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Title Page

Exploring Posttraumatic Outcomes as a Function of Childhood Sexual Abuse.

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Exploring Posttraumatic Outcomes as a Function of Childhood Sexual Abuse

### Abstract

There is sparse systematic examination of the potential for growth as well as distress that may occur for some adult survivors of childhood sexual abuse. The presented study explores posttraumatic growth (PTG) and its relationship with negative post-trauma outcomes within the specific population of survivors of childhood sexual abuse ( $N=40$ ). Results showed that 95% of the sample was experiencing clinically significant PTSD symptomatology relating to their childhood sexual abuse but in conjunction with these high levels of negative symptoms, the population evidenced PTG levels that are comparable to other trauma samples. The research has clinical relevance in terms of adding to the knowledge base about sexual abuse and the usefulness of this knowledge in therapeutic interventions and relationships.

**KEYWORDS:** posttraumatic growth, sexual abuse, childhood, trauma, counselling

### Exploring Posttraumatic Outcomes as a Function of Childhood Sexual Abuse

A recent shift towards the investigation of growth arising out of traumatic experiences has seen some explorations into how this might occur for survivors of sexual abuse. The existence of positive as well as negative outcomes provides encouraging opportunities for professionals by expanding on aspects of trauma which are much more amenable to intervention than immutable aspects of the historical abuse scenario. In the current research, quantitative methods and written descriptions were used to explore trauma outcomes arising from childhood sexual abuse and the relationship between positive and negative post-trauma perceptions. Differences in post-trauma outcomes as a function of an individual's age at time of trauma were also examined.

#### *Posttraumatic Growth*

Historically trauma literature has focused on the negative consequences of experiences such as sexual abuse. The focus on symptoms of hyperarousal, avoidance and intrusion arising from trauma culminated in the diagnostic label of Posttraumatic Stress Disorder (PTSD) being included in the third edition of the Diagnostic and Statistical Manual of Mental Disorders where it remains today (American Psychiatric Association – 4<sup>th</sup> ed. Text Revised, 2000). Alongside this view of the “sickness” associated with trauma, the pervasive view in research has been that positive outcomes from trauma equate with resilience, that is, a pre-existing capacity to cope with stress and catastrophe and resist the negative impacts of a traumatic experience.

The possibility of positive consequences of trauma has been present in philosophical works over the years (Tedeschi, Park, & Calhoun, 1998). More recently, researchers have begun to identify that a positive outcome is not merely an absence of psychopathology and positive post-trauma changes have been investigated and developed as a research construct. It is important to note that recognising such markers of positive post-trauma change does not

intend to deny the adverse effects that may result from a trauma. Much of the literature has identified that positive post-trauma changes, or *posttraumatic growth* (Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996), occurs through the process of attempts to adapt to highly negative circumstances that, at least initially, result in high levels of psychological distress.

One model of posttraumatic growth is posited by Tedeschi and Calhoun (Calhoun & Tedeschi, 2004, 2006; Tedeschi & Calhoun, 1996). They chose the term posttraumatic growth (PTG) to highlight the emphasis on positive changes being attained by some people as a result of the struggle that is endured in surviving a traumatic event. The model suggests that growth is activated by trauma and a fundamental ingredient is the event's ability to shake the foundations of the individual's assumptive world, thereby destroying long-standing assumptions about the world's benevolence, meaningfulness and one's own invulnerability (Calhoun & Tedeschi, 1998; Janoff-Bulman, 1992). According to the model, the threat to the assumptive world triggers a process of constructive rumination whereby individuals engage in renewed consideration of, and revision of, existing schemas as well as attending to changes within the self. Growth occurs when the process of rumination results in giving up prior world assumptions, in exchange for a new assumptive world which accommodates the trauma experience. Acceptance of the trauma and the alteration of schemas are inherent in this process.

Tedeschi and Calhoun developed the *Posttraumatic Growth Inventory* (PTGI) in 1996 to measure the positive changes proposed in their model. Three broad areas of growth were identified: perceived changes in self, changes in relationships with others and changes in philosophy of life. The scale has been used to explore the construct in a variety of populations defined on the basis of culture (Asukai et al., 2002; Weiss & Berger, 2006), trauma types (e.g., Cobb, Tedeschi, Calhoun, & Cann, 2006; Lev-Wiesel, Amir, & Besser, 2005; Weiss & Berger, 2006), degree of relatedness to trauma (Shakespeare-Finch, Smith,

Gow, Embelton, & Baird, 2003), and in varied populations, such as students with a mixture of traumatic experiences (Morris, Shakespeare-Finch, Rieck, & Newbery, 2005; Tedeschi & Calhoun, 1996).

