AN ABSTRACT OF THE THESIS OF

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Title: TREATMENT OF ADULT SURVIVORS OF SEXUAL ABUSE: THE EFFECTS OF DEGREE OF SEXUAL ABUSE AND LENGTH OF TREATMENT ON DEATH ANXIETY

Abstract approved: Nancy M. Knapp

The purpose of this paper was to examine the relationship between childhood sexual abuse and death anxiety as measured by Templer's Death Anxiety Scale. The focus was on two variables: degree of sexual abuse (high, low) and length of treatment (12 or less months, 13 or more months). Subjects included 45 adult female survivors of childhood sexual abuse defined as any unwanted sexual experience that occurred before the age of 18. Subjects were engaged in treatment at the time of the research. It was hypothesized that those who experienced high degrees of sexual abuse, for example penetration or rape, would report higher death anxiety than those who experienced a less severe degree of abuse such as sexual suggestions, fondling, or oral manipulation of the genitals. The results did not support this hypothesis. It was hypothesized that those who had been in treatment for 13 months or longer would have lower death anxiety scale (DAS) scores than those who had only been involved in therapy for 12

months or less. Results found those who had been in treatment longer had significantly higher death anxiety than those in treatment for 12 months or less. A statistically significant interaction of degree of sexual abuse and length of treatment as related to DAS scores was found, although the limited number of subjects categorized for low abuse does not allow for a valid analysis of the findings. Suggestions for future research were made.

TREATMENT OF ADULT SURVIVORS OF SEXUAL ABUSE: THE EFFECTS OF DEGREE OF SEXUAL ABUSE AND LENGTH OF TREATMENT ON DEATH ANXIETY

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CHAPTER 1

INTRODUCTION

Most clients who receive treatment for sexual abuse actually pursue therapy for reasons other than the abuse. Pressing issues such as low self-esteem, anxiety, unhealthy interpersonal relationships, substance abuse, or eating disorders are examples of concerns likely to bring them to therapy. The literature about sexual abuse focuses primarily on treatment involving depression (Garnefski, van Egmond, & Straatman, 1990; Gorcey, Santiago, & McCall-Perez, 1986; Mackey, Sereika, Weissfeld, Hacker, Zender, & Heard, 1992; Patten, Gatz, Jones, & Thomas, 1989; Wolfe, Gentile, & Wolfe, 1989), with very little information relating sexual abuse to death anxiety.

When a client enters therapy, a treatment plan is usually developed. This includes therapy goals with objectives mapping out how each goal might be attained. The treatment plan is generally based on the diagnoses made at the time of the intake assessment and depends on the information gained from this initial meeting. Consciously or unconsciously, however, much may be left unspoken by the client. For this reason, the therapist's awareness of unexpressed symptoms that could be indicative of death anxiety as it relates to sexual abuse may be crucial for efficient and effective outcomes.

Statement of Problem

As a result of confounding problems such as low self-esteem, substance abuse, and eating disorders, it is important to be aware of potential underlying issues that may need to be addressed once therapy begins. For example, if a severely sexually abused survivor had death anxiety originating with the occurrence of the abuse, this issue is less likely to be neglected if the therapist knows to observe the possible symptoms of death anxiety as it relates to sexual abuse. Knowing a particular client is experiencing any degree of death anxiety may allow the therapist to be more sensitive to such issues at a much earlier stage in the therapy process than if the therapist did not anticipate this possibility. Awareness of the degree of sexual abuse the client has experienced may give the therapist an idea of how much emphasis the treatment of the death anxiety requires.

Statement of Purpose

The purpose of this research was to explore the relationship between sexual abuse and death anxiety. Specifically, the relationships between a survivor's degree of sexual abuse and intensity of death anxiety scale (DAS) scores and between the length of treatment and DAS scores were examined. The intention of the study was to provide information to enable therapists to provide adult female survivors the most adequate treatment for their particular

problems as related to their sexual abuse experience. Despite the limitations for generalizing the results to all survivors of childhood sexual abuse, the findings should be useful for other populations, and will be added to the literature so further investigations can be developed.

Statement of Significance

Providing proper treatment for each individual seeking help is crucial. Screening for death anxiety may be necessary before successful treatment can be achieved with this specific population of sexual abuse survivors. This factor does not appear to be addressed by therapists when engaging in treatment of sexual abuse survivors. As a result, this oversight may have an adverse effect on the client's successful completion of therapy. Identifying specific areas of conflict may allow therapy to focus on the root of the problem at an earlier stage, thus reducing the chance of the client receiving improper treatment, needlessly prolonging treatment, or delaying a healthy resolution concerning her experience. The findings of the present study are intended to increase the possibility that sexual abuse survivors will receive the most beneficial treatment available to them.

Literature Review

Past research involving treatment of adult survivors of child sexual abuse has addressed many valid issues, such as repressed memories (Herman & Schatzow, 1987), family

characteristics (Alexander & Lupfer, 1987), and memory retrieval of incest survivors (Courtois, 1992). However, research concerning the relationship between death anxiety and sexual abuse does not appear to exist. Descriptions of the relationship of death anxiety to depression or the relationship of depression to sexual abuse do exist separately and are pertinent for this study. Apparently no research has been done in an effort to link death anxiety and sexual abuse, which is the purpose of this present study.

Depression

Survivors of sexual abuse frequently seek treatment for anxiety, depression, and/or suicide ideations or attempts, which are common symptoms of abuse, rather than for the sexual abuse itself (Browne & Finkelhor, 1986; Summit, 1983; Wolfe et al., 1989). Depression involving both adolescents and adults appears to be a common variable in sexual abuse literature. Research focusing on Multiple Personality Disorder (MPD) and Post Traumatic Stress Disorder (PTSD) indicates sexual abuse is a common underlying factor to these diagnoses.

