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Child Sexual Abuse

– Disclosure, Social Support, and Subjective Health in Adulthood

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When I despair
I remember that all through history
the way of truth and love
has always won.

There have been tyrants and
murderers
and for a time the seem invincible
but in the end they always fall.

Think of it – always!

Mahatma Gandhi

ABSTRACT

Child sexual abuse (CSA) is a known risk factor for ill-health. It is assumed that the health consequences are worse if the abuse has been considered severe or if the child has been exposed to cumulative trauma, e.g. physical abuse or other stressful life events. However, symptom development seems to vary widely between individuals. According to developmental theories the dynamic interplay between environmental and individual conditions creates a course toward either healthy or maladaptive outcomes. Social support has been shown to have a strong influence, direct or indirect, on abuse sequelae – a higher amount of support is related to better psychological functioning. However, adult victims may have difficulties forming close relationships with others due to lack of trust and other abuse aftermath. Further, despite a high risk for ill-health victims often fail to disclose the abuse. If they do tell they are not rarely met by negative reactions, which has been related to worse outcome. Delayed disclosure is related to intra-familial abuse, closeness to the perpetrator, multiple perpetrators, age at onset and severe abuse. The victim may experience a psychological disclosure dilemma: the need to tell in order to get support is weighed against the risk to receive negative reactions. Thus, the overall aim of the thesis was to contribute knowledge concerning the relationship between child sexual abuse, disclosure, social support, and subjective health in adult women reporting experiences of sexual child maltreatment.

Methods. The thesis was based on a study with a cross-sectional design using retrospective data about abuse and disclosure experiences as well as current data about health and social support. Participants (n = 152, aged 20-60 years) were recruited by advertisements in a membership magazine published by a national organisation for sexually abused women providing activities for support and healing, as well as in staff magazines for municipal employees in the Stockholm area. Data was retrieved by both a semi-structured interview and questionnaires. Analyses included quantitative methods (variable-approach and person-approach) as well as qualitative methods.

Results. The results showed that disclosure characteristics were more prominently related to health than sexual abuse characteristics. Moreover, in spite of experiences of severe abuse and negative reactions after disclosure it was possible to get access to health enhancing social support in adulthood. The relation between disclosure-related events and health was dependent on source and type of reaction, in favour of partner and friends. A positive reaction from a partner was strongly related to subjective health. It may be crucial for victims of CSA who have problems with trust and intimacy to get emotional support, acceptance and respect from a partner in overcoming these feelings. Further, two groups of women reporting good health in spite of severe abuse were found by cluster analysis. The groups were among other things characterised by a high proportion of women who had formerly been active members in the support organisation. A qualitative analysis of the member's experiences from the organisation showed that a *victim process* altering the victim identity over time seemed to constitute an important part of the individual development. However, few members who had gone through crucial steps of the victim process seemed to remain in the organisation passing the knowledge on to new members, thus creating a chronic structural problem for the organisation to deal with.

Conclusions. Social support is a crucial protective factor for victims of child sexual abuse, a group highly at risk for and ill-health and adverse outcome. Victims of child sexual abuse seek and receive social support in various ways depending on severity of abuse, timing of disclosure and choice of disclosure receiver. Thus, the whole disclosure process during life is important to consider when studying disclosure-related events in relation to social support and health. Further, different methods of analyses may contribute to the understanding of how risk and protective factors interact. Both variable- and person-based methods pointed at the importance of resources like self-esteem and social support above the amount of risk factors for health outcome. Finding ways to combine self-help with professional help might be fruitful and constitutes a further challenge for psychiatry when it comes to the task of developing new and effective care for this group.

Key words: child sexual abuse, child physical abuse, child maltreatment, subjective health, disclosure, social support, coping, self-help, mutual aid

LIST OF PUBLICATIONS

This doctoral thesis is based on the following papers, which will be referred to in the text by their Roman numerals.

I Jonzon, E. & Lindblad. F. (2004). Disclosure, Reactions, and Social Support: Findings From a Sample of Adult Victims of Child Sexual Abuse. *Child Maltreatment, 9*(2):190-200.

II Jonzon, E. & Lindblad, F. (2005). Adult Female Victims of Child Sexual Abuse: Multitype Maltreatment and Disclosure Characteristics Related to Subjective Health. *Journal of Interpersonal Violence, 20*(6):651-666.

III Jonzon, E. & Lindblad, F. (2006). Risk factors and protective factors in relation to subjective health among adult female victims of child sexual abuse. *Child Abuse & Neglect,* 30:127–143.

IV Jonzon, E., Karlsson, M. & Lindblad, F. Members' experiences from a support organisation for women sexually abused in childhood. *Submitted.*

CONTENTS

1 BACKGROUND

The awareness regarding child maltreatment in general and child sexual abuse in particular started to spread quickly in the 1980's. The development was driven mostly by women's rights organisations. Women started to tell about their childhood experiences and the process that started was inevitable. In Sweden, only a few scientific studies had been made until then and the knowledge gained from those studies was neither widely spread nor generally accepted. The literature that had the greatest impact at that time was produced in England or USA where clinicians had begun to systematise knowledge about abuse (Finkelhor, 1984; Herman, 1981; Summit, 1983). The focus was almost exclusively on girls as victims and the main interest was to understand and detect the harmful elements of abuse – to understand the nature and prevalence of the trauma.

The next wave of influential literature came at the end of the 80's. Women who had brought up the subject in the beginning of the decade had now been in therapy for a while and therapists started reporting about their clients' journey to deal with the harmful aftermath of the abuse. The term "survivor" started to be commonly used – abuse experiences were acknowledged and it was discovered how the working through process seemed to develop for most clients (Courtois, 1988; Jehu, 1988). The market started to fill with self-help books (Bass & Davis, 1988; Poston & Lison, 1989). Women's support organisations and centres that had self-help groups for this population noticed an increase in demand. One of the first theses written in Sweden on the topic child sexual abuse was presented in 1989 (Lindblad).The research was at this time utterly explorative and almost exclusively concerned children. Information on adult Swedish victims was mostly retrieved by retrospective reports from small clinical groups, that is, therapists writing about their clients.

Child sexual abuse issues started to be mirrored in the media to a greater extent, often in relation to flaws in the legal system and the psychiatric care. It turned out that the legal system and the health care system were unprepared for the amount of cases that started to demand their resources. The legal system had no functional routines, sometimes resulting in hazardous convictions, creating a debate about trustworthiness and reliability concerning child sexual abuse issues. Some research took a new direction towards forensics. In summary, researchers sought answers to questions about prevalence, correlates to ill-health, functional therapies and societal/legal inadequacies. To a great extent the issue was believed to mainly concern girls although boys as victims and female perpetrators were acknowledged. Since clinical groups or groups in contact with authorities constituted the main populations studied a tendency grew towards regarding child sexual abuse as one of the most destructive crimes. Considered as such, both clinicians and the general population wished for more knowledge – the research field started to grow rapidly.

During that period of time the idea to this thesis was born. Some researchers had started to view the problem from a stress perspective. However, one of the problems at that time was that existing models concerning child sexual abuse had not adequately defined stress and coping constructs and had not specified how those variables might interact with other environmental factors. Seeking social support was a well-known coping strategy shown to have a great protective impact on health

development with its stress-buffering function. However, child sexual abuse is taboo and is not spoken of easily. Could it be possible for a group of individuals struggling with that taboo to receive social support? Spaccarelli (1994) wrote one of the first articles presenting a holistic view outlining a developmental model. Sexual abuse as a stressor was conceptualised as a series of abuse events, abuse-related events, and disclosure-related events that each tend to increase risk for maladaptive outcomes. This new thought contrasted former models that regarded child sexual abuse as a delimit event. However, it was a model not yet empirically tested.

Assuming that victims may have a resistance against telling about abuse due to the stigma attached to it and a fear of negative reactions as well as a need for telling in order to receive a supportive response followed by emotional support seems to bring victims into a dilemma. How do victims solve this dilemma and is the choice of solution in any way related to health? The theme of this thesis was outlined by this question.

1.1 STRESS AND COPING

Within the research field of psychosocial factors and health, the stress perspective constitutes the main theoretical framework. Different social and psychological factors are either viewed as risk factors or protective factors affecting health by increasing or decreasing stress and its effects.

Stress can be described in many ways depending on the perspective chosen. In this study, stress is viewed according to a transactional model suggesting that perceived stress is a result of interplay between many factors. Excessive demands/stressors produce a typical sequence of physiological responses involving sympathetic activation. The character and intensity of this normal and often functional stress reaction is dependent on physiological, psychological, and environmental interactions. It is determined by the balance between the demands and the individual's resources to meet those demands – the person's coping abilities. Usually our resources to balance a stress reaction are enough. We get the opportunity to find our balance (homeostasis) and restore our systems by using coping mechanisms such as cognitive appraisals, seeking emotional support or simply by getting some sleep during which the body recovers in several ways (McEwen & Seeman, 1999).

However, problems may arise if the stress becomes prolonged in combination with insufficient coping skills. The sensitive biological/endocrine stress system and its stress hormones may even be altered due to exposure to stressors (Heim et al., 2000). The imbalance in the body may become chronic followed by numerous different health problems.

