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Trauma in Adult Incest Survivors

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TRAUMA IN ADULT INCEST SURVIVORS

by

Jane Kay Hedberg

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Arts
Department of Sociology

Western Michigan University
Kalamazoo, Michigan
December 1994
ACKNOWLEDGEMENTS

I would like to take this time to acknowledge the many people who assisted me in accomplishing this goal. I would like to thank the members of my committee, Dr. Paul L. Wienir, Dr. Subhash Sonnad, and Dr. Jim Petersen for taking the time to participate. As a friend and mentor, Jim Henry, has been invaluable to me in developing this project. Without the support of my mom, Nellie Hedberg, who always has emphasized the importance of education, and provided daycare to my son so I could study, I could not have finished. I am thankful to those professionals in the human services community who were supportive of my study. I cannot fully express my gratitude to those participants who were willing to share their painful experiences with me. And finally, I would acknowledge my late husband, Scott William Barnhardt, for his support in my research, and for giving me the idea in the first place.

Jane Kay Hedberg
This study explored the traumatic effect of childhood incestuous abuse on the adult survivor. Eleven subjects were interviewed for this study. Hindman's (1989) trauma scale was revised, exploring issues of relationships, mental health, and living skills dysfunctions. In addition to the global score, the scale was disaggregated. Relationships between trauma and age at onset, physical and emotional violence, frequency, identification of self as victim, current relationship with offender, and response to disclosure were explored.

Several dimensions of feeling responsible were reported by victims, including feeling that there was something about them that made others victimize them, feeling responsible for protecting younger siblings, and feeling obligated to meet the offenders' needs. Previous researchers have not explored these differences. The two most prevalent outcomes of abuse cited by respondents were depression and difficulty in trusting others.
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CHAPTER I

BACKGROUND OF THE PROBLEM

Significance of the Problem

It has been estimated that as many as one-fourth of all females and one-tenth of all males suffer from some unwanted sexual contact before the age of eighteen (Dominelli, 1989; Furby, Weinrott, & Blackshaw, 1989). While our identification of the prevalence of incest is relatively new, incest itself is not. Freud, whose theories continue to influence psychological and sociological thought, frequently discussed his patients' "fantasies" of molestation (Freud, 1933). As the human services field becomes inundated with adult survivors and child victims in need of service, a comprehensive understanding of the needs of this population is necessary. A model for understanding the long and short-term effects of incest, and how to treat them is a necessity for the human services professions.

One area of study about incest is the traumatic impact it has on victims. Many singular aspects of trauma, such as depression (Finklehor & Browne, 1985; Morrow & Sorrell, 1989; Frazier, 1991; Benward & Densen-Gerber,
Briere & Zaidi, 1989), anxiety (Benward & Densen-Gerber, 1985; Heath, Donnann, & Halpin, 1990), and substance abuse (Carson, Council, & Volk, 1988) have been studied by numerous researchers. Research on global trauma issues has been severely lacking. Hindman (1989) has looked at trauma as a global issue which affects many areas of the victim’s life. She explored numerous factors of trauma to which she then assigned a global score, but she did not look at separate components of trauma.

It is hoped that this project will provide a more comprehensive understanding of the varied response patterns of victims to sexual violence during childhood by looking at the separate components of trauma and trauma as a global score. In addition, I will explore other childhood experiences which may exacerbate the overall trauma. These include family dysfunctions such as child abuse, neglect, emotional abuse, substance abuse by parents, domestic violence between parents, and mental illness in family of origin. Individuals process stressful events in different ways, experiencing difficulty in various areas of life with some seeming to cope more effectively than others. Developing an understanding of the many areas of life which can be affected by childhood trauma, and how people process traumatic events is paramount to dealing with the treatment needs of the increasing number of
Review of Literature

The literature about the impact of incest tends to focus on individual aspects of psychological, relationship, and living skills dysfunctions found among victims.

Psychological Effects

Numerous researchers have looked at the psychological trauma of incest. Dissociative disorders such as Borderline Personality Disorder (BPD), Post-traumatic Stress Disorder (PTSD), and Multiple Personality Disorder (MPD) have been found to be particularly prevalent among adult incest survivors. Briere and Runtz (1988) discovered that PTSD symptoms occurred much more frequently in adult incest victims than in non-victims in a psychiatric facility. Briere and Zaidi (1989) found similar results in a study of a psychiatric hospital’s emergency room. In a case study of twenty adult incest survivors by Goodwin, Cheeves, and Connell (1990), a significant number had BPD, MPD, PTSD, and other dissociative disorders. Coons and Milstein (1986) reported that more than half of the MPD patients they studied were survivors of childhood physical and/or sexual abuse.

In addition to these severe psychological disorders, Briere & Runtz (1988) cited anxiety, impaired self-refer-
ence, and cognitive distortions as related to post-childhood abuse. Benward and Densen-Gerber (1985) described incest survivors in a substance abuse study as having elevated levels of depression and anxiety in comparison to non-victims. After reviewing 188 randomly chosen files of patients at an inpatient psychiatric facility, Carmen, Rieker, and Mills (1982) found that sexual abuse victims represent nearly half of the patients studied, and as a group had longer stays and were unable to manage anger appropriately. Rape victims who were also incest survivors were more likely to have depressive symptoms and blame themselves for their attacks than non-incest survivor rape victims (Frazier, 1991). Heath et al. (1990) determined that incest victims had elevated levels of depression, hostility, and anxiety.

Life Skills

Life skills dysfunctions such as substance abuse are prevalent in adult incest survivors. Carson et al. (1988) found that as many as 50% of women seeking inpatient substance abuse treatment were incest survivors. In a study by Benward et al. (1985), 44% of women in a substance abuse facility were incest survivors. Goodwin et al. (1990) and Briere and Runtz (1986) determined that suicidal ideation and behavior occurred more frequently
among incest survivors in inpatient psychiatric treatment than among patients who were not incest survivors.

Relationships

Relationships can be more difficult for incest survivors. Carson, Gertz, Donaldson, and Wonderlich (1990) characterized incest survivors as lacking in empathy and trust, having diminished social skills and having poor self-esteem. Finkelhor and Browne (1985) conceptualized feelings of stigmatization, powerlessness and lack of trust to be potential outcomes of incest, all of which may make relationships difficult. Resick and Schnicke (1990), in a comparison of victims to non-victims determined that victims have lower self-esteem, more depression, poor social adjustment, and dissatisfaction with their sex lives. These issues can make developing trusting, healthy relationships difficult.

Establishing Differences Between Victims

Some researchers have attempted to ascertain the causes of differences in functioning levels of victims. Morrow and Sorrell (1989) correlated lower self-esteem in adolescent victims to negative responses by their mothers to disclosure. Parker and Parker (1991) found incest victims who were raised in homes without other family
dysfunction were emotionally more healthy than victims who were raised in abusive and/or neglectful homes. It is more common that the family dynamics involved in an incestuous situation are rather complicated, and may include domestic violence, physical abuse and neglect of children, and substance abuse by one or more parents. Incestuous families were marked with a sense of rigidity but a lack of boundaries, individualism and personal control (Carson et al., 1990). Dominelli (1989) focused on the lack of power victims and the non-offending parents have in the incestuous family. Incest victims described being estranged from their mothers even before the abuse began, and to be in a role of caretaking for their mothers and perpetrators (Herman & Hirschman, 1977).

**Hindman: A Comprehensive View of Incest Trauma**

Hindman (1989) evaluated a group of incest survivors in therapy to determine what factors were related to elevated levels of trauma. She categorized victims into four levels of trauma, labeled as "primary severe", secondary severe", "moderate" and "minimal". She defined trauma as a three-part equation of relationship, psychological, and living skills dysfunctions, with a total of eleven factors in these categories. She found severely traumatized victims had: (a) experienced sexual respon-
siveness to their victimization, (b) been terrorized during the abuse, (c) distorted identification of victim and perpetrator roles by blaming themselves for the abuse, (d) withheld disclosure, (e) experienced a negative reaction to disclosure, (f) were in a continued unhealthy relationship with the perpetrator (or in a "trauma bond" in that those significant to the victim continued to have contact with the perpetrator), and (g) used cognitive distortions to avoid psychological pain of the abuse.

The minimally traumatized were more likely to have a clear identification of perpetrator and victim roles, reported soon after the abuse occurred, and received emotional support in reaction to disclosure. Hindman found that the traditionally examined characteristics of penetration, age at onset, number of incidents, and use of violence were not reliable predictors of trauma. These factors are based on legal definitions of severity of offense rather than on the actual process of trauma.

The originality and strength of Hindman’s work is in her comparison of victims experiencing varying degrees of trauma and in her synthesis of the numerous potential aspects of life which could potentially be affected by incestuous victimization. Her attempts to clarify differences between victims have been very useful in understanding the process of trauma and how that can differ
from victim to victim, depending on the characteristics of their victimization.

Critique of Hindman’s Research

Using Hindman’s conceptualization of trauma with some modifications could enhance understanding of the treatment needs of survivors of various types of childhood trauma. First, Hindman looked at trauma as a collective score without examining the separate components of the trauma score. It may be more illuminating to look at the separate dimensions of trauma to determine if there are differences in the etiology of trauma or in the lasting impact of trauma on survivors. Second, Hindman’s technique required intensive long term therapeutic intervention to gather information for analysis. A short-term research oriented approach might allow for assessment of similar issues in a more time-effective manner. Third, Hindman focused on the effects of incest without also exploring issues of other childhood trauma, such as physical abuse, the dynamics of which may exacerbate the client’s functioning.

