variables related to all of the research questions which were gleaned from the personal interview and case studies were quantified, put into descriptive statistics, and reported in tables as percentages. The results can be found under each research question above, with a graphical summary of their responses displayed in Table 11.

Some interesting and important findings related to the research questions are summarized below:

Research Question 1:

Differences in dissociated memories of CSA (which are correlated with dissociation variables), between the two groups (taken from Table 2):

- Nonvalidated reported much larger percentages of "Body memories" (somatic memories) than validated (nonvalidated=38.5%; validated=0%).
- Nonvalidated reported moderately higher incidences of dissociated memories than validated (38.5% versus 25%), and substanially higher repressed memories than validated (53.8% versus25%).
- Nonvalidated reported a higher percentage of delayed-memories (associated with dissociation), then validated (23.1% versus 16.7%).
- Validated reported substantially higher incidences of clear, declarative memories (contrary to dissociation), than nonvalidated (75% versus 38.5%).

Research Question 2:

Differences about the belief in the necessity of validation through corroborative evidence (how, what, and from whom) are summarized below (taken from Tables 3):

- There were few substantial differences between the two groups in the belief that validation through corroborative evidence is necessary for the remediation of their CSA symptoms (validated=75%; nonvalidated=77%). The majority expressed the belief that validation is necessary.
- A high percentage of both groups believe that validation from the therapist is important (validated=91.7%; nonvalidated=92.3%).
- A high percentage from both groups also believe that validation from mom is important (validated=83.4%; non-valiedated=53.8%).
- Unexpectedly, a higher percentage of the validated group believe that validation from a sibling (particularly a sister) is important (validated=50% versus nonvalidated 30.8%).

- Surprisingly, a higher percentage of the validated believe that validation from the perpetrator is important (validated=58.3%, versus nonvalidated=38.5%).

Research Question 3:

Self-esteem variables are summarized below (taken from Table 4):

- Nonvalidated participants had a higher percentage of negative self-statements and beliefs (correlated with low self-esteem) on all measures except shame, where both were high, with validated being moderately higher (validated=75% versus non-valided=69.2%).

- The nonvalidated group reported more crazy-bad-evil statements (non-valiated=46.2%; validated=41.7%) and more "other negative words" (nonvalidated=53.8% versus validated=41.7%).

- The nonvalidated group reported a large percentage difference in the belief that they "deserved the abuse" (nonvalidated=61.5% versus validated=25%), and a moderate difference in guilt for the CSA (nonvalidated=61.5%; validated=50%).

- Nonvalidated participants had a large difference in their expression of negative self-statements (nonvalidated=84.6% versus validated=66.7%).

- Surprisingly, the nonvalidated group also had a much higher percentage of positive self-statements (15.4%) than the validated group (8.3%).

- Validated participants were substantially higher in the belief that they were not to blame for their CSA (validated=66.7% versus nonvalidated=46.2%).

Research Question 4:

The impact that the CSA has had on their adult lives: PTSD symptoms; affective symptoms; personality/behavior problems; and their coping skills, are summarized below (taken from Tables 5, 6, 7 and 8):

- The nonvalidated group had a higher percentages for intrusive and numbing symptoms associated with acute PTSD (nonvalidated=76.9%, and 53.8% versus validated=58.3% and 41.7%).

- The validated group had a higher percentage of increased arousal (hypervigilance) more frequently associated with chronic PTSD (validated=58.3% versus nonvalidated=38.5%).

- The nonvalidated group had higher percentages with all the affective symptoms (e.g., depression, anxiety) than the validated group, with the exception of obsessive-compulsive symptoms

- Validated participants reported a substantially higher degree of obsessive-compulsive symptoms (validated=25% versus nonvalidated=0%).

- The nonvalidated group had large percentage differences (higher incidences) for the following: eating disorders; obesity-weight; multiple health problems; dependency; acting out. They had moderate differences with pain; sexual dysfunction; and promiscuity (see Tables 6, 7).

- Both groups had high percentages of relationship/intimacy problems (nonvalidated=76.9% versus validated=75%), with nonvalidated being only slightly higher.

- Both groups had high percentages in regard to negative body image, with validated being slightly higher (validated=58.3%; nonvalidated=53.8%).

- Important differences in some emotional-focused coping strategies were reported by the validated group: denial (Validated=16.7%; nonvalidated=7.7%); avoidance (Validated 58.3%; nonvalidated=7.7%); other (validated=33.3%; nonvalidated=15.4%).

- Important differences in some problem-focused coping strategies were reported by the validated group: positive social support (validated=91.7%; nonvalidated=84.6%); logical methods (validated=83.3%; nonvalidated=76.9%); Acceptance (validated=41.7%; nonvalidated=7.7%); Spirituality/Transcendence (validated=50%; nonvalidated=38.5%); other (validated=50%; nonvalidated=15.4%).

Research Question 5:

The validation variables of age, time and by whom, are summarized below (taken from Tables 3 and 9).

- The validated sample consisted of 12 of 25 participants (N=12).

- Fifty percent (50%) were not validated until they were middle-aged adults (between 30-50 years), with 33.3% validated between the ages of 6-12, and

0% between birth and 5 years of age (Note: 24% reported being sexually abused at age five or under).

- Half were validated during the abuse or shortly afterward (50%); 25% were validated upon disclosure as an adult, and only 16% upon disclosure as a child, with the smallest percent being validated years later (8.3%).

- Nine of the 12 participants (75%) were validated by a sibling (8 of those were sisters), who was also sexually abused by the same perpetrator.

- Five (5) of the 12 participants (41%) were validated by mom, and four (33%) by dad (two perpetrators and two non-perpetrators).

- Four (4) of the 12 participants were validated by the perpetrator (33.3%): one by a brother perpetrator; one by a male non-relative perpetrator; and two by a dad perpetrator.

- Seven (7) of the perpetrators were the natural fathers (28%); three were step-fathers (12%) with a total of 40% being in the father role (combined natural and step-fathers). Of those perpetrators, only one (1) admitted the abuse to both the victim and others (2.5%) (see Table 9).

Tabular Summaries

A tabular summary of the individual case study responses to the research questions can be found in Table 11. A summary of the important differences between the validated and nonvalidated group related to the research questions, are displayed in Table 12.

Table 11

Summary of Individual Case Study Responses to the Research Questions.

Case # *Name*	Question #1 Variables: *Dissociation; Memory*	Question #2 Variables: *Beliefs about Import of validation; who needs to validate them*	Question #3 Variables: *Self-esteem; See self as: crazy, bad, evil Negative Beliefs & self statements*	Question #4 Variables: *PTSD-like: Intrusive; Hypervigilent; Affective; Behavioral*	Question #5 Variables: *Age of Validation; Time of validation; Who validated*
Case #1 Geraldine N.	Clear; Repressed	Yes: Mom; Therapist; Ambivalent: Sister	*Inherited defect; crazy, bad; unclean;* Not good enough	Intrusive PTSD; Neg body; Eating Dis; Weight; OCD, Sex Dysfunction	VALIDATED 35/40 y.o.; delayed; outside treatment; sister (also victim)
Case #2 Jean W.	Clear; Suppressed	*No*: not *now* (perpetrator); needs to validate *self*	*Hates* self; *rotten* person	Depression; Neg body; Eating Disorder; Overweight	*Not* validated
Case #3 Rose N.	Clear	Yes: Mom; Therapist; Sisters	*Unworthy; Unlovable;* Stupid	Intrusive & Hypervigilent PTSD; Relationship Intimacy; Depression; Neg body; weight	VALIDATED Young child; *during* abuse; sister (also victim)
Case #4 Rosanne K.	Repressed; *some* Dissociated	*No*: not now (parents & perpetrator); Yes: Therapist *& back then*	Strong *Unlovable Schema*	Numb, Dissociative PTSD; Overly dependent; Boundaries; Depression; Psychosomatic; Overweight; Neg body; Mul Health; Pain	*Not* validated
Case #5 Julia K.	Body; Dissociated	No: not now (parent & perpetrator); Yes: Therapist *& Self & back then*	*Unclean; Crazy; bad; evil;* Not good enough; unworthy; unlovable	Intrusive & Hyper PTSD; Dissociative-Numb; Depression; OCD; Self-mutilation; Addictions; Negative body; Overweight	*Not* validated
Case #6 Barb C.	Body; Dissociated	Yes: Perpetrator; parents, siblings; Therapist	*Crazy; bad; evil;* unworthy; *Not good enough.*	Intrusive PTSD; Depression; Anxiety; Relationship-Intimacy	*Not* validated

(Table 11 continues)

Case # *Name*	Question #1 Variables: *Dissociation; Memory*	Question #2 Variables: *Beliefs about Importance of validation; who needs to validate them*	Question #3 Variables: *Self-esteem; See self as: crazy,bad,evil; Neg. Beliefs & self statements*	Question #4 Variables: *PTSD-like: Intrusive; Hyper-alert: Affective; Behavioral*	Question #5 Variables: *Age of Validation; Time of validation; who validated*
Case #7 Kate V.	Clear & Suppressed	Yes: Mother & Therapist; No: Perpetrator .	Does *not* like self or body; *unlovable*	Depression; Eating .Dis; Weight; Promiscuity; Relationship-Intimacy; Sex dysfunction	*Not* validated
Case #8 Bonnie D.	Clear & Suppressed	Yes: Mom/Family of origin; Therapist; Ambivalent: Perpetrator (dad)	Guilt; shame; *Self-blame; Unworthy*	Hyper PTSD; Anxiety; Depression; Relationship-Intimacy;	VALIDATED 36 y. o.; Delayed disclosure; *After* perpetrator died; Sister (also victim)
Case #9 Pat K.	Sensory-Body	Yes: Mom; Family of origin; & *repeatedly* from Therapist	*Damaged* person; guilt; Self-blame; *shame.*	Depression; Phobia/penis; Dissociation	*Not* validated
Case #10 Eileen O.	Clear & Suppressed	No: Not relevant	Neg beliefs about the *world: Scary* place; *not safe; unjust;* people undependable	Depression.; Anxiety; Relationship-intimacy; trust; Boundaries, identity; Psychosomatic	*Not* validated
Case #11 Kathy P.	Clear	Yes: Mother; Ambivalent: Perpetrator & Therapist	Feels like a *Fake;* esteem next to nothing; d*iscounts Self; Not good enough*	Depression: over weight; Negative body image; Sexual dysfunction	*Not* validated
Case #12 Kristie P.	Clear	Yes: Mother; Perpetrator; Therapist	*Bad; nutty; unclean;* not *normal;* guilt; shame *Self-Blame; unlovable; not good enough*	Psychosis; Hyper PTSD; depression; anxiety; OCD; Self-Mutilation; Relationship-intimacy; Psychosomatic; physical disabilities	VALIDATED 8 y. o. and beyond; During abuse; by brother (a victim and *perpetrator*); 16 y .o. by mother

(Table 11 continues)

Case # *Name:*	Question #1 Variables: *Dissociation; Memory*	Question #2 Variables: *Beliefs about: Importance of validation; Who needs to validate them*	Question #3 Variables: *Self-esteem; See self as crazy,bad,evil Neg. beliefs & self-statements*	Question #4 Variables: *PTSD-like; Intrusive; Hyper-alert; Affective; Behavioral*	Question #5 Variables: *Age of Validation; Time of validation; Who validated*
Case #13 Jean-Marie B.	Clear	Yes: *Mother, father, sister;* Therapist *No: Perpetrator*	*Discounted* Self; changed to *positive* Self-beliefs *after* validation	Sexual dysfunction; Relationship-Intimacy	VALIDATED 30s; after disclosure; Sister (also victim)
Case #14 Shann M.	(2 abuses) 1=Clear 1=*Body-Dissociated*	Yes: *Sisters;* Therapist; *No: Mother*	Negative about *world: scary, unsafe;* people: undependable; Self: *unworthy*	Depression; Anxiety; Sex dysfunction; Overweight; Relationship-Intimacy; Boundaries with men	*Not* validated
Case #15 Cori Y.	*Repressed*	Yes: *Mom, dad, siblings;* Therapist; *No: Perpetrator*	V. low self-esteem as child; high now due to therapy	Recovering alcoholic; Relationship -Intimacy	*Not* validated
Case #16 Sandi M.	*Dissociated*	Yes: *Perpetrator (dad);* Therapist	*Past: Negative* felt self was *bad;* guilt; self-blame. *Now:* changed life: *positive* self-image	*Past:* Intrusive PTSD; multiple marriages; promiscuity; dissociation. *Now:* Eating disorder; overweight	*Not* validated
Case #17 Diane B.	*Dissociated; Repressed*	Yes: *Perpetrator;* and *Son* of perpetrator (fellow victim); Therapist	*Past:* felt Self was *crazy; psychotic. Now:* Positive self-appraisal since Tx.	Depression; sleep disturb; eating disorder; overweight; Neg body image; guilt/shame over genitals, sex; Relations-intimacy	VALIDATED 7/8 y.o. child *during* the abuse and as *adult* by male friend (also victim-son of perpetrator); adult: through medical doctor
Case #18 Lecia H.	*Dissociated; Repressed*	Yes: Therapist; No: Perp or mother, brother: afraid of further abuses	Believes she's: *Crazy, bad, evil, sinner; Unworthy*	Intrusive PTSD; Anxiety; Dissociation; guilt/shame	VALIDATED 6/7 y. o. by witnesses (child friends); and mother (who blames her)

(Table 11 continues)

Case # *Name*	Question #1 Variables: *Dissociation; Memory*	Question #2 Variables: *Beliefs about Importance of validation; who needs to validate them*	Question #3 Variables: *Self-esteem; See self as: crazy,bad,evil; Neg. Beliefs & self statements*	Question #4 Variables: *PTSD-like: Intrusive; Hypervigilant; Affective; Behavioral*	Question #5 Variables: *Age of Validation; Time of validation; who validated*
Case #19 Elaine K.	*Repressed; Dissociated*	Yes: *Mother*	*Past: Evil, rotten; deserved abuse. Now:* Positive self-beliefs since therapy	Eating disorder; weight problems	*Not* validated
Case #20 Louise D.	*Dissociated*	Yes: *Mother;* Therapist	Feels *used;* and sometimes *unlovable*	Negative body image; relationships; sexual intimacy; guilt over nieces' abuse	VALIDATED 10 y.o. *during* abuse; by sister (also victim) and mother (who stopped it-protected her); Years later by *perpetrator*
Case #21 Catherine D.	Clear	Yes: *Parents;* Therapist	*Past:* Guilt and Self-blame; Short period of PTSD. *Now:* Positive Self-esteem since therapy	Eating Disorder; Weight; Negative body image Eating Disorder; Weight; Negative body image	VALIDATED 6 y. o.; *during* abuse by witness: sister; 15 y. o. *during* abuse by *perpetrator*
Case #22 Gail S.	Clear	Yes: *Sister; Husband; Children;* Therapist	*Past: Bad, evil, unclean;* guilt, shame; *Now:* likes/loves self since therapy	*Had:* Intrusive PTSD; *Now:* Recovering alcohol; sleep dis; hyper-alert; weight	VALIDATED Adult, years later by sister and brother (also victims)
Case #23 Marlene S.	Clear	*No:* Perpetrator; Yes: *Mom/dad*	*Past:* Guilt; *unlovable; unworthy. Now:* Positive Self-esteem since new marriage	*Past: Depress;* Anxiety; Hyper PTSD; Psychosomatic; Boundary identity; *Now: none* reported	VALIDATED 13 y. o. *during* the abuse; *Mom* found evidence of sexual abuse
Case #24 Gina S.	*Mostly* Clear; some *Repressed*	Yes: Perpetrator	*Ashamed* of Self; *Dirty; Unlovable;* not good enough	Depression; anxiety; panic; hypervigilance PTSD; Phobia of breasts touched; Boundary; over dependent; neg body image; weight	*Not* validated
Case #25 Sharon D.	*Dissociated*	*No* Perpetrator;	Felt *ashamed; crazy; angry; hurt.* Totally dissociated from CSA and does not remember her self-beliefs, or neg feelings	Depression; Anxiety; Intrusive PTSD; Dissociation; Sexuality: hates sex feels it's *dirty, painful;* Relationship Intimacy issues	VALIDATED 19 y.o. delayed-recall; Sister *always* knew (also victim); years later by *perpetrator (dad)*

(Table 11 continues)

Table 12
Summary of Important Differences Between Validated and Nonvalidated Related to the Research Questions.

	Validated	Nonvalidated
Research Question #1 (Memories variables correlated with Dissociation)		
Clear, Declarative Memories	75.0%	38.5%
Body Memories	0%	38.5%
Dissociated Memories	25.0%	38.5%
Repressed Memories	25.0%	53.8%
Delayed-Memories	16.7%	23.1%
Research Question #2 (Beliefs in validation: how, from whom)		
Belief: Importance of Validation	75.0%	77.0%
Important from Therapist	91.7%	92.3%
Important from Mom	83.4%	53.8%
Important from Sibling	50.0%	30.8%
Important from Perpetrator	58.3%	38.5%
Research Question #3 (Self-esteem variables)		
Negative Self-Statements	66.0%	84.6%
Positive Self-Statements	8.3%	15.4%
Crazy/Bad/Evil Self-Beliefs	41.7%	46.2%
Other Negative Words	41.7%	46.2%
Guilt	50.0%	61.5%
Shame	75.0%	69.2%
Self *Not* to Blame	66.7%	46.2%

(Table 12 continues)

	Validated	Nonvalidated
Research Question #4 (Impact of CSA on Current Symptoms)		
PTSD Intrusive Symptoms	53.8%	76.9%
PTSD Avoidance/Numbing	41.7%	53.8%
PTSD Increased Arousal	58.3%	38.5%
Depression	58.3%	69.2%
Anxiety/Fears	50%	53.8%
Addictions	58.3%	46.2%
Obsessive/Compulsive	25.0%	0%
Eating Disorders	41.7%	69.2%
Obesity/Weight	33.3%	76.9%
Pain	0%	7.7%
Multiple Health	0%	15.4%
Sexual Dysfunction	33.3%	76.9%
Promiscuity	16.7%	23.1%
Antisocial/Sexual Acting out	8.3%	15.4%
Self-Destruction/Mutilation	0%	7.7%
Overly Dependent	16.7%	30.8%
Negative Body Image	58.3%	53.8%
Relationship/Intimacy Problems	75.0%	76.9%

(Table 12 continues)

	Validated	Nonvalidated
Coping Strategies: Emotion-Focused		
Denial	16.7%	7.7%
Other	33.3%	15.4%
Coping Strategies: Problem-Solving Focused		
Positive Social Support	91.7%	84.6%
Logical Methods	83.3%	76.9%
Acceptance	41.7%	7.7%
Spirituality/Transcendence	50.0%	38.5%
Other	50.0%	15.4%
Research Question #5 (Validation Variables of *Validated*: Age; Time; Whom)		
Age of Validation		
30-40	50.0%	N/A
6-12	33.3%	N/A
0-5	0%	N/A
Time of Validation		
During Abuse	50.0%	N/A
Upon Disclosure as Adult	25.0%	N/A
Upon Disclosure as a Child	16.7%	N/A
Years Later	8.3%	N/A
Who Validated Them		
Sibling	75.0%	N/A
Perpetrator	33.0%	N/A
Mom	41.0%	N/A

(Table 12 continues)

CHAPTER 5: SUMMARY, DISCUSSION, AND RECOMMENDATIONS

> *It would have helped for him [my step-father] to admit that he had done it, and that it was wrong. I think it would have helped it go by quicker, smoother. But I was really afraid to confront him. . . . probably that and not confronting my mother, are the only two regrets that I have left. And I can't do anything about them, so I just have to let them go.* (From interview with Sandi M., a nonvalidated survivor of CSA)

The Qualitative Paradigm

Before discussing and analyzing the data from this study, it is essential to consider the basic qualitative paradigm behind the study. According to Highlen and Finley, "Consideration of basic paradigms used in qualitative research is an essential prerequisite to any discussion of qualitative data analysis" (in Leong & Austin, 1996, p. 177).

This study used an interpretive/constructivist paradigm, whose main purpose was to understand the participant's world. According to this paradigm, human interaction is seen as relative and there is no single, external, objective truth (Denzin & Lincoln, 1994). The results of this study will be discussed with this paradigm in mind, and the understanding that this qualitative process takes precedence over other quantitative methods used (see case studies: Appendixes L and M).

An Analysis of the Study Results

In this study these questions were posed: Does validation through corroborative evidence make a positive difference in how women with varying degrees of PTSD recover from childhood sexual abuse (CSA)? Is validation the "missing link" in childhood sexual abuse research? And it was

hypothesized that there would be differences between these two groups in the following areas:

1. Research question 1: Their levels of dissociation (intensity/frequency and quality), with validated having lower levels and less pronounced, and nonvalidated having higher levels and more pronounced.

2. Research question 2: Beliefs about the importance of validation in the remediation of their symptoms, with validated believing this is *less* important than nonvalidated.

3. Research question 3: Self-esteem, including negative self-statements and beliefs, particularly about self being "crazy," "bad," "evil," and their coping strategies (e.g., emotion-focused coping versus problem-solving coping), with validated expressing less negative self-statements and beliefs, and more problem-solving coping strategies than nonvalidated.

4. Research question 4: The impact of their CSA on them currently (their negative symptoms), with validated having less symptoms than nonvalidated.

Research question 5 did not hypothesize differences, as it asked about the importance of the following for validated survivors only: age of validation; time of validation (e.g., upon self-disclosure, immediately after the incident; years later); and who validated them (e.g., perpetrator, parent, friend, court—see Chapter 4, Tables 9,10, and 12).

Were there differences between the two groups on the various variables as hypothesized in the four research questions? It appears that there were differences on many of the variables studied, despite discrepancies between the test instruments (DES, IES and SERS) which showed no statistical significance, and the personal interview instrument which showed important percentage differences (for a summary of the expected versus actual results, see Table 13). This chapter will attempt to explain these discrepancies, answer the research questions, and reveal what the study found.

MANOVA Findings of the DES, IES, and SERS

The participants of this study were required to fill out three objective assessment instruments: the DES, which measures the level and frequency of dissociation; the IES, which measures the current (within the past 7 days), impact of the CSA; and the SERS, which measures self-esteem both positively and negatively. A MANOVA was conducted on these three instruments and no significance was found. It is suspected that this was due to a lack of power (the sample was too small for the amount of variables), and the commission of a possible Type II error (unable to detect an effect when it was present). This is suspected because these results differ from the descriptive statistical information gleaned from the quantification of the personal interview which analyzed the narratives of the participants, using the same dependent variables (dissociation, impact of the CSA, and self-esteem), and found important percentage differences between the two groups

Table 13
Overview of Research Variables: Expected and Actual Results by Group

VALIDATED			NONVALIDATED		
Instruments	Expected Results	Actual Results	*Instrument*	Expected Results	Actual Results
DES Dissociation	Past-same Present-reduced	*No* differences found w/MANOVA	*DES* Dissociation	Past-same Present-increased	*No* differences found w/MANOVA
IES Impact	Past-same Present-reduced	*No* differences found w/MANOVA	*IES* Impact	Past-same Present-increased	*No* differences found w/MANOVA
SERS Self-esteem	Higher self-esteem	*No* differences found w/MANOVA	*SERS* Self-esteem	Lower self-esteem	*No* differences found w/MANOVA
INTERVIEW Memories of CSA	Less dissociated and/or repressed	Less dissociated and/or repressed	*INTERVIEW* Memories of CSA	More dissociated and/or repressed	More dissociated and/or repressed
INTERVIEW Belief in importance of validation/Whom	Not as important as nonvalidated from perpetrator/others	* *More* important from perpetrator *mom/sibling*	*INTERVIEW* Belief in importance of validation	Important from perpetrator/others	* *Less* important from perpetrator *mom/sibling*
INTERVIEW Symptoms related to CSA	Less debilitating/lower	+ Less debilitating lower *except* for: OCD/Hyperalert	*INTERVIEW* Symptoms related to CSA	More debilitating higher	+ More debilitating higher *except* for OCD/Hyperalert
INTERVIEW Self-esteem	Lower Negative self-statements; guilt, shame; self-blame	+ Lower Negative self-statements; guilt, self-blame *higher shame.*	*INTERVIEW* Self-esteem	Higher negative self-statements; guilt; shame; self blame	+ Higher negative self-statements; guilt; self-blame *lower shame*
INTERVIEW Coping Styles	More problem-focused	More problem-focused	*INTERVIEW* Coping Styles	More emotion-focused	More emotion-focused
INTERVIEW Disclosure	More often disclosed in childhood	More often disclosed in childhood	*INTERVIEW* Disclosure	Less often disclosed in childhood	Less often disclosed in childhood
INTERVIEW Reaction of others to disclosure	Less Negative and More positive	* *More positive & more negative:* mom/dad/others, + *except siblings:* more positive, less negative	*INTERVIEW* Reaction of others to disclosure	More negative and less positive	* *Less positive & less negative:* mom/dad/ others + *except siblings:* more negative, less positive

* indication that the results were opposite of what was expected.
+ indication that the results were mixed: some expected, with *exceptions.*

on many of these variables. the quantification of the personal interview which analyzed the narratives of the participants, using the same dependent variables (dissociation; impact of the CSA; and self-esteem), and found substantial percentage differences between the two groups on many of these variables.

Rational for the Discrepancy in Study Results

There may be other possible reasons for the discrepancy between the findings of the DES, IES, and SERS (test instruments) and those of the personal interview. For instance, time may have been a factor. The test instruments were generally given *before* the personal interview was conducted, and before the participant was in any kind of regressed and/or altered "state." It was observed by the researcher that many of the participants, particularly those who were interviewed in person, dissociated, and/or regressed into their CSA stories through the questions that were asked. They displayed the dissociation and/or intense affective symptoms typical of PTSD (which their test instruments belied). Even in the telephone interviews, the researcher was able to sense that on several occasions, the participant was emoting and experiencing PTSD-like symptoms (extreme affect and/or dissociative symptoms) from questions that appeared to trigger "state-dependent" memories. Rossi (1993) explains the importance of state dependent memory and learning: "Mind-body information transduction and state-dependent memory, learning, and behavior mediated by the limbic-

hypothalamic system, are the two most fundamental processes of mind-body communication and healing" (p. 68). This researcher had to pause several times and occasionally intervene (use therapeutic methods) to allow the participant to regain emotional control and to continue the interview. This method is endorsed by trauma expert Yvonne Dolan, who advises: "If the client becomes overwhelmed during the. . .telling of the facts of her victimization and appears to be . . .lapsing into a flashback, she should be invited to take a momentary break from her narrative" (p. 27). Because of this, it is surmised that if the test instruments had been given after the personal interview, and before the researcher intervened with those who were displaying distressful symptoms (as required by the Consent Agreement-Appendix C), then these results may have been much higher (e.g., statistically significant DES and IES scores), particularly for the nonvalidated participants, who seemed to display more PTSD-like symptoms. Newman, Kaloupek, and Keane sum it up succinctly:

> Discrepancies often emerge among indicators when multiple measures are used to assess PTSD. Apparent contradictions may result from measurement discrepancies (e.g., differing time frames for two instruments) or from the varying presentations of the disorder over time. Alternately, some measures may focus on one dimension of the disorder, while others focus on different dimensions. Clinical judgment assists in reconciling the discordance among measures. . . .For example, when a self-report measure is not indicative of PTSD and an interview is, pertinent evidence can be sought to reconcile these differences. (as cited in van der Kolk et al., 1996, p. 246)

Newman et al., further state:

> A comprehensive structured or semistructured interview instrument is recommended to insure that all PTSD symptomatology is reviewed in

> detail. . . . The semistructured format has the particular advantage of providing organization and consistency, while allowing interviewees to discuss their experiences using their own words and metaphors. (as cited in van der Kolk et al., 1996, p. 247)

The semistructured interview was used in this study, and as stated by van der Kolk et al., it did have the advantage of allowing the participants to discuss their childhood abuse experiences using their own words and metaphors and to describe the "quality" of their experiences versus merely scaling them numerically. These narratives were then "clustered" into categories and quantified into descriptive statistical tables using percentages (see Appendixes G, H, and I).

Evidence for Some Expected Results

Many of these quantified narratives did show differences between those who were validated and those who were not, in the following areas: validated participants reported less dissociation and/or severity of dissociation then nonvalidated participants (Research question 1); validated participants reported less negative self-statements, less negative beliefs about being crazy, evil, bad , and less guilt, except for shame, than nonvalidated participants (Research question 3); validated participants reported less PTSD symptoms, less psychologically distressing symptoms, except for OCD and addictions; and they reported a higher percentage of problem-focused coping strategies, while nonvalidated reported a higher percentage of emotion-focused coping strategies (Research question 4); validated participants more often disclosed the CSA in childhood than

nonvalidated participants; and validated had a higher percentage of positive reactions upon disclosure from mom, dad, siblings, and other relatives then nonvalidated, but paradoxically, they also had higher percentages of negative responses from mother, father, and other relatives as well (see Tables 10 and 13).

Lack of Evidence for Some Expected Results

One unexpected finding was that validated participants believe that it is more important to have validation from the perpetrator than nonvalidated (Research question 2). This may be because some of those who were validated were validated by the perpetrator (33%), and interestingly, 41% of these validated participants (5 of 12) did not disclose the abuse until after the perpetrator had died. So the reporting of the belief that validation from the perpetrator is important may simply be unresolved regret for not having had the courage or opportunity to confront the abuser when he was alive. This could be linked to their shame as this group had a lower percentage of guilt, but a higher percentage of shame then the nonvalidated group. It may also be because the majority of nonvalidated participants reported that they do not believe that they will ever be validated by the perpetrator, as many perpetrators continue to deny the abuse, are still threatening, or are no longer alive.

Impact of the Childhood Sexual Abuse: Current Symptoms

Another unexpected and interesting finding is that the validated group had a higher percentage of increased arousal PTSD symptoms

(hypervigilance) than the nonvalidated group. This may be linked to their validation, as they appeared not to have dissociated as much as the nonvalidated group during the CSA, and were therefore more cognizant of the abuse they were experiencing. This makes sense, since they report having more clear, declarative memories and less dissociated, repressed, or somatic memories (see Table 2) than the nonvalidated group.

The validated group also unexpectedly reported more OCD symptoms (25% versus 0%) and addictions (58% versus 46.2%). OCD and addictions are correlated as they both have a compulsive component and are probably ways of assuaging anxiety which underlies hypervigilance. This may also be an artifact of this sample (e.g., driven, high achievers) as the majority are highly educated helping professionals who reported perfectionist tendencies (see Table 1 and case studies in Appendixes L and M). It should be noted, however, that the nonvalidated group reported much higher incidences of obesity-weight problems (76.9% versus 33.3%) which could be viewed as another form of addiction (food versus alcohol-drugs), indicating that they then have higher percentages of addictive behaviors than the validated participants. On many of the other current symptoms variables, the two groups were more alike than different (see Tables 6 and 7).

The Link Between Dissociation, Memory and Childhood Sexual Abuse

> *I don't have real negative beliefs about myself now, but I did for a long time. I think "crazy" would be the closest word. For a lot of years it felt like if I didn't hold on tight I was going to just sort of go off some psychotic edge—and that somehow I had to keep very tight control over*

> *what I was thinking, what I was doing, and life was going on around me really "hypervigilantly."* (From an interview with a validated survivor of CSA, Diane B.)

Research question 1 asks about differences between validated survivors of CSA and nonvalidated survivors in their level of dissociation. To answer this question, the link between dissociation and memory needs to be explained. *Dissociation* refers to a compartmentalization of experiences where elements of a trauma are not integrated into a unitary whole or an integrated sense of self (see detailed description of dissociation, pp. 51-52). This is the mechanism (along with repression) that many current trauma researchers recognize is at the root of traumatic memories, as it has been implicated in childhood sexual abuse (e.g., Briere, 1993; Carlson & Putnam, 1993; Herman & Harvey, 1993; Rossi, 1993; Smucker, Dancu, Foa, & Niederee, 1996; Staton, 1990; van der Kolk & van der Hart, 1991b). "Dissociation functions as a buffer against overwhelming emotions and may have profound effects on memory, compartmentalizing traumatic memories and fostering narrative accounts that emphasize or delete particular details of the trauma" (Waites, 1997, p. 119).

Current research studies of Holen (1993), Marmar et al. (1994), and Spiegel (1990) have demonstrated that having dissociative experiences at the moment of the trauma is the most important long-term predictor for the ultimate development of PTSD, which has been implicated as one of the long-term effects associated with childhood sexual abuse (Briere & Runtz, 1987;

Briggs & Joyce, 1997; van der Kolk, et al., 1996). Therefore, it would be expected that those participants who report more dissociated memories of their CSA experiences would also report more PTSD-like symptoms. This turned out to be generally true for the participants of this study. As expected, the nonvalidated subjects reported higher dissociated memories than validated subjects (38.5% versus 25%). Particularly surprising was the difference between validated and nonvalidated subjects in dissociated, body memories, with nonvalidated reporting 38.5% and validated reporting none (0%). The intensity of dissociation that is associated with somatic memories (memories only surface through bodily sensations) may account for the nonvalidated having the most delayed memories (23.1% versus 16.7%), and be a factor in their not being validated. The nonvalidated participants, for the most part, did report more PTSD symptoms: intrusive symptoms (76.9% versus 53.8%) and avoidance/numbing (53.8% versus 41.7%), except in the increased arousal/hypervigilance category, where validated reported 58.3% versus 38.5% for nonvalidated.

Self-esteem, Memory, and Dissociation

> *I sometimes feel so "crazy" because something will trigger a memory, and I'll get feelings and sensations about it, and even pictures of it—pieces of it. But then I'll feel so "crazy" because I don't have any clear memory of it. And then I say: "Well now I know this, but how can I 'prove' it? What if my mind is just playing tricks on me?" And then I get all confused and don't trust myself. It makes me feel like maybe I "am" crazy!* (From personal interview with a nonvalidated CSA survivor, Barb C.)

Memory has been linked with self-esteem, particularly traumatic memories that are dissociated or repressed and not easily available to

consciousness—they have been linked to negative self-esteem. Memory researcher Elizabeth Waites (1997) explains:

> Human beings value conscious memory. Being able to remember is commonly perceived as a form of control; not being able to remember can make one feel out of control, continually retraumatized by one's own limitations. And memory is vital to the integrity of the self. When an awareness that one is different is disconnected from important memories that might explain why, the self may seem mysteriously and uncomfortably alien. . . . This self-alienation has deep roots in the relation between the self and its memories. Remembering. . .is always an important component of identity development and consolidation. (p. 125)

This link between self-esteem and traumatic memories was seen in this study (research question 3), as the nonvalidated participants, who also had the most dissociated memories, did report higher percentages of negative self-beliefs (e.g., believing self to be crazy, bad, evil, etc.), negative self-statements, as well as higher guilt and self-blame for their CSA experiences (see Table 4). Paradoxically, they also reported a higher percentage of positive self-statements. This could simply be an artifact of the personal interview as the researcher did not directly ask the participants questions about positive self-esteem, and these statements were randomly reported. Had the researcher asked all the participants about their positive self-beliefs, this difference may not have developed. Also, since the nonvalidated subjects reported more negative self-beliefs and statements, reporting positive self-statements may have been a way of assuaging negative affect from such reports and/or an overcompensation.

Another interesting and paradoxical finding of this study was the category under self-esteem: shame and self not to blame. It is generally believed that guilt and shame are positively correlated and usually occur simultaneously. But in this study, the validated subjects had less guilt (as expected), but more shame (not

expected) than the nonvalidated. However, they also reported importantly higher percentages in the "self not to blame" category (66.7% versus 46.2%--which was expected). This leads the researcher to conclude that shame may simply be a inevitable effect of childhood sexual abuse and unrelated to guilt and self-blame in this context.

The Importance of Validation

> *Yes. I had a dream just this morning. . . and I was begging my brother to just say the truth and I'll forgive him, and he raped me!. . . it was horrible. It's like I'd do anything . . . even let him do that to me again just so he'd say he was sorry. . . if I could have people understand how wrong it is, and have people say, "yeah it's true, you're not the one that's the bad person, they are" . . . . The validation is so important to me; I don't think I'll ever get it.*
> (From interview with Barb C., a nonvalidated survivor of CSA)

Research question 2 asks about how the validated and nonvalidated participants differ in their belief that validation through corroborative evidence is important for them to heal from the abuse. It further asks how this belief is expressed, what they need to know and from whom. It was hypothesized that the nonvalidated group would believe that validation from the perpetrator was more important than the validated group, and this was not the case. In most categories under "validation from whom" (e.g., perpetrator, mom, dad, sibling, other relative) the validated participants thought that validation was more important then the nonvalidated participants. This may again be an artifact of the personal interview which asked questions in more open-ended ways and many times did not directly ask the participants from whom they needed validation, as many of the participants (validated and nonvalidated) did not report this (see Table 3). It

could also be argued that validated clients value being validated more than those who were not because they have experienced it and found it helpful in their healing. Another explanation, after reviewing the case studies, is that the nonvalidated participants, for the most part, do not believe that validation from the perpetrator, mother, or relatives will ever be forthcoming, and so they may be reluctant to express a belief about its importance. Nonetheless, there seems to be a consensus in the clinical literature (e.g., Alpert, 1995; Briere, 1997; Freyd, 1996; Hunter, 1995; Reviere, 1996; Sanderson, 1995) that acknowledgment of the abuse experience is essential for the recovery of childhood sexual abuse survivors. The participants in this study acknowledged this, and reported overwhelmingly (both validated and nonvalidated subjects) that the therapist's validation was important in their healing (validated=91.7% with 8.3% not reported, and nonvalidated=92.3%, with 7.7% not important, and 0% not reported). This affirms what Sanderson (1995) says: "It is crucial that the counsellor validate and affirm the survivor by believing her" (p. 128). It is clear that both groups also regard mom's validation as important, with the validated group believing this more important than the nonvalidated group (83.3% versus 53.8%-see Table 3).

Reaction Upon Disclosure

> *It would have absolutely made a difference in my healing if my mother had validated me: If she had protected me, if she would have believed me, and loved me. Absolutely. . . . I wanted her to say "I love you." It's a fantasy, she's never going to say that.* (From a nonvalidated survivor of CSA, Elaine K.)

While many research studies attest to the importance of validation of the survivor's experiences in regard to her or his mental health and self-esteem (Browne & Finkelhor, 1986a; Coffey, Leitenberg, Henning, Tonia, Turner, & Bennett, 1996; Elliot, 1991; Jehu, 1988; Kaldveer, 1992; Waller, 1994), it appears that validation is particularly necessary after the survivor has disclosed the abuse (McNulty & Wardle, 1994; Roesler & Wind, 1994).

Both validated and nonvalidated participants agreed that their mothers' validation is important in their healing (see above), and yet one very surprising and interesting finding of this study has to do with their mothers' reaction upon disclosure of the abuse (pertaining to research question 5b): Eighty-three point three percent (83.3%) of the validated subjects, and 61.5% of the nonvalidated subjects, disclosed their childhood sexual abuse to their mothers and 75% of the validated subjects, and 69.2% of the nonvalidated subjects, had a negative reaction from her: either she did not believe them, or she blamed them for the abuse (even though many of them were very young children).

It is not surprising that 75% of the validated participants and 61.2% of the nonvalidated participants disclosed to a sibling because in many cases the sibling was also sexually abused as a child, and able to validate them. For instance, 75% of the validated subjects were validated by a sibling, usually a sister (only two subjects were validated by a brother and of those two, one was validated by both a brother and a sister). Generally the reaction of the sibling was positive upon disclosure (validated=50%, and

nonvalidated=30.8% with 38.5% unreported). See Tables 10 and 11 for details.

Abuse Variables That Correlate with PTSD and Other Symptoms

The research has rarely found sexual abuse to be without damaging consequences for the victim, although the degree and duration of negative posttraumatic symptoms vary (e.g., Briere, 1997; Finkelhor, 1990; van der Kolk et al., 1996; etc.). Many complex factors are involved in determining the degree of trauma likely to be sustained by the childhood sexual abuse survivor. The effects of CSA are subject to many variables, such as the frequency, duration, relationship to the offender, age of the victim when it occurred, reactions of significant others to the disclosure of the abuse, and resources and nurturing relationships available to the survivor (Briere, 1997). "It appears that victimization involving violence and coercion and perpetrated by highly valued and trusted family members over extended periods of time is likely to cause the most damaging consequences" (Dolan, 1991, p. 2). For this study, incest has been defined as "a sexual act imposed on a child by any person within the family constellation who abuses their position of power and trust within the family. It includes all sexual encounters where there is a difference of age and power" (Sanderson, 1995, p. 15). With this definition in mind, it is interesting to note that the majority of the participants in this study (88%) were victims of incest and "betrayed" by a trusted family member (see Table 14). Forty percent (40%) were abused by dad or step-dad; 24% by brother(s); 4% by a cousin; 8% by a brother-in-law;

12% by an uncle (and 48% by a non-relative, although 20% of those were also abused by a relative). Also, 15 of the 25 participants reported that sexual intercourse was involved in their victimization and 56% were 8 years old and under, with 40% being 6 years and under when they were abused. Some differences between the validated and nonvalidated groups are noteworthy: A larger percentage of nonvalidated subjects were abused at a younger age--5 and under (24% versus 8%), and more often experienced dad or step-dad as the perpetrator (24% versus 16%). These higher rates of incest, early age of abuse, and the inclusion of intercourse in their abuses, help explain the nonvalidated participants' higher rates of PTSD and comorbid depression and anxiety (see Table 6, case studies, and Appendixes L and M). These findings agree with the research of Briggs and Joyce (1997), who concluded that the inclusion of sexual intercourse in abusive episodes had the consequence of leaving the victims with increased symptoms of PTSD (see Table 14).

