RELATIONSHIP AND PERSONALITY ISSUES IN ADULT FEMALE SURVIVORS OF CHILDHOOD INCEST: A CASE STUDY

By

Sharon H. Gobert

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ABSTRACT

Gobert Sharon H.
(Writer) (Last Name) (First Name) (Initial)

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This study was conducted to explore the personal relationship issues that adult female survivors of childhood incest have throughout their lifetime, and to compare it with the research that has been completed.

This study was done in the form of a case study, in which one subject, an adult female survivor of childhood incest was interviewed for seven sessions. Based on these interviews, a comparison was done in regards to the relationship issues the subject has experienced or is currently experiencing, with the literature reviewed in this study.

The conclusion of this study will present information that addresses the long-term aftereffects of incest for adult female survivors in regard to their personal relationship issues throughout adulthood.

This study also suggests additional areas of research based on the results found in this study.

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CHAPTER ONE

Introduction

Many women are victims of violence at some time in their lives. In the United States, approximately 22-37 % of women have been sexually abused as children (Russell 1986). Russell goes on to report in her book, *The Secret Trauma*, the results of a survey she conducted relative to incest in the lives of American women. In this study of 930 women, from a cross section of socioeconomic and ethnic backgrounds, more than one-third reported some kind of unwanted sexual contact in their childhood. The landmark statistic that came from this study was that of the women reporting sexual contact, about one half reported the abuse to be incestuous in nature. In other words, the perpetrator was an immediate family member. By 1988, there was research stating that 35% of all reported child sexual abuse cases were of girls under the age of six. Incest does not start with puberty; by the time teens first report the incident, they have probably been enduring it for years (Blume, 1990, p. 10). One must also consider that this number is only of the reported cases, and not all child abuse cases are reported to law enforcement officials.

It is important to note that incest is interpreted and means different things to different people and professionals. American society traditionally defines incest as: sexual intercourse between two persons too closely related to marry legally. For the purpose of this study, incest will be defined according to Wisconsin statutes, and as written by the Wisconsin Coalition Against Sexual Assault (WCASA) (2000b):

> *… incest with a child: (1) marries or has sexual intercourse or sexual contact with a child he or she knows is related, either by blood or adoption, and the child is related in a degree of kinship closer than 2nd cousin; or (2) is a person*

responsible for the child's welfare and (a) Has knowledge that another person related to the child by blood or adoption in a degree of kinship closer than 2nd cousin has had or intends to have sexual intercourse or sexual intercourse with the child; (b) Is physically and emotionally capable of taking action that will prevent the intercourse or contact from occurring or being repeated; (c) Fails to take that action; and (d) The failure to act exposes the child to an unreasonable risk that intercourse or contact may occur between the child and the other person facilitates the intercourse or contact that does occur between the child and the other person. (s .948.06)

It is also important to clarify, for this study, that the perpetrator will be restricted to father, step-father, or grandfather, and the victim will be his daughter, step-daughter or his grand-daughter. Thus, it is important to note that the term perpetrator will be used inter-changeably with the word "he," and the survivor will be referenced as "she." It is also important to note that the researcher does not imply that all males are abusers, nor does it imply that all (females) are weak and helpless victims. This is a study of incest victims and their continuous struggle to survive in a society that allows indirect domination of males, especially, as it relates to the one victim in this particular study.

Although this research project focuses specifically on incest where females are the victims, and the perpetrators are adult males in parental roles, the researcher acknowledges that males are also sexually victimized within families, and suffer similar struggles of survival in adult life. The known statistics indicate that male children are victims in five to fifteen percent of the reported cases (Courtois, 1999).

There have been extraordinary changes in the attitudes of not only the therapists, but of the general population when it comes to working with victims of childhood incest. As little as two decades ago, the word incest was dirty and ugly. "It"

was only acknowledged to happen in low economic, poorly educated families. "It" was the unspoken truth, never to be discussed, but rather swept under the rug and kept in silence forever. According to Blume, 1990, the truth is that incest knows no boundaries; it is present in every social class, culture, race, religion, and gender. Children are abused by fathers, stepfathers, uncles, brothers, grandparents and even sometimes by aunts and mothers. Although women do abuse, the majority of the perpetrators are men. A study conducted by Lubell and Peterson, 1998, found biological fathers to be the most commonly reported perpetrator.

"American society tries to hold anyone accountable for this crime other than the one who commits it. Some people refer to 'incestuous relationships' as if there were a relationship, as if there were reciprocity" (Blume, 1990, p. 1). Therapists themselves have been known to blame "cold", non-sexual mothers, or even label the victims as "seductive daughters" (Blume, 1990 p. 1). Blume (1990) also suggests that it is the most serious and most common form of child sexual abuse, and arguably, it is also the most serious of all types of child abuse.

The past two decades reveal great strides taken in establishing the prevalence and detrimental effects of sexual abuse and, specifically, incest. Public ignorance and misperception about incest continued from Freud's time until the late 1970's (Courtois 1988). Fortunately, in the late 1980's and early 1990's, the pendulum began to swing in the opposite direction. By the late 1990's, there was almost a fervid preoccupation with studying, researching, and treating sexual trauma survivors. Today, therapists no longer gasp in shock and embarrassment when a client breaks the silence and tells them that they have survived a childhood of incest abuse. Most therapists are beginning to understand the impact this traumatic abuse has on their clients. There is a common understanding among clinicians that each incest survivor had their childhood shattered, leaving them

with the endless task of trying to put the pieces of their lives back together. Forever, most will struggle with relationship stability, feelings of powerlessness, deeply engrained mistrust issues, as well as often feeling poorly equipped to cope with even basic human functioning in every day life (Graber, 1991).

These women survivors exist in a culture of their own. Most of them live day to day in a continuous battle just to go on with their lives. They are a sisterhood in their own right, a secret sorority, where individual members, unknown to each other, remain forever silent about the price they paid to belong. They often struggle from the first night that their violator decided that the victim was a mere possession to be used for the sole purpose of their sexual gratification, until the day they can finally lie in peace, no longer haunted by the dark rooms, the noises, or the nightmares.

The purpose of this case study was to explore and identify the relationship issues that survivors of childhood incest experience. Researchers such as Courtois, Finklefor, Russell, Kirschner, Lubell, and Blume have all indicated that there are many core relationship issues that survivors of abuse struggle with for the remainder of their lives. These issues affect the victim's cognitions and behaviors. Some of the effects of this traumatic experience, as listed in the research are: depression, low self-esteem, feelings of fear, and mistrust, as well as acting out inappropriate behaviors such as promiscuity, increased substance abuse, eating disorders, and the inability to enter into or maintain intimate relationships. It is believed that these maladaptive cognitions and behaviors may contribute to the revictimization of these women throughout their lives (Messman-Moore & Long, 2000).

Most survivors suffer in silence, too embarrassed to speak. Others believe it is somehow their fault, and remain forever with feelings of guilt due to the brainwashing from their abuser, that took place when their minds were so vulnerable. Many remain

invisible and still silent today, because as adults they are afraid, and too ashamed to come out of their "closets" and, as children, they are still hiding in their closets of darkness seeking safety and solace. The very person who was supposed to protect them violated these individuals.

The results of this study are even more important today. As mentioned earlier, the primary research on incest and related issues began in the early to mid 1980's, and peaked in the late 1990's. Today, as we enter the new millennium, it appears that research is on the decline for some incest issues. This could be due to some of the highly publicized cases of recovered memory / false memory controversies (Courtois, 1999). The topic of repressed memory deeply concerns most therapists today. Unfortunately, for survivors of incest, some therapists are shying away from even taking incest survivors as clients for fear of being sued. "Lawsuits charging therapists with malpractice for suggesting or implanting false memories of past abuse through the use of flawed technique and inappropriate influence have been filed in increasing numbers, most often by disgruntled former patients but more recently by third parties as well" (Courtois 1999, p. xiii). This is an unfortunate turn in the tide when it comes to helping these women finally overcome barriers placed in their lives.

Statement of the Problem

The purpose of this research project was to determine the difficulties faced by a female survivor of childhood incest in regard to the subject's adult relationships.

This research was conducted in the form of a case study following one subject, identified as an adult female survivor of childhood incest. The researcher had prior knowledge of this client, approximately eight months prior to the initial start of this study, from a previous employment relationship. Although the name of the employer is being withheld in this study, to insure strict confidentiality for the subject, the advisor of

this research paper, as well as the university was informed of this information for verification purposes.

The subject was monitored from July 2002 through September 2002 for a total time frame of twelve weeks. During these twelve weeks, there was a total of seven sessions held on a weekly basis when possible. Due to personal schedule conflicts, some sessions were held every two weeks. The time allotted for each session was determined by the subject and her desire to share information. Sessions with the subject varied in length, but were always at least thirty minutes, while other sessions lasted as long as ninety minutes.