Statement of Research Questions

Replication and Modification of Hindman’s Work

A central part of this research project is to assess
trauma in adult incest survivors using similar components as Hindman employed in a one-time research oriented interview session, as opposed to lengthy therapeutic involvement. While it is not possible to assess whether the same findings would occur if the same sample were studied longitudinally, it is possible to address the issues Hindman defined as indicative of trauma to see if respondents can provide answers which indicate some meaningful differences in overall trauma.

In addition, I set out to assess whether some elements of Hindman's conceptualization of trauma are more prevalent than others, and if disaggregating Hindman's scale leads to a more comprehensive understanding of the process of trauma. This addresses deficits in looking only at trauma as a global issue, as Hindman did and in looking at singular aspects of trauma, as many researchers have.

The following questions are drawn from Hindman's work. She critiqued the current model assessing trauma, which is based on legal system definitions. Assumptions about age at onset, frequency, and use of violence come from legal definitions that determine the punishments for various sexual offenses. In this legal system model, it is assumed that victimization at younger age, violence, and more frequent events (offenses) are more damaging to
victims. Hindman found other variables, such as response to disclosure, continued unhealthy relationship with offender, terror during abuse, and feeling responsible for one's victimization as more significant factors in the etiology of trauma.

Are Age at Onset of Incest and Trauma Related?

Hindman found that age at onset was not a significant factor, although those traumatized before puberty tended to have a higher level trauma. This may have been related to the number of years of incest, as people victimized at younger ages were typically victimized more frequently.

What Is the Relationship Between Violence During Incestuous Assault and Trauma?

Hindman found that physical violence was not related to elevated trauma, but emotional violence was. In exploring these issues, a distinction needs to be made between physical and emotional violence (terror). Terror could include lengthy anticipation of impending abuse, bizarre sex acts, ritualism, or threats to one's life to gain compliance and maintain silence (Hindman 1989).
Are Respondents Who Are Victimized More Frequently Likely to Have Elevated Levels of Trauma?

Hindman found that number of incidents is not related to trauma, although legal systems models persist in defining it as more traumatic. While it may be an issue, it is not as significant as the other previously stated factors on which she focused.

What Impact Does Disclosure and Its Aftermath Have on Trauma?

Hindman found that not disclosing during childhood or negative response to disclosure were closely linked to overall trauma.

The key issues in disclosure for the victim are power and trust. The individual who did not feel protected and supported in disclosure would be likely to experience difficulties in the development of intimate trusting relationships.

What Impact Does Current Relationships With the Offender ("Trauma Bond") Have on Trauma?

Hindman coined "trauma bond" to indicate a continued direct or indirect relationship with the offender which is not healthy. It is a continuation of contact, or of significant others having a continued relationship without recognition of the significance of the abuse to
the victim. A trauma bond could continue past the offender’s death if the client is unsupported as victim and others in the family extol the late offender’s virtues. A victim could be in a continued healthy relationship with the offender, which would not be defined as a trauma bond.

**Do Feelings of Responsibility for Victimization Have Any Bearing on Trauma?**

Hindman (1989) and other researchers (Sagatun & Prince, 1988; Corder & Haizlip, 1989) have found that identification of self as victim and the offender as the responsible party are clearly linked to overall emotional health. This can become clouded for individuals who have been conditioned to feel responsible, blamed for telling, or who experienced some physical arousal to the abuse.

**Other Research Questions**

In addition to these questions from Hindman’s work, the following additional questions are also explored in this study, the rationale for their inclusion following each question.

**What Effect Does the Presence of Other Family Dysfunction Have on Trauma?**

As cited before, Parker and Parker (1991) found that incest victims who were raised in otherwise normal
homes were healthier than victims who experienced substance abuse, mental illness, domestic violence, or physical abuse in their families of origin. Goodwin et al. (1990) determined that PTSD symptoms were more likely to occur in victims of childhood traumas, including sexual and physical abuse.

**Do Incest Survivors Experience Difficulty With Trust, Depression, Anxiety, and Dissociation?**

These have been found to be significant by other researchers (Heath et al., 1990; Finklehor & Brown, 1985; Carson et al., 1990; Frazier, 1991; Goodwin et al., 1990; Heath et al., 1990; Jackson, Calhoun, Amick, Maddever, & Habif, 1990; Benward & Densen-Gerber, 1985; Briere & Runtz, 1989; Briere & Zaidi, 1989; Coons & Milstein, 1986). These issues were not adequately addressed in Hindman's conceptualization of trauma. For example, trust, a significant part of forming relationships is not included in relationship dysfunction. Depression, anxiety, and dissociation would only be evident at clinical levels in her scale, although less severe demonstrations of these symptoms may be indicative of trauma as well.

**How Do Victims Perceive the Effects of Victimization?**

One final area of interest is in what victims per-
ceive as the traumatic impact incest has had on various aspects of their lives, and what the process of healing through their experiences has been. The goal behind this research is to gain an understanding from survivors of incest, and stems from a firm philosophical belief that people who volunteer for research are not subjects or objects, but rather active participants in a joint effort toward understanding. As such, respondents were asked to describe their perceptions of their own experiences, in addition to exploring issues that other researchers have found significant. This is to determine to what extent current research reflects the needs of the population of incest survivors, or if there are other issues which need to be addressed in further research.
CHAPTER II

METHODS

Participants

Sample Selection

A sample of known incest survivors who are currently in therapy in the Kalamazoo area were interviewed about their current and past family of origin relationships, their incestuous experiences, and their current status in terms of mental health, relationships, and substance abuse. Finding participants proved difficult. Members of the human services community who specifically work with incest cases were informed that the research was being done with an initial telephone contact outlining the project. If they expressed interest, then a copy of the interview script, a letter to potential respondents, and instructions on how to inform clients without any hint of coercion was mailed. Interested clients then contacted me directly for further information and to schedule an interview. Several therapists who were contacted declined to notify clients for various reasons, including fear of further trauma to their clients, concerns about potential liability if they recommended par-
ticipation, and lack of identified incest survivors among current clientele. Some therapists were interested in the project, however none of their clients were interested in participating. A group of therapists previously thought to have several potential respondents had participated in several other recent projects on similar topics and declined on the basis of not wanting to overwhelm their clients. After diligently pursuing participants for several months, a total of eleven people offered to participate. Three others expressed interest by calling me for more information and stated they would be interested but did not return my telephone calls to set up an interview.

The Human Subjects Institutional Review Board approved the process of obtaining respondents and the proposed subject matter of the interviews.

Characteristics of Participants

A total of eleven women between the ages of 18 and 55 participated. Five had achieved at least a Bachelor’s degree. Three had completed high school and gone no further. Three were actively or in the recent past attending college. Three were black, the remainder were white.

Six of the respondents were married, and one has been in a long-term live-in relationship for twelve years. One has had a live-in partner for a few months.
Four had no current relationships. Four reported having been involved in Lesbian relationships, either currently or in the past. Seven of the respondents had been sexually victimized during childhood by multiple offenders, four had been sexually abused by only one offender. Offenders were (step)brothers in two cases, stepfathers or mothers' boyfriends in three cases, mothers in two cases, grandfathers in two cases, fathers in six cases, and in-laws in two cases.

A total of six respondents were employed in human services positions. This may reflect a tendency for children of dysfunctional families to gravitate towards helping professions, but it is more likely due to the way in which the research was publicized. Two respondents did cite their dysfunctional upbringing as causative in their career choices.

Limitations of the Sample

The sample was drawn in a limited geographic area with no random selection. Due to the subject matter, and the exploratory nature of this study, an anonymous questionnaire was ruled out. Asking questions about past victimization, mental health issues, and substance abuse through a randomly mailed questionnaire would have been contrary to potential respondents' best interests given that strong feelings could erupt with no one to debrief
with the respondent. In the case of this sample of generally high-functioning individuals who had a therapist with whom they were working through issues, there were few difficulties in addressing the questions asked. In addition, a face to face interview allowed for observation of non-verbal cues such as facial expression to further assess the feelings associated with childhood events, and for re-directing to clarify the reasons behind responses. In an exploratory study such as this, the respondents actively participate in identifying what the issues of research need to be. It is not possible to accommodate such research needs in a mailed questionnaire.

Incest survivors who had some current involvement with therapy were determined most suitable for the study. Many therapists declined to participate, and those who did were selective in letting only clients they felt could handle the pressures of an interview know about the research.

The sample size is very small, despite much effort put forth in obtaining participants. This does not indicate a lack of incest survivors in the area, but rather a resistance to discussing trauma and victimization with a stranger. Given the subject matter this is understandable. The sample lacks in ethnic and gender variability, and is overall highly educated. There is a significant
self-selection bias which may influence overall trauma scores to be lower than would be representative of incest survivors as a whole. In addition, all participants are in therapy, which may tend to give an over-representation of some aspects of the study such as depression.

Measurements

Developing a Modified Trauma Scale

The interview script designed for this project, which was primarily based on Jan Hindman's work, was developed to measure trauma in adult incest survivors using similar conceptualizations and to address the specific research questions previously outlined. Some of the issues that she explored were not included in this research project, due to difficulty in definitions, potential for negative response from respondents, or barriers to assessment of variables in a single session. Rather than using the eleven indicators of overall trauma which Hindman employed, a total of six were used.

The factors used for this study were: Interpersonal Adjustments in Relationships, Child Interpersonal Relationship Difficulties, Mental Health Involvement, Depression/Suicidality, Substance Abuse, and Anger Mismanagement. The following table presents a summary of the differences between Hindman's scale and the scale used
for this project.

