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Appeal and Vulnerability Patterns in Girl Victims of Incest

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APPEAL AND VULNERABILITY PATTERNS IN GIRL VICTIMS OF INCEST

by

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This study compared certain personal characteristics and behaviors of sexually abused girls with those of matched controls. Experimental subjects were 49 girls, aged 6 to 16 years, who had been sexually abused by an older male family member. Fifty girls who had not experienced sexual abuse served as the comparison group, matched on the basis of age, race and socioeconomic status.

Demographic and psychological measures were completed by each research participant and her mother. Videotapes were made of an initial session in which each child met an unknown male tester.

This study hypothesized and affirmed that sexually abused girls appeared older, more personally attractive and more flirtatious than nonabused girls. Problem sexual behaviors were also reported to be higher for sexually abused subjects than for controls, as hypothesized. Contrary to the initial hypothesis, no significant differences in physical attractiveness or in pubertal development were found between the two groups of girls.

Finally, as was hypothesized, this study did find that flirtatiousness correlated with age in distinctively different patterns for the sexually abused girls and those girls who had not been abused.

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Finally, I want to thank all the young women participants of this study who have courageously survived the painful experience of being sexually abused as children. To their continuing growth this work is dedicated.

Ruth Mausert-Mooney

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CHAPTER I

INTRODUCTION

Focus of This Study

The present study analyzed descriptive data on a hypothesized cluster of behaviors and physical characteristics exhibited by sexually abused girls aged six to sixteen. These behaviors and characteristics fall into two distinct but interrelated general categories: patterns of appeal, and patterns of vulnerability.

The patterns of appeal include characteristics and behaviors that are attractive, affiliative, or attention-getting in nature. The term was chosen precisely because of its clinically meaningful ambiguity. "Appeal" means both a cry for something needed and the attractiveness one holds for another. The patterns of appeal were hypothesized to range from innocent charm, to demands for attention, to playful flirtation, to openly sexualized interactions with others.

The patterns of vulnerability include characteristics and behaviors that are submissive or are lacking in dominance. The patterns of vulnerability were hypothesized to range from unassertiveness, to over-compliance, to mildly

dissociative behaviors reminiscent of the freezing in the fight-flight-freeze triadic response-repertoire to danger.

Although less central to the thesis of this work, a third set of hypothesized characteristics--patterns of maturity--was also examined. These characteristics include apparent age and pubertal development.

Unfortunately, inquiries about patterns of appeal have provoked a controversy of extremes. Sexually abused children have been alternately credited with significant culpability in provocatively initiating or actively participating in their own sexual assault (Henderson, 1975; Krieger, Rosenfeld, Gordon, & Bennett, 1980; Lukianowicz, 1972; Virkkunen, 1975) or characterized as merely random innocent passive victims (Yates, 1982). Caricatures of the seductive child fail to recognize adult responsibility of the offender, while the stereotype of the featureless, passive object portrays the victim as powerless to protect against sexual abuse and hopeless in preventing continual revictimization. Both views deny human resourcefulness and obstruct efforts to research and understand the complex problem of child sexual abuse. This researcher is convinced that adults, and not children, are capable of full and informed consent. Nevertheless, children possess personal characteristics and behaviors that both affect and

are shaped throughout the experience of sexual abuse.

It is not currently known, and a study of this design could not determine, whether these attributes are antecedent or consequent to sexual abuse. That critical question needs to be addressed by future research. The scope of this study was to investigate the presence and interrelationships of these abuse-related phenomena long reported in clinical and research impressions, anecdotes, and case studies.

Indeed, restricting this study to descriptive data has a special usefulness. The characteristics and behaviors it studied most closely resemble those which sexually abused girls initially present. Thus, the study should aid in the detection of sexual abuse. Because these same characteristics and behaviors probably signal vulnerability to a predisposed sexual abuser, treatment involving their mitigation or extinction could well deter revictimization. This does not imply that the offender has any less responsibility for the sexual violation or any less need to change the abusive behahavior. However, recidividism among sexual offenders is very high and child victims in particular have no control over the perpetrator's admission of, or change in, behavior. Thus, this study intends that early detection, intervention and treatment of the victim of child

sexual abuse protect, empower, and enhance the freedom of the person who has been victimized.

This hypothesized set of behaviors and characteristics of sexually abused girls is generally accessible, by direct observation or report, to those with whom the girls have significant contact, independent of any disclosure of the sexual abuse. Of the variables addressed in the hypotheses, two are independent variables--abuse status and chronological age. The six dependent variables are personal attractiveness, physical attractiveness, flirtatiousness, problem sexual behaviors, apparent age, and apparent pubertal development.

The principle of unity for this hypothesized set of dependent variables is precisely their general accessibility to the astute and concerned observer, whether parent, teacher, physician, investigator, caseworker, or therapist. All the dependent variables are immediately observable in the child during the initial contact, with the possible exception of problem sexual behaviors, which are typically reported early as presenting issues by the child herself or by a concerned third party. Although the study investigated possible relationships among the dependent variables, for the general purpose of this study only the external relationship of accessibility to a concerned, observant

adult was assumed.

Definition of Incest

Child sexual abuse (CSA) can be defined as sexual activity involving a child that occurs either as a result of force or threat, or occurs between a child and a person five or more years older, regardless of use of obvious coercion (Browne & Finklehor, 1986). Sexual activities range from exhibitionism to genital fondling to oral-genital contact to anal or vaginal intercourse.

This study limited its scope to girl victims of incest. "Incest" was defined as sexual abuse involving genital contact ranging from genital fondling to oral-genital contact, to anal or vaginal intercourse perpetrated by an older male family member against a female child under the age of eighteen. The older male family member may be a biological father, step-father, adoptive father, foster father, brother, or the mother's live-in boyfriend.

The primary reason for limiting the review to girls was the significantly higher incidence of sexual abuse of female to male children (Finklehor & Baron, 1986). Also, concentration was focused upon male offenders since women constitute only about 5% of all reported CSA perpetrators against girls (Finkelhor, 1984; Russell, 1988).

Incidence

Numerous studies indicate that reported cases of sexual abuse in the United States have mushroomed since the 1970s. The American Humane Society reported a 16-fold increase in officially reported cases in the United States between 1976 and 1985, from 7,559 cases to an estimated 123,000 (Russell & Mohr-Trainor, 1984).

The second Study of National Incidence and Prevalence of Child Abuse and Neglect (National Center for Child Abuse and Neglect, 1988) estimated that sexual abuse in 1986 was reported at more than triple its 1980 rate. It estimated that 2.5 children per 1000 (about 165,000 nationwide) suffered from some form of sexual abuse in 1986, of which 2.2 per 1000 (about 138,600 nationwide) experienced sexual abuse causing demonstrable harm. A disproportionately high rate of report occurred among older groups, suggesting that some of the increment might have been due simply to an increase in reporting (NCCAN, 1988). Even with the most conservative rates of report, the known incidence is so high that child sexual abuse is considered a major health problem by most researchers (Burgess & Holstrom, 1979; Conte, 1982; Kohan, Pothier, & Norbeck, 1987).

As recently as 1975, experts in the Comprehensive Textbook of Psychiatry were still citing the figure of one

incest victim in every million children (Freedman, Kaplan, & Sadock, 1975). However, Russell (1984, 1988), in her methodologically rigorous household sample of 930 women in the San Francisco community in 1978, found that a full 16% had at least one experience of incestuous sexual abuse involving direct physical contact before the age of 18 and that 12% experienced incest before the age of 14. More generally, 38% of the sample had been sexually victimized before the age of 18, and 28% of the sample had such an experience before the age of 14.

Russell further determined that 4.9% of the total sample reported abuse by an uncle, the most common form of incestuous abuse. Abuse by a father figure (biological, step-, foster, or adoptive father) was reported by 4.5% of the total sample. In the case of father-figure incest, stepfathers were clearly the most frequent perpetrators. Of girls who had a stepfather as the principal father figure, 17% were sexually abused by that stepfather. This compares with 2% abuse rate of those whose biological father was their principal father figure in childhood.

The Ill Effects of Sexual Abuse

Assessments of the consequences of incest and adult sexual involvement with children range from endorsement,

to neutrality, to condemnation. Two psychoanalysts claim that the "consummation" of incest protects daughters from psychosis and allows for greater psychological adjustment (Rascovksy & Rascovsky, 1950). An author of the Kinsey Reports contends that the "beautiful and mutually satisfying [sexual] relationships between fathers and daughters ... have no harmful effects" (Pomeroy, 1976, p. 10).

In the 1974 Guide to Psychiatry, psychiatrist Myre Sim discounts sexual relationships between adult men and young girls as innocuous, having little effect on "the promiscuous children. ... Most settle down to become demure housewives" (p. 683). Henderson (1983) says that "research is inconclusive" regarding the psychological harmfulness of incestuous behavior (p. 34). However, a strong majority of researchers document the high negative costs of child sexual abuse (Briere & Runtz, 1987, 1988; Butler, 1978). "The recent literature indicates that there is growing evidence that child abuse produces serious problems for most of its victims" (Sirles, Smith, & Kusama, 1989, p. 225). The effects are wide-ranging, long-lasting, and constitute a serious mental health problem (Browne & Finkelhor, 1986). Incest, in particular, many researchers contend, has been underestimated as a significant determinant of emotional disturbance (Goodwin, Cormier, & Owen, 1983; Herman &

Hirschman, 1981; Summit & Kryso, 1978).

Disclosure: Obstacles, Consequences, and Importance

There is general agreement that only a minority of children ever disclose their experience of sexual abuse to anyone, and of those cases fewer still are reported to the authorities (Committee on Sexual Offenses Against Children and Youth, 1984; Haugaard & Reppucci, 1988). Russell (1988), in her retrospective study of 930 adult women, found that only 2% of intrafamilial CSA cases, and 6% of extrafamilial CSA cases, were ever reported to the police.

A child must overcome significant obstacles in order to disclose sexual abuse, particularly incest. Secrecy is typically imposed on the child by the perpetrator through various threats, either emotional or physical. Other obstacles are sexual shyness, denial, dissociation (or even amnesia), and an over-developed loyalty or desire to protect a closely related perpetrator (Gelinas, 1983).

When victims enter therapy, even as adults, they tend to seek treatment without disclosing the sexual abuse (Gelinas, 1983). Gelinas (1983) and Westermeyer (1978) suggest that the sexual abuse victim's characteristically disguised presentation misleads clinicians into treating, with very little success, secondary symptoms of undisclosed

and unrecognized sexual abuse. In one survey of college-age women, only 39% of the survivors of CSA had ever disclosed their experience of sexual abuse prior to the direct questioning during the study (Briere & Runtz, 1987).

Even after the child victim (often reluctantly or unconvincingly) discloses sexual abuse, the tendency to withdraw the allegation is quite common. In fact, Summit (1983) classifies retraction as one of the last and typical stages of the child sexual abuse accommodation syndrome. Once sexual abuse is identified, the accurately diagnosed victim of CSA presents a relatively straightforward treatment situation which directly addresses the negative effects of abuse and tends to be very effective (Gelinas, 1983).

Diagnostic, Therapeutic, and Explanatory Significance of This Study

In the face of this difficulty in accurately detecting cases of sexual abuse, the present study has attempted to develop a behaviorally anchored diagnostic tool which can be used by mental health professionals as well as by any concerned and observant adult. Moreover, the results of this study point to a spectrum of therapies--ranging from behavioral to insight therapy--that could reduce revictimization. Finally, the study's results suggest patterns of

deficient early bonding in both offender and victim as possible causes of child sexual abuse.

CHAPTER II

REVIEW OF THE LITERATURE

Characteristics of Sexual Abuse Victims: The General Framework

The broadest distinction of the characteristics of sexual abuse victims is between those antecedent to, and those consequent upon, the experience of sexual abuse. Indeed, since revictimization is one of the common results of sexual abuse, it is probable that some of the consequent characteristics become antecedents for future abuse.

Antecedent Characteristics: Risk Factors

Among possible risk factors for sexual abuse, the two acknowledged by most researchers are gender and age. Although researchers differ on exact rates, there is a broad consensus in the literature that females are more frequently the victims of sexual abuse than are males. Researchers report rates of sexual abuse ranging from 7.7% to 59% in females (Fritz, Stoll, & Wagner, 1981; Wyatt, 1985), and 3% to 30% in males (Haugaard, 1987; Landis, 1956). Summarizing eight random-sample community surveys, Finkelhor and Baron (1986) report that the mean ratio of female victims

to male victims is 2.5 to 1. Their review of CSA cases reported to agencies yields ratios of 9 to 5 female victims for every 1 male victim. They consider it fairly well established that girls are at higher risk than boys, even after taking into consideration the typical underreport of boys' abuse (Finkelhor & Baron, 1986).

Most studies find pre-adolescent girls aged 8-12 at highest risk for sexual abuse. Conte and his colleagues report that 60% of all victims are under 12 years of age at the onset of the sexual abuse (Conte, Rosen, Saperstein, & Shermack, 1985). In a 1986 Illinois survey, 60% of the 445 teen mothers questioned reported having been forced into an unwanted sexual experience; of that number, half had their first forced experience by the age of 12 and almost one-third by the age of 9 (Ounce of Prevention Fund, 1986). Concerning intra-familial abuse specifically, Gelinas (1983) reports that incest is usually initiated when the victim is between 4 and 12 years old.

Finkelhor (1980) also lists characteristics of family or environment which appear as risk factors for sexual abuse: (a) the presence of a stepfather in the family, (b) a mother who is sexually punitive, (c) having lived separate from mother at some time, (d) not being close to mother, (e) receiving no physical affection from father,

(f) yearly family income less than $10,000, (g) father much more highly educated than the mother, and (h) having 2 or fewer childhood friends. However, Russell's 1986 research found no significant disparity between the parents' levels of education (g), and found that upper middle class girls (rather than the poor as in f) were overrepresented among incest victims.

Consequent Characteristics: CSA Sequelae

The literature typically focuses on characteristics of CSA victims which are understood to be consequent upon (indeed, caused by) the experience of sexual abuse. Although many such causal inferences have a good deal of supporting evidence, they are sometimes made in studies whose research design do not permit inferences of causality. Nevertheless, given the strong consensus of the literature, they are all discussed here as CSA sequelae.

Sequelae Classifications

Sexual abuse literature has generated list after list of reported psychological sequelae of child sexual abuse in general and incest in particular. In attempts to understand the relationship among these sequelae, various classifications have been proposed.

Perhaps the most commonly accepted classificatory distinction made is between immediate and long-term sequelae. Asher (1988), Berliner and Wheeler (1987), Browne and Finkelhor (1986), Brunngraber (1986), and Tufts New England Medical Center (1984) are some of the authors who explicitly make this distinction, although most authors in the past decade make use of it. The basis for this distinction is the fairly well-founded fact that some immediate effects (for example, enuresis in children) eventually disappear, while other effects (for example, prostitution) do not appear until much later.

Many researchers propose a second classificatory dimension. Adams-Tucker (1982) reports finding six clusters of symptoms, listed in decreasing order of severity: (1) self-destructive and withdrawal/hallucinatory behavior; (2) aggression, problem sexual behavior, and running away; (3) problems at school and conflicts with parents, siblings, and peers; (4) anxiety; (5) psychosomatic disturbances; and (6) sleep disorders.

Browne and Finkelhor (1986) distinguish immediate effects into four categories: (1) emotional reactions and self-perceptions, (2) physical consequences and somatic complaints, (3) effects on sexuality, and (4) effects on social functioning. They also divide the long-term effects

into four categories, which are the same as those for immediate effects, except for the second, which becomes "impact on interpersonal relating" instead of "physical consequences and somatic complaints" (pp. 68-70).

Brunngraber (1986), following Courtois (1979), discusses the impact of both immediate and long-term effects on eight "life spheres": (1) social, (2) psycho-emotional, (3) physical, (4) sexual, (5) familial, (6) sense of self, (7) relations to men, and (8) relations to women.

Asher (1988) argues that the most critical classification of immediate effects is by age of onset, with distinctive effects discernible for pre-school, school-age, adolescent, and teenage victims. Other authors, notably Berliner and Wheeler (1987) and Finkelhor and Browne (1985, 1986), adopt a second dimension of classification that is more explicitly explanatory in intent. Considerations of both the origins and interrelationships among the various sequelae and their interactions with variables such as age at onset of abuse will be discussed after a more general overview.

In the absence of a conclusive case for any one of these secondary schemes, the current review will arrange the reported psychological sequelae according to two dimensions. The first will be a division into affective,

cognitive, behavioral, and social effects; the second will be a division into initial and long-term effects.

Listing of Sequelae

Affective Sequelae. A variety of affective sequelae to child sexual abuse has been listed in the research literature.

Browne and Finkelhor in their 1986 survey of the research conclude that fear is the most common initial effect of child sexual abuse. The Tufts study (1984) noted the pervasiveness of fear as a sequela of child sexual abuse, although it was found to be significantly worse for children aged 7 through 18 than it was for those aged 4 through 6. Weiss, Rogers, Darwin, and Dutton (1955) mention fears and phobias as common effects. Similarly, anxiety is mentioned by a wide range of authors, including Briere and Runtz (1987), Burgess, Hartman, and McCormack (1987), deYoung (1982c), Herman (1981), Lindberg and Distad (1985a), Mannarino and Cohen (1986), and Sedney and Brooks (1984). There is evidence that fear and anxiety are also frequently long-term sequelae of child sexual abuse, with fear of men being one of the specific manifestations (Briere & Runtz, 1987; Herman, 1981).

Mannarino and Cohen (1986) found sadness to be an initial reaction to child sexual abuse. Anderson (1981), Lindberg and Distad (1985a), the Tufts study (1984), and Friedrich, Beilke and Urquiza (1987) likewise document depression as a common initial sequela of child sexual abuse. Cavaiola and Schiff (1988), in studying abused adolescents, note that victims of incest and sexual abuse subjects were more likely to exhibit uni- and bi-polar depression than were other comparison groups, including one group comprised of physically abused adolescents.

Bagley and Ramsay (1985), Briere and Runtz (1988), Courtois (1979), Peters (1984), and Sedney and Brooks (1984) also report depression as one of the long-term effects of child sexual abuse. However, alternate findings were mentioned in an earlier study (1984) by Briere, and also by Meiselman (1978), both of whom found no significant differences in reports of depression between adult survivors of child sexual abuse seeking psychotherapy and other patients who had not been sexually abused.

The Tufts study (1984) found that elevated hostility and anger were common initial reactions to child sexual abuse, especially among victims aged 7-13 but also among 4- to 6-year-olds and adolescents. Herman (1981) noted that this anger was often directed against the victim's

parents, especially the mother (see also Meiselman, 1978). On his comparison of Rorschach scores between 17 adult survivors of childhood incest and 17 controls, Owens (1984) found that adult survivors of incest have significantly more difficulty dealing with angry feelings.

A fourth major affective sequela of child sexual abuse is shame and guilt. This was found especially in clinical studies by Herman (1981), Meiselman (1978), and Tsai and Wagner (1978). According to de Young (1982b), the self-injury found in some incest victims is attributed, at least in part, to attempted expiation of guilt, especially when the perpetrator or other family members blame the victim for initiating the incest.

Cognitive Sequelae. Critically negative disruptions in the cognitive functioning of victims of child sexual abuse have been documented, having both immediate and long-term pervasive impact.

Intrusive thoughts and imagery of incest beset the adult survivor (Lindberg & Distad, 1985a), while concentration problems, excessive daydreams, memory loss, and academic problems were found among sexually abused children aged 4-17 (Conte & Schuerman, 1987).

Einbender & Friedrich (1989) found lower cognitive and social functioning and lower school achievement for

sexually abused girls aged 6-14 than for the girls recruited from the community. The Tufts (1984) research found serious deficits in cognitive functioning (including intellectual and social development) of 20% of the sexually abused 4- to 6-year-olds. Severe learning disabilities were reported for 29%, and serious academic disabilities for 31%, of the sexually abused children aged 7-13 in the same study (Gomes-Schwartz, Horowitz, & Sauzier, 1985). Adams-Tucker (1982), Goodwin et al. (1983), and Runtz and Briere (1986) all documented more school problems for CSA victims than for nonabused children.

Significantly higher levels of acute and chronic dissociation were found for adult survivors of CSA than for nonabused women (Briere & Runtz 1988). Bliss (1984), Coons and Milstein (1986), Kluft (1985), and Putnam, Post, Gur-off, Silberman, and Barbara (1983) have found dissociation and Multiple Personality Disorder to correlate highly with a history of child sexual abuse.

Perfectionism (Lindberg & Distad, 1985b), powerless-ness, self-hatred, and low self-esteem (Conte, 1986) all adversely affect the cognitive set of victims of CSA. Problems with self-esteem are found to be highly correlated with child sexual abuse by many researchers (Carmen, Reiker, & Mills, 1984; Conte & Schuerman, 1987; Courtois,

1979), especially as they affect attributional style for bad events (Gold, 1986).

Behavioral Sequelae: Problem Sexual Behaviors. Perhaps most well documented among the various sequelae are problem sexual behaviors, which include sexual precocity, sexual preoccupation, sexually inappropriate behaviors, overly sexualized behaviors, compulsive masturbation, promiscuity, early pregnancy, sexual dysfunction, prostitution, subsequent sexual abuse revictimization, and increased sexual abuse of the victims' own children.

Child victims of intrafamilial sexual abuse displayed significantly more sexual problems than either the comparison group of normal children or the psychiatric outpatient children in the well-designed research of Friedrich et al. in 1987. The problems included displays of inappropriate, precocious, or compulsive sexual behaviors. Einbender and Friedrich in 1989 found that sexually abused girls aged six to fourteen demonstrated heightened sexual preoccupation and more internalizing and externalizing behavior problems than did the comparison group of normal girls.

Sexually abused 2- to 6-year-old girls were reported to have higher levels of sexualized behaviors than did comparison groups of neglected and nonreferred girls. The sexually abused girls were reported to masturbate more in

social and stressful situations, make public comments about adults' private parts, and act friendlier toward adult strangers and more solicitous of their attention (White, Halpin, Strom, & Santilli, 1988).

Clinically significant pathology in the area of sexual behaviors was observed in 36% of the school age children between the ages of seven to thirteen in the Tufts University research (Gomes-Schwartz et al., 1985). Inappropriate sexual behaviors and sexual acting out were likewise reported with greater frequency for the sexually abused children and adolescents evaluated by Cavaiola and Schiff (1988) and Mannarino and Cohen (1986).

