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A Study of the Relationship Between Self-Reported Child Sexual Abuse History and Responses on the Beck Depression Inventory

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A STUDY OF THE RELATIONSHIP BETWEEN SELF-REPORTED CHILD SEXUAL ABUSE HISTORY AND RESPONSES ON THE BECK DEPRESSION INVENTORY

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A Thesis Presented to the Faculty of the Graduate School
of Lindenwood College in Partial Fulfillment of the
Requirements for the Degree of
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ABSTRACT

The purpose of this study was to examine responses on the Beck Depression Inventory (BDI) between depressed women with a self-reported history of Childhood Sexual Abuse (CSA) and depressed women who did not report such a history. The question to be studied was whether the responses on the BDI would generally be the same regardless of the client's abuse history. Forty women seeking treatment for depression at a Midwestern counseling center served as subjects for this study. They completed a self-report questionnaire, which included an item on abuse history, and the BDI. The group reporting a history of CSA had a higher total mean score on the BDI. Results of a chi-square analysis on each of the 21 items on the BDI showed that a relationship exists between abuse history and two of the symptoms measured on the BDI: Body Image Distortion and Sense of Failure.

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This paper is dedicated to my parents

with gratitude for happy childhood memories

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CHAPTER I

INTRODUCTION

In recent years, there has been an increased interest in childhood sexual abuse among the general public and counseling professionals as well. There has also been an increase in the number of survivors of CSA who are coming forward to tell their stories.

Childhood sexual abuse, as defined by the Family Violence Research Program at the University of New Hampshire, consists of two overlapping but distinguishable types of interaction: (a) forced or coerced sexual behavior imposed on a child, and (b) sexual activity between a child and a much older person, whether or not obvious coercion is involved (Browne and Finkelhor, 1986). Sexual activity refers to some form of overt sexual behavior such as fondling of sexual areas, oral-genital contact and vaginal or anal intercourse. A common definition of a "much older person" is a person who is 5 or more years older than the child.

A subset of children who are sexually abused include those who have experienced sexual activity with a much older person who is a biological parent, step or adoptive parent, or some other blood relative of the child. This type of CSA is defined as incest and is distinguished by the parent-child relationship between the victim and the perpetrator.

The question arises as to how and if these sexual abuse experiences affect the psychological functioning of these children as they become adults. There are several theories as to the relationship between CSA and adult mental health. In general, the literature appears to conclude that depression is the most firmly established long-term effect of sexual abuse. But will survivors of sexual abuse present their depression clinically as the same or different than people who have not had such an experience? A better understanding of the answer to this question will be important to counselors so that they will be able to appropriately treat clients with a history of CSA.

The purpose of this study is to look for possible differences in the presentation of depression by examining responses on the Beck Depression Inventory of women seeking treatment for depression at a community mental health center.

CHAPTER II

LITERATURE REVIEW

Frequency of CSA

With the increased public attention to CSA has come increased research and the statistics being reported are frightening: CSA is far more prevalent than had been previously thought and considering the fact that sexual abuse memories are often repressed or denied, the actual incidence of abuse may be much higher (Ratican, 1992). A study done by Jehu in 1989 revealed that 96% of survivors interviewed stated that they kept the abuse a secret for some time.

In the late 1970's, researchers found that approximately three-quarters of a million women, 18 and over, in the general population have had such an experience, while another 16,000 cases are added each year from among the group of girls aged 5 to 17 (Finkelhor, 1979). Statistics from the U.S. Department of Health and Human Services show that for the year 1991, 129,697 cases of child sexual abuse were reported in the United States. The word "reported" in the previous statement is important because childhood sexual abuse is vastly under-reported.

In 1986, Gold reported that research suggests that as many as one of every four girls in North America may be sexually victimized before she

reaches adulthood. A survey of a nonclinical, randomly selected sample of 930 women in 1986, showed that 38% had experienced sexual abuse before age 18 (Russell, 1986). Finkelhor (1990) reported that 27% of women in a national population-based sample were sexually abused and a study conducted by Wind and Silvern in 1992 revealed that of a non-clinical sample of 259 women, 28% had been sexually abused as children.

The self-reporting of CSA history appears to be somewhat higher in clinical settings. In 1986, Gold reported that studies of females who have received help in clinical settings showed that 44% reported sexual victimization as children. Bryer, et al. conducted a study in 1987 with female patients admitted to a private psychiatric hospital and found that 33% had been sexually and physically abused as children and a striking 72% reported a history of some type of abuse (sexual, physical, or emotional) at some time in their lives. In a study done in a medical setting, 44% of women scheduled for diagnostic laparoscopy reported childhood sexual abuse (Walker, et al, 1992).

The higher numbers of women in clinical settings reporting childhood sexual abuse appears to support the idea of a causal relationship between CSA and adult psychological functioning (Berliner, 1993).

Theories of the Relationship Between CSA and Adult Mental Health

Research has shown that CSA has serious long-term effects, but to what extent the sequelae are due to the sexual abuse per se is still not known. Several theories have emerged over the years as to why this relationship exists.

Freud's seduction theory and his subsequent focus on drives, fantasy, and internal conflict was his explanation for both the abuse and the later symptomology (Berliner, 1993). Then in the 1950's, the Kinsey report stated that there was no intrinsic reason for sexual abuse experiences to be disturbing and that the symptoms were just the product of adult-overreaction (Berliner, 1993).