Post Traumatic Stress Disorder is a frequent diagnosis in survivors of childhood abuse (Briere & Runtz, 1987; Fallon & Coffman, 1991; Turkus, 1992; Young, 1992). Wolfe et al. (1989) suggest childhood sexual abuse meets the definition of "trauma" by the Diagnostic and Statistical

Manual-III-Revised (DSM-III-R) (American Psychiatric Association, 1987). Clinical descriptions of sexually abused children indicate that many survivors show at least some PTSD characteristics (Wolfe et al., 1989). Patten et al. (1989) indicate PTSD symptoms are sometimes diagnosed as major depression. In addition to clients with PTSD, depression is also exhibited by sexual abuse survivors, and often acts as a blanket which may mask the symptoms of the sexual abuse. Depression may be the presenting problem for which an abuse survivor seeks treatment. Usually this is when the survivor is an adult.

Symptoms of depression as a result of child sexual abuse appear to persist throughout the adult years. Mackey et al. (1992) completed a study on factors associated with long-term depressive symptoms of sexual assault victims. The purpose of their study was to investigate the severity of depressive symptoms following sexual assault, as indicated by self-report and a standardized instrument measuring the severity of depressive symptoms.

Subjects consisted of 69 volunteers solicited through local newspaper advertisements directed toward those who had experienced sexual assault or abuse by acquaintances, strangers, or health care professionals. Subjects were also recruited from rape crisis centers. Background assault situation variables (including resistance by the victim resulting in harm to the assailant; a pending civil suit;

and the assault taking place in the victim's home), and contextual variables (including nondisclosure of the assault to others due to shame; being sexually dysfunctional; fear of being stigmatized, blamed, or that a relationship might end; fear of sexual intercourse; and not being currently sexually active) both show a significant relationship with depression. No demographic variables were significantly associated with depressive symptomatology. The first hypothesis in the Mackey et al. (1992) study, that the majority of the assaulted women would report clinical symptoms of depression, was not supported, although two-thirds of the women who had experienced a rape in the past demonstrated depressive symptoms, and more than one-third of those symptoms were reported as being moderate or severe.

Garnefski et al. (1990) researched the influence of early and recent life stress on severity of depression in the Netherlands. The study attempted to increase knowledge on the relationship between life stress and the severity of depression by including important life events and life strains of their subjects. The authors also focused on the influence of life stressors arising in different life stages on the severity of depression. The primary purpose of the study was an attempt to differentiate between suicidal depressives and nonsuicidal depressives, and to predict suicidal behavior in the selected high-risk group.

Subjects consisted of 123 females with an average age of 42.7 who met the DSM-III criteria for major depression were selected by their general practitioner. In the Garnefski et al. (1990) study, a Dutch translation of the Beck Depression Inventory (BDI) was utilized as the instrument to assess severity of depression. In addition, a Dutch translation of the Mooney Problem Checklist was chosen to assess previous and recent life strains.

Results showed those who reported physical or sexual abuse, difficulties with parents or social relationships in general, that had occurred prior to the age of 11, had significantly higher depression scores than those who did not. Difficulties with social relationships in the first period of life (r = .29), followed by the same difficulties in later periods (r = .27 at ages 12 - 18, r = .41 one year prior to the interview) and difficulties with self-esteem within a year prior to the interview (r = .49), were found to have the strongest associations with a more severe level of depression. Difficulties with parents within the last year prior to the interview (r = .52) appeared to be the only variable having direct effects on severity of depression (Garnefski et al., 1990). Problems with parents starting at an early age in life seem to bear a direct relationship to severity of depression.

The authors concluded ineffective social functioning early in life is strongly related to the severity of

depression at a later stage. Physical or sexual abuse occurring before the age of 18 and problems with parents and other social relationships are strongly related to the severity of depression. Thus, when exploring the origin of severe depression, it seems important to pay attention to sexual or physical abuse which occurred at a young age.

Suicide

Suicide has also been described as a type of escape for some sexual abuse survivors (Briere, 1988). Attempted suicide is a common problem reported by sexual abuse survivors (McLaren & Brown, 1989, Young, 1992). According to Young (1992), such behaviors as self-mutilation and suicide attempts by sexual abuse survivors may be viewed as self-abuse by the general public. However, these behaviors are not experienced as self-abuse by many trauma survivors.

A study pertaining to suicide of patients in a military hospital was done by Brown and Anderson (1991). Their research sample is believed to be the largest group of consecutively admitted adult psychiatric inpatients to be interviewed for childhood histories of sexual and physical abuse (1,019 admissions). The subjects consisted of 66% active duty personnel and 34% civilians who were admitted as patients of the Wilford Hall Medical Center, the U.S. Air Force's largest tertiary-care medical center. Each patient was evaluated by at least one of two psychiatrists who were part of the faculty of the Center's psychiatry residence

training program. Histories of physical and sexual abuse were elicited through direct questioning.

Suicidality was the most common symptom on admission for abused patients and was also more common in the abused than the nonabused psychiatric inpatients who acted as a comparison group for the study. Significantly more of the patients with either sexual or physical abuse in their childhood were suicidal on admission. "Many of the suicidal abused patients had no accompanying Axis I psychiatric disorders and could not identify why they were suicidal, but they noted that this was a chronic, intermittent symptom beginning sometime after they had been abused" (Brown and Anderson, 1991, p. 59).

In Briere, Evans, Runtz, and Wall (1988), 80 sexually abused clients of a community mental health center gave abuse and suicide attempt histories and completed the Trauma Symptom Checklist (TSC)which consisted of five clinical subscales (Dissociation, Anxiety, Depression, Sleep Disturbance, and hypothesized Post Sexual Abuse Trauma). Females experienced more extensive sexual abuse and were typically abused to a later age than males. No gender difference existed on the age when the sexual abuse began or on the relative prevalence of incest, however. Male and female sexual abuse survivors had an equally high percentage (55%) of previous suicide attempts compared to the nonabused groups (20-25%).