As for long-term problem sexual behaviors, Briere and Runtz (1987) found that the average survivor of child sexual abuse exhibited more sexual difficulties (such as decreased sex drive) than 79% of the nonabused clinical population. Sexual dysfunction, particularly arousal and desire dysfunctions and fear of sex, is a frequently cited problem for adults sexually abused as children (Becker, Skinner, Abel & Treacy, 1982; Meiselman, 1980; Tsai, Feldman-Summers & Edgar, 1979).

Revictimization by other offenders is a serious vulnerability which haunts child sexual abuse victims (Briere, 1988; Briere & Runtz, 1988; Fromuth, 1986; Herman, 1981;

Runtz, 1987; Wyatt, 1985). Russell (1986b) reports that:

> Sixty-eight percent of incest victims were, in later life, victims of rape or attempted rape by a non-relative, compared with 38% of other women. Almost three times as many incest victims (19%) as women who were never sexually abused during childhood (7%) had been raped by their husbands. More than twice as many victims (53%) as nonvictims (26%) reported at least one unwanted sexual advance by an authority figure such as a doctor, teacher, employer (p. 31).

Early pregnancy (Herman & Hirschman, 1981), promiscuity, and prostitution (James & Meyerding, 1977; Quinsley, 1986; Silbert & Pines, 1983) are further problems that occur with much greater frequency among female survivors of child sexual abuse than among their nonabused cohorts.

Other Behavioral Sequelae. Other initial behavioral sequelae include regressive clinging (Lindberg & Distad, 1985a), finger-sucking, passivity (Conte & Schuerman, 1987), overly frequent bathing (Goodwin & Owen, 1982), and hysterical seizures (Goodwin, Simms, & Bergman, 1979; and Gross, 1979). Commonly reported are sleep disturbances, especially nightmares, insomnia and bedwetting (Adams-Tucker, 1982; Lindberg & Distad, 1985a). In addition to sleep disturbances, Adams-Tucker (1982) found, within the same group of 28 sexually abused children, withdrawal and oppositional tendencies.

The Tufts study reported aggression (both impulsivity and belligerent, self-centered behavior), as the most

commonly observed symptomatic behavior, occurring within 50% of the school-aged (7-13) sexually abused children (1984). Similarly, Conte and Schuerman (1987) isolated an aggressive factor (yelling, hitting, breaking things, or unruly, uncontrolled, defiant behavior) which accounted for a large degree (alpa =.84) of the significant difference found between the sexually abused children and those drawn from the community at large.

A fairly common response to incestuous abuse is running away from home (Cavaiola & Schiff, 1988; Herman & Hirschman, 1981; Silbert & Pines, 1983). Meiselman (1978) found that 50% of those sexually abused as children had left home before age 18 in contrast to only 20% of other female patients.

Disruptions in eating patterns constitute an initial symptom of child sexual abuse while longer-term eating disorders occur in disproportionately high rates among women with a history of CSA (Brickman & Briere, 1984; Oppenheimer, Howells, Palmer, & Chaloner, 1985; Runtz & Briere, 1986). The abuse of, and increased likelihood of addiction to, other substances, including alcohol and drugs, is documented among survivors of child sexual abuse by several reseachers including Benward and Densen-Gerber (1973), Briere (1988), Briere and Runtz (1987), Cavaiola

and Schiff (1988), Cohen and Densen-Gerber (1982), and Singer, Petchers, and Hussey (1989).

Further self-destructive behaviors (Briere, 1988; Sedney & Brooks, 1984), self-mutilation (deYoung, 1982b; Shapiro, 1987), and suicidal ideation and attempts (Anderson, 1981; Cavaiola & Schiff, 1988; Lindberg & Distad, 1985) occur with significantly greater frequency among victims of child sexual abuse than among various other comparison groups--both in the community and in treatment. Women who had experienced incest had higher rates of suicide attempts than did comparison daughters of seductive but not incestuous fathers (Herman & Hirschman, 1981). And more frequent suicide attempts were reported for women survivors of child sexual abuse than for other female mental health outpatients who had not experienced such abuse (Briere, 1988; Briere & Runtz, 1988).

Social Sequelae. Finally, the arena of social functioning and interpersonal relationships appears to be significantly disrupted in the lives of those sexually victimized as children. Initial and long-term social withdrawal is found by many researchers (Adams-Tucker, 1982; Briere, 1984; Courtois, 1979; Herman, 1981). Among school-age children (7-13) who have been sexually abused, the Tufts (1984) study found 18% were socially withdrawn, and 45%

exhibited antisocial behavior (1984). Conte and Scheuerman (1987), in their factor analysis of CSA effects, paradoxically concluded that sexually abused children were both antisocial and also overly compliant and too eager to please. Sexually abused children were also found to be oppositional (Adams-Tucker, 1982), hostile toward their parents (Herman, 1981; Meiselman, 1978), and in conflict with their parents and other authority figures (Runtz & Briere, 1986).

Social isolation and feelings of alienation are significantly more often problematic for the sexually abused child both initially and continuing into adulthood (Briere, 1984; Conte & Schuerman, 1987; Lindberg & Distad, 1985a; Tsai & Wagner, 1978). Problems in interpersonal relating begin early for sexually abused children (Conte & Schuerman, 1987). Poorer social adjustment is reported for college-aged survivors (Harter, Alexander, & Neimeyer, 1988), and difficulty with close relationships continues throughout life (Courtois, 1979; Meiselman, 1978; Owens, 1984).

Attempts at a General Theory: Origins and Interrelations of Various Sequelae

Research into the sequelae of CSA and incest is still too young to have produced recognizable "general theories."

Yet the last decade has produced some noteworthy attempts at partial theories and even sketches of general theories, attempting to explain the relationships among the various sequelae by demonstrating their common origins in specific features of the CSA experience.

A theory sketched by deYoung (1982a, 1984) addresses one set of child sexual abuse sequelae, those dealing with the victim's acquisition of highly sexualized behaviors. Framed primarily as a response to those who use this sexualization to claim that the victim was a seductive participant in her own victimization, deYoung's theory portrays the heightened sexualization as a *coping response* to the victimization. In her 1982 article, she suggests that the sexualized behaviors have five coping functions, all shaped by the experience of CSA itself: (1) attention and affection-soliciting behavior, since CSA frequently occurs as the sole "affection" and "attention" available in an otherwise affection/attention-deficient family; (2) an attempt to deal with separation anxiety, since CSA frequently threatens to break up a family; (3) assumption of the identity of sexual seductress, of which the perpetrator typically accuses the CSA victim; (4) an identification with the perpetrator's own seductiveness, since identification reduces the feeling of the victim's powerlessness;

(5) capitulation to the probability of revictimization, out of despair of either self-protection or protection by another in the family. In her 1984 clinical case study, deYoung suggests that this heightened sexualization may also be a counterphobic reaction to a traumatically frightening experience.

Currently one of the most commonly explored attempts at a general theory classifies the effects of sexual abuse as Post-Traumatic Stress Disorder. In summarizing their "Post Sexual Abuse Trauma" version of this theory, Briere and Runtz (1987) conclude that "these sequelae appear to involve: (a) classically conditioned emotional responses that generalize and elaborate over time; (b) negative cognitions and perceptions regarding self, others, and the future; and (c) archaic coping behaviors that cease to be adaptive in the postabuse environment" (p. 376).

Finkelhor and Browne (1985, 1986, 1988) suggest, as a conceptual framework for understanding the sequelae of CSA, that the experience of CSA has four "traumagenic dynamics" that make CSA trauma unique: traumatic sexualization, stigmatization, betrayal, and powerlessness (p. 180). They attempt to show how the CSA experience contains these four dynamics and how the sequelae reported by previous research flow from them.

Berliner and Wheeler (1987) have attempted to explain CSA sequelae as a result of classical conditioning and social learning. They argue that the primary immediate psychological effects of CSA are fear and anxiety, although others may be present. This fear and anxiety impedes normal development and thus causes further maladaptation, leading to long-term personality disorders. Additionally, dysfunctional social learning occurs both in the area of behavior (for example, "premature and distorted sexualization") and in the area of cognition (distrust of others, sense of personal powerlessness, and lack of self-esteem) (p. 421).

As CSA research continues to mature, these and other conceptualizations will be reworked, refined, and possibly integrated in an attempt to discern common patterns in the otherwise overwhelming array of CSA sequelae.

Factors Influencing the Type and Intensity of Sequelae

Because the sequelae of sexual abuse are numerous, occur rarely in isolation, and are considerably varied in their impact upon different children, this review will outline some of the interactions between characteristics of the child, the variables involved in sexual abuse, and the correlated symptoms.

Age at Onset. In consideration of the interaction of child sexual abuse and age, researchers indicate that early-onset sexual abuse is frequently perpetrated within the family, rather than by an outside offender. Of pre-schoolers presenting to an acute care hospital because of sexual abuse, 72.5% were victims of intrafamilial abuse (Mian, Wehrspann, Klajner-Diamond, LeBaron, & Winder, 1986). According to that study, two-thirds of all the children initially presented to the hospital with physical and/or behavioral symptoms. Adams-Tucker (1982) found that when abuse began at an early age and was longstanding, emotional disturbances were more severe. Browne and Finkelhor (1986) found no clear relationship between age of onset and degree of trauma, but suggested a possible trend for abuse at earlier ages to be more traumatic.

Among the symptoms of child sexual abuse observed in infants and very young children are acute anxiety, failure to thrive, withdrawal, fretfulness, whining, crying, clinging, impairments, feeding disturbances, and later speech disturbances (Lewis & Sarrel, 1969). Other early-onset symptoms are sleep disturbances, loss of toilet training, precocious sexual behavior (Goodwin & Owen, 1982), thumbsucking, and self-injurious behaviors, pick-ing, scratching, and tics (Courtois, 1988). Pre-schoolers

may engage in ritual cleaning and washing and perseverative symbolic destructive play (Goodwin & Owen, 1982).

The Tufts study (1984) found latency-aged school children more psychologically disturbed by sexual abuse than were the pre-school or adolescent victims, with a full 40% of 7- to 13-year-old children exhibiting significant pathology. Some of the symptoms more typical to latency are recurrent nightmares, especially of death and being trapped, anxiety and phobias regarding separation (Goodwin & Owen, 1982), depression, concentration problems, eating disorders, and pseudo-mature behavior (Courtois, 1989).

In contrast to the Tufts study (1984), both Sedney and Brooks (1984) and Sirles et al. (1989) found that initiation of sexual abuse after puberty resulted in higher levels of symptoms in the adolescent age group. According to Sirles and her colleagues (1989), adolescents were more likely to be diagnosed with a clinical syndrome than were younger victims. Teenagers may act out in rage with rebellious, delinquent behavior including sexual promiscuity, early pregnancy, abortion, marriage, substance abuse, running away and/or suicide attempts (Courtois, 1989; Goodwin & Owen, 1982).

Types of Sexual Abuse. The more intrusive the sexual acts perpetrated against the child, the more intense and

long-term are the negative effects. Russell claims that the "severity of the abuse in terms of the sex acts involved was found to be the best single predictor of the degree of trauma reported by the victim" (1984, p. 389). Children who were genitally molested experienced greater emotional disturbance (Adams-Tucker, 1982), while survivors of sexual abuse involving intercourse evidenced the most psychopathology of all (Bagley & Ramsay, 1985; Briere & Runtz, 1988; Herman, Russell, & Trocki, 1986; Sedney & Brooks, 1984).

Intercourse was more likely to be involved in abuse by stepfathers rather than by fathers (Russell, 1984). Making a distinction between "very serious" abuse (vaginal, anal, or oral intercourse) and less serious forms, Russell found that a full 47% of stepfather abuse occurred at the "very serious" level, compared to 26% of father abuse.

Degree of Coercion. The research literature supports the conclusion that forceful sexual abuse of children results in a greater number of long-term negative effects (Briere & Runtz, 1988; Finkelhor & Browne, 1986; Fritz et al., 1981; Herman, 1981; Russell & Trocki, 1986). Clinical diagnoses were more common when physical abuse accompanied sexual abuse (Sirles et al., 1989), and more violent sexual abuse was associated with step-fathers rather than

biological fathers (Russell, 1984).

Frequency of Sexual Abuse. The more frequently the abuse occurred, the more likely was the victim to be diagnosed with a psychiatric disorder (Sirles et al., 1989; Tsai et al., 1979). Repeated sexual abuse resulted in denial, psychic numbing, rage, and unremitting sadness in the child victim (Terr, 1987). Again, stepfathers were reported to sexually abuse more frequently than were fathers and the abuse was "generally considered more traumatic by victims" (Russell, 1984, p. 30).

Duration. Mian and colleagues (1986) found that the duration of sexual abuse was greater in cases of incest than in offenses perpetrated by someone outside of the family. Longer duration of abuse was found to relate to higher chronic somatization, anxiety, depression, acute and chronic dissociation (Briere & Runtz, 1988), as well as sexual behavior problems (Friedrich et al., 1987). Generally, more long-lasting negative effects and greater emotional disturbance were associated with prolonged child sexual abuse (Adams-Tucker, 1982; Herman et al. 1985; Sirles et al., 1989).

Relationship to Abuser. The closer the relationship of the abuser to the child, the more detrimental were the

sequelae of the abuse. Negative effects were more apparent in incest victims rather than those sexually abused by someone outside the family (Adams-Tucker, 1982; Russell & Trocki, 1986; Sedney & Brooks, 1984). Children abused by a parental figure were found to be more emotionally disturbed than those abused by an extended family member (Finkelhor et al., 1986; Briere & Runtz, 1988; Sirles et al., 1989).

Russell's 1984 survey revealed that 60% of incest perpetrators were biological fathers, and 33% were stepfathers. Furthermore, one out of every six women who had a stepfather as a principal figure in her childhood years, was sexually abused by him (Russell, 1984).

Number of Abusers. In their study of 278 university women, Briere and Runtz (1988) note that 39% of the child victims were sexually abused by more than one person. They further found that the number of abusers was correlated with chronic anxiety and depression in the adult survivor of child sexual abuse. Increased incidence of sexual assault in adulthood is found among CSA survivors (Briere, 1988; Fromuth, 1986), particularly among those with a history of incestuous abuse (Miller et al., 1978).

According to Russell (1986b), "victims of incest are twice as likely as other women to be sexually assaulted by

nonrelatives later in life," and are particularly at risk of revictimization by male authority figures such as employers, teachers, doctors, or therapists (pp. 30-32). Additional victimization in Russell's study was best predicted by the duration of the initial incestuous abuse.

Family Functioning. Children who were incestuously abused were found to have families of origin with decreased cohesion and adaptability. As adults these survivors had increased perceptions of social isolation and poorer social adjustment than did other college women with no history of abuse (Harter et al., 1988). Greater family conflict and less family cohesion correlated with both internalizing (self-directed) and externalizing (acting out) problem behaviors, especially sexual problem behaviors for child victims of incest (Friedrich et al., 1987).

Victims in families that exhibit other abusive behaviors, including physical abuse of the children, and alcohol abuse by the offender, were at higher risk of developing severe psychiatric disorders (Sirles et al., 1989). More of the women who had experienced overt incest, rather than merely seductive behavior, on the part of their fathers reported having violent fathers and chronically disabled, ill, or battered mothers (Herman & Hirschman,

1981).

Disclosure or Secrecy. Herman (1981) found that 58% of the incest daughters she studied never told anyone of the abuse until after leaving home. In comparing 50 sexually abused children whose abuse was undisclosed (or masked) with 31 overt cases of CSA, those with masked sexual abuse experienced school problems and psychosomatic disorders three times more frequently than did the overt comparison group (Hunter, Kilstrom, & Loda, 1981). For those with undisclosed or masked sexual abuse, the abusers were more often immediate family members, usually the fathers; and their histories of sexual abuse were chronic twice as often as were the overt cases.

Reactions of Others to the Incest and Its Disclosure. Of the sexually abused children researched by Adams-Tucker (1982), 61% received no active support from the adults, on whom they depended, in dealing with the sexual abuse. These children suffered the most severe complaints, and their diagnoses indicated far more emotional disturbance than was true for the abused children who were given support. Wyatt and Mickey (1987) found that support from the nonabusing parent and others, upon disclosure of abuse, lessened negative attitudes toward men.

The more distant the relationship between the child and the abuser, the more supportive were the reactions of significant others toward the child upon disclosure (Russell, 1986a). Anderson, Bach, and Griffith (1981) and the Tufts study (1984) found more behavioral disturbances in children whose mothers reacted with anger and punishment toward disclosure.

Antecedent Personal Characteristics of the Victim. Personal characteristics of the child such as intelligence, physical health, inherited strengths and vulnerabilities impact upon the experience of sexual abuse in such ways that diverse outcomes might well be expected in different children (Dohrenwend, 1979). Ruch and Chandler (1982) found that children who had not experienced prior mental health stresses were less traumatized by their experiences of sexual assault than were those who had experienced such stresses.

In cases of exposure to other severe life stressors, resources such as personal resilience, a healthy emotional independence, and an ability to receive support from even one significant trustworthy adult seem to be critical qualities that characterize the child who not only survives but succeeds in life, in spite of trauma (Goleman, 1987). There has been insufficient research on the personal coping

characteristics of the sexually abused child to draw similar conclusions for victims of incest.

Methodological Difficulties

The research on child sexual abuse is a growing body of literature with new data expanding at exponential rates. The controversial and sensitive delicacy of this topic further complicates attempts to synthesize the information available, which has not been gathered to date in systematic fashion. There are five types of methodological problems that have beset CSA research to this point.

Data Collection. Discrepancies in estimations of prevalence rates are attributable to factors such as differing methods of data collection (for example, self-administered questionnaires, telephone and face-to-face interviews), all of which yield varying reports. The lack of uniform criteria for defining child sexual abuse, the variation in age ranges of subjects, and the highly divergent populations from which samples are drawn (such as college students, protective services reports, community surveys, and inpatient mental health clinics) make it more surprising that any findings are replicated (Painter, 1986; Wyatt & Peters, 1986).

Sampling. Many of the studies suffer from small sample sizes which do not represent the larger population of incest victims, or from the lack of matched or appropriate control groups, if there are any at all (Asher, 1988). Biased sampling results from the obvious discrepancies between reported, detected, and all actual sexual abuse (Finkelhor, 1987). The confounding effects of the criminality, stigmatization and secrecy surrounding child sexual abuse and frequent retraction of disclosure add further distortion. Predictably, the number of false positives in the CSA groups and false negatives in the "nonabused" comparison groups will remain undetermined.

Validity. The variation in time lapse since the abuse occurred differs widely, not only from study to study, but sometimes within studies (Finkelhor & Baron, 1986). Determination of the validity of experience subjectively reported is complicated by the early, sometimes infant, age of onset and the memory loss, denial, dissociation, or distortion, not only in retrospective adult studies, but also in child research, especially when it focuses upon traumatic events (Finkelhor, 1987).

Measures. The concern of adequate outcome measures is a major issue requiring instruments that are sensitive to

a wide range of potential effects, are developmentally appropriate, unbiased and valid indicators which will not cause further trauma to subjects. The difficulties of gathering detailed yet necessary information about the nature of the abuse experience become a challenging obstacle since only two people typically witness child sexual abuse. The offender rarely considers disclosure in his best interest. Unfortunately, the potential risk of retraumatizing the child by probing for detailed history is often too great to justify ethically. Interviews with the nonoffending parent and archival records are two other valuable but clearly limited sources of information (Bybee, 1987). Many of the studies are weak in adequate history-taking, and expectations or personal biases often slant the interview data.

Design. Finally, sorting the antecedents from the consequents is a task which in many cases calls for a determination of causality, not easily achievable in the type of research required by ethics and the nature of child sexual abuse.

Summary and Need for Future Research

This review of the literature has discerned an emerging direction of research that, while affirming the

fundamentally negative effects of child sexual abuse generally, and incest specifically, acknowledges that both the types and severity of abuse's negative consequences depend to a large extent on the victim's background and specific characteristics of the abuse itself. Sexton, Harralson, Hulsey, and Nash (1988) summarize this elegantly:

> Research investigating the effects of sexual abuse have [sic] demonstrated that the response to abuse is not monolithic (Brooks, 1985). Sexual abuse occurs in a variety of ways and in a variety of environmental contexts. As a result, the responses to these events are varied (p. 8).

The sequelae of child sexual abuse will emerge more predictable and amenable to treatment as the literature draws clearer distinctions concerning the child's personal attributes; the family functioning; the onset, duration, and severity of sexual abuse; and the quality of the victim's relationship to the abuser.

Recommendations for future research include the need for studies to utilize clear and uniform definitions, larger sample sizes, appropriate control groups, unbiased sampling, and sensitive, well-designed measures. One of the most vital contributions to this field that improved research might make in the near future is early, accurate detection of child sexual abuse, leading hopefully to its prevention altogether.

Patterns of Appeal and Vulnerability

Situating itself within the above-cited body of literature on the characteristics of CSA victims, this study focuses on certain specific behaviors and characteristics of sexually abused girls that have been grouped under the umbrella terms "appeal and vulnerability." Although the final results of the study suggest the strong possibility that these characteristics are caused by the sexual abuse experience, no such assumption is made or is necessary.

The Dependent Variables

Three sources have suggested the cluster of behaviors and physical attributes investigated in this study: clinical impressions of this researcher and others,[1] converging implications of the research literature on child abuse, and anthropologist David Givens's ethological theories about sexual attraction (1978). The individual variables will be considered roughly in the order in which they might impress an observer upon first meeting the girl.

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[1] The present researcher has worked with sexual abuse victims in a number of clinical settings over the last fifteen years, including community mental health, women's centers, universities, hospitals, and out-patient clinics.

Older Appearance

Both clinicians and researchers have described child victims of sexual abuse as sometimes looking older than their actual ages, prematurely assuming adult manners, interests and sophistication (Bender & Blau, 1937; Benward & Densen-Gerber, 1972; Krieger, 1980). The overall effect of parentification, a process in which a child (victim) functions as and assumes the responsibilities of a parent, is often premature aging. A daughter's role reversal with her mother, common among incestuous families, imparts to the child a hyperdeveloped pseudomaturity (Browning & Boatman, 1977; Gelinas, 1983).

Ferenczi (1932/1949) claims, additionally, that out of identification with their aggressor, these children mature precociously. "The victim of incest reaches adulthood without the benefits of childhood," claiming "she feels 8 and 80" (Gelinas, 1983, p. 322).

Apparent Pubertal Development

Early pubertal development is reported in clinical observations by Bender and Blau (1937), who rated several sexually abused children as "normal, overdeveloped" or "unusually well developed" (p. 507). They also found that some of the subjects nearing adolescence showed a

precocious development of sex drives, and concluded that "most of them were well developed" (p. 511).

In the umbrella research project "The Psychobiological Effects of Sexual Abuse" in which the current study participates, Putnam and Trickett (1988) hypothesized that repeated sexual abuse would produce early onset puberty triggered by stress induced hormonal increases of two adrenal androgens.

