CHILDHOOD SEXUAL ABUSE AND DISSOCIATION; THE RELATIONSHIP OF FAMILY FUNCTIONING TO DISSOCIATIVE MAGNITUDE

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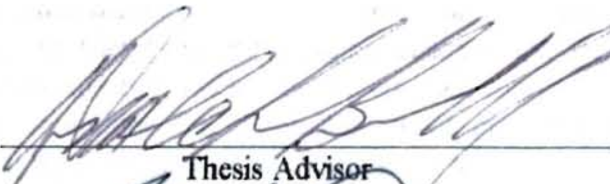

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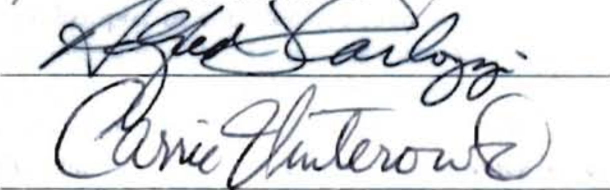

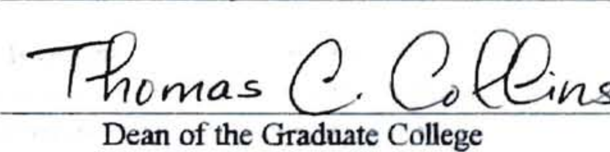

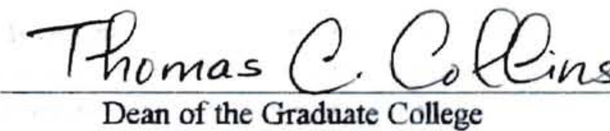

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This study was undertaken to add to the empirical data base concerning the interaction of sexual abuse and the family environment on symptom development and to broaden my theoretical base as a counselor specializing in the area of Trauma Intervention.

I would like to express my gratitude and appreciation for the enduring support that my advisor, Dr. Donald Boswell, has given me over the last two years. His humor and direction, and continual assurance that this project would have a conclusion and an enduring influence on my love of research, proved true. The friendship and honesty shared is invaluable. As a mentor, he altered my paradigm of counseling and helped me to build a stronger theoretical foundation. His encouragement to follow my instinct with research, taught me new ways to look at both my academic and professional life and integrate the varied information I discover. His advocacy during periods of crisis can never be repaid.

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CHAPTER I

INTRODUCTION

Current reviews of both commercial and scientific literature disclose arguments both for and against the high occurrence of sexual abuse histories in women of all ages and an under-estimated percentage of men who were sexually abused as children and the subsequent arguments regarding the validity of repressed memories (Fredrickson, 1992; Kluft, 1986; Terr, 1994). A specific sphere of this argument focuses on whether the mind has the ability to bury traumatic memories for many years and then suddenly, or through certain environmental triggers, re-emerge.

For the past 100 years, dissociation (a major mechanism by which memories may be repressed), has been the focus of clinicians and researchers from a wide variety of theoretical standpoints (Braun, 1984; Hilgard, 1977; Kluft, 1993; Terr, 1994).Currently, those individuals in support of the repressed memory process, have focused on delineating how dissociation, a normal function in lesser forms, (spacing out, daydreaming forgetfulness), through some type of trauma, develops into pathological symptoms that can be disruptive to the individual's life and create a feeling of disconnection from the world.

Numerous research studies on Vietnam veterans and community based disaster victims (Terr, 1994; Wilson, 1994a) have supported the development of a clear and succinct diagnosis and understanding of Post Traumatic Stress Disorder (PTSD), of which dissociation is part of the symptomology (DSM IV, 1994). Extensive data, with few contradicting arguments, support the case that these individuals suffer loss of memory.

Recently, there have been attempts at correlating these aspects of dissociation with those of adult victims of childhood sexual abuse (CSA)(Fredrickson, 1992; Terr,1994).

In the last 10 years there has been an increase in the availability of counseling for people of all income levels and a greater acceptance of therapeutic interventions for a variety of mental health issues. Clinicians have found that, as more and more women enter the therapeutic dyad, there are certain populations that present with entangled symptoms and syndromes that may have their base in PTSD and/or trauma. These can include but are not limited to; depression, panic and anxiety disorders, transitional problems, dissociative disorders and current abuse problems (Fredrickson, 1992 ; Kluft, 1993).

A review showed that clinical studies suggested (Briere, 1989; Forward & Buck, 1978; Swett & Halpert, 1993) that within this counseling environment these same women subsequently disclose that they have CSA histories. Researchers report that CSA is an etiologic factor in many affective disorders (Braun, 1984; D. Everstine & L. Everstine, 1993; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993; Nelson, Miller, & Krol, 1987).

The major emphasis and energy behind the research of the dissociative process for both clinicians and researchers, is multi-faceted. It appears there is a growing interest in discovering more valid measures and ways to find access to memories of CSA clients (Benningfield,1992;.Bernstein et al., 1986; Fredrickson, 1992; Swett & Halpert, 1993).

Clinicians and researchers suggest that if they can understand the covering up process of dissociation, then they may better design treatment procedures that can help peel back the layers of psychopathology, that have grown during the years since the original abuse. It may also help them to prevent subsequent psychopathology in more recent victims (Terr, 1994).

Current studies estimate that the incidence and prevalence of some type of sexual assault at some point in most women's lifetime is greater than expected (Bryer, Nelson,

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Miller & Krol, 1987). Sandberg, Lynn and Green (1994) reported that 20 % to 40% of women in our society will experience some sort of sexual abuse during their lifetime and that women with histories of childhood sexual abuse are more likely than non-victims to be sexually assaulted in adulthood.

Out of their 88 psychiatric patient subjects, Swett and Halpert (1993) found that 81% reported a history of abuse some time during their life. Eleven per cent reported sexual abuse only, 15 % physical only and 55% both types. Root (1991) found that eating disorders, especially bulimia, often have their base in PTSD or CSA. Root saw rates of CSA histories as high as 66 % in a study of eating disordered populations. She hypothesized that bulimia helped to avoid intrusions of traumatic memories. Morrow and Smith (1995) suggested that 20% - 45% of women and 18% of men in the United States have been sexually abused as children and that one third of students seeking counseling in one university center reported having been sexually abused as children. Current data show that these clients present with histories of extensive physical complaints (Briere & Runtz, 1988; Bryer et al., 1987; Walker, 1991) and some of the mostsevere and mullet-layered pathology (Braun, 1984; Briere, 1989; Everill & Waller,1995; Kluft, 1986; Williams, 1994).

Ellason and Ross (1995) suggested there is also a large population of schizophrenics who may have been mis-diagnosed. They suggest that with further evaluation, these individuals would show higher levels of anxiety and depression than those of correctly diagnosed schizophrenics and with the dissociative and hallucinative symptoms re-assessed, would prove to have a base in the dissociative disorders.

Researchers suggest that the resulting effect of sexual trauma may create a discontinuity in both physical and mental experience. This can be described as a breakdown in the typical correspondence of cognitive, behavioral and physiological responses between and within a persons and their environment. The stressors from this

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experience can be quite varied and reaction to these stressors may also be varied involving social, personal, psychological and biological factors. It is the subsequent reaction to these stressors that is often seen in the development of PTSD symptoms and dissociative pathology (Braun, 1984; Briere, 1989; Fredrickson, 1992). Braun, (1986), Briere, (1988), and Kluft (1986, 1993, 1994) argued that this response can be maintained or even strengthened by negative reinforcement (other physical or emotional abuse, rejection, stimulation of triggers).

Many researchers have attempted to show the correlation between CSA and increased dissociation. Malinosky-Rummel and Hoier (1992) found that their female CSA subjects scored significantly higher on their three measures of dissociation than the non-abused and that the family/risk disruption variable had a positive correlation with levels of dissociation.

It is when dissociation becomes the primary psychological defense, that it can manifest itself in dramatic and often pathological alterations in the experience of both the self and the world (Hilgard, 1977; Kluft, 1986, 1993; Van der Kolk, 1987).

Researchers and clinicians (Gold et al., 1994; Kluft, 1986, 1993, 1994; Miller, et al., 1993; Putnam, 1986; Speigel, D., 1986; Waites, 1993) have investigated dissociative symptoms that are manifested in symptomology of eating disorders, self mutilation, obsessive compulsive disorders and drug abuse. It appears that many of these dual-diagnosed patients have histories of hospitalization, self mutilation, multiple suicide attempts, spouse abuse and other forms of re-victimization and somatic complaints.

Dissociation is both a normal and psycho-physiological mechanism that plays a part in many aspects of different psychopathology and mental disorders (Bernstein & Putnam, 1986) from mild depersonalization to Dissociative Identity Disorder (DID)(Kluft, 1993: Nash et al., 1993). Dissociation is a lack of association (Braun, 1984) with the immediate environment. If the abuse continues and is compounded by current or developing

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dissociative factors that help the victim to not focus on the chaos or on the environment around them. then life becomes more and more unreal, the belief in the abuse is questioned and detachment from the daily world is strengthened (Kluft, 1986, 1994).

Some researchers suggest that part of what brings this response on involves certain aspects of the mind that accept that the body must still function (independent Observer) in the world yet at the same time finding it incomprehensible that the abuse is really occurring. As the victim learns to dissociate, the traumatic life experience becomes compartmentalized, sometimes denied or distanced from immediate access and sometimes forgotten. This both enhances the continued existence by the non-invasiveness of memories or takes away from it, through disruptive dissociative behaviors.(Briere, 1988; Harvey & Herman, 1994; Hilgard, 1977 ; Kluft, 1986, 1993).

Kluft (1986) and Briere (1989) suggested that there are many traumatic factors that are manifested in a CSA relationship that influence the development of multi-layered psychopathology, especially if the abuse occurs or originates during the developmental years before age seven. Cognitive distortion, learning disabilities or problems, and dysfunctional interpersonal and intimacy relationships are often seen and presented as initial complaints in the counseling relationship.

CSA ,especially if occurring during the formative years, has also been hypothesized to greatly alter the child's ability to attach, separate and have a belief in a safe world. (Briere & Runtz, 1988; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993; Walker, 1991). The inability to form close interpersonal relationship, depression, and lack of trust are often presented as core issues early in treatment, before more subtle or hidden dissociative symptoms or a PTSD diagnosis is evident (Kluft, 1994; Waites, 1993).

The dynamic of CSA, occurring as the child is creating his or her constructs regarding the world, precipitates residual effects, even when the abuse stops. These effects, if reinforced by numerous variables, can endure through adulthood. It is hypothesized that

such dynamics continue to feed the need to find ways to avoid the added stressors, thus increased dissociation. This layered trauma response, if repeatedly activated, can be consistent, can change day to day, hour to hour, building upon itself, and at times result in a Dissociative Identity Disorder (Formerly MPD, now DID) (Braun, 1984; Kluft, 1986).

Nigg , Lohr, Westen, Gold, and Silk (1992) and Parker, Tupling and Brown (1979) found that care does not always have to be continually malevolent to develop this symptomology. The perception of malevolence can be enough to reinforce depression, dissociation and other disturbances in interpersonal functioning. Collings, (1994), Inderbitzen-Pisaruk, Shawchuck, and Hoier, (1992), Malinosky-Rummel and Hoier, (1992), Mallinckrodt, McCreary and Robertson, (1995) and Morrow and Smith, (1995), suggest that the hole in research regarding the interaction of such mediating factors as belief systems in the development of the CSA-induced dissociative psychopathology should be addressed.