Validating Variables for Validated Participants

> *My mother was aware of it. At some point she became aware of it, and I didn't realize this until a couple of years ago when she started throwing it in my face: "Well you let this happen to you with your brother and you could've kept this from happening, and you're better than that; you were taught better than that." It was kind of like, Well mom if you knew, why didn't 'you' do something to stop it?! I was a chicken and I wouldn't say that, but that's how I felt. If she really knew, and she said she did, then why didn't she do something to stop it? And why did I have to live through what I lived through?* (From a personal interview with a validated survivor of CSA, Lecia H.)

Lecia H. (survivor-participant) was only 6 years old when her brothers forced her to be sexual with them. There were three of them: one was 6-7

years older, one 5 years older, one was 20 years older (and a father figure to her), and sexual intercourse was involved. Her abuse continued with one brother into adulthood, and even after she was married with children. It finally stopped 8 years ago, when Lecia was 30 years old. She had repressed and dissociated most of the memories, and said: "I had a complete mental block on this until after I started into counseling and it started coming out." Lecia was afraid to remember because it was too painful to remember. Perhaps she was a victim of "betrayal trauma," (Freyd, 1996). She recalled:

> I can remember one incidence with my oldest brother, who passed away last year. And that one was a hard one for me, when that came to me, because he was very, very special. He was 20 years older than I was and he was always the father figure, because I didn't have a father. . . for anything special, he was the one I always knew I could rely on. . . So when the memory came back, it was very detrimental to me. . .because that's not the way I remember him. . .that was one memory that I had completely blocked.

Lecia fit the validation through corroborative evidence criteria for this study which is defined as "some kind of external (versus self-report) attestation (confirmation) that the survivor's recollections of her childhood sexual abuse(s) are accurate" (this study, p. 24). She fits because when the abuse was first initiated by her brothers, there were other young cousins and friends who witnessed the abuses, and also her mother did acknowledge that the abuse happened, even though she blames Lecia for it. Validation through corroborative evidence only means that there is some kind of confirmation that the abuse happened, it does not necessarily include affirmation that the abuse was wrong or damaging, or that the abuser was responsible for it. It

appears that this definition of validation was not broad enough to fit what most of the survivor-participants in this study imagined validation to be. When they say they want validation, they likely mean what these survivors said: "I'd like to have acknowledgment from my family that it happened and that I was damaged by it" (Cori Y., a nonvalidated survivor, Appendix M). "I have a 'fantasy' that I would be able to talk to J. [perpetrator's son and fellow victim and witness to the CSA] about what happened and he would admit that his father did this, and that it was wrong" (Diane B., a validated survivor, Appendix M). Survivors are hoping for the kind of validation that will not only affirm or reaffirm that the abuses they remember actually happened to them, but the kind that will also assuage the guilt and shame that the majority of the participants reported feeling: They desire to hear that the childhood sexual abuse(s) was not their fault.

Research question 5 asks how important the following are to the validated participant: age of validation and time of validation. Fifty percent (50%) were not validated until they were middle-aged adults (between 30-50 years), with 33.3% validated between the ages of 6-12, and 0% between birth and 5 years of age (note: only 2 of these participants were sexually abused at age five or under). Half of them were validated during the abuse or shortly afterward (50%); 25% were validated upon disclosure as an adult, and only 16% upon disclosure as a child, with the smallest percent being validated years later (8.3%).

Nine (9) of the 12 validated participants (75%) were validated by a sibling (8 of 9 were sisters) who was also sexually abused by the same perpetrator. Four of the 12 were validated by the perpetrator (33.3%), and two of the four perpetrators were the father (see Table 9). What is important to note is that although two of the father-perpetrators validated the survivors, only one of them ever admitted that what he had done was wrong and apologized for his actions (see case study number 25, Sharon D. in Appendix M), which is what most of the survivor-participants say they want. There is agreement in the clinical literature that this kind of validation from the dad-perpetrator can help reverse some of the deleterious effects of the childhood sexual abuse. Dolan (1991) says:

> The traumagenic factors may be somewhat lessened if the sexual abuse is of short duration, if the victim is given strong familial support upon disclosure, and particularly if responsibility is placed clearly on the perpetrator by the perpetrator's acceptance of responsibility. (p. 2)

And although this might be true for some survivors, it does not seem to be important for Sharon D., the only participant whose perpetrator-father admitted the abuse publicly to her and others. Sharon did not find her father's validation important in her healing. She said:

> My dad did admit it. I called him from the hospital and he did admit it. He's apologized more than once for what he did. But it didn't help. It didn't matter. . . . I think the only thing that would have helped is if it hadn't happened at all, and all the rest is a moot point. To me it doesn't matter how often or how long it happened, that it happened once was enough. It still affects me. . . . It doesn't even make sense to question all that, because it happened and the only thing that would have changed it, is if hadn't happened. (Sharon D, Appendix M)

In Sharon's case, her father had sexually and emotionally abused her since she was very young, and for many years (from perhaps a toddler until she was 16 years old). The long duration of the abuse as well as the violence involved are probably the important variables that had made her father's validation unimportant to her. She explains:

> I was hospitalized twice over 30 days. . . because the memories of the abuse were so horrible and overwhelming that I needed to be in the hospital. I guess the abuse was rather violent. When I was remembering everything, I was very depressed.
> (Sharon D., Appendix M)

Sharon's story epitomizes the interpretive/constructivist paradigm that was used in this study, whose main purpose is to understand the participant's world. She has demonstrated the effectiveness of this process over a purely statistical one, which may have led to erroneous conclusions about the impact of perpetrator validation upon this participant. Her story has affirmed the relevance of thick descriptive narratives which have helped bring Sharon's meanings, within this context, forward.

Table 14

Age of Abuse/Perpetrator/Intercourse Variables of CSA Survivors

Case Study # Name:	V=Val N=Nonval	Age Abused From—to I=intercourse	Dad or Step Dad	Brother(s)	Cousin	Brother in-law	Uncle	Non relative
1)Geraldine N.	V	7-13/14=I					X	
2)Jean W.	N	15-17=I				X		
3)Rose N.	V	4=16=I	X					X
4)Rosanne K.	N	5-7						X
5)Julia K.	N	4-12	X					
6)Barb C.	N	under 4-17=I	X	X				
7)Kate V.	N	12-15& 15	X				X	
8)Bonnie D.	V	7-16=I	X					
9)Pat K.	N	Infant	X					
10)Eileen O.	N	14 only 1x=I						X
11)Kathy P.	N	10-11=I		X				
12)Kristie P.	V	8-13&13-18=I		X	X			X=XX
13)JeanMarie B.	V	9-16/17						X+X
14)Shann M.	N	Toddler & 8	X				X	
15)Cori Y.	N	10				X		
16)Sandi M.	N	4-16=I	X					X
17)Diane B.	V	8-13						X
18)Lecia H.	V	6-30=I		X+X+X				
19)Elaine K.	N	9&10,11,12=I						X+XXX
20)Louise D.	V	10=I		X				
21)Catherine	V	6&15						X+X
22)Gail S.	V	6-16&11=I	X					X
23)Marlene S.	V	13-30s=I						X
24)Gina S.	N	8-16&13=I		X				X
25)Sharon D.	V	V. little-16=I	X					

Summary and Implications

> *It was incredibly important to have the therapist validate me. . . I felt that he was very, very, supportive, but it's more than just support. It's validating the experience and then very gently encouraging me to find ways to move beyond it and transform it.*
> (Cory Y. a nonvalidated survivor of CSA, Appendix M)

The results of this study are summarized in chapter 4, and in Table 11 (Summary of the Individual Case Study Responses to the Research Questions), and Table 12 (Summary of the Important Differences Between Validated and Nonvalidated Related to the Research Questions).

Essentially what was found was that there were some important percentage differences between the validated survivors of childhood sexual abuse and the nonvalidated survivors in this study; some which were expected, and some which were not. But because of the limitations of this study (e.g., the low power of a too small sample and consequent lack of statistical significance and inability to generalize to the larger population) these differences may or may not be significant, and therefore correlation between variables cannot be assumed. However, some things can be surmised from looking not only at the descriptive statistics, but looking beyond them to the information gleaned from the personal interviews and resultant case studies. Here are some of the interesting findings by research questions:

1. Research question 1 (asks about differences in Dissociation): It is theorized that there is a link between dissociation and repression, dissociation and memory, and dissociation as a coping mechanism, and that

the nonvalidated group would report more dissociation than the validated group. This turned out to be true for the memory variables, but not for dissociation as a coping strategy.

- Contrary to expectation, a MANOVA conducted on the Dissociative Experiences Scale (DES) did not show any significant differences between the two groups.

- As hypothesized, nonvalidated participants reported higher percentages of dissociated (including somatic memories) and repressed memories and delayed recall of memories. Validated participants reported higher clear, declarative memories.

- As hypothesized, the "quality" of the dissociated experiences were more debilitating (lasted longer, more amnesia, etc.) for the nonvalidated than for the validated (as noted in their interviews, and by the higher percentage of somatic memories reported—38.5% versus 0% for validated).

- Contrary to expectations, the validated participants reported slightly higher percentages of the use of dissociation/repression as coping strategies than nonvalidated participants.

2. Research question 2 (asks about the belief in importance of validation: how, and from whom): It was hypothesized that the nonvalidated participants would believe that validation was more important than those who were validated, but this did not turn out to be true.

- Contrary to expectation, there was not much difference between the two groups in their belief that validation is important (75% validated versus 77% nonvalidated).

- Contrary to expectation, the validated group thought it was more important for the perpetrator to validate them (note: this could be an artifact of the personal interview instrument, as many participants in both groups did not report this).

- Contrary to expectation, the validated group thought that it was more important for mom, siblings, and other relatives, to validate them (note: this could be an artifact of the personal interview instrument, as many participants in both groups did not report this).

- Contrary to expectation, both groups equally thought that validation from the therapist was important (91.7% validated, versus 92.3% nonvalidated).

- As expected, nonvalidated participants wanted validation to confirm that the abuse they remembered actually happened (and in the way they remembered it), while the validated participants were more interested in an affirmation that the abuse was "damaging" to them, and that it was not their fault (perpetrator admitting seriousness of the abuse and taking responsibility for it).

3. Research question 3 (asks about the differences in self-esteem between the two groups): It was hypothesized that those participants who were not validated would report more negative self-beliefs and self-statements, and more frequently use the self-descriptors of crazy, bad, evil, or equivalent (e.g., damaged, rotten, etc.). It was also hypothesized that this group would have higher guilt and shame and acceptance of blame for the CSA. This turned out to be true, expect for shame, for which the validated group showed a higher percentage.

- As expected, the nonvalidated group had more negative self-statements and more negative self-beliefs than the validated group.

- As expected, the nonvalidated group more frequently used self-descriptors of crazy, bad, evil or equivalents.

- As expected the nonvalidated group reported more guilt and took more blame for the CSA than the validated group.

- Contrary to expectation, the validated group expressed more shame than the nonvalidated group (although they were both high on this variable).

4. Research question 4 (asks about the how the two groups differ in the impact of the CSA on their adult lives): It was hypothesized that the nonvalidated group would have more PTSD intrusive and numbing PTSD

symptoms and more psychologically distressing symptoms such as depression, anxiety, and others. This turned out to be mostly true with three exceptions: The validated group reported higher alcohol-drug addictions, while the nonvalidated group reported more obesity-weight problems, associated with eating addictions; the validated group reported more increased arousal PTSD symptoms (hypervigilance); and the validated group reported more obsessive-compulsive problems (OCD). It was also hypothesized that the nonvalidated group would cope differently than the validated group, reporting more emotion-focused coping versus problem-solving coping strategies. This turned out to be true.

- As hypothesized, nonvalidated participants had more intrusive and avoidant/numbing PTSD symptoms than the validated group.
- Contrary to expectation, the validated group had more increased arousal PTSD symptoms (hypervigilance) than the nonvalidated group.
- As expected, the nonvalidated participants had more affective-disordered symptoms (depression, anxiety), eating disorders, pain, multiple health issues, sexual dysfunction, self-destructive/mutilation, and sexual acting-out problems than validated participants.
- Contrary to expectation, the validated participants had higher percentages of OCD and alcohol/drug addictions than nonvalidated participants.
- Contrary to expectation, both groups scored equally high on relationship/intimacy problems.

5. Research question 5 (asks how important the following are for validated participants: age of validation; time of validation): This question is both descriptive and exploratory—descriptive in the sense that the research of Briere & Runtz (1988), Briggs & Joyce (1997), and others has affirmed the

hypothesis that early, long-term abuse by a trusted care-giver, which includes intercourse, will probably be the most devastating and produce the most severe PTSD-like symptoms. This appears to be true for most of the participants of this study who had these variables as part of their abuse. Validation however, did not seem to be an correlated with this.

Age of Validation and Age of Disclosure

The crux of this question is exploratory because the importance of the validation variables of age and time were unknown (the researcher could find no studies about the importance of validation related to age and time in the literature review), and therefore amenable to discovery. The study revealed that half of the 12 validated participants (50%) were not validated until they were middle-aged adults (30-50 years old); with 33.3% validated between the ages of 6-12; 0% between birth and 5 years of age (note: only 2 of these participants were abused at age 5 or under). There is a likely correlation between the age of validation and age of disclosure as 41.6% (5 of 12) of the participants did not disclose the abuse until after the perpetrator had died (see case studies 1, 3, 8, 17, and 18). This may be because the fear of perpetrator retaliation was no longer an issue. Many expressed the belief that once the perpetrator was dead, it was then "safe" to remember the abuse that they had experienced.

Most of the participants were validated by a sibling (75%), usually a sister who had also been sexually abused by the same perpetrator. Four of the 12 were validated by the perpetrator (33.3%), and two of the four

perpetrators were the father. What is noteworthy is that only one of the two father-perpetrators admitted the abuse and asked forgiveness (years later). The irony is that this did not seem to be important to the survivor (Sharon N., see case study 25, Appendix M), who said it was too late because she believed the abuse had already "damaged" her.

The Importance of Mother's Reaction Upon Disclosure of Abuse

One of the most interesting findings that came out of this study is the importance of mother's reaction to the participant when she disclosed the abuse. The majority of the participants revealed in their interviews that they wanted validation from their mother but did not get it. Although 83.3% believed that it was important for mom to validate them, and 83.3% disclosed their abuse to mom, only 16.7% reported positive reactions from her upon disclosure, while 75% reported negative reactions from mom upon disclosure of the abuse(s) (see Table 10). Rosanne K,. a CSA survivor was one of the participants who reported negative reactions from her mother:

> My mother didn't believe that anything bad happened to me. I told her about it since recovering it in therapy, and she said it never happened. My mother denies things happened. . . . They never believed me and nothing was ever good enough for them. (case study 4, Appendix L)

Research Studies on Disclosure

These findings were predicted by the research of Browne and Finkelhor (1986a) and Waller (1994) who found that adverse reactions to disclosure (e.g., blaming or ignoring the victim, disbelief, and punishment) are likely to be detrimental to psychological functioning. Jehu (1988) found

that even a perceived adverse response to attempted disclosure might serve to reinforce perceptions of self-blame for the specific event and could lead to more general self-denigratory beliefs becoming established, including feelings of general worthlessness, inferiority, and stigmatization (pp. 77-81).

Numerous other studies have shown that the degree of social support a person receives from parents and others following the disclosure of sexual abuse can moderate the negative long-term effects and perhaps even mediate them (Bagley & Ramsey, 1986; Roesler & Wind, 1994; Testa, Miller, Downs, & Panek, 1992; Wyatt & Mickey, 1987). This seems to be true for Louise D., a survivor-participant:

> When my mom found out that my brother had been abusing us. . .she called my sister and myself into the kitchen and she said, "I want you to tell me everything that he did to you". . .my mom let out a scream like nothing I've ever heard, and she called my dad into the room and she said: "Do you know what that bastard did to your daughters?!". . . that was probably the saving grace for me, because my mother worshipped my brother. . . . I remember. . .she never made us feel guilty. . .the responsibility was on my brother, and that's who in her mind, was gong to pay for it. . . . She never ostracized him. . . . It was O.K. because he had gotten punished for what he'd done, and I was "safe." I didn't care so much about revenge for him. I just wanted to be "safe". . .so once that was taken care of, I could move on.(case study 20, Appendix M).

Limitations of the study

A number of factors limit conclusions that can be drawn from this study for the following reasons:

- This study was primarily qualitative and as such it's generalizability is limited, and it is subject to all the limitations that are inherent in doing qualitative research: It is subjective, holistic, empirical, and interpretive. "There will be times when all researchers are going to be interpretive,

holistic, naturalistic, and uninterested in cause, and then, by definition, they will be qualitative inquirers" (Sake, 1995, p. 46).

- The sample of 25 women survivors of CSA, with 12 being validated, and 13 being nonvalidated was large for case studies research, and too small for sophisticated statistical comparisons. The study had too little power (too small of a sample) and too many variables to compare the two groups using a MANOVA. It is likely that a Type II error was committed (failed to find an effect when one was present). The use of quantifiable tests within a qualitative paradigm was thought to increase the validity of the data by triangulating the methods.

- The sample was not random. It was gender-specific (women survivors of CSA) and did not include males who had been sexually abused in childhood. The study also required the participants to have had, or presently have, PTSD-like symptoms. All but one of the participants was white, and most were college educated and above, and in the helping professions (e.g., psychotherapists, nurses, teachers) with upper middle incomes.

- The subjects were required to have been, or presently be in psychotherapy for issues related to their childhood sexual abuse, which may have reduced their current symptoms and/or altered their memories (e.g., less dissociated memories). And this study did not address the success or failure of therapy and the influence that this may have had upon their answers to the test instruments (DES, IES, SERS) and/or the personal interview questions.

- The problem of comorbidity is noted as it is not certain which came first, the CSA, or the psychosocial symptoms.

Recommendations

It is hoped that this study will generate more research into the importance of validation in the remediation of symptoms related to childhood sexual abuse. This researcher could find few studies that specifically investigated the relationship between validation and symptomatology. This is an important issue in childhood sexual abuse especially since many survivors are continually challenged about the veracity of their experiences,

which only adds to their guilt and shame. Bonnie D., a survivor of childhood incest, which she experienced from about age 7 until 16, was validated (as a middle-aged adult) by a sister who was also a victim of father's sexual abuse. And yet she still experiences guilt and self-blame over the abuse that was done *to* her, despite this validation. She says:

> I think it's important to be validated, because I see in "group" [her incest support group] what the women who are not validated go through. The fear and the self-doubt that they have, "are they really making this up?" And how do you know when you really get down to it, because people do, and it's unfortunate, and this makes me angry. . . . . They use it in divorce disputes or this or that, which leads to not validating all the rest of us that this really happened to. And that False Memory Society and all that other crap; those groups make me angry, because it doesn't validate those of us who did live it, and did go through it. And if someone said to me: "We don't believe it happened." I would tell them that *they* are crazy, because I knew it my entire life. I didn't ever *not* know that it happened. I think that validation is important. I think that's it's important to have your family's support, so at least you know that it wasn't your fault [she pauses, tears well up, and adds], or *all* your fault (parenthesis and italics added).

In future research it would be interesting to change the criteria for "validation through corroborative evidence" to explore whether manipulation of this independent variable makes a difference in the results. One example would be to require that validation be defined not only as acknowledgment that the sexual abuse happened, but further, that the perpetrator and/or witness (e.g., mom, sister, etc.) acknowledge that the sexual abuse was wrong, that it was harmful to the victim, and that the victim was not responsible for it. This would be important since as stated previously (in Chapter 2, Literature Review, pp. 56-58), the reaction upon disclosure (and/or

discovery) has a profound impact on the severity of symptoms of adults abused as children (Browne & Finkelhor, 1986; Elliot, 1991; Jehu, 1988; Kaldveer, 1992; Waller, 1994; and others). Admittedly this might be a difficult sample to find since most perpetrators of sexually abused children will not usually admit what they did, and/or take full responsibility for it. "Most survivors of childhood sexual abuse receive no corroboration, as there are usually no eyewitnesses other than the single victim and the perpetrator, and the perpetrator usually denies the accusation" (Freyd, 1996, p. 56).

This study revealed that there is a close link between traumatic memory and dissociation, and dissociation and PTSD. Therefore, it might be important to investigate whether there is a correlation between these variables and validation as well. For instance, the question might be posed: "Are people who have more dissociated memories of their CSA less likely to have validation of their abuse?" Validated subjects could then be questioned about their CSA memories to see what percentage had clear, declarative memories versus dissociation/repressed memories. Or a comparison could be done between validated and nonvalidated subjects using the recall of their traumatic memories as the independent variable.

It might be productive for future researchers to conduct this same study using only quantitative measures, with a larger and more randomly selected sample, and measuring only one or two dependent variables such as self-esteem or dissociation. It would be interesting to know if this would

produce significant statistical differences and/or similar results to the case studies in this research.

The Importance of Meaning

One of the variables that this study looked at was the meaning that the survivor ascribed to her childhood sexual abuse experiences. This was not discussed previously because there were no notable differences between the validated and nonvalidated participants in this area. But it was included under coping strategies (negative meaning is associated with emotional coping strategies, and positive meaning is associated with problem-solving coping strategies), and reported in Table 8.

In attesting to the importance of finding meaning in adversity, Caruth (1995) states, ". . .although the reality of extraordinary events is at the core of PTSD, the meaning that the victims attach to theses events is as fundamental as the trauma itself" (p. 6). Victor Frankl (1984, 1988), noted psychotherapist and Holocaust survivor, agrees. He believes that meaning which stems from adversity can be very positive. What do the women survivors in this study say about meaning and their childhood sexual abuse experiences?

- Marlene S.: "No. It was a bitch! And I see no positive purpose to it. No person should have to go through it looking for any meaning."
- Julia K.: "My brains and my ability to be creative are a result of the abuse because I often escaped into my unconscious."
- Jean W.: "Well if you can't change the past it would be nice if you could just completely forget about it, erase it."

- Cory Y.: "I'm a much stronger person today and I think that because of my experiences I have something to give to other people—and I do."

- Lecia H.: "I look on the abuse as negative, but at least I did survive it!"

- Barb C.: "One good thing about it, finding out about it, that this is true, is finding out why I'm so mixed up. Why as long as I can remember I'm feeling sad and worthless. Everything makes sense now."

- Rose N.: "There's always a reason that things happen. I feel like with what I've experienced I can help other people. I can feel their pain and with just a few words can help people. It was meant to happen."

- Sharon D.: "No. . . . I don't think people go through tragedies to find their purpose in life. I don't think God makes things like that happen. My father chose to do that, I think he's the one who's responsible for his behavior."

While many of the survivors did find some positive meaning in their abuse, most of them had mixed feelings as expressed by Geraldine N.:

> For me the meaning has become that I am a survivor. I am victor and I can do anything I want to do. I've already been to hell and back and I can do anything I want to do—all I have to do is want to do it and I can. I can survive anything!. . . the abuse. . .will always be a part of who I am, and then move on to the next step: How can I move forward? How can I not let this continue to control me any longer?. . . . I was very little, shy, and helpless, and I'm not anymore. Sometimes my anger is that my childhood was stolen! [She weeps as she says this].

Conclusions

The conclusion is not the end, not as long as there is another sexually abused child, and another story to be told by a survivor of such abuse. As Sandi M., a survivor of repeated sexual abuses when she was 4 to 16 years of age, from her step-dad (including impregnation), states:

> I think the key to not going through what I've been through. . .is to get to the child when they're a child. . .to open their eyes and offer a "safe place" for them to start processing and working through it. . . .There's still lots and lots and lots of abuse. Just talking about it in the media . . .does nothing more than desensitize people. . .talking about it doesn't seem to be the answer. It think that something has to be done to change the mindset of the perpetrator before he or she becomes a perpetrator. There's got to be a way for these kids to learn that they do not have to repeat the past behavior.

Cori Y., a survivor of sexual abuse which she experienced at the age of 10 from her brother-in-law, says:

> I'm committed to resolving the issues: what doesn't get resolved gets repeated. . . . I think that it's imperative for people to heal from the abuse and trauma that they're experienced, because if they don't, I think it gets carried on from generation, to generation, to generation. I currently do a lot of work with perpetrators. . . . I've got 25 men. . .and I see a room full of 25 "little boys" who want attention, who want love, who were abused themselves. . .and it's just heartbreaking and sad for me to see how that woundedness just keeps getting carried on in damage and injury to other people. This healing is very important.

The fact that childhood sexual abuse continues for the survivor, even into adulthood (actually and emotionally), is verified by Lecia H., a survivor who was sexually abused from age 6 until 30 by her brother. She says:

> I kept it secret all those years and I'm 37 now. . . . Even though mom knows it happened because she said so, she'd be ready to tear me apart if I said it out loud to anyone. I can just hear her comments: "It didn't happen, she's making it up". . .that was one of my first fears when we started talking about it with my counselor. . . . If my mother found out that I mentioned anything like this, she's going to be ready to *kill* me!

And finally, Elaine K., a survivor of multiple sexual abuses from multiple abusers from the age of 9 to 14, sums up the importance of giving "voice" to childhood sexual abuse:

> I had no voice for so long. I always said "yes;" I didn't know that "no" was an option. I never spoke up. . . . Now I have spoken up, I have empowered myself and that has been very healing.

Validation: The Missing Link in Recovery From Childhood Sexual Abuse?

This study began with a question: Does validation through corroborative evidence make a difference in how women experiencing posttraumatic states recover from childhood sexual abuse? It ends with an answer, the answer of 25 survivors of childhood sexual abuse, who have "voiced" their beliefs: They have affirmed that validation does make a positive difference—it is an important link to recovery. This researcher believes them.

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APPENDIX A
Personal Questionnaire

1. Your birth date:_____
Mo. Day Yr.

2. Marital Status (Circle one letter; write number in starred question, if it applies)
A. Single-never married
B. Married * How many marriages have you had?_____
C. Separated or divorced *How many times separated or divorced?_____
D. Widowed *How many times widowed?_____

3. What is your predominant ethnic heritage? (Circle one, or fill in name of *other*).
A. African-American
B. Hispanic-American
C. Native-American
D. Asian-American
E. Eastern European-American
F. Western European or Anglo-American

G Other_____

4. What is your current religious/spiritual association? (Circle one or write in *other*):
A. Spiritual (e.g., belief in God/Universality or equivalent, but no religious affiliation)
B. Atheist (no spiritual/religious affiliation or belief in God or God equivalent)
C. Catholic
D. Protestant
E. Born-again, or fundamentalist Christian, beliefs
F. Jewish
G. Eastern religion (Buddhist, Muslim, etc.)
H. New Age spiritual beliefs (e.g., past lives/transcendence, etc.)

I. Other (Please describe)_____

5. What is your highest level of education? (Circle one).
A. Below high school
B. Some high school/GED/equivalent
C. High school graduate
D. Some college

E. College graduate
F. Graduate degree
G. Post graduate degree

6. What is your present job/career? (Fill-in)_____

7. What is your current income level? (Circle one):
A. Below $10,000
B. $10-$15,000
C. $16,000-$35,000
D. $36,000-$60,000
E. over $60,000

8. Are you on any prescribed medications for symptoms related to your childhood sexual abuse, and/or for current psychological problems?
Y N

9. If so, for what? (Circle all that apply):
A. Antianxiety
B. Antidepressant
C. For panic attacks/phobias
D. Mood stabilizer
E. For obsessive/compulsive behavior
F. Antipsychotic/delusions/though disorder
G. Sleep disorder or sleep related symptoms
H. Other (name)_____For what?_____

10. Are you currently abusing, or dependent on illegal drugs, or alcohol?
Y N

11. Does anyone else think that you are abusing, or dependent on illegal drugs or alcohol?
Y N

12. If so, are you currently addressing this in psychotherapy or an addictions' support or therapy group?
Y N

APPENDIX B

Script for In-Person and Telephone Interview

Hi! My name is Jill Wollenzien-Daniels. I'm a psychotherapist in private practice, and a clinical psychology intern student with Walden University. Do you have any questions you'd like to ask me about my credentials, or who I am professionally? (I will answer any questions that the participant asks, and then proceed with the interview.)

Thank-you _____(first name of participant), for agreeing to participate in this research study, and for filling out the questionnaire and assessments. Since you've signed the consent form, I assume that you've read and understand what this study is about, and what will be expected of you, but let me briefly explain again. The purpose of this study is to understand the impact that childhood sexual abuse has on the adult, female survivor, from her point of view. It's an opportunity for you to *tell your story,* so that therapists and others can learn from what you know personally about childhood sexual abuse.

As you know, all of your answers in this interview will be coded, and I'll only be using your first name or an alias if you wish, and the first letter of your last name, so that your confidentiality is preserved. This interview will be taped so your answers can be transcribed at a later date for purposes of analyses. This will assure accuracy in reporting your answers *exactly* the way you have described them within the interview. You may refuse to answer any

question you wish, or discontinue at any time. Do you have any questions?

Then we will begin. . .

Interview Questions:

1. Can you tell me about the childhood sexual abuse you experienced?

   A. Areas that will be probed:

      1) The age when abused; frequency of abuse.
      2) The meaning the experience had for her.
      3) How *present* the experience(s) is today--the affect, how associated or disassociated the experience(s) is.
      4) Who abused her: more than one? What was the relationship of the abuser to her? How much older was the perpetrator than her?
      5) Betrayal/abandonment issues?

2. How well (clearly) do you remember the abuse?

   A. Areas that will be probed:

      1) Memories of the abuse; type of abuse; where the abuse occurred.
      2) The quality of the memories:
         a) clear declarative;
         b) dissociated/repressed or fragmented;
         c) delay in recall: how long?;
         d) when-under what circumstances did the memories surface?;
         e) somatic memories (body memories), or distressing symptoms that appear to be memories?

3. Did anyone else know about the abuse?

   A. Areas that will be probed:

      1) Any witnesses to the abuse: Who? What relationship to the survivor?
      2) Anyone that validated and verbally affirmed that she was abused.
      3) Any documentation from a hospital, or legal confirmation of the abuse.

4. Who have you told about the abuse (other than your therapist)?

   A. Areas to be probed:

      1) The amount/kind of disclosure the survivor has given.

2) The person or persons she told--the relationship of that person/persons to her.
3) The reactions she got when she disclosed: Positive? Negative? Validating? Non-validating? From whom?
4) The survivor's reaction to the reaction of others after disclosure.

5. Are there any negative beliefs you have about yourself because of the abuse?

A. Areas to be probed:

1) Beliefs about being "crazy," "bad," or "evil."
2) Beliefs that have a negative impact on her self-concept and self-esteem (e.g., that she deserved it; that she is unlovable because of it; that it was her fault, or feelings of guilt and/or shame over enjoying the attention, or for having aroused, sexual feelings/pleasure).

6. How do you think this past abuse has affected you today?

A. Areas to be probed

1) Psychological symptoms-psychopathology.
2) Physical symptoms-psychosomatic complaints.
3) Personality disorders.
4) Relationships.

7. What do you believe needs to happen for your symptoms go away, or for you to heal from this past trauma?

A. Areas to be probed:

1) Getting at the present meaning of the trauma.
2) Beliefs about what needs to happen for the survivor to heal (e.g., needs therapy; understanding; to get away from her current environment).
3) Is validation through corroborative evidence necessary for remediation of symptoms?: The research problem.

8. What do you think therapists need to know about the abuse experience?

A. Areas to be probed:

1) Validation from the psychotherapist--Does she believe it's necessary for recovery?

2) Allowing her to express what she feels is important for health-care professionals to know. Encouraging empowerment by allowing her to tell her story to the therapist/researcher/larger community.

In addition to the open-ended questions, some specific questions may be asked, as the interview dictates. Each question will be asked and followed by with a *probe question*: "Tell me more about that; I'm not sure I understand; or is there anything you would like to add?"

APPENDIX C
Research Consent Form
Study on the Effects of Childhood Sexual Abuse on Women Survivors

You are invited to be in a research study about women who have experienced childhood sexual abuse and the effects this has on their lives, from their personal perspectives. You were selected as a possible participant because you are an adult, survivor of childhood sexual abuse. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

Study Conducted By :
Jill Wollenzien-Daniels, a doctoral student in clinical psychology at Walden University: 155 Fifth Avenue South, Minneapolis, MN. 55401. 1-800-925-3368.

Background Information:
The purpose of this study is to understand the impact that childhood sexual abuse has on women who have trauma-related symptoms; and have, or do not have, corroborative evidence (some outside evidence-person, source, or through records), of their abuse. It will investigate the importance of certain factors in the remediation of these symptoms. The ultimate purpose of this study is to learn about childhood sexual abuse from the survivor's perspective, and to disseminate that information.

Procedures:
If you agree to this study, you will be asked to do the following things: Fill out three, relatively short assessment questionnaires: (1) "The Dissociative Experiences Scale," which will ask questions about the degree to which you dissociate ("space-out," or are not fully conscious/aware in certain situations; like when your mind goes off on a daydream during a boring lecture or routine job); (2) the "Impact of Event Scale," which asks you questions about how certain traumas associated with your childhood abuse experience affect you presently; (3) and, the "Self-Esteem Rating Scale," which asks about your feelings of self-worth and self-love. Filling out these assessments should take about 25 to 30 minutes.

After completion of these forms, you will be participating in an interview with the researcher (Jill Wollenzien-Daniels), that will take approximately one hour. In addition to taking notes, the researcher will also tape-record the interview, so she can have a more accurate account of what was said. The complete procedures, assessments and interview, should take approximately 90 minutes.

Benefits of being in the Study:
There are many positive possibilities that could come from being part of this study: The possibility that participation in this study will be experienced as a psychological relief, by being able to tell your story to someone who's non-judgmental and truly interested. And the realization that you may contribute to knowledge, perhaps even new understandings, of childhood sexual abuse, which may have significant implications for future treatment.

Risks of being in the Study:
There is also some possible risk involved in being part of this study, and in order to be eligible to be a participant, you must have a therapist, whom you are presently seeing, or have seen in the past, who will be available, should you need to contact her/him. Talking about your childhood sexual experiences may be uncomfortable for you, and you could possibly have some strong, emotional reactions to it.

If , upon relating your experiences, you have extreme emotional reactions which the researcher assesses are detrimental to your emotional health, the researcher will terminate

the interview, and provide immediate, emergency, outpatient psychotherapy. She will then request that you contact your therapist for additional psychotherapy. You will be responsible for paying for any additional treatment that may be required as a direct result of your participation in this study.

Compensation:
You will receive a payment of $20 for your participation in this study, which shall be given to you by check, upon completion of the assessments and personal interview. If you decide to withdraw from this study, you will be responsible for returning the $20 payment to the researcher.

Confidentiality
The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a participant. Research records, including the audio recording, will be kept in a locked file; only the researchers will have assess to these records. The audio-tapes will be destroyed upon completion of the study.

Voluntary Nature of the Study:
Your decision whether or not to participate will not affect your current or future relations with any other cooperating institution or association. If you decide to participate, you are free to withdraw at any time without affecting those relationships. Upon withdrawal however, you will be expected to repay the $20 participation fee to Jill Wollenzien-Daniels, the student researcher.

Contacts and Questions:
The researchers conducting this study are: Jill Wollenzien-Daniels, ACSW, Psychology Intern and Walden University Student; and Dr. Richard Waite, Ph.D., Research Study Chairman, and faculty member of Walden University. If you have any questions, please feel free to call or write them at:

Student Researcher:
Jill Wollenzien-Daniels, ACSW/Psychology Intern
6730 W. Edgerton Avenue
Greenfield, WI. 53220
(414) 281-6612

Research Study Chairman:
Dr. Richard Waite, Ph.D.
1024 Graham Place
Lima, OH. 45805
(419) 229-5966

You will be given a copy of this form to keep for your records.

Signature_____Date_____

Signature of
Researcher_____Date_____

APPENDIX D

DES-II

(Reprinted by permission of Eve Bernstein Carlson, Ph.D. & Frank W. Putnam, M.D.)

This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are *not* under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

1. Some people have the experience of driving or riding in a car or a bus or subway and suddenly realizing that they didn't remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. Some people sometimes find that they are approached by people that they do not know, who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

19. Some people find that they sometimes are able to ignore pain. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

25. Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

26. Some people sometimes find writing, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

APPENDIX E

IMPACT OF EVENT SCALE

(Reprinted by Permission of M. Horowitz, Dept. of Psychiatry, University of California)

Name_____Occupation_____

In 19_____ experienced this life event_____

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true .during the past seven days. If they did not occur during that time, please mark "not at all."

	FREQUENCY			
	Not At All	Rarely	Sometimes	Often
1. I thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from memory.				
4. I had trouble falling asleep or staying asleep, because of pictures or thoughts about it that came into my mind.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or it wasn't real.				
9. I tried not to talk about it.				
10. Pictures about it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.				
13. I tried not to think about it.				
14. Any reminder brought back feelings about it.				
15. My feelings about it were kind of numb.				

APPENDIX F

(William R. Nugent, and Janita W. Thomas)

SERS

This questionnaire is designed to measure how you feel about yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follow:

1 = Never
2 = Rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = Always

Please begin.

_____ 1. I feel that people would *NOT* like me if they really knew me well.

_____ 2. I feel that others do things much better than I do.

_____ 3. I feel I am an attractive person.

_____ 4. I feel confident in my ability to deal with other people.

_____ 5. I feel that I am likely to fail at things I do.

_____ 6. I feel that people like to talk with me.

_____ 7. I feel that I am a very competent person.

_____ 8. When I am with other people I feel that they are glad that I am with them.

_____ 9. I feel I make a good impression on others.

_____ 10. I feel confident that I can begin new relationships if I want to.

_____ 11. I feel that I am ugly.

_____ 12. I feel that I am a boring person.

_____ 13. I feel very nervous when I am with strangers.

_____ 14. I feel confident in my ability to learn new things.

_____ 15. I feel good about myself.

_____ 16. I feel ashamed about myself.

_____ 17. I feel inferior to other people.

_____ 18. I feel that my friends find me interesting.

_____ 19. I feel that I have a good sense of humor.

_____ 20. I get angry at myself over the way I am.

_____ 21. I feel relaxed meeting new people.

_____ 22. I feel that other people are smarter than I am.

_____ 23. I do *NOT* like myself.

_____ 24. I feel competent to deal with difficult situations.

_____ 25. I feel that I am *NOT* very likable.

_____ 26. My friends value me a lot.

_____ 27. I am afraid I will appear stupid to others.

_____ 28. I feel I am an O.K. person.

_____ 29. I feel that I can count on myself to manage things well.

_____ 30. I wish I could just disappear when I am around other people.

_____ 31. I feel embarrassed to let others hear my ideas.

_____ 32. I feel that I am a nice person.

_____ 33. I feel that if I could be more like other people, then I would feel better about myself.

_____ 34. I feel that I get pushed around more than others.

_____ 35. I feel that people like me.

_____ 36. I feel that people have a good time when they are with me.

_____ 37. I feel confident that I can do well in whatever I do.

_____ 38. I trust the competencies of others more than I trust my own abilities.

_____ 39. I feel that I mess things up

_____ 40. I wish I were someone else.

(P/+) 3,4,6,7,8,9,10,14,15,18,19,21,24,26,28,29,32,35,36,37.
(N/-) 1,2,5,11,12,13,16,17,20,22,23,25,27,30,31,33,34,38,39,40

APPENDIX G

Clustering Sheet of Interview Variables for Analysis

Beliefs about validation and recovery (remediation of symptoms)_____

Report of impact of the abuse on current symptomatology (e.g., PTSD-like symptoms)

Negative self-beliefs (e.g., "crazy," "bad," "evil")_____

Negative or positive self-appraisal (e.g., self-love/acceptance; perceptions of others' view of self)_____

Positive or negative meaning attributed to the abuse_____

Coping strategies utilized during the abuse, and currently_____

APPENDIX H
Clustering Sheets in Sub-Groupings

Beliefs About Validation and Remediation of Symptoms:

1. Validation through corroborative evidence is necessary for recovery.

2. Validation by the psychotherapist is necessary for recovery.

Negative Self-Beliefs:

1. Belief in being "crazy," "bad," or "evil."

2. Other, similar negative self-beliefs (e.g., "soiled," "damaged," "nuts').

3. Belief that the childhood sexual abuse was her fault (guilty with consequent shame).

Negative or Positive Self-Appraisal:

1. Derogatory, punitive, or negative self-statements (correlated with low self-esteem).

2. Empathic, loving, accepting, self-statements (correlated with high self-esteem).

Report of the Impact of Their Childhood Sexual Abuse on Current symptoms:

1. PTSD-like symptoms:
   A. Flashbacks/intrusive imagery/memories of the abuse; reoccurring nightmares followed by intense psychological distress and/or numbing/dissociative state.

   B. Avoidance of stimuli associated with the childhood sexual abuse; and/or numbing of general responsiveness; use of dissociation and/or repression.

   C. Increased arousal (e.g., hypervigilance, exaggerated startle response, difficulty falling or staying asleep, difficulty concentrating).

