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Trauma Symptoms in Sexual Abuse Counselors at Centers Funded by the Illinois Coalition Against Sexual Assault

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TRAUMA SYMPTOMS IN SEXUAL ABUSE COUNSELORS AT CENTERS FUNDED BY THE ILLINOIS COALITION AGAINST SEXUAL ASSAULT

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An Abstract Presented to the Faculty of the
Graduate School of Lindenwood College
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ABSTRACT

There were two purposes of this study. The first was to describe the demographic nature of counselors at the 30 Illinois Coalition Against Sexual Assault (ICASA) funded centers and their responses to a trauma symptom checklist developed for use with sexual abuse victims. The second purpose was to determine if there is a significant difference in the means of responses to the Trauma Symptom Checklist=33 when subjects were divided into two categories. Subjects (N=81) were placed in the nominal categories of Victims (those who reported personal sexual trauma, N=41, 50.6%) and Non-Victims (those who did not report personal sexual trauma, N=40, 49.4%). Subjects were 81 female counselors who volunteered or were paid to provide counseling for victims of rape and sexual abuse in Illinois ICASA-funded centers.

By mail, counselors responded anonymously to items on a personal data sheet and the Trauma Symptom Checklist-33. Demographic data was reported. The range, mean and mode of individual total scores, and an anlysis of the significant difference in mean scores between victims and non-victims was reported. The null hypothesis, that there would be no difference in mean scores, was rejected. A conclusion of the study was that counselors in ICASA centers which counsel victims of sexual assault and their families and significant

others do experience various symptoms of trauma. Future studies should focus on clarifying the causes of trauma symptomology. Limitations of the study were presented and recommendations were made for possible studies in the future.

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DEDICATION PAGE

This paper is dedicated to all the survivors who have enriched my understanding, to all the counselors who have supported and encouraged me, and to all the teachers who have shared their love of life and learning. Most importantly, it is dedicated to Patrick and Ryan, the reasons for my continued striving to improve as I model for them that learning about self and others is a life-long adventure.

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I wish to thank the Illinois Coalition Against Sexual Assault for allowing me to proceed with this research and for giving me the addresses to write each of the 30 centers in Illinois. I also thank the counselors for their time and for their honesty. After working with victims of rape and sexual abuse, they were still willing to take the time to participate in this project. Counselors are the heart of this research, and it is my hope that the information gained in this study will be of help to them in some way.

I am grateful to the readers of this paper who helped me clarify my thoughts, increase my knowledge, and sharpen my skills. Finally, I wish to thank Marilyn Patterson for her affirmation and support.

Table of Contents

List of Tables

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There were two purposes of this study. The first was to describe the demographic nature of counselors at the 30 Illinois Coalition Against Sexual Assault (ICASA) funded centers and their responses to a trauma symptom checklist developed for use with sexual abuse victims. The second purpose was to determine if there was a significant difference in the means of responses to the Trauma Symptom Checklist-33 when subjects were divided into two categories. Subjects (N=81) were placed in the nominal categories of Victims (those who reported personal sexual trauma, N=41, 50.6%) and Non-Victims (those who did not report personal sexual trauma, N=40, 49.4%). Subjects were 81 female counselors who volunteered or were paid to provide counseling for victims of rape and sexual abuse in Illinois ICASA-funded centers.

By mail, counselors responded anonymously to items on a personal data sheet and the Trauma Symptom Checklist-33. Demographic data was reported. The range, mean and mode of individual total scores, and an analysis of the signficant difference in mean scores between victims and non-victims was reported. The null hypothesis, that there would be no difference in mean scores, was rejected. A conclusion of the study was that counselors in ICASA centers which counsel victims

of sexual assault,their families, and significant others do experience various symptoms of trauma. Future studies should focus on clarifying the causes of this trauma symptomology. Limitations of the study were presented and recommendations were made for possible future studies.

CHAPTER I

INTRODUCTION

The Illinois Coalitions Against Sexual Assault (ICASA) was formed in 1977 to support the work of volunteer rape and sexual assault centers over the state of Illinois. It has evolved into an organization which is responsible for training, overseeing, and partially funding a network of 30 centers in the state of Illinois (see Appendix A). ICASA promotes legislation, research, and public education on the issues of rape and sexual assault.

ICASA centers provide counseling and legal and medical advocacy for child and adult victims and their significant others and families. From July 1 of 1993, to June 30 of 1994, ICASA centers offered their services to 11,738 new clients. Training counselors, advocates, volunteers, and the public is an important part of their mission. ICASA publishes brochures and other resource material about sexual assault and maintains a resource library for public use. It works with state and national organizations to influence legislation and end sexual violence.

Professionals who help victims have recently recognized and documented symptoms of trauma in themselves (Morrissey, 1994; Sanford, 1994). Identifying personal symptoms of trauma has allowed

counselors to utilize supervision and maintain professional standards while counseling severely traumatized clients (McCann & Pearlman, 1990; Sanford, 1994). While some of a counselor's symptoms of trauma may have been triggered by stress, personal life trauma, or illness, some have been the result of secondary traumatization, sometimes called vicarious traumatization.

As part of a practicum training at Sexual Assault Victims 1st in Collinsville, Illinois, in the researcher attended an ICASA sponsored workshop on secondary traumatization presented by Linda Sanford. Secondary traumatization is a concept different from burn-out and different from counter-transference. Secondary traumatization is an issue for those counselors who work with traumatized clients, for the agencies who employ them, and for the educators who train counselors. It is an issue which the professional community needs to document and address.

The situations of rape and childhood abuse may have varied in many aspects, but both have required understanding and empathic counselors with the knowledge and skills to provide effective treatment. Rape and childhood sexual abuse have specific symptomatologies and recovery processes which require a counselor to help the client work through trauma

symptoms and retell the traumatic events which changed their lives (Courtois, 1988; Meiselman,1990).

A review of literature has supported Post Traumatic Stress Disorder (PTSD) as a diagnosis for victims after sexual trauma (Gelinas, 1983; Meiselman, 1990; Rowan & Foy, 1993). According to the Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM IV) (American Psychiatric Association, 1994), secondary traumatization has occurred when one has learned about traumatic events, including "violent personal assault...or serious injury" (American Psychiatric Association, 1994, p. 424). Counselors have recognized their own secondary traumatization, trauma experienced from listening to clients report traumatic memories of sexual abuse and rape. Vicariously experienced trauma has only been reported recently in the literature as counselors are just now beginning to feel safe enough to admit that the client's terror has had a personal impact (McCann & Pearlman, 1990; Morrissey, 1994) and document their responses with research and literature. Rage at the horror to which women have been exposed has been one common response. Personal feelings of fear and vulnerability have been another (McCann & Pearlman, 1990).

Literature reviews of post traumatic stress disorder, vicarious traumatization, and the aspects of

both childhood sexual assault and rape were needed to fully understand the experiences of the counselors who were the subjects of the current study. These are the counselors who specialize in sexual trauma survivors. For those counselors who have experienced sexual trauma in their own lives as a result of rape or childhood sexual assault or both, reliving the memories of others has sometimes led to an increase in the frequency of trauma symptoms in their personal and professional lives and a need for personal therapeutic intervention.

Counselors at ICASA centers reported symptoms of trauma in themselves during February and March, 1995, after repeated exposure to clients who exhibited various symptoms of trauma as a result of their experiences. Reliving memories with survivors of childhood sexual assault and rape, including those ritually abused, has presented ICASA counselors with trauma (Morrissey, 1994) in their personal and professional lives.

Other counselors in agencies or private practice have been careful not to overload their schedules with victims of childhood sexual abuse and rape. These counselors have balanced their counseling schedules with clients who were less needy and clinically demanding (Rosewater & Walker, 1985; Medeiros & Prochaska, 1988). Counselors at ICASA funded centers

cannot as they have specialized in these clinically needy and demanding clients.

STATEMENT OF PURPOSE

It is important for professionals to understand the potential effects of counseling victims of sexual assault. The extent of abuse, the symptoms of trauma it creates, and the recovery processes of survivors are daily concerns of ICASA counselors of victims of child sexual assault and rape. Counselors are effected by the hours they spend listening to stories of intense traumatization. Counselors in sexual trauma centers work with people who have experienced severe trauma across the mental, physical, and emotional spectrum. As part of the recovery process, clients remember and relive events beyond the normal range of experience as if they were happening in front of the counselor. This has created environments in which counselors were vicariously traumatized.

Although this study has not proven that vicarious traumatization alone created counselor trauma symptoms similar to those of victims of sexual assault, it has determined which symptoms counselors working with these special clients were experiencing. These counselor trauma symptoms reflected the sexual assault trauma

symptoms in their clients' lives. It was also determined if those who have recovered from their own sexual trauma and become counselors, experienced significantly more symptoms of trauma.

Counselors in the 30 Illinois centers funded by the Illinois Coalition Against Sexual Assault (ICASA) have treated a highly traumatized clientele. According to the literature review, it is possible that these counselors have suffered some kind of secondary traumatization from entering into empathic relationships with severely traumatized clients. If so, both those who have and have not previously been victimized will reflect their clients' trauma symptoms.