Beck (1976) has postulated that early trauma may produce an internal schema and then when later stressors are experienced they produce feelings of hopelessness and powerlessness. This is similar to the theory presented by Abramson, Seligman, & Teasdale (1978) which states that the early experience of learned helplessness leads to a cognitive set that predisposes the person to later depression.

Related to cognitive sets are distorted beliefs. In a study by Jehu (1989) it was hypothesized that the association between CSA and mood disturbances in adulthood is mediated by certain distorted beliefs concerning

the earlier traumatic experiences that are held by victims. He found that 94% of the women in his study scored in the significant range on his Belief Inventory. Among the many distorted beliefs reported by the subjects of his study was the self-blaming belief. Eight-six percent of the women believed that they were responsible for their own victimization; 78% thought that they were worthless or bad. After a cognitive restructuring intervention derived by Beck, only 5% of the subjects still held distorted beliefs at a significant level and only 5% scored in the clinically significant range on the Beck Depression Inventory.

In recent literature, the theory that is appearing more and more is that the long-term effects of childhood sexual abuse are symptoms of a disturbed family structure. Even though the Jehu study focused on distorted beliefs, he did find substantial evidence of parental discord in the victims' family of origin. Two-thirds of the women in his study reported ineffective and/or nonnurturing parenting as well. Mullen (1993) also reported that a lack of parental supportiveness characterized the home of the sexually abused and that CSA tends to occur more frequently to children from disorganized and disadvantaged homes.

A study done by Yama and his colleagues (1993) led them to speculate that the consideration of family environment is particularly important when

discussing the long-term effects of CSA. They reported that a growing body of research indicates that victims of CSA come from families that are clearly disturbed and have multiple problems. The goal of their study was to clarify the ways in which family environment may affect the impact of childhood sexual abuse and they came up with two models to describe their data.

The first is a compensation model in which the positive or negative effects of family environment are assumed to add directly to the level of symptoms resulting from the childhood experience. Yama's results demonstrated that either depression or anxiety could be more accurately predicted when family environment was considered along with knowledge of abuse history.

The second is an interactive model in which family environment appears to buffer the relationship between sexual abuse and its sequelae. The results from Yama's study indicated that high family conflict, low control (less emphasis on rules and procedures), and high cohesiveness, all in combination with a history of sexual abuse, placed victims at greater risk for subsequent depressive symptoms. They point out that cohesiveness may play a part because it is possible that children in cohesive families experience greater betrayal.

Gelinas (1983) points to relational imbalances in the family that allows

incest to occur in the first place. Parentification, she states, is the relational pattern most typically shown in families where incest has developed. In parentification, the child gradually comes to function as the parent taking over parental responsibilities. Parentified children will meet the needs of other family members to the exclusion of their own and end up reaching adulthood without the benefit of childhood. Gelinas reports many effects in adulthood that come from such a relational imbalance.

This theory is somewhat similar to one presented in an article by Mullen (1993). He suggests that the long-term impact of CSA on mental health is secondary to the influence on the disruption of the child's development. He also adds that the impact can vary according to the phase in the child's development in which the abuse occurs. Mullen explains this by stating that abuse experiences puts children's emerging sexual identities at risk, impairs their trust in others, damages their self-esteem, undermines their sense of the world as a safe place, and disrupts their confidence in themselves. Without these characteristics, children are not protected against the vicissitudes of life and are vulnerable to mental disorders such as depression. He concludes that "the mental health difficulties in adult life associated with CSA are largely the second order effects of developmental disruptions rather that the direct result of the abuse trauma" (Mullen, 1993).

As Berliner points out in her article, in all of the theories about the association between CSA and adult mental health, the real event of the abuse is dismissed while clinical practice reveals a very different picture (1993). Researchers began to investigate the relationship between early abuse and adult functioning and found that certain symptoms distinguished abused and nonabused populations.

Effects of CSA on Adult Psychological Functioning

Most of the data on the lasting effects of CSA come from adults who give retrospective histories of the maltreatment they experienced as children and many common themes have emerged from these stories (Steele, 1986). Two sets of researchers have reviewed the literature on the long-term effects of child sexual abuse; Browne and Finkelhor in 1986 and Beitchman and his colleagues in 1992.

Browne and Finkelhor reviewed 27 research studies on the impact of sexual abuse and categorized their findings as initial effects and long-term effects. The term "initial effects" refers to the reactions occurring within two years of the termination of the abuse. They admit that the empirical literature on the initial effects should be considered sketchy because many of the studies lacked standardized outcome measures and comparison groups,

but they do report these reactions: fear, anxiety, depression, anger, and hostility, and inappropriate sexual behavior.

Their review of empirical studies with adults show that women victimized as children are more likely to manifest depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization, and substance abuse. There are also the long-term effects of difficulty in trusting others and sexual maladjustment, but these show less agreement between studies.