Table 1

Summary of Differences Between Trauma Scales

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<tbody>
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<tr>
<td>Number of Relationships</td>
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</tr>
<tr>
<td>Relationship Adjustment</td>
<td>Yes</td>
</tr>
<tr>
<td>Child Relationship Difficulties</td>
<td>Modified</td>
</tr>
<tr>
<td>Sexual Dysfunction</td>
<td>No</td>
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<tr>
<td>PSYCHOLOGICAL DYSFUNCTION</td>
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<tr>
<td>Mental Health Involvement</td>
<td>Yes</td>
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<tr>
<td>Mental Health Diagnosis</td>
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<td>LIVING SKILLS DYSFUNCTION</td>
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<td>Criminal Behavior</td>
<td>No</td>
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<tr>
<td>Substance Abuse</td>
<td>Yes</td>
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<td>Vocational Problems</td>
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<td>Anger Mismanagement</td>
<td>Yes</td>
</tr>
<tr>
<td>Self Abusive Behaviors</td>
<td>Modified</td>
</tr>
</tbody>
</table>

Omissions to Hindman’s Scale

Number of relationships and sexual relationship dysfunction were not included due to the potential for negative response from participants. Issues of sexuality,
frigidity, and promiscuity seemed to potentially offensive to respondents who are already being asked to disclose very personal issues.

Although Hindman included diagnosis of a DSM III-R classification, it is not feasible in a one-shot interview by anyone other than a fully licensed psychologist, and thus was not included in this study. Respondents were asked about their involvement in psychological services.

Hindman defined minimally traumatized respondents in this category as engaging in criminal behavior without legal intervention. Trying to obtain such information may put the researcher in a compromising position if unprosecuted criminal behavior were disclosed during the course of the interview. Hindman also included academic and career problems the respondent attributes to the abuse. Her definition incorporated school phobias or immobility caused by incestuous abuse rather than other factors such as learning disabilities, which would be difficult to assess in one interview.

Modifications to Hindman’s Factors

While Hindman put suicidal behavior and ideation under the heading of Living Skills Dysfunction, it is more appropriately put under the heading of Psychological Dys-
function, given that depression and suicidal behavior as an outcome of depression are clearly indicative of mental illness. This doesn’t change the score, only the factor’s location.

Hindman defined child interpersonal relationship adjustment as either protective services contact or self-described abusive parenting which didn’t draw the attention of child protective services. This definition was problematic in several ways. First, although I warned respondents that I would need to notify Protective Services if they reported abuse to me, I did not want to set up the project to consistently have to do so. Also, as a Child Protective Services worker, it has been my experience that parents frequently do not perceive discipline as abusive even when it fits the legal definition of abuse, thus calling into question the validity of any responses received with this definition.

Scores for the Modified Trauma Scale

Hindman’s original scale with eleven elements of trauma had a possible high score of 33 points. Scores of 33-28 were Primary Severe, 27-14 were Secondary Severe, 13-1 were Moderate and 0 was Minimal. To be placed in the Primary Severe category, the respondent would have to score a 3 on at least half of the items, and not have any
responses in the moderate or minimal categories. Asympto­
tomatic clients scored 0.

The highest total score on the modified scale used
for this project is eighteen points for someone who is a
parent or fifteen points for a non-parent who scored in
the primary severe range on all categories. This was
obtained by assigning a score of zero to three for res­
ponses to each of the relevant components of trauma
(interpersonal relationship dysfunction, child inter­
personal relationship difficulties, depression, mental
health involvement, substance abuse and anger) and then
adding those scores. The issue of child interpersonal
relationship difficulties was eliminated for non-parents.
To make comparison of respondents who have children and
those who do not more meaningful, scores were translated
into proportions based on possible totals of either
eighteen or fifteen. Scores on the modified trauma scale
used for this study were put into three categories of
high, medium, and low levels of trauma. With a larger
sample, it would be feasible to treat the trauma scores
as interval level data to reflect the variation of scores
more fully than would be possible in looking at them as
fitting into ordinal categories.
Measurement and Scoring of Each Trauma Score Factor

This section will include a discussion of how information was gathered and the scoring for each of the six elements of the Trauma Scale. Each factor will be assigned a score between zero and three, as Hindman did, with higher numbers indicating higher trauma. A copy of the interview script can be found in Appendix A, although this provided an outline of questions rather than a verbatim script. Interviews varied in content, with redirecting questions, clarifications, and validation differing based on the respondents' individual needs.

Interpersonal Relationship Adjustments

The issues examined in the area of interpersonal adjustments in relationships included domestic violence, symbiosis with family of origin member, rejection by family of origin, extra-marital relationships for self or partner, excessive verbal conflict with partner, and feeling unable or unwilling to attempt relationships. Respondents who described three or more of these indicators were given a score of three, two of the indicators were given a score of two, one indicator meant a score of one, and no indicators meant a score of zero.
Child Interpersonal Relationship Difficulties

Child interpersonal relationship difficulties were assessed by asking if the participant had ever had contact with Child Protective Services, and if so, what the extent of the contact was. A score of three was assigned if the respondent had a child removed, or had CPS intervention more than three times. If the participant had Protective Services intervention less than three times, and with no court involvement, a score of two was designated. A score of one was assigned if Protective Services has investigated but did not determine abuse or neglect to have occurred. A zero was assigned if there had never been any contact with Protective Services.

Mental Health Involvement

Respondents were first asked about the nature and extent of any therapy they had received and whether they ever had inpatient treatment. Those who had received inpatient psychiatric treatment were given a score of three. Those who had received outpatient psychiatric treatment, for more than one year, but never been inpatient were given a score of two. Clients who had received outpatient treatment for less than one year were given a score of one. There were no scores of zero, as all participants were actively in counseling as a pre-
requisite for participating in the study.

**Depression/Suicidality**

Respondents were asked if they had any difficulties with depression, and if they had been suicidal at any point in their lives. Respondents who reported one or more suicide attempts or self-mutilation necessitating mental health intervention and/or injury to self were given a score of three. One suicide attempt or self-mutilation, with or without significant injury or mental health involvement, or more than one suicide attempt that did not result in injury or mental health involvement, or ongoing problems with clinical depression that have lasted for more than one year was given a score of two. Suicidal ideation/depression lasting less than one year without suicide attempts and without mental health involvement was given a score of one. Those who reported no depression or suicidal ideation were given a score of zero.

**Substance Abuse**

Respondents were asked if they had ever had treatment for substance abuse issues, or if they ever thought treatment was necessary. Those who had treatment were asked if they were voluntary or involuntary participants
in treatment and if the treatment was inpatient or outpatient. A score of three was assigned if the respondent had inpatient substance abuse treatment, or mandated outpatient treatment. A score of two was assigned in cases of voluntary outpatient treatment, and a score of one if there were a few instances of out of control behavior without requiring treatment. Zero indicated that there were never any problems with substances.

Anger Mismanagement

Anger mismanagement was assessed by asking if the individual had problems with their temper. Respondents who indicated that they did were asked to rate their temper on a scale of one to three, with three indicating that level of anger caused injury to self or others with intervention from an outside agency necessary, two signifying out of control rages with damage to victim's property or loss of jobs or friendships, one indicating uncontrollable feelings of outrage without loss of control, and zero indicating no problem with outburst or feelings of anger. Scores assigned were directly from the respondents' self-rating of 0 to 3.

Measurement of Independent Variables

In the following section, definitions and measure-
ments of independent variables will be presented. The independent variables, as drawn from the previously stated research questions are: age at onset, violence experienced during the sexual abuse, frequency and duration, aftermath of disclosure and failure to disclose abuse during childhood, 'trauma bond' (as coined by Hindman), feelings of responsibility for the abuse, and other family dysfunction. For the most part these were scored on a standard one to five scale, with examples of the extreme scores given to respondents to aid them in rating each item.

Age at Onset

Age at onset was measured by asking participants how old they were when they were first sexually abused. This was recorded in years when possible, with notation on the interview script if the respondent approximated or gave an adjective description such as "infancy" or "before Kindergarten".

Violence During Abuse

Violence during abuse was assessed and scored by asking respondents to assess on a scale from one to five how emotionally and physically violent the assaults were. In the case of emotional violence, respondents were given
examples of one indicating the offender neglecting the respondents' needs to not be victimized and five indicating the use of threats against their lives or physical well-being; in the case of physical violence, one indicated no physical pain to client, and five indicated severe physical pain, as in the case of forced penetration. Using a one to five scale allowed for an assessment of level of violence without traumatizing respondents by asking for detailed descriptions of their abuse.

Duration of Abuse

Duration of abuse was assessed by asking how old they were when the abuse began and how old when it stopped. This became difficult at times to assess with people who had previously repressed memories of their victimization; as a result the information obtained was their earliest and latest memories. Respondents were also asked how frequently the abuse took place, which generated either frequency in a short time frame (i.e. 'once a week for a year'), a specific number of very few incidents ('it only happened once with him'), or an inability to approximate.

Disclosure

Respondents were asked whether they disclosed the
abuse during childhood, and if so what the response to disclosure was with one being favorable and five being disastrous. This frequently generated discussion about the specific outcomes of disclosure in adulthood, and about the outcome and process of disclosure in adulthood for those who did not disclose as children, and inhibitors to disclosure.

**Trauma Bond**

Trauma bond, as used by Hindman, indicated a continued unhealthy bond to the perpetrator by the incest survivor or by those close to the survivor. This was assessed by asking if the respondent still saw the perpetrator, and how that felt on a scale of 1 to 5 with 1 being not a problem and 5 being very much a problem. The questions were modified in the cases of deceased perpetrators to reflect what was going on up until the time he/she passed away. The same issues were also covered in terms of the respondent's response to others in the family being in a continued relationship with the perpetrator. Further information about the quality of the relationships with offenders was given by most respondents without a need to probe further. This is a subjective measure of the quality of the respondents' relationship with the offender to assess how victims current-
ly feel about offenders.

