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Psychological distress in adult survivors of childhood sexual abuse : the role of shame, self-esteem and blame

Kemish, Karen

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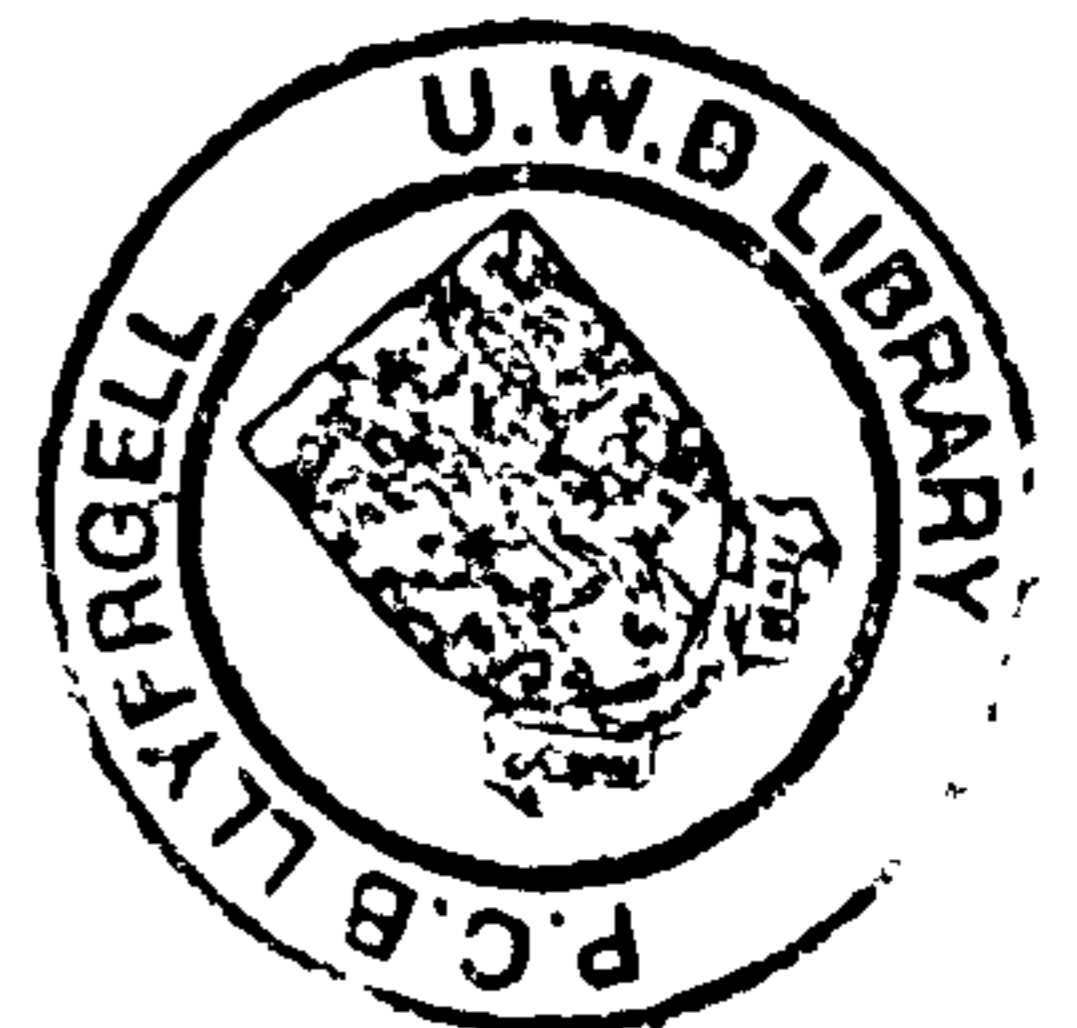
**Psychological Distress in Adult Survivors of Childhood Sexual Abuse: the Role of
Shame, Self-esteem and Blame.**

Karen Kemish

University of Wales, Bangor

**Thesis submitted in partial fulfilment of the requirement of the Degree of
Doctorate in Clinical Psychology (D.Clin.Psy)**

July 2007



Summary

Research shows that individuals who report a history of childhood sexual abuse (CSA) are more likely to develop a range of psychological difficulties in adulthood than those who report no early experiences of CSA. The concept of CSA as a risk factor for developing psychological distress is no longer in question, but the causal mechanisms that underlie these associations are still not well understood.

The feelings of shame, responsibility, and low levels of self-esteem that are commonly found in presentations of psychological distress in female survivors may implicate these characteristics as mediating risk factors in the sequelae of CSA.

A literature review was carried out to explore the theoretical knowledge of CSA, and to examine the evidence of its relationship with psychopathology, and the role of contributory features of shame, self-esteem and attributions of blame.

One hundred and fifty nine undergraduates (thirty two of whom reported a history of CSA) completed questionnaires requesting information on a history of CSA, shame, self-esteem, and attributions of blame and responsibility.

The expected association between CSA distress and psychopathology was not found and this precluded mediation analysis. However, differences were found between the Abused and Non-Abused groups on the psychopathology subtests, most notably psychoticism. Compared to the Non-abused group, the Abused group also showed higher levels of Shame and a non-significant trend towards lower Self-esteem. Shame

and Self-esteem were found to correlate with psychopathology and CSA distress correlated with Perpetrator Blame and Family Blame.

Finally, the last section of the thesis discusses implications for clinical practice, the limitations of the empirical study, and ideas for further research.

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Dr Dave Daly (Tutor, NWCPP) has shown immense kindness and endurance during the statistical analysis of this thesis, and I thank him for that. Thanks also to Dawn Thompson, Lynn Moran, and Sharon Fraser (Staff, NWCPP) for their friendly administrative advice.

With special thanks to my fellow “Coven” members for their friendship and support - especially during the last six months when it all hung in the balance.

Thanks also to my two special girls, and to Al - they continued to believe in me, even when I didn't!

Finally, for the survivors who inspired me. My admiration and thanks to the courageous women who have humbled me by allowing me to share their experiences.

Dedication

**For my daughters, Lucy and Alice who have always given me their absolute and
-unconditional loveI couldn't have done it without them.**

Section 1: Ethics Proposal

SCHOOL OF PSYCHOLOGY ETHICAL APPROVAL FORM

Please complete all parts to this form.

Please attach consent and information/debriefing sheets to all applications.

Tick one box: STAFF project MASTERS project PhD project
 CLINICAL PSYCHOLOGY project UNDERGRADUATE project

Is this an ESRC-funded project? YES NO

Title of project: **Psychological distress in adulthood: the role of shame, self-esteem and blame.**

Name of researcher(s): **Karen Kemish**

of supervisor (for student research): **Dr Isabel Hargreaves & Dr Sarah Gregory**

Date: **27th October 2006**

	YES	NO
Is your project in the area of Health and Social Care requiring sponsorship by the University of Wales Bangor? If yes, please complete your ethics application in COREC format and submit an NHS R&D form alongside it. You should still complete all sections to this form, but do not need to supply the additional information requested in boxes A or B of Part 1.		√
Does your project require scrutiny from an outside body that has its own forms? If yes, please complete your ethics application using the forms required by that outside body. You should still complete all sections to this form, but do not need to supply the additional information requested in boxes A or B of Part 1.		√
If a student project, is this part of the supervisor's ongoing research that has been previously reviewed and approved? If yes, please give the proposal number of the approved research project, and complete all sections of this form.	Proposal no.	√

PART ONE: ETHICAL CONSIDERATIONS

	YES	NO	N/A
1 Will you describe the main experimental procedures to participants ¹ in advance, so that they are informed about what to expect?	√		
2 Will you tell participants that their participation is voluntary?	√		
3 Will you obtain written consent for participation?	√		
4 If the research is observational, will you ask participants for their consent to being observed?			√
5 Will you tell participants that they may withdraw from the research at any time and for any reason?	√		
6 With questionnaires, will you give participants the option of omitting questions they do not want to answer?	√		
7 Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	√		
8 Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?	√		

If you have ticked No to any of Q1-8, but have ticked box A overleaf, please give an explanation on a separate sheet.
 [Note: N/A = not applicable]

	YES	NO	N/A
9 Will your project involve deliberately misleading participants in any way?		√	
10 Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details on a separate sheet and state what you will tell them to do if they should experience any problems (e.g., who they can contact for help)	√		

¹ In questions 1-9, if participants are children, please consider the information that you will supply to the legal guardian in each case.

If you have ticked Yes to 9 or 10 you should normally tick box B overleaf; if not, please give a full explanation on a separate sheet.

11	Does your project involve work with animals? If yes, please tick box B overleaf.		√	
12	Does your project involve payment of participants? If yes, please tick box B overleaf.	√		
13	Do participants fall into any of the following special groups? If they do, please refer to BPS guidelines, and tick box B overleaf. Note that you may also need to obtain satisfactory CRB clearance.	Children (under 18 years of age) N.B. You must ensure that you have made adequate provision for child protection issues in your protocol		√
		People with learning or communication difficulties N.B. You must ensure that you have provided adequate provision to manage distress		√
		Patients N.B. You must ensure that you have provided adequate provision to manage distress.		√
		People in custody		√
		People engaged in illegal activities (e.g. drug-taking)		√
		Participants recruited from the Neurology Patient Panel		√
		Physically vulnerable adults N.B. You must ensure that there is an appropriately CPR trained member of staff on hand at all times during testing.		√

There is an obligation on the lead researcher to bring to the attention of the Departmental Ethics Committee any issues with ethical implications not clearly covered by the above checklist.

PLEASE TICK EITHER BOX A BELOW OR BOX B OVERLEAF AND PROVIDE THE DETAILS REQUIRED IN SUPPORT OF YOUR APPLICATION.

Please tick

A. I consider that this project has no significant ethical implications to be brought before the Departmental Ethics Committee.	
Give a brief description of participants and procedure, including information on (1) hypotheses, (2) participants & recruitment, and (3) research methodology. Please attach consent and debrief forms.	

Please tick

B. I consider that this project may have ethical implications that should be brought before the Departmental Ethics Committee, and/or it will be carried out with children or other vulnerable populations.

√

Please provide all the further information listed below in a separate attachment.

1. Title of project.
2. The potential value of addressing this issue
3. Brief background to the study
4. The hypotheses
5. Participants: recruitment methods, age, gender, exclusion/inclusion criteria
6. Research design
7. Procedures employed
8. Measures employed
9. Qualifications of the investigators to use the measures
10. Venue for investigation
11. Estimated start date and duration of the study (N.B. If you know that the research is likely to continue for more than three years, please indicate this here).
12. Data analysis
13. Potential offence/distress to participants
14. Procedures to ensure confidentiality and data protection.
15. *How consent is to be obtained (see BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The University has its own Welsh translations facilities on extension 2036).
16. Information for participants (Provide actual consent forms and information sheets.)
17. Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)
18. Payment to: participants, investigators, departments/institutions
19. Equipment required and its availability
20. What arrangements are you making to give feedback to participants? The responsibility is yours to provide it, not participants' to request it.
21. Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.

Details on complaints procedure will also be provided

PLEASE COMPLETE PART TWO OVERLEAF.

PART TWO: RISK ASSESSMENT

		YES	NO	N/A	
1	Is there significant potential risk to participants in any of the following ways?	Potential adverse effects		√	
		Potential distress	√		
2	Is there significant potential risk to investigator(s) in any of the following ways?	Potential risk of violence or other harm to the investigator(s) (e.g., through work with particular populations or through context of research).		√	
		Potential risk of allegations being made against the investigator(s). (e.g., through work with vulnerable populations or context of research).		√	
3	Does the research involve the investigator(s) working alone or away from the School?	√			
4	Does the experimental procedure involve touching participants?		√		
5	Is there significant potential risk to the institution in any way? (e.g., controversiality or potential for misuse of research findings.)		√		
6	Is there significant potential risk to other members of staff or students at the institution? (e.g., reception or other staff required to deal with violent or vulnerable populations.)		√		

If you have ticked "yes" to any of the questions in the table above, please outline on a separate sheet the probability and significance of the risks involved and the means proposed for the management of those risks. Where relevant, please also describe the procedures to be followed in the event of an adverse event or emergency.

There is an obligation on the lead researcher to bring to the attention of the Departmental Ethics Committee any risk implications of the research not clearly covered by the above checklist.

PLEASE COMPLETE PART THREE OVERLEAF, THEN SIGN AND DATE THE DECLARATIONS ON THE FINAL PAGE OF THIS FORM.

PART THREE: RESEARCH INSURANCE QUESTIONNAIRE

In the case of student research, this form should be completed by the supervisor.

The purpose of this form is to decide whether the University requires additional insurance cover for a clinical/research trial and the form should be completed and returned to the Insurance Officer for a decision. *This Questionnaire should be completed for each Research Project that will involve human participation.*

Name of Sponsor: **Welsh Assembly Government.**

Title of Research: **Psychological distress in adulthood: the role of shame, self-esteem and blame.**

Number of subjects (participants) 150 plus _____

1 Is your Research going to be based solely upon the following?

~~Yes/No~~ (Delete as appropriate)

- a) questionnaires or
- b) venepuncture or³
- c) measurements of physiological processes or
- d) collections of body secretions by non invasive methods or
- e) the administration by mouth of foods or nutrients or variation of diet other than the administration of drugs or other food supplements or
- f) psychological activity (this is outside the Research definition)

If you answered 'YES', please sign and date the form and return it to the Insurance Officer. If you answered 'NO' please complete the remainder of the questionnaire.

2 Attach details of the Research and a copy of the Protocol submission to the Ethics Committee

3 Is the Research to be held in UK?

If "No" please provide full details

Yes/No (Delete as appropriate)

4 Who will be involved in conducting the Research? _____

5 If medical practitioners are involved will they be covered by the MDU(Medical Defence Union) or any other organization?

Yes/No (Delete as appropriate)

6 Does the Research involve use of drugs or surgery?

Yes/No (Delete as appropriate)

7 Are any of the research subjects known to be pregnant?

Yes/No (Delete as appropriate)

8 Are any of the research subjects under 5 years of age?

Yes/No (Delete as appropriate)

9 Is the purpose of the Research

a) investigating or participating in the methods of contraception?

Yes/No (Delete as appropriate)

b) assisting with or altering the process of conception?

Yes/No (Delete as appropriate)

10 Does the Research involve genetic engineering?

Yes/No (Delete as appropriate)

11 Will the Research use a pharmaceutical product designed or manufactured by the Institution?

Yes/No (Delete as appropriate)

12 Proposed commencement date AND period of the Research _____

13 Will the sponsor pay for addition Insurance costs if required

Yes/No (Delete as appropriate)

(If 'No' please note that the department must underwrite any additional insurance cost)

14 If other organizations are involved in the Research is UWB the lead organization for the Research Project?

Yes/No (Delete as appropriate)

(If 'Yes' please attach all details, including details of any other organizations that will be involved in the trial(s) involving human participation)

If any of the answers to 4 – 10 are "Yes" please provide full details on additional sheets

Signed _____

Dated _____

Declaration of ethical compliance

This research project will be carried out in accordance with the guidelines laid down by the British Psychological Society and the procedures determined by the School of Psychology at Bangor. I understand that I am responsible for the ethical conduct of the research. I confirm that I am aware of the requirements of the Data Protection Act and the University's Data Protection Handbook, and that this research will comply with them.

Declaration of risk assessment

The potential risks to the investigator(s) for this research project have been fully reviewed and discussed. As an investigator, I understand that I am responsible for managing my safety and that of participants throughout this research. I will immediately report any adverse events that occur as a consequence of this research.

Declaration of data ownership and IPR (for students)

I understand that any data produced through this project are owned by the University and must be made available to my supervisor on request or at the end of the project. I confirm that I am aware of the University's Intellectual Property Policy and that this research will comply with it.

(Chief investigator/supervisor)

Signed:

Date:

(Associate investigator(s)/student(s))

Signed:

Date:



For School Use Only

Reviewer 1 Approved Date.....
(name) (signature)

Reviewer 2 Approved Date.....
(name) (signature)

Proposal No.

Notes to accompany ethics application

Question 10

A leaflet entitled 'helpful resources' (enclosed) will be distributed with the questionnaire pack to all participants. The leaflet lists agencies that may be contacted for help or advice if participants are experiencing emotional distress. Following ethical approval, this leaflet will be translated into Welsh and distributed bilingually.

Part A

Enclosed:

Questionnaire booklet.

Information about the research

Helpful resources leaflet.

Risk assessment.

Prize draw ticket & PSU recording ticket.

Hypothesis / Research question

Psychological distress in adulthood often occurs subsequent to child sexual abuse. This research will try to determine whether shame, low self-esteem, and attributions of self-blame are associated with increased levels of psychological distress. If an association is established, and data permits, the study will then investigate whether they function as mediators.

Participation and recruitment

Female undergraduates will be recruited from the University of Wales, Bangor through the SONA website. SONA (available 24 hrs a day, 7 days a week) is a web-based programme that is used as a centralised matching and scheduling resource that provides participants for psychology experiments within the school. In addition, opportunity sampling techniques will be used to recruit female students participating in the North Wales Clinical Psychology Programme.

Research methodology

Participants will be asked to complete a questionnaire booklet. All responses will be anonymous and confidential (although PSU numbers will be required to award print and

course credits). The questionnaire booklet comprises questions on: age range, child sexual abuse experiences, attributions of blame, self-esteem and feelings of shame, and current level of emotional distress.

Part B

1) Title of project

Psychological distress in adult CSA survivors: the role of shame, self-esteem and blame.

2) Potential value of addressing this issue

Alleviating feelings of guilt, responsibility and low self-esteem is an important part of therapeutic work with adults who have experienced childhood sexual abuse. Results from this research looking at self-blaming attributions, low self esteem, and feelings of shame and their possible link with emotional difficulties in adulthood may underlie the importance of dealing with these variables that may be associated with, or mediate, adult distress.

3) Brief background to the study

It has been acknowledged that a history of childhood sexual abuse (CSA) is a risk factor¹ for developing psychological distress in adulthood. It is also recognised that survivors of CSA often have elevated levels of distress, which is evident in disorders such as: chronic and recurrent depression, anxiety disorders, post-traumatic stress disorder, and dissociative disorders. Despite the research, the causal mechanisms that underlie these associations are not well understood, and it is still not clear how survivors stand a greater risk of developing psychological distress in adulthood.