2. Affective symptoms:

   A. Depression.

B. Anxiety, including panic attacks and hyperarousal, sleep disorders.

C. Addictive disorders and/or obsessive-compulsive disorders, including alcohol/drugs and eating disorders.

3. Somatizations:

A. Body disturbances, pains that have no apparent explanation (e.g., vaginal pains).

B. Intense pain in certain parts of the body in response to remembering parts or all of the childhood sexual abuse (somatic-memories).

4. Personality problems:

A. Confusion with identity and boundaries: Unable to distinguish self-from another.

B. Overly dependent upon others.

C. Avoidant of others/socially isolated.

D. Confusion with thought processes (contradictory statements).

E. Antisocial acting out or sexually acting out (promiscuous).

<u>Meaning the Survivor has attributed to the Childhood Sexual Abuse Experience(s)</u>:

1. Positive meaning (e g., "I'm stronger because of this abuse." "It has made me a better parent to my children.").

2. Negative meaning (e.g., "It has ruined my whole life; I'll never be free of it.").

<u>Emotion-Focused Strategies Used During the Abuse, and Currently</u>:

1. Negative meaning attributed to the abuse(about the world/others/self).

2. Dissociation (high/low; then/now).

3. Negative social support (perceived as low, and not sought out; or sought out but not given, or given but ineffective).

4. Denial, down-playing.

5. Avoidance.

Problem-Solving Strategies Used During the Abuse, and Currently:

1. Positive meaning gleaned from the abuse (about the world/others/self).

2. Positive social support (received social support from parent or others whether sought-out or not--social support given by psychotherapist/support group).

3. Uses various logical methods (manipulation of parent/self/environment) to stop the abuse, and/or the impact of the abuse on current symptoms (symptom-relief strategies like "relaxation exercises," for diminishing anxiety, etc.).

4. Acceptance of the abuse, (e.g., "Bad things happen to good people sometimes").

APPENDIX I

Raters' Instructions and Categorizing Sheets for Interview Data

Instructions: 1) Read through and familiarize yourself with all the categories below; 2) Listen to each tape individually and circle which categories apply; 3) Note the *Observations/Comments* section after each question, and write down anything you feel is pertinent to the study; 4) Answer Q17 by elaborating on any themes, patterns or other relevant information you deem is important from listening to the taped data.

Q1. Quality of Memories of the Childhood Sexual Abuse (CSA):

1. Clear, declarative memories.
2. Dissociated/fragmented/scattered.
3. Repressed/fragmented/scattered (motivated forgetting/wanted to forget).
4. Somatic memories (body memories - body symptoms that appear to be memories.)

- Observations/Comments:

Q2. Time-Sequence of the Memories:

1. Always remembered or most always remembered.
2. Mixed: Some always remembered, some delayed.
3. Delayed-memories.

- Observations/Comments

Q3. Circumstances of the Memory Retrieval:

1. When client was *not* in a therapeutic situation.
2. During therapy for other symptoms *not* thought by client to be *related* to CSA.
3. During therapy for symptoms t*hought* by client and/or therapist to be *related* to CSA.

- Observations/Comments:

Q4. Validation of the Childhood Sexual Abuse (CSA):

1. There *was* "corroborative evidence" of the abuse (someone else who could have known said it happened to client; or there were official records of it).
2. There was *no* "corroborative evidence" of the CSA.

- Observations/Comments:

Q5. Disclosure of the Abuse:

1. Disclosed to a parent (mother/father or substitute parents).
2. Disclosed to family member(s) other than parent(s).
3. Disclosed to school or other authority (e.g., social worker, police).
4. Disclosed to an adult outside of the family.
5. *Never* told anyone as a child
6. Disclosed as an adult to parent(s).
7. Disclosed as an adult to authority (e.g. police, doctor).
8. Disclosed to therapist.
9. Disclosed to other (identify relationship).

- Observations/Comments:

Q6. Reaction Received after Disclosure:

1. Positive from parent(s).
2. Negative from parent(s).
3. Positive from family.
4. Negative from family.
5. Positive from adult.
6. Negative from adult.
7. Positive from school authority
8. Negative from school authority.
9. Positive from therapist.
10. Negative from therapist.
11. Positive from other (name).
12. Negative from other (name).

- Observations/Comments:

Q7. Beliefs About Validation and Remediation of Symptoms:

1. Validation through corroborative evidence is necessary for recovery.
   a) From whom? (e.g., perpetrator, mother, father, relative, other)
   b) When? (e.g., back then, now)
2. Validation through corroborative evidence is *not* necessary for recovery.
3. Validation by the psychotherapist is necessary for recovery.
   a) How should that validation be expressed? In words/actions.
   b) How important is it that she/he tells you she/he believes your account of the abuse?

4. Validation from the psychotherapist is *not necessary* for recovery.

- Observations/Comments:

Q8. Negative Self-Beliefs:

1. Belief in being *"crazy," "bad,"* or *"evil."*
2. Other, similar beliefs (e.g., *soiled, damaged, nuts, genetically defective, etc.*).
3. Belief that the childhood sexual abuse *was her fault.*
4. Guilt.
5. Shame.

- Observations/Comments:

Q9. Negative or Positive Self-Appraisal:

1. Derogatory, punitive, or *negative* self-statements (correlated with low self-esteem).
2. Empathic, loving, accepting, self-statements (correlated with high self-esteem).
3. Acknowledgment/acceptance that the abuse was *not her fault.*

- Observations/Comments:

Q10. Report of the Impact of Childhood Sexual Abuse on Current symptoms:

PTSD-like symptoms:

1. Flashbacks/intrusive imagery/memories of the abuse; reoccurring nightmares followed by intense psychological distress and/or numbing/dissociative states.
2. Avoidance of stimuli associated with the childhood sexual abuse; and/or numbing of general responsiveness; use of dissociation and/or repression.
3. Increased arousal (e.g., hypervigilance, exaggerated startle response, difficulty falling or staying asleep, difficulty concentrating).

- Observations/Comments:

Q11. Affective symptoms and behaviors:

1. Depression; profound sadness; deep loneliness.
2. Deep-seated shame.
3. Extreme guilt.
4 Anxiety, including panic attacks, hyperarousal, sleep

disorders, great fears/phobias, and/or paranoia.
5. Addictive behaviors and/or obsessive-compulsive behaviors, including alcohol/drugs and eating disorders or problems.

- Observations/Comments:

Q12. Somatizations:

1. Psychosomatic illnesses: Body disturbances, pains that have no apparent medical explanation or are elicited by psychological distress.
2. Intense pain in certain parts of the body in response to remembering parts or all of the childhood sexual abuse (somatic memories).
3. Multiple, major health problems (e.g., frequent hospitalizations, surgeries).
4. Extreme weight gain (obesity).
5. Extreme negative body-image.
6. Sexual dysfunction
7. Promiscuity
8. Relationship/Intimacy Problems

- Observations/Comments:

Q13. Personality problems:

1. Confusion with identity and boundaries: Unable to distinguish self-from another.
2. Overly dependent upon others.
3, Avoidant of others/socially isolated.
4. Confusion with thought processes (contradictory, non-sequitor statements).
5. Antisocial acting out or sexually acting out (promiscuous).
6. Other (describe).

- Observations/Comments:

Q14. Meaning the Survivor has attributed to the CSA Experience(s):

1. Positive meaning (e g., "I'm stronger because of this abuse." "It has made me a better parent to my children.").
2. Negative meaning (e.g., "It has ruined my whole life; I'll never be free of it.").
3. No meaning associated with , or gleaned from the abuse.
4. Unreported

- Observations/Comments:

Q15. Emotion-Focused Strategies Used During the Abuse, and Currently:

1. Negative meaning attributed to the abuse(about the world/others/self).
2. Dissociation (high/low; then/now).
3. Negative social support (perceived as low, and not sought out; or sought out but not given; or given but ineffective).
4. Denial, down-playing.
5. Avoidance.
6. Other.

- Observations/Comments:

Q16. Problem-Solving Strategies Used During the Abuse, and Currently:

1. Positive meaning gleaned from the abuse (about the world, others, self).
2. Positive social support (received social support from parent or others whether sought-out or not--social support given by psychotherapist, and/or social/support group).
3. Uses various logical methods (e.g., manipulation of parent/ self/environment) to stop the abuse, and/or the impact of the abuse on current symptoms (e.g., "relaxation exercises," for diminishing anxiety, etc.).
4. Helping others/Affiliation.
5. Spirituality/Transcendence.
6 Acceptance of the abuse, (e.g., "Bad things happen to good people sometimes").
7. Other.

- Observations/Comments:

Q17. Summary of the Themes or Patterns Gleaned from the Data:

A. What kinds of statements get repeated and/or are the most emphasized?

B. What statements and/or questions elicit affective or dissociative responses?

C. Is there a permeating theme/core belief/philosophy/cognition that is stated or 'implied' (e.g., betrayal/trust, dissociation/avoidance, re-victimization, unfair world, guilt, shame, family dysfunction, etc.)?

D. Are there glaring contradictions in statements, nonverbals (voice), or affect?

E. Additional Observations/Comments:

APPENDIX J

Rater's Interview Category Comparison Worksheet

#_____ Name:_____

Question #	Rater #1 Sallie F.	Rater #2 Charlie F.	Rater#3 Cynthia M.	% Agree
1.(1-4)				
2.(1-3)				
3. (1-3)				
4. (Y/N=1,2)				
4 a. Age Val. (1-7)				
4 b. Time Val. (1-5)				
5. (1-9)				
6. (1-12)				
7. (1-4)				
8. (1-5)				
9. (1-3)				
10.(1-3)				
11.(1-5)				
12.(1-8)				
13.(1-6)				
14.(1-4)				
15.(1-6)				
16.(1-7)				
17.(1-4)				

APPENDIX K
Data Worksheet

_____ NAME:_____

I. DEMOGRAPHICS	Digit Place	Code: **Y=1 - N=2**
1.Subject Number	_____(2 digits)	
2.AGE	_____(2 digits)	
3.Marital Status	_____(1,2,3,4, or, 5)	
4.Ethnicity	_____(1,2,3,4,5,6, or 7)	
5.Religion	_____(1,2,3,4,5,6,7,8, or 9)	
6.Education	_____(1,2,3,4,5,6, or 7)	
7.Career/Job	_____(1,2,3,4,5, or 6)	

[**(1)**=Nonprofessional; **2)** Homemaker; **(3)** Professional. Business; **(4)** Helping professional (teacher, nurse, counselor, therapist); **(5)** Student; **(6)** other]

8. Income	_____(1,2,3,4, or 5)
9. Medication	_____(Y/N)
10.Medication Types	_____(1,2,3,4,5,6,7,8, 9,10,11))
11.Substance Use	_____(Y/N)
12.Others' opinion of use	_____(Y/N)
13.AODA Therapy Status	_____(1, 2, or 3))

II. TEST DATA	(SPACE)
1.DES Amnesic	_____(6 digits)
2.DES Absorption	_____(6 digits)
3.DES Depersonalization	_____(6 digits)
4.DES Total	_____(6 digits)
5.IES Intrusion	_____(6 digits)
6.IES Avoidance	_____(6 digits)
7.IES Total	_____(6 digits)
8.SERS Positive	_____(6 digits)
9.SERS Negative	_____(6 digits)

III. QUALITATIVE	(SPACE)
1.Quality of Memory **(Q#1)**	
1)Clear Declarative	_____Y/N
2)Dissoc/Fragmented etc.	_____Y/N
3)Repressed	_____Y/N
4)Body Memories	_____Y/N
2.Time Sequence **(Q#2)**	_____(1,2, or 3)
3.Circumstance of Recall **(Q#3)**	_____(1,2, or 3)
4.Validation: Corroborative Evidence **(Q#4)**	_____(1 or 2)
5.Age of disclosure	_____(1,2,3,4,5, 6, or 7)

[**(1)** [0-5]; **(2)** [6-12]; **(3)** [13-17]; **(4)** [18-29]; **(5)** [30-49]; **(6)** [50 and up **(7)** Unreported]

Digit Places Code:=Y=1 - N=2

6.Disclosed to Whom **(Q#5)**

1) Mom _____Y/N
2) Dad _____Y/N
3) Sibling _____Y/N
4) Other Relative _____Y/N
5) Child _____Y/N
6) Authority _____Y/N
7) Medical _____Y/N
8) Other Adult _____Y/N
9) Therapist _____Y/N
10)Other _____Y/N

7.Reactions to Disclosure **(Q#6)** (**1**=pos; **2**=neg; **3**=mixed; **4**=neutral;**5**=unknown)

1) Mom _____(1,2, 3, or 4)
2) Dad _____(1,2, 3, or 4)
3) Sibling _____(1,2, 3, or 4)
4) Other Relative _____(1,2, 3, or 4)
5) Child _____(1,2, 3, or 4)
6) Authority _____(1,2, 3, or 4)
7) Medical _____(1,2, 3, or 4)
8) Other Adult _____(1,2, 3, or 4)
9) Therapist _____(1,2, 3, or 4)
10)Other _____(1,2, 3, or 4)

8.Validation Belief: From Whom? **(Q#7)**

(**1**=Yes, Important; **2**=No, *Not* Important; **3**=*Not reported*)

1) Perpetrator _____(1,2, or 3)
2) Mom _____(1,2, or 3)
3) Dad _____(1,2, or 3)
4) Sibling _____(1,2, or 3)
5) Other Relative _____(1,2, or 3)
6) Child _____(1,2, or 3)
7) Authority _____(1,2, or 3)
8) Medical _____(1,2, or 3)
9) Other Adult _____(1,2, or 3)
10)Therapist _____(1,2, or 3)
11)Other _____(1,2, or 3)

9. Neg. Self Beliefs **(Q#8)**

1) Crazy/Bad/Evil _____Y/N
2) Other Neg. words _____Y/N
3) Deserved it _____Y/N
4) Guilt _____Y/N
5) Shame _____Y/N

Digit Places Code:=**Y=1 -N=2**

10. Neg. or Pos. Self Appraisal **(Q#9)**
    1)Neg. Self Statements _____Y/N
    2)Pos. empathic, Loving Ss _____Y/N
    3)Self *Not* to Blame _____Y/N
11. Impact of CSA on Current Symptoms **(Q#10)**
    1) Intrusive Symptoms _____Y/N
    2) Avoidance/Numbing, etc. _____Y/N
    3) Increased Arousal (Hypervigilence_)_____Y/N
    4) Other _____Y/N
12. Affective **(Q#11)**
    1)Depression _____Y/N
    2)Anxiety/Fears _____Y/N
    3)Addictions _____Y/N
    4)Obsessive/Compulsive _____Y/N
    5)Eating Disorders _____Y/N
    6)Other _____Y/N
13.Somatizations **(Q#12)**
    1)Psychosomatic _____Y/N
    2)Pain _____Y/N
    3)Multiple Health Prob. _____Y/N
    4)Obesity/Weight Prob. _____Y/N
    5)Neg. Body Image _____Y/N
    6)Sexual Dysfunction _____Y/N
    7)Other _____Y/N
14. Behavioral Issues **(Q#12)**
    1)Promiscuity _____Y/N
    2)Relationship/Intimacy Problems _____Y/N
    3)Self Destructive/Mutilation _____Y/N
    4)Other _____Y/N
15. Personality **(Q#13)**
    1)Identity/Boundary _____Y/N
    2)Overly Dependent _____Y/N
    3)Avoidance/Isolation _____Y/N
    4)Confused Thoughts _____Y/N
    5)Antisocial/Sex. Acting out _____Y/N
    6)Other _____Y/N

Digit Places Code:=**Y=1 -N=2**

16. Meaning of CSA **(Q#14)** _____(1,2,3, or 4)
(**1**=Pos; **2**=Neg; **3**=*No* meaning; **4**=*None* reported)

17. Emotion-Focused Coping **(Q#15)**
    1)Negative Meaning _____Y/N
    2)Dissociation and/or Repression _____Y/N
    3)Neg. Social Support _____Y/N
    4)Denial _____Y/N
    5)Distraction _____Y/N
    6)Avoidance _____Y/N
    7)Other _____Y/N
18. Problem-Solving Coping **(Q#16)**
    1)Positive Meaning to CSA _____Y/N
    2)Positive Social Support _____Y/N
    3)Logical Methods/Man. Environ. _____Y/N
    4)Acceptance of the Abuse _____Y/N
    5)Helping Others/Affiliation _____Y/N
    6)Spirituality/Transcendence _____Y/N
    7)Other _____Y/N

19. Age of Validation w/evidence _____(1,2,3,4,5,6, or 7)
(1) [0-5]; **(2)** [6-12]; **(3)** [13-17]; **(4)** [18-29]; **(5)** [30-49]; **(6)** [50 and up]; **(7)** [*not* validated]

20. Time of Validation _____(1,2,3,4,5,or 6)
(1) During the abuse or shortly after; (2) Upon disclosure as a child; (3) Upon disclosure as an adult; (4) Years later; (5) Never validated

APPENDIX L

The Pilot Study Case Studies:

The pilot study cases are described using the participants' words according to the Research Questions and the cluster sheet categories (Appendixes H and I)

Case Number 1: Story of Geraldine N.

Childhood Sexual Abuse Experiences:

Geraldine's earliest memories of being sexually abused are when she was 7 years old, in first grade. She, her sister and her mother lived above grandma's store while dad (an engineer), was away at war. Mom worked down in the store, and they lived together with other cousins and relatives, "12 people in all." Mom was busy working down in the store and often left her in the care of her uncle by marriage (mom's sister's husband). He would tuck her into bed, and during those times, would sexually abuse her: "It stated with 'digital penetration' (fingering of my genitals, my vagina), and progressed into intercourse when I was around 12 years old." It finally ended at age 13 or 14.

Dissociation and Memory Variables: Pertaining to Research Question 1 (c):

For Geraldine, two memories are very *clear*: the one at 7 years old when her uncle 'fondled' her and 'fingered' her genitals, and the memory at 12 years old when he had intercourse with her. Other memories are *sketchy*, *fragmented*, and probably *dissociated* because she states: "I *know* there were

previous times," (when he had intercourse with her-words added). None of the memories fully surfaced until she was 35 years old and her children were grown and out of the house. "It was the 'empty nest' syndrome, I suppose." The memories started coming back after a dream she had in which she was telling this man, "I don't care who gets hurt, if you touch me again, I will kill you!" After the dream she started having symptoms: "From about 35 until 40 years old I was really having a very difficult time and thought I was going insane. . .I started hating my husband and not wanting him to touch me for no 'apparent' reason. I had 'menopausal' symptoms, even though I knew I was too young to be menopausal: with unexplained sadness and crying spells, and intensely painful migraine headaches." It was during this time of active symptomatology and "bad dreams" that she started piecing the memories together ". . .But there was no direct or orderly progression to this process." She was not in any kind of psychotherapy when she first began to remember the abuse, and therefore the memories were not elicited through therapy. She did however, pursue therapy a short time later, as a result of her symptoms.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Geraldine has mixed feelings about the validation she received from her sister. On the one hand she is glad to be validated, as it has helped her understand many of her symptoms (e.g., intense anger toward her mother, grandma, and husband), and "heal" from some (e.g., migraines). But on the other hand, she is angry at her sister for keeping her sexual abuse a secret for so long and not sharing it with her earlier, as she believes that this might

have helped her not feel so "insane," (e.g., unexplained "crying jags," nightmares and other PTSD symptoms), or develop many of the other negative symptoms she has had. She says that for most of her life she has felt very negative about herself: ". . .I always feel that people will find out about the *real* me and what a disappointment that will be. . ." Geraldine has become obsessive-compulsive, and a perfectionist to prove herself *worthy.*

> I have an inner feeling that if I take this one more step (more school, another degree) maybe then *I'll be good enough.* . .cleaning, cleaning, cleaning, when I'm upset I clean it again whether it needs it of not. . .as I've gotten older I've learned to relate that to looking for *inner cleanliness.*

Self-Esteem/Impact of Abuse: Pertaining to Research Questions3;4 (a), (b):

Geraldine has many negative beliefs about herself that she feels are connected to her early childhood sexual abuse, she states: "I have no value; not good enough; no worth. I'm *crazy, bad.* . .felt shame and guilt and that my badness was *inherited* (a genetic defect)." Geraldine states that she has less of these beliefs since being in therapy for herself, as well as from working with other women survivors as a therapist: "...working with other women in counseling and telling them 'It's not your fault,'. . .somehow I've been able to internalize that."

She explains some of the other debilitating symptoms she's experienced, which she attributes to the childhood sexual abuse:

> . . .I had this intense, unexplained anger toward my mother and grandmother (as a child and adult), and then later toward husband (at ages 35-40-words added). I over protected my daughters, imagining that they would *inherit* my *badness* and do what I did (the sexual

> abuse). . .I was consumed with guilt and was so fearful that one of my daughters, I have two daughters, what if they did what I did, what if they *inherited* whatever that characteristic was. And I was vigilant, I watched them like a hawk because I was so fearful that someone would abuse them.

Despite her over vigilance, she believes that one of her daughters was also sexually abused by the same uncle who abused her (although the daughter does not remember or admit this, despite her displays of many symptoms and 'signs' of abuse).

Geraldine also had migraine headaches for many years, which she said were, "caused by held-in anger." And "menopausal symptoms" (crying, feeling insane, nightmares—actually PTSD symptoms); negative self-beliefs ("not lovable"); hatred of her body (feels its inferior); unjustified feelings of guilt and shame, especially in relationship to her body and sex: "Sex is *not* enjoyable, it's an obligation." After the first abuse at age 7 she became increasingly afraid of the dark and to sleep alone. She remembers that she would constantly crawl into bed with her mother, and could not sleep alone as a child. This developed into a phobic-like fear of the dark, and of sleeping alone as an adult.

Geraldine feels that some negative consequences of her childhood sexual abuse are still with her: She continues to have a negative body image ('mild' eating disorder), and sees herself as fat, even when very thin: ". . .I never feel thin enough." She has low self-worth: doesn't feel lovable, worthy or "good enough," and feels she must overachieve to prove herself.". . .I'm a

perfectionist, a compulsive overachiever." Although Geraldine graduated "summa cum laude" from college, obtained a master's degree in counseling, and is presently pursing a doctorate in counseling psychology, she still never feels "good enough."

Through psychotherapy the migraines gradually went away (as she began to understand the abuse and to express anger): ". . .The anger began to come out, instead of inside my head." She also says that she does not (consciously) feel guilty for the sexual abuse anymore (although she continues to compulsively clean closets that don't need cleaning when she is stressed, and admits that this is a ritual for "inner cleanliness" (which is a likely indication that she still feels 'unclean,' and perhaps guilty at some level). She also still struggles with a fear of the dark (although it is not at a phobic level anymore).

Validation Variables: Pertaining to Research Question 5:

Validation through corroborative evidence occurred for Geraldine when she was about 35 to 40 years old:

> I truly thought that I was going insane ('crazy'), and I called my sister to ask if she knew if she was sexually abused and she said, 'Yes,' *before* I could even ask the question! She said she knew what I was gong to ask from the way I was crying and behaving, because she too had been sexually molested as a child, by this same uncle, and had gone through similar symptoms as an adult.

<u>Disclosure Variables: Pertaining to Research Question 5 (b):</u>

At age 7 or 8 Geraldine remembers trying to tell her mother and grandmother about the sexual abuse but they insisted that she was just

having bad dreams and nightmares, and dismissed it. As an adult, upon the death of the uncle (the perpetrator), she again tried to tell her mother about the abuse and why she wouldn't attend his funeral. Her mother refused to believe her and called her "cold," and "selfish," for her refusal to attend her uncle's funeral.

After recovering the memories of the abuse as an adult, she also told her male cousin with whom she was very close. He was very supportive and believed her, but since that time has become an alcoholic. She believes that her disclosure may have brought up repressed memories of his own abuse, and that he turned to alcohol as a way of coping with it. This has caused her continued guilt.

Geraldine also revealed her childhood sexual abuse to her daughter's therapist when the daughter was in therapy for depression and unexplained, intense affect after the birth of her fist child. Geraldine believes her daughter was also sexually abused by the same uncle, although the daughter has never revealed this. It was after helping with her daughter's therapy, that she then got involved in her own therapy and began the process of working through her childhood sexual abuse experiences, and other related symptoms.

Case Number 2: Story of Jean W.

Childhood Sexual Abuse Experiences:

Jean was sexually abused by her brother-in-law, who was 10 years her senior, when she was 15 years old, until she was 17. They were not forced or threatening experiences, but rather a "seduction" of a "vulnerable" young girl.

To understand her childhood sexual abuse, it is necessary to know a bit of her background and what led up to this abuse: Jean said that she had been an unattractive child with a lot of *baby fat* until about 14, 15, when she suddenly slimmed down and became quite shapely and attractive except for an acne problem. "I had bad skin." Jean was the baby of the family with brother and sisters from her mom's first marriage who were 10 to 15 years older and a brother three years older, from her mom's current marriage to Jean's dad. She always felt inferior to her brother who was mom's obvious favorite. Mother was very dominant in her family and dad just agreed with her. Jean says: "I had not had a lot of emotional support from my parents. Pretty much felt alienated from my family emotionally and misunderstood." She remembers that her mother always compared her to her brother who could do no wrong, and even though Jean was an excellent student and on the honor roll in high school, her brother always got higher grades and was better at doing things. Jean says that whatever she did was discounted by her mom and that she was criticized often. Dad did not protect or stick up for her, but was passive. Just as Jean was beginning to develop very close friendships with peers, her family moved: first far away to a big city when she was 11 years old, and then out into the country of a very small town, when she was beginning high school, leaving her geographically isolated from people and friendships. This isolation fed into her feelings of being alienated and misunderstood. She went through obsessive thoughts of death and

suicide and very negative feelings about herself and her body-image during this time.

When she was 15 years old, her sister, who was married with small children, offered her an opportunity to come and live with her family and baby sit in exchange for her being in town and able to do more things (e.g. walk to places, see people). Jean happily agreed. She went from very strict, overly protective and critical parents, to a sister who allowed her to do whatever she wanted.

This was a rebellious time for Jean and her sister fed into this since sister was very angry with dad and defied him by allowing Jean free rein. It was during this time that the sister's husband (Jean's brother-in-law) lured Jean into becoming sexually involved with him. He was 10 years older than her and a very social, popular, and good-looking man. He complimented Jean (as no other person had ever done), about being pretty and smart. He gave her a lot of "special attention," and played on her sympathy by telling her how unhappy he was in his marriage, which Jean could see as she noted: "My sister had a 'chip' on her shoulder with men." He started out by simply touching her breasts with her clothes on, and then slowly proceeded until they were having sexual intercourse and an "affair" whenever they were alone or when sister was asleep upstairs.

This man told Jean that he loved her and was sacrificing much for her (possible jail and his marriage if her sister found out) and although she had resisted at first, she also believed him and desperately wanted to be loved.

He was the first intimate and sexual experience she had had with a man. The "affair" lasted for 3 years until Jean went off to college. She broke it off with him because of her extreme guilt (having sex with her sister's husband) and because she began to realize that he had had other affairs.

She protected him and herself and never told the sister, and does not believe that she ever found out. He eventually divorced Jean's sister and married his secretary, with whom he was also having an affair.

Jean believes that the 'affair' was her fault and suffers great shame and guilt over it even today (20 years later). She had not seen this as childhood sexual abuse (previous to therapy), but as her own wrong-doing, and has still not been able to forgive herself.

Dissociation and Memory Variables: Pertaining to Research Question 1 (c):

The memories of Jean's childhood sexual abuse are very clear and present: ". . .like it was last week".

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Jean does *not* think it would help if her brother-in-law admitted what he did with her was wrong (validation), this would help her, because she firmly believes that the issues about it are *hers* and not his. She states:

> . . .I don't want retribution against him, I don't think that would help. He did tell me once, when I ran into him, the closest he ever got to an apology was, he said something like, well I had said something like, 'that's O.K. don't worry about it.' And he said, 'I don't think I helped you a whole lot, might have even screwed you up a little.'

Self-Esteem/Impact of Abuse: Pertaining to Research Questions3;4 (a), (b):

Jean expressed many negative beliefs about herself related to the childhood sexual abuse. She says:

> This was validation that my only attribute was my sexuality. I was on the honor society, I was always on the honor roll, but. . .I didn't hang out with the smart group, you know I hung out with the kids who went to parties and stuff. . .I made some bad choices, and so. . .I think one of my biggest things is: 'would I have had a different focus, would I have had a different path in my life, if I hadn't dropped out of college for 10 years?' I didn't like myself for what I did. . .for falling for the flattery. I blame myself for that, still today. . .

Jean's also very angry at herself because she runs into her ex brother-in-law occasionally, and is still sexually attracted to him and enjoys conversation with him, which she says feeds into her guilt and shame even more. "Well if I still like him, than it must have been my fault. I feel that I'm abnormal when I'm attracted to other men sexually, that I shouldn't be that way." She thinks this may also be related to being raised strict catholic and her parents' rigid attitudes toward sex. She further states: " I'm a rotten person, and I hate myself, and in general I don't think I'm a good person."

Jean "suffers" from major depression and is on antidepressants which are working well. She also has a negative body-image and eating disorder. She says: "I'm aware that I keep myself overweight so that I'm not attractive to other men, because I think I feel if I am attractive, I'll do it again. I don't trust myself."

Validation Variables: Pertaining to Research Question 5 (a), (c):

Jean did *not* have validation through corroborative evidence of the childhood sexual abuse. Although her brother-in-law did not deny his sexual involvement with her, he also never admitted that it was wrong of him, or that it was sexual abuse.

Disclosure Variables: Pertaining to Research Question 5 (b):

> . . .I never told anyone about it, except my present therapist. I always was very ashamed of it, I felt it was my fault, that I let it happen. I felt very selfish about it, that it felt good. Ashamed of my behavior that I had acted so promiscuously.

Jean did share the abuse with her current therapist, but was in therapy on and off for years, and had not shared the abuse with the other therapists, ". . .because I felt too ashamed." She is afraid to tell her husband, who has been her staunch supporter, as she fears he will think less of her. She also believes that if she were to tell her mom and dad they would reject her, and says, "...I don't think they would believe me."

Case Number 3: Story of Rose N.

Childhood Sexual Abuse Experiences:

> I was 4 when it started. It was my step-father. My mother went to the hospital to have my sister B. It was March 2nd, 1948, right after he came from the hospital, and he started by putting his 'thing' (penis-word added) in my mouth and doing all different kinds of things (sexual-words added). And somebody came to the door and rescued me that night, and he stopped. And it happened again, and he kept doing different stuff (sexual abuse), any little chance he got during my lifetime until I was 16, and then I left home. Every time that my mother would go into the hospital to have a baby, I knew that he'd be waking me up in the middle of the night and doing 'things' to me. Sometimes I'd go baby sitting, and he'd come over to the places where

I'd baby sit and he'd do the 'stuff' to me there. I'd be down in the basement washing clothes and he'd come and get me in the basement and say: 'Come on and help me calm the boys down,' and he'd be doing things to me in the attic. He'd take my mother out and get her drunk and then he'd wake me up, and the dog would snarl at him and he'd kick the dog, but he'd take me in the bathroom and do 'things' (sexual) to me too.

He did physical and emotional things to me. Also he told me he'd kill me if I ever told anybody. And then when my mother found out that this was happening she accused me because I was developing, that it was my fault, how I looked. I was just a normal teen-ager in short shorts and stuff.

I didn't even know I was suppose to have a period. . . .at 5 or 6 years old, I was bleeding because of what he did, and I was afraid. And then I actually started my period about 7 or 8 years of age, but I never told anybody I had it, because I thought I was going to get killed.

And when I was older and had a boyfriend he'd say: 'You better not get her knocked up, you better not be doing anything because I'll kill ya!' And here he was the one who was doing things to me, and my boyfriend was just over helping me with the kids, and if we'd go out we'd just go riding, go by his family's house; we didn't do anything.

I had already tried to commit suicide in 9th grade from the way I was being treated. I said, 'If there's a God why is all of this happening to me?' And here I was on the honor roll, I was up with all the babies in the middle of the night, my mother never had to get up with the kids. I had all the ironing to do, at least 3 bushel baskets a week, giving the kids their baths. Sometimes my mother would leave for two or three weeks in the summer and leave me with most of the kids. She'd go to Oshkosh with my step-father and take maybe one or two of the kids. It's like I just had to be responsible. I started beating myself on the head with a hammer because I just couldn't take any more. What stopped me, there was an 'inner voice' that said 'it's not right.' It was just like a spirit kind of a thing, maybe it was my guardian angel, I don't know.

They were trying to shove Catholic religion down my throat and they were telling me this is what I'm suppose to do, and I didn't want any part of it. And I was experiencing going to other churches and I didn't get anything out of that except going and experiencing the different types of religions. And then after I decided 'I'm going to church,' Catholic was my choice, and I felt that, 'I belong there.'

Rose's Catholic religion and spirituality became her major coping mechanisms for coping with the aftermath of her childhood sexual abuses.

Dissociation and Memory Variables: Pertaining to Research Question 1 (c):

Most of the memories of the sexual abuses Rose endured were very clear, conscious, and never forgotten.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Rose believes that validation from the *therapist* is important as well as "unconditional acceptance of the client, regardless of her problems." She thinks that it is important for her to not be pushed or forced to do things she is not ready to do (e.g. stop drinking alcohol). In response to how she will heal from her alcohol dependency she said: "I have to walk out of life the way I walked in, feeling loved." She says: ". . .when I feel good about herself, the alcohol addiction will go away . . ."

Rose did not address the issue of the importance of validation from the perpetrator, parents, or others.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions3;4 (a), (b):

> . . .I just think that everybody else is better than me and I don't have anything to offer. And everybody else is kind of smarter than I am, and then when I stop and talk to different people, it turns out I went through the pain and everything and I'm just as smart as they are a lot of times. But I don't always believe that

On the positive side she says: "I think I'm a good person, despite what I was told—that I was dumb and stupid and ignorant all my life." Rose also said that she feels "betrayal'" is a big issue because of the abuse, and has

made it very difficult for her to trust and allow herself to get close (intimate) with others, especially men. She did however, enjoy sex with her husband and desired it, but believes that masturbation is wrong and will not allow herself to engage in this pleasure.

Rose believes that the past abuses have had large, negative effects on her today. Relationships seem to be the most problematic. She said that it is particularly hard to trust people . "Everything and everybody's let me down. It's like you can't find a love that's not going to turn around and leave you. Because no matter what you do, it's never good enough. They always want more and more and more. You can't give any more of yourself.." She married a man with children and raised his kids and then he left her for another, younger woman. She feels that this is the same pattern she grew up with, like what her step-dad did to her. "Everyone that you cared about and did so much for, they just kind of shit on you, when they were done using you."

Rose also "suffers" from deep depression but refuses antidepressants. She self-medicates with alcohol. She admits: "Right now it's a crutch. It's one thing that never lets me down, it lets me sleep at night, it's a tranquilizer." She tells of her progress toward overcoming her dependency on it: "I went from drinking regular beer to light beer. . .it's less alcohol. I used to drink the 16 ounces of Pabst, and now it's down to the 12 ounces of light."

Rose has PTSD-like symptoms such as nightmares and recurring dreams that seem to be related to her CSA. She is also hypervigilant and has

many fears. She is rather shy and self-conscious and does not make friends easily. Rose is overly generous and easily gives to others, but she has great difficulty taking from others (part of her inability to trust ,and fear of rejection/abandonment). She also used to get physically sick (anxiety attacks and Somatizations) when she would be in a new situation involving people (church committees, etc.), or have to do things (perform in some way). But through therapy, she's been able to get over this reaction, and to feel more confident.

Validation Variables: Pertaining to Research Question 5 (a), (c):

There *was* validation through corroborative evidence, of the childhood sexual abuses done to Rose:

> My sister C. walked in one time when he was doing sexual things to me and she saw it. And then she said something to my mother, and then to me. I can't remember exactly what it was, but my step-father used to say: 'If you tell anybody I'll kill ya!' He was also doing it to some of the other kids, which were his own children; the boys and the girls.

Disclosure Variables: Pertaining to Research Question 5 (b):

"My mother never believed the abuse, she never believed that it happened." Rose said that people (her sisters, friends of the family) would tell her mother that her step-father was sexually abusing her, but she wouldn't believe them. Her sister C. came in on them once and told mother, but dad was able to "blow it off"(she doesn't remember how).

At 16 years old Rose lived with a foster family (friends of her family), because her own family had moved to another state, and she remained

behind to finish school. When it came time for her to go back to live with her family she revealed to her foster mother what her step-father had been doing to her. She did this so she would not have to go back home and live with him. She then talked to school authorities, and asked to be able to stay in the school, and revealed to them the sexual abuse of her step-father. Since the family had moved to another state, the school officials did not try to prosecute the step-father, or pursue the matter further.

Additionally, a boarder who had lived in her family's home, suspected that the step-father was doing something sexual with Rose, and told her foster parents about his suspicions. "And if I went to see my family, I always took someone with me so that I would make sure I got back. I was scared to go back there, but I wanted to see my brothers and sisters."

Case Number 4: Story of Rosanne K.

Childhood Sexual Abuse Experiences:

When Rosanne was a young child (5 years old, until 7 years old), her grandma was in and out of the hospital, causing her parents to leave her with her little girl friend's big brother (late teens) to baby sit. He would take the girls (her and her friend) down into the basement and do sexual things with them. (Rosanne would not go into details about the exact acts that he did with her, but did say that spanking was also involved.) He told Rosanne that he did this because he loved her, and she believed that in order to be loved she had to obey him, and do whatever he told her to do. The abuse was never witnessed by anyone other then the perpetrator's little sister (same age as

Rosanne), and although Rosanne told her parents that she was afraid of the boy and didn't want to be left with him, they did not believe he was doing anything wrong and continued to have him baby-sit for two years. She said: "I didn't want to go, but they forced me to go." The abuse stopped when her parents moved the family to a different state. As a child, she remembers feeling that her parents had saved her, even though they did not believe her when she tried to tell them what the boy was doing to her.

Dissociation and Memory Variables: Pertaining to Research Question 1 (c):

Rosanne seems to have used "motivated forgetting" and repression, in relationship to her childhood sexual abuse memories. She says there were parts of the sexual abuse that she always remembered and never forgot, but added:

> . . .I don't think I wanted to remember. . .Sometimes the memories are very clear, but I brush them out of my mind, as they make me very nervous (scared, sad and anxious), and I go back into the experience of it, and stuff I don't want to remember. But I know it happened.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Rosanne said that she believes validation from the abuser or her parents would have helped her back when the abuse happened, but she does not believe it would help now. She does however firmly believe that it is necessary for the therapist to believe her. She states: "All my life I felt like I should be just very quiet, don't make any waves, just do what everybody wanted me to do. And I went right from my parents with my husband, so it

was like it just continued—the controlling, and I became very submissive. But this has changed quite a bit since being in therapy (over 2 years)."

Self-Esteem/Impact of Abuse: Pertaining to Research Questions3;4 (a), (b):

". . .I can't understand why anyone would love me, I have a problem with that. I don't feel that I'm attractive, appearance-wise, or sexually, or in relationships with men. With men I'm intimidated easily." Rose feels unlovable and that the abuse has made her passive, dependent and easily controlled by men. She states:

> I feel like I can't be in control of myself - I was forced to do things I didn't want to do—feel like I have to. I have this feeling I need to be loved and that I have to really work at that, and do whatever someone else (a man) wants in order to do that and that's been really tough to get over. I must be very, very, good to be loved. I now get very upset if I feel my husband is trying to control me. . .

Roseanne acknowledged that she may now be overly sensitive to being controlled by men and tends to perceive it sometimes when it is *not* there.

She is still filled with shame over the abuse because the boy told her he loved her and she believed him and did what he told her to do (feels she was stupid and a "fool" even though she was only 5 years old). Rosanne says she knows it was not her fault, but when she is sick or in pain or overly tired, she will regress back to being little again and feel the same feelings (PTSD symptoms). Rose has a very serious weight problem (extreme obesity-perhaps an eating disorder) which she is working on with medical doctors, a physical therapist, and a psychotherapist. She says: "I hide myself with food." This weight has affected her physical and emotional health (serious back,

muscular problems). In addition, she has had many other debilitating health problems (Lupus, nerve damage, heart) and suffers from major depression. She also struggles with extreme dependency issues and admits to being overly dependent on her husband and others to make decisions for her.

Validation Variables: Pertaining to Research Question 5 (a), (c):

Rosanne *did not* have validation through corroborative evidence of her childhood sexual abuse. The only witness to this abuse was her little girl friend (the perpetrator's sister) who was abused with her. But she was only about 5 years old at the time, and also did not reveal the abuse to anyone.

Disclosure Variables: Pertaining to Research Question 5 (b):

Rosanne attempted to tell her mother that the boy hurt her and she was afraid of him and didn't want to go over there, but mother refused to believe her. She says:

> My mother didn't believe that anything bad happened to me. I told her about it since recovering it in therapy, and she said 'it never happened.' My mother denies things happen. She even says we were never with J. (perpetrator-added). They never believed me and nothing was ever good enough for them, so no matter what you did, even if you were right, it was knowing you were just a girl and girls don't know that much. . .

APPENDIX M

Case Studies

Case Number 5: Story of Julia K.