Attractiveness

Most of the child sexual abuse victims seen in therapy have impressed this clinician as attractive, engaging, charming, and usually very eager to please. Frequently, as noted by some researchers, this eagerness to please often assumes the form of over-compliance (Krieger, 1980) or exaggerated submissiveness (Weiss et al., 1955).

Many other researchers have remarked on this characteristically appealing attractiveness of sexually abused children, describing them as responsive, charming, affectionate, friendly, conspicuously attractive, and sexually attractive (deYoung, 1982; Runtz & Briere, 1986). Bender and Blau (1937) note that a "striking characteristic shown by these children was that they had unusually attractive and charming personalities. They made personal contacts

very easily ... and it was frequently considered that these qualities had contributed to their appeal as sexual objects" (p. 511). They conclude that "it cannot be stated whether their attractiveness was the cause or effect of the experience, but it is certain that the sexual experience did not detract from their charm" (p. 517).

Flirtatiousness. Recorded clinical impressions of sexual flirtatiousness or aggressiveness in child abuse victims go back at least as far as Freud's initial seduction theory (1896/1962). Based on the analyses of thirteen women, Freud found that pleasurable, actively aggressive prepubertal sexual experiences seemed to have been preceded by traumatic prepubertal passive sexual abuse. In short, victim seductiveness followed the victim's actual seduction by an adult offender. Although Freud later retracted this early theory as a general basis of hysteria, he never denied its applicability to particular cases (Jones, 1961).

The literature reports submissiveness, flirtatiousness, and sexual seductiveness of child victims towards therapists and hospital staff (Kohan et al., 1987; Krieger et al., 1980; Weiss et al., 1955). More generalized descriptions of overtly seductive behavior toward adults and sexual overtures to adults are also recorded by Brant and Herzog (1979) as well as by Thomas and Rogers (1981).

According to deYoung (1984), Runtz and Briere (1986) and Yates (1982), sexual abuse of children can lead to learned behaviors of "sexy dressing," seductiveness, and highly erotic responsiveness even in very young victims. McCowan (1981) lists sexual provocativeness among other symptoms of child sexual assault, while Hendersen (1972, 1975) and Lukianowicz (1972) go so far as to attribute actual responsibility for the assault to the provocative seductiveness of the child.

Problem Sexual Behavior. In the present researcher's clinical experience, virtually all child sexual abuse victims were experiencing some type of problem sexual behavior. The problem behaviors included sexual preoccupation; inappropriate sexual language; touching, or gesturing in school; excessive masturbation; exhibitionist behaviors; intense sex play with siblings, neighbors, or school peers; and sexual advances towards adults, including therapists. The abuse victims experienced problems ranging from confusion about sexual identity to promiscuity, sexually transmitted diseases, early undesired pregnancy, abortion, and revictimization by a second offender.

These same clinical impressions are supported by a broad range of clinical and research literature, including Bender and Blau (1937), Benward and Densen-Gerber (1972),

Brant and Herzog (1979), Browne and Finkelhor (1986), Ferenczi (1932/1949), Finkelhor (1987), Finkelhor and Browne (1985), Friedrich et al. (1987), Gelinas (1983), James and Meyerding (1977), Kohan (1987), Meiselman (1978), Quinsley (1986), Runtz and Briere (1986), Silbert and Pines (1983), Thomas and Rogers (1981), and Yates (1982). Many of these studies were discussed earlier in this review.

Indeed, there is probably no single characteristic of child sexual abuse victims more frequently mentioned in the literature than problem sexual behaviors.

Attractiveness and Flirtatiousness: Givens's Theory of a Special Interrelation

Cutting across and relating both of the variables of attractiveness and flirtatiousness is the work of anthropologist David Givens (1977, 1978, 1983). Givens hypothesizes a repertoire of basic human attractiveness, rooted in those features, signals, and behaviors in the infant which help to attract and engage an adult in nurturing, caring, feeding, and protecting the dependent child. Givens contends that, "to a considerable extent the motivation behind maternal and sometimes paternal care has come to rely on complex infantile signaling" (1978, p. 347). Lorenz (1943) had also observed that the infant can promote the necessary nurturing responses in the parent by virtue

of a store of dependency signals.

Against this background theory of attraction in general, Givens proposes an explanation of sexual attraction which is based on detailed ethological observations of nonverbal communication patterns. Found across species ranging from vertebrates to mammals and primates (including humans, which Givens investigates with particular scrutiny), these parallel patterns, among adults, signal nonthreatening openness and interest in mating. Specifically, Givens argues that sexual-attraction cues range from flirtation, to courtship, to seduction, and combine the same submissive and affiliative cues that constitute infant attractiveness. Eibl-Eibesfeldt (1971) also has noted how courtship behavior employs patterns of "infantile appeal" (p. 152).

It is quite possible that children are, to varying degrees, innately attractive, appealing, and engaging in order to assure their survival. If an adult misreads these infant bonding behaviors as sexually mature flirtation or even seduction, and chooses to exploit them, he sexually abuses that child. As early as 1932, Ferenczi suggested that sexual abuse results when an adult pathologically projects adult passionate sexual interest onto a child's fantasy, play, or affection.

CHAPTER III

METHOD

Hypotheses

Reflection upon the preceding chapter's constellation of particular behaviors and characteristics of sexually abused girls prompted the current study to consider the following working hypotheses. It was hypothesized that:

1. The sexually abused girls would appear older than would control subjects who had not been sexually abused.

2. The sexually abused girls would appear more physically attractive than would nonabused control subjects.

3. The sexually abused girls would be judged more personally attractive than would subjects who had not been sexually abused.

4. The sexually abused girls would appear more physically developed pubertally than would the control subjects.

5. The sexually abused girls would exhibit more flirtatious behaviors than would the girls who had not been sexually abused.

6. Flirtatious behaviors would correlate with age in distinctly different patterns for the abused girls and nonabused girls.

7. More problem sexual behaviors would be reported for the sexually abused girls than for the subjects who had not been sexually abused.

Subjects

Experimental subjects were 49 females, aged 6 to 16 (X=10.97), who had been sexually abused by an older male family member. Fifty girls, also aged 6 to 16 (X=10.94), who had not experienced sexual abuse constituted the comparison group. The two groups were matched on the basis of age, race, and socioeconomic status (as determined by the Hollingshead Rating Scale, Hollingshead, 1975). Table 1 shows the demographic characteristics of both the experimental and the control families who constituted the subject pool for the current investigation.

For purposes of matching experimental with control subjects and running statistical analyses, the subjects were divided into five age groups. Age Group 1 included ages 6 and 7. Age Group 2 included ages 8-9. Age Group 3 included ages 10-11. Age Group 4 included ages 12-13. Finally, Age Group 5 included 14-16 year olds.

Because male victims appear relatively scarce and more reluctant than females to disclose sexual abuse, the study was restricted to females.

Table 1

Demographic Characteristics of Participating Families

Characteristic	Abused Group (n = 49)	Control Group (n = 50)	Both Groups (N = 99)
Girl's age (in years)			
Mean	10.59	10.48	10.53
Range	6-16	6-16	6-16
Girl's ethnic group (%)			
White	63.3	50.0	56.6
Black	32.7	46.0	39.4
Hispanic or Asian	4.1	4.0	4.0
Family SES (Hollingshead score)*			
Mean	31.33	34.14	32.79
Range	0-61	0-61	0-61

*An index of family socioeconomic status (SES) was completed using the Hollingshead Four Factor Index of Social Status (1975). Scores ranging from 30 to 39 represent occupations such as skilled craftsmen and clerical and sales workers.

Child sexual abuse victims were recruited as subjects for the study from the Chesapeake Institute of Wheaton, MD, a private, non-profit organization specializing in the treatment of sexual abuse. Subjects were also recruited from protective service agencies of the Washington, D.C., metropolitan area and from neighboring counties.

Racially, 56.6% of the entire sample were white, 39.4% were African-American, and 4% were either Hispanic or Asian. Their socioeconomic levels, incorporating education, income and occupation, ranged from the lowest class to the upper class, with the average being middle class ($\bar{X}$=32.77, Hollingshead, 1975). The abused and nonabused populations did not differ significantly on age, race or socioeconomic status.

Criteria for victim participation in the study were abuse involving genital contact and/or penetration, by a family member (broadly understood as father, step-father, brother, or mother's live-in boyfriend), with report of the abuse to protective service professionals having occurred within the previous six months.

The preceding measures were taken in an attempt to address the major methodological problems mentioned in the review of the literature (pp. 39-42).

Materials

Child Sexual Behavior Checklist

The Child Sexual Behavior Checklist (see Appendix A) is an unpublished modification of Friedrich's Child Sexual Behavior Inventory (1986). Putnam and Trickett (1988) adapted the scale specifically for the umbrella study, and

high construct validity ratings (alpha = .91) were established by this researcher. Friedrich (1986) earlier found significant (r=.58, p < .01) cross-validation with the sexualization factor of the Achenbach Child Behavior Checklist (Achenbach & Edelbrock, 1979). A nonabusing parent or legal guardian completed the Sexual Behavior Checklist describing the child subject.

Family and Demographic Information

Demographic information about the family and a detailed developmental history of the child were taken in an interview with the nonabusing parent or caretaker. Information was gathered regarding race, education, and income, including the Hollingshead Four Factor Scale of Social Status (Hollingshead, 1975). The family demographic interview is found in Appendix B.

The Appeal-Vulnerability Scale

Developed by this researcher for the current study, the Appeal-Vulnerability, or AV, Scale was used to score the eight-minute videotape of the girl initially meeting an unknown male researcher. Appendix C contains the scale, which was originally called the Attractiveness-Maturity Rating List. The AV Scale was designed as a behavior

coding list to measure the frequency of certain discrete behaviors on the part of the child and to gather general impressions from an observer regarding certain personal characteristics of each girl.

Behaviors and characteristics for the scale were derived from this researcher's clinical observations of both children and adults, from the child sexual abuse literature, and from the ethological research of Givens (1978). As discussed earlier, Givens's theory of attraction (1978, 1983) contends that individuals possess a repertoire of behaviors and cues that promotes bonding between parent and child, and later between mates.

The combination of affiliative and submissive cues constitutes infant attraction. With pubertal maturity or sexual experience, these behaviors can become more flirtatious, sexualized, or even seductive.

Classifications of behaviors and characteristics to be included in the rating scale were determined by a team of this and three other NIMH researchers, composed of two men and two women. Factors were selected and judged to be either affiliative, submissive, dominant or dissociative. Appeal was judged to combine affiliative, attractive and attention-getting behaviors and characteristics. It constitutes a measure of personal and physical attractiveness,

in Givens's (1978) sense of "attraction." Vulnerability includes submissive and dissociative behaviors and the lack of dominant ones. Flirtatiousness, also in keeping with Givens, was considered to be a composite of appeal and vulnerability. In combination with certain indicators of maturity, appeal and vulnerability were expected to capture some sense of the girl victim of incest.

Major subscales were two: Appeal and Vulnerability. The combination of both subscales is considered a measure of Flirtatiousness. Removal of physical attractiveness from the Appeal Subscale attempts to capture personal attraction. Two final items tap perceived age and puberty. The total scale is called the Appeal-Vulnerability (AV) Scale. Table 2 summarizes the Appeal-Vulnerability Scale.

The original measure was pared down from 65 to its final 20 items after about 400 ratings were completed. This was done to render the scale simpler, easier to code, and more highly replicable. The current Appeal-Vulnerability Rating Scale, included in Appendix D, consists of 20 items. Twelve items require frequency counts of discrete behaviors, 6 others are Likert-scaled impressions of the girl, 1 an estimate of her age, and a final item allows space for significant speech content. Five of the twelve behavioral cues are considered affiliative, such as smiling

Table 2

Components of the AV Scale and Its Subscales, With Parenthetical Numbers Referring to Items on the Final AV Rating Scale Sheet

APPEAL-VULNERABILITY SCALE

FLIRTATIOUSNESS SUBSCALE

APPEAL SUBSCALE

AFFILIATION SUBSCALE
- Leans towards (1)
- Smiles (5)
- Laughs (6)
- Touches face (9)
- Touches hand (10)

SEXUALIZED BEHAVIOR SUBSCALE
- Touches crotch (12)

ATTRACTION SUBSCALE
- Personality (16)
- Conversation (17)
- Interaction (18)
- Volume (19)
- Significant speech (20)

PHYSICAL ATTRACTIVENESS SUBSCALE
- Physical attractiveness (15)

VULNERABILITY SUBSCALE

SUBMISSIVENESS SUBSCALE
- Head tilt (3)
- Eyes sweep (4)

NON-DOMINANCE SUBSCALE
- -Head forward (2)
- -Smiles with teeth (7)
- -Touches thigh (11)

DISSOCIATIVE SUBSCALE
- Spaces out (8)

APPARENT-MATURITY SUBSCALE
- Apparent age (13)
- Apparent puberty (14)

or touching one's own face, and serve to attract attention or to welcome approach. (These are Items 1, 5, 6, 9, 10.) Two cues--the side head tilt (which bares the throat) and eye sweep (which alerts and includes the other but does not glare)--appear to signal submissiveness, with no intent to threaten (Items 3 and 4). Related to Givens's cluster of dominant behaviors are three cues which seem, in this population and situation, to present more as self-protective. Teeth-show when smiling, head tilted forward, and touching the thigh possibly suggest the child's fight or flight potential (Items 7, 2 and 11). Holding or touching the crotch is interpreted for this study as a sexualized behavior. The final behavior that was added to the scale was suggested by the first two coders who could not elsewhere record a recurring "spacing out" behavior. It is not surprising that the sexualized and dissociative behaviors were not included among Givens's observations of populations who were less likely exposed to early trauma than our current sample.

The behaviors and characteristics were operationally defined and agreed upon by the team of researchers. Written copies of behavior definitions were kept on hand for consultation during coding sessions. (See Appendix E.) In order to assess construct validity of the AV Scale,

Cronbach's alpha (Bakeman & Gottman, 1986) and Kendall's Coefficient of Concordance were computed. Coefficient standards of .70 and .60 were determined for the two tests, respectively.

Videotape Recordings

Four trained observers were responsible for coding the behaviors of the children as observed in the eight-minute videotape segments. Like the child testers, the observers remained blind to the abused or nonabused status of the subjects. All were female college seniors or graduate students majoring in psychology. Their thirty hours of training consisted of: discussion of the behavior definitions, guided observation, familiarization with the original scale, and trial codings of videotapes (which were not included in final reliability counts). After maintaining inter-observer reliability ratings greater than 90% for five consecutive tapes, each observer began to code independently. Continual checks on reliability were kept and a three-hour retraining session was given each coder about half-way through her term of coding.

The observers coded each videotape twice, and 59% of all the tapes were independently coded by two or more observers. Inter-rater reliability was computed using

Cronbach's alpha, considered appropriate for nonsequential observation of behavior (Bakeman & Gottman, 1986) and Kendall's Coefficient of Concordance (W). The resulting .89 alpha and .66 W coefficients of reliability confirm high inter-observer agreement.

Procedure

This research used part of the data currently being collected for a longitudinal study investigating the psychobiological effects of child sexual abuse (Female Growth and Development in Childhood and Adolescence), co-sponsored by the National Institute of Mental Health (NIMH) and the Chesapeake Institute. The protocol of the larger study is approved by the Human Subject Research Review Committee of NIMH. The research component which constitutes this current study is also approved by the Human Subjects Institutional Review Board of Western Michigan University. Both protocol approvals are found in Appendix F. The author of the current study works as a research assistant, involved in data collection, entry and analysis, interviews and testing with the NIMH study.

Subject Recruitment

The procedure for recruiting abuse subjects for this study was the following:

1. Descriptions of the research, including referral forms, were distributed to referral agencies.

2. After report of the abuse had been registered with Child Protective Services, the caseworker informed the abuse victim and her legal nonabusing guardian about the opportunity of participating in the study.

3. Once the child's legal guardian signed, a standard informed consent was mailed to the Chesapeake Institute research site.

4. Next, this researcher or another research assistant telephoned the family to provide further information or to answer any questions and to schedule an initial appointment.

The control group was recruited through advertisements in local newspapers, laundromat bulletin boards, low income housing newsletters, well-child clinics, day care centers, and by word of mouth, in order to reach lower income families. Appendix G contains the referral and recruitment materials.

Informed Consent

Once respondents had been matched to experimental subjects on certain demographic variables, this researcher telephoned them to schedule two appointments, usually one week apart. During the first appointment, the parent and child were jointly informed of all testing procedures and videotaping and of their right to decline to participate in any part of the study or to withdraw altogether at any time. Explanations were made as simple and clear as possible and adjusted to the age and educational level of each participant. Both guardian and child were asked to sign several consent forms (included in Appendix H). No procedure was done without full written consent. Additionally, families were asked to sign release forms allowing contact of the child's school and teacher regarding her behavior at school.

Control subjects and their mothers were informed of the researchers' legal obligation to notify Child Protective Services in the event that child abuse was ascertained in the course of the interviews. In cases where it was discovered that control subjects had experienced familial sexual abuse, they were placed in a third group for future study, outside of the experimental or control group.

Mother/Guardian Interviews

Participant girls and their mothers met twice, at one week intervals, for two-hour sessions with the research staff. The mother was interviewed, separately from her daughter, by this or another researcher. Each mother or guardian completed a series of questionnaires, including the Child Sexual Behavior Checklist (Putnam & Trickett, 1988). The mother's interviewer was informed about the abuse/control status of the family in order to ask the mother a few specific questions related to the sexual abuse and to debrief control families.

The Stranger Situation

During the mother's interview, prior to the beginning of the first session, the child met another researcher in a separate room for a short warm-up session, commonly practiced by well-trained examiners.

While the daughter sat, basically waiting for eight minutes, the tester attended to paperwork. The examiner's desk faced away from the child's chair, and he held only minimal conversation with her. This initial meeting with the previously unknown male tester constituted "The Stranger Situation" and was videotaped (with prior consent from both daughter and parent).

The three male psychologists or doctoral students (ages ranged from 30-35) who served as testers were trained to keep the initial exchange superficial, deliberately avoiding any discussion of sensitive or highly personal matters, even if introduced by the girl participant. Nothing in either the conversation or the manner of any examiner could be construed as sexually suggestive or provocative. At no time was any question regarding sexual abuse asked of a child subject. The child testers were kept blind to the abuse-control status of the girl.

Human Subjects Protection

As earlier mentioned, the protocol of the current research is approved by the Human Subject Research Review Committee of NIMH and by the Human Subjects Institutional Review Board of Western Michigan University. Confidentiality in this study is insured by a Federal Certificate of Confidentiality which protects all the study's research records from subpoena. Research measures and videotapes are coded by number rather than with the subject's name. Only one recorded listing of the names and code numbers together is maintained, and that in a locked file. Completed measures and videotapes are stored in locked files at the research site until destroyed. The protocol consent

sheets and all official paperwork for NIMH identify the study as "Female Growth and Development in Childhood and Adolescence" in order to prevent reference to child abuse in written public documents.

This study has been structured to minimize all obvious potential risks or hazards. All subjects were informed of their rights to decline participation in any part of the study or to withdraw altogether at any time. When a girl displayed discomfort at separating from her mother, the interviewer offered to arrange for the mother to remain with her for the session.

Each participant mother was assured that she would be notified immediately if any significant problem was observed in her child during the present data collection. Notifications of this sort were made, and options for addressing the concerns were discussed. Families were monetarily compensated for time and travel inconveniences according to the guidelines of the National Institute of Health Normal Volunteer Office.

The combination of sensitive interviewing and rapport-building, the clinic's attractive physical environment, the provision of snacks, and the friendly concern invested by the research team in the participants contributed to positive experiences for the families involved. The high

return rate for the second interview (93%), and then for the second year of interviews (85%) seems testimony of both strong rapport and good research.

Statistical Analyses

The current study required two stages of statistical analyses. All computations were done by this researcher using the Statistical Program for the Social Sciences for Personal Computers (SPSS/PC+ V3.1) (Norusis, 1989). The preliminary analyses were run to assure that the group of sexually abused subjects and the group of normal volunteers were demographically close enough to be genuinely comparable and to help create the AV Scale. Tests were done to determine construct validity of this scale and the Sexual Behavior Checklist. Confirmation of the coders' inter-rater reliability was also part of the first run of analyses.

Preliminary Analyses

On general demographics, *t* tests were run on age and on socio-economic status as scored by the Hollingshead Four Factor Index of Social Status (Hollingshead, 1975). Chi squares were computed on race. All items on the original AV scale which involved behavior counts were subjected to

frequency checks and to either chi squares or *t* tests, depending on mean sizes. The final Likert scaled items were analyzed using the Mann-Whitney non-parametric test. Items which occurred too rarely were excluded from the scale. Behaviors that occurred either uniformly among all subjects, or were isolated to only certain age groups, were also eliminated. This was done to simplify the test and render replicability possible. Important information about highly uniform behaviors across all subjects will be reported for this study, but are not needed in the final version of the scale, intended for distinguishing between the groups. Cronbach's Alpha was then used to verify inter-item reliability of both the Sexual Behavior Checklist and the AV Scale and to assess inter-observer reliability.

Hypotheses Testing

In the final stages of analysis, each of the working hypotheses was subjected to tests for statistical significance. Preliminary scatter plots were done on the dependent variables of flirtatiousness, personal attractiveness (Appeal), and problem sexual behaviors. The graphs suggested linearity of relationships, which were confirmed by Student's *t* tests. Consequently, linear multiple regressions were performed on the three dependent variables,

across age, for the abuse group alone, for the comparison group, and for both groups combined.

On observed flirtatious behaviors, personal appeal behaviors, vulnerability behaviors, and problem sexual behaviors, t tests were run (as reported on the Child Sexual Behavior Checklist). Mann-Whitney nonparametric tests were computed on Likert scaled perceptions of physical attractiveness, estimates of pubertal development, and age differences.

Finally, analyses of variance were used to examine the interactions between age and abuse status in relationship to flirtatious behaviors, personal appeal scores, and problem sexual behaviors. Significance levels of .05 or less were required to reject the null hypotheses that no differences exist between the experimental group and control group of girls.

CHAPTER IV

RESULTS

In brief summary, the current study investigated the expectations that (a) abused girls would appear older, more pubertally developed, and more physically and personally attractive; (b) would act more flirtatiously; and (c) would report more problem sexual behaviors than would matched controls. The expectation that flirtatious behaviors would change with age for the abused girls in a very different pattern than for the controls was also investigated.