One purpose of this research was to describe the demographic nature of the ICASA counselors and to determine the kinds of symptoms of traumatization reported by counselors. Since vicarious traumatization could be influenced by previous personal sexual assault, the demographics were collected in categories of victims (those counselors who had previously experienced childhood sexual assault, adult sexual assault or both) and non-victims (those counselors who had not previously experienced childhood sexual assault, adult sexual assault or both). A description of the trauma responses of the total number of counselors responding to the instruments sent to ICASA

centers was also presented. A demographic study requires no hypothesis statement, and so none was created by the researcher.

The primary research of this study was to determine if there was a significant difference at alpha level .05 in the means of the total scores reported by victims and non-victims. The null hypothesis stated that there was no significant difference in the mean total score self-reported by the sample of victims who were counselors and the mean total score reported by counselors who were not previously victims. The alternative hypothesis was that there was a significant difference in the mean total score reported by victims who were counselors and the mean total score of counselors who were not previously victims.

A review of literature indicated that counselors were vicariously traumatized by the recovery process of their clients. This study could be significant because it can identify the types of symptomatology reported in counselors at ICASA centers and analyze differences in counselors who were previously victimized and those who were not. Analysis of data collected could lead to possible future studies and to recommendations for ICASA counselor care. There may be some limited generalization to others specializing in sexual abuse.

CHAPTER II

LITERATURE REVIEW

A review of literature identifies Post Traumatic Stress Disorder as a result of sexual assault (American Psychiatric Association, 1994). The DSM IV identifies the symptoms of trauma exhibited by these clients and sometimes reflected by counselors who work with them.

Post Traumatic Stress Disorder

A diagnosis of posttraumatic stress disorder (PTSD) has resulted from "the development of characteristic symptoms following an exposure to an extreme traumatic stressor" (American Psychiatric Association, 1994, p. 424). The stressor has been identified as experiencing or learning about traumatic events beyond the range of normal expectations. These abnormal events included, among others, sexual assault and physical attack, and for children, "developmentally inappropriate sexual experiences without threatened or actual violence or injury" (American Psychiatric Association, 1994, p.424). These symptoms may result from witnessing injury or death due to violent assault.

Post Traumatic Stress Disorder was identified when victims were re-experiencing intrusive memories, recurring distressing dreams, and "dissociative states

that last from a few seconds to several hours or even days during which components of the event are relived and the person behaves as though experiencing the event at the moment" (American Psychiatric Association, 1994, p.424). In order to protect themselves from the original trauma and from re-experiencing the trauma, people responded with "psychic numbing" or "emotional anesthesia". They may "loose interest" in life and "feel detached" from others or have a "remarkedly reduced ability to feel emotions" (American Psychiatric Association, 1994, p.424).

The symptomology of PTSD was divided into 3 categories: 1st, reexperiencing the traumatic event in some way (recurring memories, dreams, and flashbacks); 2nd, avoiding experiences associated with the trauma or numbing; and 3rd, increased arousal (demonstrated by difficulties with sleep, irritability, anger, difficulty concentrating, hypervigilance, or startle response). The PTSD diagnostic criteria required duration of symptoms for more than one month and significant distress or impairment in the social or occupational life of the individual or in some other important area of functioning such as their sex life.

These symptoms have been reported by both victims and by counselors working with victims. The current study used an instrument which identified how

frequently some symptoms of trauma (see Appendix D) have occurred in counselors over the last 2 months. Without intervention, these symptoms could interfere with the personal lives of the counselors and therefore interfere with the therapeutic process. For example, just as numbing in a client would interfere with the client's ability to form a therapeutic relationship with a counselor, numbing in a counselor would interfere with the counselor's ability to form a therapeutic relationship with the client.

Secondary Traumatization

A review of literature identified symptoms of traumatization similar to those of the traumatized victim in family members and significant others with close relationships to a victim (Figley, 1983; McCann and Pearlman, 1990). While, counselors for children and adults who have experienced physical, emotional, and sexual trauma have been helping client's and their families' heal, they have "not known how to respond to colleagues displaying similar, if not identical, symptoms" (Secondary Survival, 1994, p. 1).

Current attention to secondary trauma has focused upon those specializing in sexual abuse treatment, but it is a risk of many counselors (Secondary Survival,

1994, p. 8), including those who treat clients with chronic illness, homelessness, criminal justice problems, HIV/Aids, domestic violence, and natural disaster experiences. Responses to events or disasters which have affected large numbers at the same time have led to the identification of "critical incident stress", an acute type of PTSD, in emergency workers at environmental disasters or accidents involving the loss of life (McCann and Pearlman, 1990; Mitchell, 1985; Morrissey, 1994). There is still a need to focus more research on those who develop symptoms of trauma after a long exposure to highly stressful clients.

Counselors who have spent a significant proportion of their time working with clients who have been raped or sexually abused as children are not immune to the images, thoughts, and feelings created by exposure to their clients' traumatic memories (McCann & Pearlman, 1990). Short term reaction to these traumas have previously been identified and discussed in literature on countertransference (Blank, 1987; Danieli, 1981; Lindy, 1988), and the long term disruptive and painful psychological effects of working with traumatized clients (McCann & Pearlman, 1990) are now identified in literature as secondary post traumatic stress disorder.

Countertransference literature has referred to the counselors' unresolved or unconscious personal

conflicts which come from the counselors' own early experiences and memories. Literature reporting therapeutic responses to the horrors recounted by Vietnam veterans (Blank, 1987) described cases where counselors' unresolved traumatic experiences had intruded on the therapy process. Lindy (1988) identified symptoms of nightmares, intrusive images, reenactments, amnesia, estrangement, alienation, irritability, psychophysiological reactions, and survivor guilt in counselors working with veterans. These same symptoms have been identified in counselors of sexual assault (Wilson, et al, 1985).

Literature has discussed treatment issues for sexual abuse counselors and has warned of the dangers of over-identification with victims, increased vulnerability, and unresolved rage at the perpetrator (Colao & Hunt, 1983; Herman, 1981; McCann & Pearlman, 1990). Farber (1985) used evidence to indicate that client pathology has been transferred to counselors.

McCann and Pearlman (1990) joined the concepts of countertransference and burnout in their review of the constructivist self-development theory of personality. Their theory views the therapist's responses to client material as shaped by characteristics of both the therapist's unique psychological needs and cognitive schema (consistent

with countertransference theory) (p.136) and by characteristics of the situation (consistent with burnout literature). Burnout among sexual abuse counselors has specialized meaning. "Symptoms of burnout may be the final common pathway of continual exposure to traumatic material that cannot be assimilated or worked through" (McCann & Pearlman, 1990, p.134).

Literature describing the concepts of vicarious traumatization or secondary PTSD has identified a situation beyond countertransference and burnout since the counselors' cognitive structures have been altered by hearing traumatic material (McCann and Pearlman, 1990). It was the feeling of McCann and Pearlman "that all therapists working with trauma survivors will experience lasting alteration in their cognitive schema having a significant impact on the therapist's feelings, relationships, and life" (p. 136).

Counselors experiencing painful images and emotions from listening to traumatic memories,

> must be able to acknowledge, express, and work through these painful experiences in a supportive environment...if therapists are to prevent or ameliorate some of the potentially damaging effects of their work. If these feelings are not openly acknowledged and resolved, there is the risk that the helper may begin to feel numb or emotionally distant, thus unable to maintain a warm, empathic, and responsive stance with clients (McCann and Pearlman, 1990, p. 144).

Frustrated counselors have struggled with victims unwilling or unable to focus on traumatic memories. Many counselors reported feelings of anger as a result of working with survivors. Some were aware of the source of these emotions, others repressed them. Counselors unable to process their emotional reactions experienced denial or emotional numbing, a symptom of posttraumatic stress (McCann and Pearlman, 1990).

Recommendations for recovery from secondary PTSD, or vicarious traumatization, indicated that the counselor needed to engage in a process parallel to that of the victi, This recovery is a process of integrating and transforming the horror and violation which has been observed rather than lived. The psychological needs of trauma victims identified in a review of literature on adaptation to trauma included safety, dependence/trust, power, esteem, intimacy, independence, and frame of reference (McCann et all, 1988; McCann and Pearlman, 1990).

Current social and political climates have created an environment of crime and violence. Counselors have not only dealt with an enormous degree of vicarious trauma daily, they also have faced the stress from the current legal climate which caused them to face the risks of ethical complaints and even litigation. Every client has a right to a skilled and ethical counselor.

Every counselor has a right to an understanding work environment which recognizes the dangers inherent in working with this specialized population and identifies ways to be supportive during times of vicarious traumatization.

Literature has recommended that counselors continue to educate themselves in the symptoms and issues of sexual abuse and the new approaches and techniques developed to treat this population (Ratican, 1992). Clinicians treating sexual trauma victims have to use a wide variety of eclectic techniques and will need training, continuing education, and support.