**Feelings of Responsibility for Abuse**

Perceptions of roles and role responsibility is central to working through trauma. Respondents’ perceptions of role responsibility were assessed by asking Did you ever feel responsible for the abuse, and if so what made you feel responsible? This was not scaled, but evaluated qualitatively to determine similarities and differences.

**Other Family Dysfunction**

Other family dysfunction for the purposes of this study was assessed by asking respondents if any of the following had occurred in the family of origin: domestic violence between parents or parent and step-parent, substance abuse by either parent or step-parent, or physical violence towards children in the home in addition to the sexual abuse. Physical violence in the home was assessed on a five-point scale, with one signifying a parent causing pain but no injury and five causing injury significant enough to necessitate medical injury. Other variables were designated as either present or absent.

Responses to these questions typically generated further details from the respondent about what was hap-
pening in the family of origin during their childhoods and what is currently going on.

Measurement of Other Dependent Variables

Respondents were asked what the impact of incestuous abuse was from their perspective, to see how prevalent trust, depression, dissociation and anxiety attributed to abuse are. In a few cases respondents were asked if they experienced any of these symptoms, or if they thought these symptoms which they previously reported were related to being sexually abused.
CHAPTER III

FINDINGS

Trauma Scores

The range of overall trauma scores was from .33 to .72. The data were then put into categories of 'high' (.67-.72), 'medium' (.50-.66), and 'low' (.33-.49) due to the small number of participants. This ordinal configuration divided the number of participants approximately into three groups of equal size. There were a total of three respondents in the high category, four in the medium category, and four in the low category.

The Trauma scale was disaggregated to evaluate whether relationships between separate elements of the scale and independent variables were more evident than the overall score. A subscale of mental health involvement, relationship dysfunction, and suicidal ideation or behavior and depression was made due to similarities in variation of those components of overall trauma. Sub-scales of Hindman’s three categories of Relationship, Living Skills, and Psychological Dysfunctions did not seem to produce any further illumination.

Tabular comparisons of overall Trauma scores, the
subscale, and individual components of the trauma scale to each of the independent variables and to each other were done to determine if patterns emerged with regards to each of the research questions. Only those tables indicating relationships are included. The following table presents comparisons of components of subscale, subscore and overall trauma.

Table 2
Summary of Overall Trauma Scores and Components of Subscale

<table>
<thead>
<tr>
<th>Respondent #</th>
<th>Trauma Score</th>
<th>Relationships</th>
<th>Mental Health</th>
<th>Depression</th>
<th>Suicide</th>
<th>Subscore</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>.72</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>#2</td>
<td>.67</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>#3</td>
<td>.67</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>#4</td>
<td>.61</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>#5</td>
<td>.61</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>#6</td>
<td>.50</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>#7</td>
<td>.50</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>#8</td>
<td>.44</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>#9</td>
<td>.39</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>#10</td>
<td>.39</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>#11</td>
<td>.33</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

The rationale for considering interpersonal adjustment in relationships, mental health involvement and suicidal ideation/depression as a subscale is evident in the previous table in terms of the covariance of the three factors.

The following table provides overall trauma scores and the remaining individual trauma factors of relationship with children, substance abuse, and anger, which
were less prevalent among respondents.

### Table 3

Overall Trauma Scores and Trauma Factors

<table>
<thead>
<tr>
<th>Respondent #</th>
<th>Trauma Score</th>
<th>Child Problems</th>
<th>Substance Abuse</th>
<th>Anger</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>.72</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>#2</td>
<td>.67</td>
<td>No child</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>#3</td>
<td>.67</td>
<td>No child</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>#4</td>
<td>.61</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>#5</td>
<td>.61</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>#6</td>
<td>.50</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>#7</td>
<td>.50</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>#8</td>
<td>.44</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>#9</td>
<td>.39</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>#10</td>
<td>.39</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>#11</td>
<td>.33</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Analysis of Trauma Scores and Research Questions

**Age at Onset**

A slight relationship was seen between age at onset of abuse and overall trauma, with respondents victimized for the first time at age 7 or after tending to exhibit higher levels of overall trauma. There was no indication of a relationship between the Mental Health/Relationship/Depression subscale and age at onset. Upon analysis of separate components, it is evident that the differences are most pronounced in the area of Interpersonal Adjustments in Relationships. This is illustrated in the fol-
Following tables.

### Table 4

<table>
<thead>
<tr>
<th>Overall Trauma Score</th>
<th>Age 1-3</th>
<th>Age 7-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>High n=3</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Medium n=4</td>
<td></td>
<td>57%</td>
</tr>
<tr>
<td>Low n=3</td>
<td>n=1</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Table 5

<table>
<thead>
<tr>
<th>Relationship Adjustment Score</th>
<th>Age 1-3</th>
<th>Age 7-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>n=2</td>
<td>n=2</td>
</tr>
<tr>
<td></td>
<td>28.5%</td>
<td>50%</td>
</tr>
<tr>
<td>2</td>
<td>n=4</td>
<td>n=1</td>
</tr>
<tr>
<td></td>
<td>57%</td>
<td>25%</td>
</tr>
<tr>
<td>1</td>
<td>n=1</td>
<td>n=1</td>
</tr>
<tr>
<td></td>
<td>14.5%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Violence and Trauma

A tabular analysis of overall Trauma, of the Relationship Dysfunction/Mental Health/Depression subscale
and of separate components showed no relationship between emotional violence and trauma. A slight tendency toward higher levels of physical violence during incestuous abuse and lower levels of overall trauma can be seen in the following chart, although analyzing the subscales and individual components of trauma provided no further illumination.

Table 6

<table>
<thead>
<tr>
<th>Overall Trauma Category</th>
<th>1 (No Pain)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (Severe Pain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>n=2</td>
<td>n=1</td>
<td></td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>n=2</td>
<td>n=1</td>
<td></td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>n=1</td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Frequency and Duration

There were not sufficient differences between respondents in this study to analyze. All respondents reported being sexually abused on an ongoing basis by at least one offender. In addition, individuals who repressed memories could not approximate the number of incidents. Clients were able to state approximately how old
they were when the abuse stopped. Time frames ranged from one to fourteen years, but there were no relationships between trauma and duration evident.

Aftermath of Disclosure and Trauma

Tabular analysis showed a slight relationship between negative response to disclosure and elevated levels of trauma. By disaggregating the Trauma Score, it became clear that Interpersonal Adjustments in Relationships was the area most impacted by response to disclosure, as there were no relationships between the other components and response to disclosure.

Table 7

Response to Disclosure and Trauma Score Category

<table>
<thead>
<tr>
<th>Trauma Score Category</th>
<th>1 Favorable</th>
<th>3 Neutral</th>
<th>5 Disaster</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td></td>
<td></td>
<td>n=2 (67%)</td>
</tr>
<tr>
<td>Medium</td>
<td>n=1 (67%)</td>
<td></td>
<td>n=1 (33%)</td>
</tr>
<tr>
<td>Low</td>
<td>n=1 (33%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Six respondents disclosed sexual abuse during childhood, and all chose a score of either "very favorable" (one) or "disastrous" (five) to describe responses to disclosure. No relationship between failure to disclose and trauma was seen. Five respondents did not disclose
the abuse during their childhood. Failure to disclose was not related to elevated levels of trauma.

Table 8
Response to Disclosure and Interpersonal Relationship Adjustment

<table>
<thead>
<tr>
<th>Relationship Adjustment Score</th>
<th>1 Favorable</th>
<th>3 Neutral</th>
<th>5 Disaster</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (High)</td>
<td>n=2</td>
<td></td>
<td>67%</td>
</tr>
<tr>
<td>2 (Medium)</td>
<td>n=2</td>
<td>n=1</td>
<td>67% 33%</td>
</tr>
<tr>
<td>1 (Low)</td>
<td>n=1</td>
<td></td>
<td>33%</td>
</tr>
</tbody>
</table>

Trauma Bond

All of the respondents in this study had some type of trauma bond with the offenders. There were qualitative differences between the respondents’ experiences of trauma bonds which did not lend itself to easy evaluation.

Those in the low trauma category and one in the moderate category reported continued contact with the offender, which they defined as problematic. They had developed coping strategies around continued contact, including limited visits and rehearsal. They did not de-
fine the offender's relationships with other family members as problematic for themselves. The respondents in the high trauma category reported not seeing the offender(s) and not wanting to see him (them). The most important elements of the trauma bond for these three respondents was in the continued relationships between the offenders and close family members. Two of the three in the moderate category reported that they and their family did not have contact with the offender, which was disturbing for them because they wanted to have a normal relationship with him but realize this is not possible.

Responsibility for Abuse

Eight of the eleven respondents felt some responsibility for their victimization at the time of their abuse, although all report that they do not feel that way now. Three reported not feeling responsible, although two of these felt they would be blamed or considered 'damaged' by others. There was no relationship between trauma and how respondents defined responsibility.

Other Family of Origin Dysfunction

All of the respondents in this study reported other family dysfunction in addition to the sexual abuse they suffered. Ten reported physical abuse of children in the
home, with six stating incidents were violent enough to require medical treatment, two stating parents were out of control when disciplining and caused pain but no injury, and one reporting some injuries without need for medical attention. Six reported overt emotional abuse, including demeaning children, blaming them for things beyond their control, name calling, and screaming. Seven reported alcoholism or substance abuse by one of their parents. Two reported suicides by immediate family members. Three reported domestic violence, and another three excessive verbal abuse between parents. Four reported specific children in the family in scapegoat roles.

