Fracturing the Façade: Exploring the Impact of Childhood Sexual Abuse

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This thesis is submitted in partial fulfillment of the requirements for the degree of Doctor of Psychology (Forensic).

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submitted for the degree of:  
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is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

I also certify that any material in the thesis which has been accepted for a degree or diploma by any other university or institution is identified in the text.

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“Life experience has taught me valuable lessons that I cannot put a price on. If what I am telling you can save one child from abuse, then it will all be worth it.”
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Abstract

Examination of previous empirical literature illustrates how researchers have concentrated on documenting the impact of childhood sexual abuse (CSA) on the later psychological functioning of survivors, through comparisons with those who have not had such a history. Only more recently has there been a focus on assessing the relationship between aspects of the abuse and specific psychological difficulties. This thesis investigated the relationships between CSA characteristics and women’s later psychological adjustment. The role of attributions, coping methods, parenting competency and marital satisfaction were also investigated. Qualitative data on perception of benefit and general reflections of participants were used to explore participants’ self-esteem, locus of control, decisions relating to parenting, disclosure experiences, and attributions in relation to their abuse, including the search for meaning. Recruitment through newspapers and counselling services led to 118 women volunteering to complete a questionnaire evaluating the characteristics of their CSA and their current psychological adjustment. Of this group, 33 subsequently volunteered to participate in a telephone interview that explored in greater depth issues related to the long-term impact of their CSA. Both quantitative and qualitative analyses were conducted on the data. The women reported a high prevalence of dysfunction in their families of origin. Abuse had generally commenced by middle childhood, and lasted for a number of years and often involved a number of perpetrators. Perpetrators were most likely to be intrafamilial, with stepfathers being over-represented. Sexual activities generally involved physical contact, with participation often induced by the use of coercion. Participants demonstrated significant difficulties in psychological adjustment, but attributions regarding the abuse improved over time. Some concerns were expressed regarding parenting competency, and avoidant coping methods were favoured. In general, participants were satisfied with their current marital relationship. Significant associations were found between coping methods, attributional style, beliefs and various psychological adjustment measures. Participants, in general, demonstrated low self-esteem and displayed an external locus of control. As a consequence of their experience of CSA, many participants reported they had decided not to have children. For those who did have children, CSA was almost universally seen as having had an impact on their parenting. Disclosure of CSA was usually delayed for a number of years, with
poor outcomes generally resulting from disclosure when it occurred. Women with current partners rated them as very caring and not controlling. Participants were generally still searching for meaning in their abuse, despite many having accepted it. Survivors outlined an extensive range of long-term effects of CSA, and nominated a number of strategies that would assist in reducing these effects. The results of the study indicated that there are a number of characteristics associated with CSA which signal a higher risk of difficulties in psychological adjustment. Concerns of survivors regarding parenting were confirmed according to those who undertook this role. Unfortunately, concerns expressed by survivors that disclosure of their CSA would have had negative consequences was usually the case when they did finally disclose. However, the accessing of social and family support appeared to have an important role in changing the attributions of survivors regarding their CSA. Furthermore, change of attributions in relation to abuse may provide the key to resilience in survivors against the negative impact of CSA on later psychological adjustment.
CHAPTER 1

CSA AND PSYCHOLOGICAL ADJUSTMENT

Since the 1980’s there has been a great deal of attention paid to researching the notion that childhood sexual abuse (CSA) may have harmful long-term consequences for the psychological functioning of those who experienced it (Briere, 1988). Browne and Finkelhor (1986) conducted a comprehensive review of studies examining the long-term impact of CSA and concluded that CSA was consistently associated with very serious psychological difficulties in a proportion of survivors. These difficulties included low self-esteem, anxiety, depression, suicidality, guilt, substance abuse, interpersonal problems, sexual adjustment problems and a likelihood of revictimization in adulthood. The findings were relatively stable across a range of groups including community, college and clinical samples. The vast majority of studies investigated the impact of CSA on women rather than men, given the limited number of males volunteering disclosure of CSA experiences.

The early research into the long-term impact of CSA concentrated on documenting the psychological difficulties experienced by survivors, through comparison with adults who lacked a history of abuse, leading Briere (1988) to label it “effects research”. According to Briere, the next step was to determine the relationship between aspects of the abuse and specific psychological difficulties. The difficulty in conducting such research lay in the requirement for a greater number of participants and complex methodology. The importance of specific abuse-effects research lies in the provision of knowledge about the development of psychological symptoms relating to the abuse, leading to the potential development of specifically targeted and effective interventions.

The aim of the present research was to examine the relationship between CSA characteristics and the later psychological adjustment of women survivors. References reviewed were selected from a comprehensive search of the PsychLit database covering the period commencing with the 1990’s and on the basis of citation in other materials. The first stage of the research explored the role of attributions, in relation to the abuse,
and coping methods in predicting psychological adjustment in adult survivors. Qualitative data were gathered in relation to CSA survivors’ perception of any benefit arising from the abuse. Psychological adjustment was evaluated in terms of symptoms of emotional distress, parenting competency and marital satisfaction. The second stage of the research sought to explore in greater detail themes which had emerged from the data gathered in the first stage. In particular, issues of self-esteem, locus of control, decisions relating to parenting and the impact of CSA on parenting were investigated. CSA survivors’ attributions regarding their abuse were explored in depth, including the search for meaning in their abuse. Survivors’ were questioned regarding their beliefs about the long-term impact upon them of experiencing the abuse, and how this long-term impact could be reduced.

This chapter provides a justification for conducting the present study, as well as providing a definition of CSA. This will be followed by an examination of factors in the long-term impact of CSA on psychological adjustment, including an outline of the role of the two major factors of abuse characteristics and cognitive responses. Cognitive responses will be explored in terms of the attribution of blame and perceived benefit.