Childhood Sexual Abuse

A review of literature on childhood sexual abuse revealed child abuse in both males and females has been more prevalent than previously thought (Lew, 1986). It also revealed that the incidence of reported abuse had quadrupled from 1909 to 1973 (Ratican, 1992). Although some type of legislation defining child abuse has been part of state laws for over 100 years (Darrow, 1988), it was not until 1974 that the federal government passed the Child Abuse Prevention and Treatment Act (McCurdy & Daro, 1994).

This legislature established national uniform operating standards about the identification and management of child abuse cases. A consequence of the varying laws from state to state was that the definition of maltreatment, its investigation, and the procedures for dealing with reported abuse, have varied so there is a lack of consistency in statistical reporting or services offered to victims (Fluke, 1992; McCurdy & Daro, 1994; Pelton, 1992).

In Illinois, child sexual abuse is defined as the sexual exploitation of a child by an adult, adolescent or older child. Children do not have to be forced but may be bribed or verbally coerced into sexual acts. The determining factor in Illinois is the difference in age and sexual knowledge between the child and an older person. Sexual abuse includes vaginal, anal or oral penetration, fondling, exhibitionism, prostitution, and photographing a child for pornography (ICASA, 1994).

The annual State Child Maltreatment reports between 1985 and 1992 indicated that the rate of children reported for abuse or neglect increased 50% (McCurdy & Daro, 1994). Child abuse reports have shown an average increase of about 6% each year from 1985 to 1994. In 1992, those states separating out sexual abuse as part of their reports indicated that sexual abuse represented about 17% of their statistics (McCurdy &

Daro, 1994). In Illinois, incest is defined as sexual relations between family members including parents, stepparents, siblings, uncles, grandparent and other blood relations (ICASA, 1994). Of girls reporting sexual abuse, 16% were sexually abused by a family member and 12% of those were abused before the age of 14 (Russell, 1988).

The dynamics and characteristics of incestuous families were discussed in the literature from several different theoretical perspectives: psychodynamic, sociological or socio-cultural, family systems, and feminist (Courtois, 1988). The study of incestuous behaviors has suffered from father-daughter bias and lack of scientific rigor (Courtois, 1988). Such discussions had limitations since most information about incestuous family dynamics was derived from the study of father-daughter incest (Courtois, 1988). However, the reported statistics report that of girls with biological fathers only 2.3% are sexually abused by them. Of girls with stepfathers, 17% are sexually abused by them, in fact, girls with stepfathers are 7 times more likely to be sexually abused than other girls (Russell, 1986).

In addition, about 33% of boy victims are related to the men who molest them, and 8% of boys are sexually abused by fathers or stepfathers (Urquiza & Keating,

1990). Another issue unaddressed was the 20-25% of incest committed by a sibling, usually an older brother (ICASA, 1994).

The characteristics of abuse are dynamic and fluid within each family and no single factor or single factor theory has been sufficient to explain incestuous abuse (Finkelhor, 1986). The specific family dynamics which have been associated with sexual abuse include greater conflict, greater control issues, less cohesion and less expressiveness (Harter, Alexander, & Neimeyer, 1988; Herman & Hirschman, 1981; Perry, Wells, & Doran, 1983). Marriages in incestuous families have often been characterized by extremes of submission and domination (Gebhard, Gagnon, Pomeroy, Christenson, 1965). For counselors, these dynamics have created a difficult therapeutic relationship. As clients work out incestuous issues with their counselors, counselors must deal with their own counter-transference issues.

It has been important for sexual abuse counselors to be clear on their own roles and boundaries while being empathic and genuine. Counselors have been trained to work through social isolation, shifting reality, role confusion, and boundary diffusion (Courtois, 1988). Collective denial has been identified as an important issue in child abuse cases as the whole family has denied what happened as it was occurring and

often even after it had occurred. Family members have shared secrets and duplicity, and deceit between family members has created severe trust issues. Many incestuous families have been shown to have poor tolerance for differences from the family norm, to be overly moralistic, and have high sarcasm with low expression of humor (Courtois, 1988). These traits have presented the counselors' traumatized clients with difficult transference issues to address during the treatment process.

Family dynamics are one issue the counselor of victims of childhood sexual abuse must treat. Another issue is the severity of intra-psychic damage in their clients. Research has shown that survivors of childhood sexual assault have suffered a wide variety of both short term and long term negative consequences (Browne & Finkelhor, 1986; Ratican, 1992; Wyatt & Powell, 1983). The negative impact of child abuse on adult psychological functioning has been consistently documented through research (Bagley & Ramsay, 1986; Briere & Runtz, 1987; Briere & Runtz, 1988b; Briere & Runtz, 1989a; Elliott & Briere, 1992; Lindberg & Distad, 1985).

A review of the literature implied that the degree of the victim's damage has related to various factors including the identity of the abuser, the nature of the

abuse, and the support system available to the victim. The internal resources and perspective of the victim have also affected the degree of damage in the victim (Finkelhor, et al, 1983; Ratican, 1992; Sanford, 1990).

Adults abused as children have been diagnosed with severe mental disorders. Dissociative disorders, anxiety disorders, eating disorders, sexual disorders, affective disorders, personality disorders, and substance abuse have sexual abuse as an etiological factor (Ratican, 1992; American Psychological Association, 1994). Borderline personality and Dissociative Identity Disorder (formerly known as Multiple Personality Disorder) have an etiological basis in sexual abuse. Childhood sexual abuse has also been a contributing factor in paranoid, obsessive-compulsive, and passive-aggressive disorders (Ratican, 1992; American Psychiatric Association, 1994).

Counselors working with these severely damaged victims have difficult treatment issues. Integrating services, as part of a treatment team they have had to work with various medical professionals. They must not allowing themselves to be triangulated or rendered ineffective by the survivor's treatment process.

Survivors have been identified as exhibiting polarities in their behaviors. Repeated victimization has often occurred (Wyatt, et al.,1992), complicating

the treatment of victims as they attempt to heal from abuse by multiple perpetrators and specific trauma that was experienced at various developmental stages.

Depression, self-destructive or self-mutilating behavior and suicidal tendencies (Bass & Davis, 1988) are psychological symptoms of survivors of childhood sexual abuse. Low self-esteem, mood disturbances, sleep disturbances, anxiety, guilt, and shame were common in victims of childhood sexual assault (Bagley & Ramsay, 1986; Briere & Runtz, 1990; Briere & Zaidi, 1989; Elliott & Briere, 1992; Lindberg & Distad, 1985).

Physical symptoms are commonly reported by survivors of childhood sexual assault. Some report temporary discomfort during periods of remembering. These are identified as body memories. Long term physiological complaints such as gastrointestinal problems, headaches, backaches, skin disorders, and genitourinary disease were also reported (Browne & Finkelhor, 1986; Courtois, 1988; Ratican, 1992).

Post traumatic stress disorder-like symptoms have been described for women victims of incest for over 100 years (Cameron, 1994). Recently, long term effects of PTSD have been researched and published in theoretical and clinical discussions of childhood sexual abuse. Donaldson and Gardner (1985) were among the first to use empirical data to identify the symptoms of PTSD for

victims of rape and child sexual abuse and to consider it equal to the traumatization of Vietnam Veterans (Cameron, 1994).

Clarifications of PTSD symptomology or modifications of how the diagnosis has been used with survivors (Briere & Runtz, 1987; Courtois, 1992; Finkelhor & Browne, 1986; Fredrikson, 1992) have provided a framework. From this framework therapists and counselors have identified the list of symptoms specific to survivors of childhood sexual assault (Briere & Runtz, 1988b; Briere & Runtz, 1989a; Briere & Runtz, 1989b). This has helped counselors reframe and normalize the survivors' experiences (Briere & Runtz, 1987) and helped the profession move away from the label of pathology (Cameron, 1994).

At the same time, current multi-disciplinary research on childhood sexual assault's psychobiological and developmental impacts have begun to help us understand why PTSD is resistant to treatment (Cameron, 1994). Changes in brain chemistry have been created in survivors of childhood sexual assault (Trickett & Putnam, 1993) similar to the changes in brain chemistry created in veterans of the Vietnam War (Cameron, 1994).

The biochemical changes have made brief solution oriented therapy models inappropriate for victims of childhood sexual assault. Treatment considerations of

establishing trust, facilitating disclosure and setting goals (Ratican, 1992) have taken longer periods to work through as a result of the intense trust issues which preceded disclosure (Ratican, 1992; Seligman, 1990). Counselors who have treated childhood sexual abuse survivors have been seeing clients longer than other counselors in the current environment of short-term care due to insurance regulations. This is possible in centers which are government funded and do not require payments from insurance companies or clients.