In order to protect the subject, the location of the study was kept completely confidential, as well as any information about her that was thought to be potentially identifiable. The study monitored the subject in regards to her previous, as well as her current personal relationship difficulties that paralleled those of other survivors according to recent literature reviews.

Objective of the Study

This research was conducted in the form of a case study. The objective of this study was to document whether the subject exhibited relationship and personality issues throughout her life that were consistent with the data found in the research. The researcher chose this specific topic to hopefully identify the symptoms and the traumatic aftereffects of childhood incest, and to encourage clinicians and therapists to continue helping this population overcome the burdens placed upon them in their childhood innocence. The final goal is to have professionals understand the breadth of the emotional trauma and the impact it has on memory and to reduce the possible fear associated with working with these special women, who need the clinician's assistance and empathy to put their lives back together and allow them to move on with their lives.

Definition of Terms

For this study, the following key words were defined to further clarify the content of this research paper:

Avoidant Personality Disorder: a pattern of social inhibitions, feelings of inadequacy, and hypersensitivity to negative evaluation (American Psychiatric Association (APA), 2000, p. 685).

Dissociative Amnesia: an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be accountable as normal forgetfulness (APA.2000, p. 519).

Dissociative Identity Disorder: formerly known as multiple personality disorder, this illness is characterized by two or more distinct personalities or identities that control the individual's behavior accompanied by an inability to recall important personal information (APA, 2000, p. 519).

Dependent Personality Disorder: a pattern of submissive and clinging behavior related to an excessive need to be taken care of (APA, 2000, p. 685).

Depersonalization Disorder: a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing (APA, 2000, p. 519).

Dissociative Fugue: characterized by sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity (APA, 2000, p. 519).

Histrionic Personality Disorder: a pattern of excessive emotionality and attention-seeking (APA, 2000, p. 685).

Hypervigilance: a heightened awareness of your surroundings. Following some traumatic experiences, you may feel extremely alert and aware of your surroundings at all times (Rosenbloom & Williams, 1999).

Incest: having sexual intercourse or sexual contact with a child he/she knows is related, either by blood or adoption and the child is related in a degree of kinship closer than 2nd cousin; and the perpetrator is a person responsible for the child's welfare (WCASA, 2000a).

Parentified Child: the allocation of parental power to a child. (Minuchen, 1974).

Post-traumatic Stress Disorder: the clinical manifestation of problems associated with trauma induced during the catastrophe and represented by the post traumatic stress reactions (Courtois, 1988, p. 120). See Appendix D.

Post-traumatic Stress Reactions: a set of conscious and unconscious behaviors and emotions associated with dealing with the memories of the stressors of a catastrophe and immediately afterwards (Courtois, 1988, p. 120).

Repressed Memory Syndrome: absolutely no memory for the abuse, or remembers with significant amnesia (Courtois, 1999 p. 37).

Self-mutilation / Self-injury: involves the act of inflicting some sort of injury to the body, most often through cutting, burning, gouging, pinching, hitting, or breaking bones (Courtois, 1988, p. 302).

Sexual contact: intentional touching either directly or through clothing by the use of any body part or object for the purpose of sexually degrading, humiliating, arousing or gratification (WCASA, 2000b).

Survivor: an individual who has been sexually abused either through incest, sexual molestation, or rape (including attempted rape) as a minor and/or as an adult. A survivor does not have to be a particular gender (Levine, 1996).

Assumptions and Limitations

In this study, there have been some assumptions and limitations identified by the researcher.

1. The researcher already had previous knowledge of the dynamics of incest and had prior knowledge of some of the key relationship issues encountered by incest survivors.

2. The researcher had prior knowledge of the subject of this study, and had previously worked with this subject on some of the issues discussed in this study.

3. The researcher assumed that the subject of the study was truthful and relayed an accurate portrayal of her current life issues.

4. The researcher was aware that there was the potential for the subject to not disclose information accurately or completely.

5. This study would reflect some information from the subject's past, and there was the potential for details to be unintentionally modified by the subject.

6. The researcher was aware that the effects of childhood sexual abuse can mimic those caused by other forms of abuse such as physical and emotional abuse.

CHAPTER TWO

Literature Review

Introduction

This chapter begins with a historical review of incest in our society. Discussed is the impact that society has had on this subject, as well as the array of relationship issues that female survivors must endure based on the research that has been done regarding this special population. The chapter will also include current topics of research such as repressed/false memory and revictimization.

Historical Overview

To speak of incest in any form, as a victim, survivor, or even as a researcher, was taboo in our society until the mid 1970's. Simon and Garfunkel were singing about the *Sounds of silence,* and nothing could be closer to the truth than when mentioning the topic of incest. Silence was not only the family rule; it seemed to be society's rule. In the mid to late l970's, there were a few indomitable researchers that provided us with books such as*: "Betrayal of innocence* by Susan Forward and Craig Buck*, Conspiracy of* s*ilence* by Sandra Butler, *Incest* by Karin Meiselman, and *Kiss daddy good-nigh*t by Louise Armstrong. Blair and Rita Justice wrote a fifth resource, *The broken taboo*, published in 1979" (Courtois, 1988, p. xiv). The monumental breakthrough came in 1988 when Bass and Davis published their self-help book, *The courage to heal.* Until this time there was little known about the process of healing from childhood sexual abuse. Therapists had a very limited knowledge about treating trauma, specifically childhood sexual abuse. Therefore, they had a tendency to minimize, deny or even blame the victim (Courtois, 1988). There were very few support groups, so there was very little, if any, real help for those who had suffered from incest. At that time in our history, the

field of domestic violence was beginning to appear in the forefront of trauma therapy. Luckily, some of the preliminary concepts of this type of family abuse have been applied to sexual assault recovery.

Once society began to acknowledge the prevalence of child sexual abuse, primarily incest, the knowledge base was increased due to improved research methodologies. This opened up specialized services directed towards the prevention, detection, and intervention of child sexual abuse. Unfortunately, the omission of past victimization resulted in the unintentional side effect of continued neglect of the former victim, the adult survivor of childhood incest (Courtois, 1988).

The Long-term Aftermath

It is necessary to reemphasize that the purpose of this research was to study the aftereffects of incest, especially the symptoms linked to post traumatic stress disorder much like that of the soldier recovering from battle. During and after World War I, there were heated debates about the nature of "shell-shock". Some believed it to be the effect of moral cowardice or of the physical environment of war. The presumption behind the acceptance of "shell-shock" or post traumatic stress disorder (PTSD) as it later became known is that a single disorder can result from a variety of traumatic stressors, or a repetition of the same stressor (Van der Kolk, McFarlane, & Weisaeth, 1996). The primary purpose of the research was to find the similar scars and the battle wounds that refuse to heal. For some sexual assault victims, these wounds act as a continuous reminder of a past they stuffed away into the inaccessible parts of their minds, therefore, they cannot remember the childhood war in which they were the front line warriors.

Emotional attachment is probably the primary protection against feelings of helplessness and meaninglessness. Emotional security is essential for biological survival in children. For young children, the family unit usually provides a very effective source

of protection against traumatization, and most children are amazingly resilient as long as they have a caregiver who is emotionally and physically available (Van der Kolk, McFarlane, & Weisaeth, 1996). Healthy parental bonding with their children usually includes touching, kissing, hugging, and cuddling. The key word in this statement is "healthy". Children in healthy families learn the difference between appropriate and inappropriate touching. They learn clear distinct limits from healthy parental role models. Sexual abuse does not occur where there is respect for the individual. Dysfunctional families may lack these exact boundaries for sexual behavior, thereby causing these children to grow up confused and with unclear boundaries. Children who are incestuously abused most often suffer chronic inescapable trauma, with no outside support to either buffer the situation or validate their response to it. Not only do the victims suffer sexual intrusion, but it is often repeated and escalates in severity over time. Repeated traumas, with no assistance, leave the child to devise their own methods of coping - behaviorally, emotionally, and socially. The victim usually does so by developing strong defenses, which in turn can drain them of their psychological energy (Courtois, 1988).

Incest that occurs during the course of the victim's childhood inevitably affects their maturation and developmental processes. For many victims/ survivors, the incest experience, along with the developed coping mechanisms, has become an integrated part of their personality. This has allowed them to survive for years, and the significance of these survival techniques is now receiving the undivided attention of researchers. The development of personality disorders, specifically, hysteria, borderline, narcissistic, avoidant, dependent, or even the extreme of dissociative identity disorder, seems to appear to be directly linked with a traumatic etiology (Van der Kolk, McFarlane, & Weisaeth, 1996).

