Final Paper

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Part I

I selected the issue of post-traumatic stress disorder (PTSD) in women survivors of childhood sexual abuse (CSA). It interests me professionally as I did my second field placement at Benedictine Hospital Partial Hospitalization Program. Patients sought treatment for PTSD resulting from having experienced different types of childhood abuse (CA), including CSA. I am also compelled to work with this population after I graduate because I am a woman who experienced abuse as a child and unknowingly suffered from PTSD for some time. As an adult, I received treatment and was able to overcome the effects of the abuse and reduce the PTSD to the point where I could function and thrive in my life. I would like help others recover.

A conservative prevalence estimate of CSA in the United States is 20% (Paoluccci, Genuis, & Violato, 2001.) A retrospective study showed CSA rates for women were 22-32% (Finkelhor, Hotaling, Lewis, & Smith, 1990). In 2007, incidence statistics for child maltreatment estimated 5.8 million children referred to Child Protective Services, 7.6% suffering sexual abuse (http://www.acf.hhs.gov/programs/cb/pubs/cm07/summary.htm, retrieved November 11, 2010). Putnam (2003) found approximately 88,000 substantiated child maltreatment cases of CSA reported in 2000, 16.8% of which were women. New York Coalition Against Sexual Assault estimates there are 39 million survivors of CSA in the U.S. (www.nycasa.org/information/ factsheets/ FS_Mental%20Health.pdf, retrieved November 8, 2008). However, as MacMillan, et al. (2007), point out, official sources do not fully reflect the scope of the problem, due, in part, to underreporting.

CSA results in higher risk for psychological maladjustment (Beitchman, et al., 1992), including depression, anxiety, and inappropriate or early sexual behavior (Bagley,

et al., 1991; in Paoluccci, Genuis, & Violato, 2001). Trauma expert Judith Herman (1992) noted CSA's effects on adults include impact on cognition and memory, increase in self-harm behaviors, difficulty in relationships, and greater aggression and irritability. Rodriguez, Kemp, and Foy (1998) cite higher risk of rape and violence among survivors. Biological impacts of CSA include somatic and eating disorders, pelvic pain (Hall, 2003), back pain, headaches, sleep problems (McCauley, et al., 1997), fibromyalgia, chronic fatigue and irritable bowel syndromes (Ernst, Angst, & Foldenyi, 1993). Paoluccci, Genuis, and Violato (2001) identified outcomes including delinquent criminal behaviors, substance abuse, and prostitution, while Springer, et al., (2003) found more smoking, and Kessler (2000), more suicide in CSA survivors. Anderson and Choicchi (1997) stated CSA often precipitates a sequence of events that leads to homelessness in adulthood.

PTSD is a response to an event or events that involves intense fear, helplessness and/or horror, with symptoms that include re-experiencing of the traumatic event[s], persistent avoidance of stimuli associated with the trauma, numbing of responsiveness, and persistent symptoms of increased arousal (DSM-IV-TR, 2000). Widom (1999) found CSA survivors have an increased risk for PTSD: 37.5% of them met DSM-III-R criteria for lifetime PTSD and odds are 1.75 times greater for an abused and neglected child to develop PTSD. Saunders, et al. (1992) found a much higher incidence of PTSD, as much as 46%, in women who were sexually abused as children compared to women who were not. According to standardized assessments, the rate of PTSD in survivors of CSA is thought to be between 40 and 50% (Livingston, et al., 1993; McLeer, et al., 1994; Wolfe et al., 1994; in Rodriguez, Kemp, & Foy, 1998).

PTSD is multifaceted. Herman (1992) coined the term "complex PTSD" (CP), a

concept integrative in nature (Herman, in Cortois & Ford, 2009), for survivors who experience chronic traumatization from repeated abuse, such as prolonged periods of CSA, in contrast to a single, discrete event such as a natural disaster or rape. Herman emphasizes CP is always relational (in Cortois & Ford, 2009). A DSM-IV field trial (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997) concluded a CP construct could be applied to explain the many related dynamics occurring in circumstances where there is exploitation happening on an interpersonal level that goes beyond PTSD.

Even applying current DSM-IV (2000) PTSD criteria, symptoms are numerous and varied. PTSD can co-occur with other Axis I diagnoses, particularly mood and anxiety disorders (Howgego, et al., 2005). If trauma histories are not assessed and differential diagnoses made, misdiagnosis can easily occur (Putman, 2009), making effective treatment more difficult when underlying issues are not addressed (Herman, 1992). There is some conflict between paradigms that see PTSD as a normative response verses a psychiatric disorder (Yehuda & McFarlane, 1995). Regardless of how PTSD resulting from CSA is conceptualized, the impact on social, political and mental health domains is significant and requires urgent action (Paoluccci, Genuis, & Violato, 2001).

It is not fully understood why some develop PTSD, which so dramatically and negatively alters individuals' self-concepts and outlooks (Terr, 1991), and others are more resilient, develop a sense of self, form relationships, can problem solve and plan for a positive future (Bernard, 1993; in Greene, 2002). One of the most commonly cited factors that mediate likelihood of PTSD is age at which the trauma occurred (Chaffin, et al., 1997; Kendall-Tackett et al., 1993; Spaccarelli, 1994). According to Schoedl, et al. (2010), those reporting CSA after age 12 were at ten times higher risk for PTSD. Other

found victimization occurring before age 15 was most likely to cause greater psychological stress later in life (Draper, et al., 2008). Other PTSD vulnerability factors include intensity, frequency, duration, and degree of sexual contact (Briggs & Joyce, 1997). Epstein, Saunders, and Kilpatrick (1997) found that those who experienced penetration had the highest prevalence of PTSD of all CSA survivors,

Dissociation, defined as a structured compartmentalization of mental processes, such as thoughts, feelings, or memories, can play a role in the development of PTSD. Hetzel and McCanne (2005) found a correlation between childhood dissociation and PTSD in adulthood. They noted risk factors used to predict lifetime PTSD include a parent who was arrested or abused substances, early behavioral problems, marital instability, and substance dependency. Widom (1999) found that abused children also have a greater genetic vulnerability to developing PTSD and prior psychopathology is shown to have a relationship to PTSD.