Through a review of the research literature, chapter 2 explores the context in which CSA occurs in the childhood family-of-origin, to explain the genesis of the intergenerational nature of CSA. Research that examines the long-term impact of CSA on general psychological adjustment in terms of intrapersonal functioning will be reviewed in Chapter 3. This will be followed in chapter 4 by an examination of research investigating the impact of CSA on interpersonal functioning, including relationships with partners and parenting of children. Finally, in chapter 5 the survivors’ cognitive responses relating to their experience of CSA will be examined, to enable formulation of factors which may strengthen resilience. As a result of this review of the literature, a number of hypotheses will be generated, which aim to explore linkages between abuse characteristics, adult psychological adjustment and cognitive responses to CSA.
Subsequent chapters articulate the two studies undertaken as the basis of the current research. Chapter 6 describes the method employed in Study 1 and chapter 7 presents the results of Study 1. Chapter 8 describes the method employed in Study 2 and chapter 9 presents the results of Study 2. Finally, chapter 10 describes the conclusions and implications of findings from Study 1 and Study 2, and chapter 11 outlines implications for practice, policy and future research.

Justification for the Current Study

A study designed to examine the role of abuse characteristics and cognitive responses in the later psychological adjustment of women who experienced CSA is justified for a number of reasons. Firstly, CSA is a serious issue for the community, which has immeasurable societal and personal costs. Theory and research suggest there is an association between childhood experiences, particularly those characterized as abusive, and later psychological adjustment. The processes underlying the development of good versus poor psychological adjustment in adulthood have received little systematic research attention.

Theory and research suggest cognitive mediators of the CSA experience may play an important role in the achievement of adjustment. Furthermore, the survivor’s level of psychological adjustment has implications for the individual’s quality of social relationships. Poor quality social relationships may lead to a perpetuation of cycles of abuse through revictimization by partners and inadequate parenting. Investigation of the cognitive mediators of abusive experiences resulting in positive adjustment may indicate ways in which improved psychological adjustment could be encouraged, and thus help to prevent the cycle of abuse being perpetuated.

Childhood Sexual Abuse (CSA)

Although the research focus in the area of CSA has increased significantly over the last three decades, there is still no agreement about the prevalence of this phenomenon. It is obviously important to determine the extent to which a particular sample is representative of the prevalence of sexual abuse in the general population. Yet this remains a very difficult process. For example, in a review of the literature,
Salter (1992) found a wide variation of prevalence rates in different studies that ranged from 4% to 62% for females. Even if conservative estimates are more accurate, they suggest the existence of a serious problem. At the other extreme, it has been described as “…a problem of epidemic proportions” (Peters, Wyatt, & Finkelhor, 1986, p.19). Part of the difficulty in establishing the prevalence of CSA can be attributed to differing beliefs regarding what constitutes sexual abuse (Haugaard, & Emery, 1989).

When considering definitions of CSA, a useful starting point is provided by Russell (1986), who described incestuous abuse as “…any kind of exploitative sexual contact or attempted sexual contact that occurred between relatives, no matter how distant the relationship, before the victim turned 18 years old” (p.59). McMillen, Zuravin and Rideout (1995) have more specifically defined abuse characteristics as unwanted sexual contact involving one of the following: oral, vaginal or anal intercourse; touching of the breasts or genitalia; or touching of someone else’s genitalia. Other factors to be taken into consideration were penetration and/or the use of force, age at onset and sexual abuse frequency.

The definition of CSA used by McMillen et al., (1995) will be adopted in the current study given the importance of being able to control for the influence of particular aspects of the abusive experience. Therefore, sexual abuse will be defined as unwanted sexual contact involving the following characteristics: oral, vaginal or anal intercourse, sexual touching of self or others. Given the impact of other factors such as the use of force or threat of force, age at onset, frequency and duration, relationship to the perpetrator and the number of perpetrators, the influence of these factors will also be evaluated.

Many researchers have used a definition of CSA which specifies a minimum difference in the age of the survivor and offender (Peters, 1988; Russell, 1986). However, this criterion may exclude situations of sexual abuse perpetrated by siblings. The philosophy underlying the current research was to be as inclusive as possible of a diverse range of CSA survivors, to improve generalizability of the
findings and detect any patterns that may be present, therefore no criterion relating to age difference between survivor and offender was used.

Long-Term Impact of CSA on Psychological Adjustment

When considering the impact of CSA on psychological adjustment, aside from characteristics of the abuse, the influence of cognitive responses, including coping style, should also be investigated. In addition, CSA may be simply one negative experience out of a range of psychosocial issues present in the survivor’s family-of-origin which had an impact upon later psychological adjustment.

There has been a great deal of research focussing on the long-term impact of CSA (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Jumper, 1995; Kendall-Tackett, Williams, & Finkelhor, 1993). Major reviews of the relevant research have supported the prediction that adults who had been sexually abused during childhood would demonstrate higher levels of psychological and social distress in adulthood than non abused control samples (Browne, & Finkelhor, 1986; Haugaard, & Reppucci, 1988; Wyatt, & Powell, 1988). Consequently, research attention has focussed on examining the nature of this link between CSA history and later psychological adjustment.