*Shattered World Assumptions.* Janoff-Bulman (1992) suggested that traumatic experiences shatter three basic positive assumptions: the illusion of invulnerability; a positive view of the self; and the perception of the world as a meaningful place. The question remains, how is a traumatic experience different if one's childhood experiences prevent the development of such assumptions, as may be the case with insidious and chronic childhood sexual abuse? Draucker (2001) interviewed a sample of women who had experienced a variety of sexual assaults. Those who had been abused and hurt since they were young children had not formed the usual assumptive world view. Conversely, they grew up thinking that cruelty and injustice were normal. Clearly, their efforts at coping with the trauma were not about restoring positive illusions that had been shattered. Draucker's study illustrates that women are able to cope with trauma in a positive way despite the cognitive mechanism of restoring ones assumptive world being unfeasible or irrelevant. This suggestion fuels discussion regarding the potential of multiple pathways to growth rather than only those afforded by the shattering of assumptions.

There are a number of individual difference variables that have been implicated as predictors or correlates of PTG. For example, age, gender, personality, and coping (e.g., Calhoun & Tedeschi, 2006; Morris et al., 2005; Morris, Shakespeare-Finch & Scott, 2007; Shakespeare-Finch & Enders, 2008; Tedeschi & Calhoun, 1996). However, results have been mixed. Of particular interest in the current study of child sexual abuse survivors, is age.

*Age.* Age has been shown to be associated with PTG with a range of divergent results being elicited. Studies have found no relationship or an inverse relationship and some identify age as a positive correlate of PTG (e.g., Milam, Ritt-Olson, & Unger, 2004). It has been

suggested that the age variable may be related to the trauma type. For example, a negative relationship between age and PTG has been found in those surviving a diagnosis of cancer (Shakespeare-Finch & Morris, in press), a positive relationship in a student population (Morris et al., 2005) and no relationship in a large sample of paramedics (Shakespeare-Finch et al., 2003). Limited research has included child populations to date however, preliminary findings provide support for PTG in children (Cryder, Kilmer, Tedeschi, & Calhoun, 2006).

The theoretical assumptions of the PTG model require a reflection on maturational issues when children are being considered. For example, the stage of cognitive capability and levels of awareness of psychological processes are expected to influence the growth process in children. It is likely that the intensity of affective processes triggered by traumatic events in childhood may be distinct from other developmental processes. Therefore, it is important to consider how the approach taken by children to process traumatic events differs from those of adults. The positive association between age and growth identified by Milam et al., (2004) suggest that a specific level of cognitive maturity is necessary to experience posttraumatic growth. This is likely to arise out of a floor effect for children who fall below the age at which cognitive development allows identification of simultaneous losses and gains arising.

*Relationship with Negative Outcomes.* A number of studies have found positive correlations between PTG and posttraumatic stress, suggesting that growth and pain are inextricably linked (Lev-Wiesel et al., 2005; Morris et al., 2005). For example, Morris et al. (2005) found that different PTGI factors differed in their relationship with posttraumatic stress outcomes. For example, positive life attitude was negatively correlated with PTSD, and relationship with others was positively correlated with PTSD symptoms. The conclusions drawn were that different areas of PTG are affected by other variables and have varying relationships with negative post-trauma symptoms.



*Childhood Sexual Abuse*

Calhoun and Tedeschi (2006) identified that different aspects of PTG may be initiated by different kinds of traumas or social support contexts, however as yet, there is little research exploring the specifics of this contention. International epidemiological data provides prevalence rates for the past two decades for childhood sexual abuse (CSA), of up to 25% for males and 42% for females (Creighton, 2004). In a community-based volunteer sample from a twin registry, a history of CSA was reported by 16.7% of the women and 5.4% of the men (Nelson et al., 2002). Estimates of the proportion of cases where CSA is intrafamilial range from a third to three quarters, depending on the sample and methodology. Intrafamilial abuse is most commonly perpetrated by fathers, step-fathers and siblings. These trends indicate that CSA is impacting upon a substantial proportion of the population and is commonly perpetrated by those who are supposed to be a source of care-giving and protection.