A study by Beitchman, Zucker, Hood, daCosta, Akman and Cassavia published in 1992 was meant to extend the review by Browne and Finkelhor because there had been several new publications. They list eight long-term effects derived from a review of 32 empirical studies: sexual disturbance or dysfunction, homosexuality (small number of studies), anxiety and fear, depression, suicidality, revictimization, postsexual abuse syndrome (characterized by symptoms of fear, periods of dissociation and withdrawal, problems with anger, chronic muscle tension, and self-injurious feelings), and personality disorders (links between CSA and multiple personality disorder and borderline personality disorder have been reported but warrant further study).

They also report conclusions that may be drawn when the relationship

between abuse-specific variables and particular outcomes is examined: more evidence exists to support a more traumatic impact of postpubertal abuse than prepubertal abuse; long duration of abuse is associated with greater impact; the use of force or threat of force is associated with negative outcome; abuse involving penetration is associated with greater long-term harm; and abuse involving a father or stepfather is associated with greater long-term harm.

Their review also suggests that family variables, such as marital conflict and parental psychopathology are thought to have a pivotal impact on the long-term outcome. Also, parental attitudes towards the child and toward the child's role in the event are important determinants of the long-term outcome.

Studies done after the Beitchman article was published also list psychological symptoms manifested by women survivors. Braver, Bumberry, Green, and Rawson (1992) reported that clients with a history of CSA were more depressed, scored higher on a measure of psychological distress, and scored higher on the Borderline Personality Scale of the Millon Clinical Multiaxial Inventory than clients not reporting a history of abuse.

Wind and Silvern (1992) found that a history of dual abuse, physical and sexual, produced the highest symptom levels on measures of depression,

self-esteem, trauma, negative experiences, and sexual dysfunction.

Of all the long-term effects of CSA, depression has been found to be the most firmly established (Bagley and Ramsey, 1985; Browne and Finkelhor, 1986; Briere and Runtz, 1990). The Beck Depression Inventory (BDI) (Beck, 1976) is one of the most widely used scales to evaluate depressive symptomology. It includes 21 items reflecting symptoms and attitudes of depression. Several empirical studies have used the BDI to assess levels of depression in clients with a history of CSA.

Roesler and McKenzie (1994) reported that the abused women in their study had a mean BDI score of 16.06 which indicates a mild mood disturbance. Over one-half of the subjects in the Jehu (1988) study scored 21 or more on the BDI which is indicative of clinically significant depression.

Three studies reviewed compared BDI scores between abused and non-abused subjects. Wind and Silvern (1992) found significant differences on the BDI when they combined the Sexual Abuse and the Physical Abuse groups and compared them to a non-abused group. Results of the study by Yama and his colleagues (1993) showed that those with a history of CSA reported higher levels of depression on the BDI than those who had no abuse. And Braver, Bumberry, Green, and Rawson (1992) found significant

differences on the BDI between an abused and non-abused group with a mean score of 19.83 for those reporting CSA.

Importance of Identifying CSA Survivors Among Those Seeking Treatment for Depression

Because depression is such a common long-term effect of CSA, many CSA survivors will seek treatment for the depression without disclosing the abuse. Gelinas (1983) calls this a "disguised presentation". She states that incest victims rarely disclose their abuse spontaneously and therefore the depression becomes the focus of treatment. This type of treatment, she warns, usually becomes increasingly frustrating and relatively unsuccessful (1983).

Braver (1992) and her colleagues agree and state that if there is childhood abuse in the client's history, identifying the underlying sources of the presenting symptoms should be a clinical priority.

Gelinas has organized the characteristics of the usual disguised presentation into an Incest Recognition Profile (see Appendix A) which helps to differentiate victims from non-victims among general psychiatric patients. If the patient fits the profile, inquiry into a possible abuse history begins as soon as possible. She states that the ability of the therapist to talk of such

things implies permission for the patient to discuss it.

Bryer and his colleagues (1987) warn against not bringing up the topic and state that not initiating a discussion of CSA can transmit a message to the client that confirms their belief in the need to deny the experience.

Ratican (1992) believes that it is essential that mental health counselors be able to identify the symptoms presented by sexual abuse survivors so as to facilitate disclosure and successful resolution of the abuse memories. Identification, however, can be difficult as Westermeyer (1978) has pointed out. He states that his patients with incest histories were indistinguishable from his other patients along several dimensions.

Because many of the long-term effects of CSA relate to items on the BDI, the BDI may be well suited for assessing CSA in depressed clients. Also a question arises as to whether CSA clients who take the BDI are reporting symptoms of depression or whether their responses are confounded by the long-term effects of CSA.

Clark and his colleagues (1983,1985) used the BDI to answer a similar question with a different group of clients. They found six symptoms that may represent depressive severity that is not confounded by physical illness, and in a later study, seven symptoms that may represent criteria for depressive severity that is not confounded by symptoms of alcoholism.

In summary, the literature supports depression as one of the most firmly established long-term effects of childhood sexual abuse. Many researchers have used to BDI to demonstrate that CSA clients present as more depressed, as evidenced by higher scores on the BDI, than do clients without such a history.

Purpose

The purpose of this current study is to extend the scope of previous investigations that have compared BDI scores of abused and non-abused clients to include examination of item responses between the two groups.

Statement of Hypothesis

The specific hypothesis to be tested is the null hypothesis of independence in responses to BDI items between women seeking treatment for depression with a self-reported history of CSA and those women seeking treatment for depression who do not report such a history.