The term *coping* is used in the literature as a broad concept basically covering every resource, strategy or ability – inner and outer – a person may have access to in order to master a stressful situation (intelligence, self-esteem, a social support network, possibility and knowledge how to find information etc.). Potent protective factors, which are used in this thesis, are for example social support and a high self-esteem/self-efficacy (Berkman & Glass, 2000; Taylor, 1983). However, 'coping' is also treated as one separate protective factor in the study, thus creating an overlap of conceptions. Coping in this sense refers to a theoretical model of appraisal, originally presented by Lazarus (1993) and further developed by Shalit and Carlstedt

(1984). The coping potential is according to the model viewed as a result of one's cognitive, affective and instrumental appraisals, that is, the clarity or structure of the perceived situation, the extent/quality of emotional involvement, and the perceived control over the situation.

1.2 TRAUMATIC AND CHRONIC STRESS

Child sexual abuse (CSA) and child physical abuse are known risk factors for ill-health and has the potential to induce tremendous stress (Koopman, Gore-Felton, & Spiegel, 1997). In contrast to everyday life events, to be *traumatic* the DSM-IV (Diagnostic and Statistical Manual for Mental Disorders IV) postulates that 1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and 2) the person's response involved intense fear, helplessness, or horror. The nature of child sexual abuse is not always traumatic according to this definition, yet it may be devastating to the individual and induce strong acute and/or enduring stress.

An acute stress may cause serious disturbance in the homeostatic systems that tries to keep the body in balance. The issue becomes even more complex in the case of child sexual abuse since abuse occurs during childhood and may influence the maturation of these psychological and biological regulatory systems. Disruption of such self-regulatory processes may lead to a vulnerability to develop various behavioural, cognitive and health related problems (van der Kolk, McFarlane, & Weisaeth, 1996).

Post-traumatic Stress Disorder (PTSD) is characterised by symptoms resulting from the exposure to the extreme trauma: re-experiencing of the traumatic event, avoidance of stimuli associated with the trauma and numbing of general responsiveness, and symptoms of increased arousal. Victims of child sexual abuse do report symptoms of PTSD (Ullman & Filipas, 2005), but far from all victims suffer from such aftermath. The nature of the stress is not necessarily acute and traumatic. Instead, child sexual abuse may result in prolonged stress, or chronic stress, due to maintenance of secrecy, continuing interpersonal dysfunctional relations and further events during life directly or indirectly associated to the abuse. Sexual abuse is not over when the molestation is over – it is an ongoing process over time (Rathsman, 2001). Such chronic stress may accumulate over time and lead to depression or psychosomatic symptoms (Fava & Sonino, 2000; Pearlin, Menaghan, Lieberman, & Mullan, 1981). Thus, victims of child sexual abuse are at risk of exposure to high stress levels during life.

1.3 LONG-TERM HEALTH CONSEQUENCES OF CSA

Common reported health consequences of child sexual abuse are psychological symptoms of depression, low self-esteem, anxiety, sexual problems, obsessions/compulsions, dissociation, and posttraumatic stress responses as well as psychosomatic symptoms such as back pain, pelvic pain or gastrointestinal disorders (Cunningham, Pearce, & Pearce, 1988; Leserman et al., 1996; Linton, 1997; Moeller, Bachmann, & Moeller, 1993; Salmon & Calderbank, 1996). Victims of childhood sexual abuse represent a substantial portion of health care clients (Dinwiddie et al., 2000; Frenken & Van Stolk, 1990; Swett & Halpert, 1993). It is assumed that the health

consequences are worse if the abuse has been considered severe or if the child has been exposed to cumulative trauma, e.g. physical abuse or other stressful life events (Banyard & Williams, 1996; Higgins & McCabe, 2000; Swanston et al., 2003).

However, symptom development seems to vary widely between individuals. In 1997 and 1998 two meta-analyses was presented by Rind and colleges (Rind & Tromovitch, 1997; Rind, Tromovitch, & Bauserman, 1998) that showed surprisingly weak relations between CSA and psychological adjustment problems when non-clinical populations were studied. They concluded that previous research had been performed on biased samples and that CSA in general populations is not associated with pervasive harm. They also found that family environment was more closely related to adjustment problems than CSA. Although the articles were subject to serious critique, they have been followed by other studies suggesting that long-term consequences of CSA are multi-factorial and may have many pathways (behavioural, social, cognitive, and emotional) likely to explain the variety in symptom development (Fassler, Amodeo, Griffin, Clay, & Ellis, 2005; Kendall-Tackett, 2002; Valle & Silovsky, 2002). Researchers have now begun to broaden the perspective on how CSA and its associated variables adversely impact victims.

1.4 MODELS EXPLAINING LONG-TERM EFFECTS OF CSA

In the 1980's, one model concerning CSA was presented, namely Finkelhor and Browne's Traumagenic dynamics (1985). Since it is still often used as theoretical framework in CSA research it is shortly presented here. Based on clinical experiences of female victims it describes four common characteristics of the nature of child sexual abuse: a) *traumatic sexualisation* – the child gets a sexuality shaped by the abuse, which may result in promiscuity or aversion, prostitution, confusion about sexual identity, norms and standards etc.; b) *betrayal* – the child has been exploited by a trusted individual through sexual acts or non-protection from non-abusing others resulting in depression (loss of a trusted figure), a tendency to seek other abusive relationships, and anger; c) *powerlessness* – ineffective attempts to avoid or stop the abuse causes fear, anxiety, impaired coping skills, and possibly a need to control or dominate others; and d) *stigmatisation* – feelings of shame and guilt may develop if the perpetrator blames or demeans the child or by the pressure of secrecy giving the child a sense of being different and the only person being abused.

In contrast to this models based on clinical experience rather than empirical data, later models have been more theory-based, e.g. on information-processing theories or built on a PTSD perspective (Freeman & Morris, 2001). However, these models have a rather narrow approach disregarding other situational factors that may be equally important.

Models constituting the theoretical base of this thesis was created by developmental theorists like Cole and Putnam (1992) and Spaccarelli (1994). In the beginning of the 1990's they proposed models based on a holistic perspective. The models include interaction with the environment, that is, they assume that not only qualities of the child but also reactions and actions from others influence long-term effects. Spaccarelli in particular stressed the importance of the dynamic interplay between environmental and individual conditions that create a course toward either healthy or maladaptive outcomes. The model is viewing the load of the abuse itself and

post-disclosure reactions as stressors, which in greater numbers increases the likelihood of an adverse outcome. In addition, the model includes cognitive appraisals and coping strategies that are believed to mediate the effects of CSA and thus recognises the importance of context; living in an abusive environment results in an altered sense of self, which in turn affects coping skills. The model rests on an attractive platform of existing stress theories and has obvious parallels to the perspective of psychosocial research in general.

1.5 SOCIAL SUPPORT

The association between social support and well-being is rather constant in the literature, independent of group or issue. It seems as if the nature of human relationships is extremely powerful and healing (Berkman & Glass, 2000). However, the dispersion of what the concept covers in the scientific literature is tremendous: quantitative and structural aspects (e.g. social network size, amount of contacts) or qualitative aspects and actual provision of the support (e.g. emotional or instrumental support, degree of intimacy); received support (one-way direction) or mutual support (both giving and receiving by norms of reciprocity); or subjectively perceived support or objectively measured support. Moreover, to seek social support may be viewed as an active coping strategy to reduce stress; when available social support may be viewed as a stress buffering factor; if absent or too excessive it may be a stressor in its own right (e.g. isolation). The perspectives of social support seem infinite.

Nevertheless, empirical research has shown that several of the above aspects of social support in fact have a strong influence, direct or indirect, on abuse sequelae. That is, a higher amount of support is related to better psychological functioning (Feiring, Taska, & Lewis, 1998; Runtz & Schallow, 1997; Spaccarelli & Kim, 1995; Tremblay, Hebert, & Piche, 1999). Simultaneously, adult victims have difficulties forming close relationships with other men and women, their own parents and even their own children (Browne & Finkelhor, 1986; Cahill, Llewelyn, & Pearson, 1991; Courtois, 1988). They have been found to be more isolated than others, particularly those who have experienced severe abuse (Edwards & Alexander, 1992; Gibson & Hartshorne, 1996). Moreover, since many victims of sexual abuse grow up in dysfunctional families, and are abused by someone close to them, the perceived social support from the family in adult life has been shown to be low (Stroud, 1999).

In the present study, seeking social support was viewed as a coping strategy in order to master experiences of child sexual abuse. The process of seeking social support for a specific purpose over a long period of time and its outcomes was explored. Furthermore, perceived current social support (availability of and satisfaction with emotional, reciprocal, appraisal, and instrumental support) was also treated as a main factor having a protective effect on health according to theories suggesting biopsychosocial pathways to health (Berkman & Glass, 2000; Cobb, 1976; Cohen & Wills, 1985; Lazarus, 1993; Maunder & Hunter, 2001; McEwen & Seeman, 1999; Turner, 1983).

1.6 SELF-HELP

Talking to someone who has similar experiences as one self may have healing effects. That person will automatically have an intuitive understanding and compassion. The phenomenon of self-help has been known for decades and applies to almost any life problem. CSA victims may therefore turn to support organisations specialised in their problem, especially if their own support network is insufficient or as an alternative to professional help. These organisations usually provide mutual aid based on members' personal experiences. Self-help groups encourage reciprocal sharing of personal stories, thoughts, problems, and solutions. The group fulfils a need for a reference group, attachment/identification with others and is a source for strengthening the ego. Despite a feeling of stigmatisation, participants in self-help groups sense that they belong to some kind of community; it increases a sense of normality (Adamsen & Rasmussen, 2001; Borkman, 1999).