*Negative impacts.* It is well established in the literature that there is increased risk for serious negative outcomes for individuals with a history of childhood sexual abuse (Fergusson & Mullen, 1999; Kendall-Tackett, 1993). The wide-reaching negative impacts of childhood sexual abuse include psychological, behavioural and social difficulties (Fleming, 1999; Mullen, 1993; Nelson et al., 2002). CSA, by its nature, has an array of features which make it a particularly long-lasting and devastating trauma. It occurs during years that are vital to development and compounding this, occurs whilst the individual has limited cognitive and psychological resources.

The nature of child sexual abuse is one that often evokes shame, self-blame, powerlessness, embarrassment, and secretiveness. By its nature, it is a trauma which is less likely to be disclosed than other traumas. For example, children are often intimidated into secrecy by their abusers, thereby preventing them from accessing support which would assist them to cope with their traumatic experience. A review of studies of social support and

reactions to disclosure found unsupportive responses or negative reactions were shown to be both common and associated with a range of negative effects including psychological symptoms, somatic and health symptoms, incomplete memory and problems for adult relationships (Ullman & Filipas, 2005). Clearly, the nature of CSA as a trauma brings with it a set of unique circumstances and challenges which may have a distinctive impact on processes which result in PTG.

#### *Positive Outcomes in Childhood Sexual Abuse Survivors*

Previous studies have suggested that individuals with a history of child abuse are not necessarily a homogeneous group and that many individuals display healthy adjustment years after the abuse. For example, parental warmth, social support, family functioning and belief from a non-offending parent appear to be important determinants of the long term impact of child abuse (e.g., Twaite & Rodriguez-Srednicki, 2004; Ullman & Filipas, 2005). This suggests that although CSA is a risk factor for later maladjustment, there are a number of mediating factors that contribute to affecting this risk. A limited number of studies have gone beyond this to look at PTG in CSA survivors (Lev-Wiesel et al., 2005; McMillen, Zuravin, & Rideout, 1995).

*Posttraumatic Growth in Childhood Sexual Abuse.* One step beyond successful coping is the actual perception of benefits from a traumatic event. McMillen et al. (1995) investigated perceived benefit from child sexual abuse in a group of women where all reported childhood sexual contact that was unwanted. They measured benefit using a one question qualitative statement, asking participants to rate how much benefit they experienced using a five point scale. Almost 47% of women in their study perceived some degree of benefit. The types of perceived benefit from childhood sexual abuse included protection of other children, self-protection, increased knowledge of sexual abuse and strength. Within these categories, some women identified being less willing to trust men, and being less willing to enter into

relationships as benefits of their abuse. The accuracy of framing these changes as benefits raises questions of subjectivity. This trade-off between self-protection and satisfying adult relationships is typically seen as an adverse consequence of childhood sexual abuse (Briere & Runtz 1988), highlighting the need for the use of a structured and standardised measure of growth. Furthermore, this study has limited generalisability due to sampling criteria; the majority of the sample was African American and the majority were drawn from a sample of women known to have a maltreated child as determined by substantiated Child Protective Services reports. The study included victims of both family and non-family members, same age contact, and contact such as 'sexual' hugging and kissing.

While some of the studies using the PTGI have portions of the sample indicating that CSA is their reported trauma, there appears to be only a single study to date which has used the PTGI to examine the effects of childhood sexual abuse on adult growth. Lev-Wiesel et al. (2005) investigated identity of the perpetrator of sexual abuse (family member versus stranger) and association with positive and negative outcomes of CSA. Findings revealed that abuse by a close family member led to greater levels of both PTSD and PTG. The sample of survivors of CSA was drawn from a group of female university students who participated in the study. Almost 38% of the sample had experienced CSA, which is a high rate of incidence, and may be explained by the inclusion of broad categories of CSA such as sexual harassment and sexual exploitation in addition to rape. Results demonstrated that PTSD and PTG co-existed in this sample which may not be surprising given that it could be argued the sample are functioning at a level whereby they are engaged in post-secondary education.