When considering resiliency, some researchers cited social support as one of the greatest predictors of ability to moderate CA's effects (Beitchman, et al., 1992; in Hyman, et al., 2003). Others found evidence to the contrary (Bradley, et al., 2005; Kessler & Magee, 1994; Turner and Butler, 2003; in Hill, et al., 2010). Hyman, et al. (2003), stated survivors' sense that they were valued by others and could get advice when needed was most useful in preventing PTSD. Additionally, they found self-esteem appears to mediate CA's effect on PTSD through its influence on knowing one is capable, helping to support positive coping

strategies, and counteracting feelings of shame and worthlessness. Hill, et al. (2010), discovered self-esteem helps adult survivors counter leftover childhood feelings of helplessness and powerless. A study by Elkit (2009) looked at survivors' attachment style in adult life and reviewed research on different aspects, such as insecure attachment (Alexander, 1993; Whiffen, Judd, & Aubb, 1999), fearful attachment (Hanna, 2003), and dismissive attachment (Cooper, 2006). Clearly, CSA results in problems with attachment (McKean & Hunsley (2001) and different attachment styles have the potential to mediate effects of CSA on adult outcomes (Kutil, 1999; Runtz & Hunter, 1999).

Doll and Lyon (1998; in Greene, 2002) defined general characteristics of resilient children and youths that are, for the purpose of this paper, applicable: intellectual ability; language competence; social skills; easygoing disposition; self-efficacy, self-confidence and self-esteem; resilient belief systems, i.e. faith; and higher rates of engagement in productive activities. Education also plays a part. Widom (1999) purports having a college degree may lower risk of PTSD. Her research also demonstrates childhood victimization, including CSA, is associated with increased risk for both lifetime and current PTSD. However, she concluded it is not sufficient to have experienced childhood victimization alone, but variables such as family, individual characteristics, and lifestyle also contribute to risk factors for PTSD.

Kessler (2000), sums it up by comparing the impact of PTSD on individuals and society as equal to, or greater than, other serious mental disorders. He describes PTSD's effects, how it interferes with fulfilling individual potential in education, marriage, and employment, causing higher rates of teen pregnancy, and hindering day-to-day role

functioning. He enumerates the high cost of PTSD to society in financial and broader human terms. Women survivors often suffer from lower employment and a higher incidence of homelessness (Anderson and Choicchi, 1997) and substance abuse (Kessler, 2000). They often need Medicaid, food stamps, alcohol and drug treatment programs (Kessler, 2000) and housing (Anderson and Choicchi, 1997), leading to more demand for social welfare and placing extra burdens on taxpayers (Kessler, 2000). However, due to large budget reductions and changes in legislation, there have been major cuts in social services, negatively impacting the needs of this population.

The description of the problem thus far only scratches the surface of this issue. Ultimately, the magnitude of impact on society from women survivors of childhood abuse experiencing PTSD is significant enough that it warrants more attention on many levels—additional research, greater support for prevention and treatment, and further addressing at both social and policy levels.

Part II

Many systems interact with women survivors of CSA with PTSD. Because PTSD is framed as a psychological issue, the mental health system is primary (Kessler, 2000). Women survivors who need mental health treatment—inpatient or partial hospitalization, or outpatient care—may or may not have access to services, based on financial and geographic factors and whether appropriate services (Harper, Stalker, Palmer, & Gadbois, 2008) and properly trained clinicians (Foa, Keane, Friedman, & Cohen, 2009) are available. Awareness of services—understanding PTSD's symptoms and the value of mental health care—affects access. Social norms that encourage or discourage seeking help, and how services are presented and publicized, also effect whether survivors get

treatment (Sorenson, 2002). Women have often been made to feel responsible for their abuse and internalized the guilt. Social stigma about sexual assault makes it difficult for many women to discuss their experiences (Morrissette, 1999). Mental health providers need to do more outreach to the survivor population (Kessler, 2000).

This issue also interacts with the medical system. Women who experienced CSA often have higher incidences of physical problems (Lang, et al., 2008). PTSD is not always recognized by primary care physicians and can be missed as the cause of some physical ailments. In fact, according to Springer, et al., (2003), most physicians admit they do not screen for CSA history and thus cannot make needed psychological referrals. There is greater awareness among psychiatric practitioners, but in the current managed health care climate, psychiatrists have limited time to spend with patients or do psycho-therapy, and direct care is often passed on to physician assistants or psychiatric nurses (Paul, Lockey, Hall, & Bursztajn, 2009). In addition, due to this population being underemployed or unemployed (Anderson and Choicchi, 1997) they often cannot afford health insurance, making it more difficult to get the medical care they require.