Long term therapy issues have included grieving the loss of childhood and shame. Counselors must help clients deal with issues of forgetting, denying, distancing, and pretending. Clients who numb and compartmentalize their feelings are difficult to reach. Denial, repression, and dissociation were identified coping mechanisms which were treatment issues (Ratican, 1992) counselors must address. Forgiveness has been a major issue in treatment of victims of childhood sexual abuse (Lew, 1986). Establishing and deepening the therapeutic alliance, while working to integrate the helpless child within with the nurturing adult, has led to the disclosure of traumatic memories. Helping clients confront their perpetrators was a final issue in the therapeutic process.

Because of the numbing and denial of feelings in victims, group settings have been recommended for breaking down the isolation in survivors. Groups have helped survivors recognize, label, and express their feelings. Groups have been helpful with cognitive restructuring of the victims' distorted beliefs and with the identification and reduction of stress responses. Behavioral changes have occurred as a result of the group process (Courtois, 1986).

Some literature indicated that disclosure in private counseling may have reinforced the client's dynamics of secrecy. Ratican (1992) has recommended the use of a group or support system of fellow survivors, and Courtois (1986) recommended combined individual and group therapy as the most effective treatment. Group dynamics allows the survivor to develop trust of others while receiving sharing and empathy from those with common experiences and reactions.

Kinds of groups for childhood sexual abuse survivors have ranged from peer groups to therapeutic groups. Both short term and ongoing groups have been utilized. Reports of time-limited groups for incest survivors showed them ranging from 4 to 20 sessions (Courtois, 1986). Counselors need specialized training in group process. Psychodrama, a group process identified as helping clients become more fully

integrated, requires hundreds of hours of specialized training to become certified (American Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy, 1994-1995; Corsini & Wedding, 1989).

Symptoms of unresolved sexual abuse and posttraumatic stress were also exhibited by the elderly (Allers, Benjack, & Allers, 1992). It was recommended that groups be used with this clientele especially since groups addressed the isolation which was part of the aging developmental issue (Newman & Newman, 1991).

While groups can be the catalyst for exploring emotions and grieving the multitude of losses from incest (Courtois, 1986), they are a more difficult and exacting form of therapy for the therapist who must attend to a number of group members at the same time. A group also multiplies the amount of traumatic material a counselor must assimilate in a given time. Counselors at specialized centers dealing with sexual abuse treat clients in multiple group settings as well as in individual counseling sessions. At ICASA centers, these counselors have spent up to 20 hours or more each week in situations which could have created vicarious or secondary traumatization.

Rape

As with the statistics on child sexual abuse, documentation on rape has been inconsistent. According to the Illinois Coalition Against Sexual Assault's brochure What Do I Need to Know, over 102,000 women in the United States reported a rape to law enforcement officials. ICASA records indicate that 84% of those raped have not reported to the police. Every minute in the United States, 1.3 women have been raped. By age 18, 1 in every 3 females and 1 in every 6 males have been sexually assaulted. About 80% of all sexual assault victims knew the offender. Koss and Burkhart (1989) indicated that 15 to 22% of women have been raped at some point in their lives.

Often victims who have been raped by an acquaintance did not recognize their experience as rape until later. Recent developments in social awareness have made us look at the effects of intra-family violence on adults. Research has indicated that men who physically abuse their wives have also raped them (Martin, 1982), but only recently have state laws begun to include spousal sexual assault as a crime. Sexual assault has begun to be identified as a crime and a violent abuse of power in homes as well as society.

There is no typical victim of sexual assault. Victims of sexual assault have varied ages.

perpetrators of these assaults have been strangers, relatives, bosses, friends, husbands, and persons in positions of power such as teachers, clergy, and therapists (Buhoustos, et al, 1983; Fine, 1994).

As with child sexual assault, rape's legal definitions have varied from state to state. The 1984 Criminal Sexual Assault Act of Illinois defined the crimes of sexual assault and sexual abuse by dividing sexual violence into two categories: sexual penetration and sexual conduct (touching or fondling). In Illinois, crimes involving sexual penetration have been called Criminal Sexual Assault or Aggravated Criminal Sexual Assault. Criminal Sexual Assault is a Class 1 felony defined as penetration by force or threat of force. Aggravated Criminal Sexual Assault is a Class X felony and is defined when the assailant used a gun, caused bodily harm, committed another crime, or attacked a senior or a child (ICASA).

Regardless of the legal definition or perpetrator of the rape (date, stranger, spouse, clergy, or gang), survivors have experienced some universal responses to an intensely personal trauma. "The feeling of being utterly unable to predict or control events is a nearly universal trauma experience," states Quina and Carlson (p. 157). The immediate post-rape distress response is known as the Rape Trauma Syndrome.

Literature review has indicated that the emotional responses to rape, the Rape Trauma Syndrome, have included grieving, depression, guilt, rage, terror and loss of trust (Burgess & Holstrome, 1974). Some victims have experienced severe panic attacks and even developed agoraphobia. Low self esteem, body image distortions, intimacy and sexual difficulties have been common responses to rape (Quina & Carlson, 1989). If the symptoms have not been recognized and treated the first crisis stage has remained for years.

In the acute crisis stage, it has been normal for rape victims to experience acute anxiety attacks, obsessional thoughts, and compulsive behavior. Terror or fear for their own safety are common. Victims experience uncontrollable crying spells, irritability, hostility, anger, and rage. Sometimes the feelings of anger are directed appropriately at the offender, but at other times these feelings are projected toward themselves and others, including their counselor (Rosewater & Walker, 1985).

Many factors influence the intensity of a victim's response to rape. These include the characteristics of the crime and the victim's locus of control and coping ability. The life stress and personality variables of the victim make a difference as does the social network and developmental stage (Koss & Burkhart, 1989).

Counselors called upon to do immediate crisis counseling have been involved in helping the client move through the stages of shock, denial, anger and depression. The goal of therapy is to accept that they have been violated and to move into a new life style. Few victims seek professional help immediately after the assault. However, 31-48% of those raped eventually seek counseling. For these survivors, the primary role of the counselor has been the "identification and handling of chronic, post-traumatic responses to a non-recent experience" (Koss & Burkhardt, p. 27).

Most victims experience an acute crisis period directly following the rape. However, some women have blocked the memory of an assault incident and have not experienced their acute crisis phase until later when they recognized their victimization (Rosewater & Walker, 1985). Assaults have triggered buried memories of previous assaults or abuse. A trauma consequence of childhood sexual assault mentioned previously is frequent re-victimization as adults (Wyatt et al, 1992). The counselor then must assist clients who have felt the impact of both crises at the same time.

Many of the survival skills victims developed to keep themselves safe and alive have also been identified as symptomatic of mental disorders (Rosewater & Walker, 1985). The victim needs to gain

appreciation for the survival tactics and strengths that enabled survival. However, the symptoms of Rape Trauma Syndrome appear pathological to someone unfamiliar with the syndrome and its characteristic responses.

The counselor without specialized training who had not recognized the reactive nature of these symptoms may misdiagnose a client. The counselor's role in the treatment of a rape victim includes educating the client about societal contributions to rape and violence and dealing with misconceptions about personal responsibility for the rape. Responsibility needs to be placed on the rapist, not the victim (ICASA).

The counselor supports the rape victim through the stages of personal recovery: memory retrieval, emotional catharsis, and resolution. Cathartic needs are strong in the rape victim, and the intense emotions of anger/rage, fear, hurt, and disgust overwhelm the client (Quina & Carlson, 1989). Helping a client move through these intense emotions has created a trauma reaction in the counselor (Rosewater & Walker, 1985). Counselors may also have to support victims through preparation for court and through trials where the system appears to rape the victim as severely as the perpetrator.

The trained crisis intervention counselor has treated the rape as one incident in the client's life; the focus of treatment has been on returning the client to the previous level of functioning. The reality of rape has been that it has been a life-threatening experience. Victims feel that they have faced their own deaths. Rape has been identified as a life changing experience and part of the healing has involved mourning the death of the victim's previous identity which was lost in the assault.

Counselors working with rape victims have had to confront their own issues of vulnerability, rage, and powerlessness. According to Colao & Hunt (1983), some counselors have:

> become over-protective and controlling...which prevents clients from regaining control of their lives. Others find themselves restricting their own lives. Some also restrict the lives of other clients or close female loved ones. A male therapist ...might feel guilty about being male...(and) often...finds himself needing to prove that he is a good man (unlike the rapist), and seeks reassurance from the client at a time when she needs to concentrate her energies on herself: (Colao & Hunt, 1983, p. 209).

Counselors with specialized training in rape and sexual assault treatment have recognized that these are normal responses. Educating themselves on the mythology surrounding the issue of rape in this country, the counselor has worked through issues of transference, counter-transference and burn-out.

Some counselors, however, have experienced secondary traumatization and developed posttraumatic stress disorder symptomatology. Counselors have found themselves angry with the client or unable to focus with the client on the feelings related to the assault (Colao & Hunt, 1983). Restlessness, sleep disturbances, depression, anger, and characteristic withdrawal from experiences which used to be enjoyable can become a way of life for the vicariously traumatized counselor in the same way they have become a way of life for the traumatized victim. A workplace which recognizes the dangers inherent in working with highly traumatized clients and the symptoms of vicarious traumatization can provide supervision and support for counselors.