In a study by Briere (1988), 195 female outpatient clients were administered the Crisis Symptom Checklist (CSC) and were given an overall measure of previous suicidal behavior. Histories were taken of rape or sexual assault during adulthood (since age 16) as well as client reports of self-mutilating behavior. ANOVA results found that former sexual abuse survivors scored significantly higher on the dissociation scale of the CSC, were more suicidal in the past, and reported more self-mutilation than subjects who reported having no sexual abuse history. Simple correlation analysis indicated that more severe forms of sexual abuse accompanied by physical abuse may produce a variety of psychological problems. It was also determined that abuse involving sexual intercourse may result in high levels of dissociation and suicidality.

An additional study by Briere and Runtz (1987) found that former sexual abuse survivors were significantly more likely to have made at least one suicide attempt than nonabused clients. Abuse survivors were more likely to report a variety of dissociative experiences and self-destructiveness. According to these authors, the anger found among former sexual abuse survivors seems to produce a "chronic experience of rage" that may be directed toward the self through suicidality or self-mutilation.

Death Anxiety

There appears to be no research precisely aimed at the possibility of death anxiety in sexual abuse survivors. Such specific topics involving bereavement, suicide, and terminally ill patients (Family, 1992-93; Gibbs & Achterberg-Lawlis, 1978; Hayslip, Luhr, & Beyerlein, 1991-92) involve elements of the Death Anxiety Scale (DAS). However, little research involving a specific measurement of death anxiety in sexual abuse survivors seems to exist in the literature.

Levin (1989-90) examined the dimensionality of death anxiety using the DAS and the Minnesota Multiphasic Personality Inventory (MMPI). The DAS was factor analyzed to confirm that a general factor underlies the DAS. Analysis was further completed to extract a second-order general factor, to examine the relationships between the obtained factors and personality variables represented by the MMPI, and to determine if the above personality profile of the high DAS scorer is supported when using general factor scores in place of raw DAS scores.

Volunteers consisted of 105 individuals recruited from university classes and newspaper advertisements. The mean age was 28.2. Participants were administered the group form of the MMPI, the DAS, and the Marlowe-Crowne Social Desirability Scale. The DAS correlated negatively with sex, with females yielding higher DAS scores. DAS raw scores

were negatively correlated with the Marlowe-Crowne Social Desirability Scale. No significant relationship was found between age and DAS scores (Levin, 1989-90).

Death Anxiety and Depression

As mentioned earlier, very little research exploring death anxiety, depression, and sexual abuse in combination seems to be available. Gilliland and Templer (1985-86) conducted a study on the relationship between Death Anxiety Scale factors and subjective states to determine the relationship between the factors of the DAS and various psychometric measures of distress. Subjects consisted of 166 individuals from a general population and 120 inpatient psychiatric patients. All subjects were administered 7 psychometric instruments: Templer's Death Anxiety Scale, Bendig's Pittsburgh Revision of the Manifest Anxiety Scale, Taylor's Manifest Anxiety Scale, Spielberger, Gorsuch and Lushene's State-Trait Anxiety Inventory, the Beck Depression Inventory, Berndt's Multi-score Depression Inventory, and the Mosher Forced Choice Guilt Scale Inventory.

The DAS was positively correlated with measures of depression and anxiety for both groups of subjects, although measures of anxiety tended to correlate somewhat more highly with DAS scores than did the measures of depression. For the general population, the factor referred to as "fear of death and dying" was unrelated to depression and anxiety, but was positively correlated with the remaining factors--

"thoughts and talk of death", "subjective proximity to death", and "fear of the unknown"--that seem to be related to obsessions pertaining to death.

Gilliland and Templer (1985-86) proposed that the first factor of the DAS represents fear of death and is associated more with specific experience pertaining to death and the remaining three factors are associated causally with psychopathology. The psychiatric inpatients scored higher than did the general population on the DAS. Death anxiety was also found to be significant with the psychiatric patients. The authors concluded the total DAS score and its factors correlated more highly with trait than with state anxiety. These factors do not ordinarily shift from moment to moment, suggesting that "an individual's current death anxiety is more apt to rise or fall as defenses are broken down or shored up" (p.163-164).

In a study focusing on state-trait anxiety rather than death anxiety, Gorcey et al. (1986) examined psychological consequences for women sexually abused in childhood. They investigated the long-term psychological effects of sexual abuse by using objective measures of fear, depression, and anxiety. They proposed to subjectively confirm long-term problems in sexuality and interpersonal relationships in women who had been sexually abused as children. Subjects consisted of 41 females recruited through public advertisements and letters sent to mental health

professionals. Fifty-six female volunteers who were not victims of sexual abuse acted as a control group. All subjects were interviewed individually by a Master's level therapist trained in working with survivors of sexual assault. The subjects were next administered the BDI, the Spielberger State Trait Anxiety Inventory (STAI) and a modified version of the Fear Survey Inventory (FSI), to assess depression, anxiety, and fear. A 12-item Impact Interview was designed for the study and was administered to the sexually assaulted subjects in order to obtain information on the subjects' sexuality and interpersonal relationships.

Scores on the BDI indicated abused subjects were significantly more depressed than the control subjects. The abused subjects reported higher levels of anxiety and more generalized anxiety than the control group, as exhibited in the STAI scores. Scores on the FSI show that the abused group accounted for more fearfulness than the control group. Results from the 12-item Impact Interview Scale confirm that "almost one half of the abused subjects ranked the childhood sexual abuse experience as having more impact on their lives than any other life event." (Gorcey et al. 1986, p. 131). These same subjects reported difficulties in relating to both sexes, and in engaging in sexual intimacy. In the area of sexual functioning and intimacy, 85% of the sexually abused subjects described problems in sexual relationships.