#### *Aim and Hypothesis*

The present study was designed to address gaps in the field by exploring the construct of PTG and distress symptoms within the specific trauma type of childhood sexual abuse. Given the role of avoidance in the coping mechanisms often adopted by survivors of CSA, it

was predicted that there may be unique correlations with this factor of the IES-R compared to other studies using different trauma types. Secondly, given the specific dimensions of CSA with respect to developmental stages, it was predicted that participants who were pre-adolescent at the time of the abuse, that is, those less likely to have an established assumptive world, would be less likely to experience PTG. Quantitative survey data measured the relationship between the factors of PTG and symptoms of posttraumatic stress. Results were supplemented with written narratives from participants regarding the nature of their experience.

## Method

### *Participants*

The participant data used in this study were extracted from a larger project that examined post-trauma outcomes in survivors of multiple trauma types. The sample comprised 40 females with ages ranging from 17 to 60 years ( $M = 26.80$ ,  $SD = 9.26$ ). Sixty-three percent were single, 10% were separated or divorced and 27% were married. The mean time since the defined trauma occurred was 13.64 years ( $SD = 11.32$ ).

### *Materials*

The study used a cross-sectional survey design. Information collected consisted of age, sex, relationship status, a set of questions which were concerned with the nature of the traumatic event, the PTGI (Tedeschi & Calhoun, 1996) and the Impact of Events Scale-Revised ([IES-R], Weiss & Marmar, 1997). As a control measure, participants were asked to describe their experience and to rate the severity of their childhood sexual abuse on a 5-point Likert scale of 1 (*mildly traumatic*) to 5 (*very severely traumatic*) as well as the amount of time since the traumatic event occurred. They were also given the option of providing further information about their experiences, ways in which they had dealt with the experiences and perceptions of how it had impacted on their adult lives.

*Posttraumatic Growth Inventory.* The PTGI (Tedeschi & Calhoun, 1996) measures positive outcomes that may occur following a traumatic event. It comprises 21 items assessing five dimensions of growth: personal strength, relationships with others, appreciation of life, new possibilities and changes in religious or spiritual growth. Respondents are required to indicate the degree to which each statement applies to them as a result of experiencing the trauma on a 6-point Likert-scale from 0 (*not at all*) to 5 (*very great degree*). Tedeschi and Calhoun's development of this scale indicated a high degree of internal consistency with Cronbach's alpha coefficient  $\alpha = .93$ . The PTGI has shown an acceptable test-retest reliability and construct validity (Shakespeare-Finch & Enders, 2008; Smith & Cook, 2004).

*Impact of Event Scale – Revised.* The IES-R (Weiss & Marmar, 1997) was used to measure symptoms of PTSD. This measure has 22-items encompassing traumatic symptoms corresponding to the DSM-IV-TR (APA, 2000) criteria for PTSD. Statements are used to evaluate the degree to which intrusive symptoms, avoidance symptoms, and the symptoms of increased arousal were present as a result of the traumatic experience. The IES-R uses a five-point Likert-type response format with 0 meaning *not at all* to 4 representing *extremely*.

Scores for the factors on the IES-R were calculated by summing the ratings for each scale and the total IES-R score is the sum of all of the items on the scale. Weiss and Marmar (1997) reported high internal consistency in two studies of individuals experiencing natural disasters with alphas ranging from .79 to .92 for the IES-R subscales. The scale has also been shown to have high validity as evidenced by a .84 correlation with Posttraumatic Stress Disorder diagnosis (Creamer et al, 2003). Of particular significance to the current study is that literature has shown that individuals who have experienced childhood sexual abuse are likely to score higher on the IES-R when compared to individuals without such a history (Elliott & Briere, 1995; Twaite & Rodriguez-Srednicki, 2004).

### *Procedure*

Participants in the larger study were recruited during lectures, through local newspaper advertisements and following a radio interview about the project. Participation was voluntary and the criteria for inclusion was that the survivor perceived to have experienced an event that met the definition for trauma as described in the diagnostic criteria for PTSD (APA, 2000). Those who had reported childhood sexual abuse were extracted from the larger sample and included in the study if they fulfilled two criteria. First, participants had described their experience using the following terms: rape, sexual assault, sexual abuse, or incest.

Descriptions were varied in depth but were of a serious nature for example, "...sexually assaulted by father over a period of seven years". The second criteria was that the age at time of trauma was 19 years or below. The upper age limit at time of trauma was selected as 19 years to incorporate a sample consisting of participants abused during their childhood and those abused during their adolescence.