There are a number of ways women survivors of CSA may interact with the legal system, including criminal, civil, and family court. Women who want to take legal action against their abuser(s) may make efforts to hold abusers accountable in court. This can be difficult because each state has a different statute of limitations (Briere & Conte, 1993) and there is controversy about delayed or recovered memories in the legal field (Dorado, 1996; Freyd, 2003; Herman & Harvey, 1997; Hall, 2003), as well as the mental health (Colangelo, 2007; Herman & Harvey, 1997; Gasker, 1999; Bremner, Shobe, & Kihlstrom, 2000; Dallam, 2001; Epstein & Bottoms, 2002; Pettifor, Crozier, & Chew,

2001; Milchman, 2008) and scientific (Bremner, 2001) communities. In some states, such as Michigan, when incest survivors bring civil cases, the period of discovery does not begin until after the plaintiff discovers psychological injuries have been caused by CSA (Dorado, 1996). This population has more marital problems and higher incidence of teen pregnancy (Kessler, 2000), so they may interact with the family court system. They may experience domestic violence by an abusive partner and need an order of protection. The partner may continue to pursue them, putting the woman's life at risk (http://www.aardvarc.org/dv/orders.shtml, retrieved November 30, 2010). Women might also have to negotiate about child custody; they might be mandated for substance abuse treatment and have to regain child custody following treatment.

The family system is another one the issue interacts with if the woman has contact with her family of origin. To be considered is whether one or both parents were abusive and/or whether the non-abusive parent was supportive; e.g. when the woman disclosed (Elkit, 2009; Colangelo, 2009) or by protecting the woman when she was a child (Bellis, 2001). If there were other children involved, family dysfunction may have disrupted sibling bonds or caused sibling incest (Carlson, Maciol, & Schneider, 2006). There can be concern whether it is safe to maintain family relationships, particularly with the perpetrator or those complicit in the abuse. The survivor may need to focus on recovery and build other support social systems outside the family of origin (Cohen, 2008).

This issue can be further understood through the lens of the social sciences. Rubin, Bernsten, and Johansen (2008) looked at assumptions about the memory-based model of PTSD. They explained how the psychological community has framed PTSD from the DSM-IV-TR (2000), using a stimulus-response model requiring presence of an external,

traumatic event. They propose using an alternative, the mnemonic model, to consider the etiology of PTSD. The mnemonic model considers patients' reports of the event that occur sometimes years later and are based on memory of the event. Rubin, Bernsten, and Johansen (2008) contend when a negative event occurs it causes changes in a person. The memory of the event is not fixed, but changes over time, based on individual differences, extreme stressors related to the event, and current concerns of that individual. They describe how the interplay between the qualitative aspects of the event and the processes of recall determine if PTSD will result. The authors suggest that from a scientific point of view, the shift in perspective they are proposing will allow more progress in PTSD research. They also recognize the mnemonic model's limitations, that it does not provide an operationalization of PTSD for diagnosis purposes.

Another psychological perspective looks at the issue by considering factors that contribute to development of PTSD in survivors of CSA. Heltzel and McCanne (2005) looked at how dissociation, a defense mechanism, and childhood physical abuse play a role. They refer to other studies that establish higher levels of dissociation during or after CSA that are associated with higher levels of psychological distress in adulthood (Briere & Runtz, 1988; Chu & Dill, 1990). Hall (2003) found CSA survivors have more dissociative experiences and cited a number of studies that linked more severe, frequent, and combined forms of abuse, early age of onset, and greater numbers of perpetrators to higher levels of dissociation. She also recognizes that though research many not have yet proven this, dissociation can have positive value in helping an abused child tolerate extremely painful situations.

One of the ways the field of sociology considers trauma, including CSA, is from a feminist perspective. Webster and Dunn (2005) looked at issues of culture and how it shapes attitudes towards women and children. They identified constructs of femininity, masculinity, and heterosexuality, and how beliefs about class and race associated with privilege related to the broader topic of rape and violence against women. The authors considered how to make change not only by providing treatment but also by creating social interventions for prevention. They mentioned community resources for information for law enforcement agencies and schools. They emphasized the importance of changing social structures, such as the roles of men and women, and cultural beliefs that influence policies and legal interpretation. They referred to hallmarks of feminist ideology: staying grounded in clients' experiences; knowledge of the issue's social and historical contexts such as challenging dominant perspective; collaboration between all participating—clients, therapists, advocates, agencies, and researchers; and considering how traumatic violence brings up interpersonal issues when dealing with perpetrators.

Hill, Kaplan, French, and Johnson (2010) offered another sociological perspective by examining issues of victimization in early life and how psychosocial resources mediate and moderate its effects in adulthood. Their population, black and Hispanic low-income urban women with children, contributed to the writers' determination that socio-economic factors play a major role in increasing victimization rates. They also examined variables that effect severity of mental health problems such as physiological, social, psychological, behavioral, and structural factors. Other areas impacted by early victimization were school, work, forming and maintaining supportive relationships, leisure activities, self-concepts, and decision-making.

Medicine and science have worked to develop relevant models and made progress by recognizing PTSD as a valid outcome of CSA. There are two prominent, somewhat contradictory models. Herman (1992) and Summerfield (2001) both looked at PTSD as a normative response to damaging experiences such as childhood abuse. Early biological studies, dating back to Seyles (1956), hypothesized responses to trauma were like those seen when investigating other stresses from a neurobiological perspective (Yehuda & McFarlane, 1995). These theories helped take the onus of etiological vulnerability off the victim and placed it on the traumatic event. Seyle's work also positioned the trauma response in the context of time by showing relationship between when trauma occurred and development of symptoms, both physical and psychological (1956).