In order to systematically record these behaviors and personal characteristics, behaviors counts were taken and impressions registered on the AV Scale. This rating scale was developed specifically for this study, as discussed in greater detail in Chapter III, "Methods." The target sample of behaviors was captured in an eight-minute video segment of each girl's first meeting an unknown male tester. Additionally, the mother's or legal guardian's report of problem sexual behaviors for her daughter was measured by the Child Sexual Behavior Checklist, adapted from Friedrich (1986).

Results of the Preliminary Analyses

Preliminary analyses were run to help refine the AV Scale, to ascertain its construct validity and that of the Child Sexual Behavior Checklist, to assess inter-rater reliability, and to assure demographic comparability of the two subject groups.

Regarding measures, the Child Sexual Behavior Checklist gathered information that reflected a very high level of internal construct validity for the measure when tested by Cronbach's alpha (.91).

An early version of the Appeal-Vulnerability (AV) Scale was used by four observers to record behavior counts and impressions of the subjects gleaned from the videotapes. Means of the coder's rating on each item for each girl were used. Of the 65 items (Table 3) included in the full codings, 20 met the criteria for inclusion in the final measure. Twenty-eight behaviors occurred too rarely to be included (a total frequency of less than 25 out of more than 4,000 observed behaviors), and 13 occurred too uniformly across all subjects ($p>.35$). Three behaviors (sitting on the floor, lying on the floor and moving in the direction of the tester) were deleted from this scale because they were observed only among the youngest age groups, and therefore were not applicable to the full range

Table 3

Original Appeal-Vulnerability Scale Items: Bases for Inclusion or Exclusion on Final AV Scale

Orig. Item No.	Item	Frequency	Chi square	*t*-value	Mann-Whitney value	One-tail *p*-value	Comments
* 6	Age guess	NA	1.8230			0.0885	
7	Moves toward other	109.5					Age restricted
* 8	Leans toward other	142.5	9.4245			0.0045	
9	Lies on floor	55.5					Age restricted
10	Sits on floor	108.0					Age restricted
*11	Side head tilt	55.5	1.3899			0.1192	
12	Head or hair toss	13.0					Too rare
*13	Head tips forward	43.0	0.0899			0.3822	
14	Head tips back	7.5					Too rare
15	Chest protrudes	2.5					Too rare
16	Rocking motion	126.5	0.1644			0.6850	
17	Brows raise	4.5					Too rare
18	Eyes lower	11.0					Too rare
19	Blink	1.0					Too rare
20	Steady gaze	562.5		-0.26		0.3970	
21	Quick glimpse	256.0		-0.39		0.3490	
22	Eyes averted	264.0		-0.04		0.4840	
*23	Eyes sweep to and fro	79.0	2.1509			0.1706	
24	Mouth open	5.5					Too rare
25	Mouth compressed	14.0					Too rare
26	Pouting	1.5					Too rare

* Items retained in final Appeal-Vulnerability Scale.

Table 3--Continued

Orig. Item No.	Item	Fre-quency	Chi square	*t*-value	Mann-Whitney value	One-tail *p*-value	Comments
27	Frowning	0.0					Too rare
*28	Smiling	127.5	5.1075			0.0821	
*29	Full smiling (teeth)	80.0	0.3093			0.2891	
*30	Laughing	76.0	2.7084			0.1291	
31	Tongue show	4.5					Too rare
32	Singing	3.0					Too rare
33	Chewing	9.0					Too rare
34	Yawning	4.0					Too rare
35	Hand covers mouth	9.5					Too rare
36	Shoulder shrug	24.5					Too rare
37	Arm stretch	12.5					Too rare
38	Arms folded/smile	22.0					Too rare
39	Arms folded/no smile	40.0	0.0949			0.7580	
40	Palms up and open	14.5					Too rare
41	Chin rests on hands	40.0	0.1084			0.7420	
42	Fingers splayed	17.0					Too rare
43	Waving	0.0					Too rare
44	Hand behind head	6.0					Too rare
45	Legs spread apart	456.0		-0.24		0.4035	
46	Legs close together	186.5		0.02		0.4925	
47	Legs stretched out	26.0	0.0000			1.0000	
48	Knees crossed	65.5	0.0000			1.0000	
49	Foot aims at other	9.5					Too rare

* Items retained in final Appeal-Vulnerability Scale.

Table 3--Continued

Orig. Item No.	Item	Frequency	Chi square	t-value	Mann-Whitney value	One-tail p-value	Comments
50	Feet pigeon-toed	29.5	0.0950			0.7580	
*51	Hands touch hands	210.5	1.8905			0.1943	
*52	Hands touch face	211.0	0.4912			0.2417	
53	Hands touch hair	96.0	0.7310			0.3926	
54	Hands touch ear	13.5					Too rare
55	Hands touch neck	12.0					Too rare
56	Hands touch breast	11.0					Too rare
*57	Hands touch crotch	24.5	2.1994			0.0690	
*58	Hands touch thigh	99.5	0.7516			0.1930	
59	Hands touch lower leg	60.5	0.1778			0.6733	
60	Hands touch foot	12.0					Too rare
61	Shoe off	10.5					Too rare
*62	Spacing out	37.5	1.7290			0.0943	
*63	Significant speech	13.5	4.2433			0.0197	
*64	Voice volume	NA			-1.6699	0.0480	
65	Voice intonation	NA					Response overlap
*66	Physical attractiveness	NA			-0.1182	0.4530	
*67	Personality appeal	NA			-0.7583	0.2241	
*68	Interaction	NA			-2.0936	0.0181	
*69	Puberty	NA			-0.5317	0.2975	
*70	Conversation	NA			-0.5907	0.2774	

* Items retained in final Appeal-Vulnerability Scale.

of subjects. One final item (vocal tone) was excluded because its original Likert responses were not mutually exclusive.

Computation of Cronbach'a alpha on the twenty item AV Scale resulted in an overall coefficient of .71, an acceptable level of inter-item reliability and construct validity. Subscale coefficients for Flirtatiousness (.70), Appeal (.59), Vulnerability (.60), and Attract (.60) are likewise considered acceptable for subscale reliability.

To ascertain the level of inter-observer agreement, two calculations were computed. Kendall's Coefficient of Concordance emerges as a respectable W of .66. Cronbach's alpha rating of .89 indicates high inter-rater agreement among the four observers on each item for the 58 subjects (59% of total population of 99) who were cross-coded by two or more observers. The Guttman Split-Half analysis was additionally done, comparing raters with one another, and resulted in a coefficient of .98.

As mentioned earlier in the methods chapter, statistical comparisons on general demographics of the two groups indicate that the abused and nonabused girls do not differ significantly on age, race, or socioeconomic level. Girls were successfully matched on age (t=.06, p.954), by race (chi-square=1.359, p.244), and socioeconomic level

(t=-1.02, p.311). The racial and socioeconomic distribution approximates that of Washington, D.C., and its surrounding area. With comparability of subjects and reliability of measures and observers assured, testing of the hypotheses could proceed.

Results of the Final Analyses

The results confirmed five of the seven hypotheses. The abused girls appeared older, as predicted by Hypothesis 1. The observers guessed the abused girls to be at least one year older than their actual chronological ages significantly more often than they did the control subjects (U=973.5, p.037). The ages of nonabused girls were as frequently underestimated as overestimated (18-18). On the other hand, the abused girls' ages were more than twice as often overestimated than they were underestimated (24-11).

No significant differences were found in judgments of physical attractiveness between the two groups of girls (U=1211.0, p.480), which fails to confirm Hypothesis 2. However, on personal attractiveness, as measured by the Attract Subscale, the abused girls were found to be significantly more engaging than were the control subjects (t=2.88, p.002), confirming Hypothesis 3. Notice in Figure 1 the sudden increments in attraction with the oldest two

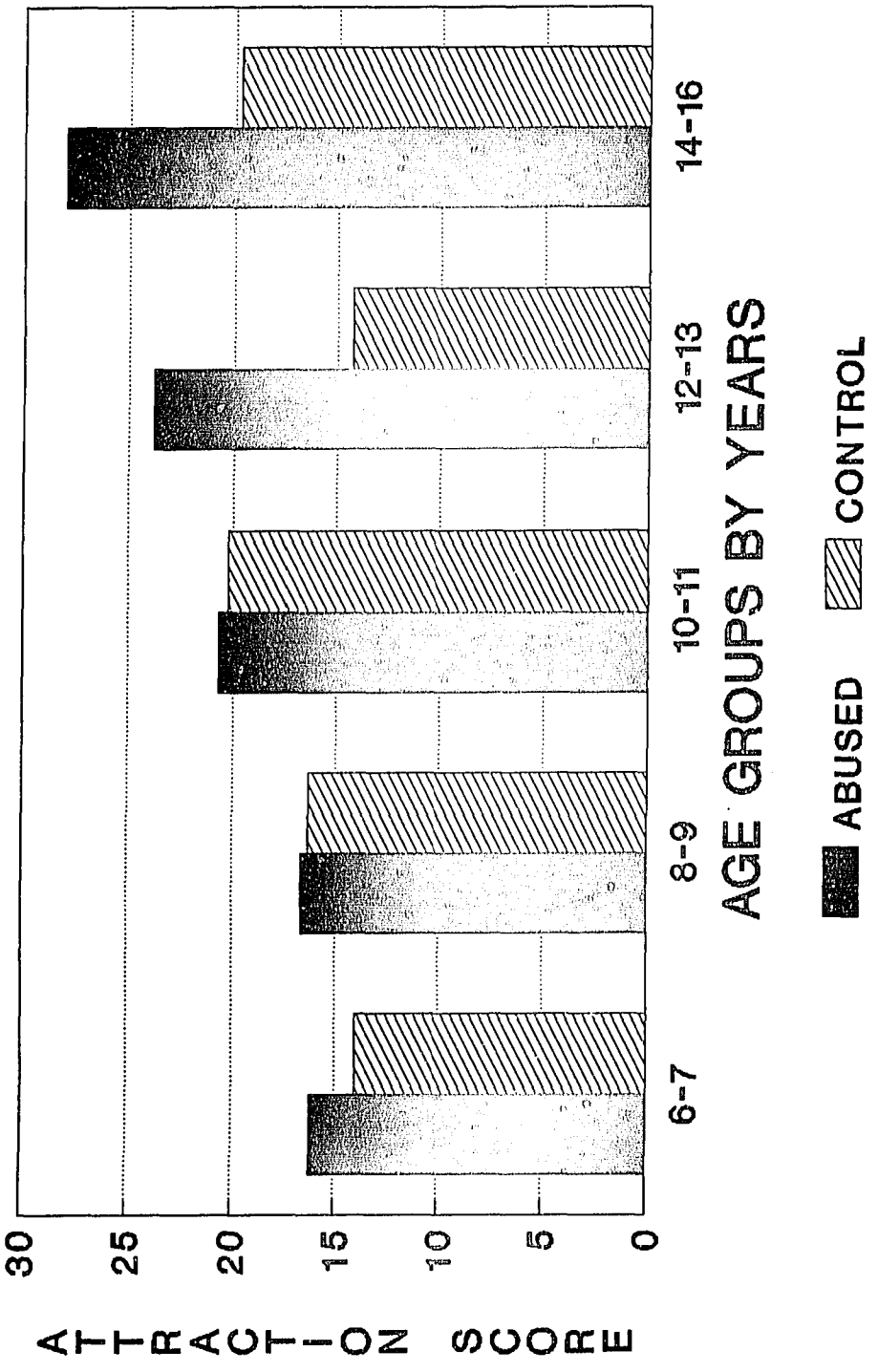

Figure 1. Personal Attractiveness.

age groups of abused girls.

No significant differences were found in observer estimates of the girl's stage of puberty between the experimental and control groups (U=1153.5 p.298), a finding which fails to confirm Hypothesis 4. The closely parallel lines of Figure 2 reflect the similarities in estimated pubertal development. This finding, and a similar finding on physical attractiveness, failed to support Hypotheses 2 and 4, that the abused girls would appear both more physically attractive and more advanced in puberty than would the control girls.

On flirtatiousness, sexually abused girls score considerably higher than their nonabused peers, achieving significance with a t value of 4.00 (p.0000). This confirms the direction anticipated by Hypothesis 5.

Flirtatiousness correlates with age in distinctly different patterns for the abused and control subjects. Scatter plots on flirtatiousness scores suggest linearity, but with markedly different slopes for the abused and control group. Student's t was computed and confirmed linear relationships between flirtatiousness and both age group (t=4.161, p.0001) and abuse/control group status (t= -4.295, p.0000). In partialling out the variance in flirtatiousness among all subjects, 13.5% is attributable to

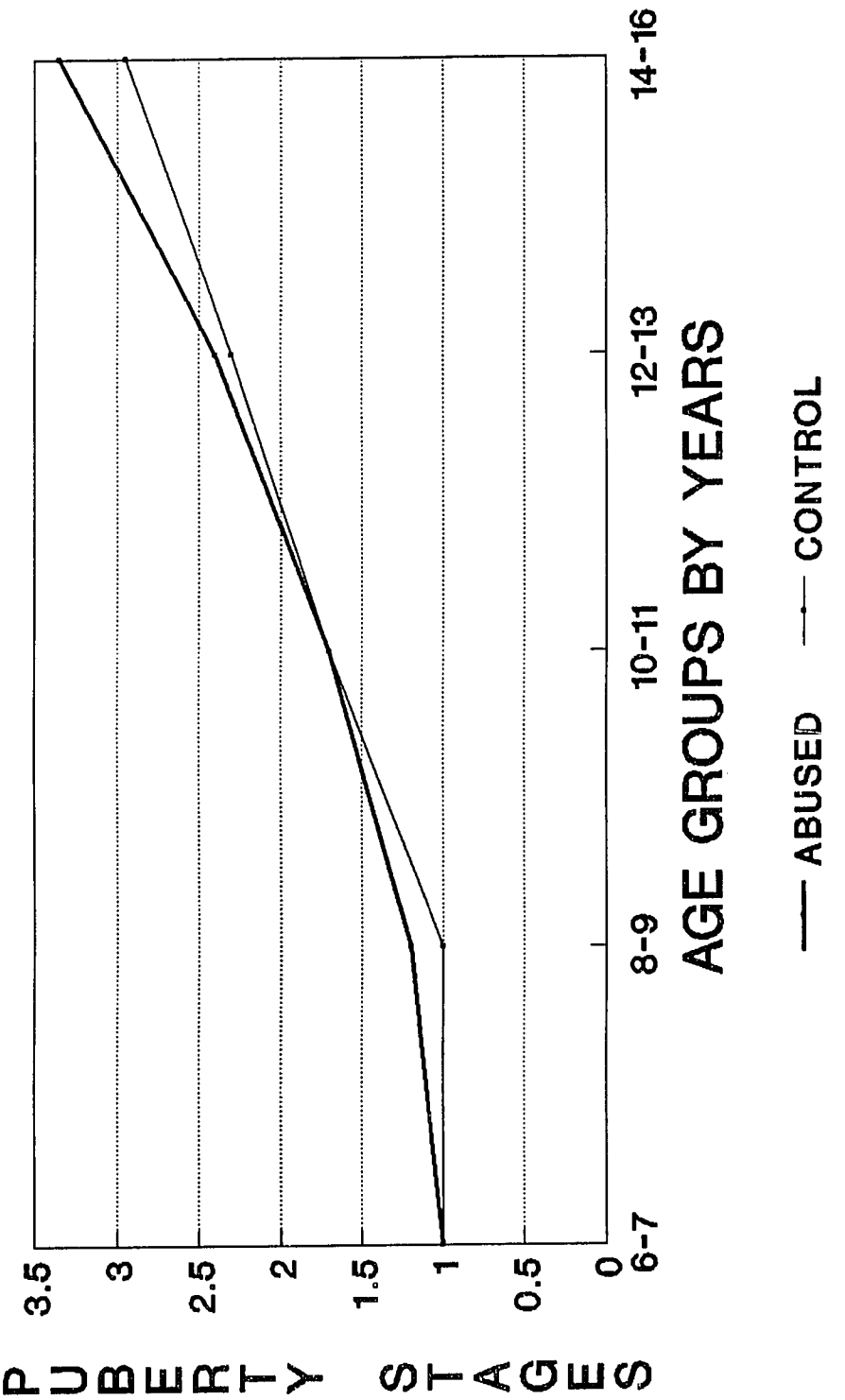

Figure 2. Perceived Stage of Puberty.

age (F=15.12, p.0002) and 14% attributable to abuse status (F=18.14, p.0000). When the two groups are regressed separately, age accounts for much greater variance in flirtatiousness within the abused group (27%, F=17.12, p.0001) than within the control group (4.4%, F=2.20, p.1149). In fact, for the controls, age is not significant in its contribution to flirtatiousness. Clear divergence in flirtatious patterns emerges.

Analyses of variance (ANOVA) were then used to examine the interactions between age group and abuse status in relationship to flirtatious behaviors. Interactions between age group and abuse/control group emerge as significant (F=2.693, p.036). Perhaps the clearest expression of the differences in patterns between the abused and control girls is a graph derived from the ANOVA (Figure 3) overlaying one group's mean (flirtatious behaviors) scores on that of the other. Diverging patterns grow obvious beginning with the 12-year-old girls in Age Group 4.

The Vulnerability Subscale was designed to tap the presence of submissive behaviors, while subtracting the effect of dominant behaviors. The combination produces a measure of "vulnerability" or lack of assertive behaviors. The sexually abused girls scored significantly higher than the control subjects on this measure of vulnerability

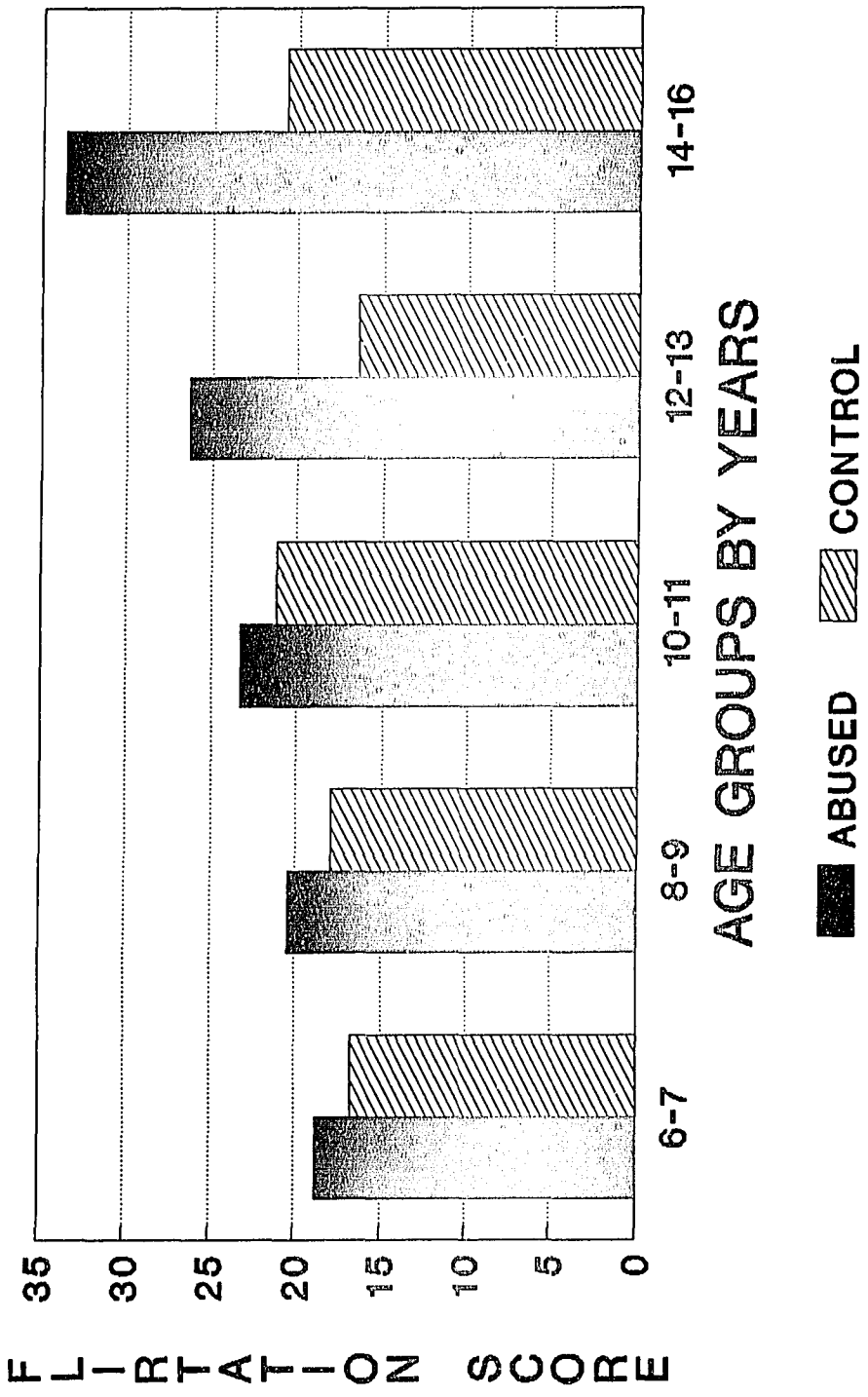

Figure 3. Flirtatious Behaviors.

(t=4.0, p.000). Figure 4 reflects the powerful contrast between the two groups. While the girls who had not been sexually abused are at almost their most assertive stage from 14 to 16 years old, the victimized girls of the same age are the most submissive, and lacking most in assertive or dominant behaviors.

The composite AV scale combines the Appeal and Vulnerability subscales with the estimates of age and stage of puberty. Computations of linear regression and analysis of variance on the appeal-vulnerability ratings reveal powerfully significant differences between the groups of abused and control subjects. A full 15% of the variance in the combined groups can be attributed to abuse status (F= 23.55, p.0000), and 18% attributed to age (F=20.95, p.0001).

Analysis of variance reveals significant effects for group (F=23.49, p.000), for age group (F=7.22, p.000), and for interactions between age and group (F=3.103, p.0009). Figure 5 depicts a graph of the ANOVA findings on A-V ratings which shows a variation on the patterns created by analysis of the flirtatiousness results. Hypothesis 6 is confirmed.

