Suicidal thoughts and behaviours in former sexual abuse victims

JOHN BRIERE
Harbor-U.C.L.A. Medical Center
AND
MARSHA RUNTZ
University of Manitoba and Klinic, Inc., Community Health Centre

ABSTRACT

The relationship between childhood sexual abuse and subsequent suicidality was examined in 195 women presenting to the Crisis Intervention program of a community health centre. As predicted, former sexual abuse victims were considerably more likely to have made at least one suicide attempt in the past (55%) than were non-abused clients (23%), and were more likely to report suicidal ideation upon intake. Further analysis revealed that sexual abuse was specifically associated with suicide attempts which occurred in childhood or adolescence. Among former sexual abuse victims, greater suicidality was correlated with multiple perpetrators, concurrent physical abuse, and sexual intercourse. Childhood sexual abuse is hypothesized to result in lowered self-esteem, guilt and self-blame, perceived powerlessness, and interpersonal dysfunction – all of which may lead to increased self-destructiveness. Clinical implications of these findings are discussed.

Recent research on the incidence and effects of childhood sexual abuse challenges long-held assumptions and beliefs concerning sexual molestation. Current data suggests, for example, that approximately 1/5 to 1/3 of adult women have experienced sexual abuse during childhood or adolescence (Bagley & Ramsay, 1985; Briere & Runtz, 1985; Finkelhor, 1979; Russell, 1983), and that such victimization is often associated with enduring psychological dysfunction (see Browne & Finkelhor, 1986, for a review of these studies). Among other problems, long-term sequelae of sexual abuse appear to include depression, guilt, poor self-esteem, and feelings of inferiority (e.g., Brickman & Briere, 1984; Briere, 1984; Briere & Runtz, 1985; Herman, 1981; Jehu, Gazan, & Klassen, 1985; Meiselman, 1978; Peters, 1984; Tsai & Wagner, 1978), as well as interpersonal problems, delinquency, and substance abuse (e.g., Briere, 1984; Courtois, 1979; Herman, 1981; Tsai, Feldman-Summers, & Edgar, 1979; Benward & Densen-Gerber, 1975; Peters, 1984; Runtz & Briere, in press).

Given such effects, it is probably not surprising that clinicians and researchers in this area cite self-destructiveness as a common problem among sexual abuse

---

Portions of this paper were presented at the annual meeting of the American Association of Suicidology, Toronto, 1985. The authors wish to thank the staff and management of Klinic, Inc., Community Health Centre, Winnipeg, Manitoba, for their support of this project. Thanks are also due Ms. April Lightfoot for her help as a research assistant. Address reprint requests and correspondence to John Briere, Ph.D., Dept. of Psychiatry, Building 1-South, Harbor-U.C.L.A. Medical Center, 1000 W. Carson St., Torrance, CA 90509.

victims. Several studies, for example, implicate sexual abuse in the development of suicidal thoughts and behaviours in children and adolescents (Blumberg, 1981; Goodwin, Simms, & Bergman, 1979; Gross, 1979), and at least three studies report that suicidal behaviour in adults may relate to a history of childhood sexual abuse (Bagley & Ramsey, 1985; Briere, 1984; Sedney & Brooks, 1984).

In the first of these latter studies, Bagley and Ramsay (1985) found a significant relationship between suicidal ideation and sexual abuse in their community sample of 377 women. The authors also noted that the four cases of suicide attempts and/or deliberate self-harm they found in this group all occurred among women with histories of childhood sexual abuse. Similarly, Sedney and Brooks (1984) reported that of 301 female college students, 16% of those with childhood sexual experiences (most of which would meet current definitions of sexual abuse) had made at least one suicide attempt in the past, as opposed to six percent with no such sexual experiences. Finally, Briere (1984) found that 43% of 153 female clients in a community health centre crisis intervention service had a history of sexual abuse before age 15, and that 51% of these former victims (versus 34% of non-victims) had made at least one suicide attempt in the past.