Researchers in neurobiology (Neigh, Gillespie, & Nemeroff, 2009) examined effects of early abuse on nervous and endocrine systems, specifically the hypothalamic-pituitary-adrenal (HPA) axis that mediates stress response and cortisol levels. They studied genetic factors that may predispose individuals to developing PTSD and carry over to subsequent generations via DNA changes. They found long-term outcomes on physical, as well as psychological, health, including cardiovascular disease, and the immune, metabolic, and reproductive systems. Other authors established child abuse and neglect is often associated with alterations in brain structure and function and biological stress functions (Anda et al. 2006; De Bellis 2001, 2005; De Bellis and Putnam 1994; Heim et al. 2002; in MacMillian, et al., 2007). Jackowski, et al. (2009), looked at changes in neurostructure and neurofunction present in brains of maltreated children with PTSD. Lipschitz, Morgan, and Southwick (2002) and Solomon and Siegel (2003) researched the developing brain's cognitive and emotional functions and how early trauma affects them.

Epidemiological studies examined the prevalence of PTSD, particularly among combat veterans, and discovered trauma did not always lead to PTSD and PTSD was at a lower than expected rate: 3-58% (DSM-IV-IV, 2000; in Yehuda & McFarlane, 1995). Other populations in this same study with similar findings were natural disaster victims, fire fighters, prisoners of war, and concentration camp survivors. Even for those who experienced extreme and prolonged exposure, most of the symptoms resolved within two or three years. Experts sought to explain chronic PTSD in particular individuals, including CSA survivors, through examining vulnerability factors.

The legal profession has examined the issue of adults who make complaints against perpetrators. Rogers (1994) studied how to evaluate claims when many years may have passed between abuse events and time claims are made. Difficulties of assessing claim validity are explored. She offered guidelines for testimony, such as exercising caution when making judgments about memory validity, and breaks down variables for assessing complaints into five categories: alleged victim factors; memory factors; therapist/examiner factors; external influences; and evidential patterns. Widom (1998) did a prospective study of long-term consequences of early childhood victimization using documented and substantiated cases that was funded, in part, by the National Institute of Justice. It looked at PTSD in adults, but included all types of abuse and neglect. The study sought to distinguish between consequences specifically associated with childhood victimization and other risk factors, such as family dysfunction, environmental vulnerability, genetic vulnerability, and childhood behavior problems in relation to the risk of development of PTSD.

Insight about trauma can also be gain by considering it from an international perspective. India is a culture very different from the U.S., with different views towards gender and childhood. In its recent history, India has had a number of major natural disasters. Kar, et al. (2007) studied PTSD in children and adolescents resulting from a super-cyclone in Orissa. Their interest was in cross-cultural validity of the PTSD construct. They also looked at vulnerability factors—cyclone exposure level, education level, and socioeconomic status—which correlated to higher incidence of PTSD. They discovered that greater fear, damage to home, perceived threat of death, death in family, or staying in a shelter did not increase incidence of PTSD. They concluded PTSD has validity as a clinical construct in India and occurrences in their study were comparable to those in other cultures. The authors cited the importance of asking children directly about their responses to the incident. In addition, they emphasized the need for public education on effects of disaster so proper screening of victims can occur.

A report from India based on in-depth interviews (Mehta, Vankar, & Patel, 2005) examined women who traumatized by communal riots in Gujarat in 2002. The authors looked at whether PTSD was a valid construct when applied to non-Westerners, specifically those in a low-income country. They discovered subjects had symptoms in the three PTSD domains (DSM-IV-TR, 2000): re-experiencing, avoidance, and hyperarousal. These symptoms associated with PTSD were related to the trauma and grief connected to the riots and resulted in a PTSD diagnosis. Their views were consistent with Kar, et al. (2007): PTSD may be a valid clinical construct in the Indian context. This qualitative study made no suggestion about solutions. However, the women from Gujarat did seek treatment from mental health providers.

Ireland has more in common culturally with the U.S. than India does, but it has its own unique history of ongoing major conflict between two religious communities. Dorahy, et al. (2009) studied complex PTSD and relational trauma and its consequences in Northern Ireland (NI), where there has been a high degree of politically motivated violence in the last 40 years. Daly and Johnston (2002) studied the impact of civil unrest in a static population, as that of NI, by looking at a shooting in a bar. Both sets of authors worked with the DSM-IV-TR but applied it to large, interconnected groups of people, as opposed to the population of individuals studied in this paper. Dorahy, et al. (2009), highlighted how affiliation with a group and shared background can provide a buffer from psychological distress by feeling connected and accepted. This is a frequently a missing piece in the lives of women who develop PTSD as a result of CSA, which is more often a private, isolating event. In addition, Daly and Johnston (2002) considered how pursuing litigation might be a protective factor.

Part III

. There is currently no federal or state legislation addressing PTSD in women survivors of CSA. Legislation exists in the state assembly and senate for PTSD in veterans: E.g. Bill #A1076 requires PTSD screening of veterans; #A0873B provides additional benefits for veterans for PTSD-related services (http://assembly.state.ny.us/ leg/?bn=A08730; S01195A creates a method to train mental health providers on mental health issues specific to veterans, including PTSD (http://assembly.state.ny.us/leg/ ?bn=A08730. More generally, # Bill #A10082 includes PTSD in the definition of biologically-based mental illness as relates to Timothy's law (http://assembly.state.ny.us/ leg/? bn=A10082. Recent federal legislation related to CA included 35 bills, but none

directly applicable to adult survivors. The Child Abuse Prevention and Treatment Act (CAPTA) of 1974 provides a clearinghouse for information, funds research, and provides grants for prevention and treatment as well as investigation and prosecution. The Keeping Children and Families Safe Act of 2003, an amendment to CAPTA, makes improvements on the bill and reauthorize programs (http://www.acf.hhs.gov/programs/cb/lawspolicies/ cblaws/capta/). Though CAPTA refers to the long-term sequelae of CA generally, it does not refer to PTSD. It limits its attention to children and the effect of CA on child development and families. As for local policies, in 2004, the NYS Office of Mental Health (OMH) initiated a Statewide Comprehensive Plan for Mental Health Services to address public mental health needs locally, focusing on outcomes and insuring accountability (http://www.omh.ny.gov/omhweb/ statewideplan/2006). This policy is aimed at adults with serious mental illness receiving community-based services but does not specifically address adult survivors of childhood abuse.