Finally, as for problem sexual behaviors, mothers' reports of these on the Child Sexual Behavior Checklist

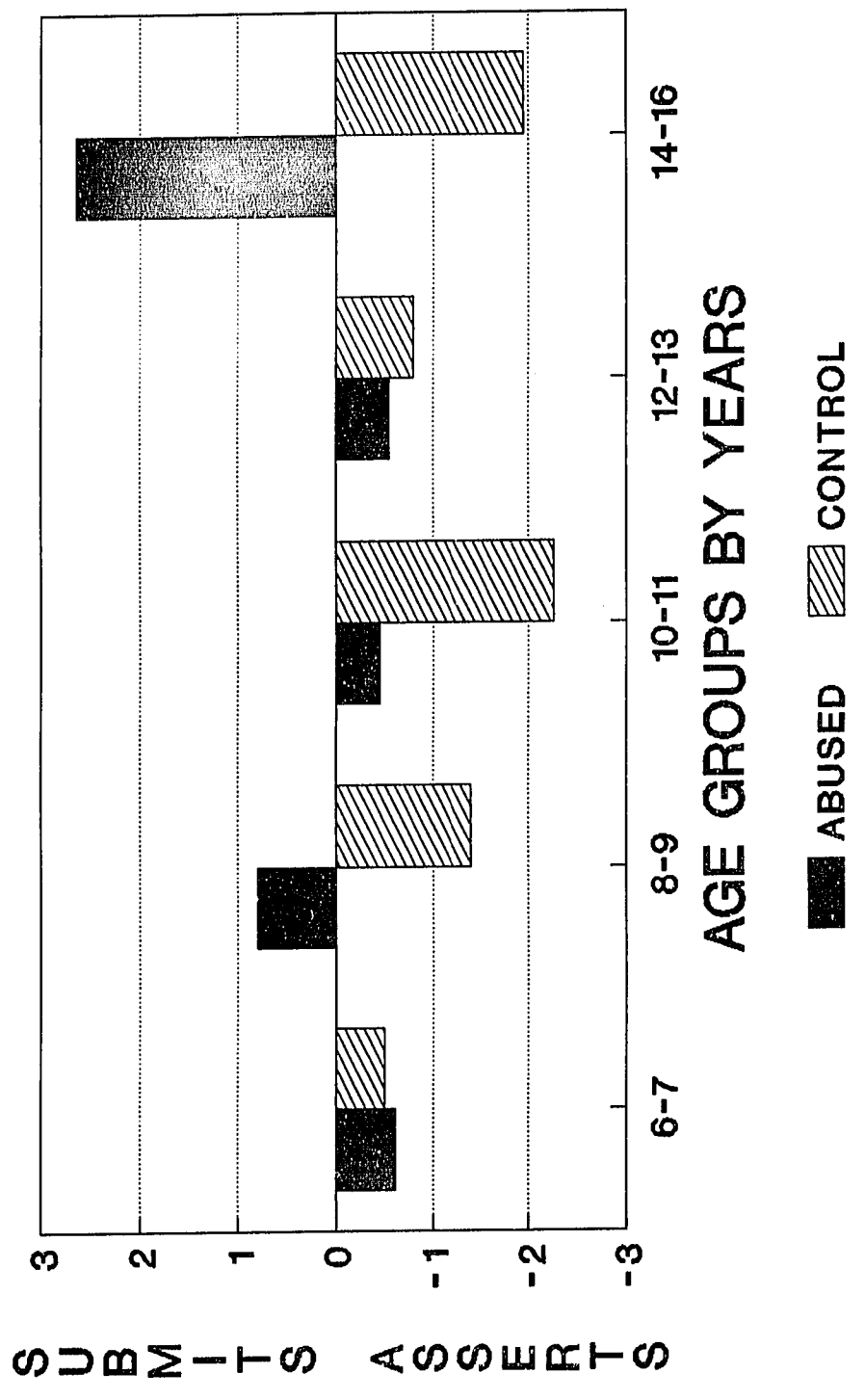

Figure 4. Vulnerability in Child Sexual Abuse Victims.

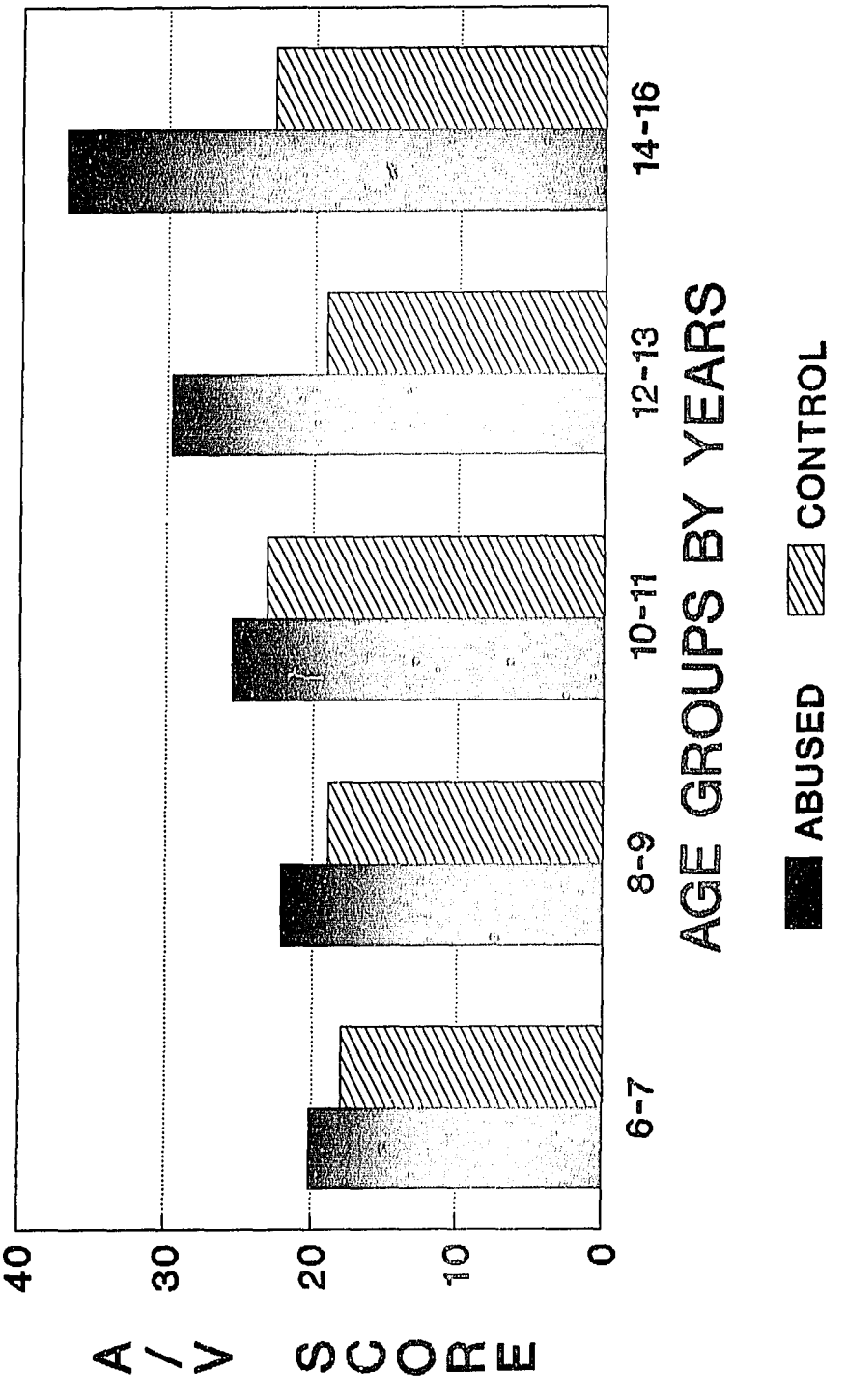

Figure 5. Appeal-Vulnerability.

were significantly higher for the abused than for the control daughters (t=2.31, p.013). This confirms the expectations of Hypothesis 7. Note the high concentration of reported Problem Sexual Behaviors in Figure 6 for the youngest age groups especially, and then again around that critical age grouping of 12- to 13-year-olds.

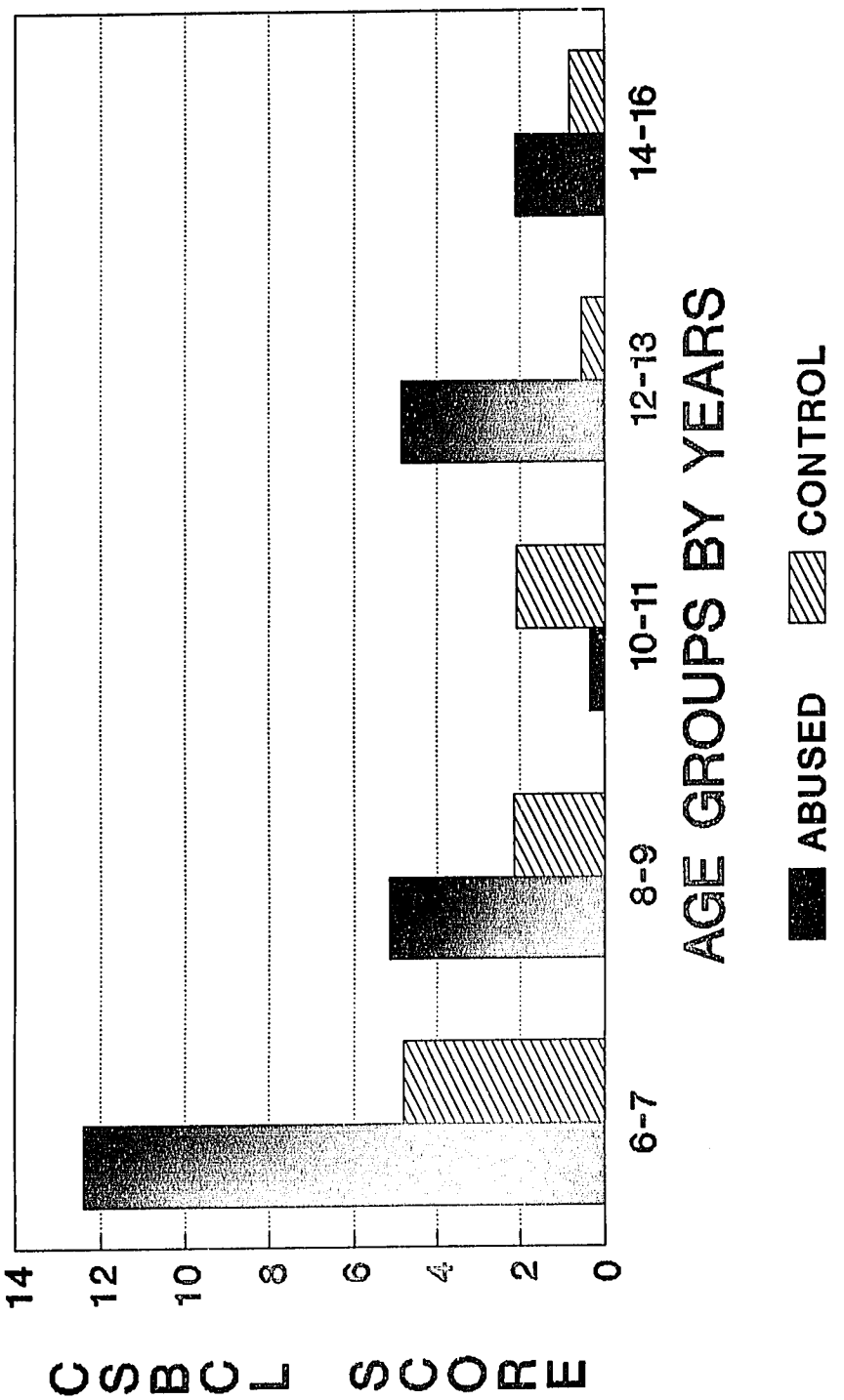

Figure 6. Problem Sexual Behaviors.

CHAPTER V

DISCUSSION

This study was planned to investigate certain behaviors and personal characteristics of girl victims of incest that could be accessible to a concerned observer upon their first meeting. When compared to a matched sample of control subjects upon initial observation, the sexually abused girls appeared older than their actual age but not more pubertally developed, more personally engaging but no more physically attractive, and more flirtatious in interaction with a strange male. Flirtatious behaviors also increased over age in a distinctive pattern for the child victim of sexual abuse, and more problem sexual behaviors were reported for her.

The process and outcome of this study were less simple than originally anticipated, and the data which emerged from studying this population are complex and rich. In order to provide a clearer picture of the sample of girls who were studied, the hypotheses will be more fully considered, along with relevant findings.

Dependent Variables

Apparent Maturity

The abused girls did appear at least one year older than their actual ages significantly more often than did their matched peers. And yet estimates of their stages of puberty did not differ significantly from those of the controls. Equivalence in puberty stage across groups is an unanticipated outcome emerging from the umbrella NIMH research, as well. Within that study, the medical procedure of Tanner Staging on breast and pubic hair development was performed on these same subjects by an experienced registered (female) nurse. The superficial estimates of puberty made by the observers from the current study correlate highly (r=.8702, p.001) with the trained medical staging (and the girl's own reported self perceptions--see Appendix I).

Whatever is making the abused girls appear old for their age, therefore, cannot be explained by advancing puberty alone. The CSA literature has implicated over-identification with the adult (mother or offender), parentification, and pseudomaturity resulting from the early abusive sexual experience. The stress of dealing with trauma of such an intimate and family-involved nature might

in itself trigger premature aging. Gelinas's words (1983, p. 322) describing the abused girl as "8 and 80" echo ominously true.

Attractiveness

The arena of attractiveness in this study is one which requires careful distinctions. Physical attractiveness was conceptualized and captured as a single, superficial trait of looking pleasant to the eye. On the other hand, personal attractiveness evolved into a complex set of behaviors and characteristics which might be more aptly understood as personal attraction.

Given this framework, first impressions found the sexually abused girls personally but not physically more attractive (or attracting) than the control subjects. The sexually abused subjects leaned toward the stranger significantly more often than the nonabused girls and were described as significantly less withdrawn and more friendly or flirtatious toward him than were their control counterparts. The abused girls captured attention by raising their voices significantly above the volume of the control subjects, and by making unusual or highly personal remarks almost four times as often. The single-item impression of personality appeal favored the abused girls, approaching

but not in itself achieving significance. (See Items 8, 68, 64, 63 and 67 in Table 3 for single item significance levels.)

The initial engaging charm of the abused girls may not, however, be a quality that endures or endears well over time. While the observers were taken by the attracting qualities of the abused girls in the first eight-minutes of videotaped meeting, teachers report less favorable long-term relationships. In the larger NIMH study, Trickett, Helmers, Zakowski and Putnam (1991) found that this same sample of abused girls were rated as significantly less likeable by their teachers than were their matched controls. Moreover, teachers also judged the abused girls significantly lower in peer sociability and assertive social skills than the contol subjects.

Appeal

It is this researcher's clinical impression that the appeal of sexually abused children is as much a demand for attention and a cry for help as it is a signal intended to attract and engage another for purposes of bonding for nurturance and survival. Perhaps because of failure or deficiencies in early bonding, these children are more desperate to connect, and more easily fall prey to contact

which exploits rather than affirms them. Once betrayed, these children are still desperate but highly distrusting. This double-bind creates the frustrating suck-in, spit-out dilemma typical of both eating disorders and, on a relational level, borderline personalities. The skills for making and maintaining trusting, intimate and lasting relationships continually elude them.

Vulnerability

Corroborating the findings of deficient assertive social skills are the current study's results on the Vulnerability Subscale. With increasing age, the abused girls exhibit fewer dominant, self-protecting or assertive behaviors, and more submissive and dissociative behaviors than the control group. Figure 4 (p. 81) dramatically reflects these contrasts, with disrepencies in assertiveness greatest for the oldest age group.

Flirtatiousness

Flirtatious behaviors, as defined by the combination of attracting/affiliative cues and submissive/vulnerable gestures, are significantly higher among the group of abused girls than their control counterparts.

It was this researcher's expectation that for most girls

flirting would peak just before puberty took full sway, subside following the onset of obvious sexual development, and then resume with more maturity and selective discrimination. It was expected that sexually abused girls would not decrease in flirtatiousness with age or follow the normal pattern. The study, in fact, confirmed distinctively different patterns of flirtatiousness for the two groups of girls. For the sexually abused girls, flirtatious behaviors only increased with each subsequent age group, showing none of the respite visible in control Age Group 4 of 12- and 13-year-olds. (See Figure 3 on p. 79).

For sexually mature, consenting adults, subtle but directed flirting may well serve its purpose in communicating interest before leaping in headfirst. However, for abused children and teenagers who have been forcefully (either physically or emotionally) and prematurely sexualized, indiscriminate and sometimes compulsive flirtatiousness often results in serious consequences, including revictimization. Within the current study, a single item which taps observers' impressions of interaction with the stranger (ranging from withdrawn to flirtatious) correlated significantly (r=.3159, p.01) with reports of exhibiting problem sexual behaviors.

Problem Sexual Behaviors

Expectations of increased problem sexual behaviors for the abused group of girls shaped the most predictable hypothesis, given its history in the sexual abuse literature. Problem sexual behaviors as reported on the Child Sexual Behavior Checklist were confirmed to be significantly higher for the abused group. The preponderance of problems reported at the earliest ages probably occurs because overt sexuality is least expected in very young children and is noted with more concern. Also, the checklist includes fewer of the later onset problems such as promiscuity or pregnancy. Nevertheless, the abused and control groups show clear differences across all age groups (as seen in Figure 5, p. 82).

Significance of the Study

The significance of the current study lies in its particular concentration on directly observable behaviors in a large sample of girls who had reported incestuous abuse within the last six months. Frequency counts of discrete behaviors stand against the observers' more global impressions of the subject and against a nonoffending parent's paper-and-pencil report of the daughter's problem sexual behaviors.

The experimental group is carefully matched with a control group that parallels the demographics, geographics, and biographics of the former group in every apparent way except for the experience of child sexual abuse. The control and experimental groups differ almost exclusively in matters intrinsic to the occurrence and report of incestuous child abuse. These events have no small impact upon the people involved, often resulting in major changes in family relationships, living arrangements, and involvement with authorities. Nevertheless, these realities cannot be separated from that of reported incest. Otherwise, families constituting the control group were subject to the same difficulties, resources, and life stressors of the experimental group. The life experiences the two groups shared range from living in homeless shelters and exposure to poverty and traumatic violence (including child physical abuse), all the way to possessing wealthy suburban homes, competitive corporate jobs, and graduate level educations.

Limits of the Study

The study struggled with very real limits. Videotaping the subjects made multiple codings possible but lost the full quality of live observation. Camera angle and distance were uniform across subjects, but less than ideal

for capturing both the full subject and subtle facial detail. The last abused subject in the youngest age group was unavailable for inclusion in this study because of mechanical failure in videotaping her. Given the newness of the art of behavioral observations of sexually abused subjects, the team of researchers reviewing the Appeal-Vulnerability Scale and its items would not constitute a formal panel of fully expert judges (except in the areas of child development and sexual abuse). Selection, classification, definition, and inclusion of test items and scales were based primarily on theoretical grounds and not always on strict statistical or operational criteria.

The original early version of the AV scale on which the codings were recorded contained too many items and required excessive time and pain in training reliable coders. The observers available for coding were exclusively young female college and graduate students. Male and female coders of different ages and educational levels might alter the quantity and quality of observations.

No videotapes of a "strange female" encounter were coded in this subject sample, although a woman psychological examiner was videotaped for the first meeting with a small number of later subjects. The data were not analyzed for possible effect of examiner across the three male

testers.

Reports of problem sexual behaviors may have been inflated by the guardian's awareness of the child's experience of sexual abuse.

Findings can be generalized only to female victims of incest by an older male family member, and whose abuse has been reported. The families who participated were functioning highly enough both to have reported the abuse to authorities and to have kept two appointments with the research team. Some of them were undergoing psychotherapy. Many families who have been vicitmized by incest are not so organized, resourceful, or highly functioning. The results of the study may not generalize equally well to them.

Future Research

Recommendations for future research would include using the revised rather than early version of the Appeal-Vulnerability Scale, possibly dropping the items on physical attractiveness and estimated stage of puberty. Use of male and female coders as well as male and female strangers may increase replicability of rating and generalizability of results. Live observation of the abused child in the presence of the actual or alleged offender (if such

proximity must continue) might show more than "videotapes with a stranger," especially when the abuse involves incest.

Studying and comparing various modes of therapy to address issues such as extinguishing, unlearning, cognitively restructuring, or gaining insight into victim behaviors and self concepts and learning new behaviors and skills, could result in reducing revictimization. Again, it is emphasized that the onus for change lies on the offender and not on the victim. However, awareness of the attitudes and behaviors which make one more vulnerable to sexual assault can result in greater safety and freedom for the potential victim--whether child or adult.

Studies of male victims are critically needed and may require entirely new formulations on cause, effect, and the measurement of relevant behaviors and characteristics. Capture of the "abused-becoming-abuser" research could scrutinize the dynamics of young juvenile sexual offenders who have themselves been abused. Finally, investigating the relational deficits, including early (even infant) bonding, of both victim and offender promises data which this researcher believes are critical to understanding and addressing the tragedy of child sexual abuse.

Conclusion

In summary, this study has investigated some of the behavioral and personal similarities and differences between girl victims of incest and girls who have not been sexually abused. The current research has attempted to avoid the major methodological problems reported in the literature, but has real limits of its own. Ideas for new and needed research in the area of sexual abuse contend with one another and even the completion of the current study. If this work contributes, in even a small way, to understanding, identifying, diagnosing or treating those who have suffered the experience of child sexual abuse, the time and effort invested are well spent.

Appendix A

Child Sexual Behavior Checklist

Subject #_____ CHILD SEXUAL BEHAVIOR CHECKLIST (Version 1.0--4/27/88) Date_____

Below is a list of behaviors that describe children. For each item that describes your child now or within the past 12 months, please circle 2 if the item is very true or often true of your child. Circle 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle 0.

0 1 2 1) Child seems unusually friendly towards adults whom she does not know well (e.g. hugs and kisses them).

0 1 2 2) Child rubs her body against people or funiture.

0 1 2 3) Child talks and acts in a flirtatious manner.

0 1 2 4) Child tries to put her tongue in other person's mouth when kissing.

0 1 2 5) Child tries to undress other children or adults against their will (e.g. opening shirts, pants, etc.).

0 1 2 6) Child undresses self in front of others.

0 1 2 7) Child sits with crotch or underwear exposed.

0 1 2 8) Child tries to look at other people when they are nude or undressing.

0 1 2 9) Child talks about sex acts.

0 1 2 10) Child imitates sexual behavior with dolls or stuffed animals.

0 1 2 11) Child imitates the act of sexual intercourse.

0 1 2 12) Child shows her private parts to other children.

0 1 2 13) Child shows her private parts to adults.

0 1 2 14) Child touches her private parts in public places.

0 1 2 15) Child tries to touch other people's private parts.

0 1 2 16) Child masturbates when stressed.

0 1 2 17) Child masturbates in public.

0 1 2 18) Child talks about wanting to be the opposite sex.

0 1 2 19) Child pretends to be the opposite sex when playing.