Childhood Sexual Abuse Experiences:

Julia had two abusers: her dad when she was 4 or 5 years old, until about the age of 12, and a 32 year old boyfriend, when she had just turned 16, which lasted until she was 17. She most clearly remembers the abuse when she was 16 to a man who was "the pillar of society," and a prominent leader in Alcoholic Anonymous (AA) where they met. During their one year relationship she states that, "He *ritualistically* abused me." He physically, sexually, violently, abused her and invited his friends over his CB to come and have sex with her. She was "branded" with the word WHORE on her arm (now covered over). This abuse experience is not applicable to this study due to her disqualifying age (the abuse must have happened before the age of 16), but is reported here because the negative consequences of this abuse were what motivated her to get into psychotherapy, where she 'recovered' delayed-memories of the earlier abuse by her father. She says that, "I was vulnerable to further abuse," and "setup" for it, due to the earlier sexual abuse by her dad, which she had dissociated from.

Julia is the oldest of all girls, and was her dad's "right-hand man. . ."I was the 'boy' her wanted." She reports that her dad (now deceased) was

alcoholic and emotionally, physically and verbally abusive to the children. He got "sick" (a massive coronary) when she was 12 years old (this is when the sexual abuse stopped). He became very depressed, often threatening to kill himself and all of them. She remembers protecting her sisters from him by having them sleep in her bed while she stayed awake and kept vigil. She says that she is hypervigilant, and has a disturbing sleep disorder today, which she attributes to this. Mother had to go to work when dad got sick, and Julia says: "She didn't protect me. . .She wasn't validating."

Dissociation and Memory Variables: Pertaining to Research Question 1:

Julia has a *clear* memory of herself at 4 or 5 years old at the bottom of the stairs, with dad at the top, naked, looking down at her, and masturbating. There are other *fragmented, dissociated* remembrances and a *sense* (body memories) of being sexually abused by her dad. She has been in therapy for the last 2 to 3 years recovering memories of her dad's abuse after having worked for many years previously (with other therapists), to resolve the sexual abuse she "suffered" at 16-17 years old, at the hands of the man 16 years her senior. Although she indicated that this abuse, "I never forgot. . .", she also stated that she remembers dissociating from some of it. "I remember dissociating, actually leaving my body during much of it, and numbing my body a lot from the pain." She assumed that she had learned how to do this from the previous abuse by her dad, which she said, "I now know I

dissociated from it. That's when I probably learned to leave my body behind. I still do that sometimes, especially when I feel threatened."

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Julia said that she needs therapy and therapist validation, and to believe herself (that all of this abuse really happened). "I think I would be a totally different person if that were there (validation from the perpetrators, or her mother—parenthesis added). I don't trust my own perceptions; don't trust my feelings, always have to check it out." She believes that validation from the perpetrators would have been important back when it happened, and for them (perpetrators—parenthesis added) to admit that "what they did was wrong." But she does not believe that validation from them *now* would help her. She says: "I wouldn't trust them enough to believe what they said." She currently believes that the one who needs to validate her most is *herself.* She states: "I feel *crazy* at times. I don't believe myself. Sometimes I think I made this up." Julia also believes that validation from the therapist is *necessary* for her to heal, and states: "I ask her (my therapist) *every time* I have a session if she believes me (that I was sexually abused)." She says that because of this validation by her therapist, she is beginning to start to believe herself.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3, 4 (a),(b):

Julia has many negatives beliefs about herself because of the abuse: For instance, she says that she feels "unclean," in relation to her genitals and

is fanatical about over cleansing that area. She feels "crazy" at times, like she's made all of this up. She has a great deal of guilt and shame, feeling that the abuse was somehow her fault, or that she should have done something about it. Says she feels "evil," and "so bad." Julia's guilt is all-consuming: She remembers as a child constantly "confessing" to her mom any little infraction in order to get mom's love and forgiveness. "I never felt redeemed, and so horrible, that no one could love me." She appears to have an *unlovable* and a *not good enough* schema. She admits that she "hates men," and is actively lesbian. She does *not* attribute her homosexuality to the abuse although she says it probably contributed to it.

She recognizes that the past abuses have affected her emotionally: She "suffers" from depression, obsessive-compulsive behaviors (e.g. cutting self, overworking, obsessive worrying), addictions (eating/working), and intrusive, PTSD symptoms, as well as a very low self-image with strong feelings of unworthiness and unlovability.

Julia presently feels that her body is very ugly (especially in the genital area which is scarred from surgeries necessitated by the sexual abuses). The abuse also affected her physical health: Genital/rectum scarring and internal injuries cause her to have very painful periods and sexual relations; her knees are deteriorating, creating extreme pain and disability; and she has other serious, obesity-related health issues. Additionally, Julia

has great difficulty in relationships with trust and intimacy, and *assumes* that she will be *betrayed.* She explains:

> It creates a totally different life, my entire life will always be based on that abuse. Like my partner (current love relationship)grew up in a family where she can *assume* that she was loved and its made it so that today she has that foundation: that she's O.K., that she deserves love, she's worthy of love, what love will feel like. And people who are abused—you don't make those same kinds of assumptions. Totally different assumptions between people who've been abused, and those who have not—they don't make assumptions because their assumptions are *warped* - assuming the *worst*: 'Sex will hurt; you don't love me.' (Parenthesis and italics added)

Validation Variables: Pertaining to Research Question 5 (a), (c):

There were no witnesses to the abuse by her dad, and she feels that she was the only one abused by him. However, there is physical evidence of sexual abuse which doctors discovered when she was an adult, and said could only have come from forced sexual abuse. She has had to have extensive surgery for vaginal and anal tears, and internal scarring; part of her labia is gone. She says she has much pain during her menstrual periods and sex because of this physical abuse. But this does not constitute "validation through corroborative evidence" for this study, since it is not possible to know if this physical abuse evidence is from the sexual abuses she "suffered" as a "child" (0-15 years old), or the later abuses at 16-17 years old.

Disclosure Variables: Pertaining to Research Question 5 (b):

Julia reports that she tried to tell her mom about the sexual abuse by her dad, when she was 12 years old, but mom squelched this by cautioning: "Don't say anything to upset your dad, because he could die." (He had just

had a massive coronary and was very ill.) She says that she still hangs onto that "introject" today, and fears expressing anger or any kind of objections in her relationships because of this. Case Number 5: Story of Julia K.

Childhood Sexual Abuse Experiences:

Julia had two abusers: her dad when she was 4 or 5 years old, until about the age of 12, and a 32 year old boyfriend, when she had just turned 16, which lasted until she was 17. She most clearly remembers the abuse when she was 16 to a man who was "the pillar of society," and a prominent leader in Alcoholic Anonymous (AA) where they met. During their one year relationship she states that, "He *ritualistically* abused me." He physically, sexually, violently, abused her and invited his friends over his CB to come and have sex with her. She was "branded" with the word WHORE on her arm (now covered over). This abuse experience is not applicable to this study due to her disqualifying age (the abuse must have happened before the age of 16), but is reported here because the negative consequences of this abuse were what motivated her to get into psychotherapy, where she 'recovered' delayed-memories of the earlier abuse by her father. She also felt that, "I was vulnerable to further abuse," and "setup" for it, due to the earlier sexual abuse by her dad, which she had dissociated from.

Julia is the oldest of all girls, and was her dad's "right-hand man. . ."I was the 'boy' her wanted." She reports that her dad (now deceased) was alcoholic and emotionally, physically and verbally abusive to the children. He

got "sick" (a massive coronary) when she was 12 years old (this is when the sexual abuse stopped). He became very depressed, often threatening to kill himself and all of them. She remembers protecting her sisters from him by having them sleep in her bed while she stayed awake and kept vigil. She says that she is hypervigilant, and has a disturbing sleep disorder today, which she attributes to this. Mother had to go to work when dad got sick, and Julia says: "She didn't protect me. . .She wasn't validating."

Dissociation and Memory Variables: Pertaining to Research Question 1:

Julia has a *clear* memory of herself at 4 or 5 years old at the bottom of the stairs, with dad at the top, naked, looking down at her, and masturbating. There are other *fragmented, dissociated* remembrances and a *sense* (body memories) of being sexually abused by her dad. She has been in therapy for the last 2 to 3 years recovering memories of her dad's abuse after having worked for many years previously (with other therapists), to resolve the sexual abuse she "suffered" at 16-17 years old, at the hands of the man 16 years her senior. Although she indicated that this abuse, "I never forgot. . .", she also stated that she remembers dissociating from some of it. "I remember dissociating, actually leaving my body during much of it, and numbing my body a lot from the pain." She assumed that she had learned how to do this from the previous abuse by her dad, which she said, "I now know I dissociated from it. That's when I probably learned to leave my body behind. I still do that sometimes, especially when I feel threatened."

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Julia said that she needs therapy and therapist validation, and to believe herself (that all of this abuse really happened). "I think I would be a totally different person if that were there (validation from the perpetrators, or her mother—parenthesis added). I don't trust my own perceptions; don't trust my feelings, always have to check it out." She believes that validation from the perpetrators would have been important back when it happened, and for them (perpetrators—parenthesis added) to admit that "what they did was wrong." But she does not believe that validation from them *now* would help her. She says: "I wouldn't trust them enough to believe what they said." She currently believes that the one who needs to validate her most is *herself.* She states: "I feel *crazy* at times. I don't believe myself. Sometimes I think I made this up." Julia also believes that validation from the therapist is *necessary* for her to heal, and states: "I ask her (my therapist) *every time* I have a session if she believes me (that I was sexually abused)." She says that because of this validation by her therapist, she is beginning to start to believe herself.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

Julia has many negatives beliefs about herself because of the abuse: For instance, she says that she feels "unclean," in relation to her genitals and is fanatical about over cleansing that area. She feels "crazy" at times, like she's made all of this up. She has a great deal of guilt and shame, feeling that

the abuse was somehow her fault, or that she should have done something about it. Says she feels "evil," and "so bad." Julia's guilt is so consuming: She remembers as a child constantly "confessing" to her mom any little infraction in order to get mom's love and forgiveness. "I never felt redeemed, and so horrible, that no one could love me." She appears to have an *unlovable* and a *not good enough* schema. She admits that she "hates men," and is actively lesbian. She does *not* attribute her homosexuality to the abuse although she says it probably contributed to it.

She recognizes that the past abuses have affected her emotionally: She "suffers" from depression, obsessive-compulsive behaviors (e.g. cutting self, overworking, obsessive worrying), addictions (eating/working), and intrusive, PTSD symptoms, as well as a very low self-image with strong feelings of unworthiness and unlovability.

Julia presently feels that her body is very ugly (especially in the genital area which is scarred from surgeries necessitated by the sexual abuses). The abuse also affected her physical health: The genital/rectum scarring and internal injuries cause her to have very painful periods and sexual relations; her knees are deteriorating, creating extreme pain and disability; and she has other serious, obesity-related health issues. Additionally, Julia has great difficulty in relationships with trust and intimacy, and *assumes* that she will be *betrayed.* She explains:

> It creates a totally different life, my entire life will always be based on that abuse. Like my partner (current love relationship)grew up in

> a family where she can *assume* that she was loved and its made it so that today she has that foundation: that she's O.K., that she deserves love, she's worthy of love, what love will feel like. And people who are abused—you don't make those same kinds of assumptions. Totally different assumptions between people who've been abused, and those who have not—they don't make assumptions because their assumptions are *warped* - assuming the *worst*: 'Sex will hurt; you don't love me.' (Parenthesis and italics added.)

Validation Variables: Pertaining to Research Question 5 (a), (c):

There were no witnesses to the abuse by her dad, and feels that she was the only one abused by him. However, there is physical evidence of sexual abuse which doctors discovered when she was an adult, and said could only have come from forced sexual abuse. She has had to have extensive surgery for vaginal and anal tears, and internal scarring; part of her labia is gone. She says she has much pain during her menstrual periods and sex because of this physical abuse. But this does not constitute "validation through corroborative evidence" for this study, since it is not possible to know if this physical abuse evidence is from the sexual abuses she "suffered" as a "child" (0-15 years old).

Disclosure Variables: Pertaining to Research Question 5 (b):

Julia reports that she tried to tell her mom about the sexual abuse by her dad, when she was 12 years old, but mom squelched this by cautioning: "Don't say anything to upset your dad, because he could die." (He had just had a massive coronary and was very ill.) She says that she still hangs onto that introject" today, and fears expressing anger or any kind of objections in her relationships because of this.

Case Number 6: Story of Barbara (Barb) C.

Childhood Sexual Abuse Experiences:

Barb recovered memories of her own sexual abuse only after discovering that her daughter (then 8 years old), and son (then 2 ½ years old), had been sexually abused by her brothers and father (the same perpetrators who abused her), and her brother's boss (a psychologist, and director of a large, mental health facility), and other males unknown to the children. Barb was always a very talented artist, who began to depict the sexual abuse that she was experiencing at home in her artwork at school. Her high school teachers noticed the scary, and horrible sexual drawings that she was making. They knew the family (as she had many brothers and sisters in the same school), and ". . .must have suspected that something very bad was going on in the family," because they recommenced that she see a psychotherapist. Barb saw many therapists through her adult years because of symptoms of intense affect, which would surface with an apparent cause. She said, "I always felt so terrible and bad, and didn't know why." Only after her children started telling the story of their sexual abuses did she begin to piece her own "nightmares," intense negative affect, and somatizations (unexplained excruciating vaginal and anal pains) together and remember some of her own childhood sexual abuse experiences. The perpetrators, particularly the psychologist brother (5 years older than Barb), who was Barb's most active and frequent abuser, all deny the abuse and contend that

the children and Barb are victims of a "false memory syndrome" (even though the children had never been in any therapy *before* they disclosed the abuses). After the children disclosed that they were sexually abused, Barb's father (one of the perpetrators) was imprisoned for the sexual assault of another grandson (Barb's nephew, her younger brother's son). But he never admitted guilt, pleading "no contest" to the charges. He also never admitted that he sexually abused Barb's children, although he told her: "You never would lie and so I suppose you are right." Some brothers (the perpetrators) and their mother, who was an accomplice to the abuse (she brought the children over to the perpetrators and allowed it), worked very hard to get the father an early release from prison. This was difficult for Barb to understand since the mother had vehemently hated the father, and had divorced him. But Barb says that her mother is strongly into denial, and protecting her psychologist son and the other family members. It was suggested by some therapists and others who had observed her mother's behaviors, that Barb's mother may have a form of Schizoid Personality Disorder, and/or Dissociative Identity Disorder as the "strange" behaviors and complete denial her mother displayed suggested these possible diagnoses. Barb's nephew who was abused by her father, is the son of Barb's younger brother, who had also been sexually abused in grade-school by his teacher, a "nun." The "nun" eventually admitted her abuse, but the parents made little of it.

Barb has had to distance herself from her family of origin because they continue to deny that her or her children were ever sexually abused by the brothers and father or anyone else. After Barb's discovery of her children's abuse, and questioning of family members about it, her nuclear family was threatened verbally and with violent actions. Their car tires were slashed, their door beaten in, their house was egged. The children were called "liars" and the husband was physically attacked.

Barb and her husband tried to prosecute the perpetrators for their "crimes" against their children, but the District Attorney decided to drop the case. He said that he believed the children, but would not prosecute because he decided that the children would suffer too much emotionally, and would be unreliable witnesses.

The daughter was sexually abused the most. And although the perpetrators used white make-up to hide their faces, she recognized the psychologist bother and her other "uncle." She was also able to describe things a child would not know from anyone else, like a description of one of the man's teeth and other unique body marks. Both children were also able to describe in detail the place, and room where they were abused, which was in a mental health facility that they had never seen or been in before. There was also physical evidence that the daughter was sexually abused as she had had numerous vaginal discharges and the pediatrician finally told the parents that she thought their daughter had been sexually abused. After that the daughter told the pediatrician that her grandfather had sexually abused

her, and later told her parents. It was the son however, who was able to talk about the abuse and give more details than the daughter, probably because he had less serious abuse: He had no penetration, and only grandfather and uncle sexually "played" with his genitals and masturbated in front of him, and on him. Although he had great fears and scary nightmares, he did not seem to have the intense "shame" or self-loathing that the daughter expressed. The daughter was forced to do unspeakable sexual acts, including vaginal intercourse. She also was abused by several men together ritualistically, and was told that she and her family would be killed if she said anything to anyone. This may account for some of her reluctance to disclose the abuse. The son was made to feel sorry for the grandpa who told him if he told anyone what was gong on, then grandpa would go to jail. When asked by his mother what jail meant, the little boy replied with fear in his voice: "A really, really, bad place!" Barb and her husband and his family believe that these men were not prosecuted because one of the men was a well-known figure in the State, and a friend of the District Attorney. Also the psychologist brother (perpetrator) made a convincing appeal about the "false memory syndrome," even though neither of the children had been in therapy or talked with anyone about the abuse prior to their disclosure to the pediatrician, and Barb had not recovered any of her memories prior to her children's disclosure. The well-known man (perpetrator) retired after the abuse allegations with no disciplinary actions taken against him. The brother is still practicing psychology and has never been prosecuted or disciplined by

the psychology board. Barb's father is out of prison having only served half of his term (2 ½ years) for his sexual abuse of his other grandson. Delayed memories of the sexual abuses she suffered as a child at the hands of her brothers, father (and mother who denies it, continue to surface for Barb as she works with many of the consequences of that abuse (intrusive PTSD symptoms) in psychotherapy.

Barb's memories of her childhood sexual abuse surface mostly through her body and appear to be "state dependent." She recalled having had flashbacks, nightmares, and memory-like episodes of her oldest brother (the psychologist and one of the abusers of her children), doing sexual things to her in very humiliating situations. She recalled a time for instance, when the neighbor boys and her other brothers were watching and participating in the abuses. The oldest brother was the "family hero," and protected by the mother. When Barb would complain to her mother that her brother had hurt her, or had "forced himself" on her, the mother would tell her it was a dream. And yet, she remembers mother keeping her out of school on those occasions when there were physical signs of abuse such as vaginal, anal, or throat rawness, or bleeding and bruising, and such. She also remembered her father being a "pervert," who had lots of pornography openly laying around the house, when she was growing up. "I remember how embarrassing it was to bring any of my friends home because he would stare at their breasts and make these really lewd, sexual comments." But Barb said that she loved her father. And "I felt sorry for him, because my mother was really mean to him

and he just took it. He was pathetic. He was very passive." She also said that he was not mean to her or rejecting (as was her mother). She felt that she had "repressed" the sexual abuses of her father because "I didn't want to hurt him."

Dissociation and Memory Variables: Pertaining to Research Question 1:

Barb's memories were *dissociated, fragmented* and *sketchy*, with delayed-recall. They only began to surface as an adult, after the discovery of her children's sexual abuses by many of the same perpetrators. She said that memories are still surfacing as she works in therapy with the flashbacks, sexually explicit nightmares, intrusive negative thoughts, images, and intense affect (extreme unexpected sadness, anger, fear, and profound loneliness). Some of the memories are clear, but most are still *disconnected fragments* and *body memories* (body sensations). She had her first childhood sexual abuse recall after working with her bodily symptoms (an intense vaginal pain that had no apparent physical cause, accompanied by extreme fear and sadness of unknown origin) in psychotherapy. She usually has to have the memory surface many times before she connects it to her symptom, which generally subsides once she had done so.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Barb believes that validation through corroborative evidence would be extremely important in her healing. She states:

> Yes. I had a dream just this morning, it was a horrible dream, and I was begging my brother to just say the truth and I'll forgive him. And

> he raped me. He said, 'O.K. I'll tell the truth after I do this.' And it was horrible, it's like I'd do anything, I'd even let him do that to me again just so he'd say he was sorry. I can't stand the injustice of it all; it's so frustrating to me. Like my brother (the psychologist/perpetrator-words added) who thought my dad shouldn't have to go to prison for sexually assaulting my nephew, he said: 'Yeah but he shouldn't have to go to prison for that.' But even people who aren't involved, who were just friends, who know my family, and they're minimizing the situation, it so infuriates me! If I could have that, if I could have people understand how wrong it is, and have people say, 'yeah it's true, you're not the one that's the bad person, they are.' It just, it never stops. It seems like whenever I'm starting to feel better something will happen, they'll do something (my family), they'll either try to call, or I'll see them, and then it just makes me relive everything. The validation is so important to me, I don't think I'll ever get it."

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a), (b):

Barb reported that she had many intrusive PTSD-like symptoms: reoccurring violent, sexual nightmares; flashbacks of the abuses, intense, unexplained sadness, fear, dread, and profound loneliness. She has somatizations: bodily pains (e.g., excruciating vaginal and abdominal pains, acute earache, sensations of her ears filling up with water) that seem to have no physical cause. She has a "phobia" of water which she now relates to some specific childhood abuse situations: when her mother held her head in the toilet and in dirty, dish water; and when her brother raped her in the shower.

Barb also emphasized that it's really hard for her to believe in herself. "I always doubt, even things that I feel very strongly about. I always think, 'Well, if I can't prove it I must be *crazy*. I always second guess myself. And that's' because I was always told that what I was thinking was not the real situation, or that I was *dreaming*." She elaborates:

> I sometimes feel so *crazy* because something will trigger a memory, and I'll get feelings and sensations about it, and even pictures of it—pieces of it. But then I'll feel so *crazy* because I don't have any clear memory of it. And then I say: "Well now I know this, but how can I *prove* it? What if my mind is just playing tricks on me?" And then I get all confused and don't trust myself. Makes me feel like maybe *I am crazy*. (Italics added.)

Validation Variables: Pertaining to Research Question 5 (a), (c):

Barb did not have validation through corroborative evidence, of her abuses. Her family of origin continue to deny that any kind of sexual abuse happened to her or her children. One sister told her that she remembered being sexually abused (intercourse) as a child and thought it was by her brother, but didn't know for sure who it was because she kept her eyes closed during all of it. But she said she had a distinct *sense* that it was the oldest brother. However, after talking with this brother (one of the perpetrators) she has now recanted her story and believes it to be a "false memory." The youngest brother (father of the boy who had been sexually abused by the grandfather) had told her at one time that he knew sexual abuse happened in the family, and that he was sexually abused. But he has since become very mentally ill, highly dissociative, and is unreliable and unavailable. Medical records of a possible abortion that Barb had had as a young teen-ager (before she was aware of having sex with anyone), which the doctor told her was the removal of a tumor, could have helped verify her sexual abuse. The reason she feels that she may have had an abortion is that she remembers having great difficulty with vaginal cramping and not getting her period, and her

mother took her to a doctor (whom she later found out did abortions). The doctor examined her and looked and acted disgusted as he scolded her for being pregnant. She was shocked, confused (as she was not consciously aware of having sex with anyone), and became quite hysterical. She told her mother, who was out in the waiting room, and then mother asked to talk to the doctor alone. When he came back into the room, he told her he was wrong about her being pregnant, and that it was a tumor, which he would have to remove. She asked for a second opinion (doubting him, as his actions, voice, belied his words). So he had his partner examine her briefly, who agreed with her doctor, and the "tumor" was removed. After Barb started recovering her memories of some of the sexual abuses done to her, she contacted the hospital where her records should have been kept, but found out that they had been burned in a fire that had occurred a few years earlier.

Disclosure Variables: Pertaining to Research Question 5 (b):

Barb has told all her family members, mother, sisters, brothers, father, what happened to her children, as well as about her own sexual abuses she remembers, and they deny that any of it is true.

Barb's mother was very cold and rejecting of her when she was small, but paradoxically enmeshing also, and increasingly dependent on Barb as she got older. She would not comfort Barb as a child, or hold her close, but used to let her crawl onto her lap and ". . .smell her crotch." This was very comforting for Barb, reassuring her that her mother was there, as she remembers being terrified that her mother would abandon her. But as an

adult she realizes how "strange," and "weird" it was for her mother to encourage this behavior. She has a great deal of anger toward her mother, for not only allowing the abuse but encouraging it with her children, by taking them over to father and brothers to be abused. Ironically, she feels peculiarly sorry for her father, who manipulated her to think that she was the only one who could love him, because as she says, "he's such a pathetic, weakly, guilty, kind of man."

Her husband is very supportive and absolutely believes her and the children, as do his family and his brother, who is a medical doctor. Her sister-in-law was one of her teachers in high school and remembers thinking that Barb was probably sexually abused by the way she acted, and from her drawings. Barb and her husband and family have severed all ties with her family of origin because of their denial and potential for more harm to their children. Barb's family continues to occasionally leave notes, or call, trying to convince her that what she and her children remember are all "false memories." Her and her children "suffer" from the loss of mother, grandma and a closeness with her family.

Case Number 7: Story of Kate V.

Childhood Sexual Abuse Experiences:

Kate's dad died when she was 4 ½ years old. and she had been his "little Princess." She felt that mother abandoned her after dad died, she says: "Mother didn't give me attention, she was very narcissistic." Kate demanded a lot of attention from mom's boyfriends and was criticized and reprimanded

for this and made to feel "odd" and "bad." She "desperately" wanted male attention and turned to idolizing her older brother (and only sibling), who was 4 years older, and did not like her demands. He teased and made fun of her, giving her only negative attention. This set the scene for her to be vulnerable to her uncle's sexual advances (mother's younger sister's husband), who was about 13 years older than Kate. The abuse started when Kate was in Jr. High (12-13 years old). Her uncle befriended her and gave her the male attention that she craved. He also told her he would teach her how to get men to love her. She explains:

> I was developing and stuff. I didn't have any boyfriends. I was having a lot of problems meeting boys because of what I thought was epilepsy, and terrible acne. I was pretty much the 'odd one' in school, and not many people socialized with me. I was very vulnerable, extremely vulnerable at that point, and my uncle offered to help me to learn how to be a better lover; that was his *spiel,* to teach me how to get what I wanted from men, and how to make men happy. I really bought it; not because I wanted to be a better lover, but it was wonderful to have someone holding me and loving me and caring about me. After awhile when he came over. . .he would tell me how to dress: I should always wear a skirt, so that if we got caught or anything no one would know...we could quickly...I think he even told me not to wear underwear, I can't remember anymore. I don't remember if I did or I didn't. It was a lot of fondling, and touching but we never took our clothes off, he never wanted to get caught. And I think that did more damage than good, because it took a long time for me to even consider walking around the house naked. Even today, I'm still inhibited sexually. It's really left its mark; It's truly left its mark with me: A lot of shame. It goes back to being secretive. I knew what we were doing was wrong but he always convinced me otherwise. I knew that he was married to my aunt and I loved my aunt. I didn't know at the time that my aunt was also a victim of incest. I really felt that I was responsible for what was happening. And I knew if I told, I would lose that attention, so I was really torn between wanting to break away from it because I was feeling shame and guilt, and wanting that attention. But it was getting ugly; I knew it was wrong and I was feeling bad. It

> was the hiding and the sneaking I think that bothered me more than anything, because I'm basically a very truthful person. So sneaking and hiding, that's not me. It ended when I told my uncle that I was seeing another fellow, and he was shocked.

Kate felt that her uncle really loved her as she loved him. She acknowledges that she was very vulnerable and craved male attention, but also feels that these acts were mutual.

Kate's step-dad also sexually abused her when she was 15 years old, during a drunken episode. She feels more disgusted with this abuse situation because she clearly said "no" and he wouldn't stop (until mother came home and he jumped off her and left). She attempted to tell her mother when she was 15 about both her uncle and step-dad, but mom refused to believe her and continues to call her a "liar". Kate had suffered from hysteria and psychosomatic symptoms (pseudo seizures) and continues to suffer from depression and relationship difficulties related to sexuality. She also had been re-victimized as an adult:

> I had been raped as well when I was 18; date rape. I lost 8 pints of blood. The doctor said I had a miscarriage, but that's actually when I lost my virginity. Mom believed the doctor, and I was too ashamed to say anything to her because she already said I was a 'tramp' and a 'whore', so if I had told her that I had been raped, she probably would have told me that I deserved it. So I never said anything about it to her.

<u>Dissociation and Memory Variables: Pertaining to Research Question 1</u>:

Kate said that her memories of the abuse with her step-dad are very *clear*, but the details of the abuse with her uncle are not so clear (suppressed but not dissociated). She believes that this is because she felt mutually to

blame for the abuse with the uncle, as she had a great passion and love for him. "The memories started to come up during sex with my ex-husband. My 'ex' was into restraint and control, and I can't do that, it brings aftershocks."

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Kate does *not* believe that it would help for her uncle to admit what he did was wrong. But she said it would really help to have her *mother* believe her. She said:

> All I ever wanted from my family was personal respect. I don't get that. I have no value to them as a person. They look on me as I'm just the person that loves *drama*. I think that's what they think. They think that I'm someone who creates these things, and so they ignore me. And they go on and on, and say, 'Oh, when are you going to just stop?' And they don't understand that this is genuine pain for me, and genuine hurt (she cries). And I've been fighting this with them for years and years and years. It gets me nowhere. If they would just listen to me and say: 'You're right.' (cries). If they'd just say: 'You know you really have had a hard life.' Like with my mom it always, ends up going back to *her* because she's so narcissistic, she turns the whole thing around to be about her. She said to me: 'And if you recall I sat you and your father down and I told you two to stop it right now.' And I knew right then and there that she was talking about aunt L.(mom's sister - her husband was the man who sexually abused Kate-words added), and my grandpa. He had slept with L. from the time she was a little girl, and so mom has some really strong issues on incest (parentheses added).

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

Kate says that the childhood sexual abuse experiences, particularly with her step-dad, have impacted very negatively on her self-esteem today. She states: "I don't like me. I'm not too crazy about me. I'm not real nuts about my body. I think the abuse has a lot to do with my eating disorder" (she's overweight).

Kate still has shame and guilt over the sexual abuse with her step-dad today.

> Because I had done the 'foreplay.' At the time I didn't look at it as foreplay; I didn't realize what I was doing. And I really shouldn't feel bad about it, but there's a twinge there that says: "Now come on, you were playing around there, you should have realized. . ."

Depression is a current symptom. She has also been chronically angry at her mother for mother's refusal to believe her, or validate the abuse, and her brother, to a lesser degree. ". . .It causes me to be very withdrawn and that makes me even angrier. . . Anything that has to do with my family I withdraw from. I don't really want to be with them anymore. . .They all betrayed me. No one in my family (excluding my kids), has ever valued me as a person."

Although Kate has been diagnosed with dyslexia and attention deficit disorder, she is pursuing a college degree, and getting high grades. Despite this, she continues to 'swallow' the *introject* the she is 'stupid.' "My mother and brother continue to 'discount' me. They always tell me how 'stupid' I am."

Kate believes that her problems with intimacy in relationships are a likely consequence of her childhood sexual abuses:

> I still have problems with sex in a relationship. . .Once I settle into a relationship, I have a lot of trouble being sexual. . .I don't know what it is, I just don't want people touching me. The one thing that I want most is to be held and loved, and yet once I have it for any length of time, I start pushing people away. It's like I don't want anybody getting too close. . .I'm very, very, much of a loner now.

Validation Variables: Pertaining to Research Question 5 (a), (c):

There were no witnesses to the childhood sexual abuse that Kate experienced. Her uncle never confessed or said he was sorry for the abuse, nor did her step-dad.

Disclosure Variables: Pertaining to Research Question 5 (b):

Kate disclosed to her boyfriend (at age 15) everything that had happened to her with her uncle and step-dad. He tried to be supportive by encouraging her to tell her mom, and went with her to do so. But mom got angry and called her a "liar," and denounced her boyfriend for getting her to make up these allegations. He got angry and lied (to hurt the mother), telling her that he had 'had' her daughter (sexually), and stormed out of the house. Shortly after this disclosure Kate had an emotional break-down, with pseudo seizures, and went to a psychiatric hospital. She relays:

> I also had my first female exam when I was out at County Hospital. I was still a virgin and the doctors were really disgusted with her for making me go through that with strangers. It was a very frightening experience for me. It was extremely shameful for me. It was the second time that I really felt my mother had betrayed me, that she didn't believe me, she went to that length to find out if I was a virgin.

After many years of marriage Kate disclosed the abuses to her husband, and although he became more understanding, she felt he still *demanded* sex, which became a serious issue in their marriage, that eventually ended in divorce.

Her daughters know about the past abuses that happened to her and they believe her and are supportive. She said that most of the support, since her disclosure has come from her various therapists.

Case Number 8: Story of Bonnie G.

Childhood sexual abuse experiences:

From the time Bonnie was around 7 or 8, until she was about 16 years old, her father would periodically sneak into her bedroom and sexually abuse her (including sexual intercourse). He gradually manipulated her with displays of tenderness and favoritism. Dad was alcoholic and abusive to mother when he drank. Bonnie thinks her mother didn't know what he was doing with her because she was so wrapped up in her father's alcoholism and was both afraid of him (he threatened to kill her if she left him), and enabling, protective of him. She never told anyone (as a child) about what dad did with her, because she felt she was partly to blame, and also because she thought that if she just endured it, her younger sister would be saved from having to go through this. When she was an adult, and several years after her father died (he died young, at 47 years old), she went into a deep depression and panic attacks, and what she termed "a mental break-down." It was during therapy that she revealed the abuse and then was able to tell her mother and family. The family believed her immediately. And her sister told her that their dad had also started to sexually abuse her just before he died (sexual molestation). Bonnie coped with the childhood abuse by *counting*

during it to avoid feeling. She still feels some guilt over it even today, especially because, as she says: "My body was reacting and that bothered me. more than the abuse sometimes, was the fact that my body was responding differently. I would question: 'Why is my body responding this way, when I detest it?' I felt my body betrayed me at times, and I responded physically (even though in my head I knew I hated it; I knew it was wrong)." She also felt guilty because her dad did not use threats or violence, and because she didn't tell anyone, or try to stop it. However, there were times when she did say "No," and he manipulated her into doing it anyway. "When I got older and would say 'No,' he'd say: 'Well this will be the last time, or just one more time,' or things like that."

As an adult, Bonnie eventually went into therapy and joined support groups where she has learned to understand the abuse better. But she continues to be terrified of dying; has panic attacks when under emotional stress; and cannot allow herself to be vulnerable and nurtured in relationships with men, because as she says: "I always feel that I must stay in control." She sees herself as an overly responsible person who takes care of others to the detriment of herself.

Dissociation and Memory Variables: Pertaining to Research Question 1:

> I don't remember a lot of things real vivid. I don't remember violence, threats, meanness. It was more of a coercion-type. In a gentle, tender-type way, the faint memories that I have of it.. I remember the more vivid memories more when I was more like 12 and 13. I can remember instances of it Those are the ones that make me feel more sick to my stomach and more upset like that. . . .He had beer on his breathe most of this time, but it wasn't like her was in a drunken state. . .There was

> intercourse involved I know that for a fact. He didn't ejaculate in me. He'd pull out and use a handkerchief, and that's one of the memories that's vivid, was the *smell*. . .: It was always late at night, and coming into my room. It was a matter of me just laying there pretending I was asleep, even though I wasn't asleep. Nothing was said, I didn't move, I was very rigid. I remember biting on my pillow, and just stiffening my whole body (like I wasn't there) and just counting in my head.
>
> . . .I always knew it, it was always there; it was never not gone. When programs would come on TV, when they started coming out more with it, I wouldn't watch them. I'd turn them off, because if I had to watch them I'd think about what happened to me, and if I didn't watch them, I didn't have to think that way. I had memories; I didn't acknowledge the memories

Validation Variables: Pertaining to Research Question 5:

Bonnie does not believe that anyone knew about the abuse when it was going on, not even her mother. She says: "My mother never knew about the abuse. . .I don't remember my mother ever waking up but a few times, and then my father would use some excuse, like he was bringing me water or something like that. To my knowledge she had never walked in on anything." Bonnie received validation through corroborative evidence of her childhood sexual abuse upon self-disclosure as an adult, when her younger sister admitted that she too had been sexually abused by their father. The father also 'inadvertently' admitted his abuse. Bonnie states:

> I think that if my father was alive today, and if I did confront him, I do not think he would deny it (says it softly with feeling). An instance happened when I was 17, and my boyfriend and I got caught at a party together where we had spent the night. And things were real weird back then. This lady filed a complaint and we had to go to the police station with our parents. My father went with me, and on the walk to the police station, he said: 'Should I state what I had done?' in case they were going to test for virginity to prove that we did or didn't have sex. This panicked me to no end. You can imagine a 17 year old knowing that her dad's going to say that he's had sexual intercourse

> with her! I said: 'No! Don't say anything!' And then I was a basket of nerves. That was the only time, other then when it was going on, that he ever brought up anything about it (parenthesis added).

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

> I think it's important to be validated, because I see in 'group' (her incest support group) what the women who are not validated go through. The fear and the self-doubt that they have, 'are they really making this up?' And how do you know when you really get down to it, because people do, and it's unfortunate, and this makes me angry, use it in divorce disputes or this or that, which leads to not validating all the rest of us that this really happened to. And that *False Memory Society* and all that other crap; those groups make me angry, because it doesn't validate those of us who did live it, and did go through it. And if someone said to me: "We don't believe it happened.' I would tell them that *they* are crazy, because I knew it my entire life, I didn't ever *not* know that it happened. I think that validation is important, I think that's it's important to have your family's support. So at least you know that it wasn't your fault (she pauses, and adds), or *all* your fault (parenthesis and italics added).

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

"I'll put myself way on the bottom of the pole and put what everybody else needs ahead of me. It's even to the point sometimes where I know I'm losing myself here." Bonnie reported still feeling guilt and shame over the childhood sexual abuse. She says: "I do think to myself: 'Why did you let it go on as long as it did? And I try to justify that by saying that I didn't want my sister to become the next victim." She says further:

> . . .and there're feelings of shame that crop up at different times (shame of allowing this to be done to me). It's hard for me not to accept part of the blame, even though I know realistically, as a child you can't. . .You know, if this had happened to my daughter, I would have a whole different perspective on it. It's hard for me sometimes to picture myself as that little person. It's almost as if myself as a child was someone else then who myself today is.

Bonnie talked about relationship problems; about her ex-husband having affairs which she would overlook. "I felt sorry for him, and he had all these excuses. It was almost a repeat of my dad, but in a different context." She said that she has problems in intimate relationships with trusting, and accepting kindness.

She has an anxiety disorder, which she believes is directly related to the abuse. She describes her *hypervigilance* and panic:

> I was having a lot of muscle problems the last couple of years, and I think what it is, is that I don't know what it is to relax. And the tightness that I feel. . .I think when my body goes under stress, it just totally tenses up, to the point where this feels normal to me. So if I do get relaxed, then I get really scared, and this adds to my anxiety. . .I get scared when I get in that full relaxed state, and I begin to panic. But now I'm starting to tell myself: 'You're relaxed, this is what relaxed feels like.' And am able to tolerate it more."

Bonnie still has bouts with depression, she states: "I have down days, but not the deep dark hole I was in. . . it will be two years that I have been off all the antidepressants." She says that she occasionally takes Zanex for her anxiety, but mostly she just carries it with her for the security. ". . .just knowing that I have it available leads to less anxiety, just carrying it in my purse,"

She said that she was also diagnosed with PTSD, and through therapy and support groups, has learned to lessen all of her symptoms.

Disclosure Variables: Pertaining to Research Question 5 (b):

Bonnie disclosed the abuse after when she was 36 years old, sixteen years after her father (the perpetrator) died. She eventually revealed the abuse to her mother, sister and brother who immediately believed her, and were very empathetic and supportive of her. She wonders:

> You know when you're my age, back then it wasn't anything that was mentioned, and now days there's just so much more knowledge and so much more letting children know you can say things. But I don't know if it was today and happening, that I'd be able to put my father in jail, I truly don't know if I'd be able to do that. I guess I would look more for a treatment-like thing. And I did have an advantage that he died at 47; I was 20. He died of cirrhosis, it was his drinking basically that killed him. So even when I dealt with the break-down, I didn't have to face him.

She explains how she first disclosed the abuse:

> I had a mental break-down that year. I've always been very self-sufficient, very able bodied, very responsible. After my nephew had died, he died at the age of 8 of a heart condition, I started just feeling flu-like symptoms and I couldn't eat. It got progressively worse to the point that I couldn't go to work, and then I didn't want to leave the house. And I kept going to the doctor, every other day I kept going to the doctor, thinking: 'Something's wrong, something's wrong.' They'd run tests, and could find nothing wrong. I lost 35 lbs. in two months time, couldn't leave the house, knew I was in trouble when I hung a blanket on the window of the bedroom. And in between this, I'm taking care of my kids (5 & 8 years old.), and I could still function enough so I could feed them, supervise them, but not myself. I couldn't go to work, couldn't eat and couldn't sleep, I was up virtually 24 hours. And finally I, on my own, said: 'Maybe I should see a psychiatrist.' The doctor I had been seeing started getting real crappie with me, too like: 'There's nothing wrong with you, why do you keep calling me, there's nothing wrong with you.' Then after I was diagnosed he said: 'Well I kind of suspected it might be something like that.' And I figured, 'Well why the hell didn't you recommend I go see somebody. . .?' I piled so much back here (points to head-words added) that there was just no more room, and I think after I got the divorce and that, I think that a part of my internal me said: 'O.K. now we're going to have you deal with this, and that your storage area is crammed full and now it's got to come

out.' It was clinical depression that they diagnosed. When I went and had the assessment, they give you the questionnaire and they ask on there about sexual abuse. I can visualize in my head the struggle that was going on inside: 'Do I say anything; don't I say anything.' Because I had never said anything to anyone (at that point). So I checked it on the thing. And then when they were reading it, and brought it up, it's almost like a two ton ball came off my shoulders. I even remember driving home from that appointment and thinking, it felt feather-weighted, it's just a very odd sensation. Of course that was not an instant cure, but it was just such a relief to have told. I struggled with the question (about sexual abuse-words added): 'Do I lie, do I tell the truth?' But I think I had hit such bottom that I was like: 'I have to tell the truth, because I have to get better,' not even knowing at the time that it had anything to do with it (the abuse with her presenting symptoms-words added). Because I remember instances when people would say things, you would see on talk shows, and these women would say how messed up their lives were and how screwed up they were, and how inept they were. And I'd sit there and I'd go: 'I went through that and I'm not like that.' And I'd sit there and go: 'What are these women talking about, it hasn't affected me' that was my thought: 'I'm a real stable, together-type person, there's no problem with that.'