However, other researchers suggested family dysfunction or a general maltreating environment may also be responsible for the trauma of sexually abused children, rather than simply the abuse experience and its aftermath (Alexander, 1985; Banyard, 1997; Cohen, 1995; Higgins, & McCabe, 1994). Observations by clinicians suggested there was an intergenerational cycle of child abuse (Egeland, Jacobvitz, & Sroufe, 1988; Rutter, 1989; Zuravin, McMillen, DePanfilis, & Risley - Curtiss, 1996). It has been proposed there are a number of mediating factors that have an important influence on the degree of transmission of abuse status. Those factors which have been well documented are the family functioning of the child’s family-of-origin and the role of family support, coping strategies and attributional style (Finkelhor, 1984; Gold, 1986; Hiebert- Murphy, 1998; Higgins, & McCabe, 1994; Steele, & Alexander, 1981; Wyatt, & Mickey, 1987).
Furthermore, as parenting capacity is clearly impacted upon by the parent’s psychosocial adjustment, a history of CSA was hypothesized to have a negative impact on parenting ability (Burkett, 1991; Cohen, 1995; Cole, Woolger, Power, & Smith, 1992). However, parenting of children is only one area of interpersonal relationship functioning of a woman who has experienced CSA; consideration should also be given to the relationship with her partner, particularly given the direct bearing this has on parenting of children. However, surprisingly, there appears to have been very little research that specifically examines the relationship between women who have been sexually abused as children and their partners, with the exception of pioneering work by Jehu (1988). This research found relationships between previously sexually abused women and their partners tended to be characterized by discord, often resulting from exploitation of the women by their partner, overdependence of the partner on the women and dissatisfaction and distress of the partner concerning specific aspects of the relationship.

Abuse Characteristics

It would appear that particular aspects of the abusive experience itself may influence the likelihood of long-term effects on the survivor’s adjustment. Such aspects include the finding that increased frequency and duration of sexual abuse and a greater number of perpetrators are related to a more severe outcome for the survivor (Johnston, 1979; Burgess, Hartman, McCausland, & Powers, 1984; Friedrich, Urquiza, & Beilke, 1986; Sirles, Smith, & Kusanna, 1989). Some researchers have suggested that an earlier age at onset of abuse has more serious consequences for the survivors (Alexander, 1993; Charmoli, & Athelstan, 1988; Russell, 1986). In addition, the use of force and/or penetration (Elwell, & Ephross, 1987) and the perpetrator being the child’s father or stepfather (Adams-Tucker, 1982; Courtois, 1979; Finkelhor, 1979; Friedrich et al., 1986; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988; Meiselman, 1978; Peters, 1976; Russell, 1986; Sirles et al., 1989) have been associated with greater victim trauma.
Cognitive Responses

The development of theories focusing on coping with traumatic experiences has assisted in explaining the cognitive process of adjustment to adverse events, including CSA (McCann, Sakheim, & Abrahamson, 1988). Generally, it is proposed that the effect of the traumatic experiences depends partially on how individuals perceive and cope cognitively with the traumatic events. Briere and Runtz (1988b) observed sequelae of CSA to include guilt, low self-esteem, distrust and helplessness, leading them to report that “…the long-term effects of sexual abuse appear to include negative thoughts, assumptions, and perceptions regarding self, others and the environment (p.94)”. Similarly, Browne and Finkelhor’s (1986) traumagenic dynamics theory of sexual abuse adjustment is founded on the belief that CSA impacts upon a child’s affect, views of the self and the world.

McMillen (1993) suggested that two cognitive responses to maltreatment, attributions of blame for CSA and perceived impact from the adverse experiences, may be relevant to the subsequent parenting of those women sexually abused as children. The study of the relationship between attributions for CSA and psychological adjustment suggests that self-blame is negatively associated with adjustment (Hoagwood, 1990; Morrow, 1991; Morrow, & Sorrell, 1989; Wyatt, & Newcomb, 1990). It has been observed that women who had experienced CSA demonstrated a range of responses, from being characterized as resilient to having a tendency for revictimization (Conte, 1985; Feinauer, & Stuart, 1996; Messman, & Long, 1996; Murphy et al., 1988).

However, care must be taken when defining revictimization, for there would appear to be different processes occurring in the context of multiple victimizations during childhood, as compared to childhood followed by adult victimization. The former may involve repeated victimization by multiple perpetrators, or repeated abuse by one perpetrator, which may place the child at risk for additional victimization experiences. Therefore, in terms of examining the link between the impact of CSA and later adjustment, revictimization will be defined in terms of child
and later adult assault, rather than multiple assaults during childhood (Messman, & Long, 1996).

**Perception of Benefit**

Researchers analyzing different adverse experiences have reported that victims often construe some benefit from the victimizing experience (Taylor, Wood, & Lichtman, 1983). This perception of benefit had been positively related to adjustment in the individuals’ reactions to several kinds of adverse experiences (Affleck, Tennen, & Rowe, 1991; Mendola, Tennen, Affleck, McCann, & Fitzgerald, 1990; Affleck, Tennen, Croog, & Levine, 1987; Thompson, 1985), including CSA (Russell, 1986). Furthermore, there appeared to be a positive relationship, as expected, between perceived impact and more objective measures of outcomes for the individual. Women sexually abused as children were also observed to have had varied perceptions of the trauma they experienced as a result of their sexual victimization (Russell, 1986).

Russell (1986) reported a significant relationship between perceived trauma and overall outcome, as measured in terms of negative life events. CSA survivors who perceived the abuse as more traumatic, also reported more adverse events later in life. However, less is known about the opposite end of this spectrum, which relates to perceived benefit from the abuse, for Russell’s (1986) perception measure did not allow respondents to indicate perceived benefit. Nevertheless, when Russell (1986) questioned adult incest survivors about how CSA had affected their lives, unexpectedly several reported positive effects.

More recently, McMillen, Zuravin and Rideout (1995) attempted to analyze this positive perception in greater detail, by establishing how many women perceived benefit, what kinds of benefit were perceived, by whom, and whether such perceptions related to adult adjustment. They found approximately half the women perceived some benefit. The benefits were classified into four main categories: protecting children from abuse, self-protection, increased knowledge of CSA, and having a stronger personality. The degree of perceived benefit was associated with
several indicators of adult adjustment including self-esteem, relationship anxiety and comfort with depending upon others. Specifically, those women who perceived themselves as becoming stronger had higher self-esteem, and those who perceived increased sexual abuse knowledge viewed others more favourably and were more comfortable in getting close to others, when compared to other participants.