Gorcey et al. (1986) suggest clinicians should not underestimate the long-term effects of early childhood sexual assaults as "the experiences may carry a deadly combination in later life: intense symptoms of anxiety and fear and depression, along with a belief that they must keep their shameful secret to themselves" (p. 132).

Summary

The existence of a relationship of death anxiety to depression and the relationship of depression to sexual abuse was evidenced in the literature review. Gilliland and Templer (1985-86) found that the DAS was positively correlated with measures of depression. Several studies concluded depression is a common symptom of survivors of sexual abuse (Browne & Finkelhor, 1986; Mackey et al., 1992; Summit, 1983; Wolfe et al., 1989). Sexual abuse survivors are frequently diagnosed with PTSD (Briere & Runtz, 1987; Fallon & Coffman, 1991; Turkus, 1992; Young, 1992), although the symptoms of PTSD are sometimes diagnosed as major depression (Patten et al., 1989). Briere (1988) concluded that a number of sexual abuse survivors use suicide as an escape. Briere and Runtz (1987) and Briere et al. (1988) discovered through their research that sexual abuse survivors had high suicide attempts in their past. Perhaps those who have endured sexual abuse may perceive death as being less traumatic than re-experiencing the abuse itself. The research completed by Gorcey et al. (1986) provides the

most pertinent evidence of a possible link between (death) anxiety and sexual abuse, although their research focused on state-trait anxiety rather than death anxiety specifically. It was concluded by these authors that abused subjects were more depressed, had higher levels of anxiety, and more generalized anxiety than the control group in the study.

Relationships between death anxiety and depression and between depression and sexual abuse exist. Therefore, it seems possible to generalize from these studies that a link does exist between death anxiety and sexual abuse.

The purpose of the current study was to investigate the effects of the degree of sexual abuse and the length of treatment as reflected in death anxiety scale scores of adult survivors of sexual abuse. First, it was hypothesized that survivors who experienced more severe degrees of sexual abuse, such as penetration or rape, would exhibit higher death anxiety than those who encountered a less severe degree of abuse involving sexual suggestions or fondling. Second, it was hypothesized that those who had been engaged in treatment for 13 months or longer would have lesser amounts of death anxiety than those who had only been involved in therapy for 12 months or less. Third, it was hypothesized there would be a relationship between the degree of sexual abuse and the length of treatment, as reflected in the subjects' scores on the DAS.

CHAPTER 2

METHOD

This study utilized a clinical sample of females to measure the degree of sexual abuse and the length of treatment as it relates to death anxiety. Two questionnaires were used to gain the information necessary for the study.

Subjects

The sample for this study consisted of 45 adult female survivors of childhood sexual abuse involved in individual or group therapy. The term "adult survivors" refers to those 18 years of age or older. Wyatt and Peters (1986) examined the issue of definitions of child sexual abuse in research studies. They focused on four studies and their separate definitions of child abuse. For the survivor, the upper age limit for child sexual abuse was 16 in two studies, and 17 for the remaining two studies. All types of contact and noncontact (no physical contact between survivor and perpetrator) abuse were included in three of the four studies. The fourth study specified the type of abuse with intra- and extra-familial abuse. Age discrepancy between survivor and perpetrator was the defining characteristic. For purposes of the present study, the definition for childhood sexual abuse was simplified to involve any

unwanted sexual experience which occurred before the survivor turned 18 years of age.

The female pronoun is used in this paper because all subjects were female. However, this is not intended to imply that only females are survivors of sexual abuse.

Thirty-eight of the 45 subjects were Caucasian, two were Hispanic, one was African American, and four did not specify their ethnic origin. Their mean age was 34, with a range from 20 to 68 years of age and a standard deviation (SD) of 9.0. The majority of the participants received an average of 12 years of education. One-third of the subjects had been in treatment for 13 months or longer, although the average length of treatment was eight months with a standard deviation of 4.7 months. Nearly two-thirds of the participants had not received treatment prior to their current engagement in therapy. For those who had joined treatment prior to attending the current agency, the mean length of prior treatment was 18 months (SD = 12), with termination of that treatment taking place an average of three and one-half years earlier.

The mean age at which the initial victimization took place was six years (SD = 3.7), with a mode of 4 years. This finding agrees with research done by Summit (1983) which states most survivors are less than

eight years of age at the time of the initial abuse. Six participants were unable to specify their age of initial victimization. The abuse persisted an average of eight years; however, 12 subjects were unable to specify the length of their abuse experience. Over two-thirds or 33 of the subjects indicated they endured both low (sexual suggestions, fondling, oral manipulation of the genitals) and high (anal or rectal penetration, rape) degrees of abuse, 9 subjects experienced low abuse only, and 2 subjects experienced high abuse only. One subject was unable to identify any specific information relating to any abuse, as she indicated that she was speculating having been abused as a child.

Empirical studies reviewed by Browne and Finkelhor (1986) found that the type of abuse endured is related to the degree of trauma in the survivor, further explaining that any genital contact (i.e., fondling, penetration, or intercourse) seems to be more serious for the survivor. In the present study, there was an average of two different perpetrators per subject, with a parent being identified by 22 subjects as the most common perpetrator. According to reviews of the literature on sexual abuse done by Summit (1983) and Browne and Finkelhor (1986), a child is more likely to be victimized by a trusted adult than by a stranger,

and this close emotional contact with the abuser makes the incident more traumatic than if the abuse was enacted by someone outside the family unit. On the questionnaire used in this study, the category which included "Other" perpetrators received the next highest tally, with 16 subjects marking this category. These perpetrators consisted of friends of the family, babysitters, ex-husbands, women in foster homes, sister's employer, boyfriends, classmates, school maintenance men, and friends. A sibling was the third most common perpetrator, with a frequency of 14; distant relative or in-law was indicated by 12 subjects. Step-parent or grandparent each had 7 counts, and stranger had 5. Authority figure and neighbor were the lowest categories, with scores of 4 and 3 respectively. Six subjects sought legal intervention for the abuse, either immediately following the incident or three to five years later. Legal resolution was achieved in two cases, three and six years later.