At present, the relationship between victimization and adult maladaptive behavior is complex to say the least. To date, there is no clear cause and effect correlation between psychological trauma and trauma related syndromes. As cited by Courtois (1988, p. 89*)* " Browne & Finkelhor (1986), reviewed empirical studies of aftereffects of childhood traumas and found that like child sexual abuse in general, incest poses a serious mental health risk. In adulthood, incest victims as a group, showed serious psychopathologies 20% more often than nonvictims." This number is most likely very underestimated, since researchers such as Courtois (1988) and Russell (1986) noted that incest survivors have a tendency to minimize their traumas due to the shame and embarrassment associated with being involved in such a taboo activity. Nevertheless, increasing knowledge and continued research in this area suggests that direct treatment of the trauma is necessary for the resolution of its aftereffects and secondary elaborations (Courtois, 1988).

More recent research has been compiled by Blume (1990, p. xxi) stating that "at any one time, more than three quarters of my clients are women who were molested in childhood by someone they knew". Russell (1986) reported 22-37% of women were survivors of childhood sexual abuse, and in more recent results today, with more sophisticated data collection, it is estimated to be 38% or higher (Courtois, 1999). Even though these numbers are reportedly higher today, it is a reasonable assumption that this is only the tip of the iceberg. We need to remember, that fewer than half of the women who experienced this trauma later remember or identify it as abuse (Blume, 1990). When information is not remembered, it cannot be reported. Therefore, Blume went on to state that she feels that more than half of all women are survivors of childhood sexual trauma.

Incest has a crippling effect on its victims. Young innocent children endure violations of body, boundaries and trust. Unless these wounds are identified and dealt with both emotionally and behaviorally, the aftereffects can permanently maim the victim for life. The very defense mechanisms that protected them during the childhood trauma can cement these experiences into place and continue to interfere with healthy adult functioning.

For the purpose of this study, the aftereffects to be studied were compiled from the Incest Survivors' Aftereffects Checklist (Blume, 1990). See Appendix B. This checklist served as a tool on which to base the dysfunctional behaviors. It is important to note that not all dysfunctional behaviors are associated with damage or harm to the mental well being of the individual. Some subtle actions or grouping of actions can be associated with incest survivors, such as wearing baggy clothing or how she interacts with people. It has become increasingly clear to clinicians that victims of incest can be the host of a vast array of complex symptoms. Studies have continued to investigate the relationship between the trauma of incest and the later development of psychopathology (Kirschner, Kirschner, & Rappaport, 1993). It is important to note, once again, that with any trauma, each victim is affected differently and also recovers differently. Therapists and researchers in this field have only chipped away at the surface of the long term effects incest has on its victims. "Browne and Finkelhor (1986) have reported that about 40% of all survivors end up requiring psychotherapy in adulthood" (Kirschner, Kirschner, & Rappaport, 1993, p. 4). Unlike a benign childhood occurrence, incest can be a malignancy that slowly deteriorates healthy tissue, leaving it permanently marred and emotionally crippled.

Incest Survivor Syndrome

The specific relationship between childhood traumas and the onset of adult psychopathologies in survivors is still a topic for continued research today. It has become increasingly clear to clinicians that a host of symptoms are generally related to the complexity of surviving childhood incest. Therefore, to better understand and enable clinicians to help this special population, a more comprehensive list of symptoms that these clients bring into treatment needs to be paralleled with how these problems formulate from the past incestual abuse. In 1993, Kirschner, Kirschner, and Rappaport coined the phrase, "incest survivor syndrome". Although the term is not listed in the *Diagnostic and Statistical Manual -IV-TR*, as an acceptable diagnosis, nor is there a list of specific criterion, the symptoms appear to be very similar, regardless of the researcher. The list of symptoms include self-esteem issues, anxiety disorders, chronic depression, eating disorders, drug and alcohol abuse, sexual dysfunctions, and self-mutilation behavior. It is also important to note, that although this list includes some of the most frequent categories for which survivors seek treatment, this list is certainly not an exclusive one. It is also important to state that each survivor may display one or more of these symptoms, as many of the pathologies interact with one another, becoming so enmeshed, that it is sometimes impossible for the clinician to work with only one issue at a time.

Survivors often present in therapy with a variety of cognitive, emotional, physical, and interpersonal difficulties. The concept of the incest survivor syndrome as developed by Blume (1990), has been a useful guide to clinicians who work with victims of incest. As children, these victims probably grew up in families in which they could not exert control over their parents' behavior, especially that of the perpetrator, or control their own boundaries and space. "They generally lived in fear and over time developed a

condition that could be described as similar to Seligman's (1975) portrayal of learned helplessness" (Kirschner, Kirschner, & Rappaport, 1993, p. 8). The incest experience is stressful for children and they have great difficulty escaping from it, so it is quite understandable that survivors may develop lasting reactions to the molestation (Kirschner, Kirschner, & Rappaport, 1993). In that sense, incest is a traumatic event and the survivor's reactions meet the criteria set forth in the revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders, IV-TR,* (APA, 2000) for post-traumatic stress disorder (PTSD). See Appendix D. Therefore, a dual diagnosis of PTSD in addition to the presenting complaint will assist the clinician as well as the patient in depathologizing the survivor.

Symptoms of incest seem to be directly correlated with the concerns for which the client seeks therapy. Typically these presenting problems can be clustered together according to the assigned aftereffects (Courtois, 1988, p. 101). These clusters are as follows:

- *Emotional reactions:* including fear, anxiety, depression, and self-destructive thoughts and behaviors.
- *Self –perceptions:* which are predominately negative and indicative of low self-esteem, shame and stigma.
- *Physical and somatic effects:* direct physical expressions of the abuse or physical manifestations of emotional stress.
- *Sexual effects:* including the full range of disorders usually associated with anxiety and physical or psychological trauma.
- *Interpersonal relating:* characterized by mistrust and conflictual, non-nurturing, or superficial relationships with friends, coworkers, partners, parents, and children.

- *Social effects:* ranging from underfunctioning to overfunctioning, from people-pleasing and extroverted behavior to hostile schizoid behavior and patterns of victimizing others or revictimization of themselves.

For cohesion, the researcher continued to use Courtois's (1988) aftereffects list, and expanded in further detail on some of the categories.

Emotional Reactions

This category of symptoms includes fear, anxiety, depression, and self-destructive thoughts and behaviors. Fear and anxiety may surface in compulsive or ritualized behavior and phobias; sleep disturbances such as nightmares, night terrors, and fear of sleeping alone or a fear of the dark. Hypervigilance, hyperactivity, as well as severe mood swings and perceptual distortions are also included in the seemingly endless list of emotional responses.

The goals and motivation of different types of self-damaging behaviors vary quite markedly and differ by degree of seriousness; however, all involve some measure of self-directed hatred and rage, often operating at an unconscious level. These behaviors can be conceptualized along a continuum from mild to severe, with overlap between them (Courtois, 1988). Self-destructive behaviors may also include getting others to be hurtful or destructive to them. According to Courtois, 1988, self-destructive behaviors include the following:

- Self-sabotage, self-defeat and self-neglect.
- Unnecessary risks and "accidents".
- Addictive and compulsive behaviors.
- Self-abusive relationships and sexual practices.
- Self-mutilation.
- Suicidality.

- Provoked death. Death may be the result of a successful suicide attempt, or the accidental result of a suicidal gesture or dangerous practice. It may also be the result of associating with dangerous individuals who are apt to murder if sufficiently challenged or antagonized.

Self-mutilation is a specific diagnostic criterion for borderline personality disorder and will be discussed in further detail when discussing specific psychopathology disorders.

Negative Self-perceptions

Many adult survivors exhibit signs of poor self-esteem along with poor inter-personal relation skills. The most prevalent of these negative perceptions is poor self-esteem. The secrecy, entrapment and betrayal by a trusted family member coupled with feelings of guilt, and complicity, cause shame and stigma reactions. Some children compensate for and defend against these feelings by always trying to be good, in the belief that being good will make the abuse stop. This shame and stigma become compounded if the incest is disclosed and the child is blamed or disbelieved, which unfortunately appears to be the case more often than not. The reactions to these situations cause the child additional feelings of isolation, worthlessness, or hopelessness. As she begins to realize that not all children have encountered the same activities with family members, she may develop perceptions of being disgusting, freakish, and unworthy of good attention from others (Courtois, 1988). Powerful schemata develop around these self-perceptions, and later develop into pathologies such as borderline personality disorder, dependent personality disorder, avoidant personality disorder, or major depressive disorder. Criteria for some of these pathological disorders are detailed in the Appendices. See Appendices D-L.

Shame is an emotion coming to the forefront in much of today's research. Researchers are just beginning to understand the power behind this emotion, both

positive and negative. With children of incest, the message processed from the abuse is one of something being inherently wrong with them, and that is the reason for the abuse. This belief, compounded by feelings of guilt and anxiety, often result in a shamed sense of self. Shame and guilt eventually create an actual belief that the self is unlovable, deserving of abuse and maltreatment, and unworthy of any positive or caring attention. By early adulthood, this survivor now has tendencies, if not definite criteria, for avoidant personality disorder and/or dependent personality disorder.