The significance of the outcome of the study is whether clients with a history of CSA give more weight to certain items on the BDI than clients without such a history. If no relationship is found, then counselors can comfortably use the BDI with this clientele knowing that the results are not

confounded by the long-term effects of CSA. If a relationship exists, counselors may want to take this into account when interpreting the score of the BDI for CSA clients or be on alert for a possible history of CSA for those clients who score higher on items for which a relationship exists.

CHAPTER III

METHODS

Subjects

Fifty-three adult female clients seeking services for depression at the Jane Crider Counseling Center were selected for inclusion the study. Clients selected for the study were those who were assigned to either of two student counselors serving their internship at the counseling center over a nine-month period. Clients are assigned to counselors at the Center by appointment availability. Twelve clients not included in the study had not completed the Beck Depression Inventory. One client was not included because she had received previous counseling for sexual abuse.

The forty clients who were selected as participants were 100% Caucasian and ranged in age from 18 to 68 years (M=35.45, SD=5.61). Fifteen clients (37.5%) were single, 10 (25%) were married, 9 (22.5%) were divorced, 3 (7.5%) were separated, and 3 (7.5%) were widowed. Their average education was 11.8 years with an average income of $747.00 per month; 8 had no income.

Counseling Center

The Jane Crider Counseling Center is located in a Midwestern town of approximately 55,000 people. It is a community mental health center that receives state funds. Individual counseling for adults and children as well as psychiatric services are offered at the center for those who meet state diagnostic criteria.

Measures

History of abuse was elicited from a self-report questionnaire (see Appendix B) administered to all clients at the time of their first visit. The questionnaire is given to the client by the secretary to be filled out in the waiting area prior to the first counseling session. The questionnaire includes 12 items about family, employment, legal history, previous counseling, psychiatric hospitalizations of the client or the client's family, alcohol or drug abuse treatment of the client or the client's family, recreational/leisure activities, medical problems, crime or abuse of the client or the client's family, and a space for additional comments. The last page of the questionnaire asks the client to list three things they would like to achieve during the counseling process.

The abuse history item asks about physical, sexual, and emotional

abuse and asks the client to describe it. This information was supplemented, when necessary, by information gathered by the student counselor on the intake evaluation form and in some cases, more detailed information was elicited from counselor progress notes.

The Beck Depression Inventory (Burns, 1980) (see Appendix C) is a clinically-derived 21-item self-report questionnaire designed to tap current depressive symptoms and attitudes with each item representing a symptom related to the diagnosis of depression. It contains 21 sets of four statements each given a weight of 0 - 3 points with 0 indicating an absence of the symptom, and 1,2, and 3 indicating increasing severity of the symptom. The scores are summed for a total score which is interpreted as follows: 1-10, normal mood; 11-16, mild mood disturbance; 17-20, borderline clinical depression; 21-30, moderate depression; 31-40, severe depression; and 40-63, extreme depression.

Beck (1967) has reported a split-half reliability of .93 for this instrument. Internal consistency coefficients for the BDI have been estimated at .81 (Dobson & Breiter, 1983) and .85 (Vredenberg, Krames, & Flett, 1985). The results of reliability and validity studies strongly support the BDI as a very useful measure for assessing depression. It has been used with a wide variety of populations including psychiatric in-

patients, psychiatric out-patients, general university populations, and the adolescent population.

Procedure

The data used in this study was collected at the end of the two student counselor's nine month intern period at the counseling center. An approval to collect and use this information was obtained from the Director of the center (see Appendix D).

Records of all clients requesting services for depression and seen by either of the two students were evaluated for use in this study. The information needed in the client's chart for inclusion in the study was a completed self-report questionnaire and a completed BDI. All charts reviewed contained a completed self-report questionnaire while 12 did not contain a completed BDI. All clients included in the study had completed the two instruments at the counseling center and were given similar instructions.

Data Analysis

The clients were assigned to the CSA group or the No CSA group as determined from the abuse item on the questionnaire. A chi-square analysis

was then performed using these two groups as the two independent, binomial variables while the four interval level dependent variables were the four response categories of the BDI. The alpha level was set at .05.

CHAPTER IV

RESULTS

Incidence of Reported Abuse

Abuse histories obtained from client records yielded 17 (42.50%) women who reported experiencing some form of childhood sexual abuse while 23 (57.50%) reported that they had no knowledge of CSA in their background. Twenty women (50.00%) reported emotional abuse, and 13 (32.50%) reported physical abuse. These numbers add up to greater than 100% due to 15 women reporting two types of abuse and four women reported experiencing all three types of abuse (See Table 1).

Table 1

Client's Report of Abuse

Emotional Abuse	Physical Abuse	Child Sexual Abuse
n=20	n=13	n=17

Two Types of Abuse	Three Types of Abuse	No Abuse
n=15	n=4	n=13

N=40

Of the 17 clients reporting CSA, 70% (n=12) reported experiencing emotional and/or physical abuse in addition to the sexual abuse. Also, 76% (n=13) of this group reported problems in their family of origin including alcoholism, divorce, or other types of dysfunction.

Beck Depression Inventory Responses

Clients reporting a history of CSA had a slightly higher mean total score on the BDI than did clients without such a history. The abused group had a mean score of 29.91 while the non-abused group had a mean score of 25.87. The CSA group had a higher item mean for all but six of the 21 items. These six items measure the dimensions of dissatisfaction, irritability, social withdrawal, work retardation, anorexia, and weight loss.