Self-help groups often grow out of needs not satisfied by existing social institutions. This was a reason for CSA support organisations to develop in Sweden during the 1980's and still is one reason for the same organisations working today. Although self-help quantitatively is a marginal form of help compared to the offers from the public health care system it provides a highly sophisticated and helpful form of support in qualitative terms. Therapeutic outcomes from such organisations have been found to be comparable to professional treatment (Humphreys, 2004; Kyrouz, Humphreys, & Loomis, 2002).

Resent work point at a development toward greater involvement of professionals in self-help settings and vice versa. It is a rather unique form of social practice partly initiated by the members themselves. The co-operation may take the form of professional co-leadership, consultation or referral in self-help groups/organisations or self-help groups becoming a part of the formal health care (Adamsen & Rasmussen, 2001). An adjacent activity is group therapy for CSA victims in which many of the effective components of self-help is being incorporated such as sharing stories and diminishing stigmatisation by creating a sense of coherence and belonging. Group therapy for CSA victims within a Swedish psychiatric setting has been proved to be successful (Lundqvist & Ojehagen, 2001; Lundqvist, Svedin, & Hansson, 2004).

1.7 DISCLOSURE

1.7.1 Disclosure dilemma

Despite CSA victims being a high risk group for adverse health development, victims often fail to get acknowledged. The main characteristic of sexual abuse is that it is performed in secrecy and perpetrators seldom confess spontaneously. Disclosure from the victim is crucial in order to stop the abuse or to receive help in childhood or later in life. Lack of disclosure is due to an inner *resistance*. Inner resistance to tell may stem from loyalty to the family, feelings of shame and guilt, fear of disbelief/non-acceptance or inability to feel intimacy and trust. The awareness of societal norms and fear of negative reactions may also cause victims to withdraw from disclosing abuse. Negative reactions from others may have roots in negative attitudes or lack of knowledge about

CSA. According to research in victimology people may be reluctant to be associated with a victim/a stigmatised person (Frieze, Hymer, & Greenberg, 1987). As a consequence some put the blame on the victim to remain the idea of a just and fair world – the victim must have done something to deserve it. Moreover, child sexual abuse is an unpleasant subject that might provoke anxiety; sometimes it may be overwhelming to the person who receives the disclosure.

The other side of the coin is the *need* of telling. Beside the prominent health effects of received social support there is a therapeutic effect in putting words to and describe one's life history (Pennebaker & Susman, 1988). Emotional relief lies in telling the truth, to let go of the stress inducing secrecy. It may enhance self-esteem to be believed and get one's reality confirmed.

These two opposite urges puts the victim into a dilemma in which they must either forgo possible social support and emotional relief in order to avoid negative reactions or tolerate some negative reactions in hope of receiving acceptance, respect and support from others. This dilemma gets updated every time the victim considers telling anyone. It is a never ending process during life to learn to handle the situations that may arise when disclosing child sexual abuse.

1.7.2 Empirical research on disclosure

In the early 1980's, several authors gave notice to the fact that children seldom tell about abuse (Herman, 1981; Russell, 1983; Summit, 1983). Since then, common research questions have been if victims tell, when they tell and the cause of delay, if any, and the reaction from the person told as well as possible benefits from such reactions. Later research on both children and adults has confirmed that few victims tell anyone, at least not immediately. Some factors repeatedly found to complicate and delay disclosure are intra-familial abuse, closeness to the perpetrator, multiple perpetrators, age at onset and severe abuse (Arata, 1998; Kellogg & Hoffman, 1997; Lange et al., 1999; Smith et al., 2000).

There is no evidence that telling someone about the abuse per se is a sufficient act of coping (Liem & Boudewyn, 1999; Shapiro & Levendosky, 1999). Instead, the reactions from the person told seem to be crucial. A positive and supportive response is often characterized by showing concern, empathy, and believing the victim, while a negative and unhelpful response is characterized by blaming the victim, denial or minimisation of the event or even abandonment (Lamb & Edgar-Smith, 1994; Mize, Bentley, Helms, Ledbetter, & Neblett, 1995; Schatzow & Herman, 1989). The type of reactions vary according to timing and to whom one discloses (Ullman, 2003). Focus has until lately almost exclusively been on the reaction by the first person told, assuming it to be the most important. A negative social reaction is indeed a harmful stressor, and is thus associated to ill-health (Arata, 1998; Everill & Waller, 1995; Lange et al., 1999). However, abused individuals may tell more than one person about the abuse but the consequences of accumulated negative responses have rarely been explored.

Disclosure in professional settings is subject to increased research. When adults disclose child sexual abuse within health care, the responses are not always constructive and victims report problems in finding professionals who listen to their needs (Denov, 2003; Frenken & Van Stolk, 1990; Gibbons, 1996; van Loon, Koch, &

Kralik, 2004). Professionals report lack of knowledge how to respond to this group of victims, own reactions of anger, embarrassment or disgust, and feelings of being overwhelmed/powerless (Frenken & Van Stolk, 1990).

2 AIMS

The overall aim of this project was to contribute knowledge concerning the relationship between child sexual abuse, disclosure, social support, and subjective health in adult women reporting experiences of sexual child maltreatment. The main research questions were: How do victims of child sexual abuse seek and receive social support? In what way may social support function as a protective factor for this group highly at risk for chronic stress and ill-health?

Paper I aimed at exploring how abuse characteristics, openness, reactions to disclosure, and current social support as perceived by adult female victims of sexual abuse were related. The analyses were focused on subgroup comparisons.

Paper II aimed at exploring how abuse characteristics and disclosure characteristics such as timing of disclosure and reactions from others during life were related to subjective psychological and psychosomatic health in adulthood.

Paper III aimed at exploring how risk factors (child maltreatment and other negative life events) and protective factors (social support, self-esteem and coping) interacted and were related to subjective health by using the power and capacity of both person-oriented and variable-oriented statistical methods.

Paper IV aimed at understanding how women reporting child sexual abuse perceived and utilised societal social support in form of contact with a support organisation for adult female CSA victims.

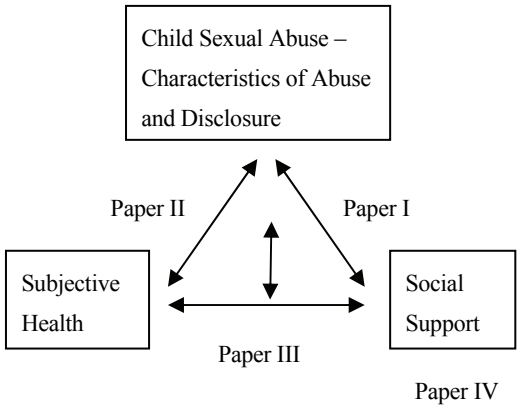

Figure 1. Overview of the project main themes and included papers.

3 METHODS

3.1 DEFINITIONS

In this study, child sexual abuse was defined as an act or situation with sexual meaning where an adult or younger person is using a child in purpose to satisfy his/her own sexual or other needs, based on Svedin (1999). An individual was considered a child until the age of 18 according to the United Nation's definition. The sexual act could be non-physical (e.g. forced exposure or viewing, verbal abuse) or physical (e.g. fondling or oral/anal/genital contact).

One further inclusion criterion for this study was to have been abused by someone close, which was defined as either having a family relation to the person or another form of trustful relation, for example a teacher or a baby-sitting neighbour.

3.2 DESIGN

The thesis was based on a study with a non-experimental cross-sectional design using retrospective data about abuse and disclosure experiences as well as current data about health and social support. Since the research question was directed towards finding differences between subgroups and different patterns of relations within the group, no control group from the general population was included. Instead, subjects were recruited from two sources; a comparison group was included mainly to be able to detect a possible biased sampling and to increase variation. The comparison group became rather small, but functioned well in spite of its size. The variance in most variables was found to be homogeneous, and directions of relationships between variables were similar in the two groups, which allowed for merging the two groups for further analyses. Yet, some differences in abuse characteristics were found between the groups, which are further elaborated on in the Discussion section.

3.3 ETHICAL CONSIDERATIONS

Major ethical considerations concerned the women's integrity and how to handle the delicate situation of asking about severe trauma without causing emotional turmoil. Questions about abuse were not asked during the interview. Instead, data on abuse was retrieved via the questionnaires, which preceded the interview. However, if anyone wanted to talk about the abuse time was given for that. In order to increase the ability to handle feelings and decrease discomfort for the interviewee, interview training was performed before the data collection started. The interviewer also had access to an external supervisor with no relation to the project. A few women were referred for professional help or to the support organisation. It was more common that the interviewees reported a positive effect of talking about these matters with a neutral person. Most women reported feelings of being important, needed and paid attention to by participating in the study. No compensation was given to the participants to avoid creating an unintentional pressure of compliance and to avoid participation due to economical reasons. The project was approved by the Ethical Committee, Karolinska Institutet (KI No 99-062).