More recent research has attempted to understand which mediating risk factors² (e.g low self-esteem, shame, or blame) have the potential to be causal risk factors³. It is generally agreed that CSA is associated with psychological distress in adulthood and it is thought that this occurs as a result of its impact on causal risk factors.

¹ A risk factor is described as a fixed marker or attribute that cannot be changed (e.g. a history of CSA).

² A mediating risk factor is one that explains the association between another risk factor and the outcome (e.g CSA and emotional distress may be linked because CSA has an impact on survivors ability to access support).

³ A causal risk factor is a variable that can be changed, and when it is changed it alters the degree of risk (e.g. low self-esteem, shame or blame).

4) The hypotheses

- i) Increased levels of shame, attributions of self-blame, and low self-esteem will be associated with increased levels of psychological distress.

If an association is established and data permits mediation analysis, it would be predicted that:

- ii) Increased levels of shame, attributions of self-blame, and low self-esteem would mediate the process of psychological distress.

5) Participants

Female-only undergraduates aged 18+ will be recruited from University of Wales Bangor (UWB), and includes students from the North Wales Clinical Psychology Programme. Recruitment methods have already been detailed in Part A 'participation and recruitment'.

6) Research design

The study will use a group comparison design. Respondents will be divided into two groups: a 'reported abuse' group and a 'no reported abuse' group.

7) Procedures employed

Participants will be asked to complete a questionnaire booklet, and are required to choose from the following options:

- i) The questionnaires may be completed, and submitted online via the UWB recruitment website (SONA). A PSU number must be submitted to enable print credits and course credits to be awarded.
- ii) The questionnaires may be accessed through SONA, printed out, completed, and deposited in a box in the Wheldon Psychology department. Students may choose between submitting a PSU number to be awarded course and print credits, or alternatively, they may collect a £5.00 photocopy card in lieu of course or print credits – this method does not require participants to submit a PSU number. If the participant chooses to receive a photocopy card, they must hand in the sealed questionnaire at the Wheldon reception, and request their

£5.00 photocopy card reward. The receptionist will write on the outside of the envelope “photocopy card awarded.” This prevents fraudulent use of the system and ensures that all participants have been awarded their reward of choice.

- iii) A hard-copy questionnaire may be collected from a box in the Wheldon Psychology department, completed, and deposited back in the Wheldon Psychology department. Students may choose between submitting a PSU number to be awarded course and print credits, or alternatively, they may collect a £5.00 photocopy card in lieu of course or print credits – this method does not require participants to submit a PSU number. If participants choose to be awarded print and course credits they will be invited to record their PSU number on a ticket stub, seal it the envelope provided, and deposit it (separately to the envelope containing the questionnaires) in the designated box in the Wheldon reception. Submitting PSU numbers and completed questionnaires separately will maintain anonymity. The researcher will open all the envelopes daily, and will submit the PSU numbers to the relevant department to enable course and print credits to be awarded. The original ticket with the PSU number is subsequently destroyed. The researcher will score and analyse the collected questionnaires, which will then be securely stored in a locked filing cabinet until after the study is complete, after which they will be destroyed.**

Note on anonymity:

It should be stressed that where PSU numbers are disclosed, it will not be possible for the researcher to make any link between the submitted questionnaires and the participants identity. Nor will it be possible for UWB staff to identify PSU numbers with participants’ questionnaire responses because the questionnaires and PSU numbers will be submitted separately, both in sealed envelopes. UWB staff will not be required to open the sealed envelopes. The researcher will open the envelopes daily, and will submit the PSU numbers to the relevant department to enable course and print credits to be awarded. All methods have been selected with a view to preserving as much anonymity for participants as possible.

8) Measures

A questionnaire booklet (enclosed) comprised questions on age range; child sexual abuse experiences; shame and self-esteem; blame and psychological disturbance. These will be measured using the following standard scales and measures:

- ***CSA experiences***

Participants will be asked questions that relate to experiences of CSA, and whether they experienced sexual abuse as a child. Their responses will be recorded on a 5-point Likert scale (*never* through to *very often*). Participants will also be asked how distressing this was for them at the time and again they will record their responses on a 5-point Likert scale (*not at all distressing* through to *extremely distressing*). The questions that follow are about past experiences of CSA, and were adapted from those used by Henderson et al., (2002). Ussher and Dewberry (1995) used these questions previously in a study that investigated the prevalence of CSA.

All questions begin with: 'When you were a child, did an adult.....'

- a) sexually expose themselves to you
- b) watch you bathing / dressing in a way that made you feel uncomfortable
- c) make you touch them in a sexual way
- d) touch you in a sexual way without genital contact
- e) touch you in a sexual way including genital contact
- f) have sexual intercourse with you

- ***Internalised Shame Scale (Cook, 1994)***

The Internalised Shame Scale (ISS) was developed to measure the extent to which respondents have internalised feelings of shame. It has been found to be especially useful in assessing trauma survivors' experiences of shame, which emerges as an element of complex trauma reactions. The ISS has been widely used in empirical research into shame but is also a useful clinical tool. It has demonstrated good construct validity and reliability in a variety of clinical and non-clinical groups. The ISS is a 30 item self-report questionnaire with 24 negatively worded items from which the shame score is derived. The remaining 6 items - originally taken from the

Rosenberg Self-Esteem Scale (Rosenberg, 1965) may be scored separately and used as an indicator of self-esteem.

- ***Attributions of Responsibility and Blame Scale (McMillen & Zuravin 1997)***

The Attributions of Responsibility and Blame Scales (ARBS) is a 40-item questionnaire, designed to provide a measure of the direction and intensity of attributions of responsibility and blame for child sexual abuse experiences. The items were designed to assess three directions of blame attributions; towards themselves, perpetrator, family member or another. This measure reports good internal consistency and construct validity.

- ***SCL 90 R - Symptom Checklist (Derogates, 1994)***

The SCL-90-R is a 90 item (each on a 5 point rating scale) self-report inventory, designed to measure a variety of psychological disturbances by reflecting the number of symptoms and perceived distress. The symptom scales specifically measure: somatisation, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. It has been validated for use as a screening instrument, and it is also widely used in clinical and research settings as an outcome measure. This instrument demonstrates very good construct validity, reliability, and utility.

9) Qualifications of the investigators to use the measures

The researcher is currently studying for the DClinPsy qualification at University of Wales, Bangor. Competence to administer measures will be assessed by the supervisors.

10) Venue for investigation

Participants may choose where to complete the questionnaires, since they complete them in their own time.

11) Estimated start date and duration of study

It is hoped that data collection will commence in October 2006 and the study will end following submission of the thesis in June 2007.

12) Data Analysis

The method of analysis appropriate for a group comparison study is a one-way analysis of variance. If following data collection, there is sufficient data to meet the criteria for a mediation model, and then further analysis may be conducted using one of the following possible options:

- i) Regression analysis
- ii) Structural equation modelling
- iii) Path analysis

13) Potential offence or distress to participant

There is a possibility that participants may be distressed by unpleasant memories of childhood trauma following completion of the questionnaire booklet. A *resources leaflet* (enclosed) will be distributed as part of the questionnaire pack that lists agencies where they may obtain help, or advice. Following ethical approval, this leaflet will be translated into Welsh and distributed bilingually.

14) Procedures to ensure confidentiality and data protection

All data collected will be anonymous to the researcher. Electronic data and hard copies will be protected in accordance with data protection procedures. At the end of the study, the data will be forwarded to the research supervisor for storage.

15) How consent is to be obtained

Written consent will not be requested, as this would violate confidentiality. Consent will be assumed by the participants' willingness to complete the questionnaires.

16) Information for participants

An *Information sheet* (enclosed) will be distributed as part of the questionnaire pack. This leaflet gives some information about the research, and clarifies the participant's rights.

17) Approval of relevant professionals

None required

18) Payment to participants, investigators, departments or institutions

UWB psychology student participants will receive print credits and course credits, or if they would prefer not to disclose their PSU number they may be awarded a £5.00 photocopy card.

19) Equipment required and its availability

No specialist equipment required.

20) Feedback to participants

Results of the study will be posted on the Intranet, which can be accessed by psychology undergraduates.

Appendix A

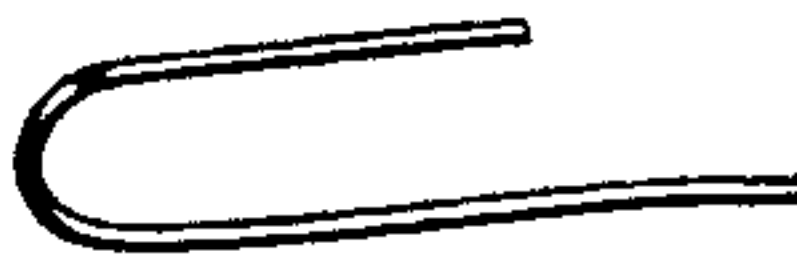
QUESTIONNAIRE BOOKLET

Please answer the questions in this booklet according to the instructions.

All responses are **completely anonymous and confidential.**

After completing the questionnaire, place it in the large envelope provided, seal it and return it to the administrative staff at the Wheldon desk. Remember to put your PSU number separately in the small envelope if you wish to claim print or course credits. If you prefer to claim a photocopy card instead of print and course credits, please hand in your sealed envelope containing the questionnaires to the administrative staff at the Wheldon desk, and ask for your photocopy card reward.

Third Party material excluded from digitised copy.
Please refer to original text to see this material.



Appendix B

Psychological distress in adulthood: the role of shame, self-esteem and blame**PARTICIPANT INFORMATION SHEET**

**Researchers: Dr Isabel Hargreaves, Dr Sarah Gregory, Karen Kemish
North Wales Clinical Psychology Programme**

Invitation

Female students only are being asked if they would like to volunteer for this study.

What is the purpose of the study?

The aim of this research is to look at factors that may be associated with the development of emotional difficulties in people with and without a history of sexual abuse.

Do I have to take part?

Taking part in this research is entirely voluntary. You can decline to take part by not filling in the questionnaires. However, due to the anonymity measures, once you have submitted your questionnaire, it cannot be withdrawn.

What does it involve?

You will be given a questionnaire booklet to complete. The booklet contains questions relating to problems you might be having at present and general feelings about yourself. The booklet also asks whether you experienced any sexual abuse during childhood, and if so, to answer some questions about your particular experiences and feelings. We realise that these are very sensitive and difficult issues but hope that the anonymity of the questionnaire will enable you to provide this valuable information.

The questionnaire will take approximately 20 - 30 mins to complete. After filling it in, place it in the large envelope provided, seal it and return it to the administrative staff at the Wheldon desk. In order to be awarded print and course credits for taking part in this research you will be required to submit a PSU number in a separate envelope to the one you have put your questionnaire into. If you prefer not to submit your PSU number, you may choose to receive a £5.00 photocopy card in lieu of print and course credits. If you prefer to receive a photocopy card, please hand in your sealed envelope containing the questionnaires to the administrative staff at the Wheldon desk, and ask for your photocopy card reward.

What are the possible benefits of taking part?

Providing and developing effective professional help for people with emotional difficulties, particularly those who have experienced childhood sexual abuse, forms a major part of my work as a clinical psychologist. The potential benefit of the research will be that therapeutic techniques may be developed and refined so that people can receive effective and appropriate help.

What are the possible side effects of treatment received when taking part?

No side effects have been identified.

What are the possible disadvantages or risks of taking part?

There is a possibility that participants may be distressed by unpleasant memories of childhood trauma following completion of the questionnaire booklet. A *resources leaflet* is enclosed as part of the questionnaire pack that lists agencies where you may obtain help, or advice. Please keep this leaflet so you can refer to it in the future.

What if something goes wrong?

The risks involved in taking part in this study are very small: however the study does have full insurance cover in the unlikely event you think you have been harmed in some way.

Will my taking part on the study be kept confidential?

Your responses will be completely anonymous and confidential and no names are recorded during the research. The study has been designed in such a way that it will not be possible to identify you.

What will happen to the results of the research study?

The results of the study may be published in a scientific journal. Please be assured that you will not be identified in any report or publication.

Further Information

Third Party Material excluded from digitised copy.
Please refer to original text to see this material.

My supervisors are Dr Isabel Hargreaves and Dr Sarah Gregory. Dr Isabel Hargreaves can be contacted by telephone: 01248 382204.

If you decide to take part, please keep this information sheet, and the 'helpful resources' leaflet that is enclosed with the pack, so you can refer to it in the future.

If you have any complaints about the conduct of the study these should be addressed to Dr Richard Hastings, (Acting Head of School), School of Psychology, University of Wales - Bangor, Bangor.

Thank you for taking the time to read this information sheet.

Psychological distress in adulthood: the role of shame, self-esteem and blame**PARTICIPANT INFORMATION SHEET**

**Researchers: Karen Kemish, Dr Isabel Hargreaves and Dr Sarah Gregory
North Wales Clinical Psychology Programme**

Invitation

Female students only are being asked if they would like to volunteer for this study. Students who participate will be given the opportunity of entering a £50.00 prize draw.

What is the purpose of the study?

The aim of this research is to look at factors that may be associated with the development of emotional difficulties in people with and without a history of sexual abuse.

Do I have to take part?

Taking part in this research is entirely voluntary. You can decline to take part by not filling in the questionnaires. However, due to the anonymity measures, once you have submitted your questionnaire, it cannot be withdrawn.

What does it involve?

You will be given a questionnaire booklet to complete. The booklet contains questions relating to problems you might be having at present and general feelings about yourself. The booklet also asks whether you experienced any sexual abuse during childhood, and if so, to answer some questions about your particular experiences and feelings. We realise that these are very sensitive and difficult issues but hope that the anonymity of the questionnaire will enable you to provide this valuable information.

The questionnaire will take approximately 20 - 30 mins to complete. After filling it in, place it in the A5 envelope provided, seal it and return it to the researcher as directed. If you wish to be entered into the £50.00 prize draw please remember to write a contact telephone number (do not write your name) on the prize draw slip and seal it in the smaller envelope separate to the one you have put your questionnaire into. You will only be contacted if you win.

What are the possible benefits of taking part?

Providing and developing effective professional help for people with emotional difficulties, particularly those who have experienced childhood sexual abuse, forms a major part of my work as a clinical psychologist. The potential benefit of the research will be that therapeutic techniques may be developed and refined so that people can receive effective and appropriate help.

What are the possible side effects of treatment received when taking part?

No side effects have been identified.

What are the possible disadvantages or risks of taking part?

There is a possibility that participants may be distressed by unpleasant memories of childhood trauma following completion of the questionnaire booklet. A *resources leaflet* is enclosed as part of the questionnaire pack that lists agencies where you may obtain help, or advice. Please keep this leaflet so you can refer to it in the future.

What if something goes wrong?

The risks involved in taking part in this study are very small: however the study does have full insurance cover in the unlikely event you think you have been harmed in some way.

Will my taking part on the study be kept confidential?

Your responses will be completely anonymous and confidential and no names are recorded during the research. The study has been designed in such a way that it will not be possible to identify you.

What will happen to the results of the research study?

The results of the study may be published in a scientific journal. Please be assured that you will not be identified in any report or publication.

Further Information

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My supervisors are Dr Isabel Hargreaves and Dr Sarah Gregory. Dr Isabel Hargreaves can be contacted by telephone: 01248 382204.

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If you have any complaints about the conduct of the study these should be addressed to Dr Richard Hastings, (Acting Head of School), School of Psychology, University of Wales - Bangor, Bangor.

Thank you for taking the time to read this information sheet.

Appendix C

Helpful Resources

Student Services Centre

01248 382024

Student Services are located on 3rd and 4th floor of the Student Union building. They are open 9am –5pm, and are able to advise on any problems you may be experiencing, including issues relating to mental health.

Student Counselling Services - Bangor

01248 382024

A professional Student Counselling Service is available to UWB students. They are based in the Glanrafon Flat behind the Students Union building, and are open 9am-5pm. There is also a student health nurse who can make home visits (tel 01248 383022).

Nightline – Bangor

01248 362121

Nightline is a service run by students for students. Two trained volunteers are on duty from 8pm – 8am to provide a listening service and respond to queries. Students can telephone, or call into their office which is situated above the launderette near the Neuadd Rathbone.

North West Wales Rape & Sexual Abuse Helpline

01286 669266

The rape and sexual abuse support centre offers a helpline, counselling and practical support to anyone (over 14yrs) who has been affected by sexual violence, whether recently or in the past. Helpline open 9am-5pm Mon-Fri, and 7pm-9pm Mon, Wed, Thurs and Sun evenings. Email: rasa@btconnect.com

GP Services Bodnant Medical Centre

01248 364492

Bodnant Medical Centre provides services for students that are not normally available in general practice. Nurse-led student health clinics are held from 12.00pm - 4pm (female doctors are also available during these times) and 3.30pm - 6pm each weekday, and students may attend without an appointment. These facilities are available to all students regardless of their registered practice.

Community Mental Health Team - Bangor

01248 370137

The Arfon Community Mental Health Team is available 9am – 5pm Monday to Friday. It offers a service to people who have severe mental health problems. This service is usually accessed via the G.P.

Samaritans - Bangor

01248 674985

The Samaritans provide a listening service (open 24hr) to people who are experiencing difficulties, are isolated, depressed or suicidal, and feel that they have no one to turn to.

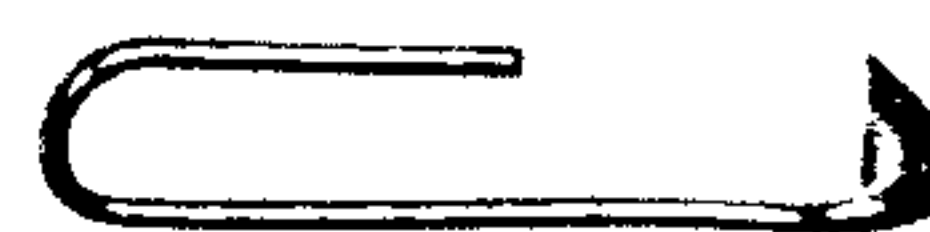
Stepping Stones

01978 352717

The main office is open 9 -12 Mon – Fri. Trained counsellors provide therapeutic services, on an individual or group basis, to adults who were sexually abused as children. There have a range of locations around North Wales.