## Results

### *Data Cleaning and Assumption Testing*

Quantitative data analyses were performed using the Statistics Package for the Social Sciences (SPSS, version 15). A 5% accuracy check coupled with an inspection of the score range for each variable was performed to confirm the accuracy of the data file. A missing values analysis revealed that missing data were random and occurred infrequently so were replaced with the individual's mean score on that given variable. The data set was assessed for skewness, kurtosis, and homogeneity of variance assumptions. No breaches of assumptions were detected. An examination of standardised residual plots ensured linearity.

### *Reliability of Measures and Descriptive Data*

Estimates of internal consistency were calculated for the two measures using Cronbach's alpha coefficients. Alphas were comparable to those found by the original authors of both the

IES-R and the PTGI and indicated that the measures and factors used with this sample possessed strong internal reliability. Reliabilities for the IES-R factors ranged from  $\alpha = .78$  to  $\alpha = .88$  and the overall scale produced an alpha coefficient of  $\alpha = .89$ . The PTGI reliabilities ranged from  $\alpha = .77$  to  $\alpha = .86$ , with  $\alpha = .93$  for the total scale. Table 1 shows alpha coefficients for the total PTGI, the IES-R, and the factors and subscales of these measurements as well as the descriptive statistics.

Results show a mean of 54.30 ( $SD = 22.83$ ) for the PTGI Total scale, with a range of 9 to 99. Whilst severity ratings ranged from 2 to five on a five point scale ( $1 = mild, 5 = very severe; M = 4.31 SD = .89$ ), over 75% of the sample rated their trauma experience as severe or very severe. There was no significant correlation between the time since the event, age and any PTGI scores or IES-R scores with Pearson's  $r$  ranging from  $-.23$  to  $.26$  ( $p > .05$ ).

Please insert Table 1 approximately here

### *Testing Hypotheses*

Pearson correlations were computed to examine the intercorrelations of the variables. As seen in Table 2, a moderate significant negative correlation was found between the relationships with others factor of the PTGI and the avoidance subscale of the IES-R. The intrusion subscale of the IES-R showed moderate correlations with the new possibilities, appreciation of life and the spiritual change factors of the PTGI. The hyperarousal subscale of the IES-R had moderate correlations with the new possibilities and spiritual change factors. Noteworthy, was the observation that the avoidance subscale of the IES-R showed the least amount of association with both the other IES-R subscales and the PTGI factors excluding relationships with others, and was the only subscale to exhibit negative relationships with said factors. All significant correlations were of medium size effects.

Please insert Table 2 approximately here

When examining the psychometric properties of the IES-R, (Creamer et al., 2003) found that correlations among subscales of the IES-R were higher in community samples than clinical samples. The current sample had a correlation pattern more similar to the clinical sample than the community sample, in fact somewhat lower again than Creamer et al.'s clinical sample (intrusion/avoidance = .32; intrusion/arousal = .82; avoidance/arousal = .18).

The second hypothesis proposed that PTGI scores would be lower for those whose abuse occurred at an early stage of childhood, compared with those whose abuse occurred during adolescence. The two groups in the analysis represented (1) children who were aged 12 years or less at the time of childhood sexual abuse ( $n=18$ ), and (2) adolescents aged 13-19 years at the time of trauma ( $n=22$ ). Those aged 12 years or less at the time of trauma reported a mean level of PTG of 52.83 ( $SD= 24.06$ ), while the those aged 13 – 19 years at the time of trauma recorded a mean level of PTG of 55.50 ( $SD = 22.27$ ). A t-test was conducted between the two age groups on the basis of their age grouping and was not significant  $t(2, 38) = -.36, p = .72$ .

#### *Clinical Cut-off Scores*

Whilst the IES-R was not created to provide a PTSD diagnoses, cut-off scores are widespread in the literature (e.g., Asukai et al., 2002; Creamer et al., 2003; Twaite & Rodriguez-Srednicki, 2004). Creamer et al., (2003) identified optimal cut-off scores through comparison with the PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993) , and determined that the highest overall diagnostic power was achieved with a cut-off of 33 on the total IES-R. This cut-off afforded a sensitivity of .91, specificity of .82, positive predictive power of .90 and negative predictive power of .84. Using this cut-off score, one of the most conservative in the literature, 95% of the current sample had clinical levels of posttraumatic stress symptoms.