There is research on issues relevant to policy. Johnson (2008) looks at CSA as a major public health issue. She points to the lack of consensus on definition and the need for specially training professionals to work with victims. She considers what is effective in treating outcomes of CSA; developing prevention policies; funding; and integrating programs that include departments of defense, justice, education, Health and Human Services, Centers for Disease Control and Prevention, and Substance Abuse and Mental Health Services Administration. MacMillan, et al. (2007) write about the necessity of policy-relevant research strategies for child maltreatment. Their research focused on Canada, but they convincingly convey the issue's international relevance.

Ruzek and Rosen (2009) stress disseminating evidence-based treatment information on PTSD to organizations that work with trauma victims, including training mental health providers and implementing collaboration among service delivery organizations. Springer, et al. (2003) elaborate further by including the criminal justice system and insurance companies, and look at prevention as well as treatment. Sorenson (2002) examines public health and population-based methods for addressing traumatic stress, trying to balance broad risk prevention approaches that decrease risk of exposure with narrower treatment and recovery strategies that lead to fewer cases of PTSD.

Morrissette (1999) synthesizes and analyzes practice theories. He follows in Herman's (1995) footsteps when he acknowledges difficulty in applying PTSD to CSA survivors due to their complex issues. He recognizes the need for a broader theoretical model that distinguishes between CSA and other childhood trauma. Cohen (2008) also builds on Herman's (1992) CP model, specifically addressing needs of women by including developmental, emotion-focused, and feminist approaches. Morrissette (1999) acknowledges benefits gained by use of the PTSD label, which is descriptive, serves to normalize the phenomenon and depathologize the survivor, and provides some clear expectation of what will occur. However, he points out, there is not clear agreement on what constitutes a traumatic event or why some develop symptoms and others do not.

Morrissette (1999) breaks theoretical models down into three categories: internal processing, behavioral/cognitive (CB), and formative models. Under internal processing models he includes psychodynamic, trauma learning, social learning, and psychosocial models. Under behavioral/cognitive models, Morrissette identifies behavioral, cognitive impact, and cognitive behavioral models. Included in Morrissette's list of formative

models are the developmental model, and the traumagenic dynamics model, which goes beyond the limitations of the PTSD model.

There are many studies done on treating trauma. Scott and Ross's (2006) case study looks at creative arts therapy's (CAT) usefulness in treating trauma. There are a number of types of therapy used with CA survivors, including mindfulness meditation-based stress reduction (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010), Bloom's Sanctuary Model (Bloom, 1997; Rivard, 2004; Rivard et al., 2003, 2004, 2005), emotion focused therapy (Paivio & Nieuwenhuis, 2001), and pharmacotherapy (Friedman, Davidson, Mellman, & Southwick; in Foa, Keane, & Friedman, 2000**).**

Eye movement desensitization and reprocessing (EMDR) is an approach found effective in addressing PTSD, however, more studies with more extensive controls are needed to address research limitations and compare EMDR to other treatments and improve confidence levels (Chemtob, Tolin, van der Kolk, & Pitman, in Foa, Keane, & Friedman, 2000). Foy, et al. (in Foa, Keane, & Friedman, 2000) looked at studies of group therapy: supportive groups; psychodynamic groups; and CBT groups. They found group therapy potentially effective and noted evidence does not favor one type of group over another. The authors reviewed limitations: completion of previous individual therapy; scheduling; trust issues; having no suicidal, homicidal, severely paranoid or sociopathic traits; similar type of trauma; and member compatibility.

Psychodynamic therapy offers another option. Kudler, Blank, and Krupnick (in Foa, Keane, & Friedman, 2000) found only a few empirical studies, and these were not conclusive about efficacy. Inpatient treatment is another approach, with the bulk of research on combat veterans and little on adult survivors of childhood trauma. In-patient

provides multi-modal, short- or moderate-term treatment when there is severe symptomotology and/or serious destabilization. Evidence suggests this intervention is effective for a period of time but, in many cases, gains are not permanent due to the disorders' chronic nature (Stalker, Palmer, Wright, & Gebotys, 2005). Analysis is also complicated by the multi-modality of approaches. Psychosocial rehabilitation is also recommended for adults with PTSD, including health education and psychoeducational techniques, self-care training, family skills training, supported housing, social skills training, vocational rehabilitation, and case management. Penk and Flannery, Jr. (in Foa, Keane, & Friedman, 2000) suggested using these techniques in conjunction with other forms of treatment.