3.4 PARTICIPANTS

Participants were recruited by advertisements in a membership magazine published by a national organisation for sexually abused women providing activities for support and healing, as well as in staff magazines for municipal employees in the Stockholm area (Solna, Huddinge, Stockholm City). A total of 175 women responded to the invitation, 145 from the organisation and 30 municipal employees. Four women did not meet the inclusion criteria (sexually abused by someone close before the age of 18) and 19 women later chose not to participate, leaving a sample of totally 152 women, 131 from the organisation and 21 municipal employees. Due to geographical/practical reasons it was possible to arrange personal meetings with only 123 women during which data from both an interview and questionnaires were gathered. The remaining 29 women (all recruited via the organisation) received the questionnaires by mail and were subsequently contacted by telephone.

Of the total sample (n=152) a majority, 91%, were Swedish subjects, approximately the same proportion as in the general population of Sweden. The age range was 20-60 years, the average age 41 ± 9 years. The women were highly educated: 57% had a university degree and 35% a high school degree (37% and 44% respectively for women in the general population in Stockholm). Forty-six percent of them were single or separated, and 54% were married or reported a permanent partner; 64% had children. A majority was working or studying (65% compared to 82% in the above general population), although many were on sick leave (26%). The 21 municipal employees were significantly older and had been exposed to less severe sexual abuse than the organisation group.

Of the 131 women recruited through the organisation, 23% had never participated in any offered activities, 23% were actively participating in a support program and 54% had earlier been active, but were now passive members. The 29 women who were contacted by mail only differed from the rest of the sample regarding participation in the organisation; 41% had never been in contact with the organisation, probably due to geographical reasons.

I. The first study was based mostly on interview data and focused on reactions from others when telling about abuse. All 123 women who were interviewed had told someone about at least one abuse event except one who told about the abuse for the first time during the research interview and was therefore excluded. Of the remaining 122 women, 102 women were from the national organisation and 20 women were from the municipalities.

II. The second study was also based mostly on interview data and focused on health in relation to disclosure/openness. The sample consisted of all 123 women who had been interviewed, 102 women from the national support organisation and 21 women from the municipalities.

III. The third study was based solely on questionnaire data and thus all 152 women were included in the study.

IV. The fourth study was a qualitative study based on interview data with focus on experiences from the support organisation. A parallel study has been planned on

experiences from the psychiatric health care. From the pool of 102 interviewed women recruited via the organisation, only interviews with 62 women who had also reported psychiatric contacts were included.

3.5 PROCEDURES

During the personal meetings with the women each woman was asked to fill in written questionnaires, and to take part in a one-hour semi-structured interview. The order of the fill-in questions was according to the principle ”the most neutral first”. Questions about abuse were asked at the end – partly to avoid emotional colouring of the answers of the other questions, partly to get a natural transition to the following interview; there were room for direct reflections, emotions and questions.

The interview had open questions about disclosure, reactions, support seeking behaviour, and any experiences of the support organisation. If the woman agreed (almost all did), the interview was taped, otherwise notes were taken during the interview.

The remaining 29 women who were not met personally received only the questionnaires by mail and were subsequently contacted by telephone for a follow up – being given an opportunity to ask questions, give comments, and get guidance in filling in the questionnaires.

To extract data from the interviews, the tapes were listened to several times and relevant information was coded. A selection of the interviews was transcribed word by word.

3.6 MATERIALS

3.6.1 Standardised questionnaires

Using standardised instruments is advantageous since it enables comparisons with other studies and increases the likelihood that the information is valid and reliable. Therefore, well-known instruments were chosen for two main variables – psychological subjective health, and current social support. One disadvantage with such measures is lack of adjustment to the target group. In an attempt to correct such flaws, minor adjustments in form of clarifying notes was added in the questionnaire where misconceptions could be anticipated. The measure of negative life events was altered somewhat more in that a few items were subtracted.

3.6.1.1 Psychological symptoms

The Symptom Checklist 90 (SCL-90) was used as a measure of current subjective mental health (Derogatis & Cleary, 1977). The Checklist consists of 90 items on nine different subscales. The participants were asked to rate the degree to which they had experienced each symptom during the past 6 months. The Global Severity Index (GSI) represents the mean value for responses to all 90 items (range 0-4). Although this is not a very sensitive or precise measure it gives an indication of the total “load” of symptoms for an individual, used in Paper II and III. Two of the subscales (depression and anxiety) were also used in Paper II.

Alcohol habits was controlled for by using the measure CAGE – Cut down, Annoyance, Guilt, Eye-opener (Mayfield, McLeod, & Hall, 1974).

3.6.1.2 Current Social Support

The Interview Schedule for Social Integration (ISSI) was originally an interview instrument used to measure social support that has been transformed into a questionnaire version (Undén & Orth-Gomer, 1989). An abbreviated questionnaire version of ISSI was used to measure current social support in adulthood. It measures both availability and satisfaction with deep emotional relations that is characterised by reciprocal trust and openness, and availability and satisfaction with relations that can give a sense of appraisal, self-worth, to be needed, share ones interests and give instrumental support. The higher and lower quartile on the ISSI-scale was used when comparing women with "high" and "low" social support.

3.6.1.3 Coping

The Coping Wheel, an instrument introduced by Shalit and Carlstedt (1984), was used to measure coping. It is a semi-projective instrument that captures the extent to which the individual feels that s/he can control different factors of his/her life, in relation to their perceived importance, and positive or negative evaluation. The investigator gives general, non-detailed instructions and guides the individual through the test.

3.6.1.4 Self-esteem

Self-esteem and self-perception were measured by the Self-esteem Scale (SES) developed at the Karolinska Hospital (Bergman et al., 1988). The scale is based on the Tennessee Self concept Scale, and contains questions on how the person perceives him- or herself on different aspects of personal qualities (social skills, moral attitude etc).

3.6.1.5 Negative Life Events

Previous distressing life experiences during life were measured by a life events scale. It was based on Holmes and Rahe's reliable and valid life changes scale with a few items deleted (Miller & Rahe, 1997). For every item the women were asked to mark at what age(s) the event happened, and to give an evaluation whether it was perceived as positive, negative or neutral at the time when the event occurred. The number of items evaluated as negative were later summed in a negative life events index.

Information about *additional trauma* such as bully victimisation during childhood and sexual/physical re-victimisation after the age of 18 was also retrieved by the questionnaire but coded separately from the index.

3.6.2 Self-constructed questionnaires

Due to difficulties finding standardised questionnaires with appropriate size, depth or content, self-made questionnaires were formed when necessary. Many measures of abuse were judged to be far too detailed and extensive, violating the integrity, others too shallow and unable to capture important aspects. Other instruments had to be adjusted to typical traits of the target group, e.g. symptom check lists not including group specific complaints.

3.6.2.1 Child Maltreatment

Participants were asked to identify all perpetrators who had sexually molested them before the age of 18. For every perpetrator they marked the age when the abuse started and ceased, how often it occurred, how close they felt to the perpetrator at the time of abuse, and what type of abuse they experienced. Perpetrators were classified in three categories: nuclear family, extended family, and other close person. There were also questions about any use of violence during the abuse.

For paper II and III an index of sexual abuse was made by adding the number of perpetrators, duration and frequency, the type of abuse they experienced, and use of violence during abuse.

Information on any physical abuse before the age of 18 was retrieved and further questions were asked about the relation to the perpetrator, frequency, and duration of the abuse. For paper II and III an index of physical abuse was constructed by adding the number of perpetrators, duration and frequency. Both indices – sexual and physical abuse – were judged to be valid, based on a study of professionals' ratings of severity on abuse characteristics by Chaffin, Wherry, Newlin, Crutchfield, and Dykman (1997).

3.6.2.2 Psychosomatic Symptoms

A symptom checklist was developed, containing 40 psychosomatic symptoms. The women were asked to rate the degree to which they had experienced each symptom during the past 6 months. The subscale somatisation from the SCL-90 was used to validate the psychosomatic symptom checklist.

3.6.2.3 Other Health Measures

In an attempt to increase control of confounding factors relevant questions from several standardised general health questionnaires were chosen to get data on previous health status (major diseases during life), number of visits to a doctor for physical or mental problems (earlier during life and during the latest year), current medication, and if they had participated in any kind of professional psychotherapy.

The questionnaire also contained questions on life style factors like smoking, exercise, regular food habits, and number of abortions during life (Wingood & DiClemente, 1997; Wyatt, Guthrie, & Notgrass, 1992).

3.6.3 Interview data

3.6.3.1 Disclosure

During the interview, the women were asked if they had told anyone about the abuse, and if so, further questions were asked about all persons they had disclosed to: when, to whom, and the subsequent reactions. Twenty-one categories of disclosure receivers were identified: non-offending mother, non-offending father, non-offending siblings, other relatives, earlier partner, present partner, own children, friends, school staff, colleagues or superiors at earlier workplace/school, colleagues or superiors at present workplace/school, and ten different kinds of professionals: traditional psychotherapist,

non-traditional psychotherapist, psychiatrist, physician, church, dentist, gynaecologist, social welfare office, local social insurance service, and other support organisation than the one used for recruiting. Further, participants were asked if they had confronted any of the perpetrators and if so, at what age.

3.6.3.2 Network Reactions

Disclosure reactions were coded as positive, negative or neutral. In cases when the women explicitly reported having experienced positive, negative or neutral reactions at the time of disclosure, these descriptions were the guiding principle for categorisation. For cases when such clear statements were missing, a reaction schedule was used for coding. The reaction schedule was derived by a qualitative analysis based on relevant parts of the semi-structured interviews from 20 women, drawn through purposeful sampling from the pool of 122 women.