Appendix D

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Please refer to original text to see this material.



Appendix E

SCHOOL OF PSYCHOLOGY ETHICS AMENDMENT REQUEST FORM

[To be used to request Ethics Committee approval for non-trivial modifications to a previously approved research project.]

Date: 4th December 2006

Title of project: **Psychological distress in adulthood: the role of shame, self-esteem and blame**

School Ethics Approval number: **881**

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Please refer to original text to see this material.

N.B. If you wish to amend your currently approved procedure to do one or more of the following:

- a) Pay participants;
- b) Work with children or other vulnerable populations (i.e. patients, people in custody, physically vulnerable adults, people engaged in illegal activities, people with learning or communication difficulties);
- c) Deliberately mislead participants;
- d) Utilise procedures that carry a realistic risk of participants experiencing physical or psychological distress or discomfort
- e) Work with animals;

AND your previous approval was based on there being no significant ethical implications of the research (i.e. you ticked box A on the original ethical approval form), then you will need to complete a new ethical approval form and give all the information required in Box B.

PLEASE DO NOT USE THIS FORM.

Please describe the nature of your amendment(s) in the box below (and on a separate sheet if necessary):

I would like to apply for permission to recruit additional female student participants from other second and third level educational facilities (eg School of Nursing and Tertiary Colleges) in and around North Wales. As an incentive to participate I would like to offer voluntary entry into a £50.00 prize draw. To facilitate this, it will be necessary for participants to write a contact telephone number (but no name) onto a separate prize draw slip, which will be submitted separate to the completed questionnaire. The participant will only be contacted if they win. It will not be possible for the researcher to make any link between the submitted questionnaires and the participant's identity and therefore anonymity is maintained.

Please consider carefully whether the amendment(s) to your research will affect the following:

		YES	NO	N/A
1	Participants' ability to give informed, voluntary consent		√	
2	Participants' ability to voluntarily withdraw from the research		√	
3	In questionnaire-based studies, participants' option to omit questions		√	
4	Maintenance of confidentiality of participant data		√	
5	The ability to give a full participant debriefing			√
7	Risks to participants, investigators, or the institution		√	

If you have answered "yes" to any of the questions above, please provide a full explanation on a separate sheet. There is an obligation on the lead researcher to bring to the attention of the Ethics Committee any further ethical implications not clearly covered by the above checklist.

- If you intend to use additional questionnaires, please attach copies.
- If the nature of your request entails changes to consent/debriefing information, please attach the amended documents.

Signed (Chief investigator/supervisor):

Signed (Associate investigator(s)/student(s):

Appendix F

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Section 2: Literature Review

Running head:

PSYCHOLOGICAL DISTRESS IN ADULT SURVIVORS OF CSA: SHAME, SELF-ESTEEM AND BLAME

Psychological Distress in Adult Survivors of Childhood Sexual Abuse: The Role of Shame, Self-esteem and Blame

Karen Kemish*

School of Psychology

University of Wales, Bangor, UK

Correspondence should be addressed to Karen Kemish, North Wales Clinical Psychology Programme, University of Wales, Bangor, Gwynedd, LL57 2DG

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Please refer to original text to see this material.

Abstract

There is a wealth of research suggesting that individuals who report a history of childhood sexual abuse (CSA) are more likely to develop a range of psychological difficulties in adulthood than those who report no such experiences. However, the causal mechanisms that underlie these associations are still not well understood. That feelings of shame, responsibility, and low levels of self-esteem are commonly found in presentations of psychological distress in female survivors may implicate these characteristics as mediating risk factors in the sequelae of CSA. This review outlines the existing knowledge of CSA, including prevalence rates and relationship with psychopathology. The possible roles of shame, self-esteem and attributions of blame as mediating risk factors for psychopathology following CSA are then explored. In conclusion, although there are a variety of compelling models implicating these variables as likely mediators, further empirical investigation is required.

Psychological Distress in Adult Survivors of Childhood Sexual Abuse: The Role of Shame, Self-esteem and Blame

There is a wealth of research within the field of childhood sexual abuse (CSA) that suggests an association with psychological problems in adulthood. It has been proposed that many survivors of CSA experience a wide range of mental health difficulties in adult life, including: depression (Andrews, 1995) and anxiety (Levitan, Rector, Sheldon & Goering, 2003); post-traumatic stress disorder (Lee, Scragg & Turner, 2001; Wisdom, 1999); and, psychosis (Read, van Os, Morrison & Ross, 2005). However, the mechanisms that underlie the proposed association between CSA and psychopathology are still not clear. For example, why should one person with a reported history of CSA go on to develop psychological difficulties when others do not? The clinical presentations of individuals who experience psychological problems and report a history of CSA have been reported to frequently reveal high levels of shame, reduced self-esteem and a tendency to take on feelings of responsibility for the abuse (Whiffen & MacIntosh, 2005). It is possible that characteristics such as these act as mediating risk factors for psychopathology following CSA. The aim of this review is to examine the CSA literature and, using this knowledge as a foundation, to then explore the features of shame, self-esteem and blame with the following aims: (i) to gain a more coherent account of how such mechanisms might underlie the suggested association between CSA and psychopathology; and, (ii) to critically appraise some of the available models implicating these variables as mediators.

In order to achieve these aims, the reported prevalence rates of CSA for the general population are first reviewed. Following this, the evidence that CSA leads to psychopathology is considered, with specific examples from depression and anxiety,

PTSD, and psychosis. As with any clinical phenomena, there will be a significant variety of mechanisms that underlie the association between CSA and psychopathology and this review does not provide a systematic examination of all factors identified thus far in the literature. Instead, a decision was made to focus specifically on the role of shame, self-esteem and blame because: (i) they are clinical phenomena that are common to a range of psychological disorders (Gilbert, 2006); (ii) they appear to be widely observed in the clinical presentations of adult survivors of CSA (Whiffen & MacIntosh, 2005); and, (iii) they are implicated by findings concerning the impact of abuse-related factors (e.g., relationship to the perpetrator) on the development of psychopathology following CSA (Steel, Sanna, Hammond, Whipple & Cross, 2004).

However, before reviewing the literature as outlined above, the method by which the systematic elements of this review were conducted is first described, followed by a discussion of pertinent methodological issues related to CSA research.

Method

Search Strategy and Selection Criteria

In accessing the literature presented in this review, the following electronic databases were searched: PsycARTICLES, PsychINFO, and ISI Web of Knowledge; between 1990 – 2007.

In examining prevalence rates the search was conducted using the following terms: “childhood sexual abuse”; “prevalence”; and, “general population” or “community sample”, with the aim of including samples from as wide a cultural and geographical distribution as possible. In addition, the reference lists of all obtained studies were read to locate additional studies and these highlighted some older publications which were also included. A total of 26 studies were examined. No age

limit was imposed and some studies did include prevalence rates for adolescents, but generally few for children under the age of 16. Studies were included that used university student populations but more discrete population samples, such as incarcerated males, were excluded. One study was excluded because it was only available in Slovakian; another study was excluded because it provided figures for sexual abuse within the context of ritualistic abuse. In total 13 studies from peer-reviewed journals were included and are described later in this review.

In identifying the types of psychopathology emerging in adulthood that have been linked to experience of CSA the following terms were used: “childhood sexual abuse”; “adults”; and, “psychological distress”, or “psychopathology”, or “mental health”. The reference lists of all obtained studies were read to locate additional studies. This search yielded a total of 47 studies from peer-reviewed journals. Studies were excluded that: did not differentiate between different types of abuse; did not clearly define CSA; were review papers or meta analyses (however, a meta analysis was later identified that highlighted evidence suggesting CSA and psychological distress were not associated, but this paper will be discussed later); was not focused specifically on therapeutic outcome or service provision or consisted of only theoretical discussion (including letters of response). In total 24 studies were identified that provided evidence for an association between a CSA and a defined disorder or difficulty in adulthood; these are reported later in this review.

Methodological Issues

Defining CSA.

Numerous attempts have been made to provide a definition of child sexual abuse that is both accurate and acceptable. The American Psychological Association (2001) put forward a definition that is more inclusive than many previously proposed:

A central characteristic of any abuse is the dominant position of an adult that allows him or her to force or coerce a child into sexual activity. Child sexual abuse may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include non-contact abuse, such as exposure, voyeurism, and child pornography. Abuse by peers also occurs (APA, 2001).

Researchers such as Ainscough and Toon (2000) suggest that this definition incorporates the most significant elements of CSA: the betrayal of trust and responsibility; the abuse of power; the wide range of sexual activity that may be involved in abuse; and, the use of force and/or threats by the abuser. Although this definition fails to acknowledge the possibility of the victim's perception of threat surrounding the abuse, it may provide a useful definition for clinical use. However, many CSA studies often use different definitions and combinations of characteristics in their definitions, these include: intercourse, masturbation, exposure, voyeurism, pornography, the use of threats or force, and ages of perpetrator and victim. In addition, some researchers simply use the legal criteria in place within their country (e.g., Helweg-Larsen & Larsen, 2002). Finally, many definitions of CSA still fail to include experiences where the child is subjected to exposure, voyeurism or pornography (Sgroi, 1982; cited in Hall & Lloyd, 1993).

Inconsistent use of definition may create wide variations within results. For example, it is possible that using a broader definition that encompasses all of the above characteristics of sexual abuse may yield results that suggest a smaller incidence of psychopathology following sexual abuse; or, studies using only intercourse as the criteria may result in a higher incidence of psychopathology following sexual abuse.

Thus, issues of definition make it difficult to confidently compare results across studies. Researchers should also be mindful that race, cultural differences and geographical locations may affect the criteria used in CSA definition which may also influence findings.

Sampling issues.

Numerous difficulties are related to the populations used for research and whether the chosen sample is representative of the general population (Kazdin, 2003). For example, due to concerns over anonymity it may be that certain “types” of people are more likely to agree to participate in studies of sensitive topics, whereas others will avoid any such exposure, resulting in a skewed sample. Ethical considerations mean that many participants in CSA research are self-selected and it is not possible to determine whether the respondents were more or less distressed, and/or had different cognitions surrounding their abuse than those who chose not to participate.

There is a predominance of research studies within the CSA literature that have used female samples. This might be because CSA occurs more often in females or that females are more likely to report incidences of CSA (as reflected by the prevalence rates reported later in this review). For whatever reason this occurs, this skew in sampling may restrict generalisability to male populations and this may ultimately impede improvements in clinical practice with males who have been sexually abused.

Whether to use clinical or non-clinical samples is also an issue. As survivors of CSA, non-clinical participants tend to be easier to access but they may not be experiencing the psychopathology of interest. Researchers are only able to infer that findings from non-clinical samples are relevant to clinical ones, and receiving (or not receiving) professional help may affect responding and influence associations between variables under investigation. For example, some research evidence suggests that

clinical populations may display a confirmatory bias and it is also possible that they may also over-emphasise their difficulties (Rind, Tromovitch, & Bauserman, 1998).

Research findings from legal samples (e.g., those who have been identified by police authorities as being victims of the crime of CSA) may not be generalisable to the general population as some research suggests that they tended to exhibit more psychological distress (Constantine, 1981).

Measuring and reporting CSA.

There may be difficulties in measuring experiences like CSA distress because of the subjective nature of the experience. One survivors' experiences and the resulting sequelae is likely to be considerably different due to a number of variables, these may include their cognitions about the abuse and the context in which the abuse occurred (Steel et al., 2004). Therefore, it is difficult to comment on whether abuse involving intercourse is in fact the most severe form of abuse and that this is the type of abuse that will cause the most distress.

The majority of CSA studies are often restricted to the use of uncorroborated self-report retrospective measures. This is contentious given the controversy surrounding survivors' memory of traumatic events (Steel et al., 2004). Although questionnaire survey is often an effective way of yielding a larger number of responses, it relies on people being able to recall past events with accuracy. Given that this is an emotive topic, responses may be subjective, and some under or over-reporting may be expected.

It may also be difficult to make comparisons across CSA studies because of the diverse range of psychometric assessments, some of which may be novel or have poor psychometric properties, which are used to assess CSA and its sequelae. Individual interviews may provide more accurate and comprehensive data and information (other

than CSA) that may be influential in the development of psychopathology; however, this method of data collection can be time consuming.

There is some evidence to suggest that different forms of abuse (e.g., sexual, physical and neglect) frequently co-occur and give rise to similar psychopathology in adulthood (Wisdom, 1999). Disentangling the effects of different forms of abuse may not be possible and this may present challenges for researchers. In addition, it may be that studies measuring CSA will only ask about CSA experiences and information on other forms of abuse which may also impact on results may be neglected.

Research designs.

CSA research presents a challenging area of study; in addition to CSA, similar to other mental health problems, there will be numerous issues that may influence the emergence of psychopathology in adulthood. Research evidence (Barker-Collo, 2001; Steele et al., 2004) suggest that a number of key factors are of particular relevance to CSA outcome, these include: the characteristics (i.e., the type of, and context) of the CSA; family dynamics and support; coping strategies; childhood development and attachment difficulties; the presence of physical or emotional abuse; and, any emerging psychological difficulties from time of disclosure to adulthood. One of the key difficulties is that individuals with a history of CSA cannot be randomly assigned because a history of sexual abuse is a fixed marker that cannot be changed. Therefore, longitudinal research may be the most effective way of researching CSA and its sequelae, producing the most coherent account of causality.

Further advantages of longitudinal research include: flexibility, the elimination of long-term retrospective reporting and the use of consistent measures throughout. Unfortunately, continual assessment of a group of individuals over a long time period (i.e., from child to adulthood) is often unfeasible and impractical in terms of cost; in

addition, participants may lose interest in the study and withdraw consent to participate over the course of time.

An alternative design frequently employed in CSA research is cross-sectional study; this takes place in a single place in time. However, although this is potentially a more cost effective and easy to manage design, it only allows the researcher to make inferences regarding association rather than causality. Cross sectional designs may make it difficult to control for particular biases, such as responder bias during retrospective reporting of incidents in childhood.

Mediation studies are increasingly used in CSA research because they allow associations to be broken down into components that reveal causal mechanisms, rather than correlational associations that are unable to infer causation. The criteria laid down by Baron and Cohen (1986) for mediation require that measurement takes place at different time points because mediation consists of causal processes that unfold over time. Unfortunately, due to the difficulties in collecting information over a long time period, most empirical tests of mediation use cross-sectional data and the strict rules of mediation are not always adhered to (Whiffen & MacIntosh, 2005). This practice prevents researchers from assessing the effects of CSA over time and makes it more difficult to look at the specific effects following CSA. Mediation studies often fail to account for such moderating variables as family support, individual resilience, or greater emotional intelligence, and these may be crucial in the development of, or protection against, adult psychopathology.

The methodological issues outlined above need to be born in mind when considering the research findings presented in the CSA literature reported in the following sections of this review.

Prevalence of CSA

Research suggests that CSA remains an under-reported but significant problem that spans countries and cultures (Sapp & Vandeven, 2005). Prevalence rates vary across studies; however, a recent study by the National Society for the Prevention of Cruelty to Children (Creighton, 2004) suggested that 16% of all children under 16 have experienced some form of sexual abuse. Cawson, Wattam, Brooker and Kelly (2000) used random sampling methods to recruit young people 18-24 years old. With a response rate of 69%, they recruited a community sample of 2,869 participants who were accessed via UK postcode address files. Their study, that used computer assisted personal and self-interviewing techniques indicated CSA prevalence rates of 21% for females and 11% for males.

A study by McGee (2003) in Ireland used random sampling of the general population of 3,118 men and women. They had a 71% response rate and following telephone interviews they recorded a 30.4% female and 23.6% male CSA prevalence rate.

Fergusson, Lynskey and Horwood (1996) studied a large ($N = 1,019$) adult community sample of males and females from New Zealand. With a response rate of 81%, they conducted face-to-face interviews and found that 17.3% of the women and 3.4% of the men reported a history of CSA.

In Denmark, a general population study examined the perceptions of early sexual experiences of over 5,800 participants. A 73% response rate was reported, and 11% of Danish adolescents aged 15-16 years old were reported to have had sexual experiences which were defined as unlawful according to the Danish Penal Code - no further explanation of Danish law and how it related to sexual abuse was provided (Helweg-Larsen & Larsen, 2002).

Two general population studies from the United States that used similar CSA criteria found that prevalence rates varied only slightly between states. In Boston 8,089 participants were recruited and an 82.4% response rate was reported; the females reported a 13.5% CSA rate and the males reported 9% (Molnar, Buka & Kessler, 2001). In Los Angeles 1,409 women were recruited with a response rate of 69%; 15% had experienced CSA (Briere & Runtz, 1988). A similar study conducted by Briere and Elliott (2003) included male participants. From their sample of 1442 adult participants they obtained a 64.8% response rate; 32.3% of females and 14.2% of males had experienced CSA. Finally in the States, using a smaller community sample of 497 adult women, Anderson et al. (1993) found 1 in 3 participants reported an unwanted sexual experience before age 16 years. They used questionnaire and face-to-face interviews and reported no response failure, variables that perhaps accounted for their slightly higher rates.

A large survey conducted in Canada reported female prevalence rates of 12.8% and 4.8% in males. This was based on a community sample of people over 15 years old with a response rate of 66% (MacMillan et al., 1997). This finding contrasts with an earlier Canadian study (Badgley, 1991) that examined CSA in 750 women aged 18-27 years; using questionnaire measures they found a prevalence rate of 32%.

In Australia, Fleming (1997) reviewed data collected from a larger cross-sectional study concerning the relationship between CSA and alcohol abuse where participants were 710 adult women randomly selected from Australian federal electoral rolls. A 20% CSA prevalence rate was identified.

CSA prevalence rates from a high school in Ethiopia showed the highest rates at 68% (Worku, Gebremariam & Jayalakshmi, 2006). However, their criteria for CSA

included verbal harassment and this accounted for a 51% prevalence rate. Alternatively, their rate for sexual intercourse on its own was still substantial at 18%.