An important first step in this process is for counselors and their work environments to avoid falling prey to the same denial systems which allow trauma to be silently suffered for so long. Taking a personal inventory of symptomology can provide counselors with an opportunity to be aware of their own trauma level and to take steps to take care of themselves so as to be able to provide ethical and empathic care for clients.

CHAPTER III

METHODOLOGY

Subjects

The 81 subjects who participated in this study were female counselors, 18 years or older, who worked under the Illinois Coalition Against Sexual Assault at 30 rape and sexual assault centers in Illinois (Appendix A). One group of subjects (N=40, 49.4%) reported that they had not been personally victimized. Of those who reported that they had been previously victimized (N=41, 50.6%), some had been victimized as adults (N=12, 29.3%), some were victimized as children (N=23, 56.1%), and some reported being victimized as children and as adults (N=6, 14.6%).

The target population was selected to narrow the focus of the study to those counselors who treat victims of rape and sexual assault. The national population of counselors were limited to a sample size of one state. Instruments were sent to centers within the state of Illinois where all counselors work under the guidelines and regulations established for counseling centers funded by ICASA. All counselors who treat rape and sexual abuse victims at ICASA funded centers were asked to return the instruments sent to each of the centers.

For the purpose of this study identification as a counselor was based on self-report and spending from 1 to 20 hours each week counseling victims of rape and childhood sexual assault.

Design

The first purpose of this research was to describe the demographic nature of the ICASA counselors and to determine the kinds of symptoms of traumatization reported by counselors. A descriptive analysis was made on the demographic responses written to the personal data sheet. A request was made for information (Appendix B) on the independent variables of counselor gender, position (paid or volunteer), educational level, age, time at center, number of hours averaged counseling victims weekly and personal trauma (childhood sexual assault, adult assault, and/or both).

Counselors were asked to place themselves in the discrete nominal categories for gender (male/female), position (paid staff/volunteer), educational level (high school/bachelors/masters/post graduate), and victim (child/adult/both)/non-victim. The continuous independent variables of age, time at the center, and weekly number of hours averaged counseling were placed on interval scales.

The interval categories for age were set from 18-27, 28-37, 38-47, and 48 or above. The time at the center was set in the interval categories of 1-2 years, 3-4 years, 5-6 years, and 7 or more years. The number of hours of counseling averaged weekly were assigned the intervals of 1-5 hours, 6-10 hours, 11-15 hours, and 16-20 hours. The results of each category were analyzed for means used to create a picture of the "average" counselor.

Symptoms of trauma experienced over the last two months were identified through a self-report instrument called the Trauma Symptoms Checklist-33. The percentiles for those reporting that they had experienced trauma symptoms were determined by analyzing the number of counselors reporting "0" (never) to the questions on the frequency of individual trauma symptoms. These scores were transformed into percentile representations.

The total scores of each questionnaire were then examined. A Stem & leaf descriptive analysis was created to show the frequency of total scores in the categories of victim and non-victim. To identify which trauma symptoms had been experienced fairly often or very often over the previous 2 month period, the percentile of counselors reporting "2" or "3" on each symptom was described. A final descriptive analysis

determined the central tendency of the individual total scores for victims and non-victims.

The primary purpose of this study was to determine if a significant difference existed between victims and nonvictims who reported experiencing symptoms of trauma. The null hypotheses statement was that counselors at ICASA centers who have been previously traumatized do not report experiencing significantly more trauma symptoms than those counselors who have not reported previous traumatization. The final design was to examine central tendency and perform a t-test analysis of the mean results to determine if there was a significant difference at alpha .05.

Materials

Data was collected using 2 self-administered instruments. One was a personal data sheet designed by the researcher (Appendix C); the second was the Trauma Symptom Checklist (TSC-33)(Appendix D).

The personal data sheet collected data on gender, position, educational level, age, time at the center, weekly hours spent counseling victims of sexual trauma and abuse and personal trauma. (See Appendix C) The positions identified were paid staff and volunteer. Educational levels were categorized as high school,

bachelors, masters, and post-graduate. Age categories were identified as 18-27, 28-37, 38-47, and 48 or above. Time at the center was categorized as 1-2 years, 3-4 years, 5-6 years, and 7 or more years. The weekly # of hours spent counseling victims were listed as 1-5, 6-10, 11-15, and 16-20. Subjects were then asked to identify Previous Personal Victimization or Trauma by circling yes or no. If the answer was yes, subjects then circled adult victim and/or child victim.

The TSC-33 was a 33-item abuse oriented instrument designed to be used, not as a clinical instrument, but as a research measure to aid the study of the impact of trauma. It was designed to be used primarily, but not exclusively in the area of long-term child abuse effects (Briere & Runtz, 1989; Elliott & Briere, 1992).

Participants in a National Symposium on Assessing the Impact of Child Sexual abuse "frequently concluded that the use of generic assessment instruments as measures of abuse effects is problematic; and that new, abuse specific measures should be developed" (Briere & Runtz, 1989). The TSC-33 has since been developed and shown "to demonstrate reasonable reliability and validity in the study of sexual abuse effects" (Elliott & Briere, 1992, p. 392; Gold, et al., 1994).

A value of this instrument was that it was restricted to reportable problems like poor appetite or

flashbacks Briere & Runtz, 1988a). This instrument allowed the data to describe the "exact pattern of abuse-related symptomatology" (Briere & Runtz, 1989, p. 152) by interpreting the data individually or in homogeneous groups or subscales. "From the 33 items of the TSC, 26 were used to form five relatively content-homogenous subscales that were subsequently tested for reliability and validity" (Briere & Runtz, 1989, p. 155). The 5 subscales of this instrument were dissociation (items 10, 11, 18, 29, 30, 31), anxiety (items 12, 13, 15, 18, 24, 25, 26, 32, 33), depression (items 1, 4, 5, 8, 9, 14, 20, 27, 28), PSAT-h- Post-Sexual Abuse Trauma-hypothesized (items 3, 10, 22, 24, 29, 30), and sleep disturbance (items 1, 2, 3, 4).

The TSC-33 rated each of the 33 symptom items on a 4-point scale for frequency of occurrence. Subjects completing the instrument respond to the 33 items by rating how oven they have experienced each in the past 2 months: 0=Never, 1=Occasionally, 2=Fairly Often, and 3=Very Often. A new instrument, the TSC-40, was created by adding 7 items to the TSC-33 in order to address the issues that limit the effectiveness of the TSC-33. However, as of 1994, these items had no psychometric data (Gold et al., 1994) and so this instrument was not used.

Limitations of the instrument included the need for more support of the discriminative validity if the instrument were to be used only for childhood sexual abuse. This is an asset for this study as it allows the instrument to report symptomology for other trauma as well. In previous administrations, clinical subjects had higher TSC-33 scores than nonclinical individuals. Scores in past administrations had increased as a function of physical abuse indicating that the scale responded to various traumatic experiences and not just those of sexual abuse (Briere & Runtz, 1989). While this is a limit of discriminative validity for childhood sexual abuse, it generalizes the instrument to identify sexual assault trauma symptomology in counselors possibly demonstrating vicarious traumatization. Other shortcomings include the lack of a subscale to measure sleep difficulties, a lower reliability (alpha .66) of the sleep disturbance subscale, and some ambiguity on the content validity of the PSAT-h subscale as a measure of sexual trauma per se (Elliott & Briere, 1994).

The TSC-33 was developed to assess the impact of the trauma of childhood sexual abuse and trauma. "The rationale for the development of the scale was that a more complete understanding of the consequences of sexual abuse and subsequent treatment planning was only

possible if the precise pattern of symptomatology could be identified" (Gold et all, 1994, p. 13). Although developed to assess the impact of childhood sexual abuse, the instrument also measures the impact of sexual abuse experienced by adults (Gold et al, 1994). "Women sexually abused as children and later sexually assaulted as adults self-reported the most symptoms on the TSC" (Gold et al, 1994, p. 22). This is relevant since women sexually abused as children have been reported to be vulnerable to adult sexual assault (Browne & Finkelhor, 1986; Gold et al, 1994; Wyatt et al., 1992).

Procedure

An envelope was sent to each of the 30 ICASA centers. In each envelope were 5 cover letters, 5 copies of the personal data sheet and TSC-33, and 5 stamped return envelopes. No names or numbers were on the envelope, personal data sheet or trauma symptom checklist to help guarantee anonymity. The envelopes were enclosed to facilitate confidentiality within the centers for the responses to the survey and the checklist. Upon receipt, the forms were separated into two nominal classifications of victims and non-victims and envelopes were destroyed to further guarantee that

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there would be no way to connect the forms with the centers from which they were sent.

Subjects were asked to identify some personal data by marking the appropriate category for their responses. The TSC-33 asks subjects to identify how frequently they have experienced 33 trauma symptoms over the past two months. A score of 0 is marked for never, 1 is for occasionally, 2 is for fairly often, and 3 is for frequently. Subjects were asked to mail back the instruments by April 1st and data was collected from March 20 until April 10, 1995.