Researchers are now beginning to look at mediating factors such as dynamics of family functioning and the construct of the family system in relation to CSA based dissociation of the CSA (North, Ryall, Ricci, & Wetzel, 1993; Nash, et al., 1993). They stress the importance of additional research to investigate the correlation of levels of dissociation to dynamics (to name a few) such as duration of abuse, type of penetration (digital, genital, etc.), age at occurrence, and the perpetrator/victim relationship. Nash et al. (1991) suggests that, even with this new research , family disruptions including divorce, moving, death, jobs or economic change in the family, are not fully being controlled for.

Like many other researchers, Briere and Runtz (1988) hypothesize that sexual abuse, especially occurring with an immediate family member, often results in the most chronic dissociation. This has been empirically supported in relation to the extreme dissociation of DID (Braun, 1986; Kluft, 1986, 1993). Literature reviews show arguments on both sides

for this dynamic and the validity of DID (Everstine & Everstine, 1993; Kluft, 1986, 1993, 1994; Waites, 1993).

As stated earlier, family and other forms of social support can act as buffering or intensifying influences on the pathogenic influences of CSA. Burkett (1991), Everill & Waller, (1994) and Inderbitzen-Pisaruk, et al., (1992) support that the family is where the child initially learns about emotions and emotional expressiveness. Gold, Milan, Mayall, and Johnson (1994) found that both validated and subjective feelings of lack of parental support, as well as family non-expressiveness and low cohesiveness, have been empirically associated with problems of adult adjustment and particularly, if presented during intake, help to predict anxiety and depression in CSA clients.

More support is found in Inderbitzen -Pisuarak et al. (1992) suggestion that behavior problems in sexually abused children and adolescents are an outcome of disturbed family system. Berkowittz and Perkins (1988) found in their study of borderline personality disorder (which can have its base in CSA) and dysfunctional families, that dissociation, influenced by a lack of and a great need for social support, may compensate for the lack of attachment. This family situation often a major source of conflict for the victim possibly instigates the use of dissociation for self soothing and control..

Halbertstadt, Cassidy, Stifter, Parke and Fox (1995) also suggest that because constructs of experience and expression appear to develop within the family through processes such as modeling, reinforcing, labeling, interpreting and coaching, that these experiences are thought to impact the individual's interpersonal and intrapersonal functioning in a variety of areas. Specifically, family expressiveness has significant association with an individual's emotional experience and resiliency against depression and experiences of anger and overall affect intensity.

One aspect of family dynamics is seen in studies that show higher levels of pathology, especially dissociation, in those women who disclosed to family members and had adverse

reactions (Everill & Waller, 1994). It is argued that dissociative need may be influenced by the child's lack of conceptualization of a safe world and thus a conclusion that the world is not safe.

This unsafe world construct may be influenced by a less cohesive family, where it has been suggested that there is much boundary confusion (Haberstadt et al., 1995). Empirically war zone PTSD victims have been noted to have intense PTSD symptomology if they come from low cohesive families (Sutker & Allain, 1995). PTSD symptoms also appear greater in those children who disclosed and had negative responses.

Nash et al.(1993) also suggest that the abuse environment is more pathogenic and that dissociation and other symptoms are more a result of the family system than of CSA. They suggest that the dysfunctional family's system creates stress and conflict that subsequently creates an intolerance for loneliness, separation and the high levels of anxiety for CSA and Borderline Personality Disorder clients. Many individuals with this disorder may also use behaviors such as mutilation and bulimia to dissociate. It has been noted that there is an addictive nature to these behaviors, that becomes connected to the dissociation and acts like an opiate for numbing and self regulation and creates both emotional constriction and isolation (Van der Kolk, 1987; Waites, 1994).

Looking at all the afore mentioned trauma responses, it appears that when sexual abuse occurs within certain contexts, dissociation becomes a welcomed response to a world where the victim may feel there is no place for them (Braun, 1984; Brier & Runtz, 1988; North et al. 1993). What might be initially a normal or adaptive behavior (withdrawal from a threatening situation that is unimaginable) and a cognitive solution to extreme anxiety of current life and memories, in the long run, due to certain environmental dynamics, can not only victimize the client into forgetting, and/or invalidating the abuse and yet living with the intrusions of symptoms but can re-traumatize them over and over again(Speigel, D., 1986).

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It is imperative, when looking at the results of dissociative research and familial interactions, to also delineate the contra-indicated resiliency factors behind dissociation (Morrow & Smith, 1995) and family dynamics that appear to decrease the need for dissociation. Historically, research of coping styles in relation to abuse has been on emotion-focused and avoidance related behaviors, where as in reality, the ability to dissociate may well give the CSA victims a sense of control and power. They may use dissociation to tolerate seemingly overwhelming trauma feelings, a family environment that did not protect them from the abuse and the restriction by family to deal with the subsequent symptoms.

Research on dissociation can help clarify ways to see this and other aspects of the victim's strengths rather than pathology. Knowledge regarding how family communication styles affect symptom development may provide data to develop both cognitive and behavioral interventions for young sexual abuse victims and adults with a CSA history. This research may help clinicians understand family dynamics in a more environment context and thus facilitate more effective CSA family counseling and family counseling in general. Clinicians may then see a decreasing number of adult victims with lifetimes affected by the sexual abuse and subsequent symptom development.

This research and the afore mentioned researchers can, by providing empirical data regarding variables other than CSA that influence dissociation, may also have an impact on clarify the multiple dynamics that cause the mind to close down and close off, especially in relation to memories.

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Research Problem

This study was designed to help delineate what factors affect the levels of dissociation in individuals with CSA histories. Specifically; to investigate and empirically clarify if certain family dynamics affected the magnitude (level) of dissociation in relation to both symptom development or resiliency against such development

Initially women were the focus of this research. A current literature review supported the premise that women with CSA have higher levels of dissociation than other control or experimental groups (Fredrickson, 1992; Kluft, 1986; Terr, 1994). It has been hypothesized that female inpatients have higher rates of reported abuse than female outpatients and that the severity of the dissociative symptomology was greater (Swett & Halpert, 1993). The adult general population as compared to the clinical population, has not been as extensively studied.

Even with the numerous clinical studies , there appeared to be a great need to break down the relationship even more and discover what factors beyond the abuse cause such multi-layered symptomology. Factors such as family interaction, type of abuse, duration of abuse and age that the abuse occurred did not appear to have been controlled for in much of the current research nor was there much evidence of these factors investigated as interacting or having a main effect on levels of dissociation. Holes were also found in the literature for studies that included men and thus this study opened to both genders.

This research, in looking at a more general population of college students attempted to show that the CSA adult with a dysfunctional family system ,as defined by certain measures and literature support, would show that the most consistent and extreme dissociative behaviors.

Purpose of Study

It was the purpose of this study to investigate the relationship of known childhood sexual abuse histories and levels of dissociation. Specifically, the independent variables of family system functioning at three levels was looked at; cohesiveness, expressiveness and conflict and their either main effect or interacting effect with a history of sexual abuse on levels of dissociation.

Significance of Study

It was hoped that through clarification of family construct dynamics that influence the more pathological dissociative symptoms of CSA victims, that a framework could be defined by which clinicians could conceptualize more effective ways to work through the often multiple layers of trauma of the older CSA victim. It was felt that this data could be applied to new intervention techniques could be empirically tested for sensitivity to CSA issues. This information could possibly help to implement interventions to help to arrest the development of similar but less embedded symptoms in younger victims. Additional data could also be gleaned in relation to the resiliency factors where dissociative symptoms were not correlated to the abuse.

Knowledge of family dynamics and the subsequent effects, can also provide a cognitive framework that clinicians could present to the clients in relation to interpersonal and therapeutic interactions that mirrored the family dynamics. This may help the client get closer to emotions, avoid being re-victimized and work with lessening the dissociation. Understanding these restrictive factors (in that some literature suggests that dissociation could be distancing the client from the emotions that need to be experienced for healing (Terr, 1994) may also enhance therapy .

Dissociative symptoms are also representative of a resiliency factor that has helped sexual abuse victims to survive within chaotic and damaging environments (Morrow & Smith, 1995). In looking at family dynamics and dissociation, future research could look at

the CSA population and the levels of functioning along with measures that clarify efficacy and locus of control beliefs in relation to the magnitude of the symptoms. This information could possibly delineate the resiliency factors in relation to lower levels of symptomology. Research based on such findings could then provide data to help develop cognitive, behavioral and emotional interventions for currently or recently sexually abused victims (Gold et al., 1994).

Research Questions and Hypothesis

Null Hypothesis I

There is no relationship between CSA and perceived family conflict on levels of dissociation.

Null Hypothesis II

There is no relationship between CSA and perceived family expressiveness on levels of dissociation.

Null Hypothesis III

There is no relationship between CSA and perceived family cohesiveness on levels of dissociation.

In the event that any of the Null Hypothesis were rejected, a series of questions were asked:

Research Question I:

Do high and low levels of perceived family conflict and CSA interact to increase levels of dissociation?

Research Question II:

Do high and low levels of perceived family expressiveness and CSA interact to increase levels of Dissociation?

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Research Question III:

Do high and low levels of perceived family cohesiveness and CSA interact to increase levels of dissociation?

Expected Findings

Alternate Hypothesis I : It was hypothesized that there would be an interaction effect on increased levels of dissociation from the combined influence of CSA and perceived high or low family conflict.

Alternate Hypothesis II : It was hypothesized that there would be an interaction effect on increased levels of dissociation from the combined influence of CSA and perceived high or low family expressiveness.

Alternate Hypothesis III : It was hypothesized that there would find an interaction effect on increased levels of dissociation from the combined influence of CSA and perceived high or low levels of family cohesiveness.

These hypothesis were based on the suggestion that family systems that have extreme levels of conflict, expressiveness, or cohesiveness (either extremely high or low) interaction constructs do not provide an environment that allows for emotional expression nor the ability to both regulate or tolerate any range of affect. Specifically, a family that operates either in a constant state of conflict or does not allow any expression of conflictual feelings would affect the abused individual's ability to receive support in dealing with the sexual abuse and the subsequent emotional response; a family that does not allow expression of a variety of emotions or is invasive in their expression and interaction with the abused individual, may affect the abused individual's ability to receive support in dealing with the sexual abuse and the subsequent emotional response; and a family that has little cohesiveness or sense of common bonding or one that is so cohesive that interpersonal

dynamics are enmeshed, may affect the abused individual's ability to receive support in dealing with the sexual abuse and the subsequent emotional response.

Three self-report measures were utilized:

1) Demographic Sheet (DS)(1995) a self report measure designed specifically for this research to address questions relating to CSA: Type of abuse, duration, relationship of perpetrator, interventions, etc..

2) The Family Environment Scale R (FES) (Moos and Moos, 1986) a self report retrospective measure sensitive to an individual's beliefs about their family system. We used the scales of cohesiveness, expressiveness and conflict.

3) The Dissociative Experience Scale.(DES), (Bernstein & Putnam, 1986) , a self report measure designed to distinguish between "normal " dissociation and more pathological dissociation as determined by earlier research. (See Method for complete description of measures).

Assumptions of This Research:

1) The individuals that volunteered for the experiment would answer the questions truthfully and have no ulterior motives for participating.

2) The three measures used for this study did not have any leading questions that could influence the participants' answers.

3) The majority of those participating, if sexually abused, had memory of this abuse.

Limitations of study

There were numerous limitations associated with this study. As many researchers suggest, self report measures are based on the assumption that subjects will answer truthfully. The sensitivity of the subject area could have affected some participants not to answer honestly. In relation to this, those with dissociative symptomology may not have been able to recall certain feelings regarding their families and some may have not had any recollection of the abuse.

As stated in the literature review, memory emergence often does not occur until the mid-twenties or thirties and most participants were in their early twenties. The number of participants was also limited. Access to classes was limited and the n reached only 141 out of the expected 300. Although this research's significant findings strongly suggest an interaction between family dynamics and sexual abuse on dissociation magnitude, the small n of 21 who were sexually abused, does not allow for much generalization.