### *Participant Narratives*

Seventy-three percent of participants ( $N = 29$ ) provided additional information. A thematic analysis was undertaken to develop a list of themes arising from the data. Prevalent topics extracted from the data included positive themes such as a feeling of growth or that other good had come out of the experience, a recognition of the presence of support, and a realisation that there was no need for self-blame. Negative themes also emerged, such as a feeling that there was no one to talk to or that it was too hard to talk about, lack of support, coping through avoidance and dissociation, and an erosion of trust. The strongest themes to emerge from the data were the feeling that the abuse was taboo, and the feeling that one had grown in some way as a result of the experience. The proceeding series of quotes exemplify the categories extracted.

*Strength.* A central theme throughout the study was a sense that a stronger self materialized as a result of the struggle to come to terms with the sexual assault. Participants were particularly unified in the way they spoke about this concept referring to themselves variously as “stronger in personal mental strength”, “getting stronger and more self sufficient as time passed” and being “stronger in myself”.

*Positive and negative themes together.* Many of the participants also spoke of both positive and negative outcomes. This theme is encapsulated in the following comments:

“Strength builds upon strength and with each new challenge, a stronger person emerges. That is not to say that going through all this was not difficult and trying. I feel that such a view can only be taken after much soul searching, for the passing of the years does not bring comfort at all unless the spirit is mended. I put this down to grasping the greater meaning of life and embracing a deep spirituality. I do not have a religious faith.”

(Case 15; Scores: PTGI 82; IES-R 83)

“The recovery process and path to understanding was very powerful and had a reach well beyond the trauma (experienced) it created healing pathways”.

(Case 21; Scores: PTGI 43; IES-R 29)

“My trust in other people seriously diminished . . . I am stronger in myself, very empathic to others in trouble and always keen to support and reach out to those in need. However, self esteem is consistently low and depression is an ongoing problem”.

(Case 19; Scores PTGI 51; IES-R 58)

*Avoidance.* The participants in this study spontaneously articulated a variety of methods of avoidance that they continued to use throughout their everyday life. One woman said “I tend to do activities that will stop me thinking or dwelling on what has happened” (Case 9; Scores: PTGI: 38, IES-R 63), while another identified that “after it happened I just went on with everyday events and the smallest things like washing the dishes would keep me occupied for hours” (Case 12; Scores: PTGI 39; IES-R 78). However, these cases recorded PTGI scores approximately 1 *SD* below the mean of the whole group.

*Support.* Whilst participants in this study spontaneously identified both experiences of support as well as the absence of support, a lack of support was particularly deleterious to their well-being. One woman said in response to the effects of sexual abuse that “I feel a need to be protected and secure that will fail me as I know we can only rely on ourselves” (Case 2 PTGI 60; IES-R 41), whereas, for another woman, “the complete lack of family and social support was particularly devastating” (Case 6; Scores: PTGI 67; IES-R 64). Perhaps worse than the absence of support, one woman noted that “people around me don’t accept the abuse, or understand what happened or what to do now. I don’t feel I receive much support from anyone” (Case 8: PTGI 22; IES-R 84) and Case 10 (PTGI 54; IES-R 48) similarly found “the people I did tell didn’t support me or said they didn’t think he would do that”.

## Discussion

Results yielded mixed support for the hypotheses. In the first instance a negative correlation between the avoidance subscale of the IES-R and positive changes in relationships with others was provided support. Much of the PTG literature to date has only reported total scores on the PTGI however, the few studies which have looked at the domains within PTG have found differential effects (e.g., Morris et al., 2005). Cobb et al., (2006) also found that appreciation of life was the sole domain related to severity of abuse in a sample of victims of intimate partner violence. Given the role of avoidance in the early stages of coping with sexual abuse, these findings may suggest that those who have continued to cope through avoidance are less likely to have disclosed their abuse experiences and this, coupled with the betrayal experience of childhood sexual abuse, renders them less likely to experience positive changes in relationships with others.

Further, the perpetration of an intentional trauma such as childhood sexual abuse by a parental figure brings its own set of challenges to adaptation and growth. Attachment theorists have suggested that viewing others favourably has profound effects on social relations. People with favourable views of others may be more likely to seek future relationships. Conversely, negative views of others are difficult to disconfirm; they are developed early in life and reinforced through thousands of self-fulfilling interactions. Changing these views requires an event of considerable magnitude. The receipt of support when it is severely needed may be one of those events. The failure to receive support however, is likely to further confirm negative views of others. Written accounts indicated that a lack of support received was potentially deleterious to individual's ability to cope with, or grow from, the traumas experienced.