0 1 2 20) Child urinates outside of the toilet.

0 1 2 21) Child delays urinating.

0 1 2 22) Child delays bowel movements for as long as possible.

Appendix B

Developmental History

DEVELOPMENTAL HISTORY: Session 1

The questions that I will be asking you and the forms that you will be filling out today and the next time we're together are mostly concerned with information about _____'s early years, her growth and development, and her current situation. I will also be asking about background information on you and your family. We need the information about you and your family because families differ so much from one another that in order to really understand _____'s development, we need to know something about the family she grew up in.

EXPERIMENTAL GROUP ONLY: As you know we will be getting some information from _____. At the moment, however, I know almost nothing about your family or the circumstances that brought you to _____. I am telling you this because if you thought I already knew a great deal about you and _____ and your family, some of the questions I am going to be asking you would sound pretty peculiar. The only thing I do know at this point is that you have been talking to _____, and none of the questions I am going to be asking you today have anything to do with that.

I am going to tape this session so I won't have to worry about writing down every little thing. If there is any time you want me to turn off the recorder--any answer you want to give to a question, or anything you want to say that you would rather not have recorded--just let me know.

Interviewer_____

DEVELOPMENTAL HISTORY

Part 1: Family Background

Please answer the following questions as completely as you can. When you return for your second visit, we will review your responses with you and answer any questions you may have.

Where a question includes several possible answers, please circle or underline the answer that is correct for you.

1. I am _____'s biological mother/stepmother/foster mother/ grandmother/other(_____). My current age is _____.

I am/am not living with _____now. (If not, probe for where living now and how often sees child.)

In the past there have/have not been times when _____ and I did not live together.

[If there were times in the past when you and _____ did not live together, please note below when that was.]

IF YOU ARE THE BIOLOGICAL MOTHER OF OUR SUBJECT CHILD, PLEASE GO TO QUESTION 3.

2. Child's biological mother's age is _____.

She is/is not living with child now. (If not, probe for where living now and how often sees child.)

In the past there have/have not been times when she did not live with the child.

[If there were times in the past when mother and child did not live together, please note below when that was.]

3. Please list the names of all children in your family and answer the following questions for each child.

a. How old is the child? (Age column)

b. Is the child a full brother or full sister, half brother or half sister, or step brother or step sister of the child who is participating in the research? (Relationship column)

c. Is the child living with our child subject at the present time? (Now column) Answer yes or no.

d. Have there been times in the past when the child did not live with our child subject? (Past column) Answer yes or no.

e. If you answered "yes" for any child on questions d., please note dates when the child did not live with our child subject (Separations column)

Name	Age	Relationship	Now	Past	Separations

4. Child's biological father's age is _____.

He is/is not living with the child now. (If not, probe for where living now and how often sees child.)

In the past there have/have not been times when he did not live with the child.

[If there were times in the past when father and child did not live together, please note below when that was.]

5. I (child's biological mother) am married to/separated from/divorced from/living with but not married to/was never married to _____'s father. (If you are not the child's biological mother please answer these questions about her as well as you can.)

A. IF YOU ARE MARRIED TO CHILD SUBJECT'S FATHER PLEASE ANSWER THE FOLLOWING. (If you are not married to him at the present time please go to 5B.)

I have been married to _____'s father for _____years.

We have/have not ever been separated or divorced. (If you have been separated or divorced since you were married, please note when that was _____.)

I have/have not been married to anyone other than _____'s father. (If you have been married to someone else please note when that was _____.)

I have/have not lived with, but not been married to, a male other than _____'s father since she was born. (If you have lived with someone else please note when that was _____.)

B. IF YOU ARE NOT CURRENTLY MARRIED TO CHILD SUBJECT'S FATHER PLEASE ANSWER THE FOLLOWING.

I was/was not married to _____'s father in the past. (If you were married please note when that was _____)

I have/have not been married to anyone else. (If you have been married to someone else, please note when that was _____)

I have/have not lived with, but not been married to, a male other than _____'s father since she was born. (If you have lived with someone other than the child's father since she was born, please note when that was _____)

I am currently NOT married to/living with anyone. I AM currently married to/living with, but not married to, someone other than the child's father.

C. IF YOU ARE CURRENTLY MARRIED TO, OR LIVING WITH SOMEONE OTHER THAN THE CHILD'S FATHER, OR WERE AT ANY TIME DURING THE CHILD'S LIFETIME, PLEASE ANSWER THE FOLLOWING.

This person's age is _____.

This person has/ has not filled a father role for _____.

_____ considers this person/her father as her primary father figure.

This person is/is not living with the child now.

In the past there have/have not been times when he did not live with the child.

[Please note when during the child's lifetime this person did live with her.]

6. Other people besides those already mentioned who are currently living in _____'s home are:

Name	Age	Relationship	Length of time has lived with child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other people besides those already mentioned who have lived in _____'s home in the past are:

Name	Age	Relationship	Length of time has lived with child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. I have lived at my current address since _____. Since _____ was born we have lived in the following places (If you changed addresses within the same city please show dates for each change):

City	State	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. The highest year of school I completed was _____.

I am/am not in school now.

9. I am/am not working now. (If you are not working now please go to Question 10)

I work _____ hours per week; the hours I work are _____
_____

The kind of work I do is _____

My most important activities or duties at work are _____
_____

The kind of business or industry that I work in is _____
_____

I have had my present job for _____

10. I have/have not worked in the past. (If you have not worked in the past please go to Question 11.)

At my last job I worked _____ hours per week; the hours I worked were _____

The kind of work I did was _____

My most important activities or duties at work were _____
_____

The kind of business or industry that I worked in was_____
_____

I had this job from_____until_____

Since becoming an adult I have had _____ jobs.

11. The highest year in school _____'s father completed was _____.

He is/is not in school now.

12. He is/is not working now. (If he is not working now please go to Question 13.)

He works _____ hours per week; the hours he works are
_____

The kind of work he does is_____

His most important activities or duties at work are _____
_____

The kind of business or industry that he works in is _____
_____

He has had this job for _____

13. He has/has not worked in the past. (If he has not worked in the past please go to Question 14.)

At his last job he worked _____ hours per week; the hours he worked were _____

The kind of work he did was _____

His most important activities or duties at work were _____
_____

The kind of business or industry that he worked in was____
_____

He had this job from_____until_____

Since becoming an adult he has had _____ jobs.

14. If you are now living with a male other than the subject child's father please answer the following questions about that person.

If you are not now living with a male other than the subject child's father, but have done so in the past for a significant period of time after the child was born, please answer these questions for that person. Answer questions based on the situation at the time he lived with you.

If you have lived with more than one male other than the child's father for a significant period of time since the child who is participating in the study was born, please also answer these questions for those persons. Answer questions based on the situation at the time they lived with you. Use back of this sheet if necessary.

The highest year in school he completed was_____.

He is/is not in school now (or at the time he lived with you).

15. He is/ is not working now (or at the time he lived with you). [If he is not working currently (or was not when you and he lived together) please go to Question 16.]

He works _____ hours per week; the hours he works are _____

The kind of work he does is _____

His most important activities or duties at work are _____

The kind of business or industry that he works in is _____

He has had this job for _____

16. He has/has not worked in the past. (If he has not worked in the past please go to Question 17.)

At his last job he worked _____ hours per week; the hours he worked were _____

The kind of work he did was _____

His most important activities or duties at work were _____

The kind of business or industry that he worked in was _____

He had this job from_____until_____

Since becoming an adult he has had _____ jobs.

17. Our family is very religious/ somewhat religious/ not at all religious.

Our religion is _____.

We go to religious services weekly/ monthly/ several times a year/ only on religious holidays.

_____ attends religious services with us regularly/ occasionally/ never.

_____ attends religious classes (Sunday school, etc.) regularly/ occasionally/ never.

My religion provides me with (please check all that apply):

_____ help in understanding things that happen to me.

_____ emotional support in times of stress or crisis.

_____ guidelines for living which I try to apply to myself and to my children.

_____ social relationships.

_____ other (please describe:_____)

* * * * * * *

Thank you for the time you have devoted to answering these questions. Please let us know if anything was not clear to you. We look forward to seeing you at your next visit.

Appendix C

Original Attractiveness-Maturity Rating List

ATTRACTIVENESS-MATURITY RATING LIST

1. SUBJECT #_____ 2. OBSERVER #_____ 3. TESTER #_____
4. DATE_____ 5. TAPE DEFECT_____
6. (With audio off) How old does this subject seem to be?_____

CODING OF TAPED BEHAVIOR

POSTURE

7. moves toward other
8. leans toward other
9. lies on floor
10. sits on floor
11. side head tilt
12. head or hair toss
13. head tips forward
14. head tips back
15. chest protrudes
16. rocking motion

EYES

17. brows raise
18. eyes lower
19. blink
20. steady gaze
21. quick glimpse
22. eyes averted
23. eyes sweep to & fro

MOUTH

24. open
25. compressed
26. pouting
27. frowning
28. smiling
29. full smiling
30. laughing
31. tongue show
32. singing
33. chewing
34. yawning
35. covered (by hand)

ARMS/HANDS

36. shoulder shrug
37. arm stretch
38. arms folded (S)
39. arms folded (C)
40. palms up & open
41. chin rests on hand
42. fingers splayed
43. waving
44. hand behind head

LEGS

45. spread apart
46. close together
47. stretch out
48. knees crossed
49. foot aims at other
50. feet pigeon-toe

SELF-TOUCH

HANDS TOUCH:

51. each other
52. face
53. hair
54. ear
55. neck
56. breast
57. crotch
58. thigh
59. lower leg
60. foot
61. shoe (off)
62 spaces out

63. SIGNIFICANT SPEECH CONTENT_____

_____

CIRCLE ONE

64. What is the volume of this girl's voice?
1. WHISPER 2. SOFT 3. MODERATE 4. RAISED 5. LOUD

65. What is the intonation of her voice?
1. BREATHY 2. BABYISH 3. ANIMATED 4. CONVERSATIONAL 5. FLAT

66. How physically attractive is this girl?
1. STRIKING 2. ATTRACTIVE 3. AVERAGE 4. PLAIN 5. UGLY

67. How appealing is her personality?
1. CAPTIVATING 2. CHARMING 3. ORDINARY 4. UNPLEASANT 5. REPULSIVE

68. Which word best describes her interaction with the stranger?
1. SEDUCTIVE 2. FLIRTATIOUS 3. FRIENDLY 4. SHY 5. WITHDRAWN

69. At what stage of puberty would you assess this girl to be?
1. PRE-PUBERTY 2. BEGINNING PUBERTY 3. MID-PUBERTY 4. ADVANCED 5. POST

70. How much would you enjoy a short conversation with this girl?
1. VERY MUCH 2. CONSIDERABLY 3. MODERATELY 4. MINIMALLY 5. NOT AT ALL

Appendix D

Appeal-Vulnerability Rating Scale

AV Rating Scale

Subject #_____ Observer #_____ Tester #_____
Date:_____ Tape Defect:_____

CODING OF TAPED BEHAVIOR

1.	Leans toward other	
2.	Head tips forward	
3.	Head tilts to side	
4.	Eyes sweep to & fro	
5.	Smiles	
6.	Laughs	
7.	Smiles w/ teeth	
8.	Spaces out	
9.	Touches face	
10.	Touches hand	
11.	Touches thigh	
12.	Touches crotch	
13.	How old does this subject seem to be?	

CIRCLE ONE

14. At what stage of puberty do you assess this girl to be?

Pre-puberty 1 2 3 4 5 Advanced

15. How physically attractive is this girl?

Very attractive 1 2 3 4 5 Very unattractive

16. How appealing is her personality?

Charming 1 2 3 4 5 Unpleasant

17. How much would you enjoy a short conversation with this girl?

Not at all 1 2 3 4 5 Very much

18. Which best describes her interaction with the stranger?

Flirtatious 1 2 3 4 5 Withdrawn

19. What is the volume of this girl's voice?

Very soft 1 2 3 4 5 Very loud

20. Note any significant speech content._____

Appendix E

Attractiveness-Maturity Rating List Definitions

ATTRACTIVENESS-MATURITY RATING LIST DEFINITIONS

1. SUBJECT #_____ Number listed on video tape of STRANGER
2. OBSERVER #_____ Tracey #1 Nancy #2 Mary # 5 Anna # 6
3. TESTER#_____ Rob #1 Bill #2 Lee #3
4. DATE_____ Date of coding
5. TAPE DEFECT_____ Note any problem viewing subject:
   10"B/O Means ten seconds of camera black-out
   Hd C/O Means the camera cut off view of the subjects head for the entire tape (8 minutes)
   O/F Means out of focus
   C on Hands Means only hands (etc.) are in camera view
   EXPLAIN any other tape defect in your own words.
6. (With audio off) How old does this subject seem to be?_____
   Mute the sound and guess the subject's age before rewinding the tape, turning on the sound, and coding behaviors.

CODING OF TAPED BEHAVIOR
Mark | for any single discrete behavior.
Mark |+ if the behavior lasts more than 10 seconds and continues past next 1' buzzer. |++ means the behavior lasted more than 2'

POSTURE includes larger body positions or movements.

7. moves toward other_____ Subject moves whole body toward the tester, camera, anywhere, EXCEPT AWAY from tester's area.
8. leans toward other_____ Subject moves upper torso, from waist or hips up, in general direction of tester.
9. lies on floor_____ Subject's leg, hip & elbow (or hand) make contact with the floor.
10. sits on floor_____ Subject sits, kneels, or squats on floor.
11. side head tilt_____ Head angles such that either ear moves closer to shoulder.
12. head or hair toss_____ Fling of hair or head jerk.
13. head tips forward_____ Nods so that more of top of head shows.
14. head tips back_____ So that chin lifts higher. 15. chest protrudes_____ Such that shoulders retract.
16. rocking motion_____ Of whole or any part of body.

EYES includes eyebrows and eyelids.

17. brows raise_____
18. eyes lower_____ Not head tip, but lids lower.
19. blink_____ Lids close in quick succession.
20. steady gaze_____ Looks toward tester (area) longer than 2 seconds, but does not seem to stare.
21. quick glimpse_____ Short look toward tester area, then away.
22. eyes averted_____ Eyes avoid tester area.
23. eyes sweep to & fro_____ Eyes brush across tester area.

MOUTH

spacing out_____staring, blank look, inattentive.
24. open_____ Lips not touching.
25. compressed_____ Lips pressed closely together.
26. pouting_____ Lower lip extends out.
27. frowning_____ Lip corners down.
28. smiling_____ Lips together, corners up.
29. full smiling_____ Teeth showing, lip corners up.
30. laughing_____ Visible or audible.
31. tongue show_____ Tongue out, other than talking.
32. singing_____ Singing, humming, whistling,etc
33. chewing_____
34. yawning_____
35. covered (by hand)_____ Hand hides at least part of mouth. Don't count yawning here.

ARMS/HANDS

36. shoulder shrug_____ at least 1 shoulder raised
37. arm stretch_____ at least 1 arm extended out from elbow or shoulder.
38. arms folded (S)_____ at least 1 hand on other arm, while smiling.
39. arms folded (C)_____ at least 1 hand on other arm, while lips are compressed.
40. palms up & open_____ fingers not clenched shut.
41. chin rests on hand_____ weight on back, palm, or heel of hand.
42. fingers splayed_____ 1 or more finger(s) spread out.
43. waving_____ toward tester or camera area.
44. hand behind head_____ 1 or more hand(s) rest (not preen)

LEGS

45. spread apart_____ from knees up.
46. close together_____ from knees up.
47. stretch out_____
48. knees crossed_____
49. foot aims at other_____ while not aligned with lower leg.
50. feet pigeon-toe_____ toes in/ankles out.

SELF-TOUCH patting, preening, stroking, covering,scratching,etc

HANDS TOUCH:

51. each other_____
52. face_____ any part, including ear, chin,jaw
53. hair_____ not eyebrows or lashes, not ear.
54. ear_____ more contact with ear than w/ hair
55. neck_____
56. breast_____ upper torso above waist.
57. crotch_____ uppermost inner thigh area.
58. thigh_____ leg above knee.
59. lower leg_____ knee and below.
60. foot_____
61. shoe(s) off_____ at least heel away from shoe.
62. clothing (name it)_____ Name the most specific body or clothing part touched.

SIGNIFICANT SPEECH CONTENT:_____

Note any unusual mention or one which seems particularly meaningful to subject.

CIRCLE ONE

Circle the most remarkable or predominant quality which applies.

63. What is the volume of this girl's voice?
1.WHISPER 2.SOFT 3.MODERATE 4.RAISED 5.LOUD

64. What is the intonation of her voice?
1.BREATHY 2.BABYISH 3. ANIMATED 4.CONVERSATIONAL 5.FLAT

65. How physically attractive is this girl?
1.STRIKING 2.ATTRACTIVE 3.AVERAGE 4.PLAIN 5.UGLY

66. How appealing is her personality?
1.CAPTIVATING 2.CHARMING 3.ORDINARY 4.UNPLEASANT 5.REPULSIVE

67. Which word best describes her interaction with the stranger?
1.SEDUCTIVE 2.FLIRTATIOUS 3.FRIENDLY 4.SHY 5.WITHDRAWN

68. At what stage of puberty would you assess this girl to be?
1.PRE-PUBERTY 2.BEGINNING PUBERTY 3.MID-PUBERTY 4.ADVANCED 5.POST

66. How much would you enjoy a short conversation with this girl?
1.VERY MUCH 2.CONSIDERABLY 3.MODERATELY 4.MINIMALLY 5.NOT AT ALL

Appendix F

Human Subjects Protection Protocols

NIMH DIRP OD

TO: Director, Clinical Center

FROM: FRANK W. PUTNAM MD (Principal Investigator) NIMH (Institute) 118

DATE

SUBJECT: CLINICAL RESEARCH PROJECT ANNUAL REVIEW

PROJECT NUMBER: 87-M-14

PROJECT TITLE: The Psychobiological effects of sexual abuse: Female growth and development during childhood and adolescence.

	Yes	No
1. I wish to renew this project.	✓	
2. I was the Principal Investigator at last review.	✓	•
3. Hazards or serious discomforts have been noted in this project.	•	✓
4. New hazards relevant to this project appear in the literature.	•	✓
5. The project involves radiation determined (by ICRS) to be not medically indicated.	o	✓
6. The project involves an IND or IDE: Indicate name of drug/device and IND/IDE number	+	✓

7. Record number of subjects:
   a. Cumulative number approved by ICRS 200
   b. Studied since last review 50
   c. Cumulative total studied 54

* Requires details on attached sheet.
o If accompanied by any protocol change, renewal must be approved by NIH Radiation Safety Committee (RSC).
+ Requires attachment of copy of current consent form and annual progress report to FDA.

Signature:	Frank W Putnam MD (Principal Investigator)	2-6-89. (Date)	Send to ICRS Chairman
Approvals:	(Chairman, ICRS)	2/14/89 (Date)	Send to Clinical Director
	(Clinical Director, Institute)	2/17/89 (Date)	Send to OMSA
	(Chairman, RSC)	(Date)	Send to OMSA

Date of Final OMSA Receipt: _____

NIH-1195 (Rev. 8-84)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892
Building : 15 K
Room : 105
(301) 496-4406

August 28, 1989

Ms. Mary Anne Bunda, Chair.
Human Subjects Institutional Review Board
Western Michigan University
Kalamazoo, MI 49008-3899

RE: Human Subjects Protection Protocol
Ruth Mausert-Mooney
Ph.D. Candidate, Psychology Department

Dear Ms. Bunda:

I am writing to support Ruth Mausert-Mooney's request to have her research covered by the Human Subject Protocol approved for the NIMH/Chesapeake Institute's study on "The Psychobiological Effects of Child Sexual Abuse," for which I am the principal investigator.

I have brought Ruth's research project under the umbrella of our larger study because I am excited about the courageous way it would use our existing data to explore an area often reported by clinicians but largely avoided by researchers. Convinced of the importance of her proposed research, I urged the Chesapeake Institute to apply for a 1989 NCCAN grant from HHS for Ruth's research and committed myself to monitoring her adherence to our Human Subjects Protection Protocol in the course of that research. I am prepared to do this even if Ruth does not get the grant.

The Code of Federal Regulations, in Section 46.114, allows for an institution such as Western Michigan University to rely "upon the review of another qualified IRB, or similar arrangements aimed at avoidance of duplication of effort." I would ask you to so rely upon the approval by NIMH's IRB of my umbrella project and allow Ruth's research to be covered by that assurance.

Please contact me if you need any further information.

Sincerely,

Frank W. Putnam

Frank W. Putnam, M.D.
Chief, Unit on Dissociative Disorders, NIMH DIRP
Investigator, NIMH/Chesapeake Research

Human Subjects Institutional Review Board

Kalamazoo, Michigan 49008-3899

WESTERN MICHIGAN UNIVERSITY

Date: September 29, 1989

To: Ruth Mausert-Mooney

From: Mary Anne Bunda, Chair Mary Anne Bunda

The Board concurs with the judgment of the NIMH Board. The Board approves your use of the data collected in the on-going study entitled "Perceived Patterns of Attractiveness and Maturity in Sexually Abused Girls" and presume that, should any changes be made in that on-going study, we would be alerted.

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 approval application. You must seek reapproval for any change in this design.

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

xc: M. Robertson, Psychology

Human Subjects Institutional Review Board

Kalamazoo, Michigan 49008-3899

WESTERN MICHIGAN UNIVERSITY

Date: September 6, 1990

To: Ruth Mausert-Mooney

From: Mary Anne Bunda, Chair Mary Anne Bunda

Re: HSIRB Project Number 90-09-09 (replaces 89-08-10)

This letter will serve as confirmation that your research protocol, "Perceived Patterns of Attractiveness and Maturity in Sexually Abused Girls," has been re-approved by the HSIRB. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now continue to implement the research as described in the approval application.

You must seek reapproval for any change 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: September 6, 1991

xc: Mal Robertson, Psychology

Appendix G

Recruitment and Referral of Subjects

INFORMATION NEEDED TO REFER FAMILIES

Description of study

The study uses a multimethod approach (interviews, standardized questionnaires, and structured observation) to obtain information about the child's intellectual and social competence, behavior problems, and psychiatric symptomatology. Additionally, a brief health screening is conducted by a registered nurse, during which a blood sample is taken to measure hormone levels and to ascertain pubertal level. Dissociative capacity also is screened. The child is never asked anything about the abuse. A nonabusing parent or guardian provides additional information about the child and family. Feedback on the child's development is provided to the parent and, with the parent's permission, can be provided to the referring agency.