One representative of the organisation was asked to critically scrutinize the definitions of the categorisations from the victim perspective. This validity test through member check yielded criticism about the concept of "neutral reactions", which according to the representative may have different meaning with respect to different parts of the social network. Because of this criticism and the low occurrence of neutral reactions, they were excluded from the analyses.

Since the exact number of disclosures and following reactions was expected to be less accurate due to possible memory deficiencies, and thus not a reliable measure, only the different types of reactions received from each part of the network were coded. If one person expressed both positive and negative reactions, both were coded. Inter-rater reliability yielded 90% agreement. Positive and negative reactions from the different parts of the network were later summed in different indices, and the number of categories of disclosure receivers reported in a case was used as a measure of involvement of the social network.

3.7 ANALYSES

The Statistical Package for Social Sciences (SPSS, version 9.0 and 10.0) and SLEIPNER 2.0 (Bergman & El-Khouri, 1998) were used for statistical analyses.

Paper I-II. Descriptive univariate statistics (percentage, mean values, standard deviations etc.) were used to present group characteristics. Bivariate correlations (Pearson's r) were used to explore the variables and their relationship with one another. Further, Chi-square tests and One-way Analyses of Variance were used to test differences between subgroups. Post-hoc comparisons were made with Scheffé corrections. Stepwise Multiple Regression models were used to explore predictors of dependent variables.

Paper III. Person-oriented approach: a hierarchical cluster analysis – Ward's model – was used to group the individuals (Bergman, 1996; Bergman & Magnusson, 1997). Chi Square Analyses and One-way Analysis of Variance established the comparability of the clusters. Variable-oriented Approach: Stepwise Multiple Regression analyses were performed.

Paper IV. A descriptive qualitative method was used, following the "Editing Analysis Style" by Crabtree and Miller (1999), with roots in both Hermeneutics and Grounded theory. The method is suitable when no theories and clear categories already exist that would enable for a theory based analysis where the text is sorted according to beforehand defined categories, and opens up for an unbiased search for variation in the data. The approach is to identify units of interest related to the research question in the text. These segments will then be subject to further analysis and interpretation.

4 RESULTS

4.1 DESCRIPTIVE DATA

4.1.1 Abuse characteristics

Child abuse characteristics are presented in Table 1. A majority of the women had been severely abused for a long period of time by someone close in the nuclear family (most commonly a father figure, 68%). The abuse often started before the age of seven, and the duration ranged between a single episode to 18 years, on average 7 ± 4.5 years. Violence during abuse was reported from 41% of the women. Sixty-nine percent reported having been physically abused during childhood, half of them every month or more, most commonly the perpetrator was a parent.

Table 1.

Child abuse characteristics presented for the two groups of women recruited in different ways.

Variable		Women's org. % (n=131)	Community % (n=21)	Total sample % (n=152)
Sexual abuse				
Number of perpetrators	1	35	67	40
	2	31	28	30
	3 or more	34	5	30
Relation to perpetrator [a]	Nuclear family	85	29	77
	Extended family	10	62	17
	Other close person	5	9	6
Age at onset of abuse	0-6	78	52	74
	7-14	20	48	24
Duration	0-4 years	24	67	30
(range 0-18 years)	5-10 years	38	29	37
	> 10 years	31	0	27
Type of abuse [b]	Non-contact	0	(1)	(1)
	Contact	15	71	23
	Penetration	83	24	75
Frequency [b]	Once	3	5	3
	A few times a year	24	67	30
	A few times a month	37	24	36
	Every week	34	5	30
Use of violence	Threat of violence	37	10	34
	Physical violence	43	29	41
Physical abuse		70	62	69
Number of perpetrators	1	49	38	47
	2	15	19	16
	3 or more	6	5	6
Relation to perpetrator	Father figure	56	47	55
	Mother figure	25	29	26
Duration	0-4 years	13	10	12
(range 0-18 years)	5-10 years	21	24	22
	> 10 years	18	10	17
Frequency [b]	Once	4	19	6
	A few times a year	27	24	27
	A few times a month	18	14	18
	Every week	18	5	16

[a] The perpetrator most closely related. [b] The highest marked alternative.

As shown in Table 1, women recruited from the communities reported less severe abuse on average, yet, abuse characteristics of all types were reported within the group.

4.1.2 Disclosure characteristics

All women, except one, had told someone about at least one abuse event. Slightly less than a third disclosed during childhood (before the age of 18) while the majority waited until adulthood. The delay was up to 49 years with an average of 21 ± 12.9 years. Very few women told anyone within one year after the first event about the abuse. Twelve percent of the women had told up to four parts of the network about the abuse (including professionals), 55% had told 5-9 parts, and 33% had told 10-15 parts of the network.

Overall, two thirds received a positive first reaction. In childhood, the most common person first told was the mother, who responded negatively in half of the cases. In adulthood, the most common was to tell a therapist or partner first, and a majority received a positive reaction. Of all 83 women who had told their mother in adulthood, a majority got a negative response.

Telling in childhood was significantly related to a negative reaction. The likelihood of telling again after receiving a first negative reaction was not significantly decreased, although 56% of those who got a negative reaction in childhood did not tell anyone again until adulthood. Focusing on mothers, 72% of those getting a negative reaction from mother in childhood told her again as adults. All women who had a new partner after having received a negative reaction from a former partner (50%) had told the new partner. However, there was a tendency of not telling again at the present workplace, having received a negative response at the previous workplace, only 28% told again.

In all age groups, a large proportion of women disclosed during the 1990's with a peak 1994, perhaps due to a media hype about child sexual abuse in Sweden between approximately 1990-1995. Over time, it has become more common with a positive reaction.

Half of all 123 women had confronted at least one perpetrator. Ten women confronted at least one perpetrator during childhood. Only ten women reported the abuse to the police, and in four cases the perpetrator was convicted.

4.2 PAPER I

Disclosure, reactions, and social support: Findings from a sample of adult victims of child sexual abuse

One main result from the study was the notion that telling during childhood seemed to be risky. It was related to reported physical abuse, use of violence during abuse, and a first negative reaction. Of those who told in childhood during a period with on-going abuse more than half were continuously abused after disclosure. They reported abuse at a higher age and by more perpetrators.

Moreover, the results showed that telling about more severe traumatic events was related to negative reactions from the social network. Severely abused women had talked to more parts of the network than less severely abused, especially to

professionals. Both women continuously abused after telling in childhood and women in the group of severely abused had not only talked to more people but had also received more negative reactions. Variables associated with negative reactions were use of violence, longer duration, and many perpetrators. Positive reactions were associated with telling in adulthood (partner, therapist or friends) and confrontation of a perpetrator.

Further analyses showed that first reaction, time of disclosure, number of disclosures, variables associated with present contact with family or perpetrator, or amount of negative reactions were not significantly related to subsequent social support. Instead, number of positive reactions was related to support ($r = .25$, $p < .01$), and confronting a perpetrator was strongly related to both positive reactions and high social support.

In short, the results showed that the whole disclosure process is important to consider when studying disclosure-related events in relation to social support. Moreover, in spite of experiences of severe abuse and negative reactions after disclosure it is possible to get access to health enhancing social support in adulthood.

4.3 PAPER II

Adult female victims of child sexual abuse: Multitype maltreatment and disclosure characteristics related to subjective health

Main results showed that no relationship was found between first reactions and health, while there were several examples of associations between further disclosure and health. In particular a 'positive reaction from a partner' was related to fewer psychological symptoms in adult victims of child sexual abuse, and 'negative reactions from friends in adulthood' were related to more symptoms. In addition, 'told mother in adulthood' was related to more psychological symptoms. Exposure also to child physical abuse proved to be the only abuse characteristic related to both more psychological and psychosomatic symptoms. Psychosomatic symptoms were also predicted by the sexual abuse characteristic 'penetration'. Abuse characteristics were found to systematically explain only 7% of the variance in health compared to disclosure characteristics explaining 16% when used in the regression model.

In summary, disclosure characteristics were more prominently related to health than sexual abuse characteristics when compared simultaneously. The relation between disclosure-related events and health was dependent on source and type of reaction. Reactions from the family of origin was unrelated or negatively related to health while reactions from current significant others like partners and friends proved to be much more strongly related to current well-being. The results also supported the notion that first reaction is subordinate to following reactions.

4.4 PAPER III

Risk factors and protective factors in relation to subjective health among adult female victims of child sexual abuse

By using cluster analysis six groups with different profiles were found, presented in Figure 2. Four groups showed familiar patterns of risk and protective factors, scoring respectively a) high-high – Good Coping, b) low-low – Scarce Resources, c) high-low – Multi-risk, and d) low-high – Low Risk. Additionally, one group representing the average – Intermediate – was found, as well as one group with a special profile, namely the Support Compensation group that showed unfamiliar traits: high risk in combination with low self-esteem and low coping but with high social support.

Protective factors

Risk factors	**Low**	**Moderate**	**High**
High	**Multi-risk** *(n = 34; GSI = 1.84)* High risk, especially physical abuse/low resources	**Support Compensation** *(n = 37; GSI = 1.36)* High risk, especially sexual abuse/rather low resources with the exception of high social support	**Good Coping** *(n = 11; GSI = 1.11)* High risk, especially abuse/high resources, especially coping
Moderate		**Intermediate** *(n = 28; GSI = 1.33)* Moderate risk, low physical abuse/ moderate resources	
Low	**Scarce Resources** *(n = 5; GSI = 2.04)* Low risk/very low Resources		**Low Risk** *(n = 24; GSI = 0.69)* Low risk/high resources especially social support

Figure 2. Four familiar profiles in the six cluster solution – characteristics, size and psychological symptoms measured by the average score on GSI, SCL-90. GSI sample mean = 1.36; values in a female normal Swedish population: 0.49 (Fridell, Cesarec, Johansson, & Malling Andersen, 2002).