Although these studies suggest that self-destructive ideation or behaviour in some individuals may arise from childhood sexual abuse, such an association has yet to be established with any certainty. First, a considerable portion of the data in the area of sexual abuse effects either consists of summarized case reports, or suffers from an absence of appropriate control groups (Conte, 1984). Second, the relatively low base rates of actual suicidal behaviour in the general population create a methodological problem, in that the cross-occurrence of sexual abuse victims and suicidal behaviours may be sufficiently low to preclude statistically reliable conclusions (e.g., the Bagley and Ramsay (1985) data on actual suicide attempts). In this regard, the ideal study might include a sufficiently large number of former sexual abuse victims to support an adequate analysis of low frequency events – such as suicide attempts – within this group. Finally, a more detailed study of sexual abuse and subsequent suicidality might examine the covariation between suicidal behaviours and those variables specific to the sexual abuse experience, such as age at first victimization, number of perpetrators, or presence of intercourse. Such information would increase our knowledge of which aspects of sexual victimization are most directly associated with later self-destructiveness.

The authors of the present study sought to address the concerns outlined above in a relatively intensive study of suicidality in former sexual abuse victims. We were also interested in replicating the somewhat unexpected findings of our earlier study (Briere, 1984) that over 50% of crisis intervention clients with a history of sexual abuse in childhood had made at least one suicide attempt in the past. The latter goal was possible due to the availability of a larger and more detailed sample of sexual abuse victims from the same community health centre utilized by Briere (1984).

METHOD

Subjects

Subjects in this study were 195 women who presented to the Crisis Counselling program of a Winnipeg community health centre. The mean age of this sample was 27.4 years. Forty-three percent had never been married, 31% were married or living as married, and 26% were divorced or separated.[1] Based on data from their intake interview, subjects were categorized into one of two groups: those with a history of sexual abuse as a child, and those with no history of abuse. For the purposes of this study, sexual abuse was defined as any self-reported sexual contact (ranging from fondling to sexual intercourse) experienced by a client on or before age 16, initiated by someone 5 or more years her senior. Because of our desire to examine specific characteristics of sexual abuse as they related to suicidality, a relatively large sample of abuse victim intakes ($n = 133$) were included in the present analysis relative to the number of non-abused subjects ($n = 62$).

METHOD

Procedure

Intake reports of the abused group were compared to those of the non-abused group on the following self-report variables: history of suicide attempts (none, one, two or more), self-reported suicidal thoughts at the time of the interview (no, yes), and the subject's age at the time of her first suicide attempt, if relevant.[2] For the sexual abuse group, the following variables were also noted: subject age at her first and last abuse incidents, lifetime number of sexual abuse perpetrators per subject (one, two, three or more), presence or absence of incestuous/intrafamilial abuse, whether intercourse/penetration (oral, anal, or vaginal) occurred during at least one abuse incident, and whether physical abuse (self-reports of violent physical contact beyond "spanking") was also present.

RESULTS

A comparison of the sexual abuse and control groups indicated that sexual abuse victims were slightly younger ($\bar{x} = 26.3$ years) than were non-abused clients ($\bar{x} = 29.6$ years) when they presented for counselling, $t\,(193) = 2.57$, $p < .011$. There were, however, no significant differences between abused and non-abused subjects in terms of marital status, $X^2(2) = 2.30$, $p < .317$.

---

[1]Although these demographics are similar to those of the average female crisis counselling client at this community health centre (Klinic, Inc.), the generalizability of the current findings may be constrained by the characteristics of this sample. Specifically, Klinic is the major outpatient crisis intervention service in Winnipeg, Manitoba, and typically serves approximately 12,000 clients per year. These individuals are often under unusual stress, and thus may differ from clients who attend less crisis-oriented services.

[2]Although the lethality of previous suicide attempts was also recorded for each subject, these ratings were subjectively assigned by the intake clinician. Because of their questionable validity, these ratings are not reported in subsequent analyses. For the reader's reference, however, 20% of previous suicide attempts were rated as "low" lethality, 42% as "medium," and 38% as "high," where high lethality was defined as probable death without intervention and no provisions for rescue.