Case Number 9: Story of Pat K.

Childhood sexual abuse experiences:

The things that I remember the most are the *body memories*, and so they're like *fragmented.* I started having my first memories when I was about 49 or 50 years old, and I was at a therapy weekend for couples. I think with the process that was done, we had do this 'breathing,' I think it was 're-birthing,' well anyway, the weekend mostly was about 'family sculpting' but they had this process in there. During this process is when I had my first memory of sexual abuse. And I felt like I was very young, like I was preverbal and that it was oral sex and I just felt horrified. It was very difficult to deal with it. And I felt it would have been different if I had remembered it other ways. But remembering it in that way, totally unprepared, it was a shock. I didn't go into therapy right away, it was several months after it that I started to see a therapist. And I only did that for a short time because my sister was very ill with cancer and she died, so I took time off and just put it on the back burner and was attentive to my sister's passing. At that time I talked to my family about it. It's hard to believe it. I still sometimes don't believe that it really happened.

There are a few things that make me believe that it did

happen: One is that most of my married life, I've had an aversion to seeing a 'penis.' I would always sort of 'cringe' inside and try to act like I wasn't cringing, but I was cringing! I felt frightened of it. We had a habit on Saturdays of letting our children come into our bed, and they would play in the bed, and we would have a real relaxed morning with that, and then we'd get up. And when I would come and look at the bed all messed up, I would feel such a rage. I would say to myself: 'Why are you feeling this rage, there is nothing to be that angry about, it's just that the bed is messed up. But I would just feel enraged, and it would always seem so strange to me. But I think that is connected to the sexual abuse. I was about 25 at the time, and I never understood that.

But after this 're-birthing' at 49 or 50, and I had been in a lot of groups like, 'adult child' groups, and had been trying to figure myself out, but all this didn't start until I was in my middle 40's. So I did start seeing a therapist and I think most of the things I remembered are 'body memories,' and some of the things seem to me very improbable. But I would feel the sensations as an infant being passed around in a group of men, and being sexually molested. This is over a span of years. I've had cranial-sacral therapy to help me deal with the feelings, and sometimes in therapy I have memories of violence, like almost choking and being choked. Being treated like a dog, and being humiliated. I've had some 'body memories' of being sodomized (has strong emotion, cries). There are not a lot of words around it, there're just images and feelings. The images are not real clear, there's usually a presence of a person. I don't see the person's face. I'm thinking it's my father. He was somebody who abused alcohol, and somebody who was very violent and erratic in his behavior. I don't have dreams that are. . .

. . .Oh, God I forgot about that. Before I ever even had this (the 're-birthing' and 'body memories') I was in a class for dreams. And I told about a dream that is a very short dream. The dream is not usually very specific; It's usually something that is a metaphor. In this dream I was an adult. I'm walking and there's two police cars in the middle of the road, and I decide to go to the left, and then there's a child with me, and I'm walking with this child, and there're a few houses that have lights on. First I feel an adult man coming behind me and I look at the child, and I say to the child: 'Run to the house, so you'll be safe,' and there are other men that come around me (she's emoting as she tells this - crying). The person there was talking to me after the class was over and that's when she (therapist) first said to me to consider that maybe there had been sexual abuse. And this had not occurred to me. I felt like there was a lot of humiliation when I was growing up, and a lot of verbal abuse, and some physical abuse, but I did not—I was so adamant that I was never sexually abused, that I just never got connected to that. It's like little events were leading up

> to my being aware of what had happened to me (parentheses and italics added).

Dissociation and Memory Variables: Pertaining to Research Question 1:

Pat talked about sensory motor memories that were 'dissociated,' with delayed recall (she recalled them after a 're-birthing' process at 49-50 years old). "The things that I remember the most are the body memories, and so they're like fragmented.. . .It's hard to believe it. I still sometimes don't believe that it really happened."

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

In response to the importance of validation, she said: "I would love it. I don't believe I'll ever hear it. I think it would help me in my healing process."

This is what Pat believes about the importance of validation from the therapist:

> I think it is important because so often I don't believe myself. And some memories seem so bizarre that you think: 'This could not possibly have happened, and I survived it.' Because with my memories there's violence and I think, 'How could this happen?' It must be an image. I'm a small child and thrown against the wall, and I think, 'How could I survive this?' So I don't know if the image represents something else. I don't know what it means. I've had a lot of 'body memories.' My therapist has explained how memory works, and about traumatic memories, but I have to hear it over and over again because it seems so bizarre. Validation is important, *repeated* validation. Repeating is important, because it's hard to imagine an adult wanting to be that way with a child (italics added).

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

> I have a lot of shame. I have a lot of guilt, and feel it was my fault. On an intellectual level I know this is not true, but on an emotional level it's true. 'I'm a *damaged person*' (that's what I believe about myself).

She further sates in reference to the abuse and how it's affected her today: "It has affected my life. I don't express my ideas; I don't have confidence that I'm a smart person; I have a lot of feelings about *worthiness.*" (She becomes very emotional here, and cries softly for many moments). She continues: "I have a million self-doubts and am obsessive about them."

She says that she also continues to have a phobic reaction to a penis, and certain sexual activity. She explains:

> I still have a hard time with my aversion to a penis, but it is better. The obvious problems are sexual. I don't desire sex as often; I find it sometimes to be threatening towards me. It can still be very scary to me. I've been in the same marriage for many years, and sometimes when I'm sleeping and he touches me in bed, my first reaction is to 'cringe'; it's so out of context. And because I had so much shame about it, it took me a long time to tell J. (her husband—word added); it took me a long time to share it. His reaction wasn't what I wanted. He just listened and he didn't understand it; well I hardly understand it. . .I think if I had had memories, you know how you have memories for other events, I think it would have been easier. But because of the type of remembering, he's looking at me like, 'I don't get it.' After awhile he did read about it, and he did go with me to therapy for a short time. . . . he's much more compassionate now.
>
> I dissociate a lot (leave my body). I did that mostly during sex but not all the time. And I think when anything frightens me too much, whatever too much is, that I tend to just 'go away.' I just *don't feel.* I switch into my head and sometimes I don't know if I don't deal with it at all." (Italics added).

She talks about other symptoms: "I don't think I've ever been 'clinically depressed' but I've been sad a lot, and done a lot of grieving."

Validation Variables: Pertaining to Research Question 5 (a), (c):

Pat did *not* have any validation through corroborative evidence of her childhood sexual abuse.

Disclosure Variables: Pertaining to Research Question 5 (b):

Pat said that she revealed the childhood sexual abuse to her older sister, who immediately believed her, and to another younger sister, who thought that she too may have been sexually abused by the father (but she died of cancer before finishing her therapy and recovering memories of the possible abuse). She also disclosed it to her other sisters who have remained 'noncommittal,' but adds, "they act as if they believe me." She has interpreted this as a "neutral response."

Case Number 10: Story of Eileen O.

Childhood sexual abuse experiences:

> I was about 14 year old. and with three other girls, all the same age, we went to the same school and we were experimental in terms of like, we'd smoke pot and we'd drink, and naturally we were interested in boys and whatever. And one of the things that was a big deal was to go to what we called 'beachhead,' because we lived on a lake and so we'd all go down by the fire and drink and you'd hear about those parties and go. And so the four of us went. . . But I always had some apprehension because I knew I was the one who had a curfew, and the others really didn't have curfews and a lot of times they'd be preoccupied with what they were doing and sometimes I'd be by myself, and that made me uncomfortable. So on that particular night my time was running out and they were all involved with other people, and I had to go, and they didn't seem to bother with me, so I was really mad at them. I took off and had to go up the bluff and trail through the woods and park to get back out, and I was really racing to try and make that deadline and...there are parts that I honestly can't remember about it. . . But I do remember being pursued and remember being really scared, I remember being thrown down. I remember that the *event* was unpleasant. . . the *event* was the rape. . .I don't have any real clear picture of the face (of the rapist-words added). I know that by the time I got home, I was still more worried about being late—So being thrown down, being abused and then still madly worrying about getting home, that still seemed to be the prevailing piece that I could think about during that time. And getting there, and getting into the

house, and my room, and having mom come in and asking me if everything's O.K., and my saying: 'Yeah, everything's fine;' feeling I can't say because everything would be trouble; being really upset, just being really worried, and being mad at my friends and not knowing what to do. And basically I did nothing is what ultimately happened with that whole thing. I didn't share it with my friends, and I didn't share it at home. I just didn't share it. I think this whole thing first came to the surface when I was 17. My boyfriend had moved to Madison and I went to visit him, and he's winking at other girls, and I know I've lost him, and that was a really hard time for me. I was feeling very lonely and very afraid and I'd taken an overdose of some kind of medications that I'd had for seizure type problems. I didn't see a future; I didn't understand; I didn't care. All I wanted to do was to fall asleep and never wake up again, that was the whole idea. To do it with the least fuss possible, that's my M.O.—you know I don't want any waves anywhere, so that's what I did. The next morning when my sisters couldn't wake me (none of this do I remember of course, this was all told to me later), but the next thing I remember is it's several days later and I'm waking up somewhere in a hospital facility. I just woke up. I think I'm in a tub and they're bathing me, that's when I remember waking up. Oh no, I did wake up once in the hospital and I was talking to a man in a coat and thought he was a doctor and he was asking me questions. And when I told him other people showed up from behind the curtains. It freaked me out, and they had to restrain me. It was dark and so I don't know if it was night or day, I assume it was night. But then I'm waking up and they're bathing me. You had locked rooms and you had to be out in the day room. I was walking around pretty much in a haze and I sort of knew where I was, but I didn't. That's when it (the rape-words added) came out, you know they were doing testing and talking to me and asking me questions. And I said, 'well yeah, this happened' (told about the rape—words added). They made it sound like that was a private conversation, but the next thing I know my mother's talking to me about it, so then I thought: 'Oh, how betrayed again!' So I just feel like you really couldn't do anything without something happening that you weren't trying to have happen at that time. So that was pretty much the end.

Dissociation and Memory Variables: Pertaining to Research Question 1:

Eileen said that she always remembered the rape, but not all the details. And that she could "block it out," even though she knew it happened. "I Like to a lot of times, put things on that level, say: 'No, this didn't happen'

and just throw it away, or bury it or something. But that's not something that I should have buried. Except that obviously I was unwilling to share it with anybody."

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Eileen did not directly respond to the question of whether she believes that validation through corroborative evidence is important for remediation of symptoms related to the childhood sexual abuse. She did however, indicate that she feels this is *not* relevant to her situation. She says:

> This identification and the who, and the what, and the kind of consequences-punishment thing; I hear a lot about that with other adults as they talk through their abuse. And I'm not always sure that that's the point. I mean, the irony of this thing is: The anger that I can remember had nothing to do with this situation. It had to do with other people. For me, other people not being there for me, that seemed to be my biggest problem as I remember.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3, 4 (a),(b):

Eileen indicated that she has many negative beliefs about herself and the world that may be related to the rape. Mostly, she believes that the world is a *scary* place. She believes it's not safe to be alone and/or trust others, and that the world ought to be *just*. "Somewhere along the line I've always felt that 'things should be more fair, things should be more just.' It's a little disconcerting for me to say: 'Well life isn't fair.' And why can't it be?'"

"I think that presently, it's very hard for me to trust someone. And it's very difficult for me to share things with people." Eileen says that the rape

affected her sexually, and had a negative impact on her relationship with her first husband:

> Sexually I think that it affected me for a long time, probably through my marriage. I was with that man for probably 11 years. It wasn't a very good marriage...and I think that part of my inability to figure out how to relate to this man and to perceive what was O.K. from him. . .contributed to it's demise. But I find that into my late 20's and 30's is when I started feeling a lot more normal in my relationships with men and feeling comfortable being touched and wanting to touch, and actually feeling very happy about the experience. It took a lot of time to be able to get to the point where I kind of grabbed a hold of my own sensuality and understood a little better about intimacy and what that might mean.

Eileen still has guilt and fear about the rape, and relays this in the following way:

> I have a hard time being by myself, and being afraid of the dark. . . .Sometimes I'll go through periods where I don't like to go into stores that I hadn't been in before, that I know are O.K., because it might not be O.K. So I think it's kind of cramped my ability to be an adventurer. I'm just much more cautious than I was before (the rape-words added). It's safety; it's fear; it's being alone; not being really sure. There're still certain things that make me feel uncertain, because you know you're O.K., you know you didn't do anything wrong, but you still have that piece that just will never quite leave you alone.

She explained this as a doubting of herself and second guessing what she could have done differently (to avoid the rape): "What if I had done this, and what if I hadn't done that?"

Anger is another problem for Eileen, she says:

> Sometimes it's very hard for me to be angry when something really bad has happened so I get real confused on that point. At other times it doesn't seem to be a problem for me, and so it's not like a perfect mechanism that goes off when it ought to. It seems to have it's own little wave, and there's no rhyme or reason to it as far as I can tell—except when I think I'm the most healthy, then it's operating on a more normal pathway. The less healthy that I'm doing, whether it be work

> or family, or personal stress, that's when it seems to go more off kilter, and when I might go back into those old coping mechanisms (fear-denial-isolation-confusion-words added). I don't want to be angry, I just want to be left alone, but I'm afraid to be alone, so it gets very confusing.

Validation Variables: Pertaining to Research Question 5 (a), (c):

There were no witnesses to the rape of Eileen, and no corroborative evidence of her childhood sexual abuse.

Disclosure Variables: Pertaining to Research Question 5 (b):

Eileen disclosed the rape to a female psychiatrist at 17 years old, when she was in a psychiatric hospital for a suicide attempt. She thought she was telling this in confidence, and that the doctor would not reveal it to her family, so when it was disclosed to her mother, Eileen got very angry, and said she felt, ". . .betrayed again!" The medical personnel and her mother and siblings believed her and tried to validate her, but this was *not* comforting for Eileen at the time. She explains her thinking back then:

> I don't remember ever talking to that woman again, whoever she was who did the interview with me. I know she was a psychiatrist, but I just felt she was the biggest jerk in the world. Now my mom's all upset and she just couldn't believe that, blah, blah, blah—all that stuff. She believed me, but it's a little disjointed how this started going around and all that. My oldest sister knew about it, and all of a sudden my brothers are mad and they want to know who, and when. This is stuff that happened years ago and I don't even want to discuss it, and they're like trying to find out all this stuff. I'm mad because people are talking to me about it, and it's none of their business as far as I was concerned at that time. . .I think back then I was more worried about what would happen to me if someone else found out. But then after it came out, then I was just mad that they knew because it was embarrassing for me and I was ashamed.

Case Number 11: Story of Kathy P.

Childhood sexual abuse experiences:

It was my brother, and he's two years older than me: I was only 10 and he was 12, but he was very mature for a 12 year old. One of my other brothers was in the hospital for a kidney operation, he had to have a kidney removed. And we had gone on a vacation when he got out of the hospital and when we got back from vacation I remember my brother saying, "Let's go fishing." We lived out in the country , out on a lake. I remember saying, 'There's no line on my rod and reel.' And he said, "That's O.K. I'll get it, it's in the tackle box," and we went down in the pasture by the lake - I really don't remember a lot, except not telling him 'No' for some reason, or if I tried to, and he didn't listen. I remember it happened on more than one occasion but I don't remember a lot of the particulars. I can't tell you how many times, or how close together they were; I don't know how long a span it covered. I can remember different places, like a log cabin my dad had built for us, it happened there. And I remember him showing himself in the bathroom one day. I don't remember how I ended up in the bathroom that day, but I had walked in and he was in the shower, and I don't know exactly what happened, but it happened then. It started at 10 but I don't even know when it stopped; it could have been when I was about 11. The memories (details) are not real clear, but I never, ever forgot, I just don't remember the details. I do remember a couple of incidences, and of it being sexual. I remember there was sexual intercourse involved.

It wasn't violent, I know that because I didn't fight him. I know in my heart I must not have told him "No." I think I may have asked him "Why?". . .at some point I may have told him, "This is enough, and leave me alone." Sometimes I look back and think: "Maybe I've magnified it in my mind, and that maybe it wasn't a *big deal.*" But it *feels* like it was a big deal. I can't imagine what has affected me for so long, not being a *big deal.*

Dissociation and Memory Variables: Pertaining to Research Question 1:

"The memories are not real clear, but I never, ever forgot, I just don't remember the details. I can remember parts of it, I just don't remember the time frame of it"

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

When asked if her brother's acknowledgment (validation) of the abuse would help her heal from the abuse, she replied: "I don't know. I guess I don't think it's a possibility. I think it would have helped more, talking to my mom. And if I had told daddy." In response to the importance of therapist validation, she said:

> I'm not sure if that's important, because I found myself in the last year sometimes thinking that she's (therapist-word added) said things, not insincerely, but because those were the things that she's suppose to say to validate it. I guess that goes back to not believing compliments too. So it's like, 'Oh, she's just saying it because she has to say it.' I never felt that way about G. (her present therapist-words added); she's such a giving, honest person, but I still have a hard time accepting.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

> I've felt like a 'fake.' People seem to perceive me as very sweet, and I always think that 'if they ever knew me they'd find out that I'm not sweet; I'm not what they perceive me as; I'm not as good as they think I am.' My mom used to tell me to stop being a 'martyr.'
>
> I think that my self-esteem has always been next to nothing. I've never thought a lot of myself or the way I look. Even if people tell me how pretty I am, I always think they're just saying that. But it's kind of pre-treatment and post-treatment, because I'm doing much better now. My best friend called the other day and he was saying something to me about. . .one of my cakes and normally I would say, 'Oh, no, no, no.' And I said, 'Thank-you.' And my daughter was washing dishes and she looked at me and said, 'kind of conceited, aren't you mom?' (Kathy laughs here). My best friend said, 'I can't believe you said that.' It's a standing joke with us now, she always says something, and waits for me to thank her. That's a major improvement.
>
> I've had a hard time saying "No," all my life. I think that the major effect that the abuse had is when I went to college and met my husband. Within three weeks we were having intercourse and I didn't want to, but I didn't know how to day 'No.' And nobody had ever tried anything, and I wasn't equipped to say 'No.' So from the first time we had intercourse I just assumed this was the man I *had* to marry. It

> wasn't a religious belief, although I grew up in a very religious home, a strong catholic home. But I don't believe it was as much a religious belief as it was a belief that that was the way my dad had taught me. That's the way things were to be, that you did not do that. So when I did, I thought that that was it. Luckily the man I married is a wonderful person. He's always been good and supportive and he loves me to distraction. It's wonderful and I ought to be happy, but I'm not. I sat in the church the day we got married and cried because I knew it was not something I really wanted to do. And it would kill him if he knew that; I'd never want him to know.
>
> I have battled weight all my life (overweight-word added), although not right now. I've lost about 30 lbs. since last March and I'm not currently overweight. It was stress; I dropped about 20 lbs. last spring in about 4 weeks, and continued to lose a little more. And I've managed to keep it off. I'm smaller than I've ever been. I'm smaller than when I got married. I definitely have a body-image problem: I look in the mirror and I see my big tummy; still that's the first thing I see is my tummy (the negative).
>
> Over the years I had a problem with sex. My husband always teased me and said I'm the only married person he knew who thought that sex was still wrong.

She talks about being very depressed, but would not go on antidepressants. She is taking 'natural,' homeopathic herbs (St John's Wort) for the depression and has seen a dramatic change. "I have cried every day of my life until last May (when she began therapy and worked with the past abuse issues-words added), just about every day. Well, it still hasn't stopped but it's not every day anymore."

> Anxiety is a problem. Put me in front of a bunch of adults and I will freeze up. And I wasn't like that as a young child, I liked to be the center of attention. I'm a perfectionist. I call myself an imperfect perfectionist, because I never quite achieve it.
>
> I get very angry to the point of being irrational (rage). That has improved dramatically since last May. People that I work with don't see that, but with my kids and my husband I get quite upset. There have been times over the years that I've just been unbearable at home. I worry that I've messed up my kids. In fact when the kids were babies, my daughter was a baby and my son was 4 years old, and I had them in the bathtub bathing, I walked into the bedroom

to get their clothes and I heard my daughter crying. I walked in, and just like kids do, she had been playing with herself in the tub, and he had reached over to touch her and had scratched her a little and it didn't hurt her or anything, but I just went ballistic! You had thought that somebody had killed one of them: I ran outside and told my husband that he had to come in right then, and I know I scared my son half to death. I know my daughter doesn't have any remembrance of it, but I've often wondered what I did to my son. And I told them both, the kids know, that something happened to me when I was a child.

Betrayal is an issue. I have the feeling of betrayal a lot, whether or not it was there.

Validation Variables: Pertaining to Research Question 5 (a), (c):

There were no witnesses to the abuse that she knows of. "I brought it up to my brother (the perpetrator) and he just acted like it was no big deal."

Disclosure Variables: Pertaining to Research Question 5 (b):

Kathy had mostly positive responses from her family when she disclosed the abuse as an adult.

I did tell a good friend of mine in high school and she kind of made it sound like 'well gee, that happens to everybody.' And then I talked to a priest about it one time, and he kind of told me it was my fault.

I told my husband right after we got married. He's always been very supportive and really good about it, he's never pushed me, he's never forced anything.

I guess I must have thought it was my fault, because I don't know why I didn't tell anybody about it (as a child-words added). I've always wondered. . . why I didn't tell somebody. Because I thought I was going to get in trouble, or whether I thought *he* was going to get in trouble?

I told one of my sisters. . .about 8 years ago. She was devastated. She cried. It never happened to her. And since then I told one of my younger brothers, last May, and nothing like that ever happened to him. I have two other brothers I've never told, although I did tell my sister-in-law last weekend. I didn't tell her who it was, and told her I wanted to talk to L.(her husband-words added) about it, because he's got some problems dealing with people. And I often wonder now, as an adult, if it's something that happened to him too."

I did tell my mother at Thanksgiving recently. I just went through a hard time last spring. I was approaching 40, my dad had died the November before, and I was not really happy in my marriage. I never really had been happy. I think I married for the wrong reasons. We've been married almost 20 years and he's a wonderful person, it's not him; it's me. But a lot of things just came together that caused me to go ahead and hunt for some help. And I think one of the things that prompted me, is: I think I always wanted my parents to hug me and tell me everything's O.K. and that I was all right. And I think when daddy died, that option was taken away. And so I finally did talk to my mom, and my sister had told me before I talked to her that, 'You can expect her not to believe you.' But she did believe me. She had been molested as a child, although. . .she didn't tell me who it was. But she kind of knew where I was coming from. It was a relief in some ways, but I didn't intend to tell her it was my brother. I was hoping she didn't think it was daddy. . .

. . .I've talked to priests about it over the years since then, and have gotten some really good responses. Every priest I've ever known personally I've told about it, and all of them, with the exception of that first one, have never condemned me, or made me feel it was my fault in any way. The priest that I have now came the closest to helping me, he said: 'You have to forgive yourself.' I never thought of it that way, because I always told myself I had nothing to forgive myself about. And he said: 'You're right you don't, but you're probably feeling like you do.' and I think he touched on something.

Case Number 12: Story of Kristie P.

Childhood sexual abuse experiences:

It started when I was about 8 years old. My cousin was 5 years older than me, so he was about 13. He was baby-sitting for my brother and I, and my sister (she was a baby at the time). He started to show me his penis and he wanted me to touch it. Then it escalated to where he had touched me, and I had touched him. And I'm not really clear how long that went on but because I stayed with my aunt and uncle quite a bit we had pretty much access to that behavior. He said that he didn't want me to tell anybody and that they wouldn't believe me anyway, and certainly I would be hurt if anybody knew. It was over a number of years, and he eventually had intercourse with me, but he didn't penetrate me very deeply, not enough to break my hymen. However right before he left to go into the service he did (not in intercourse) actually touch me inside and broke my hymen, with his finger. I remember it; I remember it hurting a lot. He also touched my brother and my brother talked to me abut it. He also force my brother to have

oral sex with him. When my cousin left to go to the service, he was 18 and I was 13, and my brother is like two years younger than I am, I missed it (the sex play), even though I knew it was wrong. I felt in a way that at least someone was paying attention to me, somebody actually wanted me.

There were a lot of issues going on in my family at the time; my dad was mentally ill. He's borderline schizophrenic and he was real ill during parts of my youth. So he was in and out of the hospitals having breakdowns. My mother was not real loving. She took care of us, our physical needs as far as shelter, clothing, food, that kind of stuff, but she was certainly not a real loving mother. I think that she was overwhelmed with what was going on with my dad, and she couldn't deal with it. So there wasn't a lot of 'appropriate' touching and loving, and sharing love, and that kind of stuff. As I got older, 10, 11, 12, and started to pull away and become my own person, I became the 'scapegoat' of the family. And my dad also physically abused me. He got violent. He was rageful. If things didn't go his way he would knock me across the room with his fists. He also did this to my brother. So he was pretty much rageful at my brother and me, and we got his rage a lot. However, he did not hit my sister, and he didn't hit my mother. It sort of came that I was the one he hit so as not to hit my mother because my mother had a real, real, bad heart. So I was the one who was getting it for her.

My parents' friends had seen it (father's physical abuse of her/her brother-words added), my aunt and uncle had seen it, everybody just thought it was fine. Nobody stepped in to help. And it just became more and more. And as my mental illness progressed, the depression, the hopelessness, I started to have more of a 'mouth.' Then I became hopeless around 14, and I did try to kill myself. I took some of my mom's pills, and actually nobody made very much of it. She just came up and gave me something to make me throw up. I did start to see somebody at the hospital, as an outpatient. And pretty much my dad said, if my therapist didn't like the way my dad was treating me, then he could just 'kiss my butt.' And the therapist actually kicked my dad out of therapy. It ended up that I was pretty much not going to therapy because of my dad, because I couldn't get there—that was when I was around 14. He had broken my ear drum, the bones in my cheeks, my nose had been broken, my jaw was broken, I had concussions. I've been thrown through doors; I mean literally thrown through a screen door. One time, I believe it was when he broke my eardrum, I had a concussion (around 14, 15) and I had to go to the doctor. He said, 'If you tell what happened, you're not going to live to see another day.' And I really believed him, so I lied to the doctor and never said anything about the abuse.

> I was in my 20s and he was still hitting me. Finally, at one point, I tried to stab him (I was maybe 23, 24); after that he never hit me again. He really, really, hurt me. They think that there's some brain damage because of it. And I'm on disability today, mostly for emotional problems, but I would say that the physical abuse probably contributed to it.

After Kristie's initial sexual abuse experiences by her cousin, she then became promiscuous, and initiated sexual intercourse with her younger brother (who had also been sexually abused by the cousin). They had sexual relations which lasted from age 13 to 18. She says:

> He took the place of my cousin. . .It was a physical thing but there wasn't any kind of love. We didn't have foreplay. We didn't kiss each other. It was sort of like: 'Wham! Bham! Thank-you mame!' There was no feeling or emotion. If we were alone in the house we'd just say, 'Oh, do you want to?' 'Yeah, I guess.' And we'd just did it; it was sort of like a detachment.

At 16, Kristie became pregnant with her brother's child, who was given up for adoption. "I didn't really understand what incest was about. Actually I didn't even realize how I go pregnant. I mean I knew I had intercourse, but I really didn't know 'the facts of life.' She hid this pregnancy until her eight month, when a nurse at her high school caught on, and called her mom and told her.

> I was in denial. I was in high school, and lived at home, and my dad didn't know I was pregnant. And my mom didn't know I was pregnant. And to this day, my dad doesn't know I was pregnant; he never knew. . .I wasn't totally in denial, but I just pretended. . .I remember saying something to my brother that I was pregnant, and he didn't know how to deal with it, so he pretended too.

Her mother took her to her doctor and Kristie told him that her brother was the father, and he told her mother. Mother blamed her because

she was the oldest. And she 'snuck' her through the pregnancy, ". . .not for your sake, but for your dad's sake." She kept the birth a 'secret' from dad by having the doctor tell him that Kristie had a ruptured tumor that he had removed. When the baby (a girl) was born, she was whisked away and "I never saw her. . .I had a really hard time. . .I never dealt with it. . .and life went on and it was never talked about." She got pregnant again at 18 by her brother, but pretended it was by a 14 year old boy she had been "fooling around with." She got her minister to come with her to tell her dad and mom about this pregnancy. Dad became so enraged that he got his shotgun and was threatening to kill the 14 year old (who he thought was the father of the baby). Kristie was able to calm him down after awhile by leaving home and living with a girlfriend for some time. After the baby was born (a boy), he lived for only 7 weeks, due to genetic defects. However, she claims: "The baby had a special relationship with my dad, even though he was only seven weeks old when he died." (She had very strong emotional reactions here, and cries for a few moments.)

Dissociation and Memory Variables: Pertaining to Research Question 1:

"At times the memories were clearer than at other times, but I never really forgot. I like to try to block them out."

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

> I still sort of have a daydream that that might happen some day (her cousin acknowledge his abuse of her-words added) because both of us are in recovery—he's got like 5 years, and so he's not all that far behind me. I think it's like God's plan: All the stuff we went through, now the healing happening.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

> I felt very *bad.* Certainly my self-esteem wasn't anything. I felt because I did this I was a *bad person.* In my family of origin, because I was a scapegoat, I was always getting that message anyway. 'Not good enough. I was bad.' So that's what I grew up believing. And I started to get in trouble at school: like skipping school, my grades went down. Life got 'nuts.' The nuttier it got in my family, the nuttier I got. And at 14 I couldn't take it anymore and I just wanted to kill myself. I didn't have any hope, I didn't fit in anywhere. I would go to church and I felt that I never fit in; I felt I really was *bad.* And that no matter what I did, I'd never get clean; I felt *unclean.*
>
> Maybe the consequences of this whole sexual abuse stuff, is that I don't feel that I can do anything right. My whole life has been where I've failed at things: I failed at working; I failed at going to school; I failed at relationships (although our relationship now isn't a failure). I went to a difficult women's college and I didn't do well there. A lot of it was not 'coping.' I would procrastinate when I'd had a paper due. I'd get scared and I would 'freak,' and I wouldn't be able to move, literally. So I'd just sit and I wouldn't do it, and then obviously I'd be in trouble. My advisor advised me to consider dropping and going into the associate program, but it was so expensive that I ended up not being able to afford it. But through this whole thing C.(her live-in fiancé of 8 ½ years-words added) was very supportive of my going to school, and all the craziness that went into my being at school. I don't drive, and that's another thing, that's a consequence of the abuse, because I failed at so much, I'm afraid to try, or I think that I'm going to kill somebody (if I drive a car). I've let a lot of things go by in my life because I didn't think I could do them.
>
> I still have guilt. Some over my cousin, but I think more over my brother, and more about my son. I feel extremely *shameful.* But it has gone from about 95 to 50, so it's lowered a lot.

Kristie talked about having an eating disorder, and being on medication for depression. She also is a recovering alcoholic (10 years sobriety). She explains her symptoms:

> I have an obsessive-compulsive disorder. I pick my body, where I have sores. I can't stop it. . .it's gotten worse. . .When I feel out of control, I find myself picking. . .I have a jerking, a very noticeable 'tic' that happens in my right shoulder that's probably related to the abuse (or

> the physical abuse). Also, I can totally blank out and just not be there (dissociation-word added). This is actually happening more now than it used to.

Validation Variables: Pertaining to Research Question 5 (a), (c):

Kristie had validation through corroborative evidence from her brother, as she notes:

> My brother knew about the abuse, because he was right there a few times when it happened. He thought it was my fault because he told me, not too long ago. . .'Why didn't you just say no, like I did?' Actually I think that was his guilt talking because he (the cousin-words added) had sexually seduced my brother too, so there was his stuff in there.

She also had corroboration about her brother's abuse from the doctor, and her mother, who knew about the sexual relationship between Kristie and her brother. The cousin perpetrator had never admitted his part in the abuse. "To this day my cousin and I have never talked about it."

Disclosure Variables: Pertaining to Research Question 5 (b):

In reference to disclosure of the sexual abuse by the cousin, Kristie said:

> I told my best girlfriend, but her family is alcoholic, so it was sort of like we were both in bad situations and she didn't think it was too serious. I didn't tell my mother or father because I was afraid at first. I didn't trust my mother, and I didn't feel that she would believe me anyway. It ended up where my brother actually did tell. And they just said, 'Well stay away from him.' They didn't really believe my brother, so it clarified right there that they wouldn't believe me either.
>
> To this day my cousin and I have never talked about it. He became an alcoholic and he went through treatment. In the last couple years, through the grace of God, or whatever, I feel like I've forgiven him. So when I see him it's not like I hate him anymore like I did before. I had blamed him for the start of my ruination, so to speak. And in therapy I dealt with that through letters I wrote him but didn't mail (she started to cry here). I'm crying about all the wasted years; the hate that I had; the feelings of inadequacy; the self-hate, where I'd

try to medicate myself with alcohol. (I'm a recovering alcoholic; I've got 10 years sobriety.)

My dad does not have one clue that any of this went on. To this day, he would just be bowled over. And at the end of the week he's going to be 73. He's older, and there's no point in talking about it with him. I told my mother about my cousin not too long before she died. She was real angry. She was angry at him, she was angry at me. She asked me why I didn't tell her and I told her the truth, I said: 'Because I didn't think you would believe me.' And that's when she got even angrier."

When I had gone to C. (addiction treatment facility-words added), we had a meeting with my brother, and I apologized to him, and he apologized to me. He acknowledged it. This helped a lot. There was a lot of healing that happened. Now B. (brother-word added) and I can talk about it. We rarely talk about it, and when we do it's only by ourselves. But we can acknowledge that that happened, and it's in the past. And there's some healing that happened between both of us.

Case Number 13: Story of Jean-Marie (Jeanne) B.

Childhood sexual abuse experiences:

Jeanne was sexually abused by her father's best friend, a 40 year old. man, when she was 9-10 until she was 16-17 years old. Whenever he could get her alone, usually in her in her bedroom, he would passionately French kiss her, and/or touch her body; catch her coming out of the shower nude; and/or glare at her with "lustful looks." One session she remembers most clearly lasted for 1 ½ hours. There was no sexual intercourse involved, but one time he started putting his hands down her pants, whereupon she started crying and he stopped. Her normal reaction was to "freeze" (and not feel) when he kissed, touched and/or fondled her.

Shortly after this abuse started, she told her mother. Mother told the father, and the parents then told Jeanne that they would handle it. Since the abuse continued after this disclosure, she assumed that it was not important

to her parents and further that, "I don't matter," and she did not continue to disclose further. When she became an adult, after going through therapy, she was able to talk to her mother about this childhood sexual abuse, and mother told her that dad did talk to the man and told him he would kill him if he ever touched his daughter again. This was a great relief to Jeanne, but she wished her parents would have told her this as a child; perhaps the abuse would have stopped. Also, her sister validated her by telling Jeanne that she believed this had happened, since the man had also done similar things to her (but only one time). Jeanne did not think that this early sexual abuse affected her in anyway, although she noted that she cannot have a sexual orgasm with a man (is inorgasmic) and seems to *freeze* this area of her body when she's in a sexual situation with a man (just as she had done during the childhood sexual abuse by dad's friend). She also recalled another sexual abuse experience when she was about 12 years old: She was baby-sitting and the dad came home with alcohol on his breathe, called her into his bedroom, and took her hand and tried to get her to touch his "hard penis". She again froze and remembers touching the sheet but not his skin. He came over the next day to pay her for baby-sitting, looked embarrassed, and never called her again to baby sit. He did not admit what he did or apologize.

Jeannne also remembered another sexual abuse experience which was similar to the CAS. It occurred when she was an adult and five months pregnant with her first child. She had a "trusted" therapist doing *Reiki*

Healing with her, and he started touching and rubbing her genitals and getting "all turned on" (sweating, panting breath, with a 'hard-on'). This time she was able to address it immediately and tell him to stop. He denied that he was doing anything wrong, but she knew he was, and never doubted this.

Dissociation and Memory Variables: Pertaining to Research Question 1:

Jeanne has very clear, declarative memories, which she didn't forget. "I was always there, I just *froze.*".

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Jeanne stated that it would have helped tremendously if her parents had been more communicative about what they did about her abuse, after she disclosed it to them. She also thought that her parents could have stopped the abuse, if they had validated her back then. She appreciated her sister's disclosure that this same man had sexually molested her as a child also. She felt relieved and validated.

When asked about how important it is for the therapist to believe the abuse, she thought that was a 'given.' She states: "Yeah it's important, why wouldn't you believe somebody? At lease initially, until I went deep. I suppose I wouldn't take anything 100% unless I went deep into the subconscious."

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

In reaction to disclosing the abuse to hers parents, who said they would handle it but didn't, she began to believe "I don't matter." She's

also had difficulty saying "No" to men (in any area). Jeanne *does not* claim any guilt or shame over the abuse, but does admit to *embarrassment*. She feels that the perpetrator is to blame for all of it.

Jeanne did not connect her inorgasmic symptoms with the abuse. She got into therapy originally for self-growth (in early 30s). She did not connect her almost sexless marriage with the abuse (her and her ex-husband were "soul-mates" and had sex only a couple times a year). "Prior to therapy, I think that I would just freeze in uncomfortable sexual situations with men. I had a hard time saying 'No.' I wouldn't say 'No.' I can't climax with a man, I can with a vibrator." She now understands the connection between these symptoms and her childhood sexual abuse.

Validation Variables: Pertaining to Research Question 5 (a), (c):

Jeanne has validation through corroborative evidence of the abuse. "He used to do it to my little sister also, but not to the extent as me. She told me this as an adult."

Asked about how important it is for the therapist to believe the abuse: "Yeah it's important, why wouldn't you believe somebody? At lease initially, until I went deep. I suppose I wouldn't take anything 100% unless I went deep into the subconscious."

Disclosure Variables: Pertaining to Research Question 5 (b):

> I told my mother, and she told my dad, and they just said that they would handle it. H. kept doing it, and so I felt they didn't handle it. . .Then after therapy (as an adult in my 30s), I was talking to. . . my sister, and she was saying: 'Oh, I remember dad yelling at H.

(perpetrator-word added), and threatening him, and telling him if he ever touched you again, he would kill him, and all this extreme stuff.' But I never knew any of that.

I was afraid (to tell). It wasn't a comfortable thing for me to be talking about. I didn't share it with my friends. I was afraid of the embarrassment. I was a very affectionate person and I don't think I thought it was my fault; I thought it was more his fault.

Case Number 14: Story of Shann M.

Childhood sexual abuse experiences:

There were two separate situations: One I have always known was an uncle who basically was fondling. . .He was sexually fondling me in my underpants. I was probably about 8, and I always knew that; I only remember it happening one time. And of course he said not to tell. And I remember having to walk away from where we were and go into the house where grandma was—because we were out, it was on the farm, and I was in the shop. And somehow he and I got left alone there, while the others went out into the fields, dad and grandpa and that kind of thing, and I went into the house with grandma and I never told a thing. I finally told somebody, when I was getting divorced. I was about 42 or 44, and I was doing therapy at the time. Right now I'm not even sure if it was a friend or the therapist that I first told. The reaction was positive to neutral, probably because it wasn't anyone who knew my uncle. (He was an uncle by marriage.)

It was at a later time that I became aware that there was, as I know it to be, 'preverbal sexual abuse' by my father. So that's why the incident with my uncle didn't have a real traumatic impact. Somehow what my sense of that is now is that I was a safe person for him (the uncle-words added) to do that with.

Dissociation and Memory Variables: Pertaining to Research Question 1:

The memory of the sexual abuse by her uncle is *clear* and *declarative*, she says: "I always knew that one." While the memories of the preverbal sexual abuse by her father are *dissociated*, and *state-dependent*: They only 'surface' when she's in a 'state' produced by a method called 'primal scream' therapy. She elaborates:

. . .when I was going through my divorce, I had a therapist who did 'primal scream' and so I used a lot of that because I had a lot of baggage; I had a whole marriage to work with, along with the divorce at the same time. . .It was 20 years of emotional abuse; he was alcoholic. So it was really the codependent thing that I really had to let go of. So having learned to use that 'primal scream' therapy, I continued to do that on occasion. Then when I was doing it alone in my room shortly after having gone to this workshop and listening to these presenters, I started having these 'visions,' (which I now believe to be memories of the abuse). The first time it happened it was real traumatic: I was coughing, choking and gagging, and thought I was going to throw up then. So it was just a real shock. It was real traumatic to have it come that way. And I thought, 'Now what do I do, where do I go with this?'