In summary, with a response rate range of 64.8% to 100%, reported CSA prevalence rates range from 12.8% to 32.3% for females and 3.4% to 23.6% for males. However, as previously highlighted, the variation seen in these prevalence rates may reflect differences in how CSA is defined, the sample used, and the methodology employed.

CSA as a Risk Factor for Psychopathology

The earliest model of CSA, named the “Seduction Theory” (Freud, 1955), was presented by Freud in 1896. Initially, Freud suggested that the “hysterical and neurotic” symptomatology presented by his patients was caused exclusively by repressed memories of early traumatic experiences. However, in the face of opposition from colleagues, Freud abandoned this model in favour of the belief that his patients’ memories were the result of internalised infantile fantasies that re-emerged in adulthood (Smart, 2000). Although Sandor Ferenczi took up Freud’s original theory in 1933, he suggested that childhood trauma, and especially sexual trauma, could not be over-estimated as a pathogenic factor (Ferenczi, 1949; Myers, 1996). Smart (2000) suggests that the dismissal of Freud’s original theory left a legacy of scepticism towards CSA and maintained attitudes of disbelief towards disclosure that have had a profound influence on contemporary perceptions.

However, over the past two decades clinical interest in the potential link between CSA and adult distress has increased as it has emerged that significant numbers of females who were accessing psychiatric services also reported a history of CSA. For example, in examining the prevalence of reported CSA experiences in female psychiatric inpatients, Briere and Zaidi (1989) report rates of 44%. Acknowledgement

of the potential impact of CSA on mental health is now mainstream; for example, a recent document from the Department of Health (Itzin, 2006) cites a history of CSA as a risk factor¹ for developing a wide range of psychopathology.

In order to clarify the current picture concerning the proposed long-term effects of CSA, the CSA literature was examined using the criteria outlined earlier in the Method section of this review. The range of psychological disorders proposed to be associated with CSA is extensive and the problems not mutually exclusive, they include:

depression (Andrews, 1995; Cheasty, Clare & Collins, 1998; Levitan et al., 1998; Gibb, Chelminski & Zimmerman, 2007); anxiety (Levitan et al., 2003; Gibb et al., 2007); post-traumatic stress disorder (Wisdom, 1999; Lee, Scragg & Turner, 2001); dissociative disorders (Bloch, 1991; Coffey, Leitenberg, Henning, Turner & Bennett, 1996); self-harm (Barker-Collo, 2001; Dube et al., 2005; Joiner et al., 2007); psychosis and related phenomena (Read, Agar, Argyle & Aderhold, 2003); sexual dysfunction (Kinzl & Biebl, 1994); and, eating disorders (Steiger & Zanco, 1990). In addition, CSA has been linked to adult interpersonal problems (Cole & Putnam, 1992; Hill, Gold & Bornstein, 2000; Dube et al., 2005); revictimisation (Messman-Moore & Long, 2003); HIV-risk taking behaviours (Bensley, van Eenwyk & Simmons, 2000); alcohol and drug abuse (Mullen et al., 1993; Bensley et al., 2000); and, medical problems (Lechner, Vogel, Garciashelton, Leichter & Steibel, 1993; Nurse, Garcia-Moreno, Phinney, Butchart & Clarke, 2005).

In the following section the evidence provided by the studies that propose a link between CSA and adult experiences of depression and anxiety, PTSD, and psychosis is evaluated. It was decided to focus in on the evidence related to these disorders because: (i) they are reported to be amongst the most common referrals in adult mental health

¹ A risk factor is described as a fixed marker or attribute that cannot be changed.

(Itzin, 2006); and, (ii) the department of health lists them as the top three long-term mental health difficulties that occur following a history of childhood sexual abuse (Itzin, 2006).

Depression and Anxiety

Andrews (1995) examined bodily shame, CSA and depression in a community sample of 101 British women (of whom 12% reported experiences of CSA). Qualitative interviews and reliable measures of depression were used to gather information on the participant's experiences of depression, CSA and psychiatric history. Despite the relatively small numbers, results suggested that CSA was strongly associated with depression, but specifically with chronic and recurrent depression rather than general depression or single episodes. Andrews acknowledged that other biographical and situational influences and cognitive factors that were not accounted for in her study are likely to play a part in this relationship between early CSA and depression. Although the longitudinal design used in this study was a strong point, it was restricted by the definition used for CSA which only included contact abuse; this may have precluded a whole range of survivors who had experienced types of abuse which may, or may not have been equally as damaging psychologically.

A Government funded research study in Canada (Levitan et al., 2003) used a multi-stage sampling design to recruit 6,597 community participants to assess CSA and its relationship to anxiety and depression. CSA was assessed using a self-report questionnaire that had been used in previous studies (MacMillan et al., 1997; Levitan et al., 1998). They also used The World Health Organization Composite International Diagnostic Interview; this is a structured interview designed to assess mental health disorders from the DSM-III-R and ICD-10, and has shown good reliability and validity (Kessler et al., 1994). In comparison to controls, they reported a marked association

between participants with a history of CSA and co-morbid depression and anxiety. The authors suggest that their use of a community sample helped avoid possible bias associated with clinical samples, but they do not state whether they assessed for bias in their community sample (e.g., over-reporting). They acknowledged that theirs, like most other studies, relied on retrospective reporting which as previously discussed may potentially be problematic. Additionally, important in terms of measurement and reporting of CSA as discussed earlier, anxiety and depression are believed to have a marked impact on accurate recall and memory (Steel et al., 2004).

PTSD

A prospective study in the U.S. (Wisdom, 1999) examined the extent to which CSA and neglect increased the risk of developing PTSD. A cohort of children ($N = 676$) who had been through the legal system following experiences of abuse and/or neglect between 1967-1971 were followed-up into adulthood. These children, as adults, were compared with a non-abused group ($N = 520$) who were identified and matched (using birth records) on the basis of gender, ethnicity and familial socio-economic status. The participants were located and interviewed; they were also assessed for PTSD using the National Institute of Mental Health Diagnostic Interview Schedule (Robins, Helzer, Cottler & Golding, 1989). This diagnostic tool is reported to closely follow the format of the DSM-III-R, and is described as having acceptable reliability and validity (Robins, Helzer, Cottler & Golding, 1989). Results showed that of the children who had been sexually abused 37.5% met DSM-III-R criteria for PTSD. This was higher than for participants who had experienced physical abuse (33.7%) or neglect (30.5%), and it compares with 20.4% in the control group who reported no history of abuse.

These results appear to suggest that CSA increases the risk of developing PTSD in adulthood. However, the failure to request a trauma history was a recognised limitation

of this study and raises questions as to whether the PTSD developed as a result of the CSA or a another subsequent event. This study also failed to use distinct groups based on type of abuse and therefore it is not clear whether multiple forms of abuse may also have been a factor in the development of PTSD.

Psychosis

Research into psychosis and its possible associations with CSA is a comparatively new area. A study by Read et al. (2003) examined medical data from 200 community mental health clients in New Zealand. They clinically evaluated the characteristic symptoms of schizophrenia that are listed in DSM-IV: hallucinations, thought disorder and delusions. Read et al. (2003) compared 92 clients whose files documented sexual or physical abuse that had occurred at some point in their lives, with 108 for whom no abuse was documented. Psychosis was found to be significantly more common in the abused group than in the non-abused group. Sixty of these clients reported a history of CSA; this was found to be a significant predictor of hallucinations (even without the additional presence of any adult abuse).

In order to explore the relationship between CSA and more serious mental illness like psychosis, and specifically schizophrenia, Read et al. (2005) reviewed 46 studies. They looked at abuse prevalence in a clinical population of women in New Zealand who had a diagnosis of serious mental illness (diagnoses included: schizophrenia, bipolar disorder, schizoaffective disorders, PTSD and borderline personality disorder; over half also had a diagnosis of psychosis). The review included studies conducted with children, adolescents and adults. They found that 48% reported a history of CSA. The authors' concluded that CSA (and child physical abuse) appeared to be a causal factor for developing psychosis and schizophrenia and, more specifically, for hallucinations, particularly voices commenting and command hallucinations. They raised the issue of

reliability of self-reported history of abuse but highlight the previous study (Read et al., 2003) where the abuse histories had been corroborated through a review of medical records. Concerns have been raised about the overlap between the diagnostic constructs of disorders like schizophrenia, PTSD, dissociative disorders and borderline personality disorders that may all present with flashbacks, trauma memories or hallucinations, and which then may be incorrectly categorised. Given that CSA has also been linked with these other disorders, perhaps it is valid to ask why, following CSA, do some people develop PTSD for example, while others go on to develop psychosis? Such issues require further research.

Although this review provides some evidence for links between CSA and psychosis, many of these studies are limited because the CSA history is usually disclosed following the emergence of the psychosis disorder. Questions remain as to the veracity of CSA memories in people who experience hallucinations and delusions. Regardless of this issue, further study is required to clarify whether CSA is a causal factor in the development of psychosis.

CSA as a Risk Factor for Psychopathology: A Note of Caution

Although there are many studies that provide evidence to suggest an association between CSA and psychopathology one must view this evidence with some caution and remain mindful of the “bottom drawer phenomenon” (Kazdin, 2003); where often those studies that have found no significant effects go unreported. In addition to the many methodological difficulties evident in CSA research as described earlier, there may be a range of other factors that impact on research findings but also influence the long-term outcome following CSA.

Rind et al. (1998) suggest that many lay people and professionals believe that CSA causes intense harm, and is pervasive in the general population. A meta-analysis of

59 student-based studies was carried out to investigate these beliefs. Their review highlighted concerns about the scientific validity of the terminology used in some of the studies. The example they use is a failure to distinguish between situations of abuse, for example abuse as harm done to a child or adolescent (e.g., the rape of a 5-year-old) and abuse as a violation of social norms (e.g., the willing sexual involvement of a 15 year old adolescent with an unrelated adult). They suggest that the first involves a clear violation with implications for serious harm, while the latter may represent a violation of social norms with little risk of serious harm. These issues are controversial but they highlight the importance of consistent terminology and definitions.

The results from this meta-analysis revealed that students with a history of CSA were, on average, only slightly less well-adjusted than controls, but that family environment explained more of the adjustment variance than CSA itself. When studies controlled for family environment, the association with CSA became non-significant. The authors acknowledged concerns in using student populations to represent the general population suggesting that: abused students may be too young for symptoms to have emerged, or that students may typically experience less severe forms of CSA and therefore are less harmed, or better able to cope with their experiences than other people in the general population with a reported history of CSA (Rind et al. 1998).

Rind et al. (1998) suggest that clinical samples may be subject to biases arising from: patients searching for a cause for their problems and being more likely to recall events that can be classified as CSA. In addition, investigator expectancies may also occur when clinicians believe that CSA is the likely cause of patients' difficulties thus increasing confirming bias. They also suggest that clinical and legal samples will contain complex cases that are less likely to be found in the general population. Such

issues compromise external validity as they cannot be assumed to be representative of the general population.

In summary, research into the long-term effects of CSA in clinical and general populations has generally found greater levels of psychopathology in individuals who report a history of CSA, than those without. However, there are methodological factors that might impact on the reliability of these findings and evidence of association should always be considered with this in mind.

Mechanisms Proposed to Underlie the Association Between CSA and Psychopathology

Abuse Related Factors Implicated in the Development of Psychopathology

Steel et al. (2004) thought that a number of abuse-related factors may influence the development of psychological sequelae of CSA. Steele and his colleagues examined abuse-related characteristics, psychopathology, coping strategies and attributional style in an adult sample of 285 male and female participants (33% of whom reported CSA). Participants were drawn from the community, from outpatient, and from inpatient clinics. Steel and his colleagues designed the Sexual History Questionnaire to obtain demographic and abuse-related characteristics; psychological distress was assessed using the Symptom Checklist-Revised (SCL-90-R) (Derogatis, 1983); attributional style was assessed with the Attribution Style Questionnaire (Peterson et al., 1982); and the Ways of Coping Questionnaire-R (Lazarus & Folkman, 1984) was used to assess coping strategies. The participants who reported a history of CSA reported higher levels of psychological distress compared to those who did not, and some of the subscales from the SCL-90-R indicated an association between CSA and psychological symptoms in adulthood.

Steel et al.'s findings suggested that the following abuse-related factors were all associated with negative long-term sequelae in adulthood: perpetrator-victim relationship (e.g., father-child); the use of force and resistance; age of onset, and participation and frequency of abuse. They suggested that the longer the duration of the abuse, and having a larger number of offenders may be implicated with increased psychological distress in adulthood. Poorer coping skills were also associated with a reported history of CSA, as were internalisation of blame for the abuse. Based on their findings, they inferred that people who have experienced enduring sexual abuse develop negative long-term sequelae in adulthood; they find it harder to trust people; have poorer coping skills, and an inability to access social support. In addition to the cross-sectional analysis used in this study, regression equation modelling was also used to analyse the data; this suggested that the abuse-related characteristics were related to adult psychological distress through the mediation of a number of coping strategies (e.g., accepting responsibility, confrontative coping) and attributions (e.g., internalising blame). Despite the Sexual History Questionnaire being a novel measure it appears to have been comprehensive in defining CSA. A limitation of the study may be that the CSA sample from both the community and from the clinical population were used to explore the mediating factors.

The findings that some abuse-related characteristics are associated with adult psychological distress through the mediation of specific attributions or coping strategies, may explain some of the inconsistent findings reported in previous studies regarding the relationship between abuse-related characteristics and the emergence of psychological distress in adulthood.

In an attempt to understand the mechanisms by which CSA and psychopathology

might be associated, Whiffen and MacIntosh (2005) examined mediating risk factors² that had the potential to be causal risk factors³. They selected 19 mediation studies from between 1990-2003 and conducted a review to evaluate studies of possible mediators of CSA and adult emotional distress. They used the statistical procedure outlined by Baron and Kenny (1986) to establish mediation, this first required that an association was found between CSA and adult distress; that the potential mediator was associated with both the CSA and with the emotional distress; and, that when both CSA and the potential mediator were considered jointly as predictors of emotional distress, only the mediator should remain statistically significant.

Unfortunately, none of the studies had used the longitudinal designs that Baron and Kenny recommend but instead used cross-sectional designs. This rendered the direction of the effects ambiguous because it is possible that emotional distress may have had an impact on the mediator rather than vice versa. In addition to this methodological limitation, only 12 of the 19 studies met the remaining criteria for mediation recommended by Baron and Kenny (1986). Although these studies used samples drawn from a variety of sources some of the sample sizes were small; not all used standardised instruments; and, one of the studies used adult measures for an adolescent population. While the authors found an increasingly consistent approach to the criteria used for CSA, they queried the reliability of memory on self-report data that had been gathered retrospectively. The authors also questioned the assumption that it was CSA per se that was associated with emotional distress rather than with other related childhood risk factors such as a lack of protection and support, violence or family dysfunction.

² A mediating risk factor is one that explains the association between a risk factor (e.g., CSA) and an outcome (e.g., emotional distress in adulthood); thus, CSA and emotional distress may be linked (i.e., mediated) by factors like family environment or survivors' coping strategies).

³ A causal risk factor is a variable that can be changed, and when it is changed it alters the degree of risk (e.g., shame, low self esteem or blame).

However, despite the limitations identified, Whiffen and MacIntosh (2005) concluded that shame, self-blame, interpersonal difficulties, family environment, and coping played a part in mediating the link between CSA and adult emotional distress. The possible roles of shame, self-esteem and attributions of blame as mediating risk factors for psychopathology following CSA are explored in more detail in the final sections of this review.

Shame

Shame is a complex emotion that has been declared the “bedrock of psychopathology” (Miller, 1996, p.151) because of its increasing profile in the sequelae of CSA. While shame is an emotion common to most people, it remains difficult to define in simple terms. Gilbert and Andrews (1998) conceptualised shame first as a primary emotion in its own right, but also as occurring in combination with other emotions (e.g., anger). They suggest that individuals:

- i) experience shameful cognitions and beliefs about the self (e.g., feeling flawed, or perceived as inadequate by others);
- ii) employ behaviours and actions to cover the shame (e.g., hiding, concealing, or attacking others);
- iii) develop and use mechanisms like expressing shame as submissive behaviour;
- iv) experience shame through interpersonal dynamic relationships (e.g., those who are shamed and those who shame others).

In 2006, Gilbert & Procter refined their concept of shame in terms of threat processing, and distinguished between “internal” and “external” types of threat. External threats are those perceived to lie outside the self (e.g., the actions of others towards the self). Internal threats are suggested to relate to the emergence of internal

experiences (e.g., emotions, thoughts and feelings thought to negatively influence self-evaluation, self-identity, and self-presentations). In this way, they suggest that shame can be perceived both as a source of threat and as a response to it.

Shame and Compassion

Gilbert's (2006) recent work on shame with the Compassionate Minds Foundation was influenced by a biopsychosocial model that incorporates the role of an affect regulatory system. Gilbert's theory was derived from neuroscience research by Panksepp (1998). Panksepp (1998) proposed two distinct, but interacting positive affect systems that were operational in humans. The first he describes as the Dopamine-based seeking system associated with drive, vitality and achievement. This automatically driven system is suggested to be activated by emotions such as fear and excitement. The second system – the compassionate system – is suggested to involve the stimulation of the neurohormones oxytocin and opiates, and is believed to be associated with affection, soothing, safeness and contentment (Panksepp, 1998; Uväs-Morberg, 1998; Depue & Morrone-Strupinsky, 2005). This system is thought to be activated by stimuli such as stroking, holding, soothing voice tone and social support (Uväs-Morberg, 1998; Wang, 2005). Panksepp (1998) suggests that the key issue is the way these two systems interact with a third system which is suggested to be serotonin-based, and predominantly threat-focused. He contends that the third system acts as a mediator in response to a perceived threat, and subsequently activates one of the other two systems.

Gilbert (2006) depicts this biopsychosocial theory by the “three circles” diagram (see Figure 1) that illustrates the interaction between the systems. Gilbert suggests that there is constant interaction between these affective systems: one automatically generates emotional perceptions of excitement (dopamine); one activates a threat response or safety seeking behaviours (serotonin); and the affiliative/soothing system

acts to dampen the responses of the first two. However, he suggests that when this system is out of balance or not accessible, maladaptive safety strategies like avoidance, aggression or dissociation can develop.