There were three items on which both groups had a mean score below 1: suicidal ideation, anorexia, and somatic preoccupation. The CSA group also had a mean below 1 on the item measuring weight loss.

The three highest means for the CSA group were on the items measuring self-accusation, body image distortion, and crying. The three highest means for the No CSA group were on the items measuring irritability, loss of libido, and indecisiveness. Table 2 contains a complete list of items in descending order according to their means for the two groups.

Table 2

BDI item means in descending order

	CSA Group		No CSA Group
1.	Self-Accusation/Blame	1.	Irritability
2.	Body Image Distortion	2.	Loss of Libido
	Crying	3.	Indecisiveness
3.	Sadness	4.	Expectation of Punishment
4.	Loss of Libido	5.	Dissatisfaction
	Irritability		Work Retardation
	Expectation of Punishment		Fatigability
	Sense of Failure	6.	Sense of Failure
5.	Guilt		Insomnia
	Indecisiveness	7.	Self-Dislike
	Fatigability		Body Image Distortion
6.	Self-Dislike		Self-Accusation/Blame
7.	Insomnia	8.	Sadness
8.	Work Retardation		Crying
9.	Dissatisfaction	9.	Weight Loss
10.	Pessimism/Discouragement	10.	Pessimism/Discouragement
11.	Social Withdrawal		Social Withdrawal
12.	Somatic Preoccupation	11.	Guilt
13.	Anorexia/Appetite	12.	Anorexia/Appetite
14.	Suicidal Ideation	13.	Somatic Preoccupation
15.	Weight Loss	14.	Suicidal Ideation

One hundred percent (n=17) of the CSA group reported some degree of symptom on four of the items: sadness, sense of failure, self-dislike, and self-accusation. Ninety-four percent (n=16) of this group reported some degree of symptom on two of the items: crying and fatigability.

Chi-Square Analysis

To test the hypotheses concerning independence in item responses between the two groups, a chi-square analysis was performed on each of the 21 items. When necessary, response categories 0 & 1 and 2 & 3 were combined because of infrequency of responses in categories 0 and 3 (Clarke, 1985).

The two independent, binomial variables were the 17 subjects comprising the "CSA" group and the 23 subjects comprising the "No CSA" group. The four interval level dependent variables were the four response categories of the BDI: "0","1", "2", "3". When the response categories were combined, the two interval level dependent variables were "0 & 1" and "2 & 3".

The results of the chi-square analysis showed that for item #3, sense of failure, the calculated value was 8.5470. Because this value is larger than the critical value of 3.84 for 1 degree of freedom at the .05 level, the null hypothesis of independence between the variables of CSA and BDI responses for sense of failure is rejected. Therefore, the alternative hypothesis that the variables CSA and BDI responses for failure are not independent is accepted. Response categories 1&2 and 3&4 were combined for this chi-square analysis because of infrequency of responses in categories 0 and 3.

Likewise, the results of the chi-square analysis for item #14, body image distortion, showed a calculated value of 5.18. Because this value is larger than the critical value of 3.84 for one degree of freedom at the .05 level, the null hypothesis of independence between the variables of CSA and BDI responses for body image distortion is rejected. Therefore, the alternative hypothesis that the variables CSA and BDI responses for body image distortion are not independent is accepted. Responses categories 1&2 and 3&4 were combined for this chi-square analysis because of infrequencies in all response categories.

A chi-square analysis for the item measuring suicidality showed a calculated value of 8.57. Because this value is larger than the critical value of 3.84 for one degree of freedom at the .05 level, the hypothesis of independence between the variables CSA and BDI responses for suicidality is rejected. Therefore, the alternative hypothesis that the variables CSA and BDI responses for suicidality are not independent is accepted. Response categories 1&2 and 3&4 were combined for this chi-square analysis, however, even with the collapse of the cells, there are still two cells (50%) with less than the accepted minimum of five. Therefore, this chi-square is suspect.

A chi-square analysis for the remaining 18 items showed calculated

values less than the critical value for one degree of freedom at the .05 level. Therefore, the null hypothesis for independence was accepted for these items.

Table 3 shows the crosstabulations for the variables "CSA" and "BDI Responses" for each of the 21 items on the BDI. It also gives the mean score and the percentage of the group that responded with some level of the symptom (a response of a 1, 2, or 3).

CHAPTER V

DISCUSSION

With respect to the hypothesis that there would be independence in responses to BDI items between women seeking treatment for depression with a self-reported history of CSA and those women seeking treatment for depression who do not report such a history, the data showed that the null hypothesis was accepted for all but two of the 21 BDI items: sense of failure and body image distortion. Therefore, this study has shown that a relationship exists between self-reported history of CSA and sense of failure and body image distortion for the subjects used in this research. A full discussion of this finding will be presented later in this chapter.

Frequency of CSA

The percentage of clients who reported a history of CSA in this study, 42.50% (n=17), is congruent with other studies conducted in clinical settings (Gold, 1986; Bryer, et al, 1987; Walker, et al, 1992). However, as Ratican (1992) points out, the actual incidence of abuse may be much higher because many women do not wish to reveal this information, others may deny the experience or dissociate from it, and still others have repressed these memories. The fact that CSA is under-reported, for whatever reason,

poses a limitation for research in this area.