The ability to trust others allows for secure and positive attachment. Incest creates mistrust of others, which may be a direct result of the betrayal which took place during the incestual activity. In families where the child incest victim has been neglected emotionally, yet parentified, the adult survivor may present as very needy and dependent. There may also be characteristics or tendencies of attachment disorder or dependent personality disorder present with this symptom. See Appendix J. Studies conducted in 1997 and 1998 by Waldman, Silber, Holmstrom, and Karp, found incest survivors to be more pessimistic, project more hostility, and have lower feelings of mastery and basic trust than women who had not experienced incest.

All of these negative self perceptions can create a world of chaos for the victim. The everyday turmoil these survivors live in, makeup for the large amount of borderline personality disorder seen in this population. This disorder is often referred to as an emotional roller coaster among clinicians.

Physical and Somatic Effects

Survivors also complain of many physical disorders such as gastrointestinal problems, chronic tension, migraines, insomnia, chronic itching or pain in the vaginal area, and nausea. Abused children can face overwhelming fear and stress daily. Since they are unable to flee the situation and are captives of their families, their bodies may

produce tremendous amounts of adrenaline and norepinephrine. It is no wonder that they may later suffer from chronic gastrointestinal and other stress related disorder (Kirschner, Kirschner, & Rappaport, 1993, p. 9). The survival of this entrapment within the family home may also indicate the prevalence of post traumatic stress disorder among incest survivors.

Many survivors find it extremely difficult to undergo routine gynecological exams, yet frequently have complaints in the vaginal and rectal areas of their bodies. Kirschner, Kirschner, and Rappaport (1993), tell of a client who would faint each time she was examined and would awaken only after the exam was complete. Courtois (1988) mentions survivors who dissociated while gynecological exams were being done to them.

Another common complaint is chronic nausea, or gagging. This condition is especially prevalent when the survivor has a history of incest that included oral sex.

Sexual Dysfunction

Sexual dysfunction in adulthood may be indicative of previous incest as well. These issues can take the extreme forms of promiscuity or abstinence, or lie anywhere in between. Eroticized children may be prone to relate to others sexually due to the direct conditioning they received in the incestual relationship. This may lead the victim on the path to revictimization. Others may react in just the opposite way and avoid any type of sexual contact and in extreme cases, any physical contact with others. Touch of any sort may be perceived as threatening or dirty. Some survivors describe their sexual relationship as “tolerating” or “doing what you need to do to please him.” Often victims speak of “not feeling anything” (Blume 1990). Clinicians may see this as a dissociative technique. Often these thought patterns coincide with the survival techniques the victim engaged in throughout their childhood and they are often not aware that more positive thought patterns should exist. Flashbacks with arousal, fantasies of rape, bondage and

sadistic and masochistic activities, as well as promiscuity are just a few of the sexual dysfunctions that may develop.

Researchers have found that a history of sexual promiscuity, running away from home, or juvenile delinquency is frequently associated with incest (Courtois, 1988). Some victims have a history of flirtatious, attention-seeking behaviors, sometimes to the point of histrionic tendencies or completely meeting the criteria for a histrionic personality disorder. Appendix I. Some victims may vacillate between periods of excessive need for sexual activity with multiple partners, primarily older "father-like" males, to periods of complete lack of desire over the life cycle. These bipolar behaviors may reflect an underlying bipolarity in affect, cognition, and behaviors. Clinicians should be aware that patients that present with these patterns may be sexual trauma survivors (Kirschner, Kirschner, & Rappaport, 1993).

Interpersonal Relationships

Adult behavior patterns may be indicative of possible incest activity as a child. It is common for an incest survivor to literally divorce themselves from their family and refuse to have any contact with family members. Some victims go so far as to change their surname, move many miles away from their family of origin, isolating themselves from any contact with family members, not list their telephone number, or addresses, or even "adopt" new families through marriage, or in extreme cases fantasize where they are able to create the "perfect" family (Courtois 1988).

Role reversal between parent and child is another pattern that may continue into adulthood. She may have her own family at a very young age but continue to perform her duties as mother/housekeeper within her family of origin. Her inability to set limits on the demands of her family, often complicated by her guilt about the incest with her abuser, along with the compliant manner, sooner or later result in her becoming

exhausted and depleted. She then copes by withdrawing and becoming emotionally unavailable to her partner, and finally, parentifying one of her own children. In this way, dynamics conducive to incest develop in the subsequent generation (Courtois, 1988). It is important to note that in order for this dynamic to continue, there must be a male with the capability of incest. If the parental male is mentally healthy, he will not turn to his children for solace, but rather, attempt to assist his partner with developing healthy life coping strategies.

Social Effects

Social functioning of survivors shows wide variability ranging from isolation, rebellion and antisocial behavior to over functioning and compulsive social interaction. Particularly affected is assertiveness; a difficult skill for women to develop because of their indoctrination to be compliant "lady-like," and "nice girls," assertiveness is virtually impossible for many untreated incest survivors. They feel that they do not deserve even the smallest gesture of good will, and consequently, very often go into situations defensively (Blume, 1990). Some survivors may be less extreme in their mistrust and rebellion, but vent the rage they feel about their abuse in social causes and social movements, thus using their energy to promote awareness for a specific cause.

An impaired ability to function well either occupationally or socially is characteristic of some survivors. The inability to concentrate, chronic anxiety, depression, with or without impulsive and hostile characteristics, affect the survivor's functioning on the job and in the community in general (Courtois, 1988).

Addictive Behaviors

Common signs of addictive behaviors associated with child sexual assault are, substance abuse, eating disorders including binge eating, gambling, impulsive spending

as well as obsessive-compulsive disorders such as excessive cleaning, bathing, and/or organization can be signs of childhood sexual abuse.

Serious self-medicating techniques with substance abuse, primarily alcohol, and also eating disorders, frequently bring survivors seeking help from clinicians (Blume 1990). One recent study has shown that a very high percentage of anorexics and bulimics are survivors of childhood sexual abuse. More recent data is being compiled in relationship to obesity and compulsive overeating to trauma survival. The above mentioned techniques are all ways in which the survivor self-medicates to deal with the pain of the trauma. As children, they were not given proper coping strategies to deal with their feelings and emotions, and as adults continue to be at a loss for life coping strategies. Many of the survivors can not identify between thoughts and feelings because they were never allowed to "feel" as a child.

Many survivors are adult children of alcoholics (ACOAs). They share with that population the additional issues of shame and guilt over being products of highly dysfunctional families. According to Fossum and Mason, cited in (Kirschner, Kirschner & Rappaport, 1993), the compulsive disorders related to eating and drug or alcohol abuse (so prevalent among survivors) can be viewed in part as defenses against their shame.

Psychological Pathologies

The personality disorders mentioned previously are often presented as dual diagnoses. Avoidant personality disorder is often diagnosed with dependent personality disorder, because individuals with avoidant personality disorder usually become very attached to and dependent on those few other people with whom they are friends. Borderline personality disorder is also frequently seen as a diagnosis for incest survivors.

Personality disorders are distinct clinical syndromes. An alternative to the categorical approach is the dimensional perspective that personality disorders represent

maladaptive behaviors of personality traits that merge into normality and into one another, (APA, 2000). Personality disorders seem to attach to trauma victims with magnetic force, and like the links of a chain, one disorder seems to be connected with traits of another.

The role of incest in the development of borderline personality disorder has been noted by clinicians working with survivors and by sexual abuse researchers. Clinically, it is apparent that chronic post-incest reactions of many abuse survivors fit the diagnostic criteria of borderline personality disorder. See Appendix H. The role of incest has not been systematically investigated, even though a clear logic now connects adult characteristics to damage of self, abuse of or lack of boundaries, and confusion or mistrust about safety and rules of relationships (Courtois, 1988).

Dissociative disorders have been associated with children who have suffered severe, repeated, and often bizarre physical, sexual, or emotional abuse, most often administered by parents and unpredictably interspersed with bouts of affection (Courtois, 1988). Dissociating serves many purposes. It provides a way out of the intolerable and psychologically incongruous situation, it erects memory barriers (amnesia) to keep painful events and memories out of awareness, it functions as an analgesic to prevent feeling the pain, it allows escape from experiencing the event and from responsibility/guilt, and it may serve as a hypnotic negation in the sense of self (Courtois, 1988, p. 155).

The most severe form of dissociation is dissociative identity disorder, earlier known as multiple personality disorder. This often develops in childhood but is usually not recognized until adolescence or early adulthood (Courtois, 1988).

Not all adults with histories of childhood abuse experience dissociative, post-traumatic, and severe personality disorder symptoms. However, clinical observations

suggest that many individuals who have been severely and persistently abused and who have disabling psychiatric difficulties show evidence of this triad of symptoms (Chu, 1998).

Repressed / False Memory Syndrome

The recovered memory/false memory controversy essentially revolves around three issues: (1) whether trauma can be forgotten and then remembered, (2) the accuracy and credibility of memories of childhood sexual abuse, and (3) the role of therapeutic influence on memories (Courtois, 1999).