The typical sexual abuse victim in this sample was 8.0 years old at her first abuse experience, and 13.9 years of age at her last. The mean lifetime number of sexual abuse perpetrators per victim was 1.8. Oral intercourse or anal/vaginal penetration occurred in 77.1% of all victims, and 56% of all victims reported concomitant physical abuse. Intrafamilial sexual abuse was reported by 60.9% of subjects.

As predicted, previous suicide attempts were considerably more common among former sexual abuse victims (54.9%) than among non-abused clients (22.6%), $X^2(1) = 17.86, p < .0001$. Similarly, clients who reported themselves to be suicidal at the time of their intakes were also more likely to have a history of sexual abuse (35.6%) than were nonsuicidal intakes (22.6%), $X^2(1) = 4.23$, $p < .040$.

Within the sexual abuse group, current suicidality was associated with total number of perpetrators and the presence of "compound" abuse (physical and sexual abuse together), whereas number of previous suicide attempts was related to compound abuse and was marginally associated with number of perpetrators and the presence of intercourse (see Table 1).

As indicated in Table 2, client age at first suicide attempt was also related to a

TABLE 1

Correlations between various abuse variables and two measures of suicidality

Abuse variables	Number of suicide attempts (n = 122–133)	Current suicidality (n = 121–132)
Compound abuse	.24***	.17**
Age at first abuse	−.06	.02
Age at last abuse	.00	.06
Number of perpetrators	.12*	.16**
Incest (intrafamilial)	−.07	.05
Intercourse	.14*	.04

Note: *p < .09, **p < .05, ***p < .005. *ns* vary due to occasional missing values.

TABLE 2

Cross-tabulation of sexual abuse history and age at first suicide attempt

		Age at first attempt		
		less than 14	14–18	greater than 18
Sexual abuse history	No	1	5	8
	Yes	13	34	22

Note: 4 cases not included due to missing values.

history of sexual abuse. One sample X^2 analysis indicated that of the 14 women whose first attempt was before age 13, 13 (92.9%) were sexual abuse victims, $X^2(1) = 4.093$, $p < .043$. Of the 39 whose first attempt was during adolescence (14-18 years), 87.2% had been victims of sexual abuse, $X^2(1) = 6.862$, $p < .009$. Women whose first attempt was during adulthood, however, were not statistically more likely to have been sexual abuse victims, $X^2(1) = 0.459$, *ns*.

DISCUSSION

Data from the present study strongly suggest an association between suicidality and a history of sexual abuse in clinical populations. Clients who were sexually victimized as children were over two times more likely to have made at least one suicide attempt in the past than were non-abused clients, and were significantly more likely to be suicidal at the time of their intake. These data support other clinical reports of greater self-destructiveness among former sexual abuse victims (e.g., Harrison, Lumry, & Claypatch, 1984; Herman, 1981), and specifically replicate our earlier finding (Briere, 1984) that over 50% of sexually abused crisis clients had attempted suicide one or more times in their lives.

Given the seeming reliability of the association between sexual abuse and suicidality within clinical groups, and its presence in non-clinical samples (e.g., Bagley & Ramsay, 1985; Sedney & Brooks, 1984), we present here three possible bases for such a relationship. Each of these hypothesize intervening impacts or effects of sexual abuse which, in turn, may motivate suicidal behaviour.

Impaired self-esteem and self-blame

A number of studies suggest that the experience of childhood sexual abuse reduces self-esteem in the victim (e.g., Bagley & Ramsay, 1985; Courtois, 1979; Herman, 1981; Jehu et al., 1985). Finkelhor and Browne (1985) link this effect to "the negative connotations ... that are communicated to the child around the experiences and that then become incorporated into the child's self-image" (p. 532). Referring to this process as "stigmatization," Finkelhor and Browne relate the experience of being unworthy or shameful to an eventual tendency toward suicidality or other forms of self-destructiveness.