It is unclear how perceiving benefit from abuse may affect parenting (McMillen, 1993) and relationship functioning. It could be suggested those who feel that they have benefited in some way from their maltreatment may be more likely to feel that maltreatment could also benefit their children, and therefore be more likely to abuse or allow abuse of them (McMillen, 1993). Yet on the contrary, it is more likely that a perception of harm may lead a mother to go to greater lengths to attempt to protect her children from such experiences. Alternatively, finding benefit from such traumatic experiences may simply indicate the presence of an effective coping style, which may facilitate integration of the experience and allow individuals to get on with their lives (McMillen et al., 1995). McMillen (1993) has also suggested that the survivor’s perception of the impact of CSA may affect attributions of blame for the abuse. This suggestion is based on the research of Tennen and Affleck (1990) who proposed that perceiving events as traumatic leads to an increased attributional search, whereas finding benefit in an adverse event makes it less likely the person will blame others for this event.

**Current Research Study**

The present study involved a retrospective survey of adult women sexually abused as children. The women were recruited through advertising at participating Centres Against Sexual Assault (CASAs) within the state of Victoria, Australia. Recruitment was also facilitated through a brief article about the research study in a range of small, local newspapers and a daily, metropolitan newspaper, which included an invitation to participate and a contact telephone number. The only eligibility criteria specified for participation indicated that survivors were required to be over eighteen years of age. The first stage of the research involved completion of a
comprehensive questionnaire. Some participants were subsequently involved in in-depth semi-structured interviews for the second stage of the research.

The primary dependent variable in the first research study was psychological adjustment, which was evaluated using a self-report symptom inventory originally designed to reflect the psychological symptom patterns of psychiatric and medical patients. The other two dependent variables were parenting and relationship functioning. The independent variables employed were CSA characteristics and cognitive responses to the sexual abuse, including attributions in relation to the CSA and perceived benefit from CSA, and coping methods.

In the second stage of the research, the independent variables of abuse severity, duration of abuse and nature of the relationship to the offender were used to predict the dependent variables of self-esteem, locus of control, intimate bonds in partner relationships and attributions in relation to the search for meaning in the abuse.

Significance of Research

Professionals who work with women who have experienced sexual abuse as children cannot change these experiences, but perhaps they can change the way they are perceived. Ideally, they should be able to offer interventions that may help to decrease the negative impact of abuse on those women’s lives. The key to understanding this process would seem to lie with those women who demonstrate resiliency. Most importantly, for parents abused as children, a changed perception of their abuse may lead to an improvement in their psychological adjustment, which may have a flow on effect for their children. This may either occur directly through improved parenting capacity, or more indirectly through improvement in their intimate partner relationship functioning. It is believed that a more comprehensive understanding of the underlying cognitive processes of women sexually abused as children will elucidate the differences between those individuals whose children are likely to become the next abused generation and those who end intergenerational cycles of child abuse.
CHAPTER 2

CHILDHOOD FAMILY BACKGROUND

It has long been recognized CSA is not an event that occurs in isolation. Children growing up in a dysfunctional family environment are at a higher risk of experiencing all forms of abuse. Therefore, when investigating the impact of CSA on adult psychosocial functioning, consideration must be given to the influence of family environmental factors (Edwards, & Alexander, 1992; Pelletier, & Handy, 1986). A number of researchers have identified characteristics that seem to be associated with the occurrence of CSA, such as marital conflict, paternal dominance, authoritarian family structure and conservative values, and parents’ sexual punitiveness. In addition, factors such as parental unavailability or absence, lack of parental support/warmth, parental substance abuse, having an emotionally or physically distressed parent, social isolation, maternal employment, an “ineffective” mother, mothers as victims in the marital relationship and girls who lack an adequate role model, have been identified as salient (e.g., Finkelhor, 1979; Higgins, & McCabe, 1994). Aside from this range of psychosocial stressors, the CSA survivor may also experience concomitant physical and psychological abuse during her childhood. Thus, this chapter will examine the impact of psychosocial issues in the family-of-origin and concomitant physical and psychological abuse on the CSA survivor’s psychological adjustment in adulthood.

Family-of-Origin Factors

The role of the childhood family-of-origin factors in the occurrence of CSA has been explored in an extensive range of research studies employing participants recruited from the community, colleges and clinical services. Findings from the research literature will be discussed in relation to each of these three types of studies in three subsections commencing with community studies, followed by studies of college students, and finally studies of participants receiving clinical treatment. Within each subsection, studies are generally discussed in chronological order to
facilitate depiction of how successive research findings have built on a cumulative body of knowledge.

**Community Studies**

Finkelhor (1979) identified parental authoritarianism and parental separation as risk factors associated with CSA. As a result, Bagley and Ramsay (1986) attempted to measure these variables in their community sample of 367 women, 82 of whom had a CSA history. The women’s recollections of parental punitiveness, coldness, and control without support, were the variables found to be most strongly linked to a CSA history. Furthermore, within the abused group, parental separation, parental coldness and lack of support were found to be independent predictors of mental health outcome. These variables continued to be significantly linked to poor mental health, even when sexual assault variables were controlled. Thus, CSA co-occurred in those homes disrupted by parental separation and identified as having parental coldness or lack of support, but CSA could not be said to be directly linked to these family variables. This was also found to be true for intrafamilial abuse cases to a lesser degree. Those children from families with parental coldness, lack of support and parental separation, reported sexual abuse by immediate/extended/friends of the family in 49% of cases. Therefore, approximately half of the intrafamilial sexual abuse cases were explained by other factors.