This study used both female and male college students. This may not have provided access to the population under study. College students, by the act of being college, show a resiliency that may relate to them not developing dissociative symptomology, even if they were sexually abused.

Although extensive demographic information was gathered in this study, many of the demographic variables; major life events or crisis, the variables of length of abuse, age that it occurred, relationship to perpetrator nor types of intervention, including but not limited to family, counseling or hospitalization, were not used as part of the interpretation of the results. This will be done in future research. Attribution style or other pathogenic factors that could also influence resiliency or levels of dissociation still needs to be assessed. The demographic sheet has not been previously used or tested for reliability or validity.

Variables

The independent variables of this research were two levels of sexual abuse; occurring or not occurring from ages 0 through 30, and family functioning with three levels: expressiveness, cohesiveness and conflict (See definitions).

The dependent variable was the levels of dissociation as measured on the Dissociative Experience Scale with mean scores from 0 to 100 with 20 as a possible indicator of a dissociative disorder (Bernstein & Putnam, 1986).

Definition of Terms

Childhood sexual abuse (CSA) was defined as occurring within the years of birth to seventeen years old. We defined sexual abuse on the demographic sheet as any touching or fondling of any body part, sexual remarks or exposure to any type of sexual material; anal, oral or genital penetration with objects, genitalia or other parts of the body and exposure to sexual acts between others.

Classifications of frequency of occurrence of CSA was defined as:

Low occurrence of sexual abuse was defined as once or twice a year.

Middle levels occurrence of sexual abuse was defined as once every two to four months to once or twice a month.

High incidences of sexual abuse included but were not limited to at least once a week to every day. Our demographic sheet described these time periods:

[How often: __every day __at least once a week __at least once or twice a month __every 2-4 months __once or twice a year __once.]

Cohesiveness was defined by scales on the Family Environment Scale(FES)(Moos & Moos, 1986) that measured the degree of commitment, help and support family members provided for one another. Low Cohesiveness (Standard score of 0-30) and high cohesiveness (Standard score of 60 and above) were defined as being indicative of restrictive family dynamics that possibly could affect the individual's intrapersonal and interpersonal interactions.

Conflict was defined by the scale of similar name on the Family Environment Scale(FES) that measured the amount of openly expressed anger, aggression and conflict among family members. Low Conflict (Standard score of 0-39) and high conflict (Standard score of 60 and above) were defined as being indicative of restrictive family dynamics that possibly could affect the individual's intrapersonal and interpersonal interactions.

Dissociation was defined within body of paper on a continuum scale as described by the DES (Bernstein & Putnam, 1986). It included the lowest levels of dissociation commonly experienced by the majority of the population ; activities such as spacing out during TV or driving to highly disruptive dissociation where there is memory loss and separation of personality. The cutoff for a dysfunctional or disruptive dissociative symptom or possible dissociative disorder was 20, with 30 being a possible indicator of Dissociative Identity Disorder.

Expressiveness was defined by scales on the Family Environment Scale(FES) that measured the extent to which family members were allowed to act openly and express their feelings directly. Low Expressiveness (Standard score of 0-39) and high expressiveness (Standard score of 60 and above) were defined as being indicative of restrictive family dynamics that could possibly affect the individual's intrapersonal and interpersonal interactions.

Emotional Abuse was defined on the demographic sheet as including but not limited to : demeaning communication that may be expressed through unwarranted and consistent criticism of behaviors, looks and/or beliefs, ridicule of behaviors, looks and/or beliefs, intimidation through verbal threats, humiliation in public and private , forced behaviors through verbal intimidation, coercion and/or manipulation.

Perpetrator/Abuser - This was defined as the person inflicting the abuse on the victim.

Physical Abuse - Physical abuse was defined on the demographic sheet as being physically hurt or attacked by someone that sometimes resulted in injuries that included but were not limited to; bruises, welts, scratches, cuts, scars burns, broken bones or severe to life threatening injuries. We also defined it as usually occurring more than once and often without provocation. Shaking, burning choking and use of lethal weapons were included in this category.

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CHAPTER II

LITERATURE REVIEW

Research of childhood and the developmental process's effect on adult intrapersonal and interpersonal relationships has been on the increase in the last ten years. Only recently, within this broad spectrum of investigation, a subgroup has emerged that focuses on causal relationships between childhood life events and adult symptomology. Within this is another subgroup research delineating the varied and multi-dimensional effects sexual abuse and family system dynamics as a mediating factor (Nash et al., 1993) on symptom development. Much of this current investigation is focused on how these family dynamics interact with the etiology of dissociative symptoms.

Nash et al. (1993) argued that these current studies on dissociation have inadequate control groups, use weak measures and do not control for nor really look at the confounding variables of other pathogenic factors both within the family and throughout the life history of the CSA individual.

Dissociation can be an extremely creative way to deal with overwhelming stimulus, specifically in relation to trauma exposure (Braun, 1984; Briere, 1989; Hilgard, 1977; Kluft, 1986). As such, it is only one of many symptoms listed under Post Traumatic Stress Disorder (PTSD) in the DSM IV (1994). In reality, it may be that dissociation is a major symptom interacting and responding to the other PTSD responses.

PTSD is defined as the development of characteristic symptoms following exposure to an extreme stressor that involves direct personal experience of an event which involves actual or threatened death or serious injury or other threat to one's physical integrity (DSM IV, 1994). This can also involve witnessing or learning about an event such as sexual

abuse, rape, earthquakes or one similar to the recent Oklahoma City bombing. The PTSD response involves intense fear, helplessness or horror. The characteristic symptoms include persistent re-experiencing of events, increased arousal, numbing of general sponsiveness, persistent avoidance of the stimuli associated with the trauma, (often by a major behavioral response such as dissociation) , sleeplessness and extreme startle response. The symptoms must be present for a month and have clinically significant distress or impairment of social, occupational and or other important areas of functioning.(DSM IV, 1994).

Although there is evidence (Bloch, 1991) that different types of trauma precipitates different responses, there is also evidence that individuals suffering different types of trauma share some common responses, one of which is dissociation. It is through over use of dissociation (Nash et al., 1993) that the individual finds it works as a primary way, (both an effective and mal-adaptive coping strategy) to reduce tension and defend against any type of increased arousal. If used continually for an amount of time where it can become an automatic response, it can interfere with the dissociative individual's daily functioning as he or she tries to avoid any type of interpersonal conflict , rejection, separation and abandonment. It is these actions that can isolate the individual from exactly what they need. Dissociation can also affect the daily suppression and access of repressed memories or feelings about the trauma (Fredrickson, 1992; North et. al., 1993; Speigel, 1986).

Dissociative research often has its base in understanding how both the unconscious and conscious mind works. Understanding the various tangents of the etiology of dissociation not only benefits treatment but the clinician's ability to understanding the normal everyday processing of both conscious and unconscious material.

History

100 years ago, French psychiatrists and neurologists were intensely focused on hypnosis and hypnotic phenomena and the puzzling divisions of consciousness involving

association, amnesia and anomalies of hysteria (Greaves, 1993; Hilgard, 1977; Kluft, 1993; North et al., 1993). Freud, Pierre Janet and Charcot were at the forefront of this focus. Janet, credited with coining the word "dissociation", developed his theory of dissociation from his interest in clinical technique of association that was prevalent during this time. He focused on the mental aspects of conflict, indecision, self deception and persistence towards goals and how the unconscious mind made these associations (Hilgard, 1977).

Janet stressed that if certain memories that have been dissociated are brought to consciousness through association, then, understanding that process may help to understand how the memories are originally repressed. He supported his theory with informal experiments through hypnotism and automatic suggestions. Current theorist mirror this belief that much of an individual's altered states of consciousness are aspects of the personality that can be described as an independent observer (Briere et al., 1988; Fredrickson, 1992; Kluft; 1982; Terr, 1994).

Around the same period as Janet, Binet of France, described "dissociation " as double consciousness and Max Dressor of Germany coined the phrase double ego; Das Dopple Ich. Charcot was one of first to describe dissociation as hysterical symptom correlated to the effects of a traumatic event that affected the brains ability to process emotions.(Hilgard, 1977; Kluft, 1982). Americans William James and Morton Prince were also investigating divided states of consciousness. Their research looked at voluntary and involuntary cognitive processes and how some processes are deliberate or automatic. (Hilgard, 1977).

During this time, the phenomena of hypnosis was often assigned to abnormal behavior related to hysteria (Briere & Runtz, 1988; Hilgard, 1977; Kluft, 1986). Janet and Charcot, described hypnosis as a hysterical manifestation of the sub consciousness. (Hilgard, 1977). Yet, as clinicians moved into the 20th century, there was a move away from using hysteria

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as an explanation and instead, describing these dissociative aspects of the mind as more adaptive rather than always pathological.

What these researchers and clinicians focused on is relevant to current research. Currently researchers are also looking at the mind's ability to separate and often protect the individual from various stimuli, (as in repression or other defense mechanisms) both related to trauma and distress and in every day life (Hilgard, 1977).

Hilgard, (1977) believes that the unification of consciousness is illusionary, that people do more than one thing at a time and the conscious representation of all the actions going on are never fully represented in complete observation (hence the independent observer). He suggested that our awareness shifts and that we are able to divide and provide selective attention. These selective attention processes can be motivated differently. Dissociation is described as an expansion of this.

The most symptomatic and potentially disruptive dissociation, Dissociative Identity Disorder, (formerly Multiple Personality Disorder) has been clinically recognized since 1815 (Ellason & Ross, 1995). By 1910, similar to recent arguments, many clinicians argued that hypnosis was causing the disorder. When, in mid-century, a decline in interest in dissociation occurred, (partially due to Bleuler's coining of the term schizophrenia which was characterized as a "splitting" of the personality)there was a renewed focus on female histrionics.

Currently research shows that even now, as many as 24% to 49% of patients with DID have been previously diagnosed with schizophrenia even though there are a number of factors that differentiate the two (Ross, Anderson, Fleischer & Norton, 1995). It has only been recently that there is a move away from the mal-adaptive nature of much female symptomology.

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Dissociation

The essential feature of dissociation is a disruption in the usually integrated functions of consciousness, memory. identity or perception of the environment. It can be seen as sudden, gradual, transient or chronic (DSM IV, 1994). Common dissociation can be experienced by the majority of males and females and is represented by the lower end of the continuum of dissociative responses (Briere & Runtz, 1988; Hilgard, 1977; Kluft, 1986, 1993). These experiences can be described as "spacing out", losing time while driving, being so engrossed by a show or book that time perception is altered and other more common daydreaming experiences. (Bernstein & Putnam, 1986).

The middle and upper end of the continuum of dissociative responses is represented by symptoms that are classified as more pathological (Briere et al, 1988; Hilgard, 1977; Kluft, 1993; Terr, 1994). Currently in the DSM IV (1994) these are classified in Dissociative Disorders. On the farthest end of the continuum is the Dissociative Identity Disorder (DID) (formerly MPD)(Kluft,1986, 1993). This is described as two or more identities or personality states that recurrently take control of behavior and that each have their own relatively enduring pattern of perceiving, relating to and thinking about the environment and self (DSM IV, 1994).

The DID individual is unable to recall large sections of personal information, the loss of which is too extensive to be attributed to normal forgetfulness and is not due to physiological effects of a substance or a medical condition. Other dissociative disorders that fall near the upper end of the continuum are: Dissociative amnesia; an inability to recall often traumatic or stressful events, Dissociative Fugue; sudden unexpected travel away from home or customary environment, accompanied by the inability to recall one's past and confusion of identity or assumption of a new identity, Depersonalization Disorder; characterized by persistent or recurring feeling of being detached from one's mental

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process and or body that is accompanied by intact reality testing and Dissociative Disorder not Otherwise specified; the predominant feature being dissociative symptoms but not enough to meet criteria for specific dissociative disorder (DSM IV, 1994).