Subjects were recruited from two Midwestern community Mental Health Centers: Mental Health Center of East Central Kansas (MHCECK), located in Emporia, KS, and Pawnee Mental Health Services (PMHS), located in Concordia, Manhattan, and Junction City, KS. Clients volunteered via specific procedures through

their therapist at the facility involved. Return rate from the solicitation forms distributed at MHCECK was 17% and the return rate for the three combined facilities of PMHS was 45%.

Materials

Two versions (Appendix A & B) of a form were designed to solicit participation. An informed consent form (Appendix C) was included. A background questionnaire (Appendix D) was developed for the present study by the investigator. The questionnaire identified specific demographic information and defined variables that directly involved the sexual abuse history of the subject. The questionnaire was presented to three professors of Psychology at Emporia State University for review. In addition, subjects were administered a standardized questionnaire and Templer's Death Anxiety Scale (DAS) (Templer, 1970) (Appendix E). The scale originally consisted of 40 true-false items which were rated according to their face validity by seven judges. As a result of the ratings, 15 total items were retained, 9 of which are scored as "true" and 6 that are scored as "false." Point biserial coefficients for three independent groups of subjects were employed to determine internal consistency. Items with point biserial coefficients of .10 significance level in two out of three analyses

were retained. A product-moment correlation coefficient of 0.83 showed adequate test-retest reliability, and a coefficient of 0.76 demonstrated internal consistency (Templer, 1970).

Each client was given the opportunity to request an explanation of the general results of the study as well as the specific results of her DAS questionnaire. These were to be discussed by her therapist (see Appendix F). For purposes of the present study, the degree of sexual abuse was defined as the extent of the sexual abuse experienced in childhood, involving two categories: 1) sexual suggestions, fondling, or oral manipulation of the genitals, 2) vaginal penetration, rectal penetration, or rape. Rape was defined in this study to involve penile penetration.

Length of treatment, as addressed on the questionnaire, took into account the total length of time each individual subject had received treatment with a mental health professional. Subjects indicated their length of treatment by circling the number closest to the longest period of treatment that they had received at the present facility. In addition, subjects were requested to indicate whether they had received treatment for sexual abuse prior to attending the current agency. If they had received such treatment, they were to specify the length of prior

treatment, as well as how long ago that treatment ended.

Age at which victimization began was also part of the questionnaire. This included the age of the survivor at the time of the first incident of abuse with the first perpetrator (if there were multiple perpetrators) and the duration of the abuse, or length of time the abuse persisted or took place.

Procedure

Two separate procedures for administering the packets were utilized due to the necessity of using different methods as dictated by the facilities involved. For the administration of the packets to the clients of MHCECK, subjects were solicited for participation through their therapist who gave them a form (Appendix A) devised by the investigator, a Caucasian female obtaining a Master's degree in Clinical Psychology. The volunteer slips were sealed in an envelope and returned to the primary investigator via a box labeled for that specific purpose. Next, separate appointments for participation in the research study were scheduled with the client by the primary investigator. Meetings were scheduled prior to the client's therapy session to control for any carryover effect immediately following a session. Each subject's therapist or an emergency services staff member was

available if any discomfort was experienced by the client's participation. Before administration of the questionnaire and DAS began, each subject was asked to read and sign an informed consent (see Appendix C). Upon completion of the forms, each client was given the opportunity to request overall findings of the study as well as her individual results on the DAS.

Packets were mailed to the therapists in the three Pawnee facilities to be distributed to the clients participating. The packets contained a revised version of the solicitation form used with the first group of subjects (Appendix B). The form allowed the clients to make the decision to participate or not to participate, and were then instructed to return the forms (blank or filled out) by mail in an envelope addressed to the primary investigator. Identical consent forms, questionnaires, the DAS, and request for results forms were used in both packets.

Design

The research design for this study consisted of a 2 (Degree of Sexual Abuse: low, high) X 2 (Length of Treatment: 12 months or less, 13 months or more) factorial design. A frequency distribution was used to determine the subjects' total length of treatment. This included the length of current treatment added to

the length of prior treatment. Death anxiety was measured as the dependent variable.

CHAPTER 3

RESULTS

The data was analyzed using a SAS(R) 5.16 VSE 2.1.7 computer program that is part of a mainframe system on the Emporia State University campus. A 2 X 2 (Degree of Sexual Abuse X Length of Treatment) analysis of variance (ANOVA) was conducted with Death Anxiety Scale (DAS) scores serving as the dependent variable. An alpha level of .05 was used throughout. Forty-four observations were used in the analysis, as one subject was unable to specify any information in relation to her speculative sexual abuse experience.

The interaction of degree of sexual abuse by length of treatment was found to be statistically significant, $F(1, 43) = 5.74$, $p < .05$. However, as indicated in Table 1, which includes treatment means, standard deviations, and cell sizes, the small cell size ($n = 2$) for low degree of abuse at 13 months or more, precludes analyzing the interaction. The main effect of length of treatment was statistically significant, $F(1, 43) = 6.80$, $p < .05$. Those subjects who had been engaged in treatment for 13 months or longer had higher death anxiety ($M = 8.3$) than the subjects who were in treatment for twelve months or less ($M = 7.0$). The main effect of degree of sexual abuse was not significant.