Implicit in the "self-esteem" explanation is that poor self-concept mitigates against valuing oneself enough to want to live or to avoid self-destruction. Such a theory, alone, does not explain why self-destruction might be actively sought. It has been shown, however, that sexual abuse victims often experience guilt and self-blame along with low self-esteem (e.g., De Francis, 1969; De Young, 1982; Lindberg & Distad, 1985), possibly as a response to the stigmatization and internalized negative evaluation described by Finkelhor and Browne (1985). Specifically, if during the abuse the victim incorporates responsibility for the act, or

sees himself/herself as "deserving it" (both of which are common messages abusers communicate to their victims – see Summit, 1983), he or she is more likely to blame self and become intropunitive. The notion of self-blame as partially motivating self-destructiveness is congruent with the observations of writers like Herman (1981), and our own clinical experience, that suicidal sexual abuse victims often describe extreme self-hatred and desire for self-punishment.

Powerlessness

Powerlessness may be described as the experience of having no control over life events which directly affect one's well-being, by virtue of one's low status, lack of resources, etc. As noted by Finkelhor and Browne (1985), "a basic kind of powerlessness occurs in sexual abuse when a child's territory and body space are repeatedly invaded against the child's will. This is exacerbated by whatever coercion and manipulation the offender might impose as part of the abuse process" (p. 532). Although Finkelhor and Browne relate suicidality more to stigmatization than powerlessness, Peters (1984) hypothesizes that the sexual abuse victim's experience of powerlessness may lead to an increased vulnerability to clinical depression, partially through the mechanism of learned helplessness (Seligman, 1975; see also Walker, 1978, for a similar reaction in battered women). This formulation has some support in the sexual abuse literature: various writers report increased perceived helplessness and powerlessness in sexual abuse victims (e.g., Katan, 1973; McVicar, 1979), as well as increased depression (e.g., Bagley & Ramsay, 1985; Briere & Runtz, 1985; Peters, 1984; Sedney & Brooks, 1984). Data from the present study also support the role of powerlessness in the relationship between sexual abuse and suicidality, given that three variables epitomizing loss of control – physical violence ("compound abuse"), sexual penetration, and increased numbers of abusers – were all associated with increased suicidality. These variables have similarly been linked to increased psychological trauma in a number of other studies (e.g., Bagley & Ramsay, 1985; Finkelhor, 1979; Fromuth, 1983; Russell, 1986).

Although a major effect of powerlessness on suicidality may involve the induction of learned helplessness and subsequent depression, another powerlessness dynamic may also be present. As noted by Farberow and Schneidman (1961), Briere and Corne (1985), and others, suicide attempts may represent a "cry for help" in certain individuals who believe themselves to have no lesser effective means of communicating their psychological pain. Thus, suicidal behaviours in some sexual abuse survivors may reflect the belief that extraordinary measures are required to gain the caring attention of others, given their perceived lack of power in more conventional contexts. A similar mechanism has been offered to explain the "acting out" of sexually abused adolescents (Runtz & Briere, in press).

Interpersonal dysfunction

A final potential dynamic in the development of suicidality among sexual abuse survivors relates to the effects of sexual victimization on interpersonal functioning. As described by Browne and Finkelhor (1986), the interpersonal sequelae of sexual abuse are thought to include problems in trusting others (e.g., Briere, 1984; Courtois, 1979; Summit, 1983), difficulties in longer-term relationships and associated fear of intimacy (e.g., Herman, 1981; Meiselman, 1978), isolation, alienation, and abandonment issues (e.g., Briere, 1984; Courtois, 1979; Herman, 1981), and increased likelihood of later revictimization (e.g., Briere, 1984; Fromuth, 1983; Miller et al., 1978; Russell, 1986). Given that suicidal behaviours often occur in the context of interpersonal strife (Farberow & Schneidman, 1961), it would not be surprising if the interpersonal problems of some sexual abuse survivors increased their vulnerability to suicidal thoughts and impulses.

It is probable that a combination of these motives, along with other unknown factors, mediate between sexual abuse experiences and self-destructive acts. Further research is indicated in this area to determine the exact "causal paths" involved in translating childhood trauma into self-injurious behaviour.