The extremely contentious recovered memory controversy erupted in 1992, with critics blaming therapists for creating false memories of abuse through improper and suggestive techniques. This countermovement and the emergence of the False Memory Syndrome Foundation (FMSF), has been labeled by some researchers and clinicians as "the age of the backlash" (Courtois, 1999, p. 23).

The treatment of adults who report abuse as children (whether their memory has been relatively continuous or has been recovered) has become a high risk area, as numerous lawsuits have been filed alleging false memory of abuse due to suggestive therapeutic practices. In this climate, clinicians have become fearful, cautious, and confused about how to practice responsibly with this population, while other clinicians opt to not work with this population at all. This polarization among therapists on this debate has become so adversarial and vehement that (Courtois, 1999, p. xv) cite "(Berliner, 1997) as routinely describing it as "the memory war" and (McConkey, 1997) who refers to it as, "the civil war within psychology." Unfortunately, one of the direct and most devastating consequences of this clinician fear is the lack of therapists willing to work with this traumatized population. Directly or indirectly this results in a *de ja vu*

situation for the victims. Once again they are neglected and denied assistance by those that could help them the most.

Clinicians need to be able to develop and perfect their interviewing techniques as well as their treatment plans in order to provide responsible care. When recovered memories are an issue, the therapist needs to tread cautiously. The failure to recognize abuse can be as harmful as overzealousness in attempting to find it. Today, the methods and techniques which therapists choose to utilize are critical not only to the success of the client, but for the safety of the clinician's right to practice (Courtois, 1999).

Revictimization

Family violence should be considered a risk factor for incest occurrence. According to Russell (1986) who cites Walker's research studies, a high percentage of battered women were themselves incestuously abused as children. In families where the wife is battered, it is not uncommon for marital rape to be present as well, and for the children to be incestuously assaulted. Three times as many individuals who had experienced incest in their childhood later were identified as victims of marital rape by Russell in 1990.

With alarming frequency, survivors place themselves in situations where they are repeatedly victims of sexual abuse or some other type of physical, mental or emotional abuse. This may occur because it is a repetition of what the survivors have been taught and are familiar and comfortable with. This repetition compulsion goes hand-in-hand with low self-esteem, and the inner belief that they do not deserve to be treated any better (Graber, 1991).

Survivors are usually unaware that they are setting themselves up for failure until it is too late. In some obscure way, it may seem as if they may be trying to relive the abusive situation, and are still struggling to "do it right this time". It can take long and

intense therapy before the survivors will realize that abuse is always wrong and there is no way to make it right.

CHAPTER THREE

Methodology

Introduction

This chapter will describe the subject of the study and how she was selected for inclusion in this study. In addition, the instruments being used to collect information will be discussed. Data collection and analysis procedures will be presented. This chapter concludes with some discussion of the methodological limitations.

Subject Description

The subject of this study was a 30-year old female, previously known to the researcher, from a previous employment agency. The subject has identified herself to the researcher, as a survivor of childhood incest. All attempts were made to keep the individual discussed in this case study unidentifiable to the general public. This includes but is not limited to the change of name, location, and the dates of clinical sessions. Any similarity to any specific person is the result of the common characteristics that exist among incest survivors. This specific subject was selected on the basis of her willingness to participate and discuss her incest, as well as the impact it has had on her adult life.

Procedure

To begin the study, a proposal was submitted to the UW-Stout Institutional Review Board (IRB) in April 2002. Approval to proceed with this study was received on May 13, 2002. The study was conducted in a standard counseling interview style, with each session being documented in case note style by the researcher. It was initially anticipated that sessions would be audio taped for increased accuracy, but at the beginning of the first session, the subject stated she did not feel comfortable with this procedure, so it was not pursued. The topics of the sessions were not pre-planned and

were completely open to any subject that the client felt like discussing. This would minimize the chance of the researcher leading or suggesting an anticipated issue for discussion.

The subject was monitored from July 2002 through September 2002 for a total time frame of 12 weeks. During these 12 weeks, there was a total of seven sessions held on a weekly basis when possible. Due to personal schedule conflicts, some sessions were held every two weeks. The time allotted for each session was determined by the subject and her desire to share information. Sessions with the subject varied in length but were always at least 30 minutes in length, while other sessions may have lasted 90 minutes.

In order to protect the subject, the location of the study was kept completely confidential, as well as any information about her that was thought to be potentially identifiable.

Instrumentation

This study was conducted in the form of a case study with one subject being observed. This particular form of research has no established values for reliability or validity. The subject was contacted to confirm a continued interest in participating in the study. The interviewer also reviewed with the subject the steps taken to assure confidentiality in regards to participating in this study. Once voluntary participation had been confirmed, a schedule of seven sessions was developed and agreed upon. At each session, the researcher recorded field notes that were later transcribed by the researcher into case note format. The case notes were reviewed with the subject to confirm accuracy in interpretation and transcription.

Data Collection

At the initial session, the consent form was reviewed along with the purpose of this study. Data for this study was acquired through in-person interviews with the

subject. Every attempt was made to prevent leading of the topic of discussion to allow the subject complete non-influenced discussion. There was a total of seven sessions conducted in a 12 week time frame. These sessions were to be audio taped to assist the researcher with accurate transcription and also to reduce the potential for researcher bias in the transcription process. Prior to the start of this study, it was mutually agreed that the tapes would be the property of the subject and these tapes would be returned to the subject once the study was completed. However, prior to the start of the first session, the subject felt uneasy about the audio taping, and, therefore the audio taping of the sessions was discontinued. The interviewer and the subject agreed that the typed case notes would be reviewed and agreed upon prior to use in this study. This double review method would insure increased accuracy and minimize the bias that could potentially occur during transcription.

Data Analysis

Data for this study was in the form of field /case notes from the sessions conducted with the subject. These case notes were then compared with the information found in the literature reviewed for this study and The Incest Survivors' Aftereffects Checklist. Appendix B. The researcher compared the relationship issues discussed in the sessions and attempted to find common relationship issues in both sources.

Limitations

The researcher acknowledges the existence of potential limitations in this study. The most obvious shortcoming was the selection process of the subject. The researcher selected this subject based completely on prior knowledge of the subject's childhood history, there was no random selection conducted. In addition, the researcher had a previous knowledge to the dynamics of incest and potential for relationship issues. This may have created a prejudice that a novice researcher would have observed and

interpreted differently. The researcher is also aware that due to the study being conducted with only one subject, there is an increased potential for the data acquired in this study to be biased. Therefore, the ability to generalize this data is limited, and cannot be considered representative of the general population.

Even with these limitations, this study makes a valuable contribution by increasing the awareness of, and initiating further investigation of relationship issues in incest survivors.

CHAPTER FOUR

Results

Introduction

This study was conducted in a qualitative case study format. It was the intent of the researcher to present a portrait of the subject in regards to one specific phenomenon- that being childhood incest by a biological father, step-father, or grandfather. This study explored several personality and relationship issues present in the current literature, associated with survival of childhood sexual abuse, specifically incest, to the relationship and personal issues discussed in interview sessions with the subject pertaining to everyday life issues. The anticipated outcome was to reveal the similarities between incest survivors primarily in regards to relationship issues, and to accentuate the importance of further studies and research to enhance the treatment and recovery process for this specific population. The ultimate futuristic goal of the researcher was to categorize the symptoms into a special treatment diagnosis, known as incest survivor syndrome by previous researchers, or some other title, to enable therapists to correctly diagnose and treat these symptoms for which survivors so often present in therapy.

Procedure

The study was conducted in a case study format, using one subject, whom has previously identified herself as a childhood incest survivor. This information was provided to the researcher during a previous session at a family violence agency, at which the researcher was employed as a sexual assault program director. The study consisted of seven sessions, with one session to be scheduled each week for a period of seven weeks. The researcher had no particular basis as to the reason for choosing the seven week time frame. This time frame was extended due to personal scheduling conflicts. Due to these

conflicts, the seven sessions took twelve weeks to complete. It was anticipated that each session would last approximately fifty minutes in length, with the subject having complete control of the session's procession and cessation. At the end of the first session, the researcher produced a psychological evaluation which is provided as an appendix in this study. See Appendix C. There were no predetermined topics of discussion; the subject was free to discuss any issue that seemed of importance to her during the session. She was also allowed to recall topics discussed in previous sessions. It is important to mention that in order to assure confidentiality for this subject some information will be not be disclosed in its entirety. This will be done in order to prevent any association to the subject resulting in the subject's identity being revealed.

Data Analysis

The results of this study uphold many of the findings previously mentioned in the study in regards to the symptomotology of incest survivor syndrome. Although incest survivor syndrome is not currently an acceptable diagnosis among clinicians, for the purpose of this report, the collection of previously discussed symptoms and history will provide adequate criteria for this diagnostic term.