Table 1

Means, Standard Deviations, and Cell Size of Death Anxiety Scale (DAS) Scores

		Degree of Sexual Abuse		
		Low	High	TOTAL
Length of Treatment	12 months or less	6.43	7.56	13.99
		(3.10)	(2.78)	(5.88)
		n = 7	n = 16	n = 23
	13 months or more	13.00	7.84	20.84
		(1.41)	(3.24)	(4.65)
		n = 2	n = 19	n = 21
	TOTAL	19.43	15.40	34.83
		(4.51)	(6.02)	(10.53)
		n = 9	n = 35	n = 44

Additional statistical analyses yielded eight significant correlational relationships. Pearson product-moment correlation coefficients were obtained for the 22 variables involved in the study. Significant positive relationships were found between the time elapsed since termination of prior treatment and age (r = .68); age of abuse and the time elapsed since termination of prior treatment (r = .60); length of prior treatment and education level, (r = .56); number of perpetrators and length of abuse, (r = .39); and age of initial abuse and overall age, (r = .33). A single negative relationship was found involving the time elapsed since termination of prior treatment and education level (r = -.56).

CHAPTER 4

DISCUSSION

It was hypothesized that survivors who experienced more severe degrees of sexual abuse such as penetration (vaginal or rectal) or rape would exhibit higher death anxiety than those who encountered a less severe degree of abuse involving sexual suggestions, fondling, or oral manipulation of the genitals. This hypothesis was not supported by the data. It was also hypothesized that those who had been engaged in treatment for 13 months or longer would have lower death anxiety scale (DAS) scores than those who had only been involved in therapy for 12 months or less. However, the findings were opposite of what was hypothesized. The subjects who had been in treatment longer had significantly higher death anxiety than those in treatment for 12 months or less.

Review of the data generated by this study may suggest that females who have been survivors of low degrees of sexual abuse such as sexual suggestions, fondling, or oral manipulation of the genitals, with no additional experience of more severe forms of sexual abuse, are less apt to engage in treatment as frequently as those females who have experienced vaginal and/or rectal penetration, or rape (each of which have been defined in this study as high degrees

of sexual abuse). As stated in the review of empirical studies done by Browne and Finkelhor (1986), the type of abuse endured appears to be most damaging to the survivor, further explaining that any genital contact seems to be more serious for the survivor. Therefore, this may offer explanation as to why more than two-thirds of the participants had endured both low and high degrees of sexual abuse, while nine subjects experienced low abuse only and two subjects reported experiencing high abuse only. The data seem to indicate it is rare for a survivor of sexual abuse to endure only one form (or degree) of abuse at a time, and it may be even more rare to endure only low or only high degrees of abuse. This may be because the events which involve the high degrees of abuse are perhaps preceded by various forms of low abuse, as defined in this study.

It was presumed that being in treatment longer would enable those who had high death anxiety to have more time to work through the anxiety and alleviate it if possible. However, the data found that those who had been engaged in treatment longer had significantly higher DAS scores than those who had been in therapy 12 months or less. An investigator might theorize that the initially strong defenses may have been broken through or let down as the sexual abuse survivor

continues in therapy. This could be related to the trust issue usually present in survivors of abuse. Courtois (1992) states "the alliance between the therapist and survivor must be strong enough to provide the psychological security necessary" (p. 24) for memory retrieval or any other aspect involved in treatment of survivors to take place. Longer treatment helps strengthen the therapeutic relationship which involves trust on both parts. The client is encouraged to gain more awareness of her feelings through therapy, which may add to the therapy process.

As children, survivors of sexual abuse use many defense mechanisms in an attempt to deal with this trauma. When some survivors enter treatment, usually for seemingly unrelated reasons years after the abuse, the story of the abuse and reactions to it are revealed. According to Shapiro and Dominiak (1990), having the ability to recognize the defensive nature of the patient allows the therapist to be more capable of helping the survivor. The survivor can be encouraged to relate the defenses specifically being used to the more painful experiences associated with the previous abuse. Being able to identify possible defenses used to hide death anxiety is as important as knowing whether the client is experiencing death anxiety (Shapiro & Dominiak, 1990). Levin (1989-90) concluded

from his examination of the dimensionality of death anxiety that less defensiveness does not necessarily suggest poor psychological adjustment, but rather a personal awareness of death anxiety.

The findings of this study are limited by a cell n of 2. Since the data were generated by a clinical sample of 45 subjects, it was hoped the results might be directly applicable. However, the sample size diminishes this possibility. The generalizability of the results to adult female survivors of sexual abuse who are currently in treatment, or to adult female survivors in general, may not be valid. Since no control or comparison groups were utilized, the significant findings should be investigated further.

As with any self-report instrument, the results of this study are questionable. Specifically, some of the subjects were unable to identity their age of initial victimization or the duration of abuse. The DAS scores are considered to be accurate, as the instrument is standardized. Therefore, the question of the results lies with the self-report questionnaire used in this study. Furthermore, the problem with the subjects being currently involved in therapy opens the possibility of the questionnaire including information gained from false or induced memories (Tarvis, 1993).

The low response rates of 17% for the Mental Health Center of East Central Kansas (MHCECK) and 45% for Pawnee Mental Health Services (PMHS) may be due to numerous reasons. The difference in administration of the packets may have attributed to the rate of response. At the MHCECK, therapists solicited participation of their clients by distributing the form shown in Appendix A, given to the therapist by the investigator. After the clients volunteered, the investigator then administered the packet to the client individually, being available to answer questions if such arose. For the three facilities of PMHS, packets were sent to the facility and distributed to therapists to present to their clients. The clients were to mail the forms back to the investigator with the self-addressed, stamped envelope provided. The phone number of the investigator was on both solicitation forms, although the first group of participants may have benefitted from direction interaction with the investigator. One could also speculate that the distribution of packets by mail was more beneficial for the subjects by allowing them to remain confidential with the exception of their signature on the consent forms or request for results forms. They did not have to be seen by the investigator as the first group of subjects did. Since the administration by mail seemed

to accumulate the most data, it is suggested that replications involve this method of distributing the packets.

Future research should include more studies involving death anxiety and sexual abuse. As evidenced in the literature review in this study, little research appears to be available combining these two topics. If the results of the present study are valid, much improvement could be made in the area of therapy involving the possibility of death anxiety of adult female survivors of sexual abuse. Therapists would be able to measure their client's death anxiety by using Templer's DAS, or a similar measurement. If necessary, treatment plans could then include the issue of death anxiety.