The posttraumatic domains of new possibilities, appreciation of life and spiritual change, conversely, were positively related to the symptom domains of hyperarousal and intrusion, which is more suggestive of the rumination process which Calhoun and Tedeschi (2006)

identify is imperative for PTG to occur. The pattern of subscale correlations in varying directions suggests that it is erroneous to sum the IES-R, particularly for this trauma and furthermore, points to the importance of exploring trauma types separately. To date there is no published paper that has investigated differences in trauma type and positive and negative post-trauma outcomes that have been assessed within the one study (i.e., hence, controlling for sample and methodological differences).

Contrary to predictions, participants who were children at the time of trauma evidenced similar amounts of PTG as those who were adolescents at the time of trauma. While not as expected, these findings are encouraging for survivors of childhood sexual abuse. Results suggest that these participants, who are still living with significant levels of distress and whose assumptive world was being established alongside their traumatic experience, have been able to experience PTG along the same dimensions as others whose cognitions were more developed at the time of the abuse. Moreover, it appears that PTG has occurred via some other mechanism than the shattering of assumptions. Carboon et al. (2005) found that whilst PTG occurred, assumptions remained stable in a sample of cancer survivors, thereby challenging Tedeschi and Calhoun's hypothesis that schema revision is a necessary precursor to PTG. They also found that intrusions and cognitive processing did not predict growth; again perhaps due to the specifics of the trauma type.

This appears to be only the second study to specifically explore PTG in survivors of CSA. As with the previous study (Lev-Wiesel et al., 2005), findings confirm that it is possible that in the struggle with childhood sexual abuse, women can experience PTG. Mean scores on the PTGI suggest that women in this study reported growth scores consistent with other samples who had experienced a mix of different trauma (Morris et al., 2005), emergency service responders (Shakespeare-Finch et al., 2003; 2005), and samples of cancer survivors (Carboon et al., 2005). These results indicate that women coping with the effects of

childhood sexual abuse, like persons struggling with the consequences of a range of major life crises, can experience PTG.

Concomitantly, the descriptive results obtained using the IES-R clearly indicates that a history of CSA resulted in the emergence of clinically significant symptoms in the vast majority of participants. Ninety-five percent of the respondents reported scores in excess of the clinical cut-off for PTSD previously identified (Creamer et al., 2003). Indeed, these means were comparable to previous findings of IES-R scores in adults who had been exposed to both a history of childhood sexual abuse and the terrorist attack on the World trade Centre (Twaite & Rodriguez-Srednicki, 2004). It is not desirable to make diagnoses on the basis of pen and paper measures however, the IES-R measure has been useful in illustrating the coexistence and independence of distress and PTG which is also consistent with previous findings. The written information further confirmed these results.

#### *Limitations*

As this study used a cross-sectional self-report design, caution must be taken in interpretation of results. That is, self-reports rely on accurate memory of events that may sometimes be distorted by time or by the nature of the trauma. However, the consistency in written information and quantitative results provides added faith in the assertions made. The adoption of the use of generally accepted labels for CSA, such as incest and sexual assault as the inclusion criteria, ensured that the sample was reasonably homogeneous in terms of the severity of their trauma. It is doubtful that these labels would have been used to describe sexual hugging and kissing for instance. The single item measure to ascertain severity was employed here in order to control for severity of abuse. That is, if a participant had rated the abuse as mild, it clearly would not have constituted a traumatic event. A potential limitation also lies in the sample size. Although the sample was adequate for the analyses performed, a larger sample size would add power to the calculations and permit a more detailed

exploration of variables for example, examining the pathway of relationships using structural equation modelling”.

### *Implications*

Research on child sexual abuse has historically offered clinicians few targets for intervention with adult survivors. Identification of the salient features of the abuse environment does not lead to a broader scope for clinicians in their interventions with sexually abused clients. Thus, the primary target for clinicians working with this population is the reactions of clients to the abuse. This research, which highlights the dual presence of competence and distress, will be useful for clinicians in terms of providing focus on the growth aspects of clients who are presenting with these difficulties and will assist in the empowering of clients. Clinicians should be open to the possibility of growth, highlighting the movement the survivor has made as it becomes evident.