And I'm not remembering the time-frame of this, but what I did end up doing, I guess I sought out the self-help groups. So I went to a few of those, and listened to the stories and saw some other people there that I connected with, and was absolutely shocked to see who was there: I went to high school with her dad and her mom, and there she was. And she was talking about her dad and I was just blown away! So it was all such an awareness for me, it was all so new, which it was for the general public at that time also. . .So then I started working with a woman who was in her doctorate program in counseling and she was very helpful. More memories were recovered but only in that 'state' (I know now that those were 'state-dependent memories'). The interesting thing about that was, it also was just months after his death (her father's-words added). So I tied that in; that it wasn't even 'safe' for me to do that until after he was gone. I know that it was sexual because that was what my 'visions,' what my inner self said. It's a double experience sometimes: Part of me is here thinking, 'I'm going to throw up in my bed,' and the other part is going through the emotions. So both things were happening at the same time; feeling the sensations, and being able to see myself.

. . .Then shortly after that, because of his death, the family farm had to be sold. I went there. I decided I needed to go. I actually went camping: I went to my home and I camped out in the house for two days. And I went and I didn't know how long I was going to be there and that was O.K.; I just needed to be there. And while I was there one morning I had the need to do that same thing, to do the 'primal scream,' and it was there again (the traumatic memories of her father's sexual abuses of her-words added): His approaching me and everything; coming up from the side, the angle, and all of these things. And so once I had that, I got up, put my blankets away, and I knew I could go home. . .I did that 'farewell work' while I was there, it was my intention, not knowing that this 'vision' would happen as well

> (memories of father's sexual abuse of her-words added). It only comes that way, it's only allowed to surface in that way, when I'm in that 'state'.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

"I can only guess, but I think it would help for someone to validate me and say that it happened; probably the therapist." Shann does not feel that her mother discovering the abuse would have helped, she said: "If mother would have discovered the abuse by my dad, then I would have had to deal with her for having allowed it, if she knew it occurred, and having been responsible for allowing it in some way." She viewed her mother as positive, she says: "Mother was a real safe person. . .but she had no power."

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

Shann talked about having boundary issues and not being able to say "No." This implies a poor sense of self as separate from others, and the idea of 'unworthiness.' She explained her other symptoms:

> Hypervigilance is one things that I'm always aware of all the time. Depression, anxiety, not being comfortable in situations where I don't know how I'm going to take care of myself. And some of that was aggravated later on by living with an alcoholic—supported that feeling of having to always take care of yourself and know how you're going to get away and those kinds of things, feeling unsafe.

She then gave an example of having a 'panic attack' in a recent situation where she felt 'unsafe.' "I need to take care of myself because no one else does. 'I'm not safe' is something I believe."

". . .Most of my life except probably the high school and college years, I've had a weight problem (overweight-word added). I think it is a protective factor."

> I think I've been sexually dysfunctional and never done anything with that (difficulty enjoying sex or having orgasm with a man-words added). I think it (the sexual abuse-words added) definitely resulted in continuing sexual abuse in my marriage. But I didn't know how to say "No" then, so I didn't have boundaries; I think that's a big issue, the boundary issue.

Validation Variables: Pertaining to Research Question 5 (a), (c):

There were no witness, or any other validation through corroborative evidence of Shann's childhood sexual abuses. She states:

> No one knew, but what I know now is I had behaviors that, I can't imagine—when we see our children rubbing themselves, or things like that, we usually notice that something's up. Instead I remember doing that in public, and they'd say, 'Oh look at Shann she's tired.' Rubbing my genitals in public and they're thinking I'm tired! That's why I think the uncle thought it was O.K. somehow because I remember that being about the same time frame even though I'm sure it (sexual abuse by father-words added) probably had gone on earlier, and for a longer time. I think I was just a baby when I was abused by my father—because I sound like a baby, that's what it *sounds* like.

Disclosure Variables: Pertaining to Research Question 5 (b):

> The reaction to my disclosing was positive to neutral, probably because it wasn't anyone who knew my uncle. I didn't tell because we lived under an authoritarian system, we always obeyed.
>
> I told my sisters. The first time I told that to my one sister, I really was very emotionally into it, and she really hooked in with me. So she was very supportive in that way, totally. In my family I'm oldest and I have a sister, and then there's my sister and brother, all in five years, and with four of us in five years, I became a mom—we were like raised in two families. We two older ones have totally different memories than the younger ones: They got to play, we two older ones had a totally different experience. But who I told was my younger sister; she did click in, she did go there with me when I was

telling her. It was probably the most dramatic telling of it that I had. I sat my children down and told them both, when I was planning on going inpatient (which was aborted due to lack of insurance coverage). And I did tell my other sister also. I think she may have been abused somewhere, but it's not something she's worked out, because our lives are so much alike and how we deal with things sometimes. Because she hasn't done a lot of work, she carries so much anger, but she doesn't seem to hook up with a good therapist. We tried to talk about it (father's abuse of her-words added) but it's not there for her (memories of sexual abuse-words added), just like it wasn't for me in a conscious state. When I told her about my uncle, she said, 'I'm certainly not surprised.' And I said, 'Did he approach you?' And she said, 'No, but he's that kind of person.'

Case Number 15: Story of Cori Y.

Childhood sexual abuse experiences:

It was more *covert* then overt. I was 10 years old and my sister and brother-in-law were staying with us for a short period of time, and I went to get something out of my closet because they were sleeping in the bedroom that I usually slept in. The rest of the family was downstairs and my brother-in-law was still in bed, and he called me to him, and put me on top of him in the bed. There was a sheet between us, but when I look back on it afterwards I realized he had an erection, and it was an awful feeling for me: I was scared; I was hurting; I was sad. What happened afterwards because of my own ignorance and the family dynamics that were going on—I knew nothing about sex or anything like that, but for 2 ½ years after that incident I thought I was pregnant! Every time I would lie on my stomach to do homework or watch television, or whatever, I'd feel a pulse (actually my own pulse in my abdomen), and I'd just get terrified that I was pregnant and that he'd done that to me. I never told anyone back then. . .

That was the only time that there was actual physical contact, but he continued seductive, sexual stuff for a long time after that. He was in the military, and he would write love letters to me. And he would want pictures of me when he'd come into town. He'd want me to pose in really seductive poses and take pictures of me. I mean they weren't nude pictures or anything but there was just a real 'icky' feeling about it.

Dissociation and Memory Variables: Pertaining to Research Question 1:

> I actually forgot about the abuse. I think it stirred up briefly in my early 20s, and then I basically repressed it, until about four years ago, and then it came up again, and I started dealing with it again in therapy.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

When asked if it would help her if her brother-in-law admitted the abuse, Cori replied:

> No! I dislike him so intensely that, no, I don't want anything from him. I'm pretty sure he abused both of his daughters. I'm very angry with my sister because she's a 'Pollyanna ostrich'. And she just kind of went along like everything was fine. . .
>
> . . .I guess in a perfect world I'd like to have acknowledgment from my family that it happened and that I was damaged by it. And that might be one of the things that is keeping me from healing completely because I keep holding on to that hope and that wish that someone will come and at least say they were sorry.
>
> . . .It was incredibly important to have the therapist validate me. I've always had a male therapist. I've tried to see a female therapist a couple of times and it didn't work. I worked with one therapist for 13 years and then I've recently switched to another therapist that I had been working with collegially, and who had alternately seen my husband and me in marriage counseling. I felt that he was very, very supportive, but it's more than just support. It's validating the experience and then very gently encouraging me to find ways to move beyond it and transform it. One of the things I've been doing in the past week, since I've talked with you and we've set up this interview, is doing some journaling and listing of people in my life who've been most hurtful, and trying to figure out what the lessons and the gifts are. I haven't been able to do that with my bother-in-law 'yet.' But it's just a matter of time; I know that it's eventually going to happen. And I guess one of the gifts is I am sensitive to how vulnerable the child is. And I believe that the child is still alive in all of us. And so that ends up being an issue for me as a therapist, and an issue for me as an individual in therapy: that the child needs a whole lot of attention."

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

Cori remembers having nightmares and intrusive PTSD symptoms as a child. She relayed the negative consequences of her childhood sexual abuse:

> I believe that victims of sexual abuse tend to be people that have poor self esteem and make pretty good targets for abusers. I think that the incredible fear and shame that came from that incident pretty much killed any potential that I had of having healthy self-esteem as a child. I didn't have much of a chance for that anyway. I grew up in a Scandinavian and German heritage family. Our family doesn't talk, they don't touch one another, they don't make eye contact. I was a child that needed all of those things, evidently more than my siblings did, because they don't see any problem with the way they were raised. I think that the sexual abuse just kind of put the icing on the cake for all the rest of it.
>
> Of course I thought the sexual abuse was my fault. I don't now, but I think it took a long, long, time for me to realize that the way everyone in my family treated me wasn't my fault. . .
>
> . . .I think, tangentially, everything in my life from that point has been related to the sexual abuse. . .I started dealing with it again in therapy, and basically looked at how it has damaged my life in almost every area. I started drinking when I was 10. I was an active alcoholic for 30 years. That's probably one of the primary symptoms. I'm on my fourth marriage. I believe that I married an alcoholic each time, all three of my marriages were physical and sexual abusers. This one is not. We are both alcoholics and we stopped drinking about a year after we got married. He's twenty years older, and his had progressed a little bit further, to the point where I didn't want to deal with his drinking. And I issued an ultimatum and said that if he wanted the marriage he had to stop drinking, and that I would stop drinking at the same time. So we have both been sober for a little over eight years now. I'm not sure I would have married him, had I been sober when I met him, but we've worked really hard to keep the marriage together. And it's a pretty satisfying and fulfilling marriage for both of us. Unfortunately there is sexual dysfunction, so I have to deal with that. . .I started looking back on the other relationships that I have been in, and I'm not sure I've ever been in a relationship with a man who has not been impotent in one way or another. I have been married three times, had a live-in relationship once, and then numerous dating relationships, some serious, and some not. Between marriages I was a single parent for 12 ½ years, and I was pretty actively dating during most of that time.

Validation Variables: Pertaining to Research Question 5 (a), (c):

There were no witnesses to the abuse, and Cori never revealed the abuse to anyone as a child.

Disclosure Variables: Pertaining to Research Question 5 (b):

> I was 48 years old when I told my mom. She's the only one in my family that knows, other than my two adult daughters. I told them about four years ago when I was at a place in therapy when I was trying to work through all of this.

Cori relays how she told her mother about the abuse:

> ...I was having an altercation with her over the phone because she's never been there for me, and this was one of the things that came out. . .and she was horrified. I asked her: 'what would have happened if I had told you what had happened when I was 10 years old?' and she said, 'I would have just died; I wouldn't have known what to do.' And I said, 'that's why I didn't tell you. You wouldn't have been there for me. It would have all been about you, and how you don't like your son-in-law.' And she sort of admitted that she was not there for me. I knew that there wasn't anyone I could confide in, I'm the youngest of 5 children. I was an unwanted pregnancy. My mother had me when she was 40. As I look back on my family history and patterns, I believe I was conceived on the 4th of July when my father was drunk and it was a traditional time for our family to spend time with my mom's family and my father's an alcoholic, and I have some suspicions that it probably had been a marital rape that ended in my conception. I haven't verified that with my mom because I know she won't talk about it, and I've decided it's not worth bringing up.

Cori has also shared her childhood sexual abuse experience with others whom she trusts: "I've told my current husband, and a couple of good friends who've been very supportive of me during some of the therapy I've encountered in the last 10-15 years."

Case Number 16: Story of Sandi M.

Childhood sexual abuse experiences:

The main abuse was my stepfather, and it started when I was between 4 or 5. . .My stepfather was not a mean person. . .it was not a threatening experience. He was actually pretty passive, my mother was the more aggressive personality in the combination. Basically it started with just touching and fondling kind of stuff, that I recall made me feel very uncomfortable. My mother got really sick, and had some surgery and a number of different things, and so I think there must have been some problems with their relationship. I was an only child. He began coming into the bedroom at night, and I would pretend to be asleep. . .it started probably for the first couple of years with touching and looking at me and masturbation (he was masturbating). And then probably when I was 7, 8, maybe 9, he began performing oral sex on me. And I just always pretended that I was asleep, which is probably the way I got through it. It was never talked about between us during the day, and we never had these little 'looks' with each other. I just avoided him as much as I could during the day. But I really cared about him. . .he was a nice guy to me and my friends. As far as I know he never messed with any of my friends, and he wasn't mean in any way. So it was very difficult for me, because I couldn't hate him. My mother and I did not have a good relationship. She was such a strong, dominant personality, and probably a little sadistic, and so I think that I thought that I was pushed toward him. And I didn't want to upset the apple cart in any way by telling anybody what was going on, even though I knew it wasn't right. This continued until I was about 12. At that point, it began to increase beyond the touching and the oral sex . . .at one point he actually did have intercourse with me, and I ultimately became pregnant. He had intercourse twice with me, before I became pregnant. I didn't tell anyone. My mother of course was furious, and thought that I was just 'sleeping around.' And I don't think I ever even tried to tell anybody. It was so weird because he and I really never talked about it, and even with the intercourse, I just laid there. I didn't have any response, so he never knew for sure if I knew what was going on or not. He never asked me about the pregnancy. He knew. He had to know, because I told him I'd been having my period for about three months. So I had the baby. And I had a great aunt who was a nun, who lived in another state and she was very close to my relatives on my grandmother's side, and because she was a nun, I guess my mother felt that she would never tell my grandparents or anybody what had happened. And she came and took the baby. . .and it was adopted by one of my distant cousins and his wife. I've never seen the baby. Never had contact with the family. Nothing. Ever. The abuse

continued, but he stopped having intercourse with me, and it went back to the oral sex and the masturbation, and that kind of stuff, until I was 16. At that point I left home. I had the baby the January before I turned 13, so I was 12 ½. I didn't go to school from probably November to January. Everybody was told I had rheumatic fever, and I had all of my homework sent home: My mother would pick it up, so I didn't get behind; I didn't fail. By that time we had moved to a town 50 miles away. My grandparents didn't see me during that time, because I supposedly had this 'illness.'

I was kind of a chunky kid at that time. And looking back I realize that I really did have an eating disorder in terms of just wanting to be fat and ugly. I just ate, and ate, and ate. And I did things like wrap my breasts with big cloths to try to flatten myself, and I wore real baggy clothes, and those kinds of things, to look as unappealing as I could. Because I was heavy, I managed to get through the first few months of school without anybody really realizing that anything was different. There were a lot of things that happened during that whole nine months, that I can't tell you because it's just not there for me; it's just pieces that are there. I vaguely remember going to the hospital, and I remember the trauma of the labor, but I don't actually remember the birth. My mother said I saw the baby, but I don't remember that. So there are a lot of things that are sort of missing about it. I don't know if any of it will come together completely.

There was a neighbor who had two daughters that I was friends with. They lived next door, and some of this is a bit foggy for me, but I know that there was a sexual relationship that went on between this man and myself. I don't remember exactly how it started. But I can picture the room, and I know that we had sex; I know we had intercourse. That was after I had the baby, so I guess I was 13, 14. I have no idea why I did it; I don't really remember that part. I just remember being in that relationship with him probably for 5 or 6 months. And again I didn't tell anyone about this.

I was also fondled or propositioned, or whatever you want to call it, by a high school teacher. You know I think that victims have a persona that says to a perpetrator: 'I am a victim.' And so I think that I was somehow setup for a number of different experiences like that, that I didn't think were wrong at that time. And I didn't like this guy, but I didn't report him either. I finally realized that it wasn't what I wanted to be doing, and. . .said to him that I'd tell somebody . . .I didn't go back, but I never reported it to anybody either.

Dissociation and Memory Variables: Pertaining to Research Question 1:

> I remember the abuse pretty clearly, I never forgot it, but like I said, there were 'blocks' of time that I don't really remember, and certain things that are much foggier. But there was a lot of physical abuse on the part of my mother, and sometimes I think that overshadows it in my mind. But I never really forgot it. It was always there.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

> . . .I think it would have helped for him (stepfather-word added) to admit that he had done it, and that it was wrong. I think it would have helped it go by quicker, smoother. But I was really afraid to confront him in my early therapy. We lost contact after my mother died. We had some conversations on the phone and a few letters back and forth, but never saw each other after about the first six months after my mother died. . . probably that, and not confronting my mother, are the only two regrets that I have left. And I can't do anything about them, so I just have to let them go.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

> In the early years, from the time I left home until probably the time I finally disclosed, I had very low self-esteem, very poor self-image. I thought many times that I was a *bad* person. And sometimes I think I did things on purpose just to prove that I was a *bad* person. I married twice: I married once when I was 16 and left home, and then I married again when I was about 26. That marriage lasted for about 13 years and it was a very abusive relationship. And I was a very passive person; a different person than I am now. It's almost like talking about a different lifetime. I believed I deserved everything I got. I absolutely took guilt for everything that happened (the childhood sexual abuses). You know it was his idea initially, but I thought I could have stopped it. And it wasn't unpleasant, I didn't hate it, so that of course added to the guilt. 'It felt good.' And even though I dreaded it, I didn't feel real bad that it happened, so then I figured 'there must be something wrong with me.' And it wasn't that he ever said anything to me. I know a lot of survivors took it on because the perpetrator told them that it was their fault. But he didn't, because we never talked about it. I guess I just told *myself* that it was my fault.
>
> . . .I was not faithful in my marriages. I was very sexual and just promiscuous, and thought that was O.K. And I guess I was looking for something I just never found. So that was one of the big symptoms. I lied very easily about just about anything, whether I

needed to or not. Starting at probably 32, 33 is when I started having flashbacks. I became very hypersensitive to any discussion about sexual abuse; could not watch a movie or news story, or read a book, or anything that had anything to do with abuse. Just totally backed away from any of that. I guess that was probably always the case, because I think the first time I was able to sit through a movie about childhood sexual abuse from start to finish and not be upset by it, was when I was in therapy, and I was 47 years old. I guess that was a denial kind of thing. I mean I did go several years without thinking about it, during my 20s when I was raising children and that sort of thing. But I did start having the flashbacks and they continued for a number of years. I haven't had any flashbacks probably in the last two years. And for awhile they were just very debilitating. But during therapy and after, they were not debilitating; they were just troublesome. I think that I had most of the clinical signs of PTSD during the years before I actually acknowledged the abuse and began to talk about it. I did have some dissociation probably from the very earliest time. I would just put myself out of the situation and be more of an observer than a participant. I really did go through some real heavy dissociation during the actual abuse. There were some times in my 20s where I'd just kind of leave. If things got too stressful, I'd just shut it out. I didn't have huge spans of time when I didn't know what was happening, or any of those things, but I just created in myself the ability to compartmentalize things that I didn't want to deal with.

. . .I still use eating as a stress reliever, not to the extent that I did as a kid. I'm not hugely over weight, but I'm probably 15 or 20 lbs. overweight most of the time. . .

. . .I have a wonderful relationship with my present husband now. I don't think that the abuse had anything to do with that, but certainly the therapy did (and getting to a point where I like myself). And I like myself very much, now. . .

Validation Variables: Pertaining to Research Question 5 (a), (c):

Nobody actually witnessed any of it, although I always felt that my mother knew. I just don't know how she couldn't know. Being an adult married woman myself with children, you know when your man gets out of bed every night and is gone for awhile. And if your bedroom is right next to the other person's bedroom, you know if the door opens and closes. I just know there had to have been signs that she knew, but she never said anything, and she never acted like she knew. Although she was very angry with me a lot, and in looking back. . .maybe she knew and wanted to deny it, and then got angry. But nobody ever knew. Nobody ever saw it.

Disclosure Variables: Pertaining to Research Question 5 (b):

The first person I ever disclosed to was a roommate that I had after a couple of marriages, and a couple of divorces—actually after my mother died (she died when I was 36). And I was very confused over my emotions of her dying because we really never had a positive relationship. But I felt quite devastated about her dying, and couldn't figure that out. And finally figured out that it probably had a lot to do with not resolving some things that I needed to. I disclosed to my roommate when I was probably 37, 38, and she believed me, and was very supportive. She encouraged me to get some counseling, and I kind of put that off. But when I decided to go back to high school, because I had quit when I got married, and when I went and got my GED (the year that my mother died). And then about three years after that, when I was around 40, I started community college, and at that time, then I sought out a counselor, a therapist, and began to work through the stuff.

In hindsight I don't know honestly if it would have mattered who it was (the counselor-words added); I think it was just my mother's passing that released something in me that said, "now I can take care of myself."

Case Number 17: Story of Diane B.

Childhood sexual abuse experiences:

It took place over a number of years, and I'm not sure exactly when it started. My assumption is that it started fairly gradually when I was in early grade school, and it became more intense and intrusive when I was in about 3rd grade (that's my best guess). It was with my next door neighbor, an adult male, and also involved in all of this was his son, who was two years older than I was. The son and I were friends and we played in the neighborhood group of friends. There's a lot of stuff before third grade that's real 'fuzzy' of what started and what happened. Somewhere in there the boy and I had started to do some touching and probably most if it would be considered normal childhood playing, exploring that probably went somewhat beyond. My guess is that he'd been sexually abused by his father and that was part of it. I don't know to what extent his father played a direct role in those pieces then. I think he did, but I just don't remember all of that very well. But, I think it was the summer before third grade, it was summer because I was wearing shorts and I was at their house and J. (the boy-words added) and I were playing and I was blindfolded and had my hands tied, and I had my shorts just down, or off, and then his father came in and was upset. My remembrance of it was that he was upset

that we were doing what we were, but I guess I feel now that it was more—somehow it was 'set up.' It was set up by him and he proceeded to touch my genital area and proceeded to force me to have oral sex with him. And that is the first really clear memory I have of something that intrusive happening. There was sexual intercourse involved over the years. If I was to diagnose father: 'a sadistic, obsessive-compulsive disordered person'. And so it got really 'bad.' I mean there were some bad years in there; he was pretty controlling.

. . .J (the boy-words added) was physically disabled (he couldn't use his legs, he wore braces), and in the neighborhood group, I'd sort of be J's helper. J had a lot of authority in the neighborhood because he was one of the oldest kids. And so there was always that piece of that relationship that was always pretty nice for me. And I'd go over and play there, which we lived in a small town, and we didn't go anywhere, or do anything, and mom was quite content to let me go and be there. . .There was a time in grade school where it became very coarse and I was very afraid of this man; everybody was afraid of this man. He was pretty stern, he had a temper. He was also a hunter and I had seen the animals after the hunt, or stung up, and he had guns. He got off on using his power with me, and would have a temper tantrum if I wasn't doing things right-or if I was resisting in some way or something, then her would threaten me with weapons: mostly guns, knives, his lighter. And he'd use his dog as a weapon, his dog would growl, or he'd threaten that he could make the dog attack me (a big, yellow lab). So I was pretty scared. I remember being afraid at night that he'd be right outside or something.

. . .Somewhere in there, I think it was when I started enjoying the sex, and when I started developing, and started getting pubic hair, that he stopped wanting to touch my genitals. I kept my clothes on after that and we'd have oral sex, and I'd suck him off. As I went into puberty, he stopped touching me or doing oral sex on me. As I look back on it, I realize that he didn't like that I was turning into a woman. He didn't like my breasts; he liked little girls. . . He was a janitor at a middle school, and so my guess is that he did it to other little kids. J was abused with me, and my guess is it was even worse when he was alone. . .

I was the 'good girl' and the 'family hero.' At 13 the abuse just stopped. From 13 to 19 I deteriorated in a lot of ways: emotionally and psychologically. It just got worse and worse and I was in college and ended up in the psychiatric hospital for about two weeks. I was depressed and living in my own world and I had done some cutting too. I was also drinking and smoking a lot of 'dope,' and that just made the deterioration go real fast. And somewhere in that experience it was almost a willful change. I think part of it was about the hospital, but I remember thinking: 'I'm not doing this again. I see these other people

that are back in here and are doing this all their life, and I'm not doing this. So what do I have to do to not do this? O.K. so I can't make up anything and believe it, I can do that.' And that was then a part that I needed to keep real control over-what was real and what wasn't, and what was a dream, and what wasn't, what really happened and what didn't. And so a lot of hypervigilance, and some rigidity, and all of that. And then I knew I needed certain things from people and I'd say, 'O.K. let's figure out a different way to get it,' and did that. It's amazing to me as I look back at myself and what I did. I knew that I liked people and needed to be in relationships with people, and that the way it was going wasn't working, and that I could get to another place and do it, but that there was going to be an in-between time that was going to be really rocky and difficult because I wasn't going to be doing it from the positive side yet. There were a few people who kind of set up some support: chaplains and friends and a psychiatrist in there too. Somewhere in all of that, I realized I had a body too and I began to feel that. And I went, 'Oh God, this is fun!' I went from really being afraid of sexual stuff-any relationship that moved in that direction I was out of, and just panicked; to really seeking that out. I was sexually 'acting out,' and then reining that back in. I didn't connect it to the sexual abuse because somewhere in high school I just stopped talking, stopped thinking about him.

Diane said that the abuse ended when the perpetrator died, she says:

He died. He died. before I could kill him (she laughs-added). There are times when I go, 'Oh good, he died.' And there are other times when I go, 'Oh F. . . .! The son of a bitch didn't get what he had coming! He had it too easy, he died!' (she laughs sarcastically-added).

Dissociation and Memory Variables: Pertaining to Research Question 1:

Diane describes the memories of the abuse, as both repressed and dissociated, with delayed-recall:

It (the abuse memories-words added) has come and gone, but it was gone for a long time during my adult life. I just sort of didn't think past J. (the boy-words added). I would think about the relationship with J. and say, 'I don't want to think about that,' and never got beyond that. I'd push it from my mind.

I wasn't anywhere close to thinking about it until, probably six years ago. It happened in therapy. I went in to talk about my marriage, and by the third session I was talking about men, and then talked about J. (the boy). And then the next session I came in and

> added more, and it took about 4 sessions and during the week in between I'd remember more. For me, it was like I allowed it to surface, but sometimes it felt very intrusive. And so it wasn't so much allowing it to surface, as it just did!
>
> I had some olfactory hallucinations and that was really a key for me, and then the memories started coming back.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Diane had had what she called, a "fantasy" that she would be able to talk to J. (former friend/son of perpetrator) about what had happened to her/them, and he would affirm that his father did this, and it was wrong. She had a talk with him, and by his answers he *did affirm* that it happened, but he did *not affirm* that it was his *father's* fault. Instead, he 'assumed' that she had initiated the sexual activity and perhaps even liked it. Needless to say, this was not the validation that she had hoped for and desires.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

> I don't have real negative beliefs about myself now, but I did for a long time. I think *crazy* would be the closest word. For a lot of years it felt like if I didn't hold on tight I was going to just sort of go off some psychotic edge—and that somehow I had to keep very tight control over what I was thinking, what I was doing, and life was going on around me really hypervigilantly.
>
> I have some sleep disturbance that goes back to that. My weight is connected to that. It was mild during the abuse, it got more extensive after, and it's been constant all my adult life: up and down. I go down to a certain point and I didn't like the attention, people looking at me, men particularly. But even from the women, I didn't like talking about it. I just knew that that was uncomfortable. Body image is a problem. But sex is pretty good, but that's taken some work to have that be O.K. I went through a real promiscuous time. So glad I found the term 'covert sexually acting out' to describe those years - late teens: 19 through 22. At that point, that's when I had the psychiatric hospitalization, when I was 19. I had a real change of body image at that point. It didn't feel as though I had a body until I was 19, and I can't describe what happened in the midst of all that. I didn't trust my

> body at all, and I didn't trust that I could do physical things. I could trust my brain, but I couldn't trust my body. As the abuse went on, I got used to it, and it became more routine. And there was a part of me that liked that relationship, and so there was a lot of conflict in the middle of all that. There was a time period when I had orgasms and that, and then we went to more my performing oral sex on him, so there became less of that. He really didn't like that (my orgasms). There was a lot of shame with that, and even today I feel a little bit of that shame; more shame than guilt. There're feelings still tied-up with J.(the boy-word added) in the midst of all that, and sometimes the feeling that I should have protected him more. I think about it, when I kind of pull into it. . .I feel more divided in my head, more split. . .And I flip flop and move real quickly through all those things, and still have a hard time pulling that all together. And that's when I feel kind of 'crazy.'
>
> I have had a problem with major depression but there's also a family history of that. Had I not had Prozac—it's a very good thing. As long as I can find somebody to give me Prozac, then I'm O.K.
>
> . . .With trusting people, I tend to be rather skeptical, but generally I'm willing to give it a shot, but back off pretty quickly if I don't like the way it's going.

Validation Variables: Pertaining to Research Question 5 (a), (c):

Diane had a witness to much of the abuse, her friend J. (who was also sexually abused by this father). She also mentioned some 'medical' evidence of the abuse. She states:

> Maybe his wife knew about this. My guess is his wife did, but I don't know that. She was around sometimes. . .The father had taken photographs of me and they are probably still in that house. . .
>
> . . .There's some corroborative physical evidence in terms of gynecologists when I was going through some fertility testing and said that, "Well, you were pregnant before." I don't know what he thought, or the words he was using, but he was saying that my cervix had some damage to it, or that my vagina had some damage which was apparent to him. And he attributed it to a pregnancy. And when that happened, I was just embarrassed about it, ashamed about it, and thought there was something wrong with me, and thought that I had done that with my hands or sex—that's as far as I went with that then. I didn't realize that that was associated with the sexual abuse, but I do today.

Disclosure Variables: Pertaining to Research Question 5 (b):

I didn't tell anyone because I thought that it was my fault. I thought that I had started this in some way. Even at a point where I thought, 'He shouldn't be doing this,' I thought, 'Oh, I'm to blame here too. I can't say this because he'll get me in trouble.' But also because I was so afraid of him."

I think I would tell my siblings but my older sister would insist that I tell my parents. I don't want to tell my parents, because he's next door, and because I don't think that it would serve any purpose for my parents at this point. Looking back on it now, my mother would have been hysterical and my father would have been furious. I don't know if they would have believed me. They would have minimized it, that it couldn't have been that much, or that bad. This is a man who my father was on boards with, they weren't really friends but they were associated with each other on certain community things. I don't think they would have believed he could do such things. I believe this was part of the times, that you didn't believe that people could do such things. Put us in a different setting and I think they would have helped. But I think it would have stopped if it would have got out to them, but I was afraid of him. He would have done something. He would have shot my dog, he was a scary man.

Case Number 18: Story of Lecia H.

Childhood sexual abuse experiences:

I was about 6 or 7 the worst of it. It was with brothers: One is 6 or 7 years older than I was, and the other one is 5 years older. We had a small house out the back, where all us kids liked to play, and we were all out there and they came in and started just playing around at first, and then it got worse. They were threatening me: If we didn't do what they said then they were going to do so and so to us. So naturally we did what they said, they were a lot bigger and they were older and we were afraid not to. I was the only one at that time that they did it (sexual abuse-words added) to, but there were others at other times, like my sister and my cousin. There was intercourse. It was like one did it, and then the other one turned around and did the very same thing (sexual intercourse).

It had caused stress between my husband and myself, because I would knock him out of the bed, or hit him along side the head and say, 'leave me alone' because I could picture all this happening all over again. And instead of seeing him (my husband), I was seeing my brother. And I'd say: 'Get out of here! Leave me alone! Get away!'

> . . .I can remember one incidence with my oldest brother, who passed away last year (and that was a hard one for me), when that one came to me, because he was very, very special. He was 20 years older than I was and he was always the father figure, because I didn't have a father. He was there when I graduated from high school, he was there when I graduated from the eight grade, he was there for my wedding, and he was there after each one of my kids were born. For anything special, he was the one I always knew I could rely on. So when that memory came back, it was very detrimental to me (her voice gets soft and sounds like she's crying), because I mean it was like, that's not the way I remember him. Because that was one memory that I had completely blocked. I wanted to remember all the good things that he had done, and having been there for me. He died of a heart attack last April. It made it that much tougher when it came back, because he's gone and all that. There was no intercourse involved with him (here she indicates that she's 'fiddling with my fingers,' in an attempt to hold back intense, sad feelings).

The sexual abuse with one brother continued after Lecia was married and had two children. It finally stopped about 8 years ago. She explains:

> . . .The little kid didn't want anyone to know because you were scared because, 'if you tell anybody that we did this, we're going to do this to you, and you won't be around anymore!' You just kept your mouth shut for fear of your life. With one brother it went on even until approximately 8 years ago, which is when I finally said 'Whoa! I'm married. I've got 2 children, leave me alone! Go away! This is wrong! You don't need to do this.' And then I had a lot of guilt because he had a car accident. I kind of blame myself for that, you know if only I hadn't of. . .but then again I had to get my sanity back. I felt guilty, because if I had went with him, or if I had took him where he wanted me to take him, he probably would not have been on the road. But he was intoxicated or on drugs, and so there probably wasn't anything I could do about it, but I did have some guilt from the beginning. That (the accident) was at the point where I really wised-up and knew I had to get help, and I had to work through it.
>
> . . .I guess that's when I really started to realize that I knew it was wrong, because I was afraid that I was going to end up collapsing from all the *secrets* and not talking. And I worried about my children. . .I didn't want that to happen to them. I'm very protective of them. I don't want them around him at all. I never left my girls out of my sight enough for that. I'm very, very, over protective.

Dissociation and Memory Variables: Pertaining to Research Question 1:

Lecia repressed and dissociated from many of the memories, and probably during the abuses. She froze her body during it. She said: "I had a complete mental block on this (the abuse) until after I started into counseling and it started all coming out."

She said that she would spontaneously regress while in bed and see her husband as her brother and relive the sexual assaults. The memory of the sexual abuse at 6 or 7 is the most vivid. She believes that there were other abuses. "In being able to work through it (in therapy) and being able to admit it, and say out loud that it happened to me, and being a survivor of it, there's more and more that's beginning to fall into place: Little bits and pieces that I can remember, now that they're starting to come more together."

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

In response to my question about how important she feels validation is toward her recovery, she indicated that validation from the therapist is the most important for her right now. She says: "It's very important because it's made me feel a whole lot better since we've been talking about it in therapy."

She does not feel 'safe' in disclosing the abuse to her brothers (perpetrators), mother or other family, as she feels they would not believe her, and might possibly hurt her or her present family, so she has no hope of any validation from them. She has recently told her husband, and he believes her, and is supportive of her.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

Lecia believed the sexual abuse was her fault (even at 6 or 7 years old). She said that she felt *crazy, bad, evil,* and *a sinner.* "I'm a nobody and. . . it was my fault. . .'You should have known better, you're better than that.' But really the biggest one is that, 'I'm a nobody.' And I couldn't ever be anything more than that."

> I couldn't do anything (which I have found out I can). This semester I'm doing what I've always wanted to do, but I just didn't think I could do it. I'm going to the university after being out of school for almost 19 years, so it a big thing.

Lecia talked about being so over stressed, "frazzled," that she would dissociate frequently:

> The counseling started because I was having some deep, deep, problems with my mother. I would stiffen every time my mother hollered, but I had to be the one who did everything. That's what we started dealing with: me trying to regain control of my life, instead of letting her control it. That's what I was doing; I was letting my mother control my life. That's where we started, because I was on the verge of a 'nervous breakdown.' I was worn to a frazzle and I was doing things I don't even remember doing. Or I'd end up somewhere and I'd say, 'How'd I get here, I don't remember. . .'

She also said that she has had nightmares and flashbacks and reoccurring dreams of the abuses: intrusive PTSD symptoms. And when she'd wake up from these *dreams*, she said: "I'd wake up finding myself hitting my husband along side the head, or knocking him out of bed. It was very real, like it (the childhood sexual abuses-words added) was happening right then."

Validation Variables: Pertaining to Research Question 5 (a), (c):

Lecia had corroborative evidence of her childhood sexual abuses, as the other kids she was playing with when the abuses first started, saw what was happening to her. Her mother also admitted to her that she knew about the abuses. She explains:

> . . .My mother was aware of it. At some point she became aware of it, and I didn't realize this until a couple years ago when she started throwing it in my face: 'Well you let this happen to you with your brother and you could've kept this from happening, and you're better than that; you were taught better than that.' It was kind of like, 'Well mom if you knew, why didn't *you* do something to stop it?!' I was a chicken and I wouldn't say that to mom, but that's how I felt. If she really knew, and she said she did, then why didn't she do something to stop it? And why did I have to live through what I lived through?!

Disclosure Variables: Pertaining to Research Question 5 (b):

Only after Lecia started talking about the abuse in counseling (recently as an adult), did she share it with her husband. "My husband is from an abusive family also, so he believed me. He has had some of the same experiences and he can relate to it. . .He was glad that I could reach out. . .I kept it secret all those years and I'm 37 now."

She never told mom or family, although she says that mom knows and has blamed her. She believes that she would get a negative response from the family if she disclosed the abuse:

> I can just hear the comments: "It didn't happen, she's making it up." Even though mom knows it happened because she said so, but she'd be ready to tear me apart if I said it out loud to anyone. That was one of my first fears when we started talking about it with my counselor. I said, "If my mother found out that I mentioned anything like this,

she's going to be ready to kill me." She'll say: "You know better than that, that's not the way it happened." And she'd blame it on me. I was an unwanted child. I was a *blue* child. I was not breathing when I was born and the doctor revived me. And my mother looked at the doctor straight in the face and said. . .I don't want her! (I had five brothers and I was the only girl, and she had given up on wanting a girl.)

Case Number 19: Story of Elaine K.

Childhood sexual abuse experiences:

I was 9. I was in a movie theater and an elderly gentleman sat down next to me. And in my memory, my mom either sat on the other side of me, or across the aisle from me, but she was at the movie theater with me. Anyway, this elderly gentleman sat down and proceeded to put his hands inside of my pants, where he fondled me for the length of the movie. I remember being so confused about that because I knew intrinsically there was something wrong with that, wondering why my mom didn't step in, and wondering why it felt good. It was very confusing, very, very, confusing.

The next time when I was about 10, my girlfriend who lived up the street from me, came to my house one day and said, 'my older brothers want you to come over, they have something for you.' The older brothers were perhaps in their middle teens: 13, 14, 15. Her parents weren't home. She took me into the living room and her brothers took their pants down and took out their penises, their erect penises, and asked if I would suck on them. And I said, 'sure,' which I don't know why I did that, but I did. Now this happened perhaps a half a dozen times.

The next time was when. . .the school that I attended was a Catholic school, and right across the street was a boys' school. Well, one day during recess,(and again I'm not sure my age, I want to say 10, 11, 12, somewhere in there), a boy came across the street and asked me if I would come with him. And he took me into a little gang-way that was kind of secluded, and asked me to perform oral sex, which I did.

The next time was with a young boy in the neighborhood who perhaps was 14 and I was between the ages of 10 and 12. He said his parents were going to be gone for two hours, and would I have sexual intercourse with him, which I did (what I thought was sexual intercourse). But later when I got married, my hymen broke at that time, so there was no penetration, even though I thought there was. He inserted his penis into my vagina, but there was no penetration. That left me feeling that I was pregnant and all kinds of just horrid, guilt feelings.

I never told my mom about it (the incident with the elderly man in the theater-words added), I just hung onto it, and had for years, and years, and years, dreamed that I was in a movie theater and it was blowing up. I still have lots of anger about that, but I don't dwell on it. I don't think about it very often. What I have done in my therapeutic process, is to come into the movie theater with a bomb strapped onto me, and I blow this 'fucker' up! I blow him up, and he's out of there! It helps, it empowers me. It's kind of funny too, because it's like he asks me to 'blow him off' and I do (literally)!. . . .What was so confusing of course, is that, if *felt good.* And I thought, 'well then it must have been me that asked for this.' Of course this is all absolute bullshit! It was nothing that I deserved.

What really put me in touch with the violations of my childhood, was when I began to have granddaughters and I looked at their little vaginas, and the purity of their blond, wispy, hair, and the softness. And I thought, 'no one deserves to have happen to them what happened to me. Absolutely no one deserves that. And I should have been protected, I should have been cared for, I deserved it, protection, as a human being, as a human female person.' I think that my mother at some level did know. I believe that, and didn't know how to deal with it, and blocked it out, because that is her life's pattern; to block out, to pretend that things don't happen; to live in this kind of a fog. And she had this horrendous marriage. She had no power. What was she going to do? She couldn't have done anything. This was the reason I didn't tell. There was nobody to protect me, what would they have done?

The attitude in my family was that. . .I have two sisters and my mom, and women in my family had no power. My father had all the power, and my mother was a 'whore,' and I was probably 'asking for this.' She was called a 'whore,' we were called 'whores.' And we weren't his children, we were the product of some affair of my mom's, which was *not* true, that was a falsehood. My father accused my mother of having an affair with our grandfather who lived with us. I do not know the truth of that, my suspicion is that, that is not true, but I really don't know. My grandfather had pulled my pants down and touched me when I was six. I was in a baby bed, a baby crib, because I was a bed wetter, and I stayed a bed wetter until I was sixteen years old. I remember my father asking me, but I don't remember my grandfather touching me, and I have searched, and searched, in my memory, and I have no memories of it, and so I've just left it go. It may not have been true. Because dad was very paranoid, very accusatory of the women in his life. He was an alcoholic. But he was my not a step-dad, he was my real dad, but he denied we were his children.

According to him, we were the product of an affair my mom had—an *imaginary affair*. It was not true, my father is my father.

I don't have any memories of dad abusing me, but he certainly was verbally abusive. 'Women just didn't deserve to live,' period. They were just 'out get some man into bed with them.' So there were a lot of sexual innuendoes and *covert* sexual abuse going on in the home all the time.