The positive and negative significant correlations found in the present study might also provide areas to be investigated in future research. Each significant correlation could act as the basis for a study involving sexual abuse, focusing on the specific correlation chosen to explore.

Replications of this study might involve using a standardized questionnaire that could further explore the sexual abuse history of clients. A control or comparison group would serve to validate any significant findings. As with any research, a larger

sample size would also increase validity of the results found.

Included in Appendix G is a list, compiled through the self-report questionnaire, consisting of various reasons why subjects in the present study were currently seeking treatment. Some common themes in the list include depression, abuse of any kind (emotional, physical, and/or sexual), relationship problems, flashbacks of abuse, and a desire to go on with life. This list also involves ideas for future research, as it indicates the similarities and differences between the various problems survivors experience which may motivate them to seek treatment. These reasons should also impact on how the treatment plan is developed for each individual client.

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Appendix A

Solicitation Form I

YOU ARE BEING ASKED TO VOLUNTEER AS A PARTICIPANT IN A STUDY INVOLVING SEXUALLY ABUSED SURVIVORS. ALL INFORMATION THAT IS GATHERED WILL REMAIN CONFIDENTIAL, AND ONLY THE PRIMARY INVESTIGATOR WILL SEE THE DATA.

DUE TO THE NATURE OF THE STUDY, THIS TYPE OF INFORMATION IS DIFFICULT TO OBTAIN. IT IS THE BELIEF OF THIS RESEARCHER THAT THE RESULTS OF THIS STUDY MAY BE BENEFICIAL TO THE SURVIVOR POPULATION BY MAKING THERAPISTS MORE AWARE OF EACH CLIENT'S SPECIFIC NEEDS.

IF YOU DECIDE TO PARTICIPATE, YOU WILL ANSWER TWO SHORT QUESTIONNAIRES. THE TIME INVOLVED WILL BE APPROXIMATELY ONE-HALF HOUR. IF YOU ARE WILLING TO CONTRIBUTE YOUR OPINIONS AND KNOWLEDGE TO THIS RESEARCH, PLEASE COMPLETE THE FORM AT THE BOTTOM OF THIS SHEET. FOR YOUR CONVENIENCE, WE SUGGEST THAT YOU PARTICIPATE BEFORE OR AFTER YOUR THERAPY SESSION. THE TESTING WILL TAKE PLACE AT THE MENTAL HEALTH CENTER, ALTHOUGH YOUR PRIMARY THERAPIST OR OTHER STAFF WILL NOT BE INVOLVED. PLEASE PLACE THE COMPLETED FORM IN THE ENVELOPE PROVIDED, AND GIVE IT TO THE RECEPTIONIST WHEN YOU LEAVE.

THANK YOU FOR YOUR COOPERATION. IF YOU HAVE ANY QUESTIONS, PLEASE CALL 343-7743.

A FELLOW SURVIVOR,
MYRA PFEIFER

****

NAME: _____

PHONE NUMBER: _____

OTHER CONTACT: _____

TIME(S) AVAILABLE FOR PARTICIPATION:

FIRST CHOICE: _____

SECOND CHOICE: _____

THIRD CHOICE: _____

Appendix B

Solicitation Form II

NEED FOR VOLUNTEERS

YOU ARE BEING ASKED TO VOLUNTEER AS A PARTICIPANT IN A STUDY INVOLVING FEMALE SEXUAL ABUSE SURVIVORS. ALL INFORMATION THAT IS GATHERED WILL REMAIN CONFIDENTIAL. YOU WILL BE IDENTIFIED ON THE QUESTIONNAIRES WITH AN I.D. NUMBER ONLY. ONLY THE PRIMARY INVESTIGATOR WILL SEE THE DATA. THE FORMS WITH YOUR NAME AND/OR ADDRESS WILL BE SEPARATED FROM THE QUESTIONNAIRES, SO THE INFORMATION YOU PROVIDE WILL REMAIN CONFIDENTIAL.

DUE TO THE NATURE OF THE STUDY, THIS TYPE OF INFORMATION IS DIFFICULT TO OBTAIN. IT IS THE BELIEF OF THIS RESEARCHER THAT THE RESULTS OF THIS STUDY MAY BE BENEFICIAL TO THE SURVIVOR POPULATION BY MAKING THERAPISTS MORE AWARE OF EACH CLIENT'S SPECIFIC NEEDS.

IF YOU DECIDE TO PARTICIPATE, YOU WILL ANSWER TWO SHORT QUESTIONNAIRES. THE TIME INVOLVED WILL BE APPROXIMATELY FIFTEEN MINUTES. IF YOU ARE WILLING TO CONTRIBUTE YOUR OPINIONS AND KNOWLEDGE TO THIS RESEARCH, PLEASE COMPLETE THE 4 FORMS ATTACHED TO THIS SHEET, AND SEND THE COMPLETED INFORMATION TO ME BY MAIL WITH THE SELF-ADDRESSED, STAMPED ENVELOPE PROVIDED. ONLY MYSELF AS THE PRIMARY INVESTIGATOR WILL SEE THE INFORMATION THAT YOU WILL PROVIDE. AS STATED EARLIER, YOUR PRIMARY THERAPIST WILL NOT BE INVOLVED. IF YOU DECIDE NOT TO PARTICIPATE, PLEASE SEND THE SET OF BLANK FORMS BACK TO ME WITH THE ENVELOPE PROVIDED.

THANK YOU FOR YOUR COOPERATION. IF YOU HAVE ANY QUESTIONS, PLEASE CALL 913-243-7671 (work) or 913-243-7151 (home).