In Gilbert's (2006) account the soothing system develops in childhood through nurturing by caregivers who unconditionally provide compassion, reassurance, and an environment of safeness. Gilbert's theory suggests that children who do not have early experiences that create memories of safeness have under-developed self-soothing systems that make them ill-equipped to understand and deal with their own emotions. Perry, Pollard, Blackley, Baker and Vigilante (1995) put forward a neurodevelopmental perspective of CSA and trauma proposing that such experiences may prevent this system from maturing, and possibly leaves an individual exposed to developing an over-stimulated, or over-sensitive, threat system. Gilbert (2005a) proposes that such individuals are less able to regulate their emotions, and have fewer experiences or memories of compassion, safeness, reassurance and contentment to draw upon and utilise as an antidote to their feelings of shame and self-criticism.

With this in mind, Gilbert and colleagues developed Compassionate Mind Therapy (CMT) that has its roots in Eastern approaches, and uses Buddhist psychology of promoting compassion for the self and for others (Gilbert, 2005). To date there has been very little robust empirical research that effectively evaluates the efficacy of CMT although some preliminary work has been undertaken (e.g., Gilbert, Clarke, Hempel, Miles & Irons, 2004; Gilbert, Baldwin, Irons, Baccus & Palmer, 2006; Gilbert & Procter, 2006).

Shame and PTSD

The posttraumatic framework that emphasises fear in the manifestation of psychopathology has previously come under scrutiny in relation to survivors of CSA.

Roth and Newman (1991) propose that fear may still be a primary factor in the development and maintenance of PTSD, but other emotions like shame and guilt may be more significant, especially in survivors of prolonged and repeated childhood trauma.

Further to this, Lee, Scragg and Turner (2001) agreed that a pure PTSD model offered clarification for only some of the difficulties encountered following CSA trauma but does not account for aspects of CSA sequelae like shame, guilt and low self-esteem that are often present in survivors.

Many researchers agree that feelings like shame and guilt disrupt the development of the cognitive triad – the constructions of the self, of others and of the world – and that this subsequently contributes to later psychopathology by impeding the emotional processing of events (Roth & Newman, 1991; Andrews, 1995, 1998; Gilbert, 1997).

The failure of a pure PTSD model to fully incorporate the complex sequelae associated with CSA has led to the development of “Complex PTSD”⁴ (Herman, 1992). This model acknowledges shame as its main feature, and shame potentially arises from prolonged trauma like CSA in which certain factors like entrapment, repeated violation of boundaries, betrayal, rejection, bewilderment, disempowerment, and lack of control are key. Taylor et al. (2005) suggest that it is the overwhelming nature of the interpersonal exploitation, the victim’s perceived helplessness, and lack of support that may lead to the development of the constellation of complex symptomatology that exceeds that of simple PTSD.

Shame and the Role of the Caregiver

Other literature has highlighted the role of the caregiver in the development of shame, with greater levels of shame associated with parental hostility, rejection, negative affective displays, and minimal validation which may prompt the

⁴ Complex PTSD has yet to be established as a distinct diagnostic category in the DSM-IV

internalisation of shame (Stuewig & McCloskey, 2005). Caregivers may also unintentionally maintain shame levels because they lack the skills to deal with the emotional reaction following abuse (Stuewig & McCloskey, 2005).

In terms of its role in human behaviour, shame is clearly a complex and multidimensional experience that has many mechanisms and functions. While shame is thought to be distinctly separate from the experience of low self-esteem, Tangney, Burggraf and Wagner (1995) suggest that shame is often clinically associated with a variety of problems related to low self-esteem. They believe that this is plausible given the idea that shame is an emotion related directly to the construction of the “self”.

Gilbert’s previously described account of the role of shame in CSA may be compelling, however, it is still speculative and relies largely on inferences drawn from neurodevelopmental and evolutionary research. Research into shame and its associated difficulties needs to be explored in direct relation to people who have experienced CSA. This may be possible by following a group of survivors, investigating their experiences over time and evaluating Gilberts Compassionate Mind Therapy.

Self-esteem

Melanie Fennell (1999) described self-esteem in terms of the way we judge or evaluate ourselves, which guides the value we attribute to ourselves as people. Furthermore, the beliefs we hold about ourselves as individuals and our core beliefs are key to self-esteem, and subsequently influence the way we think, feel, and behave.

Self-esteem and the Development of the Self

Cole and Putman (1992) propose that a history of abuse disrupts the normal process that facilitates healthy development of the self. They suggest that abuse (especially intrafamilial abuse) during the early years compromises the capacity to trust and find security in relationships. They go on to suggest that abuse occurring later in

development not only interferes with social relationships but severely affects levels of self-esteem, and is associated with more intense feelings of guilt and shame. Cole and Putnam argue that the inhibited development of a fully integrated personality and a coherent sense of self generates difficulties in adulthood that include: distress, vulnerability to depression, interpersonal problems, increased self-blaming behaviours, and maladaptive coping styles.

Self-esteem and Childhood Attachment

Alexander (1992) proposes that CSA sequelae might be explained in terms of attachment theory whereby the negative impact of CSA results from a disruption of the child's working model of attachment. A study by Liem and Boudewyn (1999) looked at how multiple maltreatments and loss experiences in early childhood interfere with the development of early attachments, creating increased vulnerability to CSA and subsequently to psychological distress in adulthood. They examined 687 male and female undergraduates; 320 were women, and 75% of them reported a history of CSA. They used measures which included: the Life Experiences Survey (Boudewyn & Liem, 1995; Liem, O'Toole, & James, 1996); the Beck Depression Inventory – short form, (Beck & Beck, 1972); the Rosenberg Self-Esteem Scale (Rosenberg, 1965); the Fundamental Interpersonal Relationships Orientation and Behaviour Scale (Schulz, 1966); and, the Brief Symptom Inventory (Derogatis & Melisaratos, 1983). They reported associations between the disruption of childhood attachments (in those with CSA experiences), and psychological distress and poor self-functioning in adulthood; survivors presented with high levels of depression and shame, low self-esteem, and self-blaming attributions. However, the authors expressed caution in associating meaningful attachment classification patterns that have developed in childhood with those that may have developed later.

Stigmatisation, Self-esteem and Attributions

Not surprisingly, if individuals are stigmatised in some way (e.g., through experiencing childhood trauma) one might expect negative feelings about the self to be generated with a damaging effect on self-esteem. The concept of stigmatisation (Goffman, 1963) initially emerged in explanation of disabled individuals' view of the self as "spoiled", which contributed to their global attribution of the self as "bad" or "flawed". Observations from clinical practice indicate that individuals who have experienced CSA often make similar personal attributions of themselves (Gilbert & Andrews, 1998).

Research by Feiring, Taska and Chen (2002) attempted to assess the nature of specific attributions for the CSA and their relation to psychological distress over time. The study recruited 137 children and adolescents who had recently disclosed sexual abuse. The participants were assessed using a battery of standardised measures, all of which were shown to have good reliability, with the exception of a novel scale that had been specifically developed to measure shame. The participants were assessed at eight weeks after disclosure, and then again one year later. Their results demonstrated that CSA related internal attributions were associated with higher levels of psychopathology and were particularly important in terms of predicting the development of PTSD. Through regression analysis, Shame was also found to be a predictor of symptomatology levels, and it mediated the relationship between abuse specific internal attributions and PTSD symptoms.

Stigmatisation, Traumatic Sexualisation, Betrayal and Powerlessness

As links between CSA and psychopathology became increasingly acknowledged, Finkelhor and Brown (1985) organised these associations into the "traumagenic dynamics" model in an attempt to specify how and why CSA contributed towards adult

psychopathology. The first element of their model was “stigmatisation” which was thought to represent the negative aspects of the abuse, with children coerced into secrecy, blamed, and often shamed following disclosure. Consequences of stigmatisation were suggested to include guilt, shame, low self-esteem, self-harm and substance abuse. The second feature of the model was “traumatic sexualisation” which was said to occur through the developmentally inappropriate shaping of a child’s sexualisation that directly resulted from their abusive experiences. This is suggested to lead to inappropriate adult sexual behaviours, a dislike of intimacy, sexual dysfunction, promiscuity, and confusion about sexual identity, morality and affection. The third element, “betrayal”, is suggested to become increasingly salient as the child realises that they had been exploited, often by someone they trusted, and with nowhere to turn for protection. Ramifications proposed included: grief reactions; dependency; mistrust; depression; hostility; and, a tendency towards challenging relationships. Finally, “powerlessness” was thought to develop following repeated episodes of abuse and includes increased fear, an inability to protect the self, the use of coercion or deception and unsuccessful attempts to end the abuse because they could not stop it, or because they were not believed when they disclosed. Perceptions of feeling powerless were thought to give rise to fear; anxiety; impaired self-efficacy and coping skills; phobias; nightmares; and, dissociation with victims attempting to compensate by becoming over-controlling in adulthood (Finkelhor & Brown, 1985).

Critics (e.g., Feiring, Taska & Chen, 2002) have suggested that this model lacked empirical validity because only four of the twenty seven studies examined were conducted with children; therefore they were theorising about children on the basis of research with adults. Little research has been carried out to validate this model because of the complexity, variety of mechanisms involved and of the subsequent difficulties in

defining and measuring them. Despite this, the model still provides a useful framework for considering the psychological influence of CSA, and it is still widely respected.

(Kendall-Tackett, Williams & Finkelhor, 1993).

Although the traumagenic dynamics model is over 20 years, it is still thought to be a valid model that encompasses many of the difficulties that CSA survivors present with following a history of CSA. Finkelhor made a number of inferences about the development of CSA sequelae which don't appear to be well grounded in empirical research. A further criticism of Finkelhor's model was that he used adult survivors instead of child victims. Given its enduring recognition as a framework within which to consider CSA sequelae, it may be useful to re-evaluate this model using sound contemporary measures, a comprehensive CSA criteria and appropriate participants.

Attributions of Blame

Attribution theory proposes an idiosyncratic need for individuals to rationalize unusual, difficult, or unwanted events (Weiner, 1986), and in doing so they attribute events as external or internal. In this way traumatic events like CSA may be associated with an external source, or alternatively, they may be interpreted as being associated with something they themselves are responsible for. Blame for child sexual abuse may be directed several ways: towards the self; towards the perpetrator; or, towards other non-protective adults.

A study by Barker-Collo (2001) examined the relationship between attributions of blame for CSA and adult psychopathology. Her sample of 126 women was recruited from an agency that provided counselling services for CSA survivors. Participants anonymously provided demographic information and completed questionnaires relating to attributions of blame and symptomatology using the Attributional Style Questionnaire (Peterson et al., 1982) and the Traumatic Symptom Checklist-40 (Elliot

& Briere, 1992) that measures Anxiety, Depression, Dissociation, Post Sexual Abuse Trauma, Sleep Disturbance and Sexual Problems. The results of this study suggest that adult reports of internal attributions of blame for CSA made in childhood are significantly predictive of negative overall symptomatology and suicide attempts during adulthood. It should be noted that this sample experienced what might be termed as severe CSA given that over half had been abused by an immediate family member and over 30% reported over fifty episodes of abuse. Their "in counselling" status at recruitment also raises questions about generalisability. Additionally, only willing participants were included in the study and it is possible that there may be other factors that differentiate those participants who were willing and those who were not. IN conclusion, Barker-Collo (2001) suggests that, despite the presence of self-blaming attributions, examining factors that act as a buffer to CSA experiences might also prove useful.

Direction of Blame

McMillen and Zuravin (1997) suggest that attributions of responsibility and blame for child sexual abuse may be important factors in subsequent adjustment. They designed the Attributions of Responsibility and Blame Scale (ARBS) to examine the direction of blame attributions (e.g., self-blame, family blame and perpetrator blame) in relation to subsequent adult adjustment. Their sample of 154 was recruited from a case comparison study of low-income mothers who reported a history of CSA using comprehensive criteria. Unfortunately, much of the sample also had contact with Child Protection Services and this potentially limits generalisability. Reliable measures of self-esteem, views of others, and intimate relationship style were conducted. Although self-blame and perpetrator-blame scores were found to be skewed, and self-blame was infrequent in this sample, there were several main effects that were highlighted

indicating that participants who blamed themselves had lower self-esteem; were less comfortable with closeness; and, had more relationship anxiety. Family blame was also associated with relationship anxiety, and higher family blame was associated with poor parenting. No main effect relationships were found between perpetrator blame and adjustment.

Although this study offered further evidence of an association between self-blaming attributions and poorer adjustment several limitations were acknowledged. The first is that at the time, this was a new measure in development, and as such it may have been sensitive to biases like social desirability. The second, and this is a constraint of many correlational studies, is the failure of such studies to determine causation. Additionally, the measures used only sampled a minority of domains that constitute adjustment and the authors concede that other measures of symptomatology may have yielded different results.

Coffey et al. (1996) used a general population sample recruited by sending questionnaires to 6,000 randomly selected women from the voters list in a New England city. They had a very low response rate of 11% but of the 666 women who responded anonymously 192 (29%) reported a history of childhood sexual abuse. The study criteria required that sexual abuse occurred before sixteen years with a perpetrator who was either at least five years older, or who had coerced the respondent to engage in sexual activity. The study was designed to investigate whether stigma, betrayal, powerlessness and self-blame mediated long-term sequelae of CSA. A path analysis of the data indicated that survivor's level of distress was mediated by feelings of stigma and self-blame. However, this study was potentially limited by its use of a novel scale used to measure stigma, betrayal, powerlessness and self-blame.

The clinical and research literature consistently suggests that children who have been sexually abused are often blamed and stigmatised by their abuser, thus predisposing the individual to establish core beliefs based on self-blame and shame (Finkelhor & Browne, 1986). There may be many reasons why children blame themselves for their abuse. Tennen and Affleck (1990) propose that by internalising the blame, the child is able to continue to believe in a just world. In addition, the victim may find it less stressful to internalise the blame than to attribute it to someone that they depend upon; this approach may also prevent the victim from prejudicing their perception of the loved parent, thus allowing the child some perceived sense of control over the course of events (Tennen & Affleck, 1990).

A number of limitations are highlighted from these studies: Not only did they use retrospective reporting of feelings of blame, two of the measures were novel; One of the studies used a population that may not have been generalisable, and none of the studies were clear about the criteria used to establish CSA for inclusion. As with other measures, caution should be advised when evaluating blame responses; there may be a social desirability effect, and the inevitable difficulties in determining causation remain.

Conclusion

This review began by examining some background information on CSA that highlights sexual abuse as an enduring and significant problem. Over the last two decades there has been much speculation concerning the incidence and variety of psychopathology following a reported history of CSA. Research into the long-term effects of CSA in clinical and general populations has generally found greater levels of psychopathology in individuals who report a history of CSA. However, not all studies have found large effects and this may be due to a variety of factors, for example variations in the criteria and definitions used.

A substantial body of research has explored how the characteristics of sexual abuse might influence the distressing sequelae often presented by CSA survivors. More recently, researchers have attempted to reveal the mechanisms that underpin these associations. Clinical presentations of individuals frequently reveal high levels of shame, reduced self-esteem, and a tendency towards taking on responsibility for the abuse, and recent studies have endeavoured to discover whether these factors act as mediators. This review has, for the first time brought together the literature for these three areas and the research suggests that they may indeed be implicated in the development of psychological difficulties that occur as a result of CSA.

A news release issued by the Dept of Health (DoH) in November 2006 reported that sexual violence and abuse are the most common causes of depression and mental health problems in women, however their report suggested that mainstream health service practitioners largely have low awareness of these issues. They suggested that many victims and survivors' treatment and care needs are not being met (DoH, 2006). This acknowledgement by the DoH highlights extremely important clinical issues in terms of providing support and interventions for CSA survivors; for example, if a client who has a history of CSA presents with depression, and undergoes traditional treatment for depression, it is likely that the benefits may be limited or short-lived; this is because the underlying mechanisms (e.g., feelings of shame, low self-esteem, and self-blaming attributions) that may be maintaining the depression have not been acknowledged and dealt with. This highlights an urgent need for further study in this area.

Paul Gilbert's (2005) biopsychosocial model of shame and his subsequent Compassionate Mind Therapy offers a novel and promising approach to working with survivors of sexual trauma because it may provide individuals with the opportunity to embrace and develop the ability for self-compassion as an antidote to their self-

defeating feelings of responsibility, shame, and low levels of self-esteem. However, there is still significant work to be done towards supporting CSA survivors through research and improved interventions; and, although promising, in particular further research is required to ground Gilberts model within its own evidence base.

Possible Research Designs and Questions for Further Research

Understanding of the mechanisms by which CSA experiences may culminate in psychopathology in adulthood presents a significant challenge; researchers often appear to fail to adhere to recommended methodological guidelines (as in mediation studies) because of logistical difficulties in carrying out correct procedure; this leads to ambiguous findings that have limited generalisation.

If CSA survivors are to be offered improved interventions researchers must attempt to carry out appropriate studies that investigate not only the mediating, but also the moderating variables that cover all the characteristics of CSA; family dynamics and support; coping strategies; childhood development and attachment difficulties; the presence of physical or emotional abuse; and, any emerging psychological difficulties, from time of disclosure to adulthood.

There is an increasing body of evidence evaluating mediating variables in relation to CSA but less research has been carried out with moderating variables. While there may be mediating variables that explain how or why external physical events take on internal psychological significance, moderating variables specify when certain effects will hold (e.g., a persons natural resilience may be a moderator), which in turn may reduce CSA survivors vulnerability to developing adult psychopathology. Moderation is tested by: testing the main effects of the predictor and moderator (of the outcome variable) as well as the interaction between the predictor and the moderator. If the interaction term is significant (i.e., if it is significantly different from zero) then

moderation has been established. Significance of the main effects are not important in demonstrating moderation (Baron & Kenny, 1986).

It should be noted however that some characteristics of CSA may be moderators or mediators (i.e., their facilitation can make things better or worse). Take family support for example, if a child experiences sexual abuse, good family support may be a moderating factor that protects her from developing psychological distress in adulthood; poor family support on the other hand, may be a mediating factor which facilitates the development of adult distress. Perhaps studying moderating, rather than mediating variables might be more salient in the search for why some people experience psychopathology following CSA while others do not.