This subject when first presented to the researcher, in a therapy session, did not seem to exhibit characteristics typically associated with incest survivors. Therefore, the researcher was not anticipating a strong correlation to the symptoms found in the literature and known previously to the researcher. As the interview sessions progressed, the researcher was intrigued by the strong similar symptomotology the subject revealed.

In order to systematically analyze the information provided by the subject, the researcher has chosen to closely follow Courtois's (1988) categorization of symptoms previously mentioned in this study.

Emotional Reactions

During several of the sessions, the subject made mention of nightmares and night terrors that she had, all with similar themes, revolving around her father or grandfather. The subject, when recalling these dreams, some of which were quite disturbing, expressed concern in that something was wrong with her for having these nightmares.

There were several times when the subject stated that she had to clean her house to what she described as "an almost excess", but she recognized that it was primarily to satisfy her husband., and not to meet the needs of her fulfillment. Many times she mentions that she enjoys gambling, but needs to "make sure she does not get out of control" with this past time. The numerous mentioning of what seemed to the researcher as obsessive-compulsive tendencies did not seem to interfere with everyday functioning.

In this category, of emotional reactions, it is important to mention that the subject never made mention of suicide ideation, self-mutilation, or displayed a provoked death wish. When discussing the hazardous occupation this subject has chosen, the researcher did investigate the provoked death wish and thrill seeking symptoms, but found the contrary to be true; rather than basking in the power and control and death defying thrills associated with this profession, the subject has gone to the opposite end of the spectrum and turned this occupation into an opportunity to help adults and children of abuse. The researcher saw this as her opportunity to be there for victims, because no one was there to help her when she needed to be believed. Although this idea was presented to the subject, it was neither acknowledged as correct nor was it denied.

Negative Self-perceptions

As with many incest survivors, self-esteem and self-image were very low with this subject. In spite of making some very significant achievements professionally and academically, this subject made numerous references to her worthlessness and

unworthiness for positive attention. The inability to trust or the strong mistrust issues of others were always present in the sessions. These characteristics again may be attributed to the subject's occupation, constantly requiring a certain amount of mistrust and hypervigilance for her safety; but, many times there was mention of mistrust issues in her marital relationship. When questioned if she thought there was the potential for her husband's infidelity, the subject denied the possibility.

Physical and Somatic Effects

Typical of most incest survivors, this subject did make mention of headaches, and several occurrences of gastrointestinal disorders. It is important to note that the subject did not fixate on these symptoms and attempted to keep them from interfering with her social or occupational duties.

Sexual Dysfunction

The subject did mention some difficulties with sexual relations with her husband. She mentioned that several times she has felt like she was "suffocating" while being intimate with her husband. She also expressed a decreased desire for physical intimacy, sometimes making reference to it being "her duty as a wife," and not truly finding it enjoyable. The subject's husband is aware of her history, and is very understanding in regards to their intimate relationship. The subject briefly mentions physical intimacy in a few sessions conducted, and the researcher noted that there seemed to be some anxiety associated with this topic, since the subject would quickly change the discussion topic during these times.

Interpersonal Relationships

The immediate family history is typical for incest survivors. This subject is an adult child of an alcoholic, and comes from a classic dysfunctional family background. She has had to try to learn "healthy" relationship tactics and behaviors primarily through

life experiences and self-help, self-taught techniques. She has attempted to divorce her father and mother on a number of occasions but has expressed feelings of intense guilt along with disappointment that they did not acknowledge this attempt at detachment. She has had very few close friends in either her childhood or as an adult. As a child, she moved frequently due to a father in the military and, in adult life, she "just never found anyone to really connect with."

Social Effects

Again, due to the subject's occupation, it is difficult to assess her assertiveness skills. The researcher is aware that strong assertiveness skills are required in this job, but when in a social, non-occupational setting, the subject seems almost overly concerned with pleasing the people she is with. It seems difficult at times for her to make decisions, and always asks for confirmation and affirmation.

Although the subject maintains a well-groomed appearance, it does not even closely parallel that behavior of a histrionic personality. Rather, this subject would rather "melt" into the crowd rather than be the center of attention.

Addictive Behaviors

The researcher did not note any addictive behaviors that interfered with occupational or social commitments. She describes herself as a social drinker, and enjoys gambling, but neither are causes of great concern for her or her family members. There are no financial difficulties at this time.

Psychological Pathologies

It is important to note that clinicians frequently make reference to characteristic tendencies when the subject does not meet the complete diagnostic criteria for a disorder. In this study, the researcher saw tendencies for avoidant and dependent personality

disorders, but it is just as important to note that these same characteristics can be seen by trauma survivors other than incest.

The client made mention of one occurrence of what may have been a dissociative situation, or even depersonalization. During one session, the subject told of an event that occurred during a gynecological exam, where the subject had "to pretend she was there" in order to allow the exam to continue. There appeared to be a significant amount of shame associated with this disclosure, so the researcher did not interview further.

Repressed / False Memory

To the researcher, this seemed to be the most intriguing aspect of the sessions. The subject revealed to the researcher in great detail accounts of one sexual assault by her grandfather, which she claims to "remember completely". The subject denies any recollection of additional assaults by her paternal grandfather. In more than one session, the subject makes reference to some "weird feelings" she has about her biological father. As a child, she confronted her mother about these feelings and suspicions, but did not receive confirmation or denial of the accusations.

The researcher found it interesting that she could recite in explicit detail the physical abuse she and her brother endured from their biological father. The physical abuse that she mentioned varied from severe spanking, to her explaining to the researcher a "game table" that her father had built and was kept in the living room of their house. The top was a chess or checkerboard pattern for playing games, but underneath her father kept a paddle for spanking the children. She went on to explain that her father had built the table at the exact height for her and her brother to bend over for spankings. She also mentioned an incident when she was quite young, where she passed out when she walked into her brother's bedroom because she saw her father beating her brother.

With the recall of some abuse in exact detail, and yet only suspicions of other abuse, this would be a facet to continue studying, as to the remembrance of traumatic events, and the complete amnesia and inability to recall other traumatic situations. This would be a case where the clinician would have to be cautious as to further investigation into the potential for repressed memory. This could potentially take months or years of intense therapy, and the results could be two-fold for the client. The discovery of these forgotten memories could either be very healing or could completely devastate the subject. This is the reason so many clinicians shy away from repressed memory therapy. It is much safer for the clinician and the client to self-discover these memories.

CHAPTER FIVE

Discussion, Conclusion and Recommendations

Introduction

This chapter will include a discussion of the results of the study as well as conclusions. The chapter will conclude with some recommendations for further research.

Discussion

Life is a sequence of events that prepares us for happy and unhappy situations. It also allows us the skills to develop coping strategies for healthy and unhealthy relationships. Most research suggests that the foundation of these strategies is the love of oneself. Ideally, a child receives this message early in childhood, through constant nurturing and positive attention. When children are deprived of this foundation, their lives can become a downward spiral rather than a pursuit for the summit.

This study only reinforces that theory. Incest survivors have often been misled, mistreated, and misinformed as to what life is all about. They are at times wrongly guided and poorly influenced to develop tactics for dealing with life. These dysfunctional influences unfortunately can continue to affect their lives until they are offered other options and choose to explore these more healthy pathways in life.

Conclusion

This study suggests that there is a common set of criteria or aftereffects that most incest survivors exhibit in their adulthood lifestyles. Many of these characteristics are secondary responses to their survival tactics they used as a child to endure this sexual abuse. This was a case study done with a subject who presented as if her childhood tragedy had not devastated her life. She appeared to be functioning socially, mentally, emotionally, and physically very well considering her extensive traumatic past. Yet, clinical interviewing seemed to peel away the protective shell, to reveal a very frustrated,

insecure, dependent person, who is still fighting her battles of yesteryear, and hoping for some resolve of these deep wounds so that the wounds of today can become the scars of tomorrow.

As stated earlier, the results of this study are more important today than ever. Just when many victims are starting to feel comfortable enough to come out of their shells, clinicians are shying away from working with these survivors for fear of litigation. With continued research, and more significant diagnostic criteria for incest survivor syndrome, it is hopeful that clinicians will once again elevate their interest into the specialty field of trauma survival. For too long, many incest survivors have been incorrectly labeled as disturbed, psychotic, or borderline personality. Incest survivor syndrome would potentially offer a category for acceptance and understanding. This would lessen the tendency to assign a damning label that may communicate a life detail to people who have no business knowing it, but rather, it would provide a label for clinicians to associate a pattern of emotional and behavioral aftereffects, evidence that incest has more complex and far-reaching consequences that have yet to be recognized by mental health professionals (Blume, 1990, p. xiv).