A potentially important finding in the present study is the relationship between age at first suicide attempt and history of sexual abuse. Ninety-three percent of women who reported a suicide attempt before age 13 had been sexually victimized as a child. A first attempt during adolescence was also strongly associated with sexual abuse, although to a slightly lesser extent, whereas a first attempt during adulthood was statistically independent of abuse status. Although the childhood data are subject to criticism based on low sample size (there were only 14 women who reported a suicide attempt before age 13), they are intriguing, nonetheless, for their support of a "diminishing effects" model of abuse-related suicidality. Specifically, it is possible that the effects of sexual child abuse on suicidality are most significant during childhood and adolescence, becoming less relevant to first instances of suicidality in adulthood. To the extent that this finding can be generalized, the clinical implications for prediction and intervention in cases of childhood suicide attempts are substantial, as discussed below. On a more theoretical level, these data also suggest a fourth possible motive for suicide: escape. Children whose early life experiences are characterized by exploitation, pain, and terror may see few options beyond a (probably vague) notion of death as a way to avoid further trauma. This notion of suicide as a "defence" against continuing sexual abuse is congruent with Reich and Gutierres' (1979) suggestion that sexually abused adolescents engage in potentially harmful activities as a means of escape and social avoidance. The possibility that one's own death (or danger of same) could be used as a coping mechanism highlights the highly aversive nature of sexual abuse and the extreme powerlessness seemingly experienced by many victims.

Clinical implications

The current data suggest that suicidality, especially with a childhood onset, is associated with prior sexual abuse in women seeking crisis intervention services. Although such findings do not imply that all suicidal individuals have histories of sexual victimization, they do indicate that the likelihood of sexual abuse is higher for women in crisis who have attempted suicide prior to adulthood or who are currently suicidal. Conversely, these findings suggest that clinicians who work with sexually abused children should be vigilant to the possibility of future suicidal or self-injurious behaviour, in addition to the other known sequelae of sexual victimization. Such data add even greater urgency to calls for early identification and treatment of childhood sexual abuse victims.

Given that the current data link sexual abuse to prior suicide attempts and current suicidality, it is likely that they have implications for the treatment of at least some "chronically suicidal" mental health clients. Specifically, individuals with suicidal behaviours dating back to adolescence or earlier should be examined for sexual abuse histories which, if present, may be associated with certain dynamics (e.g., low self-esteem, guilt, powerlessness, and interpersonal dysfunction). Treatment interventions for sexual abuse trauma which focus on these issues (e.g., Briere, in progress; Herman, 1981; Jehu, Klassen, & Gazan, 1985; Lindberg & Distad, 1985) may be of specific assistance in working with such high risk individuals.

It should be noted that the current data do not prove a causal relationship between sexual abuse and suicidal behaviour, since some third event may produce both. A number of studies, for example, indicate that suicidal children and adolescents are overrepresented in families where there is a high level of disruption, rejection, parental loss, and poverty (e.g., Dorpat, 1965; Faigel, 1966; Teicher & Jacobs, 1966; Toolan, 1962) – variables that are also potentially supportive of sexual abuse (Finkelhor, 1984). Recent research, however, indicates that when other relevant variables (e.g., family environment or social class) are statistically controlled, sexual child abuse continues to predict later psychological difficulties (e.g., Bagley & Ramsey, 1985; Fromuth, 1983; Peters, 1984). Such data support the observations of many clinicians in the area (e.g., Butler, 1978; Herman, 1981) that, along with other factors, sexual abuse is directly involved in the etiology of self-destructive behaviours for some individuals.

Finally, the current investigation was restricted to female clients, and thus may have less applicability to suicidality in males. Preliminary data gathered by the authors (Briere, Evans, Runtz, & Wall, 1986), however, suggest that adult male clients with sexual abuse histories may be as likely as their female counterparts to have serious psychological problems and to have made suicide attempts in the past. Further research on male sexual abuse victims is strongly indicated, both in terms of self-destructive behaviours and with respect to mental health variables in general.

In summary, this study reports and replicates a significant association between self-reported suicidality and childhood sexual abuse. It also suggests that this relationship may be most valid when the onset of suicidal behaviour is prior to adulthood. Further research is needed to test the generalizability of these findings to other clinical and non-clinical groups, and to further specify those variables which mediate between sexual abuse and self-destructiveness. Such research, by stressing the role of aversive childhood experiences in the development of self-harming behaviours, may offer new insights into the etiology of suicide.