Further to this is the need to explore the concept of resilience in relation to CSA survivors' sequelae; again considering why some CSA survivors are less disturbed by their childhood abuse than others. Questions to be raised may include: How were their childhood experiences before and after the sexual abuse different from those who go on to develop emotional difficulties? What were their abuse experiences, and what was the context in which it occurred? What were their experiences around disclosure? How did they adjust to their feelings about their sexual abuse? What kind of support did they have before and after the abuse? Are they more emotionally or intellectually more intelligent? What are their coping skills like? What are their subsequent interpersonal relationships like? Answers to these questions about how CSA experiences may have been moderated in CSA survivors may go some way towards helping survivors to understand and foster some of the skills that may help them to alleviate their distress.

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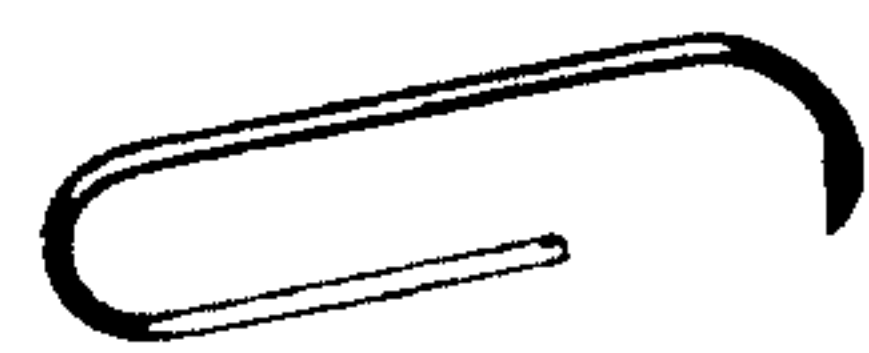
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Appendix G

Appendix

Figure 1

Three Circles Diagram Depicting the Interaction Between the Affect Systems



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Diagram taken from Gilbert (2005).

Section 3: Empirical Paper

Running head:

PSYCHOLOGICAL DISTRESS IN ADULT SURVIVORS OF CSA: SHAME, SELF-ESTEEM AND BLAME

Psychological Distress in Adult Survivors of Childhood Sexual Abuse: An Investigation of the Role of Shame, Self-esteem and Blame

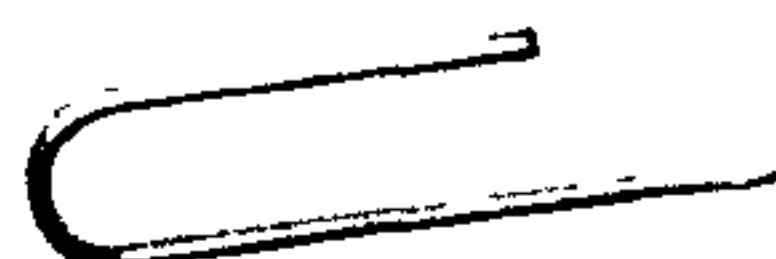
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Abstract

Objectives

The relationship between reported Child Sexual Abuse (CSA) history, subsequent distress and psychopathology was investigated. It was hypothesised that individuals reporting a history of CSA would (i) report abuse related distress; and (ii) that abuse related distress would be related to psychopathology, and both in turn to shame, blame and self-esteem; and, (iii) that shame, blame and self-esteem would mediate the relationship between abuse distress and psychopathology. It was further hypothesised that participants reporting abuse would show elevated levels of psychopathology and shame, and lower levels of self-esteem, in comparison to a Non-Abused group.

Method

One hundred and fifty-nine female undergraduates completed questionnaires requesting information on a history of CSA (from which a CSA distress score was obtained); the Internalised Shame Scale (from which a measure of self-esteem was obtained); Symptom Checklist 90 (Revised); and, the Attributions of Responsibility and Blame Scale. Twenty percent of the sample reported a history of CSA.

Results

No association was found between CSA distress and psychopathology and this precluded mediation analysis. However, in the Abused group shame and self-esteem were related to psychopathology and higher levels of CSA distress were related to greater levels of blame. In the between-groups comparison, the Abused group scored higher on the psychopathology subtests, most notably psychoticism; showed higher levels of shame; and, a non-significant trend towards lower self-esteem.

Conclusions

Although some differences between the groups were highlighted, the anomalous results regarding the CSA distress–psychopathology link make it difficult to draw clear conclusions.

Psychological Distress in Adult Survivors of Childhood Sexual Abuse: An Investigation of the Role of Shame, Self-esteem and Blame

Individuals who experience psychological problems, and who report a history of CSA, frequently reveal high levels of shame (Taska & Chen, 2002; Gilbert, 2005; Whiffen & MacIntosh, 2005; Feiring); reduced self-esteem (Cole & Putnam, 1882; Liem & Boudewyn, 1999); and, a tendency to take on feelings of responsibility for the abuse (Celano, 1992; McMillen & Zuravin, 1995). However, the question remains unanswered as to whether these feelings merely reflect the reaction to a distressing event or whether they are more instrumental in actually mediating the relationship between CSA and adult psychopathology. To-date these variables have not been studied together using an appropriate design to test a mediation based hypothesis. Therefore, this study was carried out to explore the association between CSA distress and levels of psychopathology; whether individuals with CSA experiences had increased levels of shame and blame, and lower levels of self-esteem; and, whether these factors would mediate the relationship between abuse related distress and psychopathology in non-clinical participants.

Prevalence of CSA

Research suggests that CSA remains a significant problem, although it is difficult to provide exact statistics for prevalence rates as figures vary between countries and cultures. The following statistics are presented for females from general population studies: Cawson, Wattam, Brooker and Kelly (2000) revealed a CSA prevalence rate of 21% in the U.K. In Ireland, a rate of 30.4% was found in adults reporting experiences of CSA (McGee, 2003). A questionnaire study in New Zealand revealed a female CSA prevalence rate of 17.3% (Fergusson, Lynskey & Horwood, 1996); while in Denmark

the CSA rate for females was 11% (Helweg-Larson & Larson, 2002). Studies in the U.S. reported figures of 13.5% in Boston (Molnar, Buka & Kessler, 2001) and 15% in Los Angeles (Briere & Runtz, 1988). Data from Canada found a 12.8% CSA rate. These figures on prevalence were derived from large studies that were reported as having reliable methodology; however, it is thought that variations in prevalence rates are likely to reflect differences in how CSA is defined, sample characteristics (e.g., whether a community, clinical or legal sample was used) and the methodology employed. In addition, limitations in CSA research are acknowledged in terms of the retrospective nature of reporting abuse; environmental experiences before and after the abuse; type of questions asked and attaining consistency across cultures; and, geographical locations and socio-economic situations.

Psychopathology

Within the CSA literature, an abundance of research supports the prevalence of psychological difficulties in adults who report a history of sexual abuse. In addition, CSA is recognised as a risk factor for developing mental health difficulties such as depression (Andrews, 1995); anxiety (Levitan, Rector, Sheldon & Goering, 2003); post-traumatic stress (Wisdom, 1999; Lee, Scragg & Turner, 2001); dissociative disorders (Bloch, 1991); interpersonal problems (Cole & Putnam, 1992); self-harm (Barker-Collo, 2001); eating disorders (Steiger & Zanco, 1990); psychosis (Read, Agar, Argyle & Aderhold, 2003; Read, van Os, Morrison & Ross, 2005; Bentall et al., 2007); revictimisation (Messman-Moore & Long, 2003); and, somatic problems in later life (Nurse et al., 2005).

The clinical presentations of individuals who experience psychological problems and report a history of CSA frequently reveal high levels of shame, reduced self-esteem, and a tendency to take on feelings of responsibility for the abuse.

Shame

A review by Whiffen and MacIntosh (2005) attempted to identify which risk factors had the potential to be causal risk factors in mediating the link between CSA and adult emotional distress. Their review found that shame appeared to be the most significant factor that led to psychological difficulties.

Shame is an emotion common to most individuals, and has an increasing profile in the sequelae of CSA. Feiring and Taska (2005) regarded events (i.e., others' responses) during disclosure as crucial and individuals who experienced shame at that time were more likely to develop shame that was enduring and which subsequently increased vulnerability to developing PTSD. Gilbert and Procter (2006) conceptualized shame in terms of threat processing and went on to distinguish between internal and external types of threat.

Self-esteem

Fennel (1999) described self-esteem in terms of the way we view, judge or evaluate ourselves, and these guide the value we attribute to ourselves as people. The beliefs that we hold about ourselves as individuals, and our core beliefs are of central importance to self-esteem, and subsequently affect the way we think, feel and behave.

Cole and Putnam (1992) suggest that CSA compromises the capacity to trust and find security in relationships and this is subsequently thought to have a detrimental influence on the development of the "self". This in turn affects levels of self-esteem and generates feelings of guilt and shame, which leads to difficulties in adulthood.

Alexander (1992) suggests that CSA sequelae might be explained in terms of attachment theory whereby the impact of CSA results from a disruption of the child's working model of attachment. Subsequent research by Liem and Boudewyn (1991) supports this idea. They found an association between disturbances in childhood

attachments and poor self-functioning in adulthood – specifically: low self-esteem, depression and high levels of shame and self-blame.

The stigmatization that occurs as a result of sexual abuse is also thought to play a part in the emergence of low self-esteem with survivors reporting negative feelings about the self as “damaged”, “flawed” or just “bad” (Angrosino, 1992; Szivos-Bach, 1993).

Stigmatization was one of the elements proposed in the “traumagenic dynamics” model by Finkelhor and Brown (1986) as contributing towards adult psychological dysfunction. The other features that were thought to represent some of the most significant elements of CSA were traumatic sexualisation, betrayal and powerlessness. The authors suggest that the sequelae of CSA in terms of the betrayal of trust, the abuse of power, the inappropriate sexualisation, and the perceptions of powerlessness and hopelessness give rise to a whole range of mental health difficulties in adulthood that included high levels of shame, low self-esteem and self-blame.

Attributions of Blame

Attribution theory proposes an idiosyncratic need for individuals to understand difficult or unpleasant events (Weiner, 1986), and in doing so they attribute the causes of events as internal or external. In this way traumatic events like CSA may be associated with something external, or interpreted as something they themselves are responsible for. Individuals who blamed themselves for the abuse were found to have higher levels of depression and lower self-esteem than those who blamed others (Wyatt et al., 1991).

The stigmatization and blame that is directed towards children by their abuser is thought to facilitate the establishment of core beliefs based on shame and self-blame (Finkelhor & Browne, 1986). Such beliefs have been found to make people vulnerable

to developing psychological difficulties like depression, anxiety and feelings of worthlessness.

Despite the plausibility of these models in considering the possible roles of shame, self-esteem and blame and how they might link to adult psychopathology following CSA, no one study has yet examined these variables together using appropriate methodology to test a mediation hypothesis. To establish mediation, based on the criteria set out by Baron and Kenny (1986), an association must be found between CSA and adult psychopathology; the potential mediator must be associated with both the CSA and with the adult psychopathology; and, when both CSA and the potential mediator are considered jointly as predictors of emotional distress, only the mediator should remain statistically significant.

In order to explore in detail the relationship between a reported history of CSA and adult psychopathology and the contributory roles of shame, blame and self-esteem, this study used a cross-sectional design and employed two complementary approaches to data analysis. In the first instance a within-subjects analysis is reported where data from participants reporting a history of CSA was analysed to test the following hypotheses:

- i) Individuals reporting a history of CSA will report abuse related distress.
- ii) Abuse related distress will be related to psychopathology, and both in turn to shame, blame and self-esteem.
- iii) Shame, blame and self-esteem will mediate the relationship between abuse-related distress and psychopathology.

In the second instance data was examined between-subjects, comparing data from Abused and Non-abused groups, to test the following hypotheses:

- iv) Individuals reporting a history of CSA will report increased levels of psychopathology.
- v) Individuals reporting a history of CSA will report increased levels of shame and lower levels of self-esteem.

Method

Design

This was a cross-sectional questionnaire study using a quasi-experimental design. The participants were divided into two groups dependant upon whether or not they reported a history of CSA. The dependent variables were the scores taken from the measures that the participants were required to complete: the Internalised Shame Scale, Symptom Checklist-90-Revised, and the Attributions of Responsibility and Blame Scale.

Power Analysis

A power analysis, using Cohen's Power Primer, was carried out to ensure that a sufficient sample size was generated. A significance level of 0.05 is traditionally the most widely used alpha level in statistical analysis as it increases the power of the statistical tests and minimises the probability of making a Type I error (Gravetter & Wallnau, 1996). The current study based this power analysis on two previous studies that examined the relationship between CSA and psychopathology: Derogatis (1983) achieved a large effect size (1.9), and Steel et al. (2004) achieved a small effect size (0.3). Using samples of Abused and Non-Abused participants, both these studies obtained a large effect size. For the present study a medium effect size was chosen.

Group numbers in the current study were based on Cohen's (1992) estimates using a 0.05 level of significance, with a medium effect size (Cohen, 1988). For the

present study, correlational analysis would require 85 participants, ANOVA and t-tests would require 64 participants per group, and the regression analysis for mediation would require 76 participants in the Abused group.

Participants

The sample was made up of 159 female university undergraduates studying social sciences at a British University. Given that females have been generally acknowledged as having higher rates of CSA (Rind, Tromovitch & Bauserman, 1998) it was decided to limit recruitment to women only. Participants were recruited from two different departments and they were offered printer credits, course credits, or entry into a £50.00 prize draw as an incentive. All participation was voluntary and anonymous. Twenty percent ($N = 32$) reported a history of CSA - these participants will be referred to as the Abused group. Eighty percent ($N = 127$) reported no history of CSA - these participants will be referred to as the Non-Abused group.

Measures

The Internalised Shame Scale – ISS (Cook, 1994).

The ISS is a 30 item self-report questionnaire with 24 negatively worded items from which the shame score is derived. The remaining 6 items - originally taken from the Rosenberg Self-Esteem Scale (Rosenberg, 1965) were scored separately and used as an indicator of self-esteem.

This measure was developed to assess the extent to which respondents have internalised feelings of shame. The ISS is especially useful in assessing trauma survivors' experience of shame that emerges as an element of complex trauma reactions. The ISS has been widely used in empirical research and as a useful clinical tool; it has demonstrated good construct validity and reliability in a variety of clinical and non-clinical groups. Cronbach's alpha for shame and self-esteem in non-clinical

samples was reported to be 0.95 and 0.90 respectively (Cook, 1994). Cronbach's alpha for this sample for these scales was 0.95, and 0.87 respectively.

Symptom Checklist-90-Revised - SCL-90-R (Derogatis, 1983).

This 90-item measure of psychological distress contains 9 scales measuring: Somatisation, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobia, Anxiety, Paranoia, and Psychoticism. The SCL-90-R yields a Global Severity Index (GSI) that reflects overall psychological disturbance. A higher score on the GSI (and the composite subscales) reflects a greater level of psychological distress. The SCL-90-R has been validated for use as a screening instrument, and is widely used in clinical and research settings as an outcome measure. The validity of the SCL-90-R has been established in several studies. Weissman, Sholomkas, Pottenger, Prusoff and Locke (1977) showed high correlations between the Depression subscale and the Hamilton Rating Scale. Peveler and Fairburn (1990) found a correlation of 0.80 between the Depression subscale and the Beck Depression Inventory. The same researchers also examined content validity by correlating the global indices of the SCL-90-R with the global indices of the Present State Examination and found significant correlations that ranged from 0.60 to 0.82. Cronbach's alpha for this measure for this sample was 0.97.

Experiences of CSA (adapted from Ussher & Dewberry, 1995; Henderson, Hargreaves, Gregory, Williams, 2002; Gregory, 2000).

This six item measure asks participants to indicate whether they have experienced a range of sexual abuse experiences when they were a child: including sexual exposure, voyeurism, touching or intercourse. Responses are recorded on a 5-point Likert scale (*Never to Very Often*). For this study, in order to assess the participants' sense of severity of their own reported abuse they were asked to rate how distressing the abuse episode was on a 5-point Likert scale (*Not At All Distressing to Extremely Distressing*).

This was a novel measure that generated a variable suitable for correlational analysis.

There are no standardised measures currently available. Cronbach's alpha for this measure, for this sample was 0.82.

Only participants who reported sexual abuse were required to complete the final questionnaire measure:

Attributions of Responsibility and Blame Scale – ARBS (McMillen & Zuravin 1997).

This 40-item questionnaire is designed to provide a measure of the direction and intensity of attributions of responsibility and blame for child sexual abuse experiences. The items are designed to assess three directions of blame attributions; towards themselves, the perpetrator, and family member/other. McMillen and Zuravin (1997) confirm good item-total correlations for this measure with only 3 of the 40 items scoring less than 0.30. They found Cronbach's alpha levels of 0.68 for Perpetrator Blame scale and for the Family and Self-Blame items it was 0.91. Cronbach's alpha for this measure for this sample was 0.86 for Perpetrator Blame, 0.94 for Family Blame, and 0.95 for Self-Blame.

Procedure

Ethical approval was obtained from the relevant university departments. Participants collected a questionnaire pack from an appointed place, and were able to complete the questionnaire at a time and place to suit them, and return them to a designated collection point. An information sheet was included in the questionnaire pack, and this provided information about the research, and clarified the participant's rights. Written consent was not requested as this would have violated confidentiality. Consent was assumed by the participants' willingness to complete the questionnaires. Given the possibility that participants may have become distressed by unpleasant

memories of childhood trauma following completion of the questionnaire booklet, a resources leaflet in Welsh and English, which listed agencies that offered help or advice was enclosed with the questionnaire pack.

Results

Statistical Analysis and Data Preparation

SPSS 12 (SPSS Inc., Chicago, Illinois) was used for statistical analysis. An alpha level of 0.05 was used for all statistical tests.

The measure for CSA distress was generated by adding up the scores from the distress scale as reported by the Abused group. Psychopathology was assessed using the Global Severity Index (GSI) mean score, and the symptom dimensions from the SCL-90-R measure.