A further limitation of the present study is that subjects were divided in the "CSA" and "No CSA" groups according to their response to the abuse item on the self-report questionnaire which is completed on the first visit before they have spoken to the counselor. Many women may not have felt comfortable relaying such an important issue in this manner. In fact, two of the subjects wrote "will discuss with counselor" as a response to this item. It is not known how many women answered "no" to this item thinking that they would only discuss it once they felt comfortable with or trusted the counselor. Many clients may have sexual abuse in their histories and never volunteer this information (Ratican, 1992).

The frequency of clients reporting other types of abuse (emotional and/or physical) is much higher. The present study revealed 67% (n=27) who stated that they had experienced some type of abuse at some time in their lives. This is congruent with a study conducted by Bryer, et al (1987) who found that 72% of their psychiatric subjects reported experiencing some type of abuse history.

The high number of clients in clinical settings who report CSA suggests a relationship between the abuse experience and adult mental health.

Of all the theories as to the link between CSA and adult psychological

functioning, the one presently receiving the most attention is that of the disturbed family structure. Two studies conducted in 1993 (Mullen; Yama) found that, in general, CSA tends to occur more frequently in disorganized and disadvantaged homes.

Ten years earlier, Gelinas had reported that many of the long-term effects of CSA are due to relational imbalances that occur within the family (1983). Jehu (1989) found substantial evidence of parental discord in abusive families; two-thirds of the women in his study reported a history of ineffective and nonnurturing parenting. In the present study, 76% (n=13) of the women in the CSA group reported some type of family problems. This high percentage lends support to the relationship between CSA and disturbed family structure.

Again, however, this self-reporting history must be considered as a limitation because the information given is reliant upon the adults' memories and perspective as they look back to their childhood. Because of this, it can only be said that the results reflect the clients' perception of their family environment. As Yama (1993) points out, it is possible that subjects with current symptoms of depression hold a distorted view of their families of origin, seeing them more negatively than they otherwise would.

Beck Depression Inventory Responses

The present study found that the "CSA" group had a higher mean total score on the BDI than the "No CSA" group. This is congruent with other researchers who have found significant differences when they compared BDI scores between abused and non-abused subjects. Wind and Silvern (1992), Yama et al.(1993), and Braver et al.(1992) all found that those who reported a history of CSA had higher levels of depression on the BDI than those who had no abuse. This data supports the belief that many CSA clients present at clinical settings as depressed. However, it cannot be surmised that an abusive past causes depression, but the results do add to the growing evidence that depression is a long-term psychological correlate of CSA.

The results of this study also showed that all of the subjects in the CSA group reported some level of the symptom (a response of 1,2,or 3) on four of the BDI items: sadness, sense of failure, self-dislike, and self-accusation/blame. A report of these symptoms is congruent with the findings of Jehu (1989) who studied distorted beliefs held by women with a history of CSA. He found that a large percentage of his sample possessed low self-esteem and depressive feelings; 78% felt that they were worthless or bad and 80% reported self-blame.

Gelinas (1983) has identified similar symptoms in incest victims and

has included them in her Incest Recognition Profile. They include depressed mood and affect, very low self-esteem, and guilt. In the present study, 82% (n=14) of the CSA subjects reported symptoms of guilt compared to only 52% (n=12) of the non-abused group.

Ratican (1992) points out that the pervasive guilt felt by CSA survivors is the result of self-blame. They believe that they must have done something wrong or bad to deserve their abusive treatment. This belief then leads to the belief that if they did something bad then they are bad which leaves adult survivors with a low self-esteem.

Ratican believes that the feelings of guilt and low self-esteem experienced by CSA survivors are reflected in a poor body image. This belief was supported by the current study. The symptom of body-image distortion on the BDI had the second highest mean for the CSA group. This item was also found to be related to a self-reported history of CSA by chi-square analysis.

The item on the BDI relating to body-image distortion contains four statements, the first two (responses 0 and 1) deal with feelings of looking worse in the recent past while the latter two statements (responses 2 and 3) deal with more severe feelings of permanent changes in appearance. Crosstabulation for this item showed that the highest number of responses in

the CSA group fell in response category 3, the most severe report of the symptom, while most of the No CSA group responded with a "1". The feeling of body-image distortion may result from the invasion of the body itself and many abuse survivors may feel alienated from their bodies.

The other BDI item that demonstrated a relationship with CSA by chi-square analysis was that of sense of failure. This symptom, though not discussed specifically by previous researchers, is related to feelings of low self-worth and shame in that abuse survivors feel that they and their actions have somehow fallen short of what is expected. The majority of the CSA group responded to this item by stating that when they looked back on their lives, all they could see were a lot of failures.

Gelinas (1983), Wind and Silvern (1992), Braver et al. (1992), Browne and Finkelhor (1986), Ratican (1992), and Beitchman et al, (1992) all have reported sexual dysfunction to be a commonly reported symptom among CSA survivors. In the present study, 70% (n=12) of the CSA subjects reported a loss of libido; however, 74% (n=18) of the No CSA group reported some level of the symptom as well. A limitation in reporting sexual dysfunction in the present study is that the BDI item only provides the number of women reporting a decrease in an interest in sex while sexual dysfunction involves much more.