Cardenz, Maldonado, Van der Hart, and Spiegel (in Foa, Keane, & Friedman, 2000) looked at hypnosis' usefulness with PTSD, based on subject responsiveness to hypnotic suggestion. Using hypnosis with other therapies, such as CBT and psychodynamic approaches, can significantly enhance effectiveness (Kirsch, Capafons, Cardena, & Amigo, 1998; Spiegel & Spiegel, 1987; in Foa, Keane, & Friedman, 2000). Marital and family therapy helps ameliorate marital or family disruption by supporting the person being treated for PTSD. Riggs (in Foa, Keane, & Friedman, 2000) found the few available studies were not systematic so efficacy could not be evaluated. He concluded this approach should be used only as an adjunct to treatment that focuses on PTSD itself. According to Johnson (in Foa, Keane, & Friedman, 2000), CAT lacked conclusive evidence regarding efficacy in PTSD treatment. Most empirical work has been done on assessment rather than treatment. The remainder of evidence for CAT is based on clinical reports and case studies that show significant reduction in symptoms and functional

measures. Scott and Ross (2006) explored CAT in a case study and found it enhances trauma and addiction therapy.

One of the most widely recognized interventions for PTSD is Cognitive Behavioral Therapy (CBT). McDonagh, et al. (2005) and Dorrepaal, et al. (2010) found women survivors of CSA need interventions to specifically address their configuration of symptoms. Dorrepaal, et al. (2010) found women CSA survivors with CP required more stabilization, and group therapy combining CBT with psycho-education addressed this. Further, he found women with co-morbid personality disorders needed more structured and less interactive treatments. Cohen (2008) looked at research showing CBT to be effective for treating sexual assault in adulthood. She considers how CBT is generalizable to women who experienced CSA and how to adapt it to their specific issues. To augment CBT, she draws on developmental, emotion-focused, and feminist sources: to provide clients with corrective interpersonal experiences; address issues of self-blame, power inequality, betrayal, and stigma; develop feminist consciousness; examine sex-related cognitions and emotions; build better affect regulation before exposure therapy; and reflect on time passed since abuse occurred.

Rothbaum, Meadows, Resick, & Foy (in Foa, Keane, & Friedman, 2000) looked at PTSD treatment guidelines. They reviewed CBT treatments for PTSD, using empirical studies rated on a six-level scale adopted from the Agency of Health Care Policy and Research Classification of Level of Evidence. The broke down approaches into components to study separately: exposure therapy (EX); systematic desensitization (SD); stress inoculation training (SIT); cognitive therapy (CT); cognitive processing therapy

(CPT); assertiveness training (AT); biofeedback (BIO); relaxation training (Relax); combined SIT/EX; combined EX/Relax/ CT; and combined CT/EX.

There is no evidence to support effectiveness of current policies to ameliorate the problem of PTSD for women CSA survivors, as there are no policies directly addressing the issue. However there are practice interventions whose effectiveness research supports. Rothbaum, Meadows, Resick, and Foy (in Foa, Keane, & Friedman, 2000) found of the therapies they examined, EX was the only one that showed consistently positive results for treatment of PTSD in a mixed variety of trauma victims in well-controlled studies. IT, CPT, and CT showed efficacy with female sexual assault survivors but the studies lacked methodological rigor and the treatments were not significantly better than comparison treatments. Knaevelsur and Maercker (2007) found internet-based CBT for PTSD to be a viable alternative with sustained treatment effects and large effect sizes in a randomized, controlled, clinical trial. Contrary to the idea that face-to-face contact is imperative in therapy, they found positive online relationships could be established to improve treatment process. McDonagh, et al. (2005) found CBT more effective than present-centered therapy (PCT) and waitlist (WL) in decreasing PTSD and its symptoms, resulting in CBT participants being significantly more likely than those receiving PCT to no longer meet criteria for a PTSD diagnosis six months following completion. However, CBT had a significantly higher dropout rate than PCT and WL.

Paivio and Nieuwenhaus (2001) found emotion focused therapy effective for adult survivors of CA, with statistically and clinically significant improvements in disturbance symptoms, current abuse related problems, global and specific interpersonal problems, and self-affiliation, with clients maintaining gains at nine-month follow-ups. They found

effect sizes equivalent to those in other successful treatment outcome studies. There is one study by Brom, Kleber, and Defares (in Foa, Keane, & Friedman, 2000) using empirical research on hypnosis that showed it significantly reduced decreased symptoms of intrusion and avoidance. In a randomized, controlled trial, Cloitre, et al. (2010) compared skills training in affect and interpersonal regulation (STAIR) followed by exposure against two control conditions: supportive counseling followed by exposure; and STAIR followed by supportive counseling in treating PTSD related to CA. They found that with those with chronic and early-life trauma, skills-to-exposure treatment was more effective than treatment without skills training or exposure.

Randomized, well-controlled clinical trials of pharmacological treatment support selective serotonin reuptake inhibitors (SSRIs) for reducing PTSD symptoms and producing global improvements in non-veterans. *Sertraline* showed highest efficacy and received Federal Drug Administration approval (Friedman, Davidson, Mellman, & Southwick; in Foa, Keane, & Friedman, 2000**).** Another study with positive enough results to warrant further investigation in randomized, controlled trials was Kimbrough, et al.'s (2010) study on mindfulness intervention, which showed statistically improved outcomes in PTSD, depressive symptoms, anxiety, and symptoms of avoidance/numbing. In Foy, et al. (in Foa, Keane, & Friedman, 2000) group therapy showed effectiveness based on 14 studies—two used randomized control designs, five used non-randomized control designs, and seven use single group designs with pre-post examinations.