Responses for the data sheet were gathered by way of tally and re-evaluated for accuracy. The total scores for each column were then determined in order to identify the total score for each instrument. Descriptive analysis was run on the personal data.

Within the categories of victim and non-victim, the sheets were then arranged from least total score to greatest total score in order to facilitate the statistical procedures. A record was made of the number of subjects in each category which answered 0, 1, 2, and/or 3 for questions 1-33. A list of those responses were given. An analysis of the data was then made.

CHAPTER IV

RESULTS

The first purpose of the study was to describe the demographic nature of the subjects and the trauma symptoms which they reported. A total of 82 instruments were returned to the researcher between March 20 and April 10, 1995. One instrument was discarded due to an error in copying both sides of the sheet. All of the 81 respondents were female.

Fewer of the responding counselors (N=40, 49.4%) reported no personal history of sexual trauma. Of those who identified themselves as victims of sexual assault (N=41, 50.6%), some identified childhood victimization (N=23, 56.1%), some identified adult victimization (N=12, 29.3%), and a few (N=6, 14.6%) reported that they had been victimized as children and as adults.

The mean of all responses to personal data was used to create an image of the average counselor responding to the study. A victim of personal sexual trauma being paid to counsel victims from 16-20 hours each week, the average counselor hasonly been working for the ICASA center from 1 to 2 years, has a masters degree and was between the ages of 38-47.
For a display of the demographic information on the total population see Table 1.

TABLE 1

Demographics on Total Population (N=81)

	SUBJECTS	PERCENTILES
VICTIMIZATION:		
NON-VICTIMS	40	49.4
VICTIMS	41	50.6
STAFF POSITION:		
PAID	77	95.1
VOLUNTEER	4	4.9
EDUCATION:		
HIGH SCHOOL	8	9.9
BACHELORS	21	25.9
MASTERS	44	54.3
POST-GRADUATE	6	7.4
UNIDENTIFIED	2	2.5
AGE:		
18-27	16	19.8
28-37	20	24.7
38-47	33	40.7
48+	12	14.8
HOURS COUNSELING PER WEEK:		
1-5	17	21.0
6-10	20	24.7
11-15	12	14.8
16-20	32	39.5
LENGTH OF TIME AT CENTER:		
1-2 YEARS	46	56.8
3-4 YEARS	19	23.5
5-6 YEARS	7	8.6
7 OR MORE	7	8.6
wrote in less than yr.	2	2.4

There were 77 paid counselors and 4 volunteers, two of whom identified themselves as intern counselors. Educational levels were reported as follows: (n=8,high school, 21-bachelors, 44-masters, and 6-post graduate level. Two forms did not identify educational level. There were 16 counselors between the ages of 18 and 27; 20 counselors between the ages of 28 and 37; 33 counselors between the ages of 38 and 47; and 12 counselors who reported their age as 48 or above.

The number of hours the counselors worked varied from one to over 20. There were 46 counselors who reported working at the ICASA centers from 1-2 years, 19 reported working for 3-4 years, 7 reported working from 5-6 years, and 7 reported working for 7 or more years. There were 2 respondents who wrote on the form indicating that they had been with ICASA less than one year.

The researcher was interested in describing the difference in responses from counselors who had experienced personal victimization and those who had not. Data was placed in the nominal categories of victim and non-victim and percentile responses were then reported in Table 2.

TABLE 2

Victim/Non-Victim Personal Data Demographics

	VICTIMS	(%)	NON-VICTIMS	(%)
GENDER:				
MALE	0	(0)	0	(0)
FEMALE	41	(50.6)	40	(49.4)
STAFF POSITION:				
PAID	38	(46.9)	39	(48.1)
VOLUNTEER	3	(3.7)	1	(1)
EDUCATION:				
HIGH SCHOOL	5	(6.1)	3	(3.7)
BACHELORS	10	(12.3)	11	(13.6)
MASTERS	23	(28.4)	21	(25.9)
POST-GRADUATE	2	(2.4)	4	(4.9)
UNIDENTIFIED	1	(1.0)	1	(1.0)
AGE:				
18-27	12	(29.3)	4	(4.9)
28-37	10	(24.4)	10	(25.0)
38-47	13	(31.7)	20	(50.0)
48+	6	(14.6)	6	(14.6)
HOURS COUNSELING PER WEEK:				
1-5	4	(9.8)	13	(32.5)
6-10	12	(29.3)	8	(20.0)
11-15	6	(14.6)	6	(15.0)
16-20+	19	(46.3)	13	(32.5)
LENGTH OF TIME AT CENTER:				
1-2 YEARS	26	(63.4)	20	(50.0)
3-4 YEARS	10	(24.4)	9	(22.5)
5-6 YEARS	1	(1.0)	6	(15.0)
7 OR MORE	4	(9.8)	3	(3.7)
wrote in less than yr.			2	(5.0)

A number of steps were taken to describe trauma symptoms reported by the subjects (counselors at ICASA centers volunteering to return the instruments). First, a percentile analysis was made of the individual responses (n-81) per trauma item for those who reported never experiencing the symptom (0) and those who reported they had experienced the symptom of trauma (1,2,3).

The highest percentage of those reporting a trauma symptom was 90.1%, the percentage of ICASA counselors experiencing sadness over the last 2 months. Restless sleep (85.2%) was the second most commonly reported symptom. Insomnia, spacing out, headaches, and tension were all experienced in the 70th percentiles. Additional symptoms experienced by greater than 50% of the counselors were nightmares, early awakenings, isolation, loneliness, low sex drive, stomach problems, inferiority, and memory problems. A total of 14 of the 33 symptoms were reported by over 50% of the subjects.

A description of responses to the total number of items on the TSC-33 is presented in Table 3.

Table 3

Percentile Responses to TSC-33 Items

Subjects: N=81

Never (0) Reporting (1,2,3)

Occasionally (1), Fairly Often (2), Very Often (3)

	ITEM	% NEVER	% REPORTING
1.	insomnia	22.2	77.8
2.	restless sleep	14.8	85.2
3.	nightmares	48.1	51.9
4.	early awakenings	42.0	58.0
5.	weight loss	77.8	22.2
6.	isolation	35.8	64.2
7.	loneliness	38.3	61.7
8.	low sex drive	38.3	61.7
9.	sadness	9.9	90.1
10.	flashbacks	59.2	40.8
11.	spacing out	27.2	72.8
12.	headaches	25.9	74.1
13.	stomach problems	44.4	55.6
14.	crying	82.7	17.3
15.	anxiety attacks	59.2	40.8
16.	temper problems	53.1	46.9
17.	getting along with others	67.9	32.1
18.	dizziness	79.0	21.0
19.	passing out	50.6	49.4
20.	hurt self	88.9	11.1
21.	hurt others	84.0	16.0
22.	sexual problems	71.6	28.4
23.	sexual overactivity	88.9	11.1
24.	fear of men	67.9	32.1
25.	fear of women	92.6	7.4
26.	excessive washing	88.9	11.1
27.	inferiority	43.2	56.8
28.	guilt	51.9	48.1
29.	unreality	51.9	48.1
30.	memory problems	40.7	59.3
31.	out of body exp.	77.8	22.2
32.	tension	27.2	72.8
33.	trouble breathing	65.4	34.6

The total number of points scored on each individual instrument was then used to analyze the results. There was a possible range of scores of the TSC-33 from 0-99. Of the counselors returning the instruments, 100% reported some symptomology. The lowest reported total score was 2 (for a non-victim) and the highest reported total score was 64 (for a counselor who reported herself as a survivor of adult sexual assault).

A stem and leaf demonstrates the score distribution frequency in Table 4.

Table 4

Stem & Leaf

Victim Scores		Non-Victim Scores
7776654	0	2466688999
9999988776666541	1	00111224456667889
753100	2	111155688
743332100	3	567
	4	
82	5	
4	6	
	7	
	8	
	9	

Non-victim total scores represented an approximately symmetrical distribution while the victim scores were positively skewed. With sample sizes this low, the most the researcher could hope to see is the symmetry and skewed shape of the curve. To determine anything more, a larger sample sized would need to be obtained in a future study.

To determine which symptoms might need intervention, the researcher chose to describe the frequency with which trauma symptoms had been experienced. Symptoms were analyzed by compressing the categories of those reporting the symptom fairly often (2) and very often (3) into one category and figuring percentiles.

The symptoms experienced least, those which received 1 to 5.9% report were crying, anxiety attacks, getting along with others, dizziness, passing out, hurting self, hurting others, sexual overactivity, fear of women, excessive washing, and trouble breathing. Symptoms which were experienced by 6 to 10.9% of the subjects were nightmares, weight loss, flashbacks, temper problems, sexual problems, fear of men, unreality, and out of body experiences.