A review of the literature has also pointed to sleep disturbances as a long-term effect of sexual abuse, usually resulting from recurrent nightmares. The present study found that 82% (n=14) of the CSA group responded with some level of the symptom of insomnia; however, 83% (n=19) of the No CSA group also reported some level of this symptom. Again, the limited information gained from this BDI item would prohibit this researcher from making any conclusions from this study regarding sleep disturbances.

In general, many of the symptoms found to be common among CSA survivors in the present study are congruent with symptoms found by previous researchers. However, not all of the common symptoms were measurable by the BDI in this study (e.g. dissociative elements).

An interesting result of the present study was the rank ordering of symptoms for the two groups according to their BDI item means. This perhaps gives the clearest picture of the way in which the two groups clinically presented their depression. The CSA group manifested their depression with self-accusation/blame, body-image distortion, crying and sadness, while the No CSA group manifested their depression with irritability, loss of libido, and indecisiveness. From the rank-ordering, it may be concluded that the two groups experience their depression

differently.

In discussing the results of BDI responses, it must be stated that a limitation of any study using the BDI is it's potential for fakeability. Clients, for whatever reason, may not accurately report their symptoms.

Another limitation is the small sample size and the unevenness of the number of clients in the two groups. The number of subjects in this study is too small to draw far-reaching conclusions. Perhaps a larger number of subjects would have revealed more significant differences in the relationship between a self-reported abuse history and responses on the BDI.

Likewise, a more sophisticated statistical method may have yielded different results and warrants future exploration. A statistical approach similar to that used by Clark and his associates may have yielded BDI items that discriminate well for CSA.

Conclusions

In summary, results from this study conclude that women who report a history of CSA also report a higher level of depressive symptoms on the BDI than women who do not report a history of CSA. This was demonstrated by the higher group mean score on the BDI as well as a higher item mean on all but six of the 21 items for the CSA group.

Another important finding of this study from which conclusions can be drawn is that all subjects in the CSA group reported some level of the symptom on four of the BDI items: sadness, sense of failure, self-dislike, and self-accusation/blame. It can be concluded that these are commonly manifested symptoms of CSA survivors and may be important as counselors attempt to identify CSA survivors among their female clients who present with complaints of depression.

It is also concluded from this study that a relationship exists between a self-reported history of CSA and two of the symptoms measured by the BDI: body-image distortion and sense of failure. Obviously, further study is needed in this area to more completely study this relationship.

Likewise, more study is needed in the area of identifying CSA survivors among counseling clients. Ignoring the topic with clients may lead counselors to focus treatment on an area which may be unproductive, thus rendering the treatment unsuccessful. Worse, mishandling the issue can lead to considerable harm. Counselors need to be continually educated as to symptoms experienced by CSA survivors to aid in identification.

Abuse to children, especially sexual abuse, is a horrible trauma for a child to endure and is one that will likely affect their psychological well-being, but it is not destiny. Skilled and educated counselors who keep

abreast with current research in this area may help many clients resolve their abuse experience.