Recommendations for Further Research

Research linking a direct correlation between early childhood traumas, incest in particular, and the development of psychopathology in adulthood, continues to be a primary focus today. Clinicians appear to be in agreement that a vast array of complex symptoms are related to experiencing incest. These symptoms, although not exclusive, include low self-esteem, chronic depression, eating disorders, sexual dysfunction, substance abuse, anxiety disorders and cognitive distortion issues. Throughout the literature, it seemed that the most frequent and most disturbing symptom seen by

clinicians is the generational continuance of the abuse, whether it is in abusive marital relationships, or incestuous family relations.

Most frequently incest occurs during childhood, when the victim is especially vulnerable. According to Kirschner, Kirschner, and Rappaport (1993), an increasing number of investigators, including Browne and Finkelhor have reported that 40% of all incest survivors end up requiring psychotherapy at some point in their adult lives. This fact alone only reinforces the importance of continued research in this area. As reliable and comprehensive writings on the reality of the devastating consequences of childhood abuse become available, it is even more important today for the clinician to make them required reading. The general public will also be made more aware of these devastating consequences as more self-help books hit the newsstands and have the potential to enter mainstream conversation.

Today, asking about childhood abuse, in therapy, poses a considerable challenge, or even legal risks, to even experienced clinicians. Perhaps the best clinical practice is a combination of being open, trying to understand the patient's difficulties, simply paying attention to them, while truly listening. There is considerable controversy concerning the direct questioning about childhood abuse. Critics caution that such tactics may lead to false reports and legal implications for the therapist. Lawsuits charging therapists with malpractice for suggesting and implanting false memories of past abuse are increasing in numbers in today's courtrooms. Most often these cases involve a disgruntled former patient, but more recently, numbers are increasing for third party litigations (Courtois, 1999).

Historians usually study historical facts in an attempt to use this knowledge to understand the reason why a particular event happened, and in the hopes of preventing such reoccurrences. Likewise, psychological researchers, clinicians, and theorists need to

continue to study the relationship between the trauma of incest and the later development of psychopathology. Let's not forget that Freud made a direct link between adult hysteria and childhood incest almost 100 years ago (Kerschner, Kerschner, & Rappaport, 1993). Yet with all this information, some therapists today continue to practice on the belief that cold, nonsexual mothers or "seductive" daughters are responsible for a perpetrator's abuse of the child.

Today, the entertainment industry, through music lyrics and movies, appears to be acknowledging family abuse at a faster pace than clinicians and researchers. It is instrumental that clinicians continue to help this population of secret sorority members overcome their burdens. This silence needs to be broken.

Research needs to be continued and the results need to be brought to the forefront so that awareness of this horror is brought to the watchful eye of every clinician, parent, teacher, aunt, uncle, and neighbor. The core message of this research ought to be that the only person responsible for this horrific act is the perpetrator himself, and that the legal and judicial system, in the United States, needs to hold that person accountable for their actions. Once this feat is accomplished, then society may begin to see a decline in the number of victims of intra-familial sexual abuse.

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APPENDIX A

Human Research Subjects Consent Form

Project Title: Relationship Issues in Female Adult Survivors of Childhood Incest

Sharon Gobert, a graduate student in Mental Health Counseling, at the University of WI, Stout is conducting the above titled research project.

It is not anticipated that this study will present any physical or mental, or social risk to you. If at any time the researcher feels that a professional consult should be obtained for the subject, a referral to a mental health professional will be made. The information gathered will be kept strictly confidential and any reports of the finding of this research will not contain your name or any other identifying information.

Your participation in this project is completely voluntary. If at any time you wish to stop participating in this research, you may do so without coercion or prejudice. You need only to inform the researcher that you have chosen to discontinue with your participation in the project.

Once the study is completed, the analyzed findings would be available for your information. Any material acquired during the research study, including any audiotapes will be given to you to be destroyed. In the meantime if you have any questions or concerns about participating in this research project please contact Sharon Gobert, Mental Health Counseling, UW-Stout, Menomonie, WI 54751.
Telephone (715) 232-2477.

Consent Form

I understand that my participation in this study is strictly voluntary and I may discontinue my participation at any time.

I understand that the purpose of this study is to investigate the problem stated above in the title of this research project. (Relationship issues in female adult survivors of childhood incest).

I further understand that any information about me that is collected during this study will be held in the strictest of confidence and will not be part of my permanent record. I understand that in order for this research to be effective and valuable certain personal identifiers need to be collected. I also understand that the strictest of confidentiality will be maintained throughout this study and that only the researchers will have access to the confidential information. I understand that at the conclusion of this study all records and material that may identify the participating individual will be returned to the participant for destruction. I am aware that I have not and am not waiving any legal or human rights by agreeing to this participation.

By signing below I verify that I am eighteen (18) years of age or older, in good mental health, and physical condition, and that I agree to and understand the conditions of this agreement listed above.

Signature _____Date _____

APPENDIX B

The Incest Survivors' Aftereffects Checklist

From: *Secret Survivors: Uncovering incest and its aftereffects in women*
E. Sue Blume

Do you find many characteristics of yourself on this list? If so, you could be a survivor of incest.

1. Fear of being alone in the dark, of sleeping alone; nightmares, night terrors (especially of pursuit, threat, entrapment).
2. Swallowing and gagging sensitivity; repugnance to water on one's face when bathing or swimming (suffocation feelings).
3. Alienation from the body – not at home in own body; failure to heed body signals or take care of one's body; poor body image; manipulating body size to avoid sexual attention.
4. Gastrointestinal problems: gynecological disorders (including spontaneous vaginal infections); headaches; arthritis or joint pain.
5. Wearing a lot of clothing, even in summer; baggy clothes; failure to remove clothing even when appropriate to do so (swimming, bathing, sleeping); extreme requirement for privacy when using the bathroom.
6. Eating disorder, drug or alcohol abuse (or total abstinence); other addictions; compulsive behaviors.
7. Self-destructiveness; skin carving, self abuse.
8. Phobias
9. Need to be invisible, perfect, or perfectly bad.
10. Suicidal thoughts, attempts, obsession (including "passive suicide").
11. Depression (sometimes paralyzing); seemingly baseless crying.

12. Anger issues: inability to recognize, own or express anger; fear of actual or imagined rage; constant anger; intense hostility toward entire gender or ethnic group of the perpetrator.
13. Splitting (depersonalization); going into shock, shutdown in crisis; a stressful situation always is a crisis; psychic numbing; physical pain or numbness associated with a particular memory, emotion (e.g., anger), or situation (e.g., sex).
14. Rigid control of one's thought processes; humorlessness or extreme solemnity.
15. Childhood hiding, hanging on, cowering in corners (security-seeking behaviors); adult nervousness over being watched or surprised; feeling watched; startle response.
16. Trust issues: inability to trust (trust is not safe); total trust; trusting indiscriminately.
17. High risk taking ("daring the fates"); inability to take risks.
18. Boundary issues; control, power, territoriality issues; fear of losing control; obsessive/compulsive behaviors (attempts to control things that don't really matter, just to control something)
19. Guilt, shame; low self-esteem, feeling worthless; high appreciation of small favors by others.
20. Pattern of being a victim (victimizing oneself after being victimized by others), especially sexually; no sense of own power or right to set limits or say no; pattern of relationships with much older persons (onset in adolescence).
21. Feeling demand to "produce and be loved"; instinctively knowing and doing what the other person needs or wants; relationships mean big tradeoffs (love was taken, not given).
22. Abandonment issues

23. Blocking out some period of early years (especially 1-12), or a specific person or place.
24. Feeling of carrying an awful secret; urge to tell, fear of its being revealed; certainty that no one else will listen; being generally secretive; feeling "marked" (the "scarlet letter").
25. Feeling crazy; feeling different; feeling oneself to be unreal and everyone else to be real, or vice versa; creating fantasy worlds, relationships, or identities (especially for women: imagining or wishing self to be male, i.e., not a victim).
26. Denial: no awareness at all; repression of memories; pretending; minimizing ("it wasn't that bad"); having dreams or memories ("maybe its my imagination"); strong deep, "inappropriate" negative reactions to a person, place, or event; "sensory flashes" (a light, a place, a physical feeling) without a sense of their meaning; remembering the surroundings but not the event.
27. Sexual issues: sex feels "dirty"; aversion to being touched, especially in gynecological exam; strong aversion to (or need for) particular sex acts; feeling betrayed by one's body; trouble integrating sexuality and emotionality; confusion or overlapping of affection, sex, dominance, aggression, and violence; having to pursue power in sexual arena which is actually sexual acting out (self-abuse and manipulation, especially among women; abuse of others, especially among men); compulsively "seductive" or compulsively asexual; must be sexual aggressor or cannot be; impersonal, "promiscuous" sex with strangers concurrent with inability to have sex in intimate relationships (conflict between sex and caring); prostitute, stripper, "sex symbol" , porn actress; sexual acting out to meet anger or revenge needs; "sexaholism"; avoidance; shutdown; crying after orgasm; all pursuit feels like violation; sexualizing of meaningful relationships; erotic response to abuse or

anger, sexual fantasies of dominance or rape (Note: Homosexuality is *not* an aftereffect).