No relationships between physical and emotional abuse, substance abuse by parents, and trauma were found. The only two respondents who reported substance abuse problems came from families in which substance abuse was prevalent, but six other respondents who did not have histories of substance abuse also came from substance abusing families. The three respondents in the high trauma category were the only ones who reported knowledge of physical domestic violence between their parents. Two of them also reported suicides in their immediate family. These significant life events contributed to their overall trauma, making attribution of the etiology of their
trauma difficult.

Respondents reported difficulty in sorting out what specific traumatic childhood events were the most damaging to them.

Other Research Questions

Trust

Trust was cited as an issue for ten respondents, who reported difficulty in trusting friends, co-workers, new situations, spouses/lovers, even in situations where they recognize the person is trustworthy.

Anxiety

Anxiety was cited by seven of the eleven respondents. The respondents were evenly dispersed over Trauma score categories. 'Free-floating' anxiety was often reported, although most anxiety reported centered around previously repressed memories. Respondents experienced anxiety over the content of and the feelings associated with their memories, and concern over what future memories may reveal to them.

Depression

Lifelong clinical depression was reported as an issue by ten respondents, and was almost universally at-
tributed to past experiences of abuse. Six reported being on medications.

Repression

Repression of memories of abuse, a form of dissociation was reported by ten respondents. In addition, four reported other dissociative experiences including "checking out" of situations, separation of memories and the feelings attached, and difficulty in identifying how they feel. No relationships between dissociative experiences and trauma was evident in this sample due to very little variation in the variable of repression.

Victims' Perceptions of the Effects of Victimization

All but one of the respondents reported feelings of depression, which have been life-long issues, as coming out of their childhood traumatic experiences. Five reported an impact on their sexual lives, with three stating they had problems enjoying sex and two stating that they could only relate to men in a sexual way. Difficulty in trusting people in general and men in particular was an issue for nine respondents, including some who have been in long-term and generally satisfying relationships. Five respondents reported fear of abandonment and loss. Childrearing has been an issue, in terms of not
repeating previous patterns for eight respondents. Three had eating disorders, which they linked to being abused. Relationships with family of origin members, particularly the offenders were marred by the abusive incidents.
CHAPTER IV

DISCUSSION OF FINDINGS

Critique of the Modified Trauma Scale

Assessing Trauma in One Session

It was possible to assess trauma in an interview setting with interview script which had structured questions and further probes to provide clarification of issues. Respondents were able to answer questions with little difficulty or discomfort. The use of the structured interview seemed to address deficits in research via therapy, which is time-consuming and mailed questionnaires, which would not allow for clarification of issues and could present further trauma to potential respondents. Differences in trauma scores were noted, indicating that there is a variation in the degree of trauma experienced.

Disaggregation of Trauma Scale

The trauma factors which were most commonly reported by participants were Interpersonal Adjustments in Relationships, Depression/Suicidal Ideation and Mental Health Involvement. These variables are related topically to
each other and seemed to co-vary, so they were put into a subscale. The nearly perfect co-variation between Mental Health Involvement and Depression/Suicidality may indicate a redundancy in measurement. In this sample, most respondents who were hospitalized were suicidal at the time of their hospitalization. Psychiatric hospitalization can occur for many other reasons, which may be more prevalent in a more representative sample of incest survivors.

Child Interpersonal Relationship Difficulties, Substance Abuse and Anger were not commonly reported among this sample. Explanations of variations among respondents in the areas of relationships with children, substance abuse and anger may be more evident in a study with a larger and more representative sample.

Some alterations to the scaling of individual trauma factors might provide a clearer picture of trauma. This is elaborated in the following point-by-point critique of the six factors of the Modified Trauma Scale.

**Interpersonal Adjustments in Relationships**

Participants were able to address all of the issues encompassed under the topic of interpersonal adjustments. Overall satisfaction with family of origin issues was difficult to assess, as most respondents reported dif-
difficulty with some but not all family members. Evaluating relationship difficulties with specific members and global family of origin relationship issues may provide more clarity.

All respondents had at least one indicator of difficulty with relationships, indicating that this is a significant problem area for incest survivors. The area covered by this factor may be too broad. A clearer picture of trauma may emerge if relationship dysfunction were separated into family of origin relationships, friendships/love relationships, and child relationships. Family dysfunction would include alienation, symbiosis, and rejection, with specifications of which members of the family of origin were involved.

Relationships with mothers, who in some cases were also perpetrators of physical and/or sexual abuse, were reported to be generally satisfactory by most respondents. Upon further discussion about the nature of the relationships with their mothers, some interesting dynamics arose. Four respondents characterized their relationships as more like that of siblings than of mothers and daughters. Two respondents described themselves as caretakers of their mothers, although accompanying descriptions indicated no physical ailments or frailties of age as the cause of their caretaking.
Substance Abuse Treatment

The issue of substance abuse could have been measured more effectively by introducing a more comprehensive instrument which would assess usage, as opposed to treatment issues. A person in a state of denial about substance abuse patterns may score as minimally traumatized if they reported that they never had a problem with substances, whereas with a more objective measure of substance abuse issues they might show higher levels of trauma.

Anger Mismanagement

Most respondents reported that they had problems with their temper. A deficit in the operationalization of anger became evident, as most respondents stated that they had difficulty in expressing anger, rather than in having outbursts of rage. The possibility of both extremes needs to be accounted for in the measurement of trauma. This would be a difficult area to sort out as related to victimization, since women as a whole are more likely to suppress anger than men (Thomas, 1993). Higher self-esteem is generally correlated with lower levels of overall anger (Tavris, 1989), which further complicated analysis with incest survivors who are typically found to
have lower self-esteem (Morrow & Sorrell, 1989; Briere & Runtz, 1988). The resolution of the issue of anger is not an easy one, although it is evident that some alterations to the current operational definition needs to be made.

Interpreting Relationships Between Trauma and Independent Variables

Discussions of the relationships between trauma and age at onset, violence, disclosure issues, current relationship with offender, responsibility for abuse and other family of origin dysfunction are presented in the following section.

Age at Onset

Due to the small sample size and lack of a wide range of age scores, it is difficult to interpret the findings that earlier age victimization is related to lower overall trauma. Hindman found that prepubescent victimization was equated with higher trauma than adolescent victimization, without other significant age distinctions. No respondents reported being victimized for the first time during adolescence.

Most of the respondents who reported being victimized at earlier ages tended to be older respondents (age 40 and above), who had overall lower trauma scores. This
could be partially explained by the greater distance in time they are from their victimization, or by an ability to process traumatic events in more effectively than younger respondents.

**Violence**

It was expected that emotional violence would be related to higher levels of trauma, but not supported in this study. However, the respondents who reported an extreme level of emotional violence (either a specific threat of bodily harm or extreme terror due to the offender’s violent physical presence) tended to be older which might influence overall trauma scores. A more representative sample might indicate a relationship between a climate of terror and trauma.

Physical violence during abuse was related to lower levels trauma for this sample, although Hindman found no relationship. One possible interpretation of this finding deals with identification of role as victim. It may be easier to define oneself as a victim if physical pain was involved in the victimization than if there was no physical discomfort, or even physical pleasure. One respondent did report that she felt guilty over experiencing orgasm during her molestation, an issue which complicates sexuality for her today. Hindman also deter-
mined that sexual responsiveness to molestation was prevalent in the severely traumatized patients in her study.

**Disclosure**

Lack of support in disclosure may permanently strain the relationship with the family of origin, which is part of the Interpersonal Adjustments in Relationships category. Two of the three respondents who reported disastrous responses to disclosure reported moderate to minimal satisfaction with their current relationship with their mothers, and very dissatisfying family of origin relationships.

**Inhibitors to Disclosure**

Difficulty in disclosing the incest, even as adults, may be linked to trust that significant others will respond appropriately, or may be indicative of Finkelhor’s and Browne’s (1985) stigmatization dynamic, or feeling that one is different than others because of sexual victimization.

Five of the respondents did not disclose the abuse during childhood, or did not remember disclosing. The key issues in not disclosing included fear of rejection, fear of offender, social isolation and unawareness of the inappropriateness of the incidents.
Those respondents who came from physically abusive and neglectful homes had not developed trust that anyone would respond to their needs for protection. In the case of two respondents, a very clear message was given that whatever their father did as dictator in the home was acceptable and within his rights.

Offenders who were physically and emotionally abusive coerced their victims with implicit and explicit threats of severe physical violence if they disclosed the abuse.

Six respondents described their families as socially isolated and sexually repressed. Without the knowledge from the family, or from outside institutions that sexual abuse was wrong, and without friendships or contacts outside of the family they did not have the means or the venue to articulate their victimization. Isolation from the mother was contributory for three respondents.

Even as adults, four respondents have not disclosed the abuse to family, or confronted the offenders. The primary inhibitor reported was fear that the offender or parents will deny the abuse, blame the victim, and not be supportive.

Outcomes of Disclosure During Childhood

Six respondents did disclose details of their sexual
abuse during their childhood or adolescence, although disclosure came years after the abuse had started. In addition, one respondent disclosed to authorities severe physical abuse, although she did not understand that the sexual activities she experienced were also abusive. Three defined the response to disclosure as disastrous, with the mothers being supportive in none of the cases. They didn’t believe the abuse occurred, and in two cases were physically assaultive to their children at the time of disclosure. Other family support was severely lacking; as one respondent was physically threatened by the offender’s side of the family, and two were not believed by most of the family.