Table 3
Crosstabulations, Means, & Percents

Item #1 Sadness
BDI Response

	0	1	2	3	Mean	Percent
CSA	0	9	2	6	1.82	100%
No CSA	5	10	5	3	1.26	74%

Item #2 Pessimism/Discouragement
BDI Response

	0	1	2	3	Mean	Percent
CSA	6	6	2	3	1.12	65%
No CSA	5	13	5	0	1.00	78%

Item #3 Sense of Failure
BDI Response

	0	1	2	3	Mean	Percent
CSA	0	6	9	2	1.76	100%
No CSA	5	6	10	2	1.39	78%

Item #4 Dissatisfaction
BDI Response

	0	1	2	3	Mean	Percent
CSA	3	8	5	1	1.23	82%
No CSA	4	8	8	3	1.43	83%

Item #5 Guilt

BDI Response

	0	1	2	3	Mean	Percent
CSA	3	5	5	4	1.59	82%
No CSA	11	5	6	1	0.87	52%

Item #6 Expectation of Punishment

BDI Response

	0	1	2	3	Mean	Percent
CSA	5	2	2	8	1.76	70%
No CSA	8	5	1	9	1.47	65%

Item #7 Self-Dislike

BDI Response

	0	1	2	3	Mean	Percent
CSA	0	11	3	3	1.53	100%
No CSA	2	15	3	3	1.30	91%

Item #8 Self-Accusation/Blame

BDI Response

	0	1	2	3	Mean	Percent
CSA	0	7	4	6	1.94	100%
No CSA	5	9	6	3	1.30	78%

Item #9 Suicidal Ideation

BDI Response

	0	1	2	3	Mean	Percent
CSA	7	9	1	0	0.65	59%
No CSA	13	10	0	0	0.43	43%

Item #10 Crying

BDI Response

	0	1	2	3	Mean	Percent
CSA	1	5	6	5	1.88	94%
No CSA	6	10	2	5	1.26	74%

Item #11 Irritability

BDI Response

	0	1	2	3	Mean	Percent
CSA	2	3	9	3	1.76	88%
No CSA	1	6	13	3	1.78	96%

Item #12 Social Withdrawal

BDI Response

	0	1	2	3	Mean	Percent
CSA	6	6	4	1	1.00	65%
No CSA	8	8	6	1	1.00	65%

Item #13 Indecisiveness

BDI Response

	0	1	2	3	Mean	Percent
CSA	2	5	8	2	1.59	88%
No CSA	5	5	9	4	1.52	78%

Item #14 Body Image Distortion

BDI Response

	0	1	2	3	Mean	Percent
CSA	2	4	5	6	1.88	88%
No CSA	4	12	3	4	1.30	83%

Item #15 Work Retardation

BDI Response

	0	1	2	3	Mean	Percent
CSA	4	5	7	1	1.29	76%
No CSA	4	5	14	0	1.43	83%

Item #16 Insomnia

BDI Response

	0	1	2	3	Mean	Percent
CSA	3	8	1	5	1.47	82%
No CSA	4	11	3	5	1.39	83%

Item #17 Fatigability

BDI Response

	0	1	2	3	Mean	Percent
CSA	1	8	5	3	1.59	94%
No CSA	3	7	13	0	1.43	87%

Item #18 Anorexia/Appetite

BDI Response

	0	1	2	3	Mean	Percent
CSA	8	6	3	0	0.70	53%
No CSA	13	4	3	3	0.82	43%

Item #19 Weight Loss

BDI Response

	0	1	2	3	Mean	Percent
CSA	11	4	1	1	0.53	35%
No CSA	13	2	1	7	1.08	43%

Item #20 Somatic Preoccupation

BDI Response

	0	1	2	3	Mean	Percent
CSA	6	7	3	1	0.94	65%
No CSA	8	13	2	0	0.74	65%

Item #21 Loss of Libido

BDI Response

	0	1	2	3	Mean	Percent
CSA	5	2	2	8	1.76	70%
No CSA	5	4	10	4	1.56	78%

APPENDIX A

Incest Recognition Profile (Gelinas 1981)

PRESENTING PROBLEM

Chronic depression with recent exacerbation.

Depressed mood and affect, very low self-esteem, guilt, and needy depressiveness.

Complications of a chronic mood disorder.
Substance abuse, self-injurious or suicidal behavior, impaired judgement, difficulty in parenting, poor relationships, sexual dysfunctions.

ATYPICAL ELEMENTS

Dissociative elements.

Complaints of "confusion" from a nonpsychotic person, recurrent nightmares, unpleasant memories or reactions precipitated by an event or person, episodes of depersonalization.

Impulsive Elements

Running away, seriously impulsive eating, drinking or spending, promiscuity, auto accidents, child abuse.

PERSONAL HISTORY

History of parentification.

Premature and heavy financial, housekeeping or child-care responsibilities as a child or adolescent, pseudomaturity.

APPENDIX B
Self-Report Questionnaire

Welcome to the Jane Crider Counseling Center. We offer a variety of counseling services and will work with you to develop a plan for treatment that best meets your needs.

In order to better assist you, some information would be helpful. Please fill out the following pages and return them to the secretary. If you need additional space, please use the back of the pages.

Thank you for your cooperation.

Name _____ Date _____

Who referred you to this clinic? _____

1. Please give the following information on yourself and any other persons living in your home.

Name	Relationship	Sex	Age	Highest grade level achieved
	self			

2. Please give the following information on your parents and brothers and sisters.

Name	Relationship	Sex	Age	Living/Deceased

3. Dates of your marriages — Number of children

_____

_____

_____

Dates of marriages of spouse/significant other — Number of children

_____

_____

_____

4. Present Job Dates of employment

Past jobs Dates of employment

Present job of spouse/significant other Dates of employment

5. Legal problems:

Arrests Date Result

Describe any other significant legal problems:

6. Previous counseling:

Where Dates

7. Psychiatric hospitalizations of you or anyone in your family:

Name of family member Where Hospitalized Reason for hospitalization date

8. Alcohol or drug abuse treatment for you or anyone in your family.

Name of family member	where treated	dates

9. What recreational/leisure activities do you participate in?

10. Describe any serious medical problems you have:

11. Have you or anyone in your family been a victim of a crime or abuse (physical, sexual or emotional)? Please describe.

12. Any additional information you would like to add:

This form completed by:

Client_____

Clinician

Why are you here

Your counselor will be able to be more helpful to you if he/she knows why you decided to come in for counseling at this time. Take a few minutes to think about what you would like to accomplish in therapy. What are your goals? List one to three things you would like to achieve by coming here.

1.

2.

3.

APPENDIX C

The Beck Depression Inventory

BDI

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated by things than I ever am.
    1 I am slightly more irritated now than usual.
    2 I am quite annoyed or irritated a good deal of the time.
    3 I feel irritated all the time now.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if, any, lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains or upset stomach, or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical health that I cannot think of anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.

APPENDIX D
Letter of Approval

Jane Crider Counseling Center

2747 West Clay
St. Charles, Missouri 63301
(314) 723-1100 (314) 946-1141

To: Nancy Gongaware
From: Mark Richardson MR
Re: Response to use of client data
Date: March 31, 1994

I am pleased to approve your request to use anonymous client data for your thesis. Please provide me with a copy of the data as it is integrated into your final edition.

cc: Ellen Burkemper

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