Those symptoms reported by 11 to 15.9% were inferiority, guilt, and memory problems. Those symptoms experienced by 16 to 20.9% were early morning

awakenings, loneliness, and stomach problems. Those symptoms experienced by 21 to 25.9% were insomnia, restless sleep, isolation, low sex drive, spacing out, and headaches. The symptoms experienced the most frequently by all counselors were tension (experienced by 29.6% of all counselors) and sadness (experienced by 34.6% of all counselors). No symptom was reported frequently by more than 35% of the counselors.

These percentile frequencies are displayed in Table 5.

Table 5

SYMPTOM FREQUENCY

1-5.9%	crying, anxiety attacks, getting along with others dizziness, passing out, hurting self, hurting others, sexual overactivity, fear of women, excessive washing, trouble breathing
6-10.9%	nightmares, weight loss, flashbacks, temper problems, sexual problems, fear of men, unreality, out of body experiences
11-15.9%	inferiority, guilt, memory problems
16-20.9%	early morning awakenings, loneliness, stomach problems
21-25.9%	insomnia, restless sleep, isolation, low sex drive, spacing out, headaches
26-30.9%	tension
31-35.9%	sadness

The central tendency scores of the total population were analyzed for mean, mode, and range. The mean total individual score for the TSC-33 for all 81 subjects was 18.63. The scores were bimodal with 16 and 19 the most frequently reported scores for all 81 subjects. The range of scores was 62.

The primary purpose of the study was to determine if there was a significant difference in the mean scores reported by victims and non-victims. Other measures of central tendency included an analysis of the mean, mode, and range of victims and non-victims. There were outlier scores which effected the outcome of the mean and range but these were included in the analysis since they did represent the symptomatology of a counselor currently counseling at an ICASA funded center. Table 6 describes the central tendency of the total scores for victim and non-victim. Note that the range of scores for victims is almost twice the range of scores for non-victims.

Table 6

Central Tendency Individual Totals

	VICTIMS	NON-VICTIMS
MEAN	22.29	16.03
MODE	19	21
RANGE	60	35

A t-test analysis was then run on the means of the independent variableTSC-33 scores of victims and non-victims groups in order to determine if a significant difference existed. Alpha was set at .05. The central limit theorem, one of the most important theorems in statistics (Howell, 1992) was applied to this study. This theory tells what the variance of the sampling distribution of the mean must be for the given samples size. With knowledge of the mean and standard deviation of the population, the null hypothesis can then be accepted or rejected.

Levene's test for equality of variances was run to confirm the basic assumption of equal variance in the mean scores of the independent variables of victim and non-victim and the dependent variable, total individual score. The significance obtained was 0.056. When the significance obtained is less that 0.05, the null hypothesis must be rejected. Therefore, the results indicated that the null hypothesis relative to the variances was rejected.

The samples have significantly different spreads or scatter. The calculated t-test value (t=2.48 with 68.78 degrees of freedom and a calculated probability of .016) is significant at alpha .05. There is a significant difference in the mean total score self-reported by the sample of victims who are counselors

and the mean total score reported by counselors who were not previously victims.

The researcher then must accept the alternative hypothesis statement that there is a significant difference in the mean total score reported by victims who are counselors and the mean total score of counselors who were not previously victims. The t-test for equality of means calculated a t-value of -2.48. There is a 95% confidence level that a mean difference of -2.48 falls within the confidence interval range -11.319 to -1.216 (See Table 7).

Table 7

T-Test Analysis of Means

t-tests for independent samples of TSC-33

Variable	Number of Cases	Mean	SD	SE of Mean
NON-VICTIM	40	16.0250	8.784	1.389
VICTIM	41	22.2927	13.552	2.116

Mean Difference = -6.2677

Levene's Test for Equality of Variances: F= 3.771 P= .056

	t-test for Equality of Means				95%
Variances	t-value	df	2-Tail Sig	SE of Diff	CI for Diff
Equal	-2.46	79	.016	2.544	(-11.333, -1.20
Unequal	-2.48	68.78	.016	2.531	(-11.319, -1.21

CHAPTER V

DISCUSSION

Due to sampling issues, the results of this study have a limited application. Results cannot apply to all counselors of rape and sexual assault victims, but rather must apply to those who work in centers specializing in the treatment of rape and sexual assault. In a total population of all counselors at rape and sexual assault centers, the application of results attained is limited to counselors at centers funded by the National Coalition Against Sexual Assault. The 30 centers funded by ICASA represented a limited sample of that total population. There are regional and economic differences in the various states which may influence the outcome of the study of the degrees of traumatization. These issues were not addressed in the current sample.

A sample size of 40 and 41 has limited relevance to analyze the difference in symptomology between victims and non-victims in the target population. The limited sample size in the various categories of victimization make generalizations questionable about differences in rape victims, childhood sexual assault victims, and those who have experienced both.

There were limitations and problems with the personal data request sheet which needed to be

addressed to make comparisons clearer. For example, there was no category for under a year at the center, nor was there a category for those who had worked at other centers previously but were only at the current center for a short time. Respondents indicated that there needed to be a category for those who spent more than 20 hours counseling victims. This would allow the researcher to do a future study to determine if the number of hours spent counseling had a correlation to the number or severity of symptoms of trauma reported. Finally, it would be an improvement to the existing data sheet if an area could have been made available for comments by those taking the instruments.

The TSC-33 was a self-report instrument and some respondents were undecided as to where to mark their symptomology. The test reported the frequency of symptomology but did not indicate the severity of the symptomology or the degree to which it interfered with the individual counselor's life or work. The scale needed additional items to indicate more accurately sexual problems and sleep problems. A future analysis of the current data based on subscales of dissociation, anxiety, depression, PSAT-h, and sleep disturbance could be made.

An analysis of the mean and range scores was affected by outlier scores of counselors who were

experiencing more symptomology than most others at the centers. Respondents indicated that scores were influenced by personal illness, being new at the job, and feeling isolated from communities where they felt comfortable.

There are limited conclusions to be made from this study. Results of this study may be used to support the concept that counselors of rape and sexual abuse victims do experience some symptomology of trauma. This may or may not occur from vicarious traumatization, and the current study does not provide a way to identify this. The results indicate that those counselors who have experienced victimization in their own lives, experience more symptoms more frequently than those who have not experienced personal trauma. To determine which symptoms had a significant difference, further statistical analysis would have to be made.

None of the symptoms were reported by more than 34.6% of the counselors. This might lead one to question if the majority of counselors were doing an effective job at remediating any symptoms of trauma they were experiencing. Since there were some counselors with higher outlier scores, it is possible that a few counselors are experiencing a degree of symptomology frequently enough to need personal or professional intervention of some kind.

It is the recommendation of this researcher that further analysis of these statistics be done to determine the significance of differences in an item analysis between victims and non-victims. It is also recommended that counselors continue to inventory their personal trauma symptomology and to plan strategies to intervene when their symptoms occur frequently or to a greater degree. Rosewater & Walker (1985) felt that former victims can be effective counselors if their own issues have been resolved. The existence of symptomology in both victims and non-victims leads to a recommendation for organizations to provide support for counselors in identifying their own trauma symptoms as a normal response rather than a pathological one.

Counselors at ICASA centers are exhibiting symptoms of trauma but may or may not be suffering from secondary traumatization. The symptomology varies in degree and frequency due to various influences which may include secondary traumatization. It is also a question if the degree of symptomatology exists to a degree which would interfere with "best-care" counseling for clients. The symptoms could interfere with the therapeutic process and with the personal lives of the counselors.

Though limited in its application, the results of the study have implications for those counselors

working at ICASA centers and for the training of counselors who plan on working in this specialized field. Future analysis should address random sampling issues and include a larger sample size in the total population and the subgroup populations of kinds of victims. Possible future studies could include analysis of victim subgroups, item analysis and classification of secondary trauma versus other causes of trauma symptomatology. This study was only a beginning in addressing the demographic nature of such counselors and their responses to the trauma in their jobs.

APPENDIX A: ILLINOIS MAP OF CENTERS FUNDED BY THE ILLINOIS COALITION AGAINST SEXUAL ABUSE

Where can I call for help?

- **NORTH**

Aurora
Mutual Ground
24 hrs. 708/897-8383

DuPage County
YWCA of Metropolitan Chicago
DuPage District
DuPage Women Against Rape
24 hrs. 708/971-3927

Elgin
Community Crisis Center
24 hrs. 708/697-2380

Galena
Riverview Center
Sexual Assault Intervention and Prevention Services
24 hrs. 815/777-8155, pager #506

Gurnee
Lake County Council Against Sexual Assault
24 hrs. 708/872-7799

Kankakee
Kankakee County Center Against Sexual Assault
24 hrs. 815/932-5322

Matteson
YWCA of Metropolitan Chicago
South Suburban District
24 hrs. 708/748-5672

Quad Cities
Quad Cities Rape/Sexual Assault Counseling Program
24 hrs. 309/797-1777

Rockford
Rockford Sexual Assault Counseling
24 hrs. 815/964-2991

Schaumburg
NorthWest Action Against Rape
24 hrs. 708/228-0990

Sterling
YWCA/COVE
24 hrs. 815/626-7277

Summit
DesPlaines Valley Community Center
24 hrs. 708/482-9600

- **CHICAGO**

Community Counseling Centers of Chicago/ Quetzal Center
24 hrs. 312/334-8608

Community Mental Health Council
24 hrs. 312/734-4033

Rape Victim Advocates
312/733-6954

YWCA of Metropolitan Chicago
Harriet M. Harris Center
312/955-3100

YWCA of Metropolitan Chicago
Loop Women's Services
312/372-4105

- **CENTRAL**

Charleston/Mattoon
Sexual Assault Counseling and Information Service
24 hrs. 217/348-7666 Ch.
24 hrs. 217/234-6405 Ma.