**Outcomes of Disclosure in Adulthood**

A total of four respondents disclosed their victimization to their mothers for the first time in adulthood. In two cases, the mothers expressed anger at the victim that they had not disclosed during childhood, with one wanting to avoid family problems by limiting further disclosure. The other two reported favorable responses from their mothers.

Two respondents reported disclosing in childhood and again in adulthood. Although both mothers, who previously disbelieved their daughters now believe the abuse
took place, it is too late from the daughters' perspectives for their mothers to make amends.

Trauma Bond

Hindman found that a continued unhealthy relationship with the offender, either by the victim or those important to the victim was equated with higher levels of trauma. That respondents with lower levels of trauma have continued a relationship with their offenders, however strained, on their own terms, may indicate that they have developed some mastery over the situation which evidences itself in lower trauma. For those respondents who did not see their offenders, or tried to avoid contact, higher levels of trauma may indicate a lack of resolution of their relationships and a sense of powerlessness to change the situation.

Feelings of Responsibility for the Abuse

This was a very complicated issue to assess, although it has been treated rather simplistically in literature as either present or not (Frazier, 1991; Heath et al., 1990). The categories of responsibility which evolved from the interview process were: (a) feeling responsible for the protection of siblings, (b) feeling responsible for meeting the needs of either parent, (c) the
feeling that everything that happened was their fault, (d) feeling there was something about them that made people want to molest them or (e) feeling they could have prevented the abuse by saying no. Thus the issue of responsibility is much more complex than one would expect. These issues have not been adequately addressed by Hindman or by other research on feelings of responsibility. Responsibility has been viewed as a factor that is either present or not present without an understanding of the many nuances present within the idea of responsibility.

Other Common Symptoms

Previous research about trust (Finkelhor & Browne, 1985; Carson, Gertz, Donaldson, & Wonderlich, 1990) was confirmed by the findings of this study. As discussed previously, difficulty in trusting others in one's environment makes relationships challenging at best. The rationale for distrust for this sample was to avoid being revictimized.

Depression is the most commonly cited outcome of childhood trauma (Frazier, 1991; Goodwin et al., 1990; Heath et al., 1990; Jackson et al., 1990). The respondents described lifelong problems with serious depression, for which six reported taking medication. This study also upholds previous research about anxiety (Ben-
ward & Densen-Gerber, 1985; Briere & Zaidi, 1989; Heath et al., 1990). To what extent these symptoms lie behind such outcomes as difficulty in relationships is difficult to assess but should be explored further.

Emergent Issues

Repressed Memory of Abuse

Ten of the eleven respondents repressed memory of their sexual abuse. In the cases of eight respondents, validation from other sources was available. This came in the form of acknowledgement by mothers that the abuse was known to them at the time it occurred, and by other family members who reported also having been abused by the same individual. In no case did the respondent report discussing these issues with a therapist before recall of some memories. This was not expected to be so prevalent among the sample. Respondents typically reported repression when asked about some details of their victimization or when asked about their involvement in therapy.

From reviewing the work of other researchers in the area of repression in incest survivors, a pattern similar to the presentation of participants in this study are evident. Herman and Schatzow (1987) reported that triggers significant life changes such as births, deaths, midlife
crises, crises of trust of others, and exposures which resemble or symbolize the trauma.

There was a congruency from all responses about the process. A precipitating crisis or event brought about uncomfortable feelings such as anxiety without a visible cause. Then memories would flood, with the accompanying feelings, sometimes as dreams. Clients reported that new memories would then reveal themselves periodically, as the client was able to process them. The events precipitating recall were varied, and included resemblance of adult physical surroundings to childhood home, classroom discussion of child abuse, terminal illness of offender, family member being accused of sexual molestation, recovering from drug addiction, and life-threatening illness.

Four respondents reported always remembering that they were sexually abused, but did not have recall of specific details of the abuse until a precipitating event. Courtois (1992) described Post-traumatic Stress Disorder (PTSD) as affecting memories of abuse and can present as continuous symptoms, or lie temporarily dormant. The numbing aspects of PTSD may include repression, partial or total amnesia, emotional constriction and dissociation (Courtois, 1992).

Memory repression is most prevalent in respondents who were severely physically and/or emotionally trau-
matized during the abuse, and had been sexually abused at young ages, with the abuse stopping before adolescence (Herman & Schatzow 1987). In the cases of all respondents who repressed memories in this study, abuse started in early childhood and ended before adolescence.

Given the prevalence of repression among this sample of incest survivors, this is an issue which should be explored more fully in future studies through recognition of its validity and comparison of those who have repressed memories to those who have not.

The Healing Process

All respondents reported that long-term therapy has been invaluable as a means of coping with the memories of their childhood traumas. Four had participated in groups for incest survivors at some point in their lives. Five reported being on anti-depressants to assist in alleviating the depression. Two reported their intellect as a saving grace. Eight reported their relationships with siblings, children, and extended family had gotten them through. Supportive family served as an informal support group. Three cited a faith in God as a source of strength in facing the worst days of their life. Three reported their refusal to allow their childhoods to suppress them any further as evidence of their healing.
Five of these women have built successful careers and achieved higher levels of education than most of the population. Yet there are still issues of healing on an ongoing basis, including treating depression, coping with new memories, developing trust, and managing a continued relationship with their offenders.

Research on "invulnerable" children may assist in the development of a broad understanding of trauma. These are children who succeed despite experiencing severe environmental stress of various types. Corder and Haizlip (1989) used Pines' six characteristics of the "invulnerable child" to explain the stamina of some child incest victims. These included social skills and social network, ability to gain support from adults in their environment, achievement and excellence in at least one area, intense creative activity, autonomy at an early age, and active attempts to master their environment. While some individuals have these abilities more fully developed, it is possible that other victims could be taught some of these skills.

Those in the low category of trauma had at least three of the characteristics of the invulnerable child. Most of the members of the high category described no more than one of these characteristics. These issues were not incorporated into the interview script, but
discovered after the fact. This research indicates that some variation in trauma may stem from individual personality differences.

**Traumagenic Dynamics**

Finkelhor and Browne (1985) conceptualized four traumagenic dynamics of incestuous abuse, which provide illumination of the process of trauma for participants in this study, and tie in with Hindman’s conceptualization.

Traumatic Sexualization, or disrupted inappropriate sexual development is evidenced by 37% of the participants in this study as sexualization or as fear/discomfort during sexual activity. This had a crucial impact on Relationship Dysfunction.

Stigmatization, which includes fear of being blamed for abuse, feeling 'different' from other people, or 'spoiled' by the abuse was indicated by 27% of the sample. Powerlessness exhibits itself in hypervigilance, dependency, anxiety, low self-worth, and need for external approval. At least one of these aspects of powerlessness was present in 55% of the sample. Finkelhor and Browne also correlated powerlessness with elevated levels of depression, and postulated that it affected quality of relationships.

Betrayal can impact on victims in various ways,
either making trusting people, particularly in intimate relationships very difficult, or impairing ability to choose 'safe' relationships. Ninety-one percent of the sample reported that trust is difficult, even within the context of long-term relationships with people who have demonstrated their trustworthiness, and described being in past relationships which were not emotionally supportive, and in some cases were physically or emotionally punitive. Ninety-one percent of these women had left these relationships, opting for healthier situations, or waiting for something better. The lasting impact on relationships of an inability to trust is evident for members of this sample.

One use of traumagenic dynamics to explain trauma is in defining what therapeutic issues are most prevalent for individual clients (Finkelhor & Browne, 1985).

Limitations/Generalizations

Generalizations

Findings in this study could not be generalized to a population of incest survivors, because the sample is small and non-representative. Participants were gathered through word of mouth with no possibility for random sampling. In addition, there were no males in the study, although male victims certainly exist.
This study serves as a pre-test for assessing trauma in an interview. With some revisions to the Trauma Scale, as noted in the preceding section, and with a larger more representative sample, further study in this area would be warranted. The applications of the concepts in this instrument are for initial assessments in therapy clients and for further research into the process of trauma.

A Cautionary Note

As Hindman pointed out (1989), the use of categorizing people must be done with caution. The assignment of scores on an instrument to assess trauma should not be used by offenders, victims, or others to minimize traumatic experiences. Victims with lower levels of trauma may provide some clue as to the process of working through trauma in a healthy way.

Direction for Further Research

Several interesting areas of future research present themselves from this initial study. The traumagenic dynamics discussed by Finkelhor and Browne, conceived from observations of therapy clients (1985), may provide a basis for developing more understanding of trauma. Exploring how betrayal, stigmatization, powerlessness and trau-
matic sexualization feed into trauma, particularly in life skills and relationship dysfunction may provide a more complete understanding of the treatment needs of survivors. For example, this would allow exploration of the dynamics behind such trauma factors as interpersonal adjustment in relationships, which may be most problematic in terms of fear of betrayal, sexual problems, difficulty in addressing issues of power in relationships, or coping with poor self-esteem and stigmatization, or a combination of these factors.

Differences in attribution of responsibility and ways of feeling responsible also seems warranted given the disparate responses by participants. Exploring how to assist survivors in appropriately assigning blame, and deconstructing the reasons behind self-blame could be very beneficial. Viewing feelings of responsibility as a one-dimensional concept is not adequate in understanding the incest survivor's perspective and treatment needs.