Many dissociative symptoms are also included in criteria for Acute Stress Disorder, PTSD and Somatization disorder (DSM IV, 1994). It is also important in looking at dissociative symptoms, to have a cultural evaluation because dissociative responses can be the norm for certain populations such as certain religious or tribal based population. It is noted in the DSM IV (1994) and elsewhere, that dissociative responses should not be considered inherently pathological (Briere & Runtz, 1988; Hilgard, 1977).

Bernstein and Putnam (1986) defined dissociation as the lack of normal integration of thoughts feelings and experiences into the stream of consciousness and memory. Malinosky-Rummel and Hoier (1992) defined dissociation as a response to traumatic stimuli which involves a breakdown in the typical correspondence between and/or within the three behavioral response modes including cognitive, motor and physiological responses. Other researchers have broken down dissociation into different types (Fredrickson, 1992; Hilgard, 1977; Kluft, 1993). The main divisions are flashbacks, which can not always be observed, (especially if it only involves a visual memory rather than a body response) and escape, which can result in complete immobility of the body and unawareness of one's environmental surroundings.

This dichotomy of hyper-arousal and intrusions live that side by side with numbing and constriction of dissociation, appears to give the symptomatic individual a type of subjective control. For them, the world has been so out of control that they may feel they are protecting themselves through dissociating. In reality, high levels of dissociation protect the trauma and can create a disengagement from life and treatment (Harvey & Herman, 1994; Kluft, 1986). Part of the therapist's work, then, is to help the client recognize and

process when they dissociate and look at whether it is avoidance or an attempt to connect to a memory (Braun, 1984; Hilgard, 1977; Wilson and Lindy, 1994).

Ross et al., (1992) found that dissociative experiences are common among psychiatric inpatients who may have numerous mis-diagnosis. They suggest that if these individuals, classified sometimes as schizophrenic or psychotic, are screened more carefully, they would possibly fulfill the diagnostic criteria for dissociative disorder.

It has also been suggested that the resiliency and resourcefulness of those with dissociative disorders are often overlooked. Morrow and Smith (1995) support the theory that, what at first appears to be a profusion of dysfunctional symptoms, is really a rational and reasonable coping strategy given the extremity of the stressors. They suggest this is a needed area of dissociation research.

Family Systems

The family is where the child learns the rules of what to feel and how to express those feelings. This learned expressiveness is then translated to social skills and peer interactions along with confidence in ones own self-understanding. (Haberstadt et al., 1995). It is suggested, that if the family system or environment is dysfunctional and the child feels he or she cannot vent and express the needed anger, fear and other emotions, then the need to dissociate occurs more and more often. It then becomes reinforced and strengthened through its calming effect.

Research has shown that level of parental support, victim's attribution style, methods of coping with the abuse and the severity of the abuse are related to adjustment following sexual abuse (Gold et al., 1994). Nash et al. (1993) found that these abusive families, have more conflict and are more pathological in their behavior than non abusing families, that they have higher levels of boundary confusion (cohesiveness) and are more behaviorally rigid (lack of expressiveness).

Nash et al. hypothesized that adult pathology associated with CSA may reflect the effects of this type of pathogenic home rather than that of the effects of CSA. In testing for the main effect of CSA independent of the perceived family environment, Nash et al. (1993) found CSA females as being more dissociative than non abused . They suggested that the perceived family environment is an important mediating variable in determining general levels of adult distress. Haberstadt et al. (1995) found that emotional expressiveness has only recently been looked at as an important factor in the development of dissociative symptoms. These researchers defined expressiveness as a persistent pattern of style exhibiting verbal and non verbal expression that often, but not always, is emotion related. They suggest that the family environment is where the child learns emotional expressiveness and that the interrupted normal development can have an impact on interpersonal and intrapersonal relationships in adult life. In studying expressiveness in female resiliency against depression, they found that those subjects who saw their family systems as having low expressiveness, experience a higher rate of anger and over all affect intensity. It is possible that this dynamic then can lead to a greater need to dissociate in the CSA victim.

Mallinckrodt et al.(1995) suggested that severe sexual abuse, along with family dynamics, may interfere with interceptive awareness (the ability to perceive and label internal emotional states and hunger). It appears possible that the family dynamic of low expressiveness can add to this low interceptive awareness. These researchers support the theory that the greater the dysfunctional attachment , of those individuals with sexual abuse histories, the more these individuals will describe high family conflict, low cohesion and low expressiveness when answering a retrospective family questionnaire.

Many researchers also appear to be interested in the mediating factors of attribution and motivational beliefs (Briere & Runtz, 1988; Goodwin & Attias, 1993; Hilgard, 1977; Miller et al., 1993) in relation to coping with trauma. They have attempted to understand

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why different people attribute the results and the control of these events in their lives to either internal or external causes and control. They suggest this is a weakness in dissociation research.

Mallinckrodt et al. (1995) suggested that the dynamics that include dysfunctional family environment, interrupted or nonexistent parent-child emotional attachment and the lack of the development of social competencies plays a role in the link between sexual abuse and eating disorders. They suggest that , especially with bulimia, the behavior is used to compensate for a lack of perceived effectiveness, especially within the family. The bulimic dissociation becomes a way to regulate very powerful emotions. Compared to non-abused women, incest survivors in their study described more dysfunctional attachment bonds and dysfunctional family environments.

Sexual trauma

CSA trauma, like that from war, natural disaster, or other tragic or disruptive events, has been described by clients and subjects of research as frightening, painful and psychologically overwhelming experiences which often are manifested into feelings of powerlessness, helplessness and lack of control (Morrow and Smith, 1995). These individuals described subsequent effects that occur, such as intrusive memories, flashback recurring nightmares and other conditioned associations to the original abuse, as occurring during most of their life, along with the continual need to psychologically withdraw from these intrusive memories. (Braun, 1984; Briere & Runtz, 1988; Harvey et al., 1994; Kluft, 1982, 1986, 1993; Miller et al, 1993; Swett & Halpert, 1993).

It appears that the adult victim , who rates high on the dissociative scale, may be using the dissociation in similar ways that the child victim did. He or she may be attempting to find cognitive disengagement from the environment, where too many triggers are causing them to re-experience the same victimization (Hilgard, 1977; Kluft 1982, 1993, 1994; Terr, 1994).

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The disrupted attachment and individuation from CSA, that results in such extreme dissociation, is best understood through Bowlby's (1988) model of attachment. He theorized that attachment is any form of behavior in a person trying to obtain or maintain proximity to another individual who is perceived as better able to cope with the world. Bowlby felt that both parents provide a secure base from which the child can venture and return while developing independence. This base not only provides physical and mental soothing but helps to create object permanence and the ability to self-soothe by memory. Rybici, Lepkowsky and Arndt (1989) and Sansone , Fine and Dennis, (1991) suggested that the dysfunctional family system's stress and conflict create an inability to find attachment and an intolerance for both loneliness and separation. This creates within the child a need to tune out the lonely and frightening world around them.

Briere and Runtz (1988) looked at the developmental process of a child and how the growing abused child's energy is often focused on meeting or avoiding the violence of the abuser. They suggest that this pulls energy away from the developmental tasks of individuation and separation. Where the child should be developing a sense of self-efficacy and autonomy, he or she develops a traumatic bond with the abuser and a life full of identity confusion, a sense of emptiness, and the inability to be soothed or self-soothe.

Briere and Runtz (1988) felt that sexual abuse involves the exploitation of what is "love" and the trusted relationship. In the extremely violent and or enduring sexual abuse situations the trust is so violently destroyed that these researchers hypothesize such individuals need the most intense levels of dissociation to survive, a way to distance themselves from a nightmare world. They used a non-clinical group of female sexual abuse victims and compared them to a control group of non-abused female college students and evaluated levels of functioning.

Current symptoms and the individual characteristics of the abuse situation including types of sexual abuse (penetration ,ritual), family dynamics, age of victim, age of oldest

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abuser, family relationships, duration of abuse and number of incidents was also recorded. It does not appear that they controlled for history of interventions or hospitalizations. Using the Hopkins Symptom Checklist (HSC) to look at both an acute condition of dissociation and a chronic one, Briere and Runtz found that university women with sexual abuse history reported higher levels of acute and chronic dissociation along with greater depression, somatization and anxiety than the non-abused women. They were somewhat concerned that college requires a certain level of functioning and that their findings on functioning levels of non-clinical CSA adult women are conservative. This may also create a false number of healthy samples, that in reality have CSA histories.

Nash et al. (1993) agreed with the clinical observations that sexually abused clients are more dissociative, but argued that researchers cannot attribute the dissociation to sexual abuse per se but need to look at the context in which it is embedded, especially in the interpersonal context. They suggest that researchers and clinicians must consider all pathogenic properties (e.g. social, economic, familial along with attribution distortions) which could complicate interpretation of retrospective studies. It may well be that powerlessness and lack of control of CSA victims, when compounded by family systems that reinforced these affects, creates the greatest need to dissociate.

Co-morbidity

Researchers have been focusing on how dissociative factors are manifested in the symptomology of eating disorders, (more often in bulimia), self mutilation, obsessive compulsive disorders and drug abuse (Kluft, 1993; Miller, et al., 1993; Waites, 1993). It appears that many of these dual-diagnosed patients have histories of hospitalization, multiple suicide attempts, somatic complaints, high hypnotizability, history of spouse abuse and other forms of re-victimization (Miller et al., 1993; Torem, 1986).

Kluft (1986) hypothesized that often dissociation and conversion symptoms are closely related and that MPD (now DID) and other dissociative adults often manifest borderline

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symptomology more than any other disorder. Nash, et al (1993) suggests that the impulsivity, identity disturbance, an unstable sense of self, angry outbursts and self mutilation of borderline sypmtomology is related to dissociative states or separate personalities. Berkowitz and Perkins (1988) felt that the dysfunction of the family system yet the need for social support is a major source of conflict for the CSA victim and the BPD client. Nash et al. (1993) suggest that in MPD, the borderline symptomology appears because different personalities present different moods and reactions. He suggests that MPD may well be a subgroup of borderline personality rather than the other way around. Kluft (1986) though argued that not all individuals with borderline personality disorder develop MPD.

The DSM IV (1994) describes DID (formerly MPD) as having two or more distinct identities or personality states that recurrently take control of behavior. If any of the personalities have hostile motivations, the individual can present a very destructive or chaotic life style. Kluft (1993) describes DID as disaggregate-self state disorder.

DID then, can be understood as a transient, episodic, recurrent dissociative psychosis of traumatic origin. These symptoms are similar to PTSD, yet in DID, there is the added dimension that the individual, during these dissociative experiences, feels like distinct separate people are inside, there are multiple memory gaps and a great discontinuity of attitude and experience (Greaves, 1993). To help clarify diagnosis and treatment direction of DID, some of the more subtle symptoms that clinicians can look for that are: a history of incest, cult or ritual abuse, headaches, amnesia, blank periods-loss of time, trance behaviors, rapid shifts in symptoms, using we in dialogue, history of accusations of lying, multiple suicide attempts, history of failed diagnosis and failed treatment, and borderline symptomology (Braun, 1986;Kluft, 1993, 1994). Multiple personalities represent in some sense an effort in coping with a very difficult childhood (Hilgard, 1977; Kluft, 1986, 1993; North et al., 1993).