It is also important for clinicians to have an awareness and understanding of the interactions between negative and positive post-trauma outcomes as these may influence the effectiveness of treatment provided to individuals. It may be wise to remain aware of the stage of growth and distress at which their client presents and ensure that interventions remain targeted at the correct level, thereby recognising and working through PTSD symptomatology as it arises while also being alert to the positive changes that may accompany this resolution of symptoms. The maturational issues surrounding PTG in this population will also have a bearing on the clinician’s understanding of the individual’s view of their trauma and growth. As pointed out by Tedeschi et al. (1998), clinician’s should not perceive those who are not reporting PTG as having failed to manage their trauma in a beneficial way.

*Future Research*

The results from this study indicate a number of potential future research opportunities. Firstly, there appears to be a beneficial future in researching PTG with reference to the dimensions of trauma experiences and specific trauma types. Further studies could work towards articulating the dimensions along which trauma types differ, with qualitative research being used to augment the findings of dimensions of trauma types. A study which systematically compares two or more trauma types within the one study would also be beneficial. Further, the inclusion of a measure of attachment in future research into CSA and PTG may further illuminate aspects of growth and distress in CSA survivors. Finally, it would be useful to use more comprehensive measures of CSA and the inclusion of a sample of males who have experienced CSA.

This study adds to the field of PTG and demonstrates that survivors of CSA can experience PTG despite their ongoing emotional and cognitive distress. These findings should in no way be viewed as suggesting that CSA is good or desirable. Rather, despite the highly negative consequences that it can produce, the present findings suggest that a woman's struggle with CSA can, in some ways, also lead to significant transformation. Another point to argue is that if researchers seek to measure distress in trauma survivors, they will find a level of distress and if they seek to measure growth, then a level of growth is likely found. When measuring both the positive and negative outcomes survivors attribute to an event such as sexual abuse, a more holistic picture of the survivor emerges. This appears to be predominantly a person who perceives positive changes but is not denying that the event has also had a lasting negative impact on them.

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Table 1

*Scale Reliability and Descriptive Statistics for the PTGI and IES-R*

Subscale	Cronbach's Alpha	Range	Mean	SD
IES-R Intrusion	0.88	5-32	22.45	7.02
IES-R Hyperarousal	0.78	5-24	15.93	5.47
IES-R Avoidance	0.83	2-32	21.35	7.19
IES-R Total	0.89	26-86	59.73	15.55
PTGI Relating to Others	0.79	5-34	16.48	8.24
PTGI New Possibilities	0.86	0-25	12.98	6.72
PTGI Personal Strength	0.82	0-20	12.53	5.13
PTGI Appreciation of Life	0.79	0-15	9.40	3.99
PTGI Spiritual Change	0.77	0-10	2.93	3.00
PTGI Total	0.93	9-99	54.30	22.83

Table 2

*Correlation Coefficients for PTGI, IES-R, Factors and Subscales*

	Hy	Int	Avo	IES-R	F1	F2	F3	F4	F5	PTGI
Hyp	1	.82 <sup>#</sup>	.17	.80 <sup>#</sup>	.41*	.18	.28	.19	.32*	.32*
Int		1	.33*	.90 <sup>#</sup>	.37*	.14	.34*	.21	.37*	.32*
Avo			1	.67 <sup>#</sup>	-.14	-.33*	-.09	-.16	-.12	-.23
IESR				1	.25	-.02	.21	.09	.23	.15
(F1)					1	.70 <sup>#</sup>	.65 <sup>#</sup>	.78 <sup>#</sup>	.60 <sup>#</sup>	.92 <sup>#</sup>
(F2)						1	.50 <sup>+</sup>	.59 <sup>#</sup>	.63 <sup>#</sup>	.87 <sup>#</sup>
(F3)							1	.63 <sup>#</sup>	.50 <sup>+</sup>	.75 <sup>#</sup>
(F4)								1	.49 <sup>+</sup>	.84 <sup>#</sup>
(F5)									1	.73 <sup>#</sup>
PTGI										1

Note. \* $p < .05$ , <sup>+</sup> $p < .01$ , <sup>#</sup> $p < .001$

F1 = new possibilities, F2 = relationships with others, F3 = appreciation of life, F4 = personal strength, F5 = spiritual change. PTGI = total score on PTGI, Hy = hyperarousal subscale on IES-R, Int = intrusions subscale, Avo = avoidance subscale, IES-R = total IES-R score.