Part IV

In *The Social Work Dictionary*, intervention "includes 'treatment' and other activities to solve or prevent problems or achieve goals. Thus, it refers to *psychotherapy,*

advocacy, mediation, social planning, community organization, finding and developing resources" (Barker, 2003; pp. 226-227). Because of the dearth of legislation, policy, and public attention directly addressing PTSD among women survivors of CSA, a multi-pronged approach is needed to begin to develop interventions to ameliorate the problem. Herman (2002) purported the idea that society must be enlightened as to how to address trauma from a multidisciplinary perspective in a cross-cultural context. The goal of the primary intervention proposed here is to bring greater attention to the problem. Some secondary and tertiary interventions will be briefly presented at the end of this paper.

Webster and Dunn (2005) and Cohen (2008) used a feminist perspective to look at challenges women who experience trauma, including CSA, face. The first obstacle is cultural attitudes of stigmatization. Webster and Dunn (2005) consider prevalent ideas towards females' experiences of being violated throughout the life stages and point to Freud's era and the belief that CSA was a fantasy of children. They consider more recent myths, such as denying the existence of sexual abuse of children, blaming the child when it is acknowledged, and believing CSA is rare and only strangers sexually assault children. Cohen (2008) reflects on how survivors have internalized shame and guilt associated with the abuse and their expectations of being blamed or held responsible.

Public action has occurred on issues similar but not identical to PTSD in CSA survivors, that could be adapted and applied to the issue. Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services (HHS), has put forth a new program called Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014 (http://www.samhsa.gov/about/strategy.aspx?from=carousel&position=1&date=11082010, retrieved November 14, 2010). This

program has eight initiatives, three of which are relevant to this population. The first, Initiative #8, Public Awareness and Support, could help women survivors of CSA with PTSD if it specifically targeted them and raised awareness of their problems. Beaudoin (2009) studied a media campaign targeting PTSD after Hurricane Katrina and found it drew attention to PTSD, positively influencing beliefs and preventive behavior. Though a natural disaster differs from the ongoing, chronic traumatization characteristic of CSA, the study demonstrates benefits to utilizing media to change attitudes and outcomes. Initiative #8's program goals include addressing obstacles that interfere with people in need accessing and receiving services. One major obstacle they identified, as did Webster and Dunn (2005) and Cohen (2008), is stigma and discrimination.

Herman's seminal work, *Trauma and Recovery* (1992), helped awaken society to the scope of trauma's impact and the number of people effected by it. She called for empowering victims of the largely hidden crimes of CSA and outlined stages of recovery in adulthood (Webster & Dunn, 2005). In later work, Herman (2002) asked how to hold perpetrators accountable and what victims would see as justice for crimes endured. In contrast, SAMHSA's strategic initiative #2: Trauma and Justice looks at how survivors interact with the justice system as a result of their own criminal behavior. Justice needs to be addressed from both perspectives. Initiative #2 also looks at what is necessary to serve this population, such as trauma specific services to address impact and trauma informed settings that create safety for survivors.

SAMSHA has a third initiative relevant to this problem—Initiative #1: Prevention of Substance Abuse and Mental Illness. This closely relates to the issues of long-term sequelae of CSA, preventing PTSD, and treating it when it does occur (Springer, et al.,

2003). SAMHSA's Leading Change report looks at the cost to society, and the individual, in terms of social, economic, and health-related problems (Kessler, 2000). New reforms under the Affordable Care Act of 2010 enable stakeholders and partners to increase prevention efforts nationally and insure access to affordable and effective health care (http://www.healthcare.gov/law/introduction/index.html, retrieved November 14, 2010).

To realize the goal of bringing attention and understanding to PTSD in women CSA survivors, this paper is proposing a Knowledge Dissemination Conference (KDC), funded through SAMHSA's Conference Grant program. The purpose of the program is to "disseminate knowledge about practices within the mental health services… prevention and treatment fields and to integrate that knowledge into real-world practice" (http:// www.samhsa.gov/ Grants/2008/ OA_08_002cmhs.aspx, retrieved November 14, 2010). Holding a conference would bring together PTSD experts knowledgeable about women's mental health, child development, and the unique sequelae of CSA that distinguish it from sexual assault of adult women (Cohen, 2008). It would highlight implications of the issue (Harvey, 1996; in Webster & Dunn, 2005) not just at the mental health level, but also at medical, social, legal, political, and public health levels.

Harvey (1996; in Webster & Dunn, 2005) used an ecological framework to show causes and clinical implications of trauma, demanding communities share responsibility for violence against women [and girls] and prevent future occurrences. Her work highlighted how women from communities that view violence against women [and girls] as a form of patriarchy and oppression will typically have better outcomes than women whose communities support patriarchal attitudes, including misogyny. These considerations would be addressed at the KDC and funneled into SAMHSA's social marketing

campaign via Initiative #8, targeting women CSA survivors who need to be screened for PTSD, and helping change attitudes that stigmatize and discriminate against this group.

Completing the application process and being awarded a grant would provide resources to make this KDC happen. Grants are awarded on the basis of compliance with SAMHSA's Center for Mental Health Services' (CMHA) mission: improving accessibility and availability of high quality mental health services for adults with serious mental illness and addressing emerging mental health service needs (http://www.samhsa.gov/Grants/TA/index.aspx). Applicants must meet all screening requirements, and support—State Point of Contact (SPOC) and Single State Agency (SSA) lists—is available to discuss plans. SAMHSA and Government Project and Grants Management Officers can also provide information about Federal funding and technical assistance.