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Torem, (1993) felt that eating disorders are being discovered in large groups of subjects with dissociation and MPD. Researchers have found multi-dimensional and dual diagnosed eating disorder subjects. They suggest that the eating disorder was possibly an extended syndrome of psychological suffering and a form of dissociation (Kluft, 1993;Miller, 1993; Torem, 1993). What is especially interesting is, that it appears with DID, different ego states or alters may be manifested in different aspects of the eating disorder. One may be related to the original anxiety, one with the bingeing, another to the vomiting (Miller, 1993).

Goodwin and Attias (1993) saw eating disorders as providing a number of functions. The process can keep memories away by subduing any emotion or feeling that could be used to connect to the memory. It could decrease the affects of PTSD; high anxiety, anger and explosiveness through creating a natural opiate response (Van der Kolk, 1987). The binge/purge behavior can also be a form of self punishment and pain that keeps the client from working through the memories. Clinicians suggest that this occurs as a result of the shame and guilt that is kept in an endless cycle with the punishing behavior (Goodwin, 1993; Miller et al., 1993).

Steinberg, Tobin and Johnson (1990) found that one-third of their eating disorder subjects had borderline tendencies, were depressed and had great dependency on external measures for mood regulation and self soothing. Bulimic behaviors and self mutilation, more than other symptoms, appears to help create some of this regulation by narrowing the individual's focus of attention as in a dissociative state (Heatherton & Baumeister, 1991; Nigg et al 1992). Root (1991) also hypothesized that eating disorders, especially bulimia, are a result of post traumatic stress disorder reactions to earlier sexual abuse and that the victim may be using the bulimic behaviors as a way to (dissociate) avoid the traumatic memories.

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This complicated picture of multi-layered syndromes associated with dissociation is extremely important if one is to begin to work through the trauma response of CSA victims. Too many clients spend years in therapy with mis-diagnosis and an inability to find root causes of the problems (Miller et al., 1993; Speigel, 1986).

Treatment concerns, future research and validation of DID

Dissociation research is an integral part of developing effective treatment for CSA victims. Dissociation, Kluft (1986) suggested, is a catch 22 for dissociative client in therapy. The individual has been victimized and exploited by an abuser yet must make him or herself vulnerable in therapy. He suggests that the dissociative client must learn to trust the therapist when initially what he or she may see, is another authority figure that could abuse them. If there is any sense of danger, now matter how real or imagined, the client may tend to dissociate. This may cause blocks in the therapeutic process of working through emotions.

Some dissociation may be beneficial to use in bridging to repressed memories (Fredrickson, 1992). This is often an unconscious response and if the therapist is watchful they can learn how to recognize the dissociation, use it to access memories and avoid triggers for the client's fear. Harvey and Herman (1994) suggest that memories are retrieved in a number of different ways depending on how the original abuse differs on different dimensions. These include age at which the original events occurred, the frequency, the duration, chrononicity and degree of violence and violation which attended these events and the social and etiologic context in which they occurred.

Harvey and Herman suggest most patients enter therapy for help in managing the distress of either totally recalled memories, partially recalled memories or feelings surrounding the possibility of totally repressed memories. Part of the therapeutic work, then, should involve containment of the runaway affect and a stabilization of daily functioning. These researchers stress that the focus of this type of therapy is not always to

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uncover more and more trauma but to learn to integrate the memories into a way that CSA victims can grieve the past and continue to move on and not have such a need to dissociate. The research of the etiology of dissociation can give these clinicians more tools to work with containment.

Haberstadt et al. (1995) and Nash et al. (1993) suggested that, when designing and treatment, clinicians should look at the normal developmental process and see how these pathogenic factors in which the abuse is embedded, interrupted the process. They believe that for many of these individuals, much of this pathology originated as survival skills. Research on dissociation can also benefit the validation and treatment of DID. Kluft (1986) proposes that two positions dominate the controversy of DID. One is that DID is a psychiatric disorder in its own right which has a unique and stable set of symptoms, of which one is dissociation. Once dissociation is verified by valid and reliable measures, he feels that laboratory evidence documenting different physiological changes between distinct personalities can correlate with the dissociative measures. Kluft also recommends that opponents of DID, who argue that it is created by either willful or misguided individuals or iattrogenic phenomena brought on by the therapist through indirect or direct suggestion or hypnosis can be influenced by more substantive research. These opponents may be influenced to not classify clients presenting with DID as histrionic, hysterical borderline, an individual avoiding responsibility or actually pretending to the point of self belief, if these clinicians are provided with clear scientific data.

Kluft suggests that this disbelief can re-victimizes the client who already has a history of victimization. This is a strong incentive behind the development of new dissociative research and DID diagnostic measures. He further suggests that there are also many types of presentations of DID and that part of problem for both diagnoses and belief in the disorder, comes from seeing DID as one type presentation or only going with media description. He lists at least 22 presentations that he has seen and hypothesizes that,

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although the prevalence is really unknown at this time , from his own research, he has found that 1 out of 100 adults have DID with an average of 6-16 personalities.

Sachs (1984) believed that DID is strongly related to the clients pre-existing social systems. Even protecting the client from these symptoms does not reverse symptoms. Sachs feels that one must look at the parts of that social system that are destructive and either work through and or disengage the client from those systems. This includes but is not limited to seeing where the client fits into the family system both past and present. Was it their parent that abused? What family members intervened? Are they an DID parent? Sachs feels that, if the patient comes from a dysfunctional support system, it is especially important to develop new strong ones through group processes, assertiveness or self esteem groups, possible parenting classes to learn nurturing parenting, learning about leisure, drug counseling if needed and learning ways to develop healthy relationships

It is in the debate of repressed memories that dissociation research, especially in the area of the developmental and pathological development of dissociative symptoms, can help provide more factual evidence relating to the mind's ability of detaching and distancing itself from trauma. Dissociation research not only benefits the
study of how CSA victims develop the symptomology but also can help in early interventions with CSA and other catastrophic trauma victims who may develop post traumatic stress disorder (PTSD) and dissociative symptoms soon after the event (Benningfield, 1992; Fredrickson, 1992; Terr, 1994; Walker, 1991). It is hoped that data provided by our research will help provide a foundation for more effective intervention and treatment techniques.

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CHAPTER III

METHOD

Participants

83 female and 58 male participants, ages ranging from 17 years old to 49 years old voluntarily participated through requests of their professors at both a southwest junior college and a southwest state college. These participants were mostly Caucasian (n=108) with smaller representations of other ethnic populations; African American (n=3), Native American (n=12), Hispanic (n=2), Asian (n=5) and 7 participants only rating themselves as other. Although all participants participated on a volunteer basis, some were presented the option of receiving extra credit for participation. (See Table 1A for further clarification.)

Instrumentation:

Demographic Sheet. -(DS)

The DS was a demographic sheet expanded from a pilot project in 1992. It has not been tested for validity or reliability. Use was oriented to separate out subjects with sexual abuse history from those with physical, emotional or no abuse history. It also included questions relating to relationship to the perpetrator(s), frequency of the sexual abuse, other traumatic life experiences, adult victimization and age at onset of the sexual abuse of the victim. Analysis of these mediating variables has not been done. Future analysis will look for significant interactions with CSA in relation to dissociation magnitude.

The Family Environment Scale: 2nd Edition, (Moos & Moos, 1986)

The FES was used as a retrospective scale to look at family dynamics. Participants were asked to answer the questions in relation to the family system that they grew up in. An extra sheet was added to the packet to remind them of this focus.

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The scales : cohesiveness, conflict and expressiveness were analyzed in relation to their standard scores. Scores were classified as low (Standard scores of 0 through 39), medium (Standard scores of 40-59) and high (standard scores of 59 and higher). This matched the FES standard scores of considerably below average: 0-39, average: 40-59 and considerably above average: 59 and higher.

The FES, a 90 item paper and pencil instrument measures social and environmental characteristics of families. It is based on a three dimension conceptualization of families; with subscales for each section. There are three forms of the FES but the Real form (Form R), measuring an individual's perception of their true family environment was deemed most appropriate. Reliability and validity were established through extensive testing (Moos & Moos, 1986).

The form used in this study, included three scales; Cohesion, Expressiveness and Conflict. Internal consistency reliability estimates range on the Form R from .61 to .78. Test re-tests reliability for 2, 3, 12 month intervals range from .52 to .91. The face and content validity are supported by very clear statements about family situations. The manual is said to provide extensive construct validity and other validity evidence.

Dissociative Experience Scale. (DES) (Bernstein & Putnam, 1986)

The DES is a 28 item instrument with scores ranging from 0 - 100 that are summed and divided by 28. It was designed to measure dissociation as the lack of normal integration of thoughts, experiences and feelings into the stream of consciousness and memory. In that the authors did not view dissociation as a problem in itself , the scale was designed along a continuum from minor distractions to the major psychopathology of DID (formerly MPD). We used the scores of 20 or above (Ross et al., 1992) as indicative of a disruptive / symptomatic dissociative disorder. A cut off of 30 or higher suggested the possibility of

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DID. The DES was designed from interviews with subjects diagnosed with dissociative disorders from the DSM III criteria (1987) and from interviews with experts. Median scores range from normals at 4.38, schizophrenics at 20.63, those with PTSD at 31.25 and DID at 57.06. Ross et al., (1992) suggests that the DES has good split half reliability with coefficients from eight groups ranging from .71 to .96. DES's stability over a four to eight week re-test had a reliability coefficient of 84.

The ability of the group median scores to differentiate MPD from other diagnostic groups has been replicated (Ross et al., 1992). DES performs well as both a predictor of MPD and general dissociative disorders. With its three subscales (amnesia, depersonalizing and absorption) the DES, through replicated studies, is highly reliable, internally consistent, strong in construct validity, a temporally stable instrument and has very good convergent/ discriminate validity(Bernstein and Putnam, 1986; Dubester and Braun, 1995). Subscales were not used for this study.

Procedure:

The pencil and paper instruments, counter-balanced, were handed out face down to participants. The experimenter read the confidentiality form: including information on obtaining counseling if questionnaires raised any sensitive issues - described the random order of the forms (to counter-act sensitivity or self-consciousness in answering the sexual abuse questions on the demographic sheet), gave a brief description of testing procedures , (including the right to leave), that people may finish at different times and described the research interest in family dynamics and cognitive functioning.

The packets were then completed by small groups of volunteer participants who chose designated times to participate or participated during a scheduled class period. Questions

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were answered in one sitting, between 25 to 45 minutes. Participants then brought packets forward and received a copy of the consent form and a form about counseling, complaints or obtaining end research . Confidentiality forms and questionnaires were kept separate.

CHAPTER IV

RESULTS

Statistical Analysis.

In order to test Ho:1 a 2 x 3 (sexual abuse history by level of family conflict- [SAHxFC] analysis of variance was conducted. Significant Main effect for SAH was found; F(1,123)= 11.130; p=.001, and a main effect for FC; F(2,123)= 4.682; p=.011. Cell means and results of this analysis are presented on Table 2. From Table 2 it can be seen that individuals for the sexually abused group scored consistently high across the three levels (Cell means: low 20.50; med. 21.71; high 21.30). This pattern is quite different than those found from the non abused individuals. In contrast, the means increased with the levels of conflict (cell means: low 6.50; med. 11.95; high 15.51).

In order to test Ho: 2 a 2 x 3 (SAH x level of family expressiveness- [SAH xFE]) analysis of variance conducted. A significant main effect for SAH was found; F(1, 135)=10.872; p=.001 and an interaction effect for SAH x FE; F(2,135)=5.904; p=.003. Cell means and results of analysis are presented on Table 3. From Table 3 the interaction can be seen where individuals for the SAH x FE high and low group scored significantly higher than those in the SAH x FE mid level (Cell means; low 25.57, med-12.20, high-36.50). In contrast the means for the non-SAH x FE group were low across all levels (Cell means; low-13.43, med-11.12, high-10.67).