To try to establish possible causal relationships and chronology, Bagley and Ramsay (1986) reinterviewed 20 of the sexually abused women who had mental health concerns. These CSA survivors had experienced the risk factors of parental separation for six or more months, or had experienced high levels of parental punitiveness and a lack of support. CSA, and especially intrafamilial sexual abuse, did not appear to occur independently of other family structure and environment aspects. The risk factors interacted in reinforcing poor mental health and low self-esteem, making children vulnerable to assault in such an emotionally deprived environment. It appeared poor self-esteem contributed to the child’s inability to resist abuse and to their lack of confidence in being able to disclose to an adult. Thus, the family environment may have provided the conditions for CSA to occur and to
continue. Bagley and Ramsay (1986) noted it was difficult to approach adults characterized as high on parental punitiveness, coldness, and control without support, which was operationalized in the family as a general ethos of obedience. Within such households, it was easier for adults to engage in child sexual exploitation.

From the results of a large-scale probability survey, Russell (1986) found a substantial difference in the vulnerability of females raised by stepfathers compared to biological fathers. Of those women raised by a stepfather for their first 14 years, 17% were sexually abused by him before this age, whereas this was the case for only 2% of women raised by a biological father. These findings suggest stepdaughters were eight times more likely to be abused by the stepfather raising them, than daughters being raised by their biological fathers. In terms of the total sample, women raised by a stepfather and biological mother were most likely to be incestuously abused by age 18 (28%), followed by those raised by biological mothers only (18%) (who were presumably abused by other male family members). Those women raised by both biological parents or adoptive parents were the least likely to be incestuously abused (15%). There was a highly significant association between the type of family background and multiple incest victimization, following the same pattern.

Russell (1986) found girls with stepfathers were not significantly more likely than other girls to be victimized by nonrelatives. Contrary to the prevailing social view, Russell found incest survivors were more likely to come from homes with higher incomes and to have a higher level of education. Russell argued the validity of these findings on the basis that her community sample provided an accurate representation of the social class composition of the community. Further analysis of the data indicated the percentage of survivors of both extrafamilial and intrafamilial CSA before the age of fourteen years, who came from the high income category, was higher than the percentage of women in this income category who had not experienced CSA. Whereas women coming from the lowest income group were the most likely not to have experienced CSA, followed by extrafamilial abuse and then incestuous abuse.
Consistent with findings that incest survivors came from families with higher incomes, Russell (1986) found survivors were also more likely to have a higher level of education than victims. The opposite finding had been expected by Russell given the belief that academic progress deteriorates as a result of distress associated with abuse. This finding may reflect the phenomenon of CSA survivors who strive to do well academically to compensate for their feelings of inadequacy emanating from the experience of CSA (Herman, 1981).

Russell (1986) found a curvilinear relationship between the mothers’ education level and their daughters’ incestuous abuse. Daughters whose mothers were high school graduates had the highest risk of abuse, compared to those whose mother did not complete high school or were college graduates. Furthermore, there was not a statistically significant relationship between a disparity in the parents’ educational and occupational status and an increased risk of incest for their daughters. In addition, Russell found religious background was not significantly related to the experience of CSA and neither was a rural background a risk factor for incestuous abuse.

Russell (1986) found that in approximately 75% of cases in which mothers were aware of the incestuous abuse, it was less severe abuse in terms of the sex acts involved. In contrast, in 72% of cases in which mothers were not aware of the abuse, significantly more severe types of abuse had occurred. Therefore, the more severe cases were those most likely to remain secret, perhaps due to the depleted self-esteem of the child survivor (Bagley, & Ramsay, 1986). In addition, if the incest perpetrator was a member of the nuclear family and the abuse was more severe, it was significantly less likely to produce a supportive response (from mothers or other family members) following disclosure.

The influence of family factors associated with the risk of CSA was investigated by Peters (1988) using a community sample of adult women survivors of CSA (n = 119). It was found that 40% (n = 48) of the women reported no sexual abuse, 14% (n = 17) reported noncontact only CSA and 46% (n = 54) of women reported at least one incident of contact CSA (and potentially both contact and
noncontact abuse). When the level of maternal warmth in the family-of-origin was controlled, the three groups differed significantly in terms of psychological difficulties, with the contact abuse group demonstrating a significantly higher level of psychological difficulty than either the noncontact abuse or no abuse groups. Findings for the contact CSA group indicated maternal warmth was a stronger predictor, than even severity of abuse, of psychological difficulty. However, the addition of the abuse variables of duration and number of incidents markedly improved prediction of psychological difficulty in adulthood.

In a study of professional women (n = 2,964), Briere and Elliott (1993) investigated the relationship between family environment and the impact of CSA, as a function of the familial relationship of the offender. The sample was classified into five groups: no abuse (n = 2,068), extrafamilial abuse (n = 354), extended family abuse (n = 158), immediate family abuse (n = 125), and both extrafamilial and intrafamilial (extended and immediate family) abuse (n = 126). Family dysfunction and trauma symptoms varied according to whether sexual abuse occurred in the immediate family, the extended family, outside the family, both intrafamilially and extrafamilially, or not at all. Those without an abuse history reported less family dysfunction and demonstrated better adjustment than any of the abused groups. Abuse within the immediate family was associated with greater family dysfunction, than either abuse within the extended family or extrafamilial abuse. When family dysfunction was controlled for, adjustment differences between the four groups disappeared, although the abused versus nonabused effect remained. This finding suggests family functioning mediates the relationship between CSA and symptomatology but does not completely explain it.