. . .And the aftermath of this, is that three of my children were sexually abused. I have boys. They were all sexually abused by the same boy baby sitter. I didn't find this out until my oldest son went into therapy too. It perpetuates. I felt so furious about this. He had a good reputation in the neighborhood. He was admired, he was a good student. He was outgoing, and the kids loved him. And he was performing oral sex on them and having the kids do it to him. They were little kids, they were little: 5, 4, 3,. . .

Dissociation and Memory Variables: Pertaining to Research Question 1:

I always remembered them (the memories of CSA-words added), and I carried them in a little pocket, and carried them up in here (touches her upper chest area), my upper chest, and in my gut. I carried them around in a black ball so to speak, and I thought if anyone ever opened that up, they would see that I deserved this abuse, that I was less than human. That indeed if you looked inside of that, you would see that I was a *rotten person*, otherwise why would all these things have happened to me? And so I must have deserved it.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

It would have absolutely made a difference in my healing, if my mother had validated me: If she had protected me, if she would have believed me, and loved me. Absolutely. That was one of the things I wanted from my mother. I wanted her unconditional love, and wanted her to say, 'I love you.' It's a fantasy, she is never going to say that. . .It still hurts. I want my mother's love. I want her to say the words. I want to hear it.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

I believed that I was *evil*, that I was *bad*, that I deserved this. And that if you peeled that away, you would see the *rotten core*. I remember when I was young and I got the measles, and at that time

they used to quarantine houses, and I remember the health department coming to the house and putting the sign on saying, 'Quarantined.' And I thought, 'That describes me, I'm quarantined; I'm no good; I'm evil; I'm a whore; I must be attracting these boys to me.' So it was a very unhealthy thinking. . .I remember just living like in a fog, not being cognizant of anything, wondering who was going to come up and ask me to perform oral sex. It was a fear. I just didn't even want to be outside because I was afraid somebody would come and ask me this, like they could see inside of me, that I had already done this—Like a big sign on me: 'I perform oral sex!'

I certainly have a clear idea now that this was wrong. First of all my parents didn't protect me. I was a little girl, I was a child, I deserved protection and so I'm real clear on that: That this should not have happened to me, and I didn't deserve it; there is no black core within me. That I am a human being who deserves the best of everything.

The big thing that I did was turn to food. I used food to cover up all my feelings, to cover up all the hurt. It was my protection. And as I became larger I thought, O.K. I can be larger because then people can't hurt me; I can't be hurt if I have this layer of protection around me. And the more I ate, the hungrier I got, and it didn't help. I have a much healthier relationship with food now days, though I feel that food will always be an issue for me.

. . .I got into therapy when I couldn't stop eating. It is an eating disorder. The way it was identified for me was a compulsive binge eating. I know when I went into therapy I said, 'I want to talk about my eating,' and she said, 'No, I want to talk about your abuse.' And I said, 'No, that's all done with, I don't want to talk about that,' but of course I did talk about it, and I journaled about it, and did all my anger work. And reclaimed the life that was taken from me, and re-framed. Re-parenting, reclaiming, I did lots and lots and lots of inner child work. I loved it because I didn't have a childhood!' I did all kinds of fun things: I blew bubbles, played with water guns, played with mud pies and laid in the sand and made sand angles. One of the things I did was go out into the lake and just screamed at the top of my lungs and just screamed and screamed and screamed because I had no voice for so long. I always said 'Yes.' I didn't think 'No,' was an option. I never spoke up. . .

Validation Variables: Pertaining to Research Question 5 (a), (c):

Elaine did *not* have corroborative evidence of her sexual abuses, although she believes that her sister was involved in one of the incidences:

> I remember my older sister being part of this. . .being part of, where this young man came across from the boys' school and said, 'come on over.' I remember my sister being there very clearly, and I have asked her about this, and she said she wasn't there. I see her in my mind very clearly, but she says she wasn't there, so. . .

Disclosure Variables: Pertaining to Research Question 5 (b):

> I never told my mom about it (the incident with the elderly man in the theater-words added), I just hung onto it, and had for years, and years, and years and years, and dreamed that I was in a movie theater and it was blowing up.
>
> I didn't disclose as a child. I have talked with my sisters about it, I've talked to my children. I've talked to my husband. I've talked at length in 'safe' support groups. I was older already when I started to talk about this, like I said, after I had granddaughters, in 1990. I had told my husband that I had been sexually abused, but not the details of it, and one time when we were making love, it's almost as though I needed to heal that part of myself, and I just started screaming! And he did not know what was going on, and he just held me. He held me and I kept saying: 'I am not a whore. I am not a whore. I am not a whore.' And I got a lot of relief after that.
>
> So I've done a lot of screaming-type therapies; I've done a lot of that-catharsis; I've done body work; I've done re-birthing; I've done soma synthesis. I've done lots of message, self message, message from others. I started to disclose when I was in this kind of experience, this kind of 'state' (state-dependent memory-words added). And I told each of my children. My children did not want to hear, so I just told them: 'I want you to know that I was sexually abused, different perpetrators, that this is part of my history.' And my oldest son, he said, "Oh mom, this should not happen to kids." And I immediately became the mother and started to protect him. They were very uncomfortable about my disclosing, they did not want to know details. I said: "I want you to know my history, and why I am so adamant about equality in female-male relationships, and how I can get almost militant about abuses; you have to know that's where I'm coming from." They listened. They never asked any questions, and didn't want

to know details. My father is dead, my mother is living, and I have made a conscious decision not to speak with her about it for several reasons: Number one, she lives in a fantasy world, she lives in a fog. She lives in an idea that we had this idealic childhood. I simply don't want the heartache of telling her about this. This is a conscious decision on my part. And when I am with her, my boundaries are set very clear, that she is not going to re-abuse me. She broke her hip, and I find myself spending a lot of time with her, because she needs a lot of care. As an adult woman today, morally I need to take care of her. And I will take care of her even though she didn't care for me as a child. I was uncared for, unprotected, just left to do whatever the hell I wanted to do, kind of raised myself. My sisters were very supportive, they believed me, but none of my sisters said it happened to them. They don't remember any abuses, or choose not to remember.

Case Number 20: Story of Louise D.

Childhood sexual abuse experiences:

It was my older bother who abused me (seven years older than me), and I was probably around 10. I don't have a recollection of the exact age, I just remember the house we were living in—we had just moved into the house, and by the grade I was in; I just put pieces together for myself. I was very, very, attached to my brother and worshipped him. I had spent a lot of time with him, and he used to take us places and do things with us. He started to come into my bedroom at night and sexually abuse me (gets quiet and has some feelings or slight dissociation here-added). It started just with fondling at first, if the recollection is correct, that's my memory of it, and then he—my breasts were just forming, and in the beginning that was the main focus of the abuse, sucking on my breasts and that kind of activity. And then later (some of it is disjointed for me), it evolved into actual intercourse. I don't think this was more than a year's span that this went on, it may have been two years. I always felt afraid and uncomfortable. I remember before my mom found out, a period of time before, I would build 'booby traps' in my room so I would be woken up if he came in. I remember wearing 6, 7 pairs of underpants, and extra clothes, and putting things around my bed to trip him, because if I was awake, he usually didn't bother me. He'd sneak in when I was asleep and just come into bed with me, and before I knew it he was on top of me and I couldn't do anything about it

Dissociation and Memory Variables: Pertaining to Research Question 1:

> I wasn't always there during the abuse. There were times when I could feel myself go away. It was like my physical being was present, but my spirit was someplace else. I think it became a coping mechanism. And compartmentalizing things too. So I could put it away, and dissociate from it, and be able to function and not have to think about it.
>
> . . .I think I always remembered the abuse. But dates and times are 'fuzzy': Like putting it in a sequence in the rest of my life; I had to do it according to other memories. It's like I built these little compartments for my life. I always imagined my 'psyche' was like this filing cabinet with a bunch of different drawers, and different problems went into different drawers, and that was a drawer that I think I started when I was probably in 8th, 9th, grade where I'd start feeling real frantic about what happened, and I thought, "I can't let this control my life" (those aren't the exact words I used)—but from little on I've always believed that if you're afraid of something and face it, it can't hurt you. Basically I'd sit and force myself to look at it. I started that in high school. So every time a memory came up, or a memory would surface, I'd back off from what I was doing, and I'd look at it—I'd acknowledge that "yes, this really happened, and I'm not to blame." I always looked on it as a monster, and even wrote a poem about it a number of years later, and called it: '*Monsters in the Attic*,' because my brother live up in the attic. I did that all through all my adult life.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Louise definitely believes that her mother's validation and actions toward her perpetrator bother were extremely important and stopped the abuse from continuing. She also believes that it is of utmost importance that the therapist believes the client's account of the abuse—that this is necessary for the client to heal from it. She says:

> . . . .You can't work with somebody if you don't believe them. I don't see how anybody could help another person by telling them, 'this is not your experience.' But I think we need to be very, very, careful not to feed someone information on abuse, especially someone who's struggling in the beginning stages of coping with it. You're so confused as to what's real and what isn't, and when someone who you've come to rely on, a therapist especially, gives you hints on what may have

happened, (for me that's *never* happened), but I can imagine what that would have done. I had a situation once where my brother told me, 'Well, you're crazy, or this has happened, or that.' And that throws someone into such a state of confusion because you're having enough difficulty in trying to figure out what's real for yourself, and then if somebody says, 'well maybe this is what happened to you,' I think it could be very, very, harmful. And I think in some situations people who may not have been abused to the extent that they are reporting it, some of that information may have come from their well-meaning therapists. Therapists just need to be able to allow the person to deal with what's there, instead of digging too deeply. I think if you poke around too much, you push people into crisis before they've got their other skills to be able to face things. I think that a person will face what they need to face, but it has to be on their own time schedule, it can't be on the therapist's time schedule.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

. . .every once in a while that still surfaces (feelings of being *unlovable*), because of what happened with my brother, I think I felt *used,* and when people are *used* in my mind it's probably the greatest degradation. Then people become objects, and aren't lovable because they're 'things.' And so I had to work through some of that. . .I didn't feel guilty because he was bigger and stronger than me, and I wasn't asking for it. I would wake up to it, so it was not something I enjoyed or would have invited, or I probably would have had to deal more with guilt. And the fact that people around me looked at it in horror was very helpful. But the *shame* was there because I was embarrassed and humiliated and it was something I didn't want to tell anybody. I only told people when I absolutely had to in order to get through it. . .

. . .But what it did cause for me is I really didn't like my body. I just felt very, very self-conscious about my whole physical being. In fact I felt totally unattractive. I thought I was ugly. I thought I was fat. And the thing is, I look at pictures of myself as a child and I look thin. . .But the sexual abuse I think was more key in my body image than anything else. I'm still way over weight, which is the residue of a life-long time of trying to 'cover up.' In a sense, 'fill up what was empty.' But I don't think I have an eating disorder.

. . .There were periods during my life when I did get 'flashbacks' about the abuse and these were usually associated with him (brother-added) coming home on leave, or us going to visit him, or whenever I had direct contact with him—then the memories would be more active. And then the situation when I found out about my niece's

> abuse, that really was the time when it (abuse flashbacks-added) was most active and difficult for me.
>
> There were negative effects that I struggled with, especially in one relationship. I had a friendship that. . .got out of control and went into some physical (sexual) stuff. I was in one committed relationship which created some real moral problems for me. I think that's where 'dissociation' comes in; they were so compartmentalized that one never touched the other. I realized that I just needed to take charge of my life and make a decision. So I did, and continued in the first committed relationship and terminated the other. In the other relationship the person made me feel very physically attractive, and was very much enamored of my body, which I thought was really bizarre. It was good in the sense that it made me get over that hurdle (poor body image; moral indecision-added), but in a sense it was a violation of a committed relationship. And I don't know if I would have entered into that relationship if it hadn't been for the abuse, because it was during the time I was starting to remember more, and it was at the same time that my niece had told me (about her father's abuse of her-added). It was a friendship that developed into something very sexual and I would not have entered into it, had I not been trying so desperately to work through all the other stuff. I see good that came out of it, but if it had continued it would have been detrimental to both of us.

Validation Variables: Pertaining to Research Question 5 (a), (c):

Louise did have validation through corroborative evidence of her childhood sexual abuse. Her sister was also abused by the same brother and told the mother who talked to her daughters about the abuse, believed them, and confronted the brother about it. She was also validated as an adult, just recently, when her brother's daughters revealed that they too were sexually abused by their father (Louise's brother-her perpetrator). And by her brother, the perpetrator himself, who recently admitted the sexual abuses and apologized for them:

> He has just recently admitted it (the sexual abuse-words added). I had a confrontation with him when he was home in January. That was the

first time he's ever actually admitted outright, and actually said he was sorry for what he'd done. That didn't help me, because I didn't really care whether he was sorry. I had worked through my own anger with him and the frustration that I felt with what had happened to me , and how that had affected me in relationships in my adult life. And so whether he was sorry or not made no difference to me. My concern was his children, because I know that he also sexually abused his two daughters, and I'm afraid, also his son.

He never brought the kids to visit. We'd go down to visit, but he very skillfully kept us separated: the aunts and uncles separated from the kids. I had been concerned about the kids because of their behavior, and so I went and spent a week with them when the oldest one was probably eight years old, just to check it out, to see if the kids were 'safe.' And if they weren't safe, then I was going to do something about it. I stayed there close, and couldn't see any of it, and talked to the kids about 'good touch,'-'bad touch,' and all that kind of stuff—you know I was about 22 at the time and not very well trained in anything, but felt I had to do something. But I didn't have any hard evidence of any problems, so I went away.

And through a number of different encounters with my niece, his oldest daughter, I found out that my earlier suspicions were right. She was hospitalized for severe depression. She attempted suicide, and severely dissociated, and couldn't figure out why. She hated her father and didn't really understand it. And when she started talking to me about why she was in the hospital. I said, 'No matter what's happened in the past, you can always tell me, and it's fine. I will support you through whatever it is.' And she said, 'Well, I think I was sexually abused .' And I said, 'And who do you think did that?' She said she thought it was her dad. And during that conversation, that was the first time I ever admitted to anybody, other than a therapist, or a confessor, that her father had also abused me. And probably the first time in her life that anyone in the family acknowledged the fact that she wasn't to blame. She had just come to the awareness because she had totally blocked it out. So having me affirm it was a real confirmation for her. But it also threw me into a real severe depression, because I felt I had failed. I had made an attempt to see if the kids were O.K., and I had failed at it. . .

Disclosure Variables: Pertaining to Research Question 5 (b):

Louise disclosed her brother's sexual abuse of her when she was a child, after her sister, who was also being abused by the brother, told the mother. When she was in her mid-30s, Louise revealed the abuse to her

niece, who was in the hospital for suicide attempts related to her father's abuse of her. And she recently revealed the abuse to the rest of her family of origin as well. She talked about the initial disclosure and it's importance:

> My younger sister was also abused. When my mom found out that my brother had been abusing us, and I'm still trying to retrieve that memory; I'm not sure if my sister told my mother, or if my mother found my brother in our room; I have no idea if I told my mother something was happening, or what. I don't know. I can't retrieve it, and my sister can't retrieve it. But my mom called my sister and myself into the kitchen and she said, 'I want you to tell me everything that he did to you.' I was probably about 11 or so, and that's what stopped it. My mom let out a scream like nothing I've ever heard, and she called my dad into the room and she said, 'Do you know what that bastard did to your daughters?!'
>
> And that was probably the saving grace for me, because my mother worshipped my brother; He was the 'perfect child.' And the fact that she chose us over him was a relief. She told him he had to get out of the house, he couldn't stay. So within a few months he was enlisted in the service and was out of the house.
>
> I don't remember her talking to him about it. Nothing was ever said again in the house about it. I remember one time, I was in the hospital (I was 19 years old). I was in one hospital and my mother was in another hospital, and she was dying of cancer, and I had just had surgery. And I called her up because I couldn't get there to see her, and I was worried about her, and wanted her to know I was thinking about her, and she asked me: 'Did you make your life choice (being a nun-never marrying) because of what happened to you?' And that's the only time in her life that she made reference to it, other than that day that she confronted us with it.
>
> I remember in the conversation she never made us feel guilty, like it was our fault; the responsibility was on my brother, and that's who in her mind, was going to pay for it. He was always welcome in the house, she never ostracized him, which never really was a problem for me. It was O.K. because he had gotten punished for what he'd done, and I was 'safe.' I didn't care so much about revenge for him, I just wanted to be 'safe.' I didn't want to feel that uncomfortable, or feel afraid all the time, so once that was taken care of, I could move on. It was very important that my mom stepped in like that. It was unusual because my dad was always the protector in our family.
>
> My mom was a very strong woman but when it came, especially to me, she really didn't like me—I was kind of like a thorn in her side. I was the one kid too many. I was the 4th one. Basically when I was

born she handed me to my sister (my older sister's 10 years older than me) and said: 'This one's yours.' My sister literally 'mothered' me. And I grew up knowing that all along. So knowing that she cared enough for me to protect me, was very, very important, very special!

Case Number 21: Story of Catherine D.

Childhood sexual abuse experiences:

It was with a neighbor man. I was about 6 years old. I know because I was in first grade, and my sister was a couple of years older, she was 8. The thing is we trusted this man very much. All the children in the neighborhood trusted him because he had been a very nice man. And he used to invite us in to see his house, and play with his toys; he had just lots of things for children. And he had this dog named Spotty. And Spotty had speckles and he had one eye missing. He was a very friendly dog, and I really loved to play with him because I felt sorry for him, and I liked to take care of him, and he liked me and all that. . Mr. K. was real friendly and would give us candy and stuff. I remember one day when we were playing, and we went to his house . . .and so this one day I went in with my sister, and she was playing somewhere, and I was in a room doing something. I don't remember exactly what I was doing, or why I was in another room, but he came in and he started telling me how pretty I was, and 'your pretty, pretty hair' and stuff. . .I had this real long hair, really long hair. And then he started touching me in my body, and I just froze. I didn't know what to do. And he said in a very gruff voice, "Take your panties down!". . .and he said, "Take your panties down!" And I just did it. . .I was a very obedient child, and I took my panties down; I remember that. Then he started taking his pants down. He showed me his 'thing.' He showed me his, you know, penis. And I was very, very, afraid and I started crying. I think he touched me, I think he was touching me, but all I remember was getting very, very numb. I just got real scared. I couldn't move, and I started crying. And my sister came in, and I remember this very clearly: My sister came and she started yelling at me, "Pull your pants up! Pull your pants up! Don't ever do that again!" And she grabbed my hand and we ran, and she pulled me. I was like shocked. I think I was like in a daze. And we ran home, and my dad was at home. My dad was gone a lot because he was in the military. And my dad was home, and I was really crying, and my sister was really mad. And she went to my dad and she told him right away. And she said, "Mr. K. took his pants down and showed us his pee-pee, and she had her pants down too!" And my dad was really, really angry (at him). And I remember my dad did not swear around us and he said something like, "Oh that son of a bitch! I'm going to kill him!" And I

just couldn't stop crying, and my sister was yelling at me to stop crying. And my mother came in and she was comforting me. And then my dad, I don't remember what happened real clear about that, but I just don't think I knew that much. I just remember my dad went over and he yelled at him, and I think he hit him. I just don't know for sure,. he may have hit him. He may even have called the police or something, I don't know, I think that's what happened. But I do know that my mom and dad were really good with us. They let us know that it wasn't our fault; that it wasn't my fault. My sister though, kind of blamed me for taking my pants down. I still remember that, and I think that affected me. Even as an adult in my marriage, because I've always had trouble going to bed without my underpants on. I just think that may have been because of that. I think I had some guilt over that; over taking my pants down. . .

. . .I was also sexually molested as a teenager. . .It was when I was about 15, and I was helping my math teacher. . .I was a very 'good girl,'. . . I was obedient, and pretty much did what I was told. . .we were raised very strict Catholic, and we had some pretty strong religious beliefs. We were raised in a catholic school, my sister and me. And anyway, the janitor came in, he was a middle-aged man, maybe older, and he was showing me how to clean the board, and. . .he started telling me how pretty my hair was, what a pretty figure I had, and that kind of thing, and I just got very embarrassed. And he started touching my breasts and I don't know why I didn't do anything, because I didn't like it. But I got really stiff. I froze up, and I was just paralyzed. I didn't know what to do, and I just started crying. And when I started crying, it must have done something. It must have shocked him, because he stopped, and he looked at me (maybe he realized I was a real human being), and he looked at me and said something like, 'Oh my God, what am I doing?! I shouldn't be doing this, it's wrong,' (something along those lines), and all I could do was cry even harder, and he ran out of the room. I was really paralyzed for quite awhile, and I don't remember how I got home. . .I told my mom . . .and she was really upset. But she didn't blame me. I think she called the school, and I remember that he was never there again. I think he left. I don't know what ever happened to him, but he was never there again. And so that was taken care of. It was comforting that my mother handled it, and I felt grateful, but I guess what bothered me though, was the fact that again, I really didn't do anything. I mean I didn't say, 'No.' I stood there. I froze. I did feel guilty, because I felt I was older and being older, I really ought to have known better. And that one took me a while to get over. I remember as a child, after the first incident, that I did have some nightmares, and had to sleep with my parents for awhile, but then it got better.

Dissociation and Memory Variables: Pertaining to Research Question 1:

Catherine reports having mostly, *clear, declarative,* memories, but may have 'somatized' some of them. She states:

> I never really forgot it. I pushed it out of my mind. I don't think I ever forgot it, but I didn't connect it to my weight problem later on in my life. And I didn't connect it to my sexual problems with my husband. I really didn't realize that what had happened so long ago could affect me today.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

> . . .My parents' validation was very important, the fact that they didn't blame me, and responded so quickly. They took care of the problem right away; they made me feel protected. And of course my therapist. She has really been important. I don't see her much now, but I know I that she'll be there if I ever need her. It was very, very, helpful for my therapist to suggest that there might be a connection between the abuse and the food thing. I never connected the weight, or the sexual problems with the abuse, and it really helped to be able to see that connection. And to know that that's quite normal for a survivor of sexual abuse—that these are typical symptoms. I think that really helped me to do more introspection, and deal with some of the behaviors. I'm not as afraid as I use to be of doing things by myself. I still prefer to do things with others, but I am not afraid to do some things alone. I am not afraid; I don't have panic attacks any more. I still am compulsive, I like to be in control. My house is as neat as a pin, but I think that has to do with wanting to have that control. But my sex drive has really improved, and I can now enjoy sex (most of the time, anyway). And so I really think that things have changed.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

> . . .I never thought that I was crazy, but I think if my parents had denied any of this had happened, I might have felt that way. But I really knew it all happened, and I had good support. . .But I think I did feel guilty. I don't today. But I did because I didn't do anything, because I sat there and cried. I felt bad about myself, like 'something's wrong with me, why can't I stick up for myself?' Or 'I'm not a very strong person.' I didn't feel evil in any way. I should have been stronger, perhaps. I know now that that is a mistake. A child really can't defend herself. So I know today that's not right. I still have some

shame, over it, but not very much, mostly 'shame on them.' I do believe it was their fault. Even a 15 year old child doesn't know what to do, doesn't expect that to happen, and so it's hard to know what to do. . .

. . .After the incident with the janitor, I did notice. . .I didn't notice it then, but I did start to eat differently. I started to put on the weight. Maybe I was depressed, I don't know, we didn't know about that back then. I wasn't as active. I think it was protection, I really do. And I remember that was the first time I ever cut my hair really short. I decided I was going to have a new hairdo. But I had always had this beautiful, long, blond hair, that I loved. And I cut it very short (like a boy). And I now look back and think: 'Well, that's because of what happened.' Because they both talked about my beautiful, long hair, and I became very ashamed of my body. I remember becoming very ashamed of my body, and it's kind of ironic, but the more ashamed I became, the more I ate. It's almost like I wanted to cover it up. Like I wanted to make myself ugly in some way. I don't look too over weight now, but for awhile I did think I had an eating disorder.

. . .that's when I went into therapy. I went into therapy because I just couldn't seem to regulate my weight, I just couldn't stay thin. Every time I'd lose weight, I'd have panic attacks, and would get really scared and didn't know what it was. I hadn't connected it to the abuse until my therapist pointed out that maybe there was something in my past. And then I told her about what had happened to me as a child, and it all really seemed to make sense. . .I also had some issues with my husband. Now I realize they're related to that, to the abuse, but also to my early religious training. You know we were raised very strict Catholic and you didn't have sex before you were married, and I didn't. So he's the only man I've ever had sex with, and so it was difficult. I've had difficulty with having an orgasm. I never really had one until I got into therapy and worked with all of this. That really changed for me; it's quite wonderful now. I can enjoy sex and I really never could before. I always felt guilty, it was something you had to do, an obligation. And I just didn't see the connection before, and I think therapy helped me a great deal.

Validation Variables: Pertaining to Research Question 5 (a), (c):

Catherine had validation through corroborative evidence of her childhood sexual abuses. Of the first abuse she states: "My sister came in when it was happening, she was right there."

The abuse by the janitor when she was 15, was validated by his admission to her: ". . .he looked at me and said something like, 'Oh my God, what am I doing?! I shouldn't be doing this, it's wrong,' (something along those lines)."

Disclosure Variables: Pertaining to Research Question 5 (b):

Catherine disclosed the abuses to her parents immediately after they happened to her. And as an adult she disclosed to others as well. She states:

> I told my therapist about it. But I didn't tell my husband about it, until I had been in therapy and realized that maybe this had affected our sex life. And when I realized that, and started working with some of that, then I could share with him. Well, I think it helped him to realize that it wasn't just him. I think he thought a lot of it, my not enjoying sex. . .he may have thought it was his fault, or there was something wrong with me. So I think it did help him a lot. And our sex life has just gotten much, much better, in fact it's a lot of fun now.

Case Number 22: Story of Gail S.

Childhood sexual abuse experiences:

> It was just after I had turned six. I know that because my oldest sister N. had come home for my birthday. She moved out of the house when she was 16 and was living with some people in another state. We had moved to M. (another state-added) and she stayed in W. with friends of the family, to finish high school. And it was after her visit that he started coming into my bedroom and touching me and doing it to me. It was my father. He and my mom both drank a lot. He was an alcoholic and she drank with him too. He would get her drunk and she'd fall asleep, and then he'd come into my bedroom and wake me up and start touching me real rough, you know in my genitals and all. At first it was touching and fingering me and then he'd do oral sex. He'd corner me whenever he could, or take me in the basement to clean it up and then start touching me and putting his hands down my pants and rubbing against me. I don't remember how often he did it, but it was a lot. Whenever he could get me alone. There were 8 kids and N. was the oldest. She's my half sister, 11 years older, and she took care of us a lot because my mom had so many kids and was sick so much. My dad was mean when he drank, and he drank a lot. He used to beat N. and B.

(brother-added) especially bad. B. and N. were from a different dad and my dad hated them, he picked on them a lot and made it really hard on N. That's why she stayed in W. (different state-added), she wanted to get away from him. I remember my parents being really angry at her after she moved out: dad called her a 'damned liar' and would get real mad if mom called her, or talked to her. Now I know that she had told the people she was living with what my dad had done to her and he called her a 'liar.' But I didn't know that he had done that to her too back then; I just knew he was doing it to me.

And it progressed into me doing oral sex on him, and involved intercourse. He used to pull out when he came and it was sticky in my bed. He did that because he didn't want to get me pregnant—I learned that later on.

. . .My mother didn't know, but you'd think she should have known because my sheets were always sticky. You'd think she would have noticed that he was gone from their bedroom a lot, or something. I tried to tell her once but she told me I was dreaming and my dad would never do that. She got real angry and said I was listening to N. and that she didn't want me to be a liar too, so I never said anything again. I never told anyone until I got married. But I knew he was abusing B. (brother-added) too, I could hear it. He did something sexual with B. I know, but B. has never said exactly what it was. He wasn't too mean to me, but he yelled a lot, and he physically abused my mom and some of the other kids too. He wasn't mean to me as much I think, because I didn't fight him. I just did what he said. I was real scared of him; we all were. And mom didn't protect us. She was real religious and she prayed the rosary a lot. We were Catholic. She went to church a lot and maybe that was her way of blocking all the bad stuff out, her way of feeling good. They made us go to church a lot, and catechism. They shoved religion down our throats and I was really angry at God for awhile. I became an atheist for a time. I remember thinking: 'How can God let this happen to me? Why doesn't he stop it?'

. . .There was another one too. He was my dad's friend, and he lived with us for awhile. It was when I was about 11 or 12 (before I had my period), and he would come into my bedroom or take me in the basement and fondle me and do oral sex. And then one day we had intercourse. He did that twice; I think my dad 'sold me.' I think he paid my dad to do that to me because I sort of remember hearing them talk, and it seemed that way. I felt very bad. Like it was my fault because I didn't say "No;" I just let it happen. I was really scared and my dad told me to shut up and not tell anyone or he'd kill me and my mom, and I believed him. He was very scary and violent a lot. And I just took it. If I froze my dad would get real, real mad and slap me, so I had to respond and I felt real, real, ashamed of that (she gets very soft

and she cries here). I knew it was wrong and I went along with it. The other man didn't threaten me, he just did it to me, and I let him, and I felt very guilty about that, very bad. I don't remember how it stopped with him, maybe he moved out then or something.

. . .but my dad kept doing it until I got pregnant from my boyfriend at 16. Then he called me a 'slut' and a 'whore' and they were both (parents-added) really angry at me. But they let us get married (probably to save face), and that's how I got out of the house. . .

Dissociation and Memory Variables: Pertaining to Research Question 1:

"I never forgot the abuse, but some of the details are 'fuzzy.' I guess I didn't want to remember, I didn't want to feel the shame."

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

What has been most useful to me in my healing journey is the support that I've gotten from my husband and children. The validation from my sister N., and the support from AA and my therapist. They believe in me, and that helps me to believe in me. I don't know what others need, but that's what's helped me: to know that someone cares what happens to me.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

Oh, I used to really hate myself! I thought I was *bad,* and *evil,* and *unclean.* And the guilt and shame would consume me at times and that's when I think I'd drink. I think I used alcohol to numb the feelings—and food. I've had a battle with weight most of my adult life-and I think it's probably related to the abuse-it's my layer of protection. I still have a hard time feeling 'safe' around certain men. But therapy has really helped me, and AA and my husband and children. He's reliable. He's always there for me, and he doesn't ever blame me, even when we argue, he's still supportive.

I don't hate myself anymore, in fact *I* really like, *love me*! I think my dad's death freed me to forgive him because he's no longer a threat. And now I can see how sick he was and feel sorry for him. And I don't believe it was my fault, any of it. Probably because I know it happened to my sister, and my brother, and maybe even two other sisters (but they're not admitting it yet). So I know it wasn't just me. And I've done some really positive things with my life; I've overcome a lot of hurdles. I have a loving husband and a good marriage, and I

went back to school and got a nursing degree. So I know I can support myself, I can take care of myself, and that's a really good feeling.

I'm still overweight, but it doesn't bother my husband, and I know that I'll probably always battle with that. The nightmares and flashbacks are gone and I'm able to sleep well at night, but I guess I'll always be a light sleeper. I always know that alcohol will be a problem for me, so I don't drink at all. I think it's an inherited thing.

Validation Variables: Pertaining to Research Question 5 (a), (c):

Gail had corroborative evidence of the childhood sexual abuse by her father from her sister N. and brother B. She recalls:

> . . .I knew he was abusing B. too, I could hear it. . .She told me that dad had done the same things with her, and she didn't know he was also abusing me. She thought that if she let him have his way with her that he wouldn't touch me, but she was wrong.

Disclosure Variables: Pertaining to Research Question 5 (b):

Gail tried to disclose, the abuse as a child, to her mother, but got a disbelieving, negative response, and did not reveal it again until she married, and left home. She states:

> . . .My mother. . .I tried to tell her once, but she told me I was dreaming and my dad would never do that. She got real angry and said I was listening to N. (her sister-added) and that she didn't want me to be a 'liar' too. So I never said anything again. I never told anyone until I got married.
>
> . . .We can all now talk about it: my brothers and sisters and I, since mom and dad died. I think we didn't feel safe to talk openly about it until dad died 9 years ago. That was such a relief! It was like a weight off my shoulders. Even as an adult, and even though I had moved away from him, he still remained a scary person to me. Now I feel sorry for him. He was sick.
>
> . . .Mom lived in denial. She didn't have any power, she didn't believe she could change it, so she just pretended that it never happened. She didn't want to know. We think she was abused herself, I mean sexually. Probably her father—grandpa was mean. We were afraid of him. So we think that probably he abused her, but she never told, she never shared any of it. N. told her 'foster parents', the people she lived with when we moved. But there was nothing they could do

because we had moved to a different state. And my dad always denied it and called us 'liars,' and 'sluts,' and 'whores,' and that kind of thing.

. . .I kept in contact with my mother until she died of cancer, but I stopped talking to *him,* and just stayed away from him as much as I could. And I never, ever let him be with my children. They never knew their grandfather. I told my first husband and he used to throw it up in my face, but he hated my dad. And my present husband is very kind. He believes me. He's a good man, he's helped me a lot. He's protective of me and I like that.

Case Number 23: Story of Marlene S.

Childhood sexual abuse experiences:

It all began when I met the person that I married, his name was A. And it's so easy to look back and realize how I could have been involved with someone like him, although it's rather embarrassing to look back at it now. I was 13 and he was 19. I was in Jr. high. and he was still in high school. He had some problems in school so he was still in school at 19. I actually don't remember how we met, I just remember in the school yard or something. I remember seeing him and thinking he was so good-looking. It's hard to remember back how I would have felt at that age, at 13, but somehow it was exciting that a person that much older than me, he was a cute guy and he was attractive to me, and he could probably see that I was pleased that he noticed me. We started talking, more in public at first. I remember being in the school yard and we'd be around friends and that, and we just started talking. I was all starry-eyed because of his age. . .And of course being that young, I was very careful to keep it from my parents initially because I'm sure they would have had a big fit. And so I decided instead of having my parents say no, I wouldn't ask them. Other girls weren't seeing anybody, so I was kind of standing out of the crowd, even though he wasn't a boyfriend at that time; it took a while. We probably started being alone when I was about 14. And I'd see him after school. It was kind of exciting because I say him as a 'firey' kind of person and only years later did I realize that he was actually 'emotionally unstable' and prone to violent outbursts. But being who I was at the time, I easily accepted blame for upsetting him. And it became part of a pattern: I was someone to blame for his unhappiness and his feelings of anger.

We started spending more time together. He drove a car and would pick me up from school and take me here or there, and there were more opportunities to be alone. There wasn't a lot of supervision

at home. My dad ran a tavern and we lived in the living quarters behind the bar. They both worked in the bar and were busy. My parents were also in the throes of getting a divorce and were preoccupied. So this was a nifty place to spend my time, with someone who I thought really, really, cared for me and paid a lot of attention to me. And I understood that this was something that I should not talk about at home.

A. was initiating a lot, of petting and kissing and drinking. The lifestyle we had at home allowed for me coming home later than I should, and so nobody noticed much how this was progressing. We lived in a small town, and we'd find these little places to park. I can still remember the night that I lost my virginity. It was not a pleasant experience. I felt as though I was doing this for 'the cause,' for the purpose of showing love. "He'll know I'll love him." And to my utter dispair, he didn't believe that he was first with me, and that I was a virgin. That was absolutely devastating, it was upsetting, it was frustrating, it was tearing my heart out. Then I think he called me a "whore" or something like that (he used a lot of profanity), and I became so upset that I jumped out of the car (we were in a woods or something) without saying a word, and ran home. It had to be four or five miles. And I remember sitting outside when I got home and cowering behind the house where the basement doors were, and it wasn't that long afterwards when he came to the backyard (it was dark in the backyard) and he found me back there. And I was sobbing, and I was shaking, and I was emotionally just feeling battered. It was shocking because he found me in this condition, and yet didn't believe me, and never did. So I continued to try to prove it by being accommodating, by saying: "Yes, yes, yes," by taking abuse, by doing things I didn't want to do sexually. Finally I ran out of energy and reasons to be with him in my own mind, and I wanted out. And I'm not saying it was because I was being so smart at 14, but I was s*cared*! There wasn't anybody I was telling this to, but I realized that having somebody tell you when you're going to have sex, and what you're going to do, performing. In other words, performing oral sex on demand, either that or there would be yelling. And there were times when I'd come home physically roughed up. It's very hard to look back on this because it's totally embarrassing and yet where I came from, I saw a lot of this kind of thing in my dad's tavern. My dad wasn't exceptionally physical with my mother in a negative way, but a lot of the people who frequented the bar were drinkers and 'carousers,' and 'shovers,' and hitters and all that, so I thought it was 'normal.' And also, I had convinced myself that if I'd just be nice enough, he'd get over it, and it would stop. I was sure it was my fault, and with no one

to talk to about it, I really believed that. I was very shy and very into myself, so I had no sounding boards.

Eventually my parents came to know about A. and me. I didn't tell anybody, but my mom would hear the yelling, my dad was always busy in the bar. A. would yell and swear. He pretty much thought that all women were "just fucking men over," and from the Virgin Mary on down, he thought that women were no good. His language was so dirty that I just can't even imitate it. As I recall it, my mother found evidence in my clothing. She saw my panties, and I don't recall if she found them after the first night, I can't remember that part of it. She suspected or she knew, and all of a sudden she came to me in the dining room, and she said something like: "Mar, I found your panties." I didn't even understand what she was talking about, but somehow she had detected that we were having sex. She came over to me and put her arms around me and started crying. And of course, being detected, I started crying too, even though I didn't know why I was crying. It was awful, I was in this big 'pit,' with this 'man' that I was afraid of. And I felt like it was something that I couldn't get out of. How could I tell her that all this time I'd been afraid to tell anybody.

Sometimes he'd find me at school, and walk with me while I walked home (I think he lost his license, because he would drink sometimes and drive around fast).

One day I distinctly remember having all of these people around us, just people I went to school with, nobody I was friends with, and telling him I didn't want to see him any more, and him walking next to me, holding my elbow. You know, escorting me home. He couldn't do anything else because we were in the middle of all these people. But I was too frightened of him, even in a crowd of people to say something. But I was shy to begin with, that's why looking back, I was a perfect candidate. I didn't have a lot of self-esteem. I had no self-esteem. Nobody ever said: 'Guess what, you're turning into a young woman and you deserve people who are good to you because you're a nice person.' So I thought, 'This must be it, he's a good-looking guy and he's attracted to me. So what if he's abusive and forces me to have sex and uses me?' And a lot of this I didn't even understand at the time.

Back then, I never thought of this as sexual abuse, I thought of it as a bad relationship. Little did I know that it was so much more serious. Therapy helped me realize that I was being victimized. First of all, I was just a kid!

My parents knew a lot about the violence that was going on, but eventfully what they knew was happening really became confirmed because I became pregnant. I was just about 15. It was just too ugly, too awful. . .I remember. . .when I was about four months pregnant, and I don't know what set him off, but A. just went nuts! And just swearing and 'Fuck this,' and that. And he just went on and

on. I went to the kitchen and took out a little paring knife and I cut my wrist. Because there was no way to cope with it, there was nothing to do. I'm pregnant, this guy is a maniac, I'm realizing it every day more and more. . .for instance, if it were raining, he'd get angry and say: 'It's fucking raining,' and throw things, and slam things. The stress was appalling. I was having bouts of eczema that made me look like a burn victim. . .So we rushed to the clinic, where they took 7 stitches to close my wrist. And we started, the fist time of many, protecting his role in any of this. So we made up some concocted story of how I slipped on a kitchen rug and cut my wrist. I can't believe we got away with it!

. . .O.K. there I am pregnant, and now my patents say: 'For sure you are not going to be with him,' and what not. . .Now of course I'm feeling all 'aglow 'that I'm going to be a mother (I was a kid, having a kid!), all those hormones start working. Now that it came to be such a critical issue, and a timeline involved my mother said: 'You are not staying with him, you are not marrying him.' And of course years ago, it was not like it is today: If you got pregnant, you got married. Either that ,or you're going to give the baby up for adoption, or go away to a convent for 6 months or something. My mother got tough; it's funny, she got tough for these few months when I said: 'No, we're going to get married, we love each other.' I was scared to death of this guy, but somehow I interpreted the attention, the violence, as *love*, and thought that a baby would make it all better! So my mother sat down with this guy, she even went to his parents, and demanded that he control his temper. Because his temper was the really horrible part. I was scared to death of him when he'd lose his temper. And you never knew when he'd blow. He didn't need to be provoked, it grew worse. And years later it got so horrendous, it was unbelievable. So when my mother demanded that this had to change or 'else' (and I don't remember what she said to pull this off), he went without losing his temper for three weeks. And the minute that the timeline was over, when we had signed papers to get married (my dad had to sign because I wasn't old enough), he started losing his temper again!

I still remember how my dad handled things. He was against it enough not to come to the wedding but when he could have done something, at least I think he could have, he didn't. It seemed like the seriousness of the situation and the long-term consequences were never considered. It sounds like I'm blaming my parents because I am holding them responsible, even to this day. Because if they weren't in charge, who was in charge when I was that age? So in that respect, they are responsible for shirking their duty. They're not responsible for what I did; they're responsible for what they *didn't do.*

After ten years of marriage, five children by him, and four serious attempts to leave him, Marlene finally divorced this man, and the abuses ended. Many of her 'psychosomatic' symptoms, such as the extreme eczema, also ended. She states: ". . .I looked like a burn victim. I had places on my jaw that dripped. The fluids dripped. There was no skin. . .Six weeks after he was out of the house, my skin cleared up. It couldn't have been more dramatic!"