The health screening and the psychological measures are administered at our project offices at The Chesapeake Institute in Wheaton, Maryland, during two sessions which are usually scheduled about one week apart. Both adult and child are paid for their participation on an hourly basis. The total payment per family for the two sessions is approximately $130.00. Transportation costs are also provided. Families are then contacted at yearly intervals for two years for follow-up visits.

Eligibility

To be eligible for this study, the families need to meet the following criteria:

1. The child victim is female and currently between 6 and 15 years of age.

2. The initial or most recent disclosure of the sexual abuse occurred within the last 6 months.

3. The abuse included genital contact and/or penetration.

4. The identified perpetrator is a family member broadly defined (parent, step-parent, sibling, uncle, live-in boyfriend, etc.)

5. A non-abusing parent or guardian is available and willing to participate in the project.

-over-

Project Name: **Female Health and Development During Childhood and Adolescence**

Permission

Project personnel may contact me so that I can get more information in order to decide whether I wish to participate.

Adult's name - Please Print	Adult's Signature
Relationship to child	Child's Name and Age
Address	Phone Number (day or evening?)

Caseworker's name and address

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

125

National Institutes of Health
Bethesda, Maryland 20892
Building :
Room :
(301) 496-

Dear Parent:

When families experience the types of problems which have brought you to the Department of Social Services, there is often concern and worry about the effects on the children involved. The National Institute of Mental Health and the Chesapeake Institute of Wheaton, Maryland, are co-sponsoring a project designed to learn more about the effects of these problems on girls' physical and psychological development.

Participation in this project will involve a total of about 5 or 6 hours of your child's and your time in two meetings about one week apart. The child will do some tasks and games with a psychologist. While this is going on you will provide some information on your child's development to an interviewer, and fill out some forms. Later your child will have a brief health screening by a registered nurse. Feedback on your child's development will be provided to you.

Protection of your rights

If you agree to let us contact you, at that time we will explain more about the project, the types of questions we will ask, and give you a chance to ask questions. If you decide to participate in the project, you will have the right to refuse to answer any questions at any time. You will not be identified by name in any reports on this project.

Payment for your time

All participants (the adult an the child) will be paid for their time. Altogether the family will receive approximately $130.00 for the two visits. Transportation costs will also be paid (up to $22.00) per visit.

Thank you very much for considering this request.

Frank W Putnam, MD., Penny Trickett, Barbara Everett

Drs. Frank Putnam, Penny Trickett, and Barbara Everett

Project Name: Female Health and Development During Childhood and Adolescence

Permission

Project personnel may contact me so that I can get more information in order to decide whether I wish to participate.

Adult's name - Please Print	Adult's Signature
Relationship to child	Child's Name and Age
Address	Phone Number (day or evening?)

Caseworker's name and address

NEWSPAPER ADVERTISEMENT

PAID VOLUNTEERS! Looking for girls ages 6-15 and their mothers to participate in an NIH-sponsored study of female growth and development. Families will be paid $130 for participation, plus travel costs. Contact Dr. Trickett or Dr. Everett at 301-949-5000.

Appendix H

Consent Forms

DOCTOR'S ORDER/PATIENT AUTHORIZATION FOR CLINICAL PHOTOGRAPHY/VIDEO TAPE/MOTION PICTURE

INSTRUCTIONS

PART A - to be dated, completed and signed by physician. **PART B** - to be signed by patient, dated and witnessed. (NOTE: If patient minor or ward, parent or legal guardian must sign). Authorization to be filed in medical record.

PART A. DOCTOR'S ORDER FOR *(Check one)*

☐ PHOTOGRAPHS

☐ VIDEO TAPES

☐ MOTION PICTURES

DATE

NAME OF PATIENT

DESCRIPTION OF PHOTOGRAPHS/VIDEO TAPES/MOTION PICTURES *(Specify)*

Child is videotaped at the beginning of the psychological testing session, during the hypnotic screening, and during the blood drawing.

SIGNATURE OF PHYSICIAN

PART B. CONSENT FOR:PHOTOGRAPHS/VIDEO TAPES/MOTION PICTURES

I authorize the National Institutes of Health to make the above described photographs/video-tapes/motion pictures. The above descr photographs/video tapes/motion pictures to be used only for purposes of patient care, medical research, and medical education.

SIGNATURE OF PATIENT

DATE

SIGNATURE OF PARENT OR LEGAL GUARDIAN

WITNESS

RELATIONSHIP TO PATIENT

PATIENT IDENTIFICATION

NIH-661 (Rev. 4-78)
DOCTOR'S ORDER/PATIENT AUTHORIZATION FOR CLINICAL PHOTOGRAPHY/VIDEO TAPE/ MOTION PICTURES

GPO

MEDICAL RECORD	CONSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUDY • Adult Patient or • Parent, for Minor Patient

INSTITUTE: National Institute of Mental Health

STUDY NUMBER 87-M-14 PRINCIPAL INVESTIGATOR: Frank W. Putnam

STUDY TITLE:

Female Growth and Development during Childhood and Adolescence

INTRODUCTION

We invite you (or your child) to take part in a research study at the National Institutes of Health. It is important that you read and understand several general principles that apply to all who take part in our studies: (a) taking part in the study is entirely voluntary; (b) personal benefit may not result from taking part in the study, but knowledge may be gained that will benefit others; (c) you may withdraw from the study at any time without penalty or loss of any benefits to which you are otherwise entitled. The nature of the study, the risks, inconveniences, discomforts, and other pertinent information about the study are discussed below. You are urged to discuss any questions you have about this study with the staff members who explain it to you.

This study is concerned with the relationships between physical growth and development and psychological changes which occur as girls pass through childhood and enter adolescence. Participation in the study will take approximately a total of 5 hours on two different days at our offices once a year for three years. Participating families will be paid for their time.

During each session you will fill out checklists and questionnaires about your and your child's health and medical or other problems you or your child may have had. Your child will have a physical examination by a doctor or nurse to find out where she is in terms of pubertal growth. Approximately 3 tablespoons of your child's blood will be drawn. When the blood is drawn, the needle will hurt for a moment, just like getting a shot. Sometimes a small bruise forms where the needle enters the vein. Your child will be given some measures of social and emotional development and asked to fill out questionnaires about friends and family. Part of this session will be videotaped. Both parent and child measures have been completed by many adults and children who usually find them to be interesting and enjoyable. We will also be asking you to sign a release of information form so that we may contact your child's teacher at school to get information about her academic work and behavior in school.

MEDICAL RECORD	CONTINUATION SHEET for either: NIH 2514-1, Consent to Participate In A Clinical Research Study NIH 2514-2, Minor Patient's Assent to Participate In A Clinical Research Study

STUDY NUMBER: _____ CONTINUATION: page 2 of 3 pages

We would like to measure your child's ability to be hypnotized, since this ability appears to change as children grow older. Many researchers in hypnosis believe that normal children frequently go in and out of hypnotic trances spontaneously. This test involves giving your child a standard set of suggestions, e.g. "Your arm feels very light, as if it were floating. Now you feel it start to rise up on its own" and then measuring if the arm moves. Hypnosis is very safe. A board-certified psychiatrist, trained in hypnosis, will be administering this test and will only do so if he/she believes that your child will be able to participate without any ill effects. Sometimes people who have been hypnotized describe feeling light-headed or sleepy afterwards. Occasionally they may have a mild, transient headache. If these symptoms should occur, they will disappear on their own in a short time. On rare occasion, hypnosis will cause people to remember painful or frightening experiences that have happened to them. If this should occur, the doctor doing the hypnosis will help your child process this experience and we will discuss this with you.

I have read the above, and any questions about the study have been answered. I understand the purposes of the study. I also understand that the agreement to participate does no obligate me to participate in future studies. I consent to participate in this study as described. I understand that I may interrupt the procedures or withdraw from the study at any time. I understand that the information collected will be combined with those of others for purposes of data analysis, that no member of the family will be identified by name in any presentation of the data, that all records collected are confidential, and that the findings of the study may be distributed through scientific channels.

MEDICAL RECORD	CONSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUDY • Adult Patient or • Parent, for Minor Patient	continuation: page 3 of 3 pages

STUDY NUMBER: 87-M-14

OTHER PERTINENT INFORMATION

1. **Confidentiality.** When results of a study such as this are reported in medical journals or at meetings, the identification of those taking part is withheld. Medical records of Clinical Center patients are maintained according to current legal requirements, and are made available for review, as required by the Food and Drug Administration or other authorized users, only under the guidelines established by the Federal Privacy Act.

2. **Policy Regarding Research-Related Injuries.** The Clinical Center will provide short-term medical care for any physical injury resulting from your participation in research here. Neither the Clinical Center nor the Federal government will provide long-term medical care or financial compensation for such injuries, except as may be provided through whatever remedies are normally available under law.

3. **Payments.** If you are a patient, you are not paid for taking part in NIH studies. Exceptions for volunteers will be guided by Clinical Center policies.

4. **Problems or Questions.** Should any problem or question arise with regard to this study, with regard to your rights as a participant in clinical research, or with regard to any research-related injury, you should contact the principal investigator, Frank W. Putnam, M.D., or these other staff members also involved in this study: _____ ; _____ ; _____ ;
Building 15K, Room 105. Telephone: (301) 496 4406.
National Institutes of Health
Bethesda, Maryland 20205

5. **Consent Document.** It is suggested that you retain a copy of this document for your later reference and personal records.

COMPLETE APPROPRIATE ITEM BELOW, A or B:

A. Adult Patient's Consent.
I have read the explanation about this study and have been given the opportunity to discuss it and to ask questions. I hereby consent to take part in this study.

_____
Signature of Adult Patient & Date Signed

B. Parent's Permission for Minor Patient.
I have read the explanation about this study and have been given the opportunity to discuss it and to ask questions. I hereby give permission for my child to take part in this study,
(Attach NIH 2514-2, Minor's Assent, if applicable.)

_____
Signature of Parent(s) & Date Signed

_____
(if other than parent, specify relationship)

_____
Signature of Investigator & Date Signed

_____
Signature of Witness & Date Signed

PATIENT IDENTIFICATION

CONSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUDY
• Adult Patient or • Parent, for Minor Patient

MEDICAL RECORD	MINOR PATIENT'S ASSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUD • Attach to NIH 2514-1, Consent to Participate In A Clinical Research Study

INSTITUTE: National Institute of Mental Health

STUDY NUMBER: 87-M-14 PRINCIPAL INVESTIGATOR: Frank W. Putnam, M.D.

STUDY TITLE: Female Growth and Development during Childhood and Adolescence

You are invited to take part in a research study being conducted at the National Institute of Mental Health. The following principles apply to all people who take part in our studies: (1) The decision to take part is entirely up to you--you should take part only if you want to. (2) Knowledge may be gained from the study that will help others. (3) You are completely free to drop out of the study at any time. Your doctors believe that you have a right to do this and will not hold it against you. (4) Whatever information is obtained from you during the study is completely confidential.

The purpose, risks, discomforts, and other details of the study are discussed below. Please feel free to ask any questions you may have about the study.

We are interested in how you think and feel as you grow and develop. We want to find out how you feel and behave as your body changes both inside and outside. Here are the things you will be asked to do if you decide to be in the study:

1. A doctor or nurse will examine you, just as your doctor examines you when you go for a check-up. The exam will tell us about your physical growth.

2. You will give the doctor or nurse about 3 tablespoons of your blood once every year. A needle will be put in a vein in your arm and some blood will be taken out. The needle will hurt just for a moment and then it will stop. Sometimes a small bruise forms where the needle enters the vein, but it goes away in about a week. The blood will tell us how your body is changing inside.

3. You will talk to a doctor, nurse, or their helper about the times when you were ill or other things that have made you worry about yourself.

STUDY NUMBER: 87-M-14

4. You will be asked to work on tests like the ones you take in school. You will not get a grade on the tests. You will be asked to name things or you will mark whether the sentence is like you or not like you. The study will take about five hours of your time once a year for three years. You will get paid for helping us. You may stop being in the study at any time, and no one will be angry with you.

5. You will be asked to take a test that measures your ability to be hypnotized. The doctor will ask you to close your eyes and he will give you some suggestions, such as your arm feels very light and is beginning to float up by itself, and see how easy it is for you to do the things that he suggests. Hypnosis is very safe, but before you take this test, the doctor will ask you some questions to make that it is alright for you to do this. A few people have a mild headache, sleepiness or feel light-headed after being hypnotized. If you should have these feelings they will disappear on their own after a short time. Sometimes people who are hypnotized remember things that they have forgotten, including things that have frightened them when they were younger. If this should happen with you, the doctor can help you understand and talk about this experience.

I have read what was written (or it was read to me) and I understand the things that I will be doing here. I will be in the study knowing that I can stop if I want to. I know that the information about me will be put together with the information about others in the study and my name will not be used in any papers written about the study.

For helping us, you and your parent(s) will be paid some money through the Normal Volunteer Office of the National Institutes of Health.

I have had this study explained to me in a way that I understand, and I have had the chance to ask questions. I agree to take part in this study.

Signature of Minor Patient: _____ Date: _____

Signature of Investigator: _____ Date: _____

MEDICAL RECORD	MINOR PATIENT'S ASSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUDY • Attach to NIH 2514-1, Consent to Participate In A Clinical Research Study

INSTITUTE: National Institute of Mental Health

STUDY NUMBER: 87-M-14 PRINCIPAL INVESTIGATOR: Frank W. Putnam, M.D.

STUDY TITLE: Female Growth and Development during Childhood and Adolescence

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1. A doctor or nurse will examine you, just as your doctor examines you when you go for a check-up. The exam will tell us how you are growing outside.

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MEDICAL RECORD	MINOR PATIENT'S ASSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUDY	continuation: page 2 of 2 pages

STUDY NUMBER: 87-M-14

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I have read what was written (or it was read to me) and I understand the things that I will be doing here. I will be in the study knowing that I can stop if I want to. I know that the information about me will be put together with information about others in the study and my name will not be used in any papers written about the study.

I have had this study explained to me in a way that I understand, and I have had the chance to ask questions. I agree to take part in this study.

Signature of Minor Patient: _____ Date: _____

Signature of Investigator: _____ Date: _____

MEDICAL RECORD	CONSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUDY • Adult Patient or • Parent, for Minor Patient	continuation: page 3 of 3 pages

STUDY NUMBER: 87-M-14

OTHER PERTINENT INFORMATION

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_____ ; _____ ; _____
Building 15K, Room 105. Telephone: (301) 496 4406
National Institutes of Health
Bethesda, Maryland 20205

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I have read the explanation about this study and have been given the opportunity to discuss it and to ask questions. I hereby consent to take part in this study.

_____
Signature of Adult Patient & Date Signed

B. Parent's Permission for Minor Patient.
I have read the explanation about this study and have been given the opportunity to discuss it and to ask questions. I hereby give permission for my child to take part in this study.
(Attach NIH 2514-2, Minor's Assent, if applicable.)

_____
Signature of Parent(s) & Date Signed

_____
(if other than parent, specify relationship)

_____
Signature of Investigator & Date Signed

_____
Signature of Witness & Date Signed

PATIENT IDENTIFICATION

CONSENT TO PARTICIPATE IN A CLINICAL RESEARCH STUDY
• Adult Patient or • Parent, for Minor Patient

NIH-2514-1 (10-84) P.A.: 09-25-0099

MEDICAL RECORD	ADDENDUM TO GENERAL ADMISSION CONSENT

AUTHORIZATIONS FOR MINORS/CERTIFICATIONS BY LEGAL GUARDIANS AND INTERPRETERS

NOTE: This form (NIH-1225-2) and the respective consents/certifications are void unless attached to a properly completed form NIH-1225-1.

PATIENT

NAME (Last, first, middle)

The consents listed below for travel and/or leave are to be signed only by PARENT or LEGAL GUARDIAN. They are to be completed for each person UNDER EIGHTEEN YEARS OF AGE who is admitted to the Clinical Center.

TRAVEL/ LEAVE CONSENTS

TRAVEL: In the event of the absence of patient's parent or legal guardian, I hereby give consent for the above named patient to travel alone when discharged from the Clinical Center.

SIGNATURE (Parent or Legal Guardian) Relationship Date

LEAVE: At the discretion of the attending physician, I hereby give consent for the above named patient to be issued passes to leave the Clinical Center, NIH, for periods not to exceed 12 hours, unless prior clearance is given by me for a longer period, for each such pass

SIGNATURE (Parent or Legal Guardian) Relationship Date

INTERPRETER CERTIFICATION

I have translated to the best of my ability all items on the General Admission Consent Form (NIH-1225-1) and those listed above on this NIH-1225-2. I have also asked and translated ALL questions and answers asked of me by the Clinical Center Staff and the patient to the best of my ability.

SIGNATURE DATE

ADDRESS (Street, City, State, Country) ZIP CODE TELEPHONE NO. (Area Code)

LEGAL GUARDIAN CERTIFICATION

I, _____, am the parent or legal guardian of the above named patient. In case of emergency I can be reached at the following address or telephoned at the following number

SIGNATURE DATE

ADDRESS (Street, City, State, Country) ZIP CODE TELEPHONE NO. (Area Code)

Patient Identification

ADDENDUM TO GENERAL ADMISSION CONSENT
NIH-1225-2 (9-87)
P.A. 09-25-0099

Appendix I

Tanner Staging

Clinic Visit

Patient I.D._____
Date _____
Visit No. _____(1,2,3)
Patient Group _____ (Control = 1, Abuse = 2)
Patient Age _____ Birth date _____

bp 1 _____ bp 2 _____
pulse 1 _____ pulse 2 _____

Height _____ (cm) Height percentile _____
Weight _____ (kg) Weight percentile _____

Exam -

Tanner Breast _____ (1-5)
Pubic Hair _____ (1-5)
Axillary Hair _____ (Y/N)
Acne _____ (Y/N)
First Menses _____ (Y/N)
Age _____

Child's Perception -

Breast _____ (1-5)
Pubic Hair _____ (1-5)
Height _____
Weight _____

1. mother
2. stepmother
3. foster mo.
4. grandmo.
5. other

Parent's Perception _____ (code)

Breast _____ (1-5)
Pubic Hair _____ (1-5)
1st menses of child _____ (Y/N)
Age for child _____
Date of 1st menses of parent _____
Significant sexual developm. _____ (Early = 1, Late = 2)
Relationship _____

			(0) Time___	(20) Time___	(40) Time___
LH	_____	Cortisol	_____	_____	_____
FSH	_____	Cort. Bind.	_____	_____	_____
DHEA	_____	d-4AD	_____	_____	_____
Testos	_____				
Estrad	_____				
Proges	_____				

BIBLIOGRAPHY

Achenbach, T.M. (1978). The child behavior profile: I. Boys aged 6 through 11. Journal of Consulting and Clinical Psychology, 46, 478-488.

Achenbach, T.M., & Edelbrock, C.S. (1979). The child behavior profile: Boys aged 12-16 and girls aged 6-11 and 12-16. Journal of Consulting and Clinical Psychology, 47(2), 223-233.

Achenbach, T.M., & Edelbrock, C.S. (1981). Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. Monographs of the Society for Research in Child Development, 46(1, Serial No. 188).

Achenbach, T.M., & Edelbrock, C.S. (1983). Manual for child behavior checklist and revised child behavior profile. Burlington: University of Vermont.

Adams-Tucker, C. (1982). Proximate effects of sexual abuse in childhood: A report on 28 children. American Journal of Psychiatry, 139(10), 1252-1256.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed. rev.). Washington, DC: Author.

Anderson, L.F. (1981). Notes on the linkage between the sexually abused child and the suicidal adolescent. Journal of Adolescence, 4, 157-162.

Anderson, S.C., Bach, C.M., & Griffith, S. (1981, April). Psychosocial sequelae in intrafamilial victims of sexual assault and abuse. Paper presented at the Third International Conference on Child Abuse and Neglect, Amsterdam, The Netherlands.

Asher, S.J. (1988). The effects of childhood sexual abuse: A review of the issues and evidence. In L.E.A. Walker (Ed.), Handbook on the sexual abuse of children (pp. 3-18). New York: Springer.

Bagley, C., & Ramsay, R. (1985, February). Disrupted childhood and vulnerability to sexual assault: Long-term sequels. Paper presented at the Conference on Counselling the Sexual Abuse Survivor, Winnipeg, Manitoba, Canada.

Bakeman, R., & Gottman, J.M. (1986). Observing interaction: An introduction to sequential analysis. Cambridge, U.K.: Cambridge University Press.

Barnard, C.P., & Hirsch, C. (1985). Borderline personality and victims of incest. Psychological Reports, 57, 715-718.

Becker, J.V., Skinner, L.J., Abel, G.G. & Treacy, E.C. (1982). Incidents and types of sexual dysfunction in rape and incest. Journal of Sex and Marital Therapy, 8, 65-74.

Bender, L., & Blau, A. (1937). The reaction of children to sexual relations with adults. American Journal of Orthopsychiatry, 7, 500-518.

Bender, L., & Grugett, A.E. (1952). A follow-up report on children who had atypical sexual experiences. American Journal of Orthopsychiatry, 12, 825-837.

Benward, J., & Densen-Gerber, J. (1975). Incest as a causative factor in antisocial behavior: An explanatory study. Contemporary Drug Problems, 4, 322-340.

Berliner, L., & Wheeler, J.R. (1987). Treating the effects of sexual abuse on children. Journal of Interpersonal Violence, 2(4), 415-434.

Bliss, E.L. (1984). A symptom profile of patients with multiple personalities, including MMPI results. Journal of Nervous and Mental Disorders, 117(2), 197-201.

Brady, K. (1979). Father's day. New York: Dell Publishing.

Brant, R.S.T., & Herzog, J.M. (1979, October). Psychiatric assessment of sexually abused toddlers. Paper presented at the Meeting of the American Academy of Child Psychiatry, Houston, TX.

Brickman, J., & Briere, J. (1984). Incidence of rape and sexual assault in an urban Canadian population. Journal of Women's Studies, 7, 195-206.

Briere, J. (1984, April). The long-term effects of childhood sexual abuse. Paper presented at The Third National Conference on the Sexual Victimization of Children, Washington, DC.

Briere, J. (1988). The long-term clinical correlates of childhood sexual victimization. Annals of New York Academy of Sciences, 528, 327-334.

Briere, J., & Runtz, M. (1987). Post sexual abuse trauma: Data and implications for clinical practice. Journal of Interpersonal Violence, 2(4), 367-379.

Briere, J., & Runtz, M. (1988). Symptomatology associated with childhood sexual victimization in a nonclinical adult sample. Child Abuse & Neglect, 12, 51-59.

Browne, A., & Finklehor, D. (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99(1), 66-77.

Browning, D., & Boatman, B. (1977). Incest: Children at risk. American Journal of Psychiatry, 134, 69-72.