More expansive research with the previously discussed modifications to Hindman's conceptualization of trauma would also be advisable. Expanding the area of interpersonal relationship dysfunction to distinguish between relationships with lovers/spouses, friends, and family of origin would be advisable. Incorporating a separate measure for substance abuse and altering the
definition anger mismanagement would also be suggested. Ideally the potential sample could be expanded to include survivors who are not in therapy. This might generate some differences in the amount of participants with depression, which would be assumed to be higher among therapy clients than in the general population. With a sample that includes people not in therapy, it may be advisable to include a standardized measure for depression.
CHAPTER V

CONCLUSION

Assessment of Trauma

The Trauma Scale

The purpose of this study was to assess the traumatic impact of incest on survivors. A trauma scale was developed using the work of Jan Hindman (1989) as a foundation. The scale assessed trauma by exploring the issues of interpersonal relationship dysfunction, child interpersonal relationship difficulties, mental health involvement, depression/suicidality, substance abuse and anger mismanagement, all of which Hindman posited were areas indicative of the traumatic impact of incest.

The scale was disaggregated, subscaled, and taken as a whole to assess the global and individual aspects of trauma. Trauma as a dependent variable was assessed to determine if there were relationships between the traditional factors of age at onset, physical violence, and frequency of abusive incidents versus Hindman’s factors of emotional violence (terror), identification of self as victim, unhealthy current relationship with offender and response to disclosure.
While Hindman’s data were collected in a long-term therapeutic setting, it was possible to assess trauma in an interview setting. Some of her trauma factors were deleted or altered to make measurement in one setting feasible and to ensure the emotional well being of participants. Questions about sexual dysfunction and promiscuity were deleted due to potential discomfort and negative response by participants. Issues about criminal behavior were deleted to ensure that the researcher did not become an accessory after the fact to unpunished criminal behavior. Abusive parenting was deleted to maintain the confidentiality of the study and avoid mandated reports to Child Protective Services. Psychological diagnosis and academic problems were not feasible in a one-shot session and were deleted.

After completion of this pilot study, it seems evident that alterations in the definitions of some of the factors which make up the trauma scale are necessary. Substance abuse should be measured with a separate scale or instrument and then factored into trauma. If the potential sample were expanded to include people not in therapy, an instrument to diagnosis depression (as opposed to asking participants if they have problems with depression) may be useful. Separation of the Interpersonal Adjustments in Relationships category to distin-
guish between different types of relationships might be more useful. This would allow exploration of quality of relationships with friends, lovers/spouses, and individual members of the family of origin. It is possible that Mental Health Involvement and Depression/Suicidality were redundant measures. This could also be addressed by administering a separate instrument to measure depression. Anger, as measured by Hindman and replicated in this study, only included temper outbursts. Another related issue is inability to feel or express anger, which needs to be included in a definition of anger.

The most common highly scored trauma factors noted were depression, relationship dysfunction, and mental health involvement. Trust, not included in the trauma scale was nearly universal and should be incorporated into the Interpersonal Adjustment in Relationships factor.

Trauma and Research Questions

It was difficult to analyze data due to the limited number of participants. Tabular analyses were done and indicated slight relationships between trauma and the independent variables of age at onset of abuse and negative response to disclosure. There was not sufficient or clear variation in the independent variables of frequency of abuse, identification of self as victim and trauma
bond with offenders.

Negative response to disclosure was related to elevated trauma, as was expected, although failure to disclose was not. This was particularly evident in the area of interpersonal adjustments in relationships, possibly indicating issues of mistrust which continue to impact survivors into adulthood.

Age at onset later in childhood was related to elevated levels of trauma, although the findings are confounded by two factors. First, those who had been initially molested in early childhood tended to be older respondents, whose overall trauma levels may be lower due to their age. A second issue is that there was not wide range of ages at onset of abuse. All of the respondents were either under the age of four, or between seven and ten years of age at the time of onset of abuse. There were no participants in their adolescence, or in middle childhood years.

Physical violence during victimization was inversely related to trauma, possibly indicating an ability to more clearly define the incidents as abusive, as opposed to clouding issues of whether the person was actually victimized by the abuse.
Emergent Issues

Depression, anxiety, dissociation of memories and feelings, and difficulty in trusting others were all prevalent in this sample, indicating the validity of these issues for incest survivors. The inclusion of these in a conceptualization of trauma may be advisable. Trust seems most likely to affect relationships with others. Depression could be assessed separately, as indicated above with the use of an independent scale.

Repression

Repression of memory was an issue for ten respondents, four of whom had some knowledge of being abused without specific memories and six experiencing a total repression of memories for part of their adulthood. This is an issue which needs to be explored more fully in view of the controversy surrounding it, particularly in terms of the process of memory recovery and coping with memories and the associated feelings.

Other Family of Origin Issues

Other family dysfunction was prevalent in this sample. The only two categories that seemed to be related to higher levels of trauma were domestic violence between parents and suicide by a member of immediate family. It
is understandable that the latter would be severely traumatising. While the presence of domestic violence would be expected to have a traumatic impact, one would not expect it to be more significant than child abuse violent enough to cause an injury requiring medical attention. This may be related to feelings of fear and powerlessness at seeing an adult authority figure in a powerless position, or it may also be an additive effect, as all families in which domestic violence occurred also had elevated levels of child abuse, while not all families in which child abuse occurred had domestic violence.

Feelings of Responsibility

Further research in the area of feeling responsible for abuse would be advised. Participants had many unexpected ways in which they had felt responsible, including feeling it was their responsibility to care for their mothers or offenders by submitting to abuse, feeling they were responsible for the protection of younger siblings, and feeling there was something about them that caused someone to molest them. This is an issue which needs further clarification with more incest survivors.

Final Issues

Continued research in the area of the traumatic
affect of incest on its victims will assist the human services field in meeting the treatment needs of this group with the goal of assisting them in becoming survivors of childhood trauma. This is a very significant area for further research.

Research in this area also serves another purpose: to enhance societal awareness of the broad impact incest has and the cultural norms which encourage its continuation.

The context in which incest occurs is a "rape-prone" society in which women and children can be victimized by men (Sanday, 1981). While it may be enticing to consider incest as a rare act perpetrated by mentally ill or pathological individuals, its prevalence makes this myth unbelievable, and belies the impact of the patriarchal paradigm of norms, values, and role definitions (Domenelli, 1989). Parker and Parker (1986), in their study of fathers who molested their children did not find psychotics, or people who are criminals outside of their own home. Gordon and O'Keefe (1984), in their review of family agency records of nearly a century did not find indications that family sex offenders were more pathological, alcoholic or psychotic than other male clients. The tendency is for society to ignore the potentially violent implications of systems based on ownership,
differential power, and entitlement (McIntyre, 1981). While the strength of the patriarchy may be declining, it's influence on our legal and welfare systems continues. As women's issues become more recognized, slow movements toward change occur. One aspect of the role sociologists can play in issue of incestuous abuse is to continue to expose and analyze the experiences of survivors to 'give voice'.
Appendix A

Interview Script
INTERVIEW SCRIPT: TRAUMA IN ADULT INCEST SURVIVORS

DATE:__/__/__

1 AGE:__

2 SEX: 1=F  0=M

I TRAUMA (dependent variable)

Relationships:

3 I want to talk with you a little bit about your relationships. What I mean by relationships with our first couple of questions is interpersonal relationships. What I mean here is a sexual relationship with more than a friend. Whether this was a marriage, or living together or whatever. What is your current relationship? 1=Living with someone (married or not). Seeing that person exclusively. 2=Seeing someone seriously, but maintaining separate residences. 3=Seeing someone but not seriously 4=Dating more than one person 5=Not dating anyone. 6 Living with someone, but also seeing other people.

__________________________________________________________________________

__________________________________________________________________________

4 In your intimate relationships has there been any concerns you have had about how they have gone? (I am looking here for issues of domestic violence, verbal conflict, or other 'Relationship Quality Indicators')

__________________________________________________________________________
5 How has your relationship with your family of origin been?

6 If you were to rate your overall satisfaction in your current relationship with a 1-2-3-4-5 scale, with five being not at all satisfied, and 1 being very satisfied, where would your relationship be? (skip if not applicable based on answer to Question #2)

7 How about if we used the same scale to rate your satisfaction with your relationship with your family of origin? 1-2-3-4-5. One is very satisfied and five is not at all satisfied.

8 Who in your family are you emotionally closest to?

9 Who are you least close to?

Let's talk for a moment about children.

10 Do you have children? Y/N

11 If so, how would you characterize your relationship with your child?

12 In the course of being a parent, have you ever had contact with child protective services? If so, what was the nature of the
13 What was your opinion about how the case was handled?

14 I am wondering if you can tell me about whether you have had any of feelings of depression significant enough that you have thought about suicide, or attempted suicide.

15 Have you had any contact with Community Mental Health?

I would like to explore for just a moment the area of substance abuse. I want to remind you this is completely confidential. Without going into details about type of substance, and whether it is illegal or legal. I am looking more for treatment issues.

16 Have you ever had substance abuse treatment? Y/N.

17 If yes, was it inpatient or outpatient?______

18 voluntary or mandated?___________.

19 If no, have you ever felt like you needed treatment or ever considered getting treatment?___________________________.

20 Have you ever had any problems with your temper?

21 (If yes). If you were going to give your temper a score with 3 getting into a physical fight or the police being
called 2 being angry enough to throw dishes, or losing a friendship over an outburst and 1 just having really angry feelings that feel kind of overwhelming how would you rate yourself?

II SEXUAL ABUSE HISTORY 1-2-3

Now I would like to discuss with you a little bit about your victimization. Most of these questions are going to be rated on a scale of 1 to 5 again, or have just very short answers to them. This isn’t going to be a big descriptive thing where you have to describe it all in detail.