In a study conducted in New Zealand, Mullen, Martin, Anderson, Romans, and Herbison (1994) posted surveys to a random community sample of women (n = 2,250). All of the 248 women who reported a history of CSA were subsequently invited to be interviewed, along with an equivalent number of nonabused controls, to investigate the effect of CSA on social, interpersonal, and sexual functioning in adulthood. Male acquaintances and male relatives outside of the immediate family were found to be the most common offenders. However, stepfathers were
disproportionately represented, with 10% reported as being sexually abusive as compared to only 1% of biological fathers, results consistent with the findings of Russell (1986). Mullen et al.’s findings that CSA survivors were not more likely to come from lower socioeconomic families, were consistent with those of Russell. The exception was Mullen et al.’s finding that those reporting abuse involving penetration (3.8% of total study participants) were more likely to come from lower socioeconomic backgrounds (40.9%). In addition, survivors who reported genital abuse (15.9% of total study participants) were more likely to be from a lower socioeconomic background, although this trend did not reach statistical significance.

Mullen et al. (1994) observed that women growing up in a non-nuclear family with either one or both parents absent, had a relative risk of 2.04 of being abused and were over three times more likely to experience abuse involving intercourse. Parental separation and frequent changes of family residence also increased the risk for CSA. Having a mother who was perceived as providing low levels of care and concern, but simultaneously being intrusive and punitive, was reported by only 21.3% of the control group compared to 37.3% of CSA survivors, and 56.3% of those reporting abuse involving intercourse. Similarly, a reportedly poor level of perceived care and control from the father was provided to 34.5% of CSA survivors compared to 19.6% of the nonabused control group. Those women who had experienced physical abuse as children were also more likely to have experienced concomitant sexual abuse (13.5%) compared to controls (2.2%). This was particularly the case for survivors of abuse involving intercourse (31.3%). In terms of physical punishment after the age of 12 years, these figures rose to 14.3% for controls, 32.5% of CSA survivors and over 50% for survivors of abuse involving intercourse.

Mullen et al. (1994) also found the risk of CSA was increased by factors such as lacking a confidante as a child, growing up in a family without any obvious religious commitment or worship, parental discord, parental mental health problems and parental alcohol problems. When these risk factors for CSA were examined in terms of adult social and interpersonal functioning, growing up in a non-nuclear family or experiencing parental separation was found to be associated with sexuality problems, premarital pregnancy and a tendency to experience a decrease in
socioeconomic status. The lack of a close confidante as a child was linked to sexuality problems and marital failure. Poor mental health in a parent, including alcohol abuse, correlated with the daughter perceiving her adult relationship with her mother negatively (when the mother was the parent with mental health issues) and with a range of sexual and relationship difficulties (when her father was the parent with mental health issues). If the relationship between the parents was marked by discord, this correlated with all adverse outcomes investigated (decrease in socioeconomic status, separation and divorce, low care-high control partner, dissatisfaction with sex life, difficulties with own sexuality, premarital pregnancy) in relation to the child survivor’s later functioning. Concomitant physical abuse was associated with a decrease in socioeconomic status and strongly related to separation and divorce.

In their community study of women working at a university (n = 259), Wind and Silvern (1994) sought to investigate if perceived parental warmth and nonabusive family stressors mediated the strength of relationships between childhood sexual and/or physical abuse and later psychological adjustment. In this sample, 53% of women had not been abused (n = 137), 22% had experienced nonincestuous sexual abuse (n = 56), 6% had survived parental incest (n = 17) and 9% had experienced physical abuse (n = 24). Perceived parental emotional support and acceptance, and family stress in terms of psychosocial issues were evaluated. Survivors of parental incest and/or physical abuse were found to have significantly higher rates of all psychological symptoms compared to those who had not been abused. Parental support was rated as significantly higher, and family stress as lower, by nonabused women, compared to those who had experienced intrafamilial abuse (incest or physical abuse). In contrast, those who had experienced extrafamilial sexual abuse did not rate either parent more unfavourably than those in the nonabused group.

Consistent with the findings of Peters (1988), Wind and Silvern (1994) found both a history of sexual and/or physical abuse and unsupportive parenting were significantly associated with trauma, even after each was statistically controlled for by the other. Therefore, abuse and unsupportive parenting independently contributed to trauma symptoms. Sexual and physical abuse also remained significantly
predictive of negative experiences in adulthood and self-reported promiscuity, even after parenting was controlled for, to the extent that parenting was not found to contribute to the prediction of these variables beyond abuse. Relationships between family stress and later adjustment were found to be accounted for by parenting. Survivors of intrafamilial abuse were more likely to be raised by parents they perceived as cold and unsupportive and to experience higher rates of life stressors than those who had not been abused. Unsupportive parenting was found to mediate the relationships of childhood abuse to adult depression and low self-esteem, but not trauma symptoms, which may be more closely linked to the actual abusive acts.

Summary

A number of themes have emerged from the findings of community studies into the relationship between family functioning in the family-of-origin and the risk and impact of CSA. The presence of a stepfather has consistently been shown to increase the risk of sexual abuse by this person. Findings concerning the socioeconomic status of the family-of-origin have been somewhat inconsistent, although a finding that more severe abuse cases were from lower socioeconomic backgrounds suggests a possible link between socioeconomic status and abuse severity. Similarly, findings in relation to parental education have been equivocal. A curvilinear relationship was found, with mothers who had completed high school being associated with the greatest risk for their daughters. Although religious background was found to have no significant relationship to an increased risk of sexual abuse, a lack of religious commitment in the family did increase risk. Rural background was not found to be a risk factor for incestuous abuse, although if the family had frequent residential moves the risk of sexual abuse increased.

General family dysfunction was associated with a greater frequency of CSA, however the occurrence of abuse was not a direct function of the family variables, these simply provided the conditions for sexual abuse to be more likely to occur. CSA was found to be predictive of negative experiences in adulthood and self-reported promiscuity, after parenting was controlled for. Parental separation, a lack of parental support and family stressors increased the likelihood of sexual abuse.
CSA survivors characterized their relationships with each of their parents as less close than those of nonabused controls. Specifically, mothers who were low on care and concern but were highly punitive were linked with more severe sexual abuse, as were fathers rated as low on care and control. Unsupportive parenting was found to mediate the relationship of childhood abuse (sexual and physical) to depression and self-esteem, but not trauma symptoms.