28. Pattern of ambivalent or intensely conflictive relationships (intimacy is a problem; also focus shifted from incest issues).
29. Avoidance of mirrors (connected with invisibility, shame/self-esteem issues, distrust of perceived body image).
30. Desire to change one's name (to dissociate from the perpetrator or to take control through self-labeling).
31. Limited tolerance for happiness; active withdrawal from happiness, reluctance to trust happiness ("ice-thin").
32. Aversion to making noise (including during sex, crying, laughing, or other body functions); verbal hypervigilance (careful monitoring of one's words); quiet-voiced, especially when needing to be heard.
33. Stealing (adults); stealing and starting fires (children).
34. Multiple personality.

APPENDIX C

Psychological Report

Initial Interview: **July 2002**

Client Name: **XXXXXXXXX**

Reason for Contact: **Subject of Research Case Study for UW-Stout**

Date: **July 2002**

Assessments / Instruments Administered: **None**

Background Information

This client is a 30 year –old Caucasian female, who agrees to be the subject of a case study being conducted by Sharon Gobert, a graduate student in mental health counseling at UW – Stout. The topic of the case study is aftereffects of childhood incest, and this subject has identified herself as an appropriate subject for this study. To insure confidentiality for this client, from here on out, she will be referred to as Jane Doe, or Ms. Doe.

Ms. Doe is the older of two children, and grew up in a middle class family in a small town in the Eastern United States. Her parents divorced when she was very young, approximately at the age of 8 years old, and describes her parent's marriage up to that point as a cold and distant. The subject recites significant physical abuse to her and her brother, but does not recall any abuse to her mother. She recalls a very close relationship with her grandparents. Both of her parents are living today, and she has occasional contact with both parents. Ms. Doe has one brother, whom she has stayed very close to, even though there is a significant distance in there home towns.

Ms. Doe was in the U.S. Army for a period of three years, at which time she met her current husband, to whom she has been married to for ten years. Ms. Doe made

slight mention of some relationships she had prior to meeting her husband, but did not go into specific details. She has no children at this time. She describes her marriage as a happy and strong relationship, with the usual ups and down, but denies any significant marital problems.

Ms. Doe is currently employed fulltime and her occupation will remain unstated to insure her confidentiality, but the researcher does find her occupation to be of note considering her background. Her husband is also employed full-time, and she denies any financial stressors or dilemmas at this time.

Within the last year, Ms Doe has completed her Bachelor of Science degree in criminology, and graduated with honors from a private university.

Behavioral Observations

Jane Doe is a middle-age, well-groomed female. She is appropriately dressed for the interview in casual clothing. She is very polite, friendly, and engages is conversation easily. She maintains appropriate eye contact throughout the interview. She does not appear to be overly anxious or nervous, and no fidgeting is noted. Speech is very clear and concise and not rapid.

During this initial interview, we reviewed the consent form, and verified that she was still willing to participate in the study. We also discussed the strategies for attempting to insure her anonymity throughout the study.

She seemed completely focused on her discussion, and was very concise about the details. She seemed very comfortable telling me when she did not want to continue with specific topics. She did not display frustration when asked to clarify specific details; on the contrary, she seemed very patient and willing to repeat the details to ensure clarity of the situation. Absolute and concise details seems very important to

this client, but this may be related significantly to her occupation, rather than the striving for perfectionism.

Treatment Plan

There is no specific treatment plan for this client. There is a plan to meet for seven sessions over a twelve week period. These meetings will be approximately 50 minutes in length; with the client having total control over topics of discussion and length of sessions. The researcher will record field notes at each session, and then the researcher will transcribe them in case note format Ms. Doe will review and revise the case notes to her acceptance. At the end of the study, it is agreed that the case notes and the computer disc they are stored on, will be turned over to the subject for disposal.

Summary and Recommendations

Ms. Doe appears to be functioning well and shows no present evidence of psychological distress. From our discussion, Ms. Doe has had a fairly traumatic childhood history. She expresses feelings of abandonment from her father and a family history of substance abuse and mental illness with her mother. She discloses a childhood sexual assault by her paternal grandfather, at a very young age, and questions a prior sexual assault by her father. Some specific details are still unaccountable, but she does remember the feelings of betrayal and helplessness from multiple family members when she questioned them of the incident. Recent family history reveals that her biological father was accused of molesting his daughter from a second marriage. During the next six sessions, it is anticipated that we will discuss life issues with Ms. Doe, and will acquire information that is comparable to the research data found.

APPENDIX D

Diagnostic Criteria for Post-traumatic Stress Disorder (309.81)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-TR, p. 467).

A. The person has been exposed to a traumatic event in which both of the following were present:
    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.
    2. the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
    1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
    2. recurrent distressing dreams of the event.
    3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following:
    1. efforts to avoid thoughts, feelings, or conversations associated with the trauma.
    2. efforts to avoid activities, places or people that arouse recollections of the trauma.
    3. inability to recall an important aspect of the trauma.
    4. markedly diminished interest or participation in significant activities.
    5. feelings of detachment or estrangement from others

6. restricted range of affect (e.g., unable to have loving feelings)
7. sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before trauma), as indicated by two (or more) of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hypervigilance
   5. exaggerated startle response

E. Duration of the disturbance (symptoms of Criteria B, C, & D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairments in social, occupational, or other important areas of functioning.

APPENDIX E

Diagnostic Criteria for Major Depressive Disorder, Single episode (296.2x)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 375).

A. Presence of a single Major Depressive Episode (see p. 356).

B. The major depressive Episode is not better accounted for by Schizoaffective Disorder and is, not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p. 362). a Mixed Episode (see p. 365), or a Hypomanic Episode (see p.368). Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

Diagnostic Criteria for Major Depressive Disorder, Recurrent (296.3x)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 376).

A. Presence of two or more Major Depressive Episodes (see p. 356).

B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p. 362). a Mixed Episode (see p. 365), or a Hypomanic Episode (see p.368). Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

APPENDIX F

Diagnostic Criteria for Dysthymic Disorder (300.4)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 380).

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. **Note**: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

   (1) poor appetite or overeating

   (2) insomnia or hypersomnia

   (3) low energy or fatigue

   (4) low self-esteem

   (5) poor concentration or difficulty making decisions

   (6) feelings of hopelessness

C. During this 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode (see p. 356) has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, in partial remission. **Note**: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children and adolescents) of

Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368), and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of chronic Psychotic Disorder, such as Schizphrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

APPENDIX G

General Diagnostic Criteria for a Personality Disorder

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 689).

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more of the following areas:
   (1) Cognition (i.e., ways of perceiving and interpreting self, others, people and events).
   (2) Affectively (i.e., the range, intensity, lability, and appropriateness of emotional response)
   (3) Interpersonal functioning
   (4) Impulse control
B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

APPENDIX H

Diagnostic Criteria for Borderline Personality Disorder (301.83)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 710).

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. identity disturbance: markedly and persistently unstable self-image or sense of self.
4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note**: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. chronic feelings of emptiness.
8. inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. transient, stress-related paranoid ideation or severe dissociative symptoms.

APPENDIX I

Diagnostic Criteria for Histrionic Personality Disorder (301.50)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 714).

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. is uncomfortable in situations in which he or she is not the center of attention
2. interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
3. displays rapidly shifting and shallow expression of emotions
4. consistently uses physical appearance to draw attention to self
5. has a style of speech that is excessively impressionistic and lacking in detail
6. shows self-dramatization, theatricality, and exaggerated expression of emotion
7. is suggestible, i.e., easily influenced by others or circumstances
8. considers relationships to be more intimate than they actually are

APPENDIX J

Diagnostic Criteria for Avoidant Personality Disorder (301.82)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 721).

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
2. is unwilling to get involved with people unless certain of being liked
3. shows restraint within intimate relationships because of the fear of being shamed or ridiculed
4. is preoccupied with being criticized or rejected in social situations
5. is inhibited in new interpersonal situations because of feelings of inadequacy
6. views self as socially inept, personally unappealing, or inferior to others
7. is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

APPENDIX K

Diagnostic Criteria for Dependent Personality Disorder (301.6)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 725).

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. needs others to assume responsibility for most major areas of his or her life
3. has difficulty expressing disagreements with others because of fear of loss of support or approval. **Note**: Do not include realistic fears of retribution.
4. has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
5. goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
6. feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7. urgently seeks another relationship as a source of care and support when a close relationship ends
8. is unrealistically preoccupied with fears of being left to take care of himself or herself

APPENDIX L

Diagnostic Criteria for Obsessive-Compulsive Personality Disorder (301.4)

From: *The Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV-T, p. 729).

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
2. shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
3. is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
4. is over conscientious, scrupulous and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
5. is unable to discard worn-out or worthless objects even when they have no sentimental value
6. is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
7. adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
8. shows rigidity and stubbornness