RÉSUMÉ

La relation entre l'abus sexuel durant l'enfance et les tendances suicidaires subséquentes a été examinée auprès de 195 femmes se présentant au programme d'intervention en période de crise d'un centre de santé communautaire. Tel que prédit, les victimes d'abus sexuel durant l'enfance étaient considérablement plus portées à avoir tenté de s'enlever la vie dans le passé (55%) que les patientes n'ayant pas été victimes de tels abus (23%). En plus, ces premières étaient plus portées à rapporter des pensées suicidaires lors de l'entrevue initiale. Des analyses supplémentaires révélèrent que l'abus sexuel était spécifiquement associé avec les tentatives suicidaires qui avaient eu lieu dans l'enfance ou l'adolescence. Parmi les victimes d'abus sexuel, une plus grande tendance au suicide était corrélée avec des agresseurs multiples, un abus physique concomitant et l'accomplissement de l'acte sexuel. Il est prédit que l'abus sexuel chez les enfants résulte en une faible estime personnelle, de la culpabilité et du blâme personnel, une perception d'impuissance et une incompétence interpersonnelle — toutes des variables pouvant mener à une augmentation de l'auto-destruction. Les implications cliniques de ces résultats sont discutées.

REFERENCES

Bagley, C., & Ramsay, R. (1985, February). *Disrupted childhood and vulnerability to sexual assault: Long-term sequels with implications for counselling*. Paper presented at the conference on Counselling the Sexual Abuse Survivor, Winnipeg, Manitoba.

Benward, J., & Densen-Gerber, J. (1975, February). *Incest as a causative factor in anti-social behaviour: An exploratory study*. Paper presented at the meeting of the American Academy of Forensic Science, Chicago, IL.

Blumberg, M.L. (1981). Depression in abused and neglected children. *American Journal of Psychotherapy, 35*, 342–355.

Brickman, J., & Briere, J. (1984). Incidence of rape and sexual assault in an urban Canadian population. *International Journal of Women's Studies, 7*, 195–206.

Briere, J. (1984, April). *The effects of childhood sexual abuse on later psychological functioning: Defining a "post-sexual-abuse syndrome."* Paper presented at the Third National Conference on Sexual Victimization of Children, Washington, DC.

Briere, J. (in progress). Therapy for the sexual abuse survivor. New York: Springer Publishing Co.

Briere, J., & Corne, S. (1985). Previous psychiatric hospitalizations and current suicidal behavior in crisis line callers. *Crisis Intervention, 14*, 3–10.

Briere, J., Evans, D., Runtz, M., & Wall, T. (1986). *Sex differences in the effects of sexual abuse on adult mental health*. Unpublished manuscript.

Briere, J., & Runtz, M. (1985, August). *Symptomatology associated with prior sexual abuse in a non-clinical sample*. Paper presented at the annual meeting of the American Psychological Association, Los Angeles.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research.

Psychological Bulletin, 99, 66–77.

Butler, S. (1978). *Conspiracy of silence: The trauma of incest*. San Franciso: Volcano Press.

Conte, J. (1984, November). *The effects of sexual abuse on children: A critique and suggestions for further research*. Paper presented at the Third International Institute on Victimology, Lisbon, Portugal.

Courtois, C. (1979). The incest experience and its aftermath. *Victimology: An International Journal, 4*, 337–347.

DeFrancis, V. (1969). *Protecting the child victim of sex crimes committed by adults*. Denver, CO: American Humane Association.

DeYoung, M. (1982). *The sexual victimization of children*. Jefferson, NC: McFarland.

Dorpat, T.L. (1965). Broken homes and attempted and completed suicide. *Archives of General Psychiatry, 12*, 213–216.

Faigel, H.C. (1966). Suicide among young persons. *Clinical Pediatrics, 5*, 187–190.

Farberow, N.L., & Schneidman, E.L. (1961). *The cry for help*. New York: McGraw-Hill.