When the six clusters were compared on health status it turned out that two of the groups followed predictable patterns: Multi-risk and Low-risk represented the linear-based postulates "the more risk factors the worse health" and "the more resources the better health". Two other groups represented the opposite, namely the Good Coping and Scarce Resources groups. The former is known as a classical resilient group, showing better health than expected in a group with such high amount of risk factors and severe abuse experiences. The latter is sometimes called "highly vulnerable persons", suffering from ill-health in spite of low scores on risk factors.

The Intermediate and the Support compensation groups showed mean values on health measurements. Interestingly, the Support Compensation group showed a pattern similar to the resilient pattern in the Good Coping group. In spite of high risk

and rather low resources their health was moderate, reporting only social support as a protective factor. Two prominent characteristics of these two groups were large proportions of low educated women and women formerly active in the support organisation (60-70%).

Self-esteem and social support were strongly related to both psychological and psychosomatic health in the regression models. The first entered variable in the model predicting psychological symptoms was self-esteem, explaining as much as 56% of the variance in GSI in the first step. The other variables entered in the following order: social support, the index of physical abuse, and negative life events. The final model explained 64% of the systematic variance in psychological symptoms. In the second model 37% of the systematic variance in psychosomatic symptoms was explained. The strong association between self-esteem and health shown in the regression model was non-existent in the Support Compensation group showing that social support per se, without its association to self-esteem, can be strongly related to health.

In summary, the Support Compensation group showed traits that would have gone unnoticed should only the variable-oriented regression analysis has been used to explore the data. Different methods of analyses may contribute to the understanding of how risk and protective factors interact. Both methods used pointed at the importance of resources above the amount of risk factors for health outcome.

4.5 PAPER IV

Members' experiences from a women's support organisation

This qualitative study aimed at understanding how women reporting child sexual abuse perceived and utilised societal social support in form of contact with a support organisation for female CSA victims. Different facets of the victim identity – and especially the changes of these facets over time – seemed to constitute an important part of the self reported individual development.

The first steps were to identify oneself as a victim and to acknowledge and in at least some sense understand the different aspects of being a victim. Main *motives for contacting a support organisation* could be identified as interpersonal (e.g. to receive confirmation that you are not the only woman with abuse experiences and that you are normal, to have the opportunity to express yourself about your abuse experiences and to be believed), offer related (getting access to specific activities) or generally related to needs of help.

> *It was a big step for me to take. Really. It was the same as, well, just standing with the truth in front of you, that is to say... that you had been a victim of sexual abuse and that it really had affected you. 'Cause I had denied that all of my life, really.*

> *I felt I didn't really get help from the psychiatry the way I wanted – I wanted to know if I could get some more help then.*

Many of the motives described above were also reported by the women as the actual *benefits* of the membership. By means of the benefits from being a member the victim identity could later on fade away, especially the negative connotations of this concept. Such benefits described were for example a possibility of forming friendships, identification with others, confirmation of normality of physical appearance, receiving a unique understanding, membership serving as a reminder of victimisation and a sense of security that the organisation exists in case of need. The women told of a kind of support based on a deep understanding of the problems that could not be received in any form of professional health care by someone who had not the same experiences.

> *Well, what was good was to come to a place and see such beautiful, cool and strong women who had been abused. Because then I still had an idea that you were disgusting, stupid and a failure sort of. I think that, I don't think I had let that go if I hadn't met them.*

> *Anyway, I met sisters who spoke the same language, who immediately understood what I meant. Eh, emotionally, about the abuse and stuff, without me having to paraphrase into different pictures with thousands of words or trying to find parallels. They understood what I said, and I understood what they said, we spoke the same language. It was so incredibly relieving and strengthening.*

> *...to be a member is to remind myself that this is important, to not forget this, but belay there! – you have to take the abuse seriously.*

Creating an identity based on the abuse, as the concept "survivor" presupposes, could eventually turn out unnecessary and negative. Many of the *negative experiences* reported concerned the victim role – the resistance when confronting the victim role or the endurance of the victim role, that is, getting stuck. Other negative experiences concerned the strenuous atmosphere due to the gathering of many persons with both intra- and interpersonal problems and a stereotyped conception about the world expressed through contempt of men and lack of empathy for victims of female perpetrators.

> *It is a part of my life, but it mustn't become all of it. It mustn't only be me sitting talking about sexual abuse, anxiety, nervousness, injuries and sick leaves and... because then there is nothing positive about it. And then it becomes... it's like one of these "victim groups", sort of. And I cannot regard myself as.... 'cause I'm not only that. I am not only a big sexual molestation, sort of.*

> *"We are survivors" – and I felt that... that...it became so heavy... or I felt this... My god, are we going to walk around as "survivors"? I wanted to become a living person. Of course that has to be the goal!*

> *There was very much... contempt of men I thought sometimes... that it was only the men who were bad and that all of us had been abused by men...*

Few members who had gone through crucial steps of the victim process seemed to remain in the organisation passing the knowledge on to new members. Thus, an organisation of this kind may not have enough role models to counterbalance the help seekers, creating a chronic structural problem for the organisation to deal with.

Motives to leave the support organisation were related to a feeling that it was time to finish when they had got what they wanted, e.g. a successful and accomplished healing. For others, needs of orienting in a new direction and leaving the victim role or to get further aid were more salient motives. The negative experiences of conformity and stereotyped conception of the world played a decisive role for a few women when decreasing their contact with the organisation.

> *Those years I had were enough. I didn't have more to give, 'cause I mean, even if I told my story it was their stories that they had to work through and get on with. The only thing I could show them was that I felt good, I suppose.*

> *... that is, it's not so important any longer for me. 'Cause I feel that life goes on. You have to do other things as well in life. And then I feel that the sexual abuse that I have been a victim of, I will always bring it with me, but it is… it's not the same thing today as it was before.*

> *I wouldn't want them to disappear and of course I will always continue to support them. But I miss another form of group and a little less spiteful view on men and a somewhat more responsible… that is, to throw back the responsibility where it belongs, to the women who let this happen. I think that is the main reason why I haven't been there much.*

To conclude, different facets of the victim identity seemed to constitute an important part of the self reported individual development in members of a support organisation for female child sexual abuse victims. The identity procedures seemed to be stimulated not only by the seemingly more powerful parts of the offer of the organisation but also by less intense activities, even through the information magazine. These reports are useful for identifying psychological mechanisms of relevance. Further, our findings may also have implications for understanding some of the structural problems that organisations of this type encounter.

5 DISCUSSION

5.1 DISCLOSURE, REACTIONS AND HEALTH

In order to understand the psychological forces involved in the disclosure dilemma one option is to go back to the model of Traumagenic dynamics. CSA means that the child has been exploited and betrayed by a trusted individual. The betrayal results in distrust, anger, risk for further abuse, intimacy problems and depression (grief over loss of a trusted figure). In many disclosure situations the victim is put in a similar condition: when telling, the victim often chooses a trusted person expecting acceptance, belief and understanding. In case of a negative response betrayal is renewed, and possibly also stigmatisation. Thus, a negative response re-establishes fundamental traumatic components. This is perhaps most clearly shown by the significant relation between negative reactions from friends in adulthood and ill-health (Paper II). Some victims may trust solely upon friends in lack of partner and family putting the person in a dependent situation in which a new betrayal may be devastating.

Assumed that every negative disclosure event psychologically resembles the original abuse the victim may be seen as continuously entrapped in a disclosure process constantly demanding coping resources. In lack of such resources some victims disclosing severe abuse seem to fall into a negative spiral indicated by the relationship between severe abuse, telling many people and receiving many negative reactions (Paper I). Apparently, as Spaccarelli's model suggests, the load of the abuse itself and negative post-disclosure reactions in greater numbers increases the likelihood of an adverse outcome, which is also supported by empirical data from this (Paper II) and other studies on stressful life-events (although not explicitly defining disclosure-events as negative life-events) (De Graaf, Bijl, Ravelli, Smit, & Vollebergh, 2002; Horwitz, Widom, McLaughlin, & White, 2001) and disclosure reactions (Arata, 1998; Lange et al., 1999).

Clearly, there is a point in making an effort to reduce the risk of negative reactions. Openness per se or many disclosures does not constitute a guarantee for receiving support. The results suggest that the importance and impact of disclosure-related events on health is dependent on source; the likelihood of receiving a positive response and support dependent on which part of the network is approached, discrediting the family of origin in favour of partners and friends.