Concomitant physical abuse and physical punishment were found to increase the risk of sexual abuse and for this abuse to be more severe. Isolation proved to be a major factor, with an increased risk of sexual abuse of those lacking a confidante as a child, and a tendency for mothers to be more likely to be aware of the abuse in those cases where the abuse was less severe. The degree of family dysfunction varied according to the familial relationship of the offender, with higher dysfunction associated with abuse by more immediate family members.

College Studies

In a report based on a study conducted with college students (n = 796), Finkelhor (1984) found 19% of the women reported some kind of childhood sexual victimization. Women from families with lower incomes (under $10,000) were more likely to have been abused (33% compared to 19% of the whole sample). However, CSA was not restricted to this group, with almost 20% of those women from families with higher incomes (over $20,000) also experiencing CSA. Social isolation was also found to be associated with CSA, with 44% of women growing up on farms reporting abuse. However, the family characteristics found to be most strongly associated with CSA related to the child’s parents.

Finkelhor (1984) found having a stepfather greatly increased the risk of abuse, with 47% of females with stepfathers experiencing CSA (but not necessarily perpetrated by the stepfather). Stepfathers were five times more likely to sexually abuse a daughter than her natural father would. In addition, girls with stepfathers were more likely to be abused by other men, including being five times more likely to be abused by a friend of their parents. It was proposed that this increased risk may
have resulted from exposure to sexually predatory men who did not have biological ties to the child. Thus, these friends of the stepfather may not feel as great a restraint as when this was the “real”, rather than the step-daughter of a friend. Yet some stepdaughters had been abused prior to meeting their stepfather, suggesting the abuse may have been perpetrated by friends of the mother, who were opportunistic men brought into the home who exploited the daughter if she was accessible. The nature of the daughter’s relationship to her father figure also had an impact on her vulnerability to abuse. Daughters were more at risk if the father had conservative family values (38%) or provided little physical affection (31%), perhaps because such men believed children should be obedient and women should be subordinate. These values were instilled in their daughters, and children who were deprived of affection may have been more vulnerable to sexual exploitation.

Finkelhor (1984) also found daughters who lived without their mothers were three times more likely to experience CSA. Daughters were also more at risk if their mothers were emotionally distant (34%), often ill (35%), or not affectionate (32%). Although it was postulated that some of this vulnerability may have been due to a lack of supervision, those whose mothers worked were not at a higher risk of CSA. Alternatively, a lack of communication was proposed to be a source of risk for daughters whose mothers were somehow unavailable, for these daughters did not receive support from their mothers, including having their emotional needs met. It was suggested such emotional neediness may have made the daughters obvious targets for sexual offenders. As an indicator of power inequality in the marital relationship, a disparity in the parents’ educational level, with the father being well educated and the mother not, was associated with a higher risk of CSA for the daughter (44%). The messages that mothers conveyed about sex were also found to be important, with the risk of CSA for daughters of sexually punitive mothers being 35%. Finkelhor found that a number of family background factors were not associated with an increased risk of CSA including family violence, religion, ethnicity, family size and crowdedness. However, given the sample was of college students from New Hampshire, there was acknowledged to be little diversity in terms of either religion or ethnicity.
As part of a larger study, Alexander and Lupfer (1987) examined family characteristics and long-term consequences associated with CSA in a group of college women (n = 586). Approximately 25% (n = 149) of the participants reported experience of contact CSA, with 7% (n = 40) reporting abuse by a nuclear family member, 9% (n = 53) describing abuse by an extended family member, and 10% (n = 56) describing abuse by a non-relative. Consistent with the findings of Finkelhor (1984), it was found that women who had been abused by nuclear family members described their family as significantly more traditional with respect to parent-child relationships and male-female relationships, than either women who had not been abused, or those who had been abused by extended family members or outsiders. However, all women who had been sexually abused, regardless of the type of perpetrator, described their family-of-origin as significantly less cohesive and less adaptable than women who had not been sexually abused.

Although it was hypothesized that women who were sexually abused by nuclear family members would have come from families described as excessively cohesive to the point of being enmeshed, the findings did not support this (Alexander, & Lupfer, 1987). Instead, it was proposed that “enmeshed” may represent a different concept to the measurement of cohesiveness. Although families experiencing father-daughter incest obviously do not maintain internal boundaries between subsystems with regard to sexuality, roles and even personal ownership (Alexander, 1985), they do not necessarily demonstrate the sense of emotional bonding, interdependency and hypersensitivity shown by extremely cohesive families (Olson, Russell, & Sprenkle, 1983). The lack of empathy by both parents for their child, combined with the child’s reluctance to disclose the abuse to the other parent, revealed the depth of emotional distance characterizing families within which CSA was occurring. Those families whose children had been abused by extended family members or outsiders were described as similarly disengaged. However, it is quite possible that retrospective perception of the family as being disengaged, may simply be due to the occurrence of the abuse.

Alexander and Lupfer (1987) also hypothesized that families with father-daughter incest would be characterized as rigid (as shown by their very traditional
power structure and resistance to change). On the other hand, families whose children had been abused by extended family members and outsiders were expected to appear chaotic (as shown by their apparent lack of protectiveness). However, their findings indicated that the latter families were equally as rigid and unresponsive to change as the former families. It was suggested that the adaptability measure was potentially assessing a lack of responsiveness to problems arising within the family, in addition to developmental change within the child, which should have produced different kinds of precautions by the parents.