Finkelhor, D. (1979). *Sexually victimized children*. New York: Free Press.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free Press.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530–541.

Fromuth, M.E. (1983). *The longterm psychological impact of childhood sexual abuse*. Unpublished doctoral dissertation, Auburn University, Auburn, AL.

Goodwin, J., Simms, M., & Bergman, R. (1979). Hysterical seizures: A sequel to incest. *American Journal of Orthopsychiatry, 49*, 698–703.

Gross, M. (1979). Incestuous rape: A cause for hysterical seizures in four adolescent girls. *American Journal of Orthopsychiatry, 49*, 704–708.

Harrison, P.A., Lumry, A.E., & Claypatch, C. (1984, August). *Female sexual abuse victims: Perspectives on family dysfunction, substance abuse and psychiatric disorders*. Paper presented at the Second National Conference for Family Violence Researchers, Durham, NH.

Herman, J.L. (1981). *Father-daughter incest*. Cambridge, MA: Harvard University Press.

Jehu, D., Gazan, M., & Klassen, C. (1984/85). Common therapeutic targets among women who were sexually abused. *Journal of Social Work and Human Sexuality, 3*. 25–45.

Jehu, D., Klassen, C., & Gazan, M. (1985/86). Cognitive restructuring of disturbed beliefs associated with childhood sexual abuse. *Journal of Social Work and Human Sexuality, 4*, 49–69.

Katan, A. (1973). Children who were raped. *Psychoanalytic Study of the Child, 28*, 208–224.

Lindberg, F.H., & Distad, L.J. (1985). Post-traumatic stress disorder in women who experienced childhood incest. *Child Abuse and Neglect, 9*, 329–334.

McVicar, K. (1979). Psychotherapy of sexually abused girls. *Journal of the American Academy of Child Psychiatry, 18*, 342–353.

Meiselman, K. (1978). *Incest*. San Francisco: Jossey-Bass.

Miller, J., Moeller, D., Kaufman, A., Divasto, P., Fitzsimmons, P., Pather, D., & Christy, J. (1978). Recidivism among sexual assault victims. *American Journal of Psychiatry, 135*, 1103–1104.

Peters, S.D. (1984). *The relationship between childhood sexual victimization and adult depression among Afro-American and white women*. Unpublished doctoral dissertation, University of California, Los Angeles, CA.

Reich, J.W., & Gutierres, S.E. (1979). Escape/aggression incidence in sexually abused juvenile delinquents. *Criminal Justice and Behaviour, 6*, 239–243.

Runtz, M., & Briere, J. (in press). Adolescent "acting out" and childhood history of sexual abuse. *Journal of Interpersonal Violence*.

Russell, D.E.H. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse in female children. *Child Abuse and Neglect*, 7, 133–146.

Russell, D.E.H. (1986). *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.

Sedney, M.A., & Brooks, B. (1984). Factors associated with a history of childhood sexual experience in a nonclinical female population. *Journal of the Academy of Child Psychiatry*, *23*, 215, 218.

Seligman, M.E.P. (1975). *Helplessness: On depression, development, and death*. San Francisco: W.H. Freeman and Co.

Summit, R. (1983). The child sexual abuse accommodation syndrome. *Child Abuse and Neglect*, *7*, 177–193.

Teicher, J.D., & Jacobs, J. (1966). Adolescents who attempt suicide: Preliminary findings. *American Journal of Psychiatry*, *122*, 1248–1257.

Toolan, J. (1962). Suicide and suicide attempts in children and adolescents. *American Journal of Psychiatry*, *118*, 719–727.

Tsai, M., Feldman-Summers, S., & Edgar, M. (1979). Childhood molestation: Variables related to differential impacts on psychosexual functioning in adult women. *Journal of Abnormal Psychology*, *88*, 407–417.

Tsai, M., & Wagner, N. (1978). Therapy groups for women sexually molested as children. *Archives of Sexual Behaviour*, *7*, 417–429.

Walker, L.E. (1978). Battered women and learned helplessness. *Victimology: An International Journal*, *4*, 525–534.

First received 22 April 1986
Final revision 29 June 1986