22 First, I need to know how many perpetrators there were?_______

23 What was (were) his/her (their) relationship(s) to you?__________________________________________

24 How old you were when the abuse began?______.

25 And how old you were when it stopped?___________

26 I want to look for just a brief moment at violence. On a five point scale, with five being very physically violent and 1 being not violent at all, how would you characterize your victimization? 1-2-3-4-5

At times, people will have problems figuring out who was responsible for what took place.

27 Did you ever feel responsible for the abuse? Y/N If Yes, what things made you feel responsible?
28 Did you tell anyone of the abuse in childhood? Y/N
29 If so, what was the response to disclosure, with 1 being very favorable and 5 being disastrous? 1-2-3-4-5
30 Do you still see the perpetrator? Y/N
31 If so, how is that for you on a scale 1-2-3-4-5 with one being not a problem at all and five being very much a problem?
32 Do others in your family still have regular contact with the perpetrator? Y/N
33 If yes, how does that feel for you on the same 1-2-3-4-5 scale, with one being not at all a problem and five being very much a problem?

III FAMILY OF ORIGIN
I want to ask a little bit about the background of your family of origin, just to get an idea of other events which may have been important to you. By family of origin we mean the family in which you were raised as a kid.
34 How many children were there in the family? _brothers_ _sisters_
35 If more than one, what is your birth order position?
36 What is your relationship with your mother (non-offending parent) with one being very strong or positive and five being very poor? 1-2-3-4-5
Did any of the following occur in your family of origin when
you were a child living there?
37 Substance abuse by either or both parents? Y/N.
38 Domestic Violence between your parents, or parent and mate? Y/N
39 Violence toward children in family? This is other than the sexual abuse Y/N
40 If yes, how much? 1 will be pain but no injury. 5 is a significant injury such that medical treatment was needed. 1-2-3-4-5

OK, we are about done. I have asked you a lot of questions that have had rather confining responses. Now I am just going to ask a really open-ended question, which you can answer or not.
41 Is there a particular part of your life you feel has been affected by your childhood experiences of abuse?
Appendix B

Human Subjects Institutional Review Board Approval
Date: June 22, 1994
To: Jane Hedberg
From: Kevin Hollenbeck, Chair
Re: HSIRB Project Number 94-03-11

This letter will serve as confirmation that your research project entitled "Trauma in adult survivors of incest" has been approved under the full category of review by the Human Subjects Institutional Review Board. My review indicated that you attended to all of our requested revisions except the inclusion of the telephone number of the Vice President of Research on the consent form (387-8298). To save time and correspondence, I will assume that you will make that change to the consent form and send the board a copy of the Informed Consent in its final format of our records.

The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: June 22, 1995

xc: Weiner, SOC
Appendix C

Letter to Therapists
Dear (Therapist’s Name):

I am conducting a research project on adult survivors of incest and trauma. You may be familiar with the work of Jan Hindman, M.S.W., who has studied the evidence of trauma in incest survivors by looking at dysfunctions in living skills, mental health and relationships. I have devised an interview script based upon her review of findings with a group of patients in therapy with her. I wish to administer this to adult survivors of incest during a one-time face-to-face interview. This will take approximately two hours of the participants’ time. I am willing to schedule at the client’s convenience in terms of time and place. Interviews could be conducted at WMU or at the client’s home.

Aside from reports of suicidal ideation or violence toward another adult and child abuse, all information would be kept confidential. If it were necessary I would report the above to the proper authorities (i.e. Gryphon Place and Child Protective Services) and to you. Otherwise, any information relayed to me during the course of the interview would not be reported to anyone, including yourself.

I enclose a copy of my interview script for you to review. If you have anyone currently in therapy with you who fits this criteria, I would greatly appreciate it if you would consider letting them know the research is being done. I also enclose a letter for potential participants, and a copy of my resume, including references.

To guard against subtle coercion, it must be very clear to the client that participation is voluntary, confidential, and has no bearing on their continuation in therapy. To ensure this, I also enclose a script to be read verbatim to the client when informing them of the research.

I thank you sincerely for your time and hope you will consider assisting me in gaining participants for this study.

Any questions can be directed to me at (616) 337-5073.

Sincerely,

Jane K. Hedberg
P.O. Box 272
Nazareth, Michigan 49074-0272
SCRIPT FOR THERAPISTS
(to be read verbatim)

"I have a colleague who is a social worker and also a graduate student in Sociology. She is currently doing some research on adult incest survivors. I would like to give you this letter explaining more about it, if you’re interested. But I want it to be very clear that it is completely up to you whether you participate or not. Choosing to participate or not doesn’t have any impact on our relationship. I would not be present during the interview, and will not be informed of the contents, unless you divulge information to Ms Hedberg that you are actively suicidal, or a risk to a child or another person. Then I would be contacted, in addition to Gryphon Place and/or Child Protective Services. So, if you are interested, then you may contact her to set something up."
Appendix D

Letter for Participants
Dear Potential Participant:

Greetings. My name is Jane Hedberg. I am a graduate student at Western Michigan University. I am currently doing research for my thesis on adult incest survivors in therapy and their feelings about their victimization. I am trying to see if there are aspects of individual’s victimization that seem to have been particularly related to trauma. Your participation would require about two hours of your time to talk with me.

I understand that this is a very delicate and painful topic to consider discussing with someone. I have been a social worker for almost seven years and have had a lot of experience talking with people about this very topic and other very painful things that have happened. I am not a therapist, and am not a replacement for your therapist. The questions that I would need to ask you are for the most part very short-answer. I would be talking to you about your feelings about your relationships with your family of origin, the perpetrator, and about your current situation. This would include your current relationships, and talking about feelings of depression, past suicidal feelings, your relationship with your children (if applicable), substance abuse, and anger. I would also be collecting some details about your abuse, but again these would be short answer and not long drawn out responses. Your therapist is still the person you need to work through things with.

If you decided to participate, there would be no record on the response sheet of your name, or any identifying information about you. Anything you told me would be completely confidential, unless you told me that you were suicidal or of physical threat to someone else, such as children, or if you told me about someone else abusing children. Then I would have to notify the appropriate authorities. In the case of child abuse, I would have to call Child Protective Services. In the case of being suicidal, or of being a physical threat to an adult other than yourself, I would have to immediately call Gryphon Place for an emergency mental health screening. This is the law. If there were questions you didn’t want to answer you could choose not to. You could quit your interview at any time. Choosing not to participate has no influence of your relationship with your therapist, or continuing in therapy. You would receive $25.00 if you complete the interview.

My purpose in wanting to do this is so therapists working with people who have had similar experiences can understand better what people may need to heal. This is an initial study that I hope to do on a bigger scale in the future. I hope you will consider doing this. If you have any other questions please give me a call at 388-3864 or 337-5073 so we can discuss it further. Also give me a call if you are interested in participating, as soon as possible.

Thank you

Jane Hedberg
Appendix E

Informed Consent Form
I have been invited to participate in a research project entitled "Trauma in Adult Incest Survivors". I understand that this research is intended to study the different aspects of adult life which may be affected by sexual victimization in childhood. I further understand that this project is Jane Hedberg's thesis project. I understand that Jane Hedberg is not a therapist, but is a field social worker who has worked for more than six years as a social worker and has talked to many clients about difficult issues, including sexual abuse.

My consent to participate in this project indicates that I will be interviewed by Jane K Hedberg at the location of my therapist's office, or at WMU, or at my home if I choose on one occasion. I understand that this session will not be of any cost to me. Short-answer questions will be asked regarding my victimization and my current life situation. Topics covered include substance abuse, quality of relationships with family of origin, children, and lovers, anger management, feelings of depression, and suicidal ideation.

As in all research, there may be unforeseen risks to participants. If an accidental injury occurs, appropriate emergency measures will be taken; however no compensation or treatment will be made available to me except as otherwise specified in this consent form. I understand that one potential risk of my participation in this project is that I may be upset by the content of the interview. I understand, however, that Jane Hedberg is prepared to provide crisis counseling should I become significantly upset. I also have a therapist with whom I am actively in therapy who can discuss these issues with me. I am responsible for the cost of my therapy.

One way in which I may benefit from this activity is having the chance to talk about my victimization, which research indicates is beneficial. I also understand that the knowledge gained through this research may be beneficial to other incest survivors.

I understand that all information collected from me is strictly confidential, with two exceptions. If I report any feelings or behavior which is imminently a risk to myself or someone else, Jane Hedberg must report this to necessary authorities to ensure my personal safety or the safety of those around me. An example of this would be reports of feeling actively suicidal or homicidal, or feelings or actions of injuring another adult, or reports of actions physically or emotionally harmful to any children. Suicidal
and/or violent behavior or feelings would be immediately reported to Gryphon Place and to my therapist for immediate evaluation of my emotional well-being. Reports of possible child abuse, either by myself or by someone I know would be immediately reported to Child Protective Services and to my therapist for appropriate intervention. All other information would be kept confidential. This means that my name or any identifying information about me will not be recorded on the interview script used by Jane Hedberg. The only paper on which my name will appear is this consent form, which will be kept in a secure place within Jane Hedberg’s office for three years at which point they will be destroyed.

I understand that I may refuse to participate or quit at any time during the study. My choice to participate or not participate has no bearing on my continuation in counseling. I also understand that, with the exception of information about suicidal or violent ideation or child abuse, no information will be shared with my therapist. If I have any questions or concerns about this study, I may contact either Dr. Paul L. Wienir, Department of Sociology at 387-5291 or Jane Hedberg at 388-3864, or the Western Michigan University Human Subjects Institutional Review Board Vice President at 387-8298, or the Human Subjects Review Board at 387-8293. My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

Signature ___________________________ Date _____________
BIBLIOGRAPHY