Requests for applications (RFAs) are posted on SAMHSA's website. Applications are due March 30 and September 30 of each year, excluding 2010, making 2012 the year this applicant would apply. To be eligible, an agency must be a domestic public or private non-profit entity. Limitations include the grant go towards only one KDC and come from one SAMHSA center, such as CMHA. Not all centers fund KDC grants in any given year. The maximum grant award is $50,000 and depends on availability of funds. David Morrissette, Ph.D., LCSW is the contact for mental health grant topics.

A NYS agency fit to apply for a KDC grant would be Mental Health Association of Ulster County (MHAUC). The MHANY 2009 legislative agenda included Anti-Stigma & Public Awareness of Mental Health Issues. Out of this agenda, MHANYS developed a project—Building Connections: The Sexual Assault/Mental Health Project (http://www.mhanys.org/programs/bc/index.php, retrieved November 5, 2010). Building Connections

is a project of the Office of Mental Health (OMH) Trauma Initiative that began in 1995. The Trauma Initiative works in four arenas: statewide policy and programs, state psychiatric centers, community programs, and training and technical assistance. In May 2000, OMH established a Trauma Unit that guides the Building Connection Project, a collaborative effort between NYSCASA and MHAUC.

Brown's (2002) research evaluated the effectiveness of a conference for substance abuse practice. She illuminated how conferences serve as collaborative information-sharing forums. The goals outlined in her paper are similar to those for the KDC: bring together researchers, treatment providers, grant makers and policy makers, and establish common language and objectives; broaden understanding of treating PTSD in women survivors of CSA; expand providers' knowledge of research methods and evidence-based treatment practices; and identify and develop research questions for investigation of issues and treatment methods related to and applicable in everyday practice. The outcome would be greatly increased awareness of PTSD in women CSA survivors.

Brown (2002) utilized initial and five-month follow-up evaluations to gather feedback from attendees. This paper is proposing a pre-test post-test, self-administered, anonymous questionnaire. The pre-test would be completed at conference outset to measure knowledge attendees have coming in; and the post-test at conference completion to assess what new or different knowledge attendees have attained. Similar to Brown's model, there would be a section for participants to express opinions about the KDC's value in increasing awareness of the issue, using a Likert scale. Five months hence, the post-test would be re-administered to assess knowledge retention and benefits of subsequent learning resulting from further contact with other KDC attendees or experts

on this issue, additional research, or application of knowledge gained at the KDC. Again, space would be given to reflect on and compare original impressions of conference usefulness towards the goal of greater awareness, using the Likert scale.

In this last section, this paper will present additional interventions that could be implemented if increased awareness of PTSD in women survivors of CSA creates greater commitment to the issue. In Canada, there is an award-winning psychiatric inpatient program (http://www.homewood.org/healthcentre/ retrieved November 10, 2010), which utilizes Bloom's Sanctuary Model. It is called Program for Traumatic Stress Recovery (PTSR) and serves adults with PTSD, including CSA survivors. PTSR could be introduced in the U.S. if public funding were obtained, patients paid out-of-pocket, or a private entity helped finance it. Sandra L. Bloom has continued to develop her work. In "Bridging the Black Hole of Trauma: The Evolutionary Significance of the Arts" (2010), she looks at the power of performance to re-integrate a self fractured by traumatic experience(s). The arts are an area rich in opportunity for self-expression and healing.

A Canadian sculptor and CA survivor created a Child Abuse Monument he describes as a voice for all abused children. It serves as a memorial and is intended it to have the kind of impact the Vietnam Memorial did to change attitudes towards an issue people have tried to distant themselves from and deny (http://www.irvingstudios.com/reaching_out_america/roa_index.htm, retrieved November 16, 2010). There are many such efforts in the U.S. using literary, fine, and performing art forms relating to this issue. A project of this nature could be started locally in the Hudson Valley.

An intervention more fully explored elsewhere by Forest (2010a; 2010b) is exercise as an alternative or adjunct to psychotherapy and pharmacotherapy to less

expensively and safely treat mental disorders in group therapy settings. Her research supported exercise's efficacy in addressing anxiety and depression. Ottati and Ferraro (2009) had similar findings and established support for exercise offering a safe, effective treatment substitute for combat-related PTSD that yields a long-term, symptom-free prognosis and is cost-effective when administered in large groups. They found that exercise's lack of side effects and far reaching benefits more than offset possible limits of reduction in global symptoms, especially considering its effect on reducing specific symptom clusters. These results could be valid for the population examined in this paper, though more research would need to be done to assess feasibility and applicability.

The time for society to dedicate more attention to the issue presented in this paper is imminent. Public awareness of and attention to PTSD for combat veterans is currently high due to the Iraqi and Afghani wars. The Veterans Administration (VA) has spent the last three decades researching trauma's effect on war combatants, building knowledge in scientific analysis, behavioral genetics and pathophysiology, treatment efficacy, and evidence-based treatments (Keane, 2008). Keane's (2008) discussion of what direction to go in science and practice is relevant to women survivors of CSA with PTSD. He points out the need for interdisciplinary studies and that the complexity and cost of these are so great few funding agencies are ready to commit. A KDC would be a place to begin. Keane (2008) suggests studying: variables in risk and resiliency over time; neuroscience; measurement/assessment models; intervention trials; longitudinal studies; and working from a sound theoretical framework. The large body of research and heightened awareness about PTSD in veterans sets the stage for focusing on another significant and substantial population with PTSD—women survivors of CSA. It is the contention of this

writer, and others (e.g. Kessler, 20008) that it is more cost effective in the long run to address prevention and work on early outreach and treatment for this population then to allow the significance of their problems to go unrecognized and have individuals and society pay the high price later.

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