A FELLOW SURVIVOR,
MYRA PFEIFER

Appendix C

Informed Consent Form

Informed Consent Document

The Department of Psychology/Special Education at Emporia State University supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

In order to enhance information for treatment you are being asked to complete two questionnaires. These questionnaires will be completed confidentially. Minimal discomfort sometimes occurs when people fill out questionnaires.

"I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach."

_____ _____

Signature of Participant Date

Appendix D

Background Questionnaire

I.D. CODE# _____ RACE _____ DATE OF BIRTH _____

1. EDUCATION LEVEL COMPLETED _____

2. REASON FOR CURRENTLY SEEKING TREATMENT _____

_____

3. LENGTH OF TREATMENT FOR SEXUAL ABUSE AT THIS FACILITY (PLEASE CIRCLE AMOUNT IN MONTHS):
1 2 3 4 5 6 7 8 9 10 11 12 13 MONTHS OR MORE

4. HAVE YOU BEEN IN TREATMENT FOR SEXUAL ABUSE PRIOR TO ATTENDING THIS AGENCY? NO _____ YES _____
IF YES, HOW LONG WERE YOU IN TREATMENT? _____
IF YES, HOW LONG AGO DID THIS TREATMENT TERMINATE? _____

5. AGE WHEN ABUSE BEGAN _____ 6. DURATION OF ABUSE _____

7. WHICH OF THE FOLLOWING MOST ACCURATELY DESCRIBES YOUR ABUSIVE EXPERIENCE? PLEASE CIRCLE ALL WORDS/PHRASES THAT APPLY:

A. SEXUAL SUGGESTIONS, FONDLING, ORAL MANIPULATION OF GENITALS

B. VAGINAL PENETRATION, RECTAL PENETRATION, RAPE

8. RELATIONSHIP TO PERPETRATOR? PLEASE CIRCLE ALL WORDS THAT APPLY:

A. STRANGER B. NEIGHBOR

C. SIBLING (BROTHER/SISTER) D. PARENT (MOTHER/FATHER)

E. DISTANT RELATIVE AND/OR IN-LAW

F. STEPPARENT (STEP-MOTHER/STEP-FATHER)

G. GRANDPARENT (GRANDMOTHER/GRANDFATHER)

H. AUTHORITY FIGURE (BOSS, PRIEST/RABBI/MINISTER, TEACHER, THERAPIST, DOCTOR)

I. OTHER (PLEASE DESCRIBE)_____

9. WAS THERE LEGAL INTERVENTION? NO _____ YES _____

9a. IF YES, HOW LONG AFTER THE ABUSE? _____

10. WAS THERE LEGAL RESOLUTION? NO _____ YES _____

10a. IF YES, HOW LONG AFTER THE ABUSE? _____

Appendix E

Templer's Death Anxiety Scale (DAS)

ANSWER THE FOLLOWING ITEMS AS TRUE (T) OR FALSE (F)
AS THEY APPLY TO YOU.

1. I am very much afraid to die.
2. The thought of death seldom enters my mind.
3. It doesn't make me nervous when people talk about death.
4. I dread to think about having an operation.
5. I am not at all afraid to die.
6. I am not particularly afraid of getting cancer.
7. The thought of death never bothers me.
8. I am often distressed by the way time flies so very rapidly.
9. I fear dying a painful death.
10. The subject of life after death troubles me greatly.
11. I am really scared of having a heart attack.
12. I often think about how short life really is.
13. I shudder when I hear people talking about a World War III.
14. The sight of a dead body is horrifying to me.
15. I feel that the future holds nothing for me to fear.

Appendix F

Request for Results

If you would like an explanation of the general results obtained from this study, please fill out the information below in order to receive the results.

NAME _____ CODE # _____

ADDRESS _____

_____

Feedback on individual results of the death anxiety questionnaire can be made available through your primary therapist. Please be aware that this is the only information that your therapist will have access to, if you choose to give your permission for such feedback. If you would like such feedback for therapy purposes, please fill out the information listing your primary therapist and his/her business address, and your code number.

THERAPIST _____

FACILITY ADDRESS _____

_____

YOUR CODE # _____

Appendix G

Reasons for Currently Seeking Treatment

Reasons For Currently Seeking Treatment

* unhappy with current life situation
* flashbacks of the abuse
* suicidal ideations
* problems in relationships possibly due to the abuse
* incest/abuse
* support group for incest survivors
* husband sexually abused daughter
* Borderline Personality Disorder
* want to get through this and go on with life
* maintain stability with flashbacks, help control suicidal feelings
* sexual abuse
* marriage problems
* having visions of abuse
* come to terms with the abuse so it won't effect daily life so much
* suggested that it may help handle stress
* depression, anxiety, compulsive behaviors
* want to work it out and go on with life
* felt confused about feeling empty
* grief over loss of infant son
* unresolved issues about abuse, current contact with abuser
* fear of losing mind/ total loss of control
* trouble with boyfriend/ trouble handling anger and other emotions
* self-mutilation, low self-esteem, lack of appetite, outbursts of rage, loss of sense of smell
* chronic depression from childhood sexual abuse and two rapes

* alcohol problems

* mood swings

* family problems

* need to talk/ why marriage failed/ for peace of mind

* life is a piece of shit

* physical problems, abnormal pap results, triggered flashbacks

* chose to learn new ways to enhance self-esteem

* eating disorder, nail-biting, trichotillomania, reestablish trust

* husband had an affair

* work-related problems, relationship difficulties (confusion)

* past physical, emotional, and sexual abuse

* sexual abuse to self and sons, depression

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Myra M. Pfeifer
Signature of Author

November 4, 1993
Date

TREATMENT OF ADULT SURVIVORS OF SEXUAL ABUSE: THE EFFECTS OF DEGREE OF SEXUAL ABUSE AND LENGTH OF TREATMENT ON DEATH ANXIETY

Title

Doug Cooper
Signature of Graduate Office Staff Member

11-5-93
Date Received