All data was tested prior to analysis using Kolmogorov Smirnov Z. The GSI psychopathology variable ($z = 1.80$; $p = 0.00$) and the CSA distress variable ($z = 5.5$; $p = 0.00$) were non parametric. Where Cohen's d (1992) calculations are reported the effect sizes are as follows: 0.10 = small effect or statistical difference between the groups; 0.25 = moderate effect; and > 0.40 = large effect.

The analysis first focuses on an examination of whole sample characteristics. Following this the results section is structured to follow the study hypotheses: first CSA distress, psychopathology, shame, blame and self-esteem are examined within the Abused group; between-group differences (Abused and Non-Abused groups) are then considered.

Sample Characteristics

Of the total sample ($N = 159$) in this study the prevalence rate of reported CSA was 20% ($N = 32$). This was unexpectedly low as other local studies using

undergraduate participants have reported CSA rates of 28% (Henderson, Hargreaves, Gregory, & Williams, 2002) and 25% (Gregory 2000), respectively. Of the Abused group, 47% ($N = 15$) were in the 18 – 24 age range; 22% ($N = 7$) were in the 25 – 34 age range; 25% ($N = 8$) were in the 35 – 44 age range; and, 6% ($N = 2$) were in the 45 – 54 age range. Of the Non-Abused group, 61% ($N = 78$) were in the 18 – 24 age range; 29% ($N = 37$) were in the 25 – 34 age range; 9% ($N = 11$) were in the 35 – 44 age range; and, 1% ($N = 1$) was in the 45 – 54 age range. No participants were over the age of 54 in either group. Over half (58%; $N = 93$) of the total sample were aged 18-24; making this a relatively young sample.

Hypothesis 1: Individuals Reporting a History of CSA will Report Abuse Related Distress

Levels of reported CSA distress.

Contrary to expectation the Abused sample did not report a high level of abuse related distress ($M = 7.22$, $SD = 6.80$). The range of distress scores was 0 – 24 with a maximum possible score of 35. Cronbach’s alpha for this measure in this study was reasonable at 0.82.

Frequency of reported CSA characteristics in current sample.

The frequency with which the reported CSA occurred can be seen in Table 1 and indicates a fairly low frequency. The majority of the Abused group experiences were endorsed as occurring *Rarely* and there were few indications of abuse that occurred *Very Often*.

(Insert Table 1)

Reported CSA characteristics in comparison with previous samples.

Table 2 indicates that participants endorsed a variety of experiences of CSA, but the majority of the Abused group's CSA experiences were related to exposure. Only a very small number had experienced intercourse, which is generally thought to be the most severe form of CSA (Bauserman & Rind, 1997; Rind et al., 1998), although this figure was comparable with previous local samples (see Table 2). Further comparison with studies by Gregory (2000) and Henderson (1996) indicate that sexual exposure has remained constant over time in this local undergraduate population; however, the current sample reported more incidents of voyeuristic behaviours towards them.

(Insert Table 2)

Hypothesis 2: Abuse Related Distress will be Related to Psychopathology, and both to Shame, Blame and Self-esteem

Contrary to expectation, no significant relationship was found between CSA distress and psychopathology, $r, (158) = 0.15, p > 0.05$. However, participants who reported higher levels of CSA distress did report higher Perpetrator Blame, Self-Blame and Family Blame. In addition, participants who reported higher levels of Shame reported higher levels of psychopathology; and, lower levels of Self-esteem were also associated with higher levels of psychopathology. Higher levels of Shame were also related to lower levels of Self-esteem. These results are shown in Table 3.

(Insert Table 3)

The relationship between CSA distress and subtypes of psychopathology.

Further examination revealed no significant relationship between CSA distress and any of the nine SCL-90-R sub-scales; although the subscales themselves correlated significantly as would be expected (see Table 4).

(Insert Table 4)

Hypothesis 3: Shame, Blame and Self-esteem will Mediate the Relationship between Abuse-related Distress and Psychopathology

Given that psychopathology following abuse is a well-established finding, the failure to reveal a correlation between reported CSA distress and psychopathology in the current study was an unexpected result. This finding prevented further analysis into the possible mediating roles of Shame, Self-esteem and Blame as the assumptions laid down by Baron and Kenny (1986) were not met. This sample were substantially skewed and kurtotic and attempts to rectify the problem using square root and log 10 transformations were unsuccessful; this may explain why it was not possible to correlate CSA distress and psychopathology.

Hypothesis 4: Individuals Reporting a History of CSA will Report Increased Levels of Psychopathology

Examining group means against norms for psychopathology.

The means from the SCL-90-R in this study were compared with those of other studies (see Table 5). The adult non-patient norms from the original SCL-90-R research (Derogatis, 1983) were, without exception, found to be much lower than those of the Abused and the Non-Abused group in this study. Given the predominant number of young people in both samples, the adolescent norms in Derogatis (1983) were

investigated, and with the exception of one, the means were found to be consistently higher than those of this Non-Abused group. It was not possible to clarify this discrepancy. A study by Steel et al. (2004) used a non-patient community sample and their results (seen in Table 5) are more comparable with the Abused and the Non-Abused groups in the current study. The exceptions were the means for the subscales for Phobia and Psychoticism (on which the Abused and the Non-Abused groups in this study were lower) and Paranoia (on which the Abused and Non-Abused groups in this study were higher).

(Insert Table 5)

Between groups differences on subtypes of psychopathology.

A one-way analysis of variance (ANOVA) was carried out to examine the various dimensions of the SCL-90-R (psychopathology) in the Abused group and the Non-Abused group. ANOVA was used because it is robust to violation of the non-parametric assumption with moderate to large sample sizes greater than 15 cases per cell (Green, Salkind & Akey, 2000). Results of the ANOVA indicated that there were significant differences between the groups in the following SCL-90-R subscales: OCD, Interpersonal Sensitivity, Depression, Anxiety, Phobia, Paranoia and Psychoticism, with the Abused group scoring higher in each instance (see Table 6).

Given the envisaged difficulties in making statistical comparisons between the small sample of the Abused group ($N = 32$) and the larger sample of the Non-Abused group ($N = 159$) Cohen's d pooled effect sizes were calculated to show the magnitude of the difference between the groups. Table 6 shows the ratio of the mean differences between the two groups. Obsessive Compulsive and Hostility items both indicated a

moderate effect size. The Interpersonal Sensitivity, Depression, Anxiety, Phobia, Paranoia, GSI and Psychoticism in particular, generated a large effect size. The significant findings relating to paranoia and psychoticism are in line with previous research linking CSA with psychosis and related clinical phenomena (Read et al., 2003; Read et al., 2005; Bentall et al., 2007).

(Insert Table 6)

Between groups differences on psychoticism subscale items.

Given the magnitude of the effect for the between groups difference on psychoticism, the individual psychoticism items were investigated further using one-way ANOVA (see Table 7). (The psychoticism dimension includes items indicative of a withdrawal, isolation, schizoid lifestyle, hallucinations and thought control and provides for a graduated continuum from mild interpersonal alienation to dramatic psychosis.)

Results indicated that the means for the Abused group were higher on all items, and were significantly different on 4 of the 10 items. Cohen's *d* pooled effect sizes were also calculated for these between group differences. The largest effect size was found for the item: *having thoughts that are not your own*. This finding is in line with the psychosis literature that suggests that hallucinations, and specifically voices commenting, and command hallucinations are more likely to occur following a reported history of CSA (Read et al., 2003; Read et al., 2005).

(Insert Table 7)

Hypothesis 5: Individuals Reporting a History of CSA will Report Increased Levels of Shame and Lower Levels of Self-esteem

A one-way ANOVA compared reported Shame levels between groups; there was a marginally significant difference between the groups with the Abused Group reporting the highest levels (Table 8). In terms of Self-esteem, although no statistical difference was observed, the Abused group reported the lowest levels. This trend is in line with the hypothesis. Cohen's *d* calculations indicated a medium effect size for both Shame and Self-Esteem. In comparison, Gregory (2000) found only a negligible effect size (0.09) for Self-esteem in her CSA sample. This type of analysis could not be carried out on the data relating to Blame reported in this study as these questionnaire items were only completed by the Abused group.

(Insert Table 8)

Summary of Results

The Abused group reported very low levels of CSA distress and contrary to expectation no relationship was observed between CSA distress and psychopathology. Although, within the Abused group, higher levels of Shame and lower levels of Self-esteem were found to be related to greater psychopathology and reported CSA distress was related to higher blame scores. In terms of between-group differences, as predicted, differences were found between the Abused and Non-Abused groups on the psychopathology subtests; the most notable of these being psychoticism. Also, as predicted, higher levels of Shame, and a trend towards lower levels of Self-esteem were also found in the Abused group.

Discussion

This is the first study to attempt to examine the role of shame, blame and self-esteem as mediating factors in the relationship between abuse related distress following CSA and psychopathology in adulthood. The Abused group in this study showed a low level of distress; this was an unexpected finding and may have accounted for the lack of predicted association between reported CSA distress and adult psychopathology. However, in partial support of the hypothesised association, in participants who reported CSA, higher levels of shame and lower levels of self-esteem were found to be related to greater psychopathology; and, CSA distress was related to higher blame scores.

A range of between-group differences were found supporting and extending previous findings in this area of research. Of particular note was the finding that participants who reported a history of CSA scored higher than those who did not in terms of psychopathology, in particular psychoticism.

The result concerning the association between CSA distress and psychopathology precluded mediation analysis. However, there are a number of factors that may have contributed to this lack of association, these include: the skew of the sample, the low reported abuse levels, low reported distress, and the possibility that the participants may have under-reported their distress; these could account for the anomalous results. The findings from this study will be discussed further but it is important to first consider other potential limitations of this study.

Sample

Overall, the sample size of this study was good. According to power calculations the sample size used for this study was acceptable for correlational analysis. However, the sample size for the Abused group was underpowered compared to the Non-Abused

group for the between group analysis. Despite this, some interesting differences between the groups were revealed.

The prevalence rate of reported CSA for this study was low at 20% compared to previously reported figures found in similar local samples: Henderson, Hargreaves, Gregory and Williams (2002) reported a 28% prevalence rate and Gregory (2000) reported 25%. It is possible that this masked the ability to correlate CSA distress and psychopathology. The lack of correlation in the present study supports the idea that CSA may have less impact on adult emotional well-being than expected (e.g., Rind et al., 1998). However, the between group analysis did indicate some evidence of increased psychopathology and this warrants further consideration.

In order to maximise recruitment, and given that the measures were anonymous and highly sensitive, only questions considered essential to the study were presented in the questionnaire. Extraneous information was not collected, therefore it was not possible to ascertain whether the undergraduate sample might already have been vulnerable to elevated psychopathology from issues unrelated to their reported history of CSA (e.g., background factors, support systems or coping skills).

It might be suggested that that an undergraduate sample might be more intelligent. Is it possible that this makes them more emotionally intelligent, less amenable to dysfunctional perceptions of their abuse, and therefore less vulnerable to developing psychopathology? Perhaps undergraduate samples are simply better able to cope with CSA distress than CSA survivors found in other populations.

The issue as to whether a student sample is representative of the general population is longstanding, and generalisability issues remain contentious for research studies of this nature. However the open access policy adopted by many universities that

encourages undergraduates from a range of social classes and cultures may make results more representative.

This undergraduate sample had a mandatory requirement to participate in three hours of experiments per semester and this was considered as voluntary participation. However, the author suggests that as a compulsory requirement participation can only be considered voluntary in as much as they can choose their preferred experiments from a given list. Although this study was able to guarantee complete anonymity, the student participation system is generally not designed to promote anonymity; a lack of confidence may have prevented valuable participation from CSA survivors who were more distressed by their CSA experiences. Further to this is the suggestion that if only willing participants are included in the sample it is possible that there may be some factor that differentiates those who decline to participate.

It has been suggested that a proportion of asymptomatic CSA survivors can be explained because there has been insufficient time for symptoms to occur (Kendall-Tackett et al., 1993; Rind et al., 1998). Given that this undergraduate sample were predominantly young, it is possible that increased symptoms of psychopathology in this sample have yet to emerge.

Severity of CSA

Individual differences, perceptions and appraisals about the CSA are thought to be important determinants of outcome (Whiffen & MacIntosh, 2005). Perhaps outcome may also be dependent upon the extent of distress that is experienced at the time of the abuse. Given the subjectivity of CSA experiences it is impossible to comment on what constitutes "severe" but the extent of distress (as it is observed in this study) may be a revealing feature.

Without minimising participants' experiences in any way, the levels of abuse that were reported in this study compared to those of other local studies (Gregory, 2000; Henderson et al., 2002) were at the less severe end of the spectrum, with fewer incidences of contact abuse, and less reported psychopathology. Perhaps a less severely abused sample like the one in this study, experience less distress and are therefore able to cope better with their feelings.

Psychopathology

In terms of psychopathology, it is noteworthy that the current study differs from the majority of research as it was carried out with participants who reported a history of CSA, but who were possibly unaware that they may have been experiencing emerging symptoms of psychosis. This is contrary to research which has traditionally used participants already diagnosed with psychosis, and who then reported a history of CSA (Read et al., 2003; Read et al., 2005).

Other Abuse Related Variables

It is important to determine whether CSA per se is responsible for psychopathology in adulthood or whether it can be attributed to the numerous other risk factors that often co-exist: e.g., social or environmental factors, family dysfunction, CSA related variables or other forms of child maltreatment, which have also been acknowledged as generating similar sequelae to sexual abuse (Kraemer et al., 2001). This study did not look at abuse related variables, and it is possible that some other variable not accounted for may have had a role to play in the increased levels of shame, low self-esteem, attributions of blame or psychopathology; thus making it difficult to draw clear conclusions.

Measures and Definitions

Measurement in studies of trauma survivors has been considered a weak area given that

retrospective, self-report data relies heavily on accurate memory to recount the distress that was experienced at the time of the abuse (Steel et al., 2004; Whiffen et al., 2005). Subsequently, the ISS, the SCL-90-R and the ARBS that were chosen for this study were well respected diagnostic measures with good psychometric properties. The measure used to define CSA experiences, which also provided the criteria for inclusion into this study also showed good psychometric properties. The measure used to assess CSA distress in this study was a novel tool; it is acknowledged as a weak measure that would benefit from further examination in a larger sample.

Further Discussion of Results

The findings of this study indicate elevated psychoticism in the Abused group; this is most meaningful in recognising the possible emergence of psychosis following a reported history of CSA, and lends support to the body of literature proposing CSA as a causal factor in the development of psychosis. The largest effect size was generated by the psychoticism item: *having thoughts that are not your own*; this supports recent research suggesting that command hallucinations are likely to occur following a reported history of CSA (Read et al., 2003; Read et al., 2005). It is interesting to note that research by Bak et al. (2005) implicated the level of distress as one of the most crucial elements.

Caution is advised when examining findings from studies using adults with psychosis as their childhood recollections may be distorted by psychotic thinking. Nevertheless, the research suggests that psychosis is a consequence of extreme variations of cognitive psychological development and this may help to explain the diverse range of symptoms experienced by patients (Bentall et al., 2007).

Theoretical implications

It is possible that the novel measure used in this study to explore CSA distress may not have been effective. The development of a more suitable measure to assess distress following CSA would be valued.

There are difficulties in asking CSA survivors to assess and record how they felt at the time of the abuse; this is not only because of issues of recall, but because all events that occur in childhood, or otherwise, become a part of the self, and this influences how an individual cognitively processes information about the world. Is it really possible to get an accurate retrospective response of distress, or might CSA survivors' cognitive processing systems lead to a displacement of the distress associated with the CSA event(s)? Perhaps these displaced feelings are characterised by feelings of shame and low self-esteem. Further research on the current cognitive processing of past events like CSA would be beneficial.

Clinical implications

There has been less attention paid to moderators than to mediators involved in CSA and its sequelae. This is despite the fact that individual differences have been cited as important factors in psychological outcome following CSA. Exploring characteristics that promote resilience, or act as a buffer to CSA trauma and subsequent psychological difficulties may help clinicians to "tap into" an individuals' resilience following trauma and minimise the risk of developing psychological sequelae.

Ideas for Further Study

Given that it is still not understood why only some CSA survivors go on to develop psychopathology in adulthood, it might be useful to study CSA survivors who do not exhibit psychological distress following their experiences of CSA. This might

entail examining moderating factors in greater detail and making comparisons between those who develop psychopathology and those who do not.

Further research that examines CSA survivors and assesses any tendency towards psychosis may be a valuable field as this may turn out to be a target area for early intervention which according to the National Service Framework for Mental Health appears to be a key factor not only in reducing the impact of psychosis but also in reducing morbidity (Department of Health, 1999).

Given that males are often poorly represented in the field of CSA research it may be useful to explore the issues of shame, self-esteem and attributions of blame in male survivors of CSA to determine whether there are any gender differences.

Conclusion

The question remains as to why some CSA survivors go on to develop psychopathology in adulthood while others do not. Clinical presentations continue to include high levels of shame, low self-esteem and attributions of blame but until researchers are able to quantify the contribution of these features more clearly, clinicians can only intervene in response to survivor's individual presentations.

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Tables

Table 1.

Frequency of Reported CSA Characteristics for Abused Group (N = 32)

Abuse Type	Endorsed Response				
	Never	Rarely	Sometimes	Often	Very Often
1 Exposure	14	12	4	2	0
2.Voyeurism	20	9	1	2	0
3.Touch excluding genitals	17	6	5	3	1
4.Touch sexually	25	3	0	3	1
5.Touch including genitals	22	5	2	2	1
6. Intercourse	30	2	0	0	0

Key:

1. Abuser sexually exposed self to participant
2. Abuser watched participant bathe/dress in voyeuristic way
3. Abuser touched child in a sexual way excluding genitals
4. Abuser made participant touch them in a sexual way
5. Abuser touched child in a sexual way including genitals
6. Abuser had sexual intercourse with participant

Table 2.