In order to test Ho:2 a 2 x 3 (SAH x by level of family cohesiveness- [SAH x FCO]) analysis of variance conducted. A significant main effect was found for

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SAH: $F(1,135)=12.172$; $p=.001$ and a significant interaction effect for SAH x FCO: $F(2,135)=3.759$; $p=.026$.

Cell means and results of analysis are presented on Table 4. From Table 4 the interaction is seen where the individuals for the SAH x FCO high and low levels scored significantly higher than those in the SAH x FCO mid levels (Cell means; low-26.75, med-10.83 and high-24.00). In contrast, means for the no SAH x FCO scored low across all levels (Cell means; low-13.00, med-12.31, high- 9.16).

Hypothesis III:

In order to test Null Hypothesis III, a 2 x 3 (CSA by level of family cohesiveness- [CSA x FCO]) analysis of variance was conducted. A significant main effect was found for CSA: F observed $(1,135) = 12.172$; $p=.001$ and a significant interaction effect for SAH x FCO; F observed $(2,135) = 3.759$; $p=.026$. Cell means and results of analysis are presented on Table 4. From Table 4 the interaction is seen where the individuals for the CSA x FCO high and low levels scored significantly higher than those in the CSA x FCO mid levels (Cell means; low-26.75, med-10.83 and high-24.00). In contrast, means for the no CSA x FCO scored low across all levels (Cell means; low-13.00, med-12.31, high- 9.16).

The focus of this study was to determine if there was an interaction between the individual's experience of childhood sexual abuse (CSA) and the family dynamics of conflict, expressiveness and cohesiveness. It was expected that there would be an interaction between these variables and high scores on the Dissociative Experience Scale. The above findings support the rejection of the Null Hypothesis I, II and III, that there would be no difference between groups.

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CHAPTER V

DISCUSSION

Due to the small number of participants in the study, results should be interpreted with caution. Even so the preliminary findings are very encouraging. Not only does the clarification of the interaction of family dynamics with sexual abuse help to delineate the various etiologic factors affecting dissociation, but it may also help clinicians to understand how family dynamics also influence resiliency in the face of trauma. These findings are not only suggestive of the interaction between family dynamics and sexual abuse on dissociative magnitude but may also help clarify the relationship between dissociation and family dynamics independent of sexual abuse. This information may elucidate core factors behind both dissociation and resiliency regardless of trauma. Part of this clarification may come from further investigation of those who were sexually abused yet scored in the middle range of the standard scores for the three family dynamics; conflict, expressiveness and cohesiveness and the low range of the Dissociative Experience Scale.

It could be that this research possibly represents that if an individual is sexually abused and family dynamics restrict forms of emotional expression, that the individual may find a way to distance themselves from the trauma through dissociation. Berkowittz and Perkins (1988) suggested, that the dysfunction of the family system (in relation to borderline subjects who often have a sexual abuse history), becomes a major source of conflict for the sexual abuse victim and symptoms (such as dissociation) that help distance from the conflict of family and the abuse are intensified.

Further clarification of the relationship of dissociation and these family dynamics to levels of depression or anxiety, amnesiac barriers to memory of the abuse, social anxiety

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and levels of emotional lability may provide additional insights into how differing family dynamics affect coping strategies and symptom development. One must also look at the compounding variables such as relationship of the abuser. duration of the abuse type of abuse and interventions to fully clarify how the family system truly affects the individual's coping style in adult life. The delineation of these factors is not for the mere research value of understanding the etiologic base of dissociation. Here also is a source of rich information that can be utilized by clinicians. As the different components of sexual trauma symptom development are understood, the clinician not only has a data base from which he or she can develop effective treatments for adult survivors of sexual abuse; such as understanding what symptoms may be underlying presenting issues. They may also gain the ability to form possible hypothesis of the client's locus of control and attitudes towards self efficacy and apply this to early intervention. In a time when preventive treatment is becoming more and more a clinical focus, this information can also provide an understanding of resiliency factors that can be applied to both cognitive and behavioral interventions.

The findings of this present study support Kluft's (1986) and Briere's (1989) research that suggests there are many traumatic factors, such as family functioning (FF), that are manifested within the childhood sexual abuse (CSA) relationship and that these factors influence the development of multi-layered psychopathology, including dissociation. This is important information for therapists who may see cognitive distortion, dysfunctional interpersonal and intimacy problems, panic or depressive disorders, or even learning disabilities presented as initial complaints in the counseling relationship. Dissociation can both mask or underlie these problems. Understanding the origin of such presenting symptoms can facilitate treatment.

This study's findings suggest that a clinician could be presented with certain family dynamics such as high or low expressiveness, high or low cohesiveness or high family

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conflict, compounded by sexual abuse and be receptive to the possibility of a dissociative profile. They could be presented with a highly dissociative profile with or without a sexual abuse presentation, and be sensitive to a variety of interpersonal dynamics that could be affecting the client's current functioning. The clinician could also be presented with only a history of sexual abuse and few symptoms and be sensitive to the subsequent emergence of dissociative or trauma related symptoms or dysfunctional interpersonal dynamics. All of this information can be applied to a more effective treatment plan for the sexual abuse client.

Within this study, the majority of those identifying the CSA occurrence and dissociative symptomology (n=21) were in the 0-7 age period (n= 14) and 8 to 16 year old age period (n=14) with some identifying both age periods. (See Table A1 and A2). Our significant findings also support the literature that suggests women and a smaller population of men with CSA histories have higher levels of dissociation than other control or experimental groups (Fredrickson, 1992; Kluft, 1986; Malinosky-Rummel and Hoier, 1992; Terr, 1994). (See Table 2, Table 3, Table 4). Future research needs to continue to clarify the many factors such as type of sexual abuse, duration of abuse, age that the abuse occurred, to see if any of these factors have an interacting or main effect on levels of dissociation or other symptoms. Once again , it is the delineation of these factors that can evolve more effective treatment plans and early intervention.

It is suggested that, overall, this current study's significant findings support research such as Nash et al.(1993) who suggest that the environment of the abuse may be more pathogenic than the abuse and that the pathology of dissociation and other aspects may be more a result of the family system than of CSA. The unexpected finding of a significant main effect of FF/conflict with no abuse helps support this theory. A highly conflictual family could create stress and high levels of anxiety and thus, a need to dissociate. Future researchers might want to control for, or investigate variables such as possible amnesia of

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the abuse, attachment and individuation dynamics, other traumatic life events and trait anxiety levels, to assess whether the pathogenic environment is the stronger variable in any interaction with trauma and the resultant symptomology.

To be able to provide a theoretical base to help the client understand how current behaviors may be reinforcing their symptom presentation, the clinician needs to understand how the interaction of CSA and FF are manifested in long term dissociative pathology (Braun, 1984; Briere, 1989; Fredrickson, 1992). This may be facilitated by researching attachment issues and adult interpersonal interactions. Researchers may discover, when finding dissociative factors that are significantly influenced by family dynamics and occurring during the formative years, that such dynamics may alter the child's ability to attach, separate, and have a belief in a safe world (Briere & Runtz, 1988; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993; Walker, 1991). They may see a relationship to adult interactions. The afore mentioned researchers suggest that this enduring symptom presentation occurs if sexual trauma creates a discontinuity in both physical and mental experience and may be reinforced. Subsequently, this dynamic may cause a breakdown in the typical correspondence of cognitive, behavioral and physiological responses between and within a person and their environment. If there is no intervention, the individual may continue these patterns into adult life. Future research could clarify how this response has been maintained or strengthened (Braun, 1986,; Briere, 1988,; Kluft, 1986, 1993, 1994). Variables such as different types of negative reinforcement such as disclosure with a negative response(which includes no response), subsequent adult abuse, other life crises, frequency of sexual abuse and who the perpetrator was may be mediating variables.

What is imperative and underlying this and other CSA research, is an expectancy that, as more researchers and clinicians understand the development of trauma symptoms, the better able they are to develop effective, early intervention and treatment modalities.

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Such research can also provide data relating to resiliency factors in those who have CSA histories but do not develop extensive symptoms. This may be an important component to developing intervention models for treatment of recent victims, whether abuse or community disaster.

This research's limited findings do support the hypothesis that CSA dissociative phenomena occurs in similar patterns to PTSD war victims, where lapses of memory, validity of flashbacks, have been empirically tested. These findings , along with other research correlated to the more accepted war and violence PTSD, may help identify and give validity to the way CSA dissociative factors are manifested in the victim's repression of memories. It is suggested, that this type of research, provides supports for the mind's ability to close off or close down, or hide away. This could provide more empirical validation for the phenomena of repressed memories. Such results could impact the development of valid measures sensitive to the possibility of repressed memories and new treatment procedures to access the CSA client's memories. (Benningfield, 1992; Bernstein et al., 1986; Fredrickson, 1992; Swett & Halpert, 1993).

Findings also support and lay foundations for future research in regard to the way symptoms of eating disorders, self mutilation, obsessive compulsive disorders, drug abuse and other patterns of distancing from the abuse, may have a dissociative quality (Waites,1993). Thus dissociation research not only benefits the study of CSA victims and trauma victims, but will also prove beneficial to the general investigation of the cognitive process and the study of both the unconscious and conscious mind.

Future research

In the Discussion section above, several suggestions were made for future research. Additional questions that are important to address are :

1) Will different types of CSAH, (penetration, fondling, exposure to sexual material) , duration and frequency of abuse, or the relationship of perpetrator to the victim have an

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effect on levels of dissociation and on other symptom development?

2) Will dissociative levels be higher with adults with CSA that also have adult victimization? 3) Does perceived supportive or negative response after disclosure affect levels of dissociation in CSA subjects? 4) Are there other unknown mediating factors; Intervention in life of victim, other major life crisis, attribution style of victim, demographics (socioeconomic) and age of victim, that affect levels of dissociation?

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References

American Psychiatric Association (1984). Diagnostic and Statistical Manual of Mental Disorders. (4th ed.). Washington, D. C. : Author.

Benningfield, M. F. (1992). The use of hypnosis in the treatment of dissociative patients. Journal of Child Sexual Abuse, 1, 17-31.

Berkowitz, A. & Perkins. H. W. (1988). Personality characteristics of children of alcoholics. Journal of Consulting and Clinical Psychology, 56, 206-209.

Bernstein, E. M. & Putnam, F. W. (1986). Development reliability and validity of a dissociation scale. The Journal of Nervous and Mental Disorders, 174, 727-735.

Bloch, E. L. (1991). Post-traumatic stress disorder: Therapeutic approach-avoidance: an illustrative case. Psychotherapy, 28 , 162-167.

Braun B. G. (1984). Towards a theory of MPD and other dissociative phenomena. Psychiatry Clinical North American, 7, 171-193.

Braun, B. G. (1986). Issues in psychotherapy of multiple personality disorder. In Braun, B. G. Treatment of Multiple Personality Disorder. (pp. 1-28).Washington, D. C.: American Psychiatric Press.

Briere, J. & Runtz, M. (1988). Symptomology associated with childhood sexual victimization in a non-clinical adult sample. Child Abuse and Neglect,12, 51-59.

Briere, J. (1989). Therapy for Adults Molested as Children: Beyond Survival. New York: Springer Publishing Company.

Bryer, J. B., Nelson, B. A., Miller, J. B. & Krol, P. A. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. American Journal of Psychiatry, 144, 1426-1430.

Burkett, L. P. (1991). Parenting behaviors of women who were sexually abused as children in their families of origin. The Family Process, 30, 421-433.

Bryer, J. B., Nelson, B. A., Miller, J. B. & Krol, B. A. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. American Journal of Psychiatry, 144, 1426-1430.