Brunngraber, L.S., (1986). Father-daughter incest: Immediate and long-term effects of sexual abuse. Advances in Nursing Science, 8(4), 15-35.

Burgess, A.W., Hartman, C.R. & McCormack, A. (1987). Abused to abuser: Antecedents of socially deviant behaviors. American Journal of Psychiatry, 144, 1431-1436.

Burgess, A.W., & Holstrom, L.L. (1979). Rape: Crisis and recovery. Englewood Cliffs, NJ: Prentice-Hall.

Butler, S. (1978). Conspiracy of silence. San Francisco: New Glide.

Bybee, D. (1987, May). Measurement issues in child sexual abuse. Paper presented at the biennial meetings of the Society for Research in Child Development, Baltimore, MD.

Carmen, E.H., Reiker, P.R., & Mills, T. (1984). Victims of violence and psychiatric illness. American Journal of Psychiatry, 143, 378-383.

Cavaiola, A.A., & Schiff, M. (1988). Behavioral sequelae of physical &/or sexual abuse in adolescents. Child Abuse & Neglect, 12, 181-188.

Cohen, F.S., & Densen-Gerber, J. (1982). A study of the relationship between child abuse and drug addiction in 178 patients. Child Abuse & Neglect, 6, 383-387.

Committee on Sexual Offenses Against Children and Youth. (1984). Sexual offences against children, Vol. 1. Ottawa: Canadian Governmental Publishing Centre.

Conte, J.R. (1982). Sexual abuse of children: Enduring issues for social work. In J.R. Conte & D. Shore (Eds.), Social work and child sexual abuse (pp. 1-19). New York: Haworth.

Conte, J.R., Rosen, C., Saperstein, L., & Shermack, R. (1985). An evaluation of a program to prevent the sexual victimization of young children. Child Abuse & Neglect, 9, 319-328.

Conte, J.R., & Schuerman, J.R. (1987). The effects of sexual abuse on children. Journal of Interpersonal Violence, 2(4), 380-390.

Coons, P.M., Bowman, E.S., Pellow, T.A., & Schneider, P. (1989). Post-traumatic aspects of the treatment of victims of sexual abuse and incest. Psychiatric Clinics of North America, 12(2), 325-330.

Coons, P.M., & Milstein, V. (1986). Psychosexual disturbances in multiple personality: Characteristics, etiology and treatment. Journal of Clinical Psychiatry, 47(3), 106-110.

Corwin, D.L. (1986, May). Sexually abused child's disorder: Fact or fantasy?. Panel presented at the Fourth National Conference on the Sexual Victimization of Children, Children's Hospital National Medical Center, New Orleans, LA.

Courtois, C.A. (1979). Characteristics of a volunteer sample of adult women who experienced incest in childhood or adolescence (Doctoral dissertation, University of Maryland, College Park, 1979). Dissertation Abstracts International, 40, 3194A-3195A.

Courtois, C. A. (1988). Healing the incest wound. New York: Norton & Company.

De Mott, B. (1980). The pro-incest lobby. Psychology Today, 13(10), 11 ff.

Delson, N., & Clark, M. (1981). Group therapy with sexually molested children. Child Welfare, 60(3), 175-181.

deYoung, M. (1982a). Innocent seducer or innocently seduced? The role of child incest victims. Journal of Clinical Child Psychology, 11(1), 56-60.

deYoung, M. (1982b). Self-injurious behavior in incest victims: A research note. Child Welfare, 61, 577-584.

deYoung, M. (1982c). The sexual victimization of children. Jefferson, NC: McFarland and Company.

deYoung, M. (1984). Counterphobic behavior in multiply molested children. Child Welfare, 63(4), 333-339.

Dohrenwend, B.P. (1979). Stressful life events and psychopathology: Some issues of theory and method. In J.E. Barrett, R.M. Rose & G.I. Klerman (Eds.), Stress and mental disorder (pp. 1-15). New York: Raven Press.

Edelbrock, C., & Achenbach, T. (1980). A typology of child behavior profile patterns: Distribution and correlates for disturbed children aged 6-16. Journal of Abnormal Child Psychology, 8(4), 441-470.

Eibl-Eibesfeldt, I. (1971). Love and hate: The natural history of behavior patterns. New York: Holt, Rinehart and Winston.

Einbender, A.J., & Friedrich, W.N. (1989). Psychological functioning and behavior of sexually abused girls. Journal of Consulting and Clinical Psychology, 57(1), 155-157.

Ferenczi, S. (1949). Confusion of tongues between the adult and the child: The language of tenderness and of passion. International Journal of Psycho-Analysis 30, 225-230. (Originally read in German at the 12th International Psychoanalytical Conference, Wiesbaden, West Germany, 1932).

Finkelhor, D. (1980). Risk factors in the sexual victimization of children. Child Abuse & Neglect, 4, 265-273.

Finkelhor, D. (1984). Child sexual abuse. New York: MacMillan.

Finkelhor, D. (1987). The sexual abuse of children: Current research reviewed. Psychiatric Annals, 17(4), 233-241.

Finkelhor, D., & Baron, L. (1986). High risk children. In D. Finkelhor, S. Araji, L. Baron, A. Browne, S.D. Peters, & G.E. Wyatt (Eds.), A sourcebook on child sexual abuse (pp. 60-88). Beverly Hills, CA: Sage Publications.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. American Journal of Orthopsychiatry, 55(4), 530-541.

Finkelhor, D., & Browne, A. (1986). Initial and long-term effects: A conceptual framework. In D. Finkelhor, S. Araji, L. Baron, A. Browne, S.D. Peters, & G.E. Wyatt (Eds.), A sourcebook on child sexual abuse (pp. 180-198). Beverly Hills, CA: Sage Publications.

Finkelhor, D., & Browne, A. (1988). Assessing the long-term impact of child sexual abuse: A review and conceptualization. In L.E.A. Walker (Ed.), Handbook on sexual abuse of children (pp. 55-71). New York: Springer Publishing.

Freedman, A.M., Kaplan, H.I., & Sadock, B.J. (Eds.). (1975). Comprehensive textbook of psychiatry (2nd ed.). Baltimore: Williams & Wilkins.

Freud, S. (1962). The etiology of hysteria. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 3, pp. 191-227). London: Hogarth Press. (Original work published in 1896).

Friedrich, W.N., Beilke, R.L., & Urquiza, A.J. (1987). Children from sexually abusive families: A behavioral comparison. Journal of Interpersonnal Violence, 2(4), 391-402.

Friedrich, W.N., Grambsch, P., & Koverola, C. (1989, June). The child sexual behavior inventory: A comparison of normal and clinical populations. Paper presented at International Academy of Sex Research, Princeton, NJ.

Friedrich, W.N., Urquiza, A.J., & Beilke, R. (1986). Behavior problems in sexually abused young children. Journal of Pediatric Psychology, 11, 47-57.

Fritz, G., Stoll, K., & Wagner, N. (1981). A comparison of males and females who were sexually abused as children. Journal of Sex and Marital Therapy, 7, 54-59.

Fromuth, M.F. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. Child Abuse & Neglect, 10, 5-15.

Gelinas, D.J. (1983). The persisting negative effects of incest. Psychiatry, 46, 312-332.

Givens, D.B. (1977). Shoulder shrugging: A densely communicative expressive gesture. Semiotica, 19(1/2), 13-28.

Givens, D.B. (1978). The nonverbal basis of attraction: Flirtation, courtship, and seduction. Psychiatry, 41, 346-359.

Givens, D.B. (1983). Love signals. New York: Crown Publishers.

Gold, E.R. (1986). Long-term effects of sexual victimization in childhood: An attributional approach. Journal of Consulting and Clinical Psychology, 54, 471-475.

Goleman, D. (1987, October 13). Thriving despite hardship. New York Times, pp. C10-C11.

Gomes-Schwartz, B., Horowitz, J.M., & Sauzier, M. (1985). Severity of emotional distress among sexually abused preschool, school-age, and adolescent children. Hospital and Community Psychiatry, 36(5), 503-508.

Goodwin, J. (1985). Post-traumatic symptoms in incest. In R. Pynoos, & S. Eth (Eds.), Post-traumatic stress disorder in children (pp. 157-186). Washington, DC: American Psychiatric Press.

Goodwin, J., Cormier, L., & Owen, J. (1983). Grandfather-grandaughter incest. Child Abuse & Neglect, 7, 163-170.

Goodwin, J., & Owen, J. (1982). Incest from infancy to adulthood: A developmental approach to victims and their families. In J. Goodwin (Ed.), Sexual abuse: Incest victims and their families (pp. 77-91). Littleton, MA: John Wright-PSG.

Goodwin, J., Simms, M., & Bergman, R. (1979). Hysterical seizures: A sequel to incest. American Journal of Orthopsychiatry, 49(4), 698-702.

Gross, M. (1979). Incestuous rape: A cause for hysterical seizures in four adolescent girls. American Journal of Orthopsychiatry, 49(4), 704-708.

Harter, S., Alexander, P.C., & Neimeyer, R.A. (1988). Long-term effects of incestuous child abuse in college women: Social adjustment, social cognition, & family characteristics. Journal of Consulting & Clinical Psychology, 56(1), 5-8.

Haugaard, J.J. (1987). The consequences of child sexual abuse: A college survey. Unpublished manuscript. Department of Psychology, University of Virginia, Charlottesville, VA.

Haugaard, J.J., & Reppucci, N. (1988). The sexual abuse of children. San Francisco: Jossey-Bass.

Henderson, D.J. (1972). Incest: A synthesis of data. Canadian Psychiatric Association Journal, 17, 299-313.

Henderson, D.J. (1975). Incest. In A.M. Freedman, H.I. Kaplan, & B.J. Saddock (Eds.), Comprehensive textbook of psychiatry (2nd ed., pp. 1530-1539). Baltimore: Williams and Wilkins.

Henderson, J.L. (1983). Is incest harmful? Canadian Journal of Psychiatry, 28, 34-39.

Herman, J.L. (1981) Father-daughter incest. Cambridge, MA: Harvard Press.

Herman, J.L., & Hirschman, L. (1981). Families at risk for father-daughter incest. American Journal of Psychiatry, 138(7), 967-970.

Herman, J.L., Russell, D., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. American Journal of Psychiatry, 143, (10), 1293-1296.

Hollingshead, A. B. (1975). Four-factor index of social status. Unpublished manuscript. Yale University, Department of Sociology, New Haven, CT.

Hunter, R.S., Kilstrom, N., & Loda, F. (1985). Sexually abused children: Identifying masked presentations in a medical setting. Child Abuse & Neglect, 9, 17-25.

James, J., & Meyerding, J. (1977). Early sexual experience and prostitution. American Journal of Orthopsychiatry, 134, 1381-1385.

Jones, E. (1961). The life and work of Sigmund Freud. (Edited and abridged in one volume by L. Trilling & S. Marcus). New York: Basic Books.

Kaufman, I., Peck, A.L., & Tagiuri, C. (1954). The family constellation and overt incestuous relations between father and daughter. American Journal of Orthopsychiatry, 24, 266-279.

Kilgore, L.C. (1988, April). Effects of early childhood sexual abuse on self and ego development. Social Casework: The Journal of Contemporary Social Work, 224-230.

Kluft, R.P. (Ed.). (1985). Childhood antecedents of multiple personality. Washington, DC: American Psychiatric Press, 1985.

Kohan, M.J., Pothier, P., & Norbeck, J.S. (1987). Hospitalized children with history of sexual abuse: Incidence and care issues. American Journal of Orthopsychiatry, 57(2), 258-264.

Krieger, M.J., Rosenfeld, A.A., Gordon, A., & Bennett, M. (1980). Problems in the psychotherapy of children with histories of incest. American Journal of Psychotherapy, 34(1), 81-87.

Landis, J. (1956). Experiences of 500 children with adult sexual deviants. Psychiatric Quarterly Supplement, 30, 91-109.

Lewis, M., & Sarrel, P.M. (1969). Some psychological aspects of seduction, incest, and rape in childhood. Journal of the American Academy of Child Psychiatry, 8, 606-619.

Lindberg, F.H., & Distad, L.J. (1985a). Post-traumatic stress disorders in women who experienced childhood incest. Child Abuse & Neglect, 9, 329-334.

Lindberg, F.H., & Distad, L.J. (1985b). Survival responses in incest: Adolescents in crisis. Child Abuse & Neglect, 9, 521-526.

Lorenz, K. (1943). Die angeborenen Formen moeglicher Erfahrung [The inborn forms of possible experience]. Zeitschrift der Tierpsychologie, 5, 235-409.

Lukianowicz, N. (1972). Incest I: Paternal incest; Incest III: Other types of incest. British Journal of Psychiatry, 120, 310-313.

Mannarino, A. & Cohen, J. (1986). A clinical demographic study of sexually abused children. Child Abuse and Neglect, 10, 17-23.

McCowan, D.E. (1981). Father/daughter incest: A family problem. Pediatric Nursing, 7, 25-28.

McLeer, S., Deblinger, E., Atkins, M.S., Foa, E.B., & Ralphe, D.L. (1988). Post-traumatic stress disorder in sexually abused children. Journal of the American Academy of Child and Adolescent Psychiatry, 27(5), 650-654.

Meiselman, K. C. (1978). Incest: A psychological study of causes and effects with treatment recommendations. San Francisco: Jossey-Bass Publishers.

Meiselman, K.C. (1980). Personality characteristics of incest history psychotherapy patients: A research note. Archives of Sexual Behavior, 9(3), 195-197.

Mian, M., Wehrspann, W., Klajner-Diamond, H., LeBaron, D., & Winder, C. (1986). Review of 125 children 6 years of age and under who were sexually abused. Child Abuse & Neglect, 10, 223-229.

Miller, J., Moeller, D., Kaufman, A., DiVasto, P., Pathak, D., & Christy, J. (1978). Recidivism among sex assault victims. American Journal of Psychiatry, 135, 1103-1104.

Molner, G., & Cameron, P. (1975). Incest syndromes: Observations in a general hospital psychiatric unit. Canadian Psychiatric Association Journal, 20, 373-377.

National Center for Child Abuse and Neglect. (1988). Second study of national incidence and prevalence of child abuse and neglect. Washington, DC: Author.

Norusis, M. (1989). Statistical program for the social sciences for personal computers (SPSS/PC+ V3.1) [Computer program]. New York: SPSS, Inc.

O'Carroll, T. (1982). Paedophilia: The radical case. London, U.K.: Owen.

Oppenheimer, R., Howells, K., Palmer, R., & Chaloner, D. (1985). Adverse sexual experience in childhood and clinical eating disorders. Journal of Psychiatric Research, 19, 357-361.

Ounce of Prevention Fund. (1986). Child sexual abuse: A hidden factor in adolescent sexual behavior. Chicago, IL: Illinois Department of Children and Family Services.

Owens, T.H. (1984). Personality traits of female psychotherapy patients with a history of incest: A research note. Journal of Personality Assessment, 48, 606-608.

Painter, S.L. (1986). Research on the prevalence of child abuse: New directions. Canadian Journal of Behavior Science/Revue Canadienne des Sciences du Comportement, 18(4), 323-339.

Peters, S.L. (1984). The relationship between childhood sexual victimization and adult depression among Afro-American and white women. Dissertation Abstracts International, 45, 3079B. (University Microfilms #84-28, 555).

Pomeroy, W.B. (1976, November). A new look at incest. Forum, pp. 9-13.

Putnam, F. W. (1989) The psycho-biological effects of childhood sexual abuse. Unpublished research proposal. Washington, DC: National Institute of Mental Health.

Putnam, F.W., Post, R.M., Guroff, J.J., Silberman, E., & Barbara, L. (1983). One hundred cases of multiple personality disorder (New Research Abstract No. 77). Presented at the annual meeting of the American Psychiatric Association, New York.

Putnam, F. W., & Trickett, P. K. (1988). The Psycho-biological effects of sexual abuse. Unpublished manuscript. Washington, DC: National Institute of Mental Health.

Quinsley, V.L. (1986). Men who have sex with children. In D. Weisstub (Ed.), Law and mental health: International perspectives (Vol. 2, pp. 140-172). New York: Pergamon.

Ramey, J. (1979). Dealing with the last taboo. Sex Information and Education Council of the United States [SIECUS], 7, 1-2, 6-7.

Rascovsky, M.W., & Rascovsky, A. (1950). On consummated incest. International Journal of Psychoanalysis, 31, 42-47.

Renshaw, D.C. (1987). Evaluating suspected cases of child sexual abuse. Psychiatric Annals, 17, 262-270.

Rosenfeld, A.A. (1979). Incidence of a history of incest among 18 female psychiatric patients. American Journal of Psychiatry, 136, 791-795.

Rosenfeld, A.A., Nadelson, C., Krieger, M., & Backman, J. (1979). Incest and sexual abuse of children. Journal of the American Academy of Child Psychiatry, 16, 327-39.

Ruch, L.O., & Chandler, S. M. (1982). The crisis impact of sexual assault on 3 victim groups: Adult rape victims, child rape victims, and incest victims. Journal of Social Science Research, 5, 83-100.

Runtz, M. & Briere, J. (1986). Adolescent acting out and childhood history of sexual abuse. Journal of Interpersonal Violence, 1(3), 326-34.

Runtz, M.G. (1987). The sexual victimization of women: The link between child abuse and revictimization. Paper presented at the annual meeting of the Canadian Psychological Association, Vancouver, B.C.

Russell, A.B., & Mohr-Trainor, C. (1984). Trends in child abuse and neglect: A national perspective. Denver, CO: American Humane Association.

Russell, D.E.H. (1984). The prevalence and seriousness of incestuous abuse: Stepfathers vs. biological fathers. Child Abuse & Neglect, 8, 15-22.

Russell, D.E.H. (1986a). The secret trauma. New York: Basic Books.

Russell, D.E.H. (1986b). The incest legacy. The Sciences, 26, 28-32.

Russell, D.E.H. (1988). The incidence and prevalence of intrafamilial sexual abuse of female children. In L.E.A. Walker (Ed.), Handbook on sexual abuse of children (pp. 21-36). New York: Springer.

Russell, D.E.H., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. American Journal of Psychiatry, 143(10), 1293-1296.

Sedney, M.A., & Brooks, B. (1984). Factors associated with a history of childhood sexual experience in a nonclinical female population. Journal of American Academy of Child Psychiatry 23(2), 215-218.

Sexton, M., Harralson, T., Hulsey, T., & Nash, M. (1988, November). Sexual abuse and hypnotic susceptibility: Correlates in adult women. Paper presented at the Society for Clinical and Experimental Hypnosis Convention, TN.

Shapiro, S. (1987). Self-mutilation and self-blame in incest victims. American Journal of Psychotherapy, 61(1), 46-54.

Silbert, M., & Pines, A.M. (1983). Sexual child abuse as an antecedent to prostitution. Journal of Sex and Marital Therapy, 8, 57-64.

Sim, M. (1974). Guide to psychiatry. Edinburgh, London, U.K.: E.& S. Livingston.

Singer, M.I., Petchers, M.K., & Hussey, D. (1989). The association between sexual abuse and substance abuse in an adolescent clinical population. Child Abuse & Neglect, 13, 166-175.

Sirles, A., Smith, J.A., & Kusama, H. (1989). Psychiatric status of intrafamilial child sexual abuse victims. Journal of American Academy of Child & Adolescent Psychiatry, 28(2), 225-229.

Standage, K.F. (1975). The etiology of hysterical seizures. Canadian Psychiatric Association Journal, 20, 67-73.

Summit, R. (1983). The child abuse accommodation syndrome. Child Abuse & Neglect, 7(2), 177-193.

Summit, R., & Kryso, J. (1978). Sexual abuse of children: A clinical spectrum. American Journal of Orthopsychiatry, 43, 237-251.

Tanner, J.M. (1962). Growth at adolescence. Springfield, IL: Charles Thomas.

Terr, L.C. (1987). Severe stress and sudden shock: The connection. Sam Hibbs Award Lecture, American Psychiatric Association Convention, Chicago, IL.

Thomas, J.N., & Rogers, C.M. (1981). Sexual abuse of children: Case finding and clinical assessment. Nursing Clinics of North America, 16, 175-188.

Trickett, P.K., Helmers, K., Zakowski, S., & Putnam, F.W. (1991, August). The social networks and classroom behavior of sexually abused girls. Poster presentation at the annual meetings of the American Psychological Association, San Francisco, CA.

Trickett, P.K., & Kuczynski, L. (1986). Children's misbehaviors and parental discipline strategies in abusive and nonabusive families. Developmental Psychology, 22(1), 115-123.

Trickett, P.K., & Susman, E.J. (1988) Parental perceptions of child-rearing practices in physically abusive and nonabusive families. Developmental Psychology, 24(2), 270-276.

Tsai, M., Feldman-Summers, S., & Edgar, M. (1979). Childhood molestation: Variables related to differential impacts on psychosexual dysfunctioning in adult women. Journal of Abnormal Psychology, 88, 407-417.

Tsai, M., & Wagner, N.N. (1978). Therapy groups for women sexually molested as children. Archives of Sexual Behavior, 7, 417-427.

Tufts New England Medical Center, Division of Child Psychiatry. (1984). Sexually exploited children service and research project. Final report for the Office of Juvenile Justice and Delinquency Prevention. Washington, DC: U.S. Department of Justice.

Virkkunen, M. (1975). Victim-precipitated pedophilia offences. British Journal of Criminology, 15(2), 175-180.

Weiss, J., Rogers, E., Darwin, M.R., & Dutton, C.E. (1955). A study of girl sex victims. The Psychiatric Quarterly, 29, 1-27.

Westermeyer, J. (1978). Incest in psychiatric practice: A description of patients and incestuous relationships. Journal of Clinical Psychiatry, 39, 643-648.

White, S., Halpin, B.M., Strom, G.A., & Santilli, G. (1988). Behavioral comparisons of young sexually abused, neglected, and nonreferred children. Journal of Clinical Child Psychology, 17(1), 53-61.

Wolfe, V.V., Gentile, C., & Wolfe, D.A. (1989). The impact of sexual abuse on children: A PTSD formulation. Behavior Therapy, 20, 215-228.

Wyatt, G. (1985). The sexual abuse of Afro-American women and white women in childhood. Child Abuse and Neglect, 9, 507-519.

Wyatt, G.E., & Mickey, M.R. (1987). Ameliorating the effects of child sexual abuse: An exploratory study of support by parents and others. Journal of Interpersonal Violence, 2(4), 403-414.

Wyatt, G.E., & Peters, S. (1986). Issues in the definition of child sexual abuse in prevalence research. Child Abuse and Neglect, 10, 231-240.

Yates, A. (1982). Children eroticized by incest. American Journal of Psychiatry, 139(4), 482-485.