5.2 SOCIAL SUPPORT AND HEALTH

Telling a partner was associated with positive reactions, high levels of perceived social support (Paper I) and health (Paper II). Having an intimate relationship is generally known to be health promoting for everybody. However, it may be crucial for victims of CSA who have problems with trust and intimacy to get emotional support, acceptance and respect from a partner in overcoming these feelings. This is in line with Cohen's stress buffering hypothesis (Cohen & Wills, 1985), stating that "buffering effects will be observed when the support functions measured are those that are most relevant for the stressors faced by the person". To share one's inner feelings and work through the deepest wounds concerning integrity, physical touch and sexuality is only enabled in a

close relationship. Thus, an intimate relationship seems to be of outmost importance for this group of women since it is healing the parts most harmed according to the model of Traumagenic dynamics: sexual traumatisation and betrayal. Along the same line, one finding in a recently presented thesis on CSA victims in group therapy was that victims wish help to develop deeper relationships to partners. The women struggled with hesitations and fears of getting too close to other people, interpreted by the author as a fear of not being able to keep limits for the integrity (Lundqvist, 2005).

In contrast to the harmful negative reactions from friends mentioned above, relations to positively responding friends seem to be valuable and a vast majority of friends was reported to have responded with support. This seems reasonable since friends become more important as a source of support later in life. Gradually, individuals extend their networks from parents to peers who eventually become an essential source of support.

A majority of the participants in this study had told their mothers of abuse, either in childhood or adulthood or both. Reactions were most commonly negative (Paper I). Solely 'having told the mother in adulthood' was associated to more psychological symptoms (Paper II). There was also a non-significant tendency towards siblings responding negatively. Thus, it is plausible to conclude that what matters the most is the current life situation and available resources here and now. The past and the family of origin might be nothing but a source of frustration, of no benefit to current well-being. The present relationships with self-chosen persons seem superior in their capacity to enhance well-being.

A sound relationship affects self-esteem, the continued positive experience of a person's self-worth, but the process is two-ways. A social environment conducive to self-esteem enables the person to connect him- or herself with significant others and to receive appropriate feedback. Self-esteem strengthens feelings of belonging, approval and success (Liem & Boudewyn, 1999; Rosenthal, Feiring, & Taska, 2003). Social support, self-esteem and subjective health are highly intertwined which is highlighted by results in Paper III showing a strong co-variation between the concepts. One contribution of this thesis concerns the result in Paper III, showing that health may be associated to social support per se, without co-variation with self-esteem.

Nevertheless, the two-way interpretation of the relation between social support and health must be considered. Due to the cross-sectional design the alternative explanation may be just as valid: those who already are healthy may have better prerequisites to receive social support (and positive reactions) from the network. However, the first interpretation seem more reasonable in the light of both clinical experience (Courtois, 1988; Jehu, 1988) and the subjective impression from the interviews.

5.3 SOCIETAL SOCIAL SUPPORT AND HEALTH

Dakof & Taylor (1990) showed in a study of cancer patients, that different actions were perceived to be helpful from different persons in the network. Intimate others were most valued for the emotional support they provide, while physicians were more valued for informational support. Apparently, professionals ought to have another function in victims' lives, supplying support in form of information and knowledge or simply giving treatment. However, if the private social network is not providing support, social

support from professionals might be of greater importance. A large proportion of women with low support chose to tell a therapist first. They had also seen more professionals and had a tendency of being active in the support organisation (Paper I). Having told and/or having visited many professionals were also associated to many symptoms (Paper I and III). In addition, quite a few women reported a disappointment with previous professional contacts (Paper IV). These results indicate a need for professional health care, which stands in contrast to the lack of understanding of the issue within psychiatric health care described in the literature, presumably causing many women to continuously seek professional contacts (Lundqvist, 2005; Read & Fraser, 1998). One recent national survey study even show that CSA victims experience abusive events in the health care system (Swahnberg, 2004). In conclusion, this calls for greater educational efforts for health care staff as well as development of adequate treatment.

In absence of other sources of support it is reasonable to turn to professionals for help, or approach an organisation where one can meet others with the same experiences. It is also plausible that the amount of support can fluctuate during different phases in recovery. During an intensive period when in treatment, support from professionals and organisations may be necessary while it gives a relief not to have contact with friends and partners who may demand reciprocity in the relationship. Thus, the participants reported of several types of societal health care utilisation. A majority of the women had been in psychotherapy. Some victims mentioned therapies lasting nearly 20 years. For a period of time it might be absolutely necessary to form such a relationship between care taker and care giver, but if the contact gets long lasting it might even be devastating to the individual. Strong needs of support by the victim and a close relation based on personal support given by the professional may cause an unhealthy dependency. Reports of unprofessional therapists is tragically not rare (Broden & Agresti, 1998). There may be a risk that professionals try to function as substituting social support givers.

In paper III two groups of "resilient" women with good health was found through cluster analysis. They had a high proportion of formerly active participants in the women's support organisation yet did not differ from the other four groups in therapy attendance (Paper III). This finding highlights a possible qualitative difference between voluntary social support and professional support consequently initiating the fourth qualitative study that aimed to explore the healing parts in that kind of societal support.

5.4 QUALITIES OF SELF-HELP

When making qualitative analysis one is always at risk of finding the results one is looking for. There is a controversy whether a single researcher performing the analysis increases that risk or not. To be on the safe side, the results in the fourth article were derived through team discussions between three researchers. One author (M Karlsson) was associated with another field of research – social work. The multi-disciplinary approach broadened the perspective and added important angles to the interpretations of the interviews.

Different aspects of the victim identity – changing over time – seemed to constitute an important part of the self reported individual development. The identity

process seemed to be stimulated not only by the seemingly more powerful parts that the organisation had to offer, but also by less intense activities, even such as reading the information magazine. This notion resembles recent reports on the positive effects of psychological treatment via internet (Hirai & Clum, 2005; Pull, 2006). Merely reading about other persons having experienced similar situations may be sufficient to help people feeling more at ease and understanding themselves better. This is truly interesting, in particular from a cost-benefit perspective of public economy. To be able to supply help even to isolated persons by such easily distributed means would be very useful.

No reported benefit was related to cure or relief of symptoms. Instead, the women mentioned benefits related to being understood, receiving and/or giving support, getting information, and learning ways to cope with their situation, which is in accordance with earlier findings (Karlsson, 2002). However, some women reported *accomplished healing* as one motive to leave the support organisation, suggesting few women with experiences of the whole victim process remain in the organisation passing the knowledge on to new members. Thus, an organisation of this kind may not have enough role models to counterbalance the help seekers, creating a chronic structural problem for the organisation to deal with.

Issues concerning self-help versus professional help has been discussed and studied for a long time. The interest of how both types of knowledge may be combined is growing .What is characterising self-help is that experiences and interpretations of the participants becomes the base for constructing a common reality concerning their problem. The experiential knowledge accumulated by the women gives them a possibility to understand and find ways to handle their situation. Professional help is based on scientific knowledge and clinical experience, and thus formed out of an "outside" understanding of the problem (Borkman, 1999). In the light of the increasing collaboration between self-help organisations and professionals it might be the case that support organisations for CSA victims would benefit from such structural models in order to relieve pressure from the remaining role models (Adamsen & Rasmussen, 2001; Karlsson, 2004).

5.5 PERSONAL REFLECTIONS

Many of the women in the study rated their health as good or very good in spite of former exposure to severe child maltreatment, subsequent negative reactions and other stressful life events. This should not be interpreted as if child sexual abuse not is harmful to the individual. Child sexual abuse probably alters a person's life fundamentally. Another more plausible interpretation is that these women have been able to find a stress reducing coping strategy based on acceptance of the abuse whereas women still suffering from ill-health are struggling with abuse-related issues.

Problem focused coping is more appropriate in situations where something can be done, less so in situations that have to be accepted. In contrast, emotion focused coping is more appropriate in situations that have to be accepted. The so called third wave of cognitive behavioural therapies (e.g. Dialectical Behaviour Therapy and Acceptance and Commitment Therapy) focus on the value and acceptance of personal struggles as a part of human nature. Thoughts from ancient eastern wisdom on acceptance, meditation and coming at ease with all aspects of life are being

introduced to a greater extent in modern psychotherapies (Lau & McMain, 2005). This new perspective includes an allowance of psychic pain and psychic health to co-exist, as described by Kåver (2005). The assumption that the "normal" state of life is absence of pain and suffering results in a fight against all "bad" and "abnormal" states. Instead, if a person by greater acceptance can learn to live with all ingredients of life, even anxiety and depression, it would probably affect the subjective health positively.

One may wonder how such a shift in health perspective will influence the development of the concept of well-being. One advantage of subjective health measures is that they capture subjective feelings, conceptions and symptoms as perceived by the person, thus giving a relevant picture of individual experiences of well-being. The subjective perceptions are independent of actual presence of objectively measured disease or symptoms. A commonly described disadvantage is the risk of biased reports due to expectations, social desirability or mood. Especially the impact of mood has been subject to exploration showing for example that depressed persons report more symptoms than non-depressed. This methodological troublesome issue in scientific research might paradoxically disappear if the new perspective on health is applied, although it will probably create other problems for researchers to overcome.

From one perspective, this thesis shows that the human being seems to be able to tolerate and overcome quite a lot of psychological and physical pain. The lasting impression from the interviews is that all women were extremely strong in either one of two ways: 1) having a capacity to survive in the presence of great psychological and physical stress despite low availability of resources, sometimes at the cost of a subjective well-being, or 2) having a capacity to tolerate and accept the past, to focus on the present and handle abuse-related stressful situations with pride and integrity rewarded with subjective good health. Thus, the women do not seem to be "destroyed" or "demolished", as some women described themselves in the interviews. Put in a more positive view, the lack of resources in adult life is hopefully not due to incapacity or lack of potential but rather a sign of recourses locked in or wrongly directed. My belief is that all individuals have the possibility to regain what was being taken from them.