Collings, S. J. (1994). The long-term effects of contact and non-contact forms of child sexual abuse in a sample of university men. Child Abuse and Neglect, 19, 1-6.

Dubester, K. A. & Braun, B. G. (1995). Psychometric properties of the dissociative experiences scale. The Journal of Nervous and Mental Disease, 183, 231-235.

Ellason, J. W. & Ross, C. A. (1995). Positive and negative symptoms in dissociative identity disorder and schizophrenia: A comparative analysis. The Journal of Nervous and Mental Disease, 183, 236-241.

Everill, J. & Waller, G. (1994). Disclosure of sexual abuse and psychological adjustment in female undergraduates. Child Abuse and Neglect, 19, 93-100.

Everstine, D. S. & Everstine, L. (1993). The Trauma Response: Treatment for Emotional Injury New York: W. W. Norton & Co.

Forward, S. & Buck, C. (1978). Betrayal of Innocence and Its Devastation. New York: Penguin books.

Fredrickson, R. (1992). Repressed Memories: A Journey to Recovery From Sexual Abuse. New York: Simon and Schuster.

Gold, S. R., Milan, L. D., Mayall, A. & Johnson, A. E. (1994). A cross-validation study of the trauma symptom checklist: The role of mediating variables. Journal of Interpersonal Violence, 9, 12-26.

OKLAHOMA STATE UNIVERSITY

Goodwin, J. M. & Attias, R. (1993). Eating disorders in survivors of multimodal childhood abuse. In Kluft, R. P. (eds.), Clinical Perspectives on Multiple Personality Disorder. (pp. 327-342), Washington D. C.: American Psychiatric Press.

Greaves G. B. (1993). A history of MPD. In Kluft, R. P. (eds.), Clinical Perspectives Multiple Personality Disorder. (pp. 355-380).Washington D. C.: American Psychiatric Press.

Haberstadt, A. G., Cassidy, J., Stifter, C. A., Parke, R. D. & Fox, N. A. (1995) Self-expressiveness within the family context: Psychometric support for a new measure. Psychological Assessment, 7, 93-103.

Harvey, M. R. & Herman, J., L. (1994). Amnesia, partial amnesia and delayed recall among adult survivors of childhood trauma. Consciousness and Cognition, 3, 295-306.

Heatherton, T. F. & Baumeister, R. F. (1991). Binge eating as escape from self awareness. Psychological Bulletin, 110, 86-108.

Hilgard, E. R. (1977). Divided Consciousness: Multiple Controls in Human Thought and Action. New York: John Wiley and Sons Inc.

Inderbitzen-Pisaruk, H., Shawchuck, C. R. & Hoier, T. S. (1992). Behavioral characteristics of child victims of sexual abuse: A comparison study. Journal of Clinical Child Psychology, 21, 14-19.

Kluft, R. P. (1982) Various interventions in the treatment of multiple personality disorder. American Journal of Clinical Hypnosis, 24, 230-240.

Kluft, R. P. (1986) Personality unification in multiple personality disorder: a follow up study. In Braun, B. G. (eds.) Treatment of Multiple Personality Disorder. (pp. 29-60). Washington, D. C.: American Psychiatric Press.

Kluft, R. P. (1993). Clinical Perspectives on Multiple Personality Disorder. Washington D. C.: American Psychiatric Press.

Kluft, R. P. (1994) Counter transference in the treatment of multiple personality

OKLAHOMA STATE UNIVERSITY

disorder. In Wilson, J. P., & Lindy, J. D., (eds.) Countertransference in the Treatment of PTSD. (pp. 122-150). Guilford Press: New York.

Malinosky-Rummel, R. R. & Hoier, T. S. (1992). Validating measures in sexually abused and non-abused children. Psychological Assessment, 13, 341-357.

Mallinckrodt, B., McCreary, B. A. & Robertson, A. K. (1995). Co-occurrence of eating disorders and incest: The role of attachment, family environment and social competencies. Journal of Consulting Psychology, 42, 178-186.

Miller, D. A., McKlusky-Fawcett, K. & Irving L. M. (1993). The relationship between childhood sexual abuse and subsequent onset of bulimia. Child Abuse and Neglect, 17, 305-314.

Moos,R. & Moos, B. (1986). Family Environment Scale Manual. (2nd ed.) Palto Alto, Calif.: Consulting Psychologists Press.

Morrow, S. L. & Smith, M. L. (1995). Constructions of survival and coping by women who have survived childhood sexual abuse. Journal of Counseling Psyc ology, 42,24-33.

Nash, M., R., Hulsey, T. L., Sexton, M. C., Harralson, T. L., & Lambert, W. (1993) Long term sequela of childhood sexual abuse : perceived family environment, psychopathology, and dissociation . Journal of Consulting and Clinical Psychology, 61, 276-283.

Nigg, J. T., Lohr, N. E., Westen, D., Gold, L. J. & Silk, K. R. (1992). Malevolent object representations in borderline personality disorder and major depression. Journal of Abnormal Psychology, 101, 61-67.

North, C. S., Ryall, J., M.. Ricci, D., A., & Wetzel, R. D. (1993). Multiple personalities, Multiple Disorders ; Psychiatric Classification and Media Influence. New York: Oxford University Press.

OKLAHOMA STATE UNIVERSITY

Parker, G.. Tupling, H. & Brown, L. B. (1979). A parental bonding instrument. British Journal of Medical Psychology, 52, 1-10.

Putnam, F. W. (1986). Treatment of multiple personality: state of the art. In Braun, B. G. (eds.)Treatment of Multiple Personality Disorder.(pp. 175- 198). Washington, D. C.: American Psychiatric Press.

Root, M. P., Fallon, P. & Fredrich, W. N. (1985). Bulimia: A Systems Approach to Treatment. New York: W. W. Norton.

Ross, C. A., Anderson, G., Fleisher, W. P. & Norton, G. R. (1992). Dissociative experiences among psychiatric inpatients. General Hospital Psychiatry. 14, 350-354.

Rybicki, D. J., Lepowsky, C. M. & Arndt, S. (1989). An empirical assessment of bulimic patients using multiple measures. Addictive Behaviors, 14, 249-260.

Sachs, R. G. (1986). The adjunctive role of support systems in the treatment of multiple personality disorder. In Braun, B. G. (eds.). Treatment of Multiple Personality Disorder (pp. 175-198).Washington, D. C.: American Psychiatric Press.

Sandberg, D., Lynn, S. J. & Green, J. P. (1994). Sexual abuse and re-victimization: Mastery, dysfunctional learning and dissociation. In Lynn, S. J. and Rhue,J. W. (eds.), Dissociation: Clinical and Theoretical Perspectives (pp. 242-267). New York : The Guilford Press.

Sansone, R. A., Fine, M. A. & Dennis, A. B. (1991). Treatment Impressions and Termination experiences with borderline patients. Journal of Psychotherapy, 45, 173-180.

Speigel, D (1986). Dissociation, double binds and post traumatic stress in multiple personality disorder. In Braun, B. G. (eds.), Treatment of Multiple Personality Disorder (pp.61-78).Washington D.C.: American Psychiatric Press.

Steinberg, S., Tobin, D.& Johnson, C. (1990). The role of bulimic behaviors in affect regulation: Different functions for different patient sub-groups? The International Journal of Eating Disorders, 9, 51-55.

Sutker, P. B. & Allain, A. N. (1995). Psychological assessment of aviators captured in W.W. II. Psychological Assessment, 7, 66-67.

Swett, C., & Halpert, M. (1993). Reported history of physical and sexual abuse in relation to dissociation and other symptomology in women psychiatric patients. Journal of Interpersonal Violence, 8, 545-555.

Terr, L. (1994). Unchained Memories True Stories of Traumatic Memories, Lost and Found. New York: Basic Books.

Torem M. S. (1986) Eating disorders in patients with MPD. In Kluft, R. P. (eds.), Clinical Perspectives on Multiple Personality Disorder. (pp. 343-353). Washington D. C.: American Psychiatric Press.

Van der Kolk, B. A. (1987). Psychological Trauma. Washington, D. C.: American Psychiatric Press, Inc.

Waites, E. A. (1993). Trauma and Survival. New York: W.W. Norton and Co. Inc.

Walker, L. E. (1991). Post-traumatic stress disorder in women: Diagnosis and treatment of battered women syndrome. Psychotherapy, 28, 21-29.

Williams, M. B. (1994). Establishing safety in survivors of severe sexual abuse In Williams, M. B., and Sommer, J. F. (eds.), Handbook of Post-Traumatic Therapy. (pp. 162-178).

Wilson, J. P., (1994a). The need for an integrative theory of post-traumatic stress disorder. In Williams, M. B., and Sommer, J. F. (eds.), Handbook of Post Traumatic Therapy. (pp. 3-18).

Wilson, J. P., & Lindy, J. D., ed. (1994b). Countertransference in the Treatment of PTSD. New York: Guilford Press.

Yapko, M. D., (1995). Essentials of Hypnosis. New York: Brunner/Mazel Publishers.

APPENDIXES

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APPENDIX A
DEMOGRAPHICS

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TABLE A1
CHARACTERISTICS OF THE SAMPLE

Variable	n	PERCENTAGE OF TOTAL N
Sex		
Male	59	41.1
Female	83	58.9
Age (years)		
17 - 25	108	78.7
26 - 34	18	12.8
35-43	10	7.1
44 -49	2	1.4
Missing Age data	3	2.12
Ethnic Origin		
African American	3	2.1
Native American	12	8.5
Hispanic	2	1.4
Caucasian	108	76.6
Asian	5	3.5
Other	7	5.0
Missing Data	4	2.9
Marital Status		
Single	96	68.1
Married	34	24.1
Divorced	5	3.5
Separated	2	1.4
Missing Data	4	2.8
SES Status		
Low	22	15.6
Middle	89	63.1
High	26	18.4
Missing Data	4	2.9

TABLE A2
CHARCTERISTICS OF ABUSE

Variable	n	% of Total n
Type of Abuse		
Physical	25	5.64
Emotional	52	4.64
Sexual	21	6.42
Perpetrators		
father	13	9.2
mother	11	7.8
stepmother	2	1.4
step-father	5	3.5
grandmother	2	1.4
aunt	1	.7
uncle	6	4.3
male cousin	7	5.0
female family friend	2	1.4
male family friend	8	5.7
male stranger	3	2.1
other	12	8.5
Life Crisis at Time of Abuse		
Overall Total	20	14.2
Moving	9	6.4
Death	9	6.4
Divorce	8	5.7
Job Loss of Family Member	6	4.3
Other	7	5.0

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APPENDIX B

TABLES OF RESULTS

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Table 1

Sexual Abuse x Family Functioning-Conflict
DES Cell Means

	Low Conflict	Medium Conflict	High Conflict
No Sexual Abuse	Mean=6.50 (n=30)	Mean=11.95 (n=55)	Mean=15.51 (n=35)
Sexual Abuse	Mean= 20.50 (n=4)	Mean=21.71 (n=7)	Mean=21.30 (n=10)

Source of Variation	**Sum of Squares**	**df**	**F**		**Significance Level**
Main Effects					
Sexual Abuse:	1372.828	1	F	11.130	.001 sig.
Family Conflict:	1154.920	2	F	4.682	.011 sig.
2-way Interaction					
Sexual Abuse by Family Conflict	171.883	2	F	.697	.500 Ns

There is a main effect of a history of sexual abuse in predicting dissociation scores on the DES. There is a main effect of conflict with no sexual abuse on predicting higher dissociative scores on the DES. Conflict does not appear to affect the levels of dissociation for those who were sexually abused. Those who have a history of a highly conflictual family and have not been sexually abused appear to have higher levels of dissociation.