Dissociation and Memory Variables: Pertaining to Research Question 1:

"I always remembered it, but I have forgotten some of it, only because my life has turned around for me, and I no longer *need* to remember it"

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Marlene does *not* believe that validations through corroborative evidence is important in the remediation of her symptom related to the childhood sexual abuse. She believes this:

> He admitted (the perpetrator-added) what he did was wrong every Saturday morning after the abuse, when he sobered up! So his admitting he was wrong and apologizing just kept me going: 'Hope springs eternal'. . .No, I don't think it helped. What would have helped was him getting help for his alcoholism and severe emotional problems. And my parents protecting me from him in the first place, by not allowing me to get emotionally hooked into him at such a young age; that would have helped a great deal.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

> . . .I didn't think I was evil, but I learned to cover up things. I felt so *guilty*. It's so hard for me to remember that part of it, because I like myself and I love myself now. But I do know that I had low self-esteem. I didn't believe in myself; I didn't believe I had any

> capabilities; I didn't think that I was somebody that would be sought after. So I felt very lucky to have this person wanting me. I also felt very sorry for him. He was a very verbal person and he would tell me how unhappy he was feeling and his emotional pain. His mother had him when she was in her forty's and he was an only child and was very dark skinned. And he would tell me how he felt he was adopted. He never felt that he belonged, even in his own home. He would bleach his skin and all that. So all these things he would tell me, and tell me. And I just felt sorrier, and sorrier, and felt more compassion. And thought, "If only I show him I love him enough, he'll feel better." And I didn't realize at the time that I was selling myself or that I was being victimized.
>
> Through a haze of events, I remember fear, I remember depression. I remember feeling like the only place I could be by myself to even compose my thoughts was to lock myself in the bathroom. And sometimes I would stand there and pray that I would die, except that I didn't want to leave my children. In seven years we had 5 children. That whole time was such a stressful, scary, period of my life. I developed eczema so badly, I looked like a burn victim. . .Through all those years I had this horrible stress feeling, sort of the 'flight or fight' thing. Well I couldn't run, so I was there. I guess my body was ready to fight all the time. I couldn't eat, couldn't sleep and I was scared to death every day. As I talk about it, I can feel what it felt like.
>
> After the fourth and final separation, I didn't care if he killed me, which he always threatened to do. More than once he held a loaded gun to my head. But I finally didn't care if he killed me, because I couldn't live like that anymore, it was like a death sentence. The police reports that were filled out on him included everything from ripping out my hair to slapping me. He once broke his thumb hitting me and went to work and claimed he broke it lifting a sofa on the job, so he could get workmen's compensation. There were so many instances, I can't even begin to remember. But I finally decided that it was over, because I was in fear of what my kids were experiencing—they were already going through horrible, emotional trauma.

Marlene does not report any current psychological symptoms that she believes are related to her childhood sexual abuse, and attributes this in part to her present marriage (of 18 years). She says:

> I had this huge period of time with this unfortunate circumstance, with a rather sick person in my life. And I've had even a longer period in my life with this other wonderful person. And I think I held up my

> end of the bargain of this marriage, and it's grown, and I feel like I'm a pretty terrific person!

Validation Variables: Pertaining to Research Question 5 (a), (c):

There *was* validation through corroborative evidence of the childhood sexual abuse perpetrated on Marlene:

> . . .my mother found evidence in my clothing. She saw my panties, and I don't recall if she found them after the first night, I can't remember that part of it. She suspected or she knew, and all of a sudden she came to me in the dining room, and she said something like: 'Mar, I found your panties.' I didn't even understand what she was talking about, but somehow she had detected that we were having sex. . .

Disclosure Variables: Pertaining to Research Question 5 (b):

Marlene disclosed some of the abuse, and how fearful she was of this man, to her mother, only after her mother had 'discovered' their sexual involvement. She says:

> After my mother had this 'encounter' (discovered my panties and our sexual activity), with me, she talked to me several times after that about it. And I remember telling her that I wanted to break up with him, but I was afraid. As my parents started realizing what was going on, they made' weak' attempts at breaking us up. Mom finally told my dad, and this one particular time he made a stand, and said that I was not to see him. He actually told A., 'You are not to see her.' A. came down to our house, and when my dad yelled at him to leave me alone and to get the hell out, A. pulled out from his sleeve a butcher knife, and threatened us all with it—threatened me with it. And I don't remember how that got resolved, but my dad still allowed me to date A. after that.
>
> Looking back, and that's so many years ago, there wasn't anyone I felt I could go to for help. There weren't people at school. counselors and things like that weren't available. At church, holy smokes! That's the last place. You're not going to walk up to a sister at church and say, 'Guess what sister...' And it became uglier because there was more secrecy, and more secrecy made it uglier, and it went back and forth until it became a big, dark, *secret*. . .

Case Number 24: Story of Gina N.

Childhood sexual abuse experiences:

I was probably about 8 years old. The perpetrator in my case was my brother and he was 3 years older than me. The first time I remember it happening, we were outside: Him, my younger brother and myself. We were in this little plastic pool, and we were laying there and he just, as if he were playing, exposed his genitals. At the age I was at, I really didn't know that that was inappropriate. I didn't think anything of it; we all thought it was pretty neat. Now looking back, in retrospect, I can see how he was trying to see what would be my response. This had been something he obviously had been thinking about and planning. It was in no way a forced thing physically, it was done in the manner of manipulation, /mind control.' He always had very good control over myself and my brother, like getting us to do his housework, or his chores and stuff. So he was a very controlling person even before the sexual part of it came into play. At times I was afraid of him. If we were arguing and I would get angry at him, I'd have to run for my life, because he'd grab me and almost want to kill me it seemed like at the time. He had a lot of anger in him. He didn't like anyone saying anything to him that would make him feel unloved. You couldn't just cut the argument off. You couldn't just say something and walk away, he had to have the last word, he had to win. Always we were alone and he knew probably that no one would be around for some time, and I remember incidences - I don't remember how it actually happened, the touching thing, but that's just something I guess is gone from my memory. But every time after that he'd 'Gina do you want to do that one thing?' I didn't know that I could really could say 'No.' I didn't feel afraid, but I knew it was something that I really didn't want to do. So then we'd go into one of the bedrooms and it'd be touching: He'd want me to touch his genitals and he'd touch my breasts and my genitals, and after a period of time, then he initiated intercourse. I can't remember how soon after the touching that that happened; I think it's due to my blocking out things. Maybe I was about 10, I don't know for sure. It seemed like to insure that that (intercourse) would work out well and go real smoothly, he'd go down stairs and get my grandma's wine bottles and we'd drink some wine first. He'd never, ever threaten, or say 'Don't tell anybody.' It'd always be like, he'd say: 'It's a neat thing, this is our neat thing, but we don't want anybody to find out about this because we'd get into a lot of trouble.' And I believed him. But after a period of time, I remember when I did not want to do that (sex with brother). And as young as we were, we would smoke cigarettes, and he'd use that, and say: 'Come on down stairs and we'll smoke a cigarette,' and he'd work it out so that I'd have sex with him,

or he'd threaten to tell on me for smoking. I remember too, even aside from the sexual thing, he'd always have to have me build up his self-esteem by saying he looked muscular, or he'd ask me if his genitals looked good and things like that. He'd do the 'double biceps pose' and say, 'Now which one is bigger,' and I'd have to do my best at guessing which one, because if I'd guess the wrong one he'd say, 'No, 'this' one!' And then he'd do the 'fighting pose,' and say: 'Watch this!' It was extreme insecurity, which I didn't understand at the time, I just knew I was real nervous. It reminded me a lot of how my dad was, so insecure about his body and stuff and always asking me these same kinds of questions. But as far as I can remember, and I've really searched my memory about this, my dad was never sexual with me.

It just went on (the CSA-added) for a period of years, I don't really know how often anymore, I can't really recall. But whenever the opportunity arose for him and he felt comfortable (and no one was around), this is when I guess it happened. . .I was neutral at first about it, but when we started having intercourse, then no, I didn't like it then. . .If I enjoyed it at all, it was because of the curiosity thing. 'Oh, we're exploring each others body and I never saw that before.' But actually it was unpleasant to touch him, it felt weird in a way.

There were a couple of close calls where we had to rush out of the bedroom because someone came home.

I remember one thing I did, and I didn't know why then, but now I think it was related to the sexual abuse, I *hated* my picture being taken, and I'd cry and later I'd find that picture and scribble my face out. My mom couldn't understand why, and now she does of course. But I'd absolutely just *hate* myself! I didn't like people to look at me from the side; I hated my profile.

The last time that it happened, was when I was about 16. He'd approached me one time when we moved to California where my step-father lived, and we were alone, I was in my bedroom, and he knocked on the door and said: 'Hey Gina do you want to do that one thing?' And I said, 'No.' And I knew, I could feel that the circumstances were probably going to cause him to ask me that, and I was totally dreading it, and I didn't want to. And when he came to the door and asked that I said 'No.' And he said: 'Ever?' And I said 'No.' But we did have intercourse one more time after that. I remember that time feeling horrible about it, more horrible than any time about it. It was like I could throw up right now just thinking about it, because that is a very vivid memory, and you can remember things more clearly as you are older (detaches/dissociates a bit here - parenthesis added). I think I continued to have sex with him even when I clearly didn't want to, just to please him. He had a way of building me up. As a young girl I was

strong. I liked to pick up weights and stuff. I was a tomboy, was always hanging around boys and stuff, so he'd always say things like: 'Yeah, you know Gina is really strong, she could be Miss Olympia some day,' and, 'look at how much Gina can lift.' And it was true, I could lift more than some of his friends could. And of course I liked that because it was like somebody giving you, building up some self-esteem a little by saying that. But by the same token, he knew that these things would play into his motives and get me to want to do that 'thing' (sex) with him). The funny thing is, I know he loves me very much and I don't hate him. I hate what happened, and I feel disgusted about it, but we always had a closeness. He would always tell me about his girlfriends - sexual things about him and them. And when I was younger I didn't think anything was wrong with that. I'd just think it was cool, and we'd talk about all the details. I don't think there was anyone else he told this to. I don't think he talked to his friends this way, because a lot of this would show insecurity to them. But I didn't know any different, and I was somebody he could totally feel comfortable around. . .

. . . And I look back then, and I gave myself to people, and they took something I'll never get back, but it's like I gave it. Well, except for R. (my first boyfriend) who raped me. I was about 13. It started out where we willingly had intercourse, and again, I just didn't have a clue that I could say 'No.' It was just the thing to do: You're drinking beer, you have cigarettes, you go out and you have sex. We went to his mom's house when she wasn't home and we had sex. Then after that, if I didn't want to he'd just say: 'Well don't pull that shit on me; you know you want it. You can't treat me like that, I'm you're boyfriend and you know you want it. I'm not just some bum off the street.' And then he'd push me on the bed and he'd force me to have sex. He'd rape me. There were sometimes when I thought that it was something that I liked to a point, because you'd feel like you were really desirable. After awhile though, I really didn't want him to be like that because I started feeling really bad about myself. It started wearing on my mind that someone was treating me really bad, and I let them. If I went over to his house and we'd get into an argument, I could never leave. He'd stand at the door and we'd be fighting physically, and I'd be so mad at him, I'd be clawing and scratching at him and say: 'Get the F...out of my way.' And he'd say: 'You're not going to treat me like that.' And then for some reason, my punishment was always to throw me into the bedroom and force me to have sex. It was sickening. Once R. came into picture there was no sexual contact with my brother. . .

Dissociation and Memory Variables: Pertaining to Research Question 1:

> . . .I'd block it out and when it wasn't happening (the abuse-added), I don't think I thought about it. And when it was happening, it was just like, 'get it over with.' It may be because of my age, it was so long ago, that I've forgotten some things; or it may be that I've completely blocked out certain memories of certain times that it happened. But I can be sure of one thing, that it did happen, and that it happened on a pretty regular basis, maybe once a week, or so.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Gina believes that validations from the perpetrator is important in her ability to heal from the childhood sexual abuse. She states it this way:

> . . . yes, it would help a great deal! I feel if we could ever sit in a room and have tears, and he would say: 'Gina I'm so sorry, I don't know why I did that.' Oh, absolutely, that would make me feel like validated, because who else could validate those feelings other than the person who hurt you? Everybody else seems to understand, but they didn't do it, so they have no reason not to feel bad for me. But for him it's still not acknowledged. And that's where the anger comes in. It's like, 'What do you mean, of course you did that, of course you hurt me!'

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

> I felt ashamed of myself; I felt dirty. Then I started to feel anger toward my brother and that anger really escalated. Because when we had discussions he always had to be right. You can't disagree with S. even slightly. It was another form of control he used to try to have over me and after awhile I stopped letting him do that. I remember one incident when S. and I were arguing and I walked away, into my room, and burst in there, ripped my jacket, and slammed me against the wall! He tried to do that same thing, he tried to control me, not let me walk away from a conversation. But I wasn't afraid this time. My older brother came in and pulled him off me.
>
> I think the one thing that's affected me today is in my sexual relationship with my husband. To the point of when we are together, I absolutely cannot stand for him to touch my breasts. It triggers, it brings me right back to one of those days when he'd (brother-added) touch my breasts. It's because your nipples are so sensitive, and it they're touched it kind of triggers something. It also affects yours hormones and everything. I think there's a chemical.

They say memory is like a pain too, it never leaves you, you know, like a 'body memory.' So that's one area. And I feel bad because that's not normal. You should be able to be completely free with the person you love and are married to. And that's a handicap right now for me. And I don't think that could ever go away. It's amazing, I'm 32 years old, and just touching my breasts can bring me back to 8 years in a matter of seconds!

I think I've become kind of a controlling person in some ways. I need to be in control and I get, I don't like to use the word 'hyper,' because that to me is a physical thing, but tend to be real talkative, and I've given inappropriate 'confessions' at times about some of my feelings. Not about 'that' (CSA-added) particular thing, but you tend to want to lead up to getting to that with somebody, but you know you're not going to (share the abuse), it's just that I tell other things about myself. I learned that 'inappropriate confession' thing from my pastor. Confession (telling about one's problems) is good when it's done in a very safe and appropriate way. You don't want to tell somebody you just meet, your whole life story. But I would tend to do that. I would meet somebody, and I would feel comfortable talking with them, and I would tell them things about me, personal problems, which really wasn't right. I was 'needy,' like I needed to talk to somebody .

I think I still am dealing with some anger. I have made, a long time ago, that first step, which is the decision to forgive him, and I think that's a continual thing. I don't think it's ever going to be: 'O.K. I'm there now, I'm done.' Because of the fact that I haven't been able to confront him, and he's not confrontable. And that's another thing that I've leaned: You may never be able to have that person apologize . . .It won't come to that with S., I don't feel.

I've struggled with anxiety and panic attacks most of my life, but I really wouldn't know if that is directly related to the childhood sexual abuse or not. And any of my relationships with men have not been healthy, which I don't know if that's related to the abuse with S. or not. I became pregnant at 15 years old (from my boyfriend G.) and I really wasn't sure what I was going to do with it. I didn't know what to do; I didn't feel right either way, but I had talked about it with my mom and step-dad. I did choose to have an abortion, which is something I do regret today, but at the time I did choose that. . .

Validation Variables: Pertaining to Research Question 5 (a), (c):

There was *no* corroborative evidence of the childhood sexual abuse. Gina states: ". . .No one ever witnessed the abuse, or even suspected what we were doing."

Disclosure Variables: Pertaining to Research Question 5 (b):

Gina told her childhood girlfriends about the sexual activity with her brother, but then recanted it after noticing their disapproval. She finally disclosed to a trusted boyfriend at the age of 16, who then told her step-sister, and mom and step-dad. Disclosure continues to be a complicated issue for Gina. Here is her account of it:

> . . .The very first person I told was a boyfriend. I was around 16 years old. He was the opposite of R. (ex-boyfriend who raped her-added). He was real sweet to me. He was 'normal', and real nice, not controlling or possessive. Even so, I had no right being intimate (sexual) with him, but he never pushed it, and it didn't happen for some time after we were dating. He didn't want to lose me as he said, he didn't want to push that issue. I stopped wanting to be intimate with him. Part of the reason is twofold: I wasn't really attracted to him. I was attracted to his kindness, but not physically. And when it came time to be intimate, I let it come out in a burst of tears one day. I said, "I want to tell you something. The reason I don't like having sex is because of what happened to me." And I told him about it (sex with my brother). And at the time, he was room mates with S. Then I had to expect this person not to treat my brother different, and he did. He managed to treat him just the same, without letting it show or anything. He absolutely believed me and he was really angry. He held me and he cried with me. It was helpful to know that someone cared.
>
> The thing that did hurt me after I told this boyfriend about it, was my mom's response. I was on the phone to my boyfriend talking about it, and I was crying and crying and my mom heard me and came into my room. Her thing, and I understand it, is: 'Hush, hush, don't let dad find out what's going on.' She's so used to hiding everything. She didn't know what I was crying about, but she probably was getting an idea. And then I told her. I was crying and I told her.

She didn't respond the way I was hoping she would. She didn't really hold me and hug me and cry. She was really more concerned with what my step-dad was going to think if he'd hear this. And that really, really, hurt me. I wanted to go tell my step-dad, because S. (brother-added) would have been out of the house if he'd known this, but who cares? So my mom was protecting S. more than me. And she almost wanted to pretend it didn't happen. I understand why, but it really hurt. It's like I finally after all those years told her, let her know, and she didn't do anything. Subconsciously I think I still have an anger toward my mom. I love her dearly, but I can feel that there's still some kind of anger toward her. I was always left alone as a child, and I feel that maybe if she'd been there more often this wouldn't have happened. But she's living with enough guilt; there's no reason to ever let her know that I think that. She did her best from what she came from, I guess. But she wasn't there. (gets emotional - sounds 'younger'). I was too young to be left alone. I was 11 years old coming home drunk with nobody in the house. I remember crying and sitting up and rocking in my bed and waiting for my mom to come home and she never did. Even crossing my fingers and my hands and thinking that would help. I remember being on the top bunk, looking out the window at each car that came by, thinking that was her, and I was terrified because I was by myself. I fell asleep, so I don't think she ever came home that night. For whatever reason all that happened, I don't know, but then when she did find out about it (sexual abuse with brother), it was not the kind of response I'd hoped for, like: 'Oh my God! My poor child!' That came later, but she wasn't able to deal with it, that's what it was. We were able to talk later (when I was about 28). Now we can talk, but we don't ever talk about it in detail. She isn't objective enough, it would hurt her too much to hear details. It hurts *me* to talk about it, much less to tell her. She's not strong enough to hear that and it would make her feel more guilty than she can think about.

I told my boyfriend G., and G. told my step-sister, and she told my step-dad. I didn't hear about it directly, my mom told me how my dad reacted. Of course they felt very bad for me. I remember one of my step-sister's comments about me: 'Well no wonder Gina is so screwed up!'

My step-dad did eventually talk to me about it, and again not in detail. But the one thing that he stressed is something that really angers me. He said he thought that I might be mad at myself. But I'm not mad at myself; I'm clear on that. I don't know why people want to bring this whole other thing into it. Like he said: "Well maybe you felt if you had fought him off more vigorously.' This shows that he really doesn't understand it, because there was no fighting. He was assuming that this was a rape, a physical rape, and it wasn't. It was

manipulation, and that's just the same as if someone's putting a gun to your head!

I told my pastor about the abuse, and it was a positive response. But I've never been comfortable telling him about the breast problem because he's a male. He knows about it, but not the details. I don't think that he's trained to deal with that.

I forgot, during the time when it was happening, when I was still young yet, I think it was right at the beginning of that time, I was probably 9 maybe. I would stay over at my girl friend's house, with my other friends, and I don't know why I said this to them, but I'd say: 'You know what, me and my brother do this 'thing' together, we touch each other's . . .' (I forget the words I used.).And then when they looked at me funny. And I said: 'No, I'm just kidding' Because then I realized I shouldn't have said something. And then I tried to cover it up, but I think that they believed me, and always wondered.

As an adult I'm telling more people who I can trust, like my counselor, my pastor. I almost wanted to tell my sister because here's the other side of this: I almost feel like I have a responsibility to people who may become another victim of his, and that's his daughter, and cousins, and his nieces.

I've thought about sharing it with my older brother A. But then again I don't know if he'd even look on it as a victim thing, because he doesn't have an understanding of that kind of thing. My brothers and sister could see that S. and I always had more of a rage toward each other at times. And I remember telling them one time: 'I'm really angry at S., and I have more reason than anyone knows!'

I haven't shared it with my sister because I'm protecting her. Because then she's going to have to feel an anger toward him. She's very protective, so who does she choose? She loves S., but she loves me too. If my brother A had popped in on us in the middle of something like that, I don't think that he would have seen it as abuse. I think he would have saw it as the two of us 'doing it.' Because that makes it easier on somebody to have to deal with, because he didn't force me, because it looked like I was willing, and it would probably just seem like something we did as kids, and that kind of thing. Even though everybody knows that S's a manipulator, and he's proud of that. He's proud that he can manipulate people. He feels better to this day, if he can buy something off someone if he feels he's 'conned' them into it, rather then it's just a good deal. He really takes pride in that.

Case Number 25: Story of Sharon D.

Childhood sexual abuse experiences:

I'm not sure when it started, I don't really know. I know I have to have been very young. But I do know that I was about 15 or 16 when he was still abusing me. I remember being in high school and not having any memories of childhood at all. Bits and pieces of things that had happened before, and memories of where we had lived, but that was very, very, rare. I discovered I had been sexually abused by my father after I got married and moved away. . . I just didn't remember it. . .I was diagnosed with a Dissociative Disorder, so I definitely dissociated from it. . .Then I started to have nightmares and flashbacks of the abuse, and that's how I knew. . . I'm not sure if intercourse was involved. I prefer not to talk about the details, but it was sexual, and it consisted of things that he did *to* me. . .I was hospitalized twice over 30 days because the memories of the abuse were so horrible and overwhelming that I needed to be in the hospital. I guess the abuse was rather violent. . .

My dad. . .didn't just sexually abuse me, he psychologically tortured us. My sister and I were both straight A students, and I was an honor student; we were both very gifted academically. And he would do things that would undermine our success at school like: I had a very important position on the drill team. And this one time, I had to be up to the school at a certain time, and my dad unplugged the alarm clock, so I missed an important event, and got kicked off the team. He unplugged it on purpose, so I'd miss the drill meet. He would come into my room and rip everything off the walls. He'd just totally destroy my room, and break things, which would really upset me because my room was the only room in the house that was clean. You could actually see the floor, everything was picked up, it was neat. I did the walls myself, and he would go in there periodically and destroy everything. . .the rest of the house was filthy, the bathroom was disgusting, everything was filthy. And it was always our fault. He'd tell us, 'you're nothing. I own you, you're scum, you're worthless, you're not worth anything.' One day I came home 10 minutes late and he had thrown my bed out in the yard! Of course all the neighbors saw this, which was totally humiliating to me. So he did stuff like that (I was a teen-ager at that time). To this day I don't remember how my bed got inside. I just remember coming home and my bed was thrown out in the yard.

Dad was an alcoholic, but I don't know if he was drunk when he did that [sexual abuse] or not. He was just always angry and he only drank on the weekends because he was in the service, so he

> couldn't be drunk. But he'd come home Friday night, and wouldn't stop drinking until Monday. He was passed out in the living room. I can remember that. I remember his drinking when I was in high school, but my sister remembers him drinking when we were really young, and always being drunk, and I just thought it started in high school. I had no memory of him ever drinking alcohol until I was in high school. It's like I disappeared mentally until high school. In therapy I just remembered more and more of the abuse. I was probably 18 or 19 years old when I started remembering. There are three of us, a sister that's a year younger than me, and a brother that's three years younger than me. I don't know if my brother was sexually abused, but he got the brunt of both my mother's and my father's physical abuse. He got most of it.
>
> Mother was physically abusive, but not sexually. She was just never home. My father was extremely abusive to her as well, verbally. It was just awful. . .

Dissociation and Memory Variables: Pertaining to Research Question 1:

Sharon reported having *dissociated memories* and *delayed recall*. She was 18-19 years old when she began to recover memories of her childhood sexual abuse, through nightmares, flashbacks, and in therapy.

Beliefs About Validation and Symptoms: Pertaining to Research Question 2:

Sharon has validation from the perpetrator, of the childhood sexual abuse that was done to her, but does *not* feel that this is important in her 'healing.' She states:

> . . .My dad did admit it. I called him from the hospital and he did admit it. He's apologized more than once for what he did. But it didn't help. It didn't matter. I think the only thing that would have helped is if it hadn't happened at all, and all the rest is a moot point. To me it doesn't matter how often or how long it happened, that it happened once was enough, it still affects me. To me it doesn't even make sense to question all that, because it happened and the only thing that would have changed it, is if it hadn't happened. He did admit it, but it didn't matter to me because it can't change what happened. And I think at that point he was so very sick. They thought he was a sociopath at the hospital. It's been years since I've been in the hospital and I haven't

thought about that until just now. But it doesn't matter to me, because whether you put a label on it or not, it doesn't change who he is.

Self-Esteem/Impact of Abuse: Pertaining to Research Questions 3; 4 (a),(b):

I totally dissociated the abuse, so I don't remember if I had any negative beliefs about myself during that time. Once I remembered the abuse I never thought I deserved it, but I was very ashamed (has shakiness in voice, feelings here). Angry that it happened to me, and angry that I didn't know it was wrong. I knew it wasn't 'normal', but I didn't know that if child protective services knew about it, they could intervene. I guess I had hoped it wasn't 'normal.' It was just 'crazy.' I think I knew it was his fault and not mine, but it still affected me, the things he told me still hurt. I don't think I had a lot of negative beliefs about myself because I was very popular at school, always at the head of my class, in charge of everything. Any kind of activity, if I competed, I always won. I had validation from school, that's where I put all my energy, into school and into whatever extracurricular activities I learned. So I became a very high achiever.

It definitely affected my sexuality. That was probably the thing I had to work on most in therapy. Just totally avoided sex. I hated it. I felt very dirty, and painful. It was something to be avoided and nasty and not something that you could enjoy with your husband. I was hospitalized twice over 30 days because the memories of the abuse were so horrible and overwhelming that I needed to be in the hospital. I guess the abuse was rather violent. When I was remembering everything I was very depressed.

Today I'm *not* still angry at him. But it's affected my relationship with my sister very much. We live probably about 10 minutes apart and hardly ever see her, or hear from her. Because she hasn't worked through the abuse, and for some reason we just don't get along. . .of course my brother-in-law hates my father, so does my husband. He prefers that I not talk to my dad, or ever see him.

My husband's still very hurt over what he did to me. That's his right to be hurt over it, but I have a right to work through it, and decide what kind of relationship I want to have with my father now. If he answers the phone, I'll talk to him. If my mother invites me to go with her and he's there, I can choose to go or not. My sister, on the other hand, won't have anything to do with my father. She will hang up the phone if he answers; she does not ever want to see him again. If I run into him, I'll be very cordial to him and I'll talk to him. Even that upsets my husband. My husband's still very angry at my father. I told him, 'That's your choice. I'm not going to be hateful to the

> man, he has to live with what he did. I can protect myself, I'm an adult now.'

Validation Variables: Pertaining to Research Question 5 (a), (c):

There was validation through corroborative evidence of the childhood sexual abuse that was perpetrated upon Sharon. She explains: ". . .My dad did admit it. . .he's apologized more than once for what he did. But it didn't help. It didn't matter. . . .Mom did walk in on it once, but I kind of covered up for him. . ." She adds:

> . . .When I told my sister, she told me, 'Well yeah, of course.' She always remembered the abuse. She didn't forget her childhood, so she knew of the abuse, and I just had 'blocked' it out. She confirmed it all. But once I started having the flashbacks, I knew about the abuse and I didn't need my sister to validate it, because then I knew it happened. And my aunt (father's sister-words added) said 'yes it happened,' because all of us had the same abuser: my father. . .

Disclosure Variables: Pertaining to Research Question 5 (b):

> After I started remembering the abuse, I first disclosed it to my husband. He believed me right away because he knew my father. He knew he was an *ass hole*. It wasn't much of a stretch that he'd done this kind of stuff to me. So I got a positive response from him.
>
> I told my mother about the abuse, I told her what he'd done, and she knows that he sexually abused my sister too, but she just doesn't get it. She blames my sister. She walked in on my dad abusing my sister and she blamed it on my sister! I could not believe that she's sitting there and blaming it on my sister! My sister was a child. I don't remember how old she was but I think she was younger than a teenager. When she found out about my abuse the reaction was mixed: She was very hurt and sad and supportive, but on the other hand she still lives with him. She doesn't think it was that bad.
>
> I also told my sister and my aunt about the abuse. My aunt felt very guilty, because she knew that he had sexually abused her and my other aunt. She had come down to visit us this one time, just to check things out. And she knew, and she didn't do anything. She didn't say anything. She didn't take us out of there. I mean she

knew how horrible it was. But I'm not angry at her, because I didn't want to leave. I wouldn't have wanted to be taken away from my home.

I also had three very close college friends that knew about the abuse that happened to me, and they were very supportive when I was in the hospital.

The reason that I choose not to disclose the abuse that happened to me to many people, especially my colleagues, is because I've seen people who have been made fun of, or discriminated against. I experienced a college professor, a licensed clinical psychologist, who made fun of people in class , who had been in the hospital. He said that they were not as competent therapists as somebody who'd not been in the hospital. To me, I think it's just the opposite. I think if people go in the hospital to really work on stuff, and get their life together, they're more competent than somebody who just keeps shoving it under the surface and never works with it.

APPENDIX N

Recruitment Letter to the Walden Psychology Student List Serve

NEEDED WOMEN SURVIVORS OF CHILDHOOD SEXUAL FOR DISSERTATION STUDY.

> *"Voice is an indicator of self. Speaking one's feelings and thoughts is part of creating, maintaining, and recreating one's authentic self" (Jack, 1991, p. 32).*

Please Colleagues, I need your HELP!

If you qualify, or have any clients who do, please tell them about this study and have them call, write, or email me (information below).

To be eligible you must be willing to be interviewed and "tell your story," as this is a qualitative study investigating the impact of childhood sexual abuse on the adult, female, survivor. You must have been, or currently be in therapy for at least six months , where the abuse has been, or is being addressed. Participants will be required to take three short assessments which will take about 30 minutes, and engage in a 60 to 90 minute personal interview with the student researcher (by phone, or in person). Results will be shared with you upon request. All contacts and records will be kept confidential. $20 will be pain to all the participants who complete the study. To ensure confidentially, please contact me by phone at the number below, or you may contact me at my other email address (do *not* use my Walden account). Please leave only your first name and number or email (other then your Walden account), where I can reach you.

Pleas allow your 'voice' to be heard in a way that may make a difference...

Thanks for your attention!

Jill Daniels, Psychotherapist/Psychology Intern
Hypnotherapy Clinic of Southeastern WI
6730 W. Edgerton Avenue
Greenfield, WI. 53220
(414) 281-6612

jwoldan@execpc.com

APPENDIX O
Recruitment Letter to Therapists

Dear Therapist:

Hi! My name is Jill Wollenzien-Daniels, ACSW. I'm a clinical psychotherapist, and psychology intern, working on completing my doctoral degree in psychology at Walden University. I'm conducting a dissertation study with women who have experienced childhood sexual abuse. It is a qualitative study, in which the survivor's account of her abuse will be important. I'm looking for 15 to 20 participants who have a history of childhood sexual abuse, and some degree of posttraumatic symptoms (flashbacks, nightmares, body memories, dissociation, extreme affective states, etc.). I'm particularly interested in discovering if validation through corroborative evidence (evidence from an outside source, e.g., a relative, or medical records, etc.) is a necessary factor in the remediation of their symptoms. Therefore, I will need two groups of survivors: those that have some kind of corroborative evidence, and those who do not have any corroborative evidence. The participants will be "blind" to the issue of "validation through corroborative evidence," and will only know that I'm interested in understanding how their childhood sexual abuse has impacted on them presently.

Although I do not anticipate that this study will present any risks to the participants, and perhaps even be therapeutic for them to "tell their stories;" it is possible that a few could have some extreme emotional reactions. Therefore it is a requirement of this study that participants, either be currently in therapy, working on issues related to their childhood sexual abuse, or have been in therapy previously, for at least 6 months, and worked on issues related to their abuse. All participants must have access to a therapist, should this study elicit reactions that deem this necessary.

As part of the study, I will ask them to fill out three, relatively short assessments: (1) The *Dissociative Experiences Scale*, which will ask questions about the degree to which they dissociate ("space-out," or are not fully conscious/aware in certain situations; like when the mind goes off on a daydream during a boring lecture or routine job); (2) the *Impact of Event Scale*, which asks questions about how certain traumas associated with their childhood abuse experience, affect them presently; (3) and, the *Self-Esteem Rating Scale*, which asks about their feelings of self-worth and self-love. Filling out these assessments should take about 25 to 30 minutes.

After completion of these forms, they will be participating in an interview with me, that will take approximately one hour, which will be audio-taped for accuracy. After I complete my data collection for this study, the tapes will be destroyed. The assessments and

interview should take a total of about 90 minutes. I will interview them either at your office/clinic or a place convenient for them. They will also be given a $20 check upon completion of the assessments and interviews.

If you have any clients who fit these criteria, or know of any who do, please tell them about this study. If they are interested, have them sign the enclosed, "Release of Confidentiality Form," allowing me to contact them and explain more personally the details of the study, or they may call or write me at:

Student Researcher:
Jill Wollenzien-Daniels, ACSW/Psychology Intern
6730 W. Edgerton Avenue
Greenfield, WI. 53220
(414) 281-6612

Thank-you for taking your valuable time to read this letter, and for your cooperation in this matter!

Sincerely,

Jill Wollenzien-Daniels, ACSW, Psychology Intern

APPENDIX P
Recruitment/Informational Letter to Participants

Dear Participant:

Hi! My name is Jill Daniels. I'm a clinical psychotherapist, and psychology intern, working on completing my doctoral degree in clinical psychology at Walden University. I'm conducting a study with women who have experienced childhood sexual abuse, and I'm interested in knowing about how this experience has affected you, and the kinds of symptoms you may be experiencing as a result of your abuse.

I would greatly appreciate your participation in this study, as it will help me and other therapists and researchers gain insight into this sensitive area and improve our understanding, and maybe even our ability to help people who have experienced childhood sexual abuse.

As part of the study, I would like you to volunteer to fill out three, relatively short assessments: (1) The *Dissociative Experiences Scale*, which will ask questions about the degree to which you are not fully conscious/aware in certain situations; like when your mind goes off on a daydream during a boring lecture or routine job; (2) the *Impact of Event Scale*, which asks you questions about how certain traumas associated with your childhood abuse experience, affect you presently; (3) and, the *Self-Esteem Rating Scale*, which asks about your feelings of self-worth and self-love. Filling out these assessments should take about 25 to 30 minutes.

After completion of these forms, you will be participating in an interview with me, that will take approximately one hour. I will be the only one present during that time. However, since we will be dealing with sensitive, emotional issues, you need to have a therapist available that you can consult with during or after the interview, should you feel the need. With your permission, in addition to taking notes, I would also like to tape-record the interview, and after I complete my data collection for this study, the tapes will be destroyed. Although I could ask you to just fill out the assessments, I feel it is important to understand your experiences, and the impact that childhood sexual abuse has had on you personally, in order to better understand how to help you and other survivors in their healing process. Your participation in this study is purely voluntary, and there will be no negative consequences for you, or from any organization that you belong to, should you decide at some future date, to withdraw from this study.

I do not anticipate that this study will present any risk to you; It may even be experienced as a psychologically healthy relief to be able to share your history with

nonjudgmental person, who is interested in hearing what you have to say. However, I also recognize that, talking about your childhood sexual experience may be uncomfortable for you, and that you could possibly have some strong, emotional reactions to it. You will be responsible for paying for any additional treatment that may be required as a direct result of your participation in this study.

The information I gather from you, through the interview, or that you give me on the assessments, will be recorded in anonymous form, using only your first name (or an alias, if you prefer), and the first initial of your last name (e.g., Jill W.). I will not release information about you to anyone else in a way that would identify you. The information you give will be used for my study. But since the purpose of this study is to learn about childhood sexual abuse from the survivor's perspective, and to disseminate that information, it is possible that the information collected in this study could be used in future studies, and for educational purposes.

You will receive a payment of $20 for your participation in this study, which shall be given to you by check, upon completion of the assessments and personal interview. If you decide to withdraw from this study, you will be responsible for returning the $20 payment to the researcher.

You can withdraw from this study at any time, without any penalty, other than repayment of the $20 fee. And the information collected from you up to that point will be destroyed if you so desire.

Once the study is completed, I would be glad to send you the results. In the meantime, if you have any questions, please feel free to call or write me at:

Student Researcher:
Jill Wollenzien-Daniels, ACSW/Psychology Intern
6730 W. Edgerton Avenue
Greenfield, WI. 53220
(414) 281-6612

APPENDIX Q
Curriculum Vita

JILL WOLLENZIEN-DANIELS

PERSONAL DATA

Born: Madison, Wisconsin. May 1st, 1943.

EXPERIENCE

- COUNSELING CENTER OF MILWUAKEE, Milwaukee, WI.
- UPC BEHAVIORAL HEALTH SERVICES, Milwaukee, WI.
- MATT TALBOT RECOVERY CENTER, INC., Milwaukee, WI.
- SOUTHERN WISCONSIN CENTER FOR THE DEVELOPMENTALLY DISABLED, Union Grove, WI.
- BAYSIDE CLINIC, Kenosha, WI.

Psychology Pre-Doctoral Intern, September, 1997—September, 1998
Work experiences included: psychotherapy, psychometric evaluations, intakes and assessments. Treated various multicultural populations with most DSM-IV diagnoses, and a myriad of intervention methods.

HYPNOTHERAPY CLINIC OF SOUTHEASTERN WISCONSIN, Greenfield, WI:
Director/Psychotherapist—April 1991—Present
A state certified, private, outpatient, psychotherapy clinic serving a variety of clients: individuals and groups, adults, children, couples, families, with various DSM-IV diagnoses. Using a plethora of intervention methods. Specializing in Ericksonian Hypnotherapy.

MILTON H. ERICKSON INSTITUTE OF NORTHERN IL., Evanston, IL.
Co-therapist and Co-trainer with Ph.D. Supervisor, 1989—1994
Psychotherapy, hypnotherapy and co-trainer in workshops for health care professionals in methods of Ericksonian psychotherapy and hypnotherapy methods. Use of brief, strategic, and paradoxical intervention methods with variety of clients: individual adults; couples; families. Multicultural.

FAMILY SERVICE OF RACINE, Racine, WI.
Psychotherapist, 1990—1991
Psychotherapy with individual adults, children, groups, couples and

families.

THE INSTITUTE FOR PSYCHOSOCIAL HEALTH, Whitefish Bay, WI.
Psychotherapist, and Co-therapist with ACSW Supervisor, 1982—1992
Psychotherapist and Co-therapist, in private practice facility; working with adults with psychosexual, trauma, and gender-identity issues: Individual adults, couples, groups, and families.

DE PAUL REHABILITATION HOSPITAL, Milwaukee, WI.
Psychotherapist and Co-therapist with ACSW Supervisor, 1981-1982
Student practicum with chemically dependent/abusive individuals, couples, families, groups: adults and adolescents.

PARENTS ANONYMOUS, INC., Whitefish Bay, WI.,
Social Worker, Psychotherapist, 1980—1981
Group facilitator with individual parent perpetrators and/or victims of child abuse. Co-facilitator with MSW supervisor. Head of Speakers' Bureau; workshop presenter.

STATE DEPARTMENT OF HEALTH AND SOCIAL SERVICES: CORRECTIONS, Milwaukee, WI.
Social Worker—Probation/Parole Agent, 1977-1979
Rehabilitation of adult male and female offenders. Purchase of Services Committee member.

CITY OF MILWAUKEE POLICE DEPARTMENT, Milwaukee, WI.
Police Officer, 1976-1977

EDUCATON

WALDEN UNIVERSITY
Doctor of Philosophy—Clinical Psychology—1998
Dissertation: "Validation: The missing-link in childhood sexual abuse?"

UNIVERSITY OF WISCONSIN-MILWUAKEE
Masters of Social Work, 1982

UNIVERSITY OF WISCONSIN-MILWAUKEE
Bachelor of Science—Criminal Justice/Psychology, 1976

SKILLS

- State certified Social Worker.
- State certified Marriage and Family Counselor.
- ACSW and Diplomat status in Social Work.
- Consultant, and certified hypnotherapist through the American Society of Clinical Hypnosis.
- Broad training and experience in psychotherapy and with a variety of intervention and treatment methods
- Extensive training and experience in Ericksonian methods of hypnotherapy and other methods of hypnosis.
- Workshop trainer and facilitator of various methods of psychotherapy and hypnotherapy.
- Extensive training and experience in working with adult and child survivors of childhood traumatic abuse. Teacher of intervention methods for trauma survivors.
- Training and proficiency in trauma resolution; critical incident intervention methods; EMDR; hypnotherapy; imagery rescripting; psychosynthesis; thought field therapy; gestalt; NLP; inner-child work; mind/body methods; internal family systems; sex therapy; paradoxical techniques; solution-focused therapy; cognitive behavior therapy; RBT; and a myriad of other intervention-treatment methods.