5.6 METHODOLOGICAL ISSUES

5.6.1 Design

Advantages of non-experimental research are its discovery potential and realism. However, one constantly faces the problem of the post hoc fallacy, the belief that simply because one thing happens after another, the first event was a cause of the second event. In cross-sectional studies it is impossible to study causation, only relations may be sought. It is therefore of primary importance to work with alternative hypothesis. The effort in this thesis has been to bring up into view every rational explanation of new phenomena to avoid the risk of improper interpretation. To be optimal, research on long-term effects of CSA should be longitudinal.

Seeking the roots of adult health one faces even more problems in form of a multitude of contributing factors: hereditary traits, parental personality, environmental circumstances and other plausible explanations. The study suffers from lack of control of independent variables since the issue does not lend itself to

experimentation or randomisation. In order to approach this problem some major confounding factors were controlled for (e.g. alcohol habits, re-victimisation, and previous major disease).

In non-experimental research almost all variables are systematically correlated even more blurring the picture. Using multiple regression is a way to handle that, since the method of analysis has the potential to control for co-variation. A somewhat troublesome result of using that method, though, is that the terminology may lure the scientist to slip into the above post hoc fallacy. Commonly used words like "predict" and "explain" must be used with caution.

5.6.2 Sample

Another methodological concern is to what extent the results can be generalised. In contrast to other earlier national studies of CSA victims performed on smaller clinical groups, this study presents a non-clinical sample. By recruiting women from two different populations generalisability increased. Women from the communities were on average somewhat older, abused to a lesser extent and were more integrated in society, implying higher levels of functioning. However, comparisons between the two groups showed great similarities in ranges and direction of relations in variables allowing for merging the two groups and thus increase variation.

It turned out that the group of organisation members was rather heterogeneous, exemplified by approximately 20% of the members never having participated in any activity offered by the organisation (Paper IV). Thus, the support organisation was not only contacted by severely abused women most in need of support as one might assume from the higher levels of abuse severity in that group. Diverse motives for contacting the organisations were reported in Paper IV.

Still, since women were self-selected some biases in the sample were found. The total sample consisted of highly educated women of whom a majority were members of a support organisation implying a capacity to find information and take initiative. This is probably a group of highly motivated women. Low educated women might be difficult to recruit in this way. To conclude, the women are not representative for all female victims of child sexual abuse, and the findings ought to be replicated in other groups of victims.

5.6.3 Methods

A combination of methods – quantitative and qualitative – was used to give a more complete picture of the relationships of variables and make the most out of the data set. If the results are similar across different methods it increases the credibility of the findings. Within the great "smorgasbord" of statistical methods those used in the thesis were chosen from the criteria of being appropriate to the research question. An example of how two approaches mutually strengthen each other and result in more credible conclusions is the use of both a variable-oriented and a person-oriented approach in Paper III.

Cluster analysis is an exploratory data analysis tool, which aims at sorting different objects into groups based on a set of values. One of the most critical decisions when using a pattern-analysis is on what variables to include, since changing only one

of them will change the whole classification. Therefore, a classification is neither true nor false and should be judged on the usefulness of results. Thus, the groups identified and described in this thesis are no "true" groups. The usefulness of the results perhaps rather lies on a methodological level, showing that pattern-based methods can complement variable-based methods in finding non-linear or higher order relations in a data set. Other matter that was considered to get trustworthy results was to only include reliable variables and to limit the number of variables in order to get more homogenous clusters. The homogeneity was further strengthened by using a residue procedure – removing single individuals forming unique clusters.

Further, to create a deeper understanding of the women's thoughts, feelings and behaviours a qualitative method was used in Paper IV. Qualitative methods are sometimes criticised for their scientific vagueness whereas quantitative methods are held higher. However, the method chosen should fit the research question asked. Qualitative methods are used to explore the meaning of something to those involved, to understand a certain context or how involved persons are affected by that context. It relies on basic assumptions that reality exists only in relation to the observer, that subjectivity is inevitable and must be handled, and that data is a source for generating concepts and relationships between concepts.

Finally, using many methods have resulted in a broad understanding of methodological options as well as a general know-how of how to use and interpret different analysis tools, though at expense of specialisation.

5.7 LIMITATIONS

It has been impossible to assert the validity of the independent variable *child sexual abuse* in this thesis due to the very nature of the crime – it is being performed in secrecy leaving but few evidence except self-reports from victims. Thus, this study concerns women *reporting* child sexual abuse. The underlying assumption is that reports are generally reliable in the sense that abuse did occur although the extent and nature of the abuse may be subject to memory distortions. Another assumption is that reasons for under-reporting (e.g. having no health problems, having distorted memories) or over-reporting (e.g. having serious health problems and searching for a reason) abuse events will counterbalance each other. In short, it was judged to be reasonable to assume that this thesis do study the phenomenon of and correlates to child sexual abuse.

This thesis only concerned female victims. Gender differences in long-term consequences of abuse has been reported in terms of sexual abuse experiences, psychological symptoms, coping, PTSD, and some aspects of disclosure and social reactions from others (Ullman & Filipas, 2005) and the results of this thesis cannot be generalised to male victims.

5.8 CONCLUSIONS

> *First it has to have a meaning to tell, a purpose. It also has to be the right time... you know, we scan people, very, very quickly and know that "Ok, here I can tell, here I can't tell". I see it on the facial expression, feel the vibes, small, small signals. Before, this was very stressful for me, I was very tense about this. Today I have another confidence. It's not so traumatic any longer. I don't have to take responsibility for the other person's feelings about it.* (Woman in the study)

This thesis shows that even in a sample of women reporting severe child maltreatment, individuals with a positive outcome can still be found. A major conclusion is that social support is a crucial protective factor for victims of child sexual abuse, a group highly at risk for and ill-health and adverse outcome. Moreover, victims of child sexual abuse seek and receive social support in various ways depending on severity of abuse, timing of disclosure and choice of disclosure receiver; in particular, partners appear important for well-being. Even severely abused women experiencing many negative reactions are able to benefit from social support when finally finding a reliable resource. Thus, the whole disclosure process during life is important to consider when studying disclosure-related events in relation to social support and health.

The thesis adds empirical support to the transactional model of Spaccarelli in that disclosure-related events do seem to function as stressors, likely to increase the total stress load in the individual leading to chronic distress and affecting health in the long run. Still, it is possible to find coping strategies that decrease the imminent risk of stress overload. Different methods of analyses contribute to the understanding of how risk and protective factors interact. Both variable- and person-based methods pointed at the importance of resources like self-esteem and social support above the amount of risk factors for health outcome. Although social support, self-esteem and subjective health are highly intertwined, one conclusion is that health may be associated to social support per se, without co-variation with self-esteem.

Finally, some groups of victims may obtain a good health in adulthood in spite of severe abuse experiences. Such a pattern was in this study related to a formerly active participation in a support organisation, where a transformation of the victim identity over time seemed to constitute an important part of the individual development. One conclusion is that self-help organisations are able to contribute to increased individual well-being by means of unique beneficial mutual aid elements. The power and qualities that lies in the nature of voluntary human relations and the different qualities of professional help complement each other, giving victims an option to find suitable ways to healing.

5.8.1 Clinical implications

The so called victim process that many women seem to undergo during their participation in the activities of the support organisation is an observation that can hopefully inspire to the development of psychiatric care and professional psychotherapeutic approaches. The finding that even self-help received from a distant

position from the support organisation may be effective highlights the importance of the qualitative aspects of measures offered to this group.

The structural findings in the support organisation – few mature members with experiential knowledge remain in the organisation implying lack of good role models – shed light upon a danger for organisations of this kind. It is important to be aware of such inherent structural organisational threats and hopefully these threats can be met at a structural level. A deepened collaboration with professionals initiated and continuously monitored by the victims themselves may be one possible solution. Finding ways to combine self-help with professional help might be fruitful and constitutes a further challenge for psychiatry when it comes to the task of developing new and effective care for this group.

For the victim it is important information that severity of abuse is not fatally implying a bad prognosis. An intimate relationship with a partner and self-esteem turned out as crucial factors related to outcome whereas issues concerning the family of origin were less important for well-being. This is of importance both as an aspect of the assessment phase and as a possible focus for psychotherapeutic approaches. A victim with deficits in this respect may need interventions aimed at facilitating the building of reciprocal social relations, since social support stands out as an important protective factor for this group, at risk for chronic stress and ill-health.

5.8.2 Future research

Urgent topics for future research are to refine the different pathways to social support during different periods of time after first disclosure demanding longitudinal research. The reasons for disclosure may be altered during the healing process when the needs of the victim change. The underlying considerations, thoughts, and emotions, especially the impact of shame may have contrasting qualities.

Because support from a partner proved to be beneficial further investigations should be made on how victims of sexual abuse form romantic relationships. Therapeutic methods aimed at facilitating mating and building reciprocal social relations need to be developed and evaluated.

The overlapping concepts of self-esteem and health should also be further explored. Whether self-esteem is an antecedent to resilience or a health outcome variable or both depending on the context is a complicated issue.

Studies on treatment effects in victims of child sexual abuse from new alternative methods based on acceptance would add important knowledge to the research field.

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The only devils in the world are those running around in our own hearts, and that is where all our battles ought to be fought.

Mahatma Gandhi

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