Reported CSA Characteristics in Comparison with Previous Samples

Types of CSA reported	Kemish <i>N</i> = 32	Gregory (2000) <i>N</i> = 25	Henderson (1996) <i>N</i> = 22
1 Exposure	56%	56%	77%
2.Voyeurism	37%	20%	23%
3.Touch excluding genitals	47%	48%	36%
4.Touch sexually	22%	44%	50%
5.Touch including genitals	25%	60%	55%
6.Intercourse	6%	6%	9%

Key:

1. Abuser sexually exposed self to participant
2. Abuser watched participant bathe/dress in voyeuristic way
3. Abuser touched child in a sexual way excluding genitals
4. Abuser made participant touch them in a sexual way
5. Abuser touched child in a sexual way including genitals
6. Abuser had sexual intercourse with participant

Table 3.

Correlation Matrix: CSA Distress, Psychopathology, Shame, Self-esteem, and Blame in the Abused Group (N = 32)

	Shame	Self-Esteem	Perpetrator Blame	Self Blame	Family Blame	CSA Distress	GSI
Shame	1.00	-0.59**	-0.11	0.33	0.15	0.15	0.65**
Self-esteem		1.00	0.21	-0.21	-0.02	-0.10	-0.35**
Perpetrator Blame			1.00	0.35	0.24	0.49*	0.00
Self Blame				1.00	0.30	0.37**	0.26
Family Blame					1.00	0.55**	0.19
CSA Distress						1.00	0.15
GSI SCL-90-R							1.00

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

Table 4.

Correlation Matrix: CSA Distress and SCL-90-R Sub-scale Scores for Psychopathology in the Abused Group (N = 31)

	CSA Dis	Som	O.C	I.S	Dep	Anx	Hos	Phob	P.I.	P.S.
CSA Distress (CA Dis)	1.00	0.05	0.18	-0.03	0.04	0.10	-0.02	0.25	0.04	0.06
Somatic (Som)		1.00	0.66*	0.70*	0.74*	0.76*	0.66*	0.69*	0.47*	0.69*
Obsessive Compulsive (O.C.)			1.00	0.83*	0.77*	0.81*	0.65*	0.74*	0.74*	0.81*
Interpersonal Sensitivity (I.S.)				1.00	0.84*	0.78*	0.79*	0.72*	0.88*	0.84*
Depression (Dep)					1.00	0.85*	0.81*	0.63*	0.69*	0.77*
Anxiety (Anx)						1.00	0.70*	0.74*	0.66*	0.79*
Hostility (Hos)							1.00	0.57*	0.57*	0.72*
Phobia (Phob)								1.00	0.68*	0.82*
Paranoid Ideation (P.I.)									1.00	0.77*
Psychotic (P.S)										1.00

* Correlation is significant at the 0.01 level

Table 5.

Comparing Group Means for SCL-90-R Sub-Scales in Non-clinical Samples

Sub-Scale	M (SD)	Kemish Abused N = 32	Kemish Non-abused N = 127	Steel et al (2004) Abused N = 85	Steel et al (2004) Non-abused N = 172	Derogatis (1983) Non-Abused N = 974	Derogatis (1983) Adolescent Non-abused N = 806
Somatic	M (SD)	0.90 (0.82)	0.70 (0.67)	0.79 (0.63)	0.69 (0.69)	0.43 (0.47)	0.67 (0.52)
Obsessive Compulsive	M (SD)	1.29 (0.75)	1.00 (0.75)	1.35 (0.87)	1.09 (0.82)	0.44 (0.49)	1.00 (0.65)
Interpersonal Sensitivity	M (SD)	1.41 (0.92)	0.93 (0.78)	1.31 (0.93)	1.02 (0.91)	0.35 (0.43)	1.14 (0.76)
Depression	M (SD)	1.33 (0.86)	0.92 (0.75)	1.36 (0.89)	1.09 (0.86)	0.46 (0.52)	0.95 (0.72)
Anxiety	M (SD)	0.99 (0.80)	0.60 (0.65)	1.05 (0.92)	0.69 (0.70)	0.37 (0.43)	0.74 (0.64)
Hostility	M (SD)	0.97 (0.82)	0.75 (0.71)	0.82 (0.75)	0.77 (0.77)	0.33 (0.42)	0.89 (0.78)
Phobia	M (SD)	0.54 (0.70)	0.31 (0.54)	1.03 (0.83)	0.84 (0.82)	0.19 (0.38)	0.44 (0.52)
Paranoid Ideation	M (SD)	0.99 (0.84)	0.67 (0.66)	0.57 (0.80)	0.36 (0.57)	0.34 (0.46)	0.99 (0.74)
Psychoticism	M (SD)	0.75 (0.81)	0.36 (0.45)	0.81 (0.82)	0.63 (0.75)	0.15 (0.25)	0.70 (0.62)

Table 6.

One-way ANOVA Showing the Differences Between Groups on the SCL-90-R Sub-Scales

Sub-Scale	M (SD)	Abused N=31	Non-abused N=127	F	p	Cohen's d
Somatic	M (SD)	0.89 (0.81)	0.69 (0.66)	2.02	0.16	0.28
Obsessive Compulsive	M (SD)	1.29 (0.75)	1.00 (0.74)	3.72	0.05	0.27
Interpersonal Sensitivity	M (SD)	1.41 (0.91)	0.92 (0.78)	8.95	0.03	0.48
Depression	M (SD)	1.33 (0.85)	0.91 (0.74)	7.31	0.01	0.52
Anxiety	M (SD)	0.98 (0.80)	0.60 (0.65)	7.78	0.00	0.56
Hostility	M (SD)	0.96 (0.82)	0.75 (0.70)	2.22	0.10	0.26
Phobia	M (SD)	0.54 (0.69)	0.30 (0.53)	4.32	0.04	0.68
Paranoid Ideation	M (SD)	0.99 (0.84)	0.66 (0.66)	5.41	0.02	0.45
Psychoticism	M (SD)	0.75 (0.81)	0.35 (0.44)	13.49	0.00	0.93
GSI	M (SD)	1.04 (0.69)	0.73 (0.60)	6.39	0.01	0.48

Table 7.

One-way ANOVA Showing the Differences Between Groups on the Psychoticism Items

Item	M (SD)	Abused N = 31	Non-abused N = 127	F	p	Cohen's d
No 1	M SD	0.41 (0.95)	0.28 (0.74)	0.73	0.39	0.16
No 2	M SD	0.16 (0.58)	0.04 (0.30)	2.30	0.13	0.43
No 3	M SD	0.90 (1.24)	0.53 (0.99)	3.05	0.08	0.61
No 4	M SD	0.51 (1.09)	0.15 (0.55)	6.60	0.11	1.63
No 5	M SD	1.25 (1.10)	0.68 (0.90)	8.79	0.00	0.72
No 6	M SD	0.80 (1.07)	0.23 (0.67)	13.59	0.00	1.62
No 7	M SD	0.64 (1.17)	0.23 (0.66)	6.65	0.01	1.31
No 8	M SD	0.96 (1.32)	0.46 (0.90)	6.43	0.01	0.89
No 9	M SD	0.77 (1.17)	0.50 (0.88)	1.96	0.16	0.48
No 10	M SD	0.77 (1.25)	0.46 (0.98)	2.25	0.13	0.59

Key:

- No 1 The idea that someone can control your thoughts
- No 2 Hearing voices that other people do not hear
- No 3 Other people being aware of your private thoughts
- No 4 Having thoughts that are not your own
- No 5 Feeling lonely even when you are with people
- No 6 Having thoughts about sex that bother you a lot
- No 7 The idea that you should be punished for your sins
- No 8 The idea that something serious is wrong with your body
- No 9 Never feeling close to another person
- No 10 The idea that something is wrong with your mind

Table 8.

One-way ANOVA Comparison of Group Means for Shame, and Self-esteem

	M (SD)	Abused <i>N</i> =32	Non- abused <i>N</i> =126	<i>df</i>	<i>F</i>	<i>p</i>	Cohen's <i>d</i>
Shame	M	38.65	32.11	156	3.91	0.05	0.38
	SD	(17.64)	(16.44)				
Self-esteem	M	14.37	15.44	157	1.65	0.20	-0.25
	SD	(4.34)	(4.15)				



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Appendix H

Section 4: Critical Review

Running head:

PSYCHOLOGICAL DISTRESS IN ADULT SURVIVORS OF CSA: SHAME, SELF-ESTEEM AND BLAME

**Psychological Distress in Adult Survivors of Childhood Sexual Abuse:
Contributions to Theory, Clinical Practice and Learning**

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Contributions to Theory, Clinical Practice, and Learning

This study focused on the relationship between a reported CSA history, CSA distress and adult psychopathology. Given that no obvious correlation between CSA and psychopathology was found it was not possible to demonstrate shame, self-esteem, blame as risk factors in the development of adult psychopathology. However, further analysis of the groups in this study highlighted some interesting differences within the Abused and the Non-Abused groups which may lend some support to the existing research on CSA and adult psychopathology.

Implications for Future Research and Theory Development

The question remains as to why CSA survivors with mental health difficulties consistently present with high levels of shame, low of self-esteem and attributions of blame and whether these factors have some role in mediating the well-established association between CSA and adult psychopathology.

A number of methodological difficulties may be encountered when conducting research that is of a sensitive nature. One of the issues highlighted in this study regarded the recruitment of volunteers. The undergraduate population used in this study had a mandatory requirement to participate in three hours of experiments per semester. Given that participation was considered to be 'voluntary' it might be suggested that participation was only voluntary in as much as the students were able to choose the experiments they might prefer to participate in order to obtain course credits. As the undergraduate course credit system is generally not designed to promote anonymity, a system that registered their participation and maintained anonymity was negotiated and employed. Although complete anonymity was assured, there may have been a danger that individuals might suspect that their questionnaires could be traced, and it is possible that this may have prevented valuable participation.

The investigation of the Subscales in the SCL-90-R highlighted some unexpected findings. The most surprising were the results for the Psychoticism subscale that indicated that the Abused group in this study experienced higher levels of psychoticism and especially in response to the item *having thoughts that are not your own*.

Recent psychosis research has focused on hallucinations, and most specifically voices commenting, and suggest that command hallucination are likely to occur following a reported history of CSA (Read, Agar, Argyle & Aderhold, 2003; Read, van Os, Morrison & Ross, 2005). This area of research is fairly new, but this may turn out to be a target area for early intervention which according to the National Service Framework for Mental Health appears to be a key factor not only in reducing the impact of psychosis but also in reducing morbidity (Department of Health, 1999).

In addition to psychoticism, large effect sizes were generated for the subscales of Interpersonal Sensitivity, Depression, Anxiety, Phobia and Paranoia. These results are consistent with some of the existing literature that links CSA and psychopathology. Although researchers have consistently found associations between CSA and depression (Andrews, 1995; Steel et al., 2004), and increased levels of anxiety (Levitan, Rector, Sheldon & Goering, 2003) the author is not familiar with any literature that highlights associations between CSA and Phobia, Paranoia and Psychoticism. Results of a recent study by Whiffen and MacIntosh (2005) have highlighted interpersonal difficulties as a mediator between CSA and adult psychopathology. Given the subscale results from this study, it is suggested that Phobia, Paranoia and Psychoticism warrants further investigation with a larger sample size using appropriate and specific measures.

This study indicated the occurrence of shame and low self-esteem in the Abused group and this concurs with much of the contemporary literature (Feiring & Taska, 2002a; Whiffen & MacIntosh, 2005; Andrews, 1995; Gilbert, 2005). These findings are

also consistent with clinical observations of individuals who report a history of CSA. Attributions of self-blame are also found in the presentations of CSA survivors but in the Abused group in this study these attributions were not found and this was surprising. It is possible that these attributions develop concurrent to the psychopathology that prompts survivors to seek help. Research has linked CSA that involves intercourse with feelings of self-blame (Coffey et al., 1996); the minimal reporting of this type of abuse in the current study may explain why self-blaming attributions were not found in this sample in this study. Again, this warrants further investigation with clinical and non-clinical participants.

The severity of abuse in *this sample* has been touched upon briefly, and the suggestion that the Abused sample in this study were at the less severe end of the spectrum warrants further discussion about what makes abuse severe, and who decides? In an attempt to rate severity, researchers have implicated CSA-related variables that include: age at onset of abuse, duration, relationship with perpetrator, grooming methods, coercion or use of force and the factors surrounding disclosure (Steel et al., 2004). A meta-analysis suggested that CSA involving intercourse was the most severe form of abuse (Rind, Tromovitch & Bauserman, 1998). Clinical observations and presentations of female CSA survivors indicate that the individual nature of the experience, their level of distress, and their perceptions might be more accurate indicators of abuse severity. One survivors' experience of CSA and the resulting sequelae is likely to be considerably different from the next because the severity of their abuse is rated according to numerous variables that may include their beliefs, cognitions and the context in which the abuse occurred. It is therefore difficult to comment that abuse involving intercourse is the most severe form of abuse and that this is the type of abuse that will cause the most distress. In consideration of these factors the "severity" of

CSA experiences in this study was assessed using a novel CSA distress scale. It was hoped that this new measure would account for individuality, and suitably capture CSA distress, however it is considered as a weakness of the study. Given that there is no standardised measure for CSA distress available, it is suggested that distress, as a variable of CSA warrants further investigation, especially given its subjectivity and lack of clear qualification in the literature.

Further difficulties were encountered with definitions; many CSA studies often use different definitions and combinations of characteristics in their definitions; these include: intercourse, masturbation, exposure, voyeurism, pornography, the use of threats or force, and ages of perpetrator and victim. Some researchers simply use the legal criteria in place within their country (e.g., Helweg-Larsen & Larsen, 2002). In addition, many definitions of CSA still fail to include experiences where the child is subjected to exposure, voyeurism or pornography (Sgroi, 1982; cited in Hall & Lloyd, 1993). Inconsistent use of definition may create wide variations within results.

As with most research, this study has raised more questions than it has answered. If improved interventions are to be developed to inhibit the risk of emotional distress, longitudinal research is needed that takes account of the context in which the abuse occurs; the relationships of the people involved in the abuse; context at disclosure; age; grooming methods; frequency and 'severity' of abuse; and familial support, and coping styles. By controlling for these and other confounding variables it might yet be possible to predict with greater accuracy how CSA provides the framework that facilitates the development of psychopathology; and furthermore how issues of shame, self-esteem and blame may be implicated in such developments. There currently appears to be a focus on what mediates CSA and its sequelae, but scant attention is paid to the moderators, or the characteristics that may promote resilience, or act as a buffer to CSA

trauma and subsequent psychological difficulties. Greater understanding of these factors may facilitate clinical interventions to improve resilience against trauma, and reduce the risk of developing psychological sequelae.

Implications for Clinical Practice

Given that CSA survivors continue to report high levels of shame, low self-esteem and a tendency to take on responsibility for the abuse, the author continues to reflect on these issues as contributory factors in the aetiology of psychopathology. However, until researchers are able to quantify the contribution of these features more clearly, clinicians can only intervene in response to the difficulties that CSA survivors bring to therapy.

Issues of improved training and CPD for Clinical Psychologists have been raised as a result of informal discussions with colleagues about this research and specifically about working with CSA survivors. The anecdotal response from seven out of eight of the authors' peers reported apprehension at the prospect of undertaking therapy with CSA survivors and all reported feeling ill-equipped to conduct therapy with survivors. This was surprising given the respondents' level of, and progression through training; this is acknowledged as an area for further training, ongoing CPD and supervision.

Process/Personal Issues Arising From the Conduct of the Research

I have developed enormous respect and admiration for the women who endured sexual abuse in childhood and who have the courage to face their difficulties. These are the women from whom I took my inspiration to carry out this research. The process of carrying out the research has afforded me valuable knowledge both as a researcher and as a clinician; it has enthused my continued personal development in the area of shame and its implication with CSA and has subsequently led to an interest in Compassionate Mind Therapy (Gilbert, 2005). This is a therapy that advocates the development of

interventions that tone up and foster certain types of positive emotions like compassion, rather than toning down negative emotions like anxiety, fear, anger and sadness which other therapies have tried to do. Although this intervention is still in its infancy in terms of an evidence-base, it shows promise of being an exciting new prospect in working with survivors of CSA; it offers individuals the opportunity to develop the ability for self-compassion as an antidote to their self-defeating feelings of responsibility, shame, and subsequent levels of low self-esteem.

My reflection on work-life balance during this time highlighted definitions that used words like stability and harmony and I realised that the process of writing this thesis was anything but stable or harmonious. I was informed that a failure to promote a work-life balance generates an increased vulnerability to mental illness, characterised by increased distress, impaired cognitive functioning, atypical behaviour, emotional dysregulation and maladaptive behaviour – at various times I think I scored on all counts! On a serious note, given the nature of this research and the fact that I have concurrently worked with several CSA survivors, I was aware of the danger of becoming too immersed in this emotive subject and I attempted to maintain a modicum of the recommended work-life balance. Maintaining this kind of balance meant juggling my own needs and those of my children with the requirements of the D.Clin.Psy. and I was often faced with difficult dilemmas.

This research has provided the opportunity to develop a whole range of new skills that included: planning, participant recruitment (which I naively thought would be straightforward, but which in reality created practical difficulties in terms of recruiting and maintaining anonymity), research and statistical skills, balancing my study and work life with the needs of a family, being mindful of increased anxiety and managing

it, and finally in accordance with Paul Gilbert's theory (2005) demonstrating self-compassion when I 'got it wrong.'

I was aware that the most demanding aspect of this piece of work was going to be the empirical paper - specifically the section devoted to data analysis and interpretation. Although painfully aware of my limited numerical skills, I could not have imagined the depth of this challenge, or how close I came to admitting defeat. Throughout this challenge I clung to the belief that I am inherently more skilled as a clinician than as a researcher. Although clinical work is where my heart lies, I can be content in the knowledge that any future research in which I participate would be approached in a more relaxed way that reflected my newly acquired skills.

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Word Counts

Thesis Abstracts.....	389
Ethics Proposal.....	4,369
Literature Review.....	10,015
Empirical Paper.....	5,962
Critical Review.....	1,965
Sub Total.....	22,700

References, appendices and tables

Ethics proposal - references and appendices.....	8,273
Literature review - references and appendices	2,527
Empirical paper - references and tables.....	2,583
Critical Review - references and appendices.....	260
Sub Total.....	13,643

Additional word counts

Title, summary, contents pages, declaration, acknowledgements...	871
Sub Total.....	871

Total thesis word count..... 37,214