Danville
YWCA Sexual Assault Crisis Services
24 hrs. 217/443-5566

Decatur
Growing Strong: Sexual Assault Center
24 hrs. 217/428-0770

Macomb
Western Illinois Regional Council
Community Action Agency Sexual Assault Program
24 hrs. 309/837-5555

Peoria
The Center for Prevention of Abuse
InnerStrength
24 hrs. 309/691-4111

Quincy
Sexual Assault Prevention and Intervention Services
24 hrs. 217/223-2050

Springfield
Rape Information and Counseling Service
24 hrs. 217/753-8081

Urbana
A Woman's Fund/Rape Crisis Services
24 hrs. 217/384-4444

- **SOUTH**

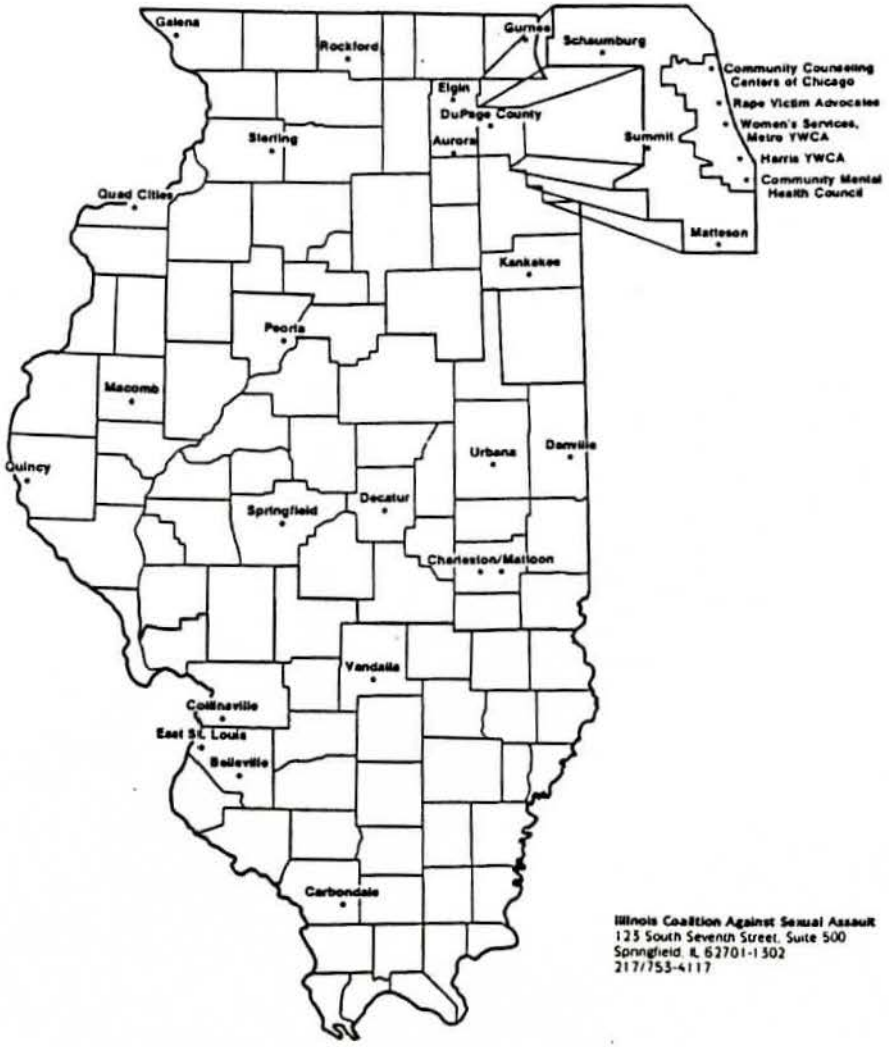
Belleville
Sexual Assault Victim's Care Unit
24 hrs. 618/397-0975

Carbondale
Rape Action Committee
24 hrs. 618/529-2324

Collinsville
Sexual Assault Victims 1st
24 hrs. 618/344-0605

East St. Louis
Volunteers of America
618/271-9833

Vandalia
Sexual Assault and Family Emergencies
24 hrs. 618/283-1414



Illinois Coalition Against Sexual Assault
123 South Seventh Street, Suite 500
Springfield, IL 62701-1302
217/753-4117

APPENDIX B: COVER LETTER

March 20, 1995 53

To: Counselors of Rape/Sexual Abuse Victims
ICASA Funded Centers in Illinois

From: Cynthia Presson, graduate student at Lindenwood College
Past Practicum student at S.A. Victims 1st, Collinsville

Re: Graduate Research Project : Secondary Traumatization of Counselors who specialize in rape and sexual assault.

Last October I attended the ICASA workshop on Vicarious Traumatization given by Linda T. Sanford. This raised the question for me as to the degree of traumatization experienced by counselors who work at ICASA funded centers. I also wondered if counselors who have experienced sexual assault or abuse in their own lives report significantly more symptoms. It is my hope that a research project on this topic could lead to increased awareness of the needs for counselors who specialize in sexual trauma.

Please complete the personal data sheet and the Trauma Symptom Checklist (TSC-33) which was designed to identify the symptoms of PTSD in victims of sexual assault. They have been printed on the same sheet to prevent mix-up. To protect confidentiality numbers will be assigned to the sheets as they arrive. If possible, please post by April 1 and make additional copies if you have more than five counselors at your center.

Thank you for your help in completing this research project.

APPENDIX C: PERSONAL DATA SHEET

PERSONAL DATA REQUEST

GENDER	MALE	FEMALE		
POSITION	PAID STAFF	VOLUNTEER		
EDUCATION LEVEL	HIGH SCHOOL	BACHELORS	MASTERS	POST GRAD.
AGE	18-27	28-37	38-47	48 OR ABOVE
TIME AT CENTER	1-2 YEARS	3-4 YEARS	5-6 YEARS	7 OR MORE

WEEKLY AVERAGE # OF HOURS SPENT COUNSELING VICTIMS OF SEXUAL TRAUMA AND ABUSE

1-5	6-10	11-15	16-20

PREVIOUS PERSONAL VICTIMIZATION OR TRAUMA

YES	NO

IF YES PLEASE IDENTIFY:

ADULT VICTIM	CHILD VICTIM

APPENDIX D: TRAUMA SYMPTOM CHECKLIST-33

The Trauma Symptom Checklist (TSC-33)

J. Briere & N. Runtz

How often have you experienced each of the following in the last two months?

	Never	Occasionally	Fairly Often	Very Often
(1) Insomnia (trouble getting to sleep)	0	1	2	3
)2) Restless sleep	0	1	2	3
(3) Nightmares	0	1	2	3
(4) Waking up early in the morning and can't get back to sleep	0	1	2	3
(5) Weight loss (without dieting)	0	1	2	3
(6) Feeling isolated from others	0	1	2	3
(7) Loneliness	0	1	2	3
(8) Low sex drive	0	1	2	3
(9) Sadness	0	1	2	3
(10) "Flashbacks" (sudden, vivid, distracting memories)	0	1	2	3
(11) "Spacing out" (going away in your mind)	0	1	2	3
(12) Headaches	0	1	2	3
(13) Stomach problems	0	1	2	3
(14) Uncontrollable crying	0	1	2	3
(15) Anxiety attacks	0	1	2	3
(16) Trouble controlling temper	0	1	2	3
(17) Trouble getting along with others	0	1	2	3
(18) Dizziness	0	1	2	3
(19) Passing out	0	1	2	3
(20) Desire to physically hurt yourself	0	1	2	3
(21) Desire to physically hurt others	0	1	2	3
(22) Sexual problems	0	1	2	3
(23) Sexual overactivity	0	1	2	3
(24) Fear of men	0	1	2	3
(25) Fear of women	0	1	2	3
(26) Unnecessary or over-frequent washing	0	1	2	3
(27)Feelings of inferiority	0	1	2	3
(28) Feelings of guilt	0	1	2	3
(29) Feelings that things are "unreal"	0	1	2	3
(30) Memory problems	0	1	2	3
(31) Feelings that you are not always in your body	0	1	2	3
(32) Feeling tense all the time	0	1	2	3
(33) Having trouble breathing	0	1	2	3

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