Table 2

Sexual Abuse x Family Functioning - Expressiveness
DES Cell Means

	Low Expressiveness	Medium Expressiveness	High Expressiveness.
No Sexual Abuse	Mean=13.43 (n=28)	Mean=11.12 (n=83)	Mean=10.67 (n=9)
Sexual Abuse	Mean= 25.57 (n=7)	Mean=12.20 (n=10)	Mean=36.50 (n=4)

Source of Variation	**Sum of Squares**	**df**	**F**		**Significance Level**
Main Effects					
Sexual Abuse:	1286.723	1	F	11.130	.001 sig.
Family Expressiveness:	602.976	2	F	4.682	.011 sig.
2-way Interaction					
Sexual abuse x Expressiveness	1397.468	2	F	5.904	.003 sig.

There is an interaction between a history of sexual abuse and levels of family expressiveness in predicting dissociation scores. Those who were sexually abused and experience lower and higher levels of expressiveness tend to have higher dissociative scores.

Table 3

Sexual Abuse x Family Functioning - Cohesiveness
DES Cell Means

	Low Cohesiveness	Medium Cohesiveness	High Cohesiveness
No Sexual Abuse	Mean=13.00 (n=27)	Mean=12.31 (n=61)	Mean=9.16 (n=32)
Sexual Abuse	Mean= 26.75 (n=8)	Mean=10.83 (n=6)	Mean=24.00 (n=7)

Source of Variation	Sum of Squares	df	F	Significance Level
Main Effects				
Sexual Abuse:	1510.937	1	F 12.172	.001 sig.
Family Cohesiveness:	287.467	2	F 1.158	.317 Ns
2-way Interaction				
Sexual abuse x cohesiveness	933.309	2	F 3.759	.026 sig.

There is an interaction between a history of sexual abuse and family cohesiveness in predicting dissociation scores on the DES. Those with a sexual abuse history and low or high levels of family cohesiveness tend to have higher dissociative scores.

Table 4

Dissociative Experience Scale Statistics

Mean	Standard Error	Standard Deviation	median	mode	range
13.064	.988	11.846	8.00	3.00	60.000

Percent of those scoring in 3 ranges

Mean Range = 0-19	Mean Range = 20-30	Mean Range = 30 and above .
78%	12%	10%

APPENDIX C

DEMOGRAPHIC SHEET

DEMOGRAPHIC SHEET
(DS, 1995)

1) Age __
2)Ethnic origin:
__African American __Native American __Hispanic
__White __Asian Other (please describe)______________________
3) Marital status:
__Single __Married __Divorced __Separated __Widowed
4) Please describe who raised you from birth to 17 years old: (parents, step parents, grandparents, etc.)____
5)Perception of family income from birth to 17 yrs. old:
__low income __middle income __high income

(Please read these definitions)

These definitions will provide a base by which to answer the next series of questions. These are not specific definitions but more to provide a context within which you may feel you have experience.

Sexual abuse will be defined on the demographic sheet as any touching or fondling of any body part, sexual remarks or exposure to any type of sexual material; anal, oral or genital penetration with objects, genitalia or other parts of the body and exposure to sexual acts between others.

Emotional Abuse will be defined on the demographic sheet as including but not limited to: demeaning communication that may have been expressed through unwarranted and consistent criticism of behaviors, looks and/or beliefs, ridicule of behaviors, looks and/or beliefs, intimidation through verbal threats, humiliation in public or private , forced behaviors through verbal intimidation, coercion and/or manipulation.

Physical Abuse will be defined on the demographic sheet as being physically hurt or attacked by someone that at times resulted in injuries that included but are not limited to; bruises, welts, scratches, cuts, scars, broken bones or severe to life threatening injuries. This occurred more than once and often without provocation. It may have also involved shaking, burning choking and use of lethal weapons.

DS

6) Were you abused in any way:
From 0 - 7 years old? __yes __no
Type of abuse: (check one or more)
__Physical __emotional __ sexual
How often: __every day __at least once or twice a week __at least once a month
__every 2-4 months __once or twice a year __once
7) From 7-16 years old? __yes __no
Type of abuse: (check one or more)
__Physical __emotional __sexual
How often: __every day __at least once a week __at least once or twice a month
__every 2-4 months __once or twice a year __once
8) From 16-30 years old __yes __ no
Type of abuse: (check one or more)
__Physical __emotional __sexual
How often: __every day __at least once a week __at least once or twice a month
__every 2-4 months __once or twice a year __once
9)From 30 years old and older __yes __no
Type of abuse: (check one or more)
__Physical __emotional __sexual
How often: __every day __at least once a week __at least once or twice a month
__every 2-4 months __once or twice a year __once
10) My abuser was :
__father __mother __step mother __step father __grandfather
__grandmother __aunt __uncle __male cousin __female cousin
__female family friend __male family friend __male stranger
__female stranger other(describe)________________________________
11) Did any other major life changes occur during the abuse period?
__yes __no
(If yes, please mark one or more): __moving __death __divorce
__job loss for one or both parents
other (describe)____
12) Have you ever been in a research experiment before?: __yes __no
13) Is psychology your major? __yes __no

END

APPENDIX D

INFORMED CONSENT

Informed Consent

Oklahoma State University / Applied Behavioral Sciences

I understand that I am being invited to participate in a research study sponsored by Oklahoma State University's Applied Behavioral Science and Education Department. This research is being conducted by Margaret Zingman and Donald Boswell, Ph. D. The purpose of this study is to examine the influence of perceptions of childhood family environment on coping strategies in adulthood. This research will take place at Oklahoma State University. The one-time procedure, which should last no more than one hour, will consist of participants filling out three randomly-ordered questionnaires.

There are no physical risks involved for those who choose to participate in this study. Some of the questions are of a personal nature that could be psychologically stressful to some of the participants. Should I have any discomfort and would like a counseling referral, I may call the researchers' numbers listed below

Benefits of this research are as follows: first hand observation of a psychology experiment, exposure to information regarding the research topic and taking part in helping clinicians develop intervention procedures.

I understand that confidentiality will be maintained. All measures and forms will be numbered only. There will be no use of my name, except on this release form, which will be kept separate from the study. Should this study be published, my name cannot be connected to the study nor could it be revealed. I will be assigned a participant number and this will be the only form of identification. I understand that my participation is completely voluntary and I may withdraw from the study at any time without penalty or loss of any benefit to which I may be entitled. If significant new findings develop during the course of the study that could relate to my willingness to continue in the study, they will be provided to me. I understand I will receive a copy of this consent form.

If I am interested in the results of the study I may contact Margaret Zingman at 918 836-7999 or Dr. Donald Boswell at 405 744-6036. Results of this research will be given to me upon request, once the project is completed.This study has been reviewed by the Institutional Review Board, an independent committee (as required by federal regulations) organized to look at ethical ramifications of research implemented by this University. It is composed of faculty and staff of Oklahoma State University, as well as lay members of the community who are not associated with the University, except through this affiliation. I may also contact Jennifer Moore at the Institutional Review Board at 405-744-5700 and will be given opportunity to discuss questions about participation in this project.

I understand the above and freely consent to take part in this research study.
I acknowledge receiving a copy of this informed consent.

Participant____________________________________ Date____________

Investigator___________________________________ Date____________

APPENDIX E
ADVERTISEMENT AND DEBRIEFING FORMS

ADVERTISEMENT
For Participation in an ABSED Psychology Experiment
(To be read in classes and posted)

Margaret Zingman and Dr. Don Boswell are looking for males and females, age 18 years old and older who are interested in participating in a psychology research project investigating the effects of childhood family functioning on coping strategies in adulthood. The experiment will consist of filling out three randomly ordered questionnaires that should take no more than 45 minutes to complete. There are no physical risks to this experiment although some of the questions are of a psychological nature that may be stressful to some of the participants. Your teacher will have dates and times available for participation. Those wishing to participate may inform their teacher who will provide the researchers with a list.

Margaret Zingman (918) 492-3607
Donald Boswell Ph. D.
Applied Behavioral Science and Education Department
Oklahoma State University

DEBRIEFING FORM

Post-Experiment Debriefing

Thank you for your participation . We had explained that we felt their were no physical risks involved in this research but that some of the questions were of a personal nature that could be psychologically stressful to some of the participants. If you have experienced this discomfort and are already involved with a counselor we encourage you to discuss this process with them. If you would like a counseling referral, you may call the researchers' numbers :

Margaret Zingman at 918 836-7999 or Dr. Donald Boswell at 405 744-6036.

Please remember that confidentiality will be maintained. All measures and forms will be numbered only. There will be no use of your name, except on the release form, which will be kept separate from the study. If you are interested in the results of the study, as was stated in the release form you may contact the researchers listed above. Results of this research will be given to you upon request, once the project is completed.

We also hope that if you feel the need to call the Institutional Review Board, an independent committee (as required by federal regulations) organized to look at ethical ramifications of research implemented by this University, you may also contact Jennifer Moore at the Institutional Review Board at 405-744-5700 and will be given opportunity to discuss questions about participation in this project.

Thank you for taking part in our research

Margaret Zingman
Donald Boswell Ph. D.
Applied Behavioral Science and Education Department
Oklahoma State University

APPENDIX F
IRB FORM

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 12-20-95 **IRB#:** ED-96-057

Proposal Title: CHILDHOOD SEXUAL ABUSE AND DISSOCIATION: RELATIONSHIP OF FAMILY FUNCTIONING TO DISSOCIATIVE MAGNITUDE

Principal Investigator(s): Donald Boswell, Margaret Zingman

Reviewed and Processed as: Modification

Approval Status Recommended by Reviewer(s): Approved

ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING.
APPROVAL STATUS PERIOD VALID FOR ONE CALENDAR YEAR AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.
ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Reasons for Deferral or Disapproval are as follows:

Modification received and approved.

Signature: Date: May 9, 1996

Chair of Institutional Review Board

VITA

Margaret Lee Zingman

Candidate for the Degree of

Master of Science

Thesis: CHILDHOOD SEXUAL ABUSE AND DISSOCIATION: THE RELATIONSHIP OF FAMILY FUNCTIONING TO DISSOCIATIVE MAGNITUDE.

Major Field: Applied Behavioral Studies

Education: Graduated from Barlow High School. Amenia New York in May 1973; received Bachelor of Arts Degree in Writing from Eckerd College, St. Petersburg, Florida in January of 1979; completed post-BA study in Psychology from University of Louisville in December of 1991 and Langston University, UCT in Tulsa, Oklahoma in May of 1994. Completed the requirements for the Masters of Science Degree in Community Counseling at Oklahoma State University in December of 1996.

Experience: Practicuum and Intern experience was completed at the Woman's Resource Center in Tulsa, Oklahoma from August 1994 through May of 1996. Counseling work was continued at this site during the time period between practicuum and internship. Employment history includes work at the above center from August, 1994 until present; Rehabilitation counseling through writing workshop at the Center for The Physically Limited in Tulsa, Oklahoma from September of 1992 through May of 1994. Case coordination and supervision of Guardian ad Litem crisis and investigation counselors, individual crisis counseling and family counseling for child abuse victims at the Guardian ad Litem in St. Petersburg, Florida from February of 1986 until May of 1988; Individual preventive counseling and community referral assistance at the Exchange Center for the Prevention of Child abuse in St.Petersburg, Florida from January of 1985 through December of 1985.

Professional Memberships: Student Affiliate (1991 - 1994) and Graduate Student Affiliate (1994 - present) of the American Psychological Association (APAG); American Association of University Women (AAUW), 1992 - present; past member of Psi Chi Psychology Honor Society 1990 -1992; Student Affiliate Member of the International Society for the Study of Dissociation (ISSD), 1996- present; President of the UCT Psychology Club, 1992-1992.