In an Australian study of university students, which attempted to replicate Finkelhor’s (1979) study, Goldman and Goldman (1988) surveyed 991 students, including 603 females, of whom 27.6% (n = 188) reported experiencing CSA. Consistent with Finkelhor’s (1984) findings, 40% of women growing up within a rural family reported experience of incestuous abuse. This risk factor was also borne out by the finding that 54% of incestuous experiences occurred when the father’s occupation was classified as a farmer or agricultural worker. When family income was classified as low, middle or high, of the 126 women in low income families who had CSA experiences, 33% reported an experience with an older partner and 7.1% with a father. Yet when income, father’s occupation and parents’ educational level were combined into a total socioeconomic status score, no clear pattern emerged. In cases where fathers were reported to be “often drunk”, 32% of women reported CSA experiences with an older partner, and 47% reported some kind of incestuous experience. It was proposed by Goldman and Goldman that alcohol abuse may simply be an accompanying factor to CSA, indicating a lack of inhibition or marital unhappiness. When the mother was classified as “often drunk”, 37% of daughters reported a CSA experience with an older partner and 51% reported some kind of incestuous relationship.

When considering parental factors, Goldman and Goldman (1988) found that in terms of an ineffective mother, when the mother was reported as “often ill”, 37% of females had CSA experiences with an older partner. When the mother was reported as “often nervous”, 33% of females indicated CSA experiences with an older partner and 39% reported some type of incestuous experience. In terms of absent
fathers, females who had lived without a father due to death, separation or divorce, appeared to be at greater risk of CSA. Of the 112 fatherless females, 34% experienced CSA and in single parent and re-marriage families, 39% had CSA experiences, and 7.8% had a CSA experience with a grandfather. When the parents’ marriage was perceived to be unhappy, 34% of females reported CSA experiences with an older partner, and 44% were incestuous experiences. It was also found that increasing family size was associated with increasing risk of CSA for daughters, particularly when there were five or more children. In large families (n = 124), 42% of the females reported some kind of incestuous experience. The finding of a low rate of father-daughter incest for the total sample suggested sibling sexual experience or cousin sexual experience may have occurred in these large families.

Jackson, Calhoun, Amick, Maddever and Habif. (1990) compared the general family environment of a group of female college students (n = 40), 22 of whom had experienced sexual molestation by a family member and 18 who did not have a CSA history. These two groups were significantly different on four family environment factors. The abused group indicated their families had been significantly less cohesive, with a lower active recreational orientation and moral religious emphasis, suggesting less involvement by parents with their children and lower interest in the more abstract aspects of their upbringing. The abused group also perceived their families as much more controlling than the nonabused group. For example, 62% of the abused group reported that decisions were made by their father alone, compared to only 11% of the control group. In addition, 28% of the incest group reported experience of childhood physical abuse, whilst none of the control group reported this.

Parker and Parker (1991) also sought to examine various aspects of family experiences in childhood among college students (n = 492), 27% (n = 135) of whom experienced CSA, including 4% who were incest survivors (either biological/step/adoptive parents). Only a measure of perceived competence in social situations was found to discriminate between the nonabused and the abused groups, and even between the nonincestuously abused and incest survivors. In relation to the variables of treatment by father, treatment by mother and childhood happiness, no
significant differences were found between the abused and nonabused groups. “Bad” treatment by either parent and an unhappy childhood indicated greater impairment among survivors, which was usually also the case when compared with the nonabused group. Thus, it seemed that only when abuse was associated with poor parental treatment did greater impairment exist. Although there were no significant differences in perceptions of poor parental treatment between nonabused and abused groups, perception of good treatment by fathers dropped to 50% for incestuously abused females. Given the circumstances, this relatively high figure suggests perception of even a sexually abusive father is not completely negative and relates to more general childhood experiences. In addition, abuse characteristics such as the participant’s relationship to the offender, abuse severity, the survivor’s age at onset of the abuse, the duration and frequency of abuse were not found to be associated with varied levels of impairment in perceived competence in social situations.

In another study of family cohesiveness and control factors, Yama, Tovey, & Fogas (1993) assessed female college students, comparing those with a history of CSA (n = 46) to a control group of women without such a history (n = 93). Consistent with the findings of Alexander and Lupfer (1987), it was confirmed that there were no significant differences between intrafamilial and extrafamilial CSA survivors in perceptions of their family, and so the two groups were combined for further analyses. Yama et al demonstrated that either depression or anxiety could be more accurately predicted when in addition to knowledge of CSA history, family environment was considered. Specifically, CSA was related to higher levels of depression when the family-of-origin was perceived as high on conflict, and it was related to lower levels of depression when families were perceived as high on control. CSA also appeared to be associated with greater depression when the family-of-origin was perceived as more cohesive. It was proposed that an interactive model may explain these findings, for the family environment appeared to buffer the relationship between CSA and later depressive symptoms. In particular, the findings indicated high family conflict, low control (more lax rules and procedures), and high cohesiveness, all combined with a CSA history, placed survivors at higher risk for
subsequent depressive symptoms. It was proposed that survivors who perceived their families-of-origin as more cohesive would demonstrate higher levels of depression, due to experiencing a greater sense of betrayal.

In an attempt to identify family environmental characteristics that may pose risk factors for CSA, Benedict and Zautra (1993) compared students with a history of CSA (n = 76, females = 52, males = 24) and their siblings (within 6 years of age), with a matched control group and their siblings (within 4 years of age) who had no history of CSA. There were no significant differences between CSA survivors and their siblings’ perceptions of their family environment. Compared to the control group, the CSA group was found to have a significantly greater degree of parental absence, family conflict, parental illness, and being a stepparent family. In contrast, the control groups were higher on family cohesion, intellectual-cultural orientation and active-recreational orientation. Parental absence was found to be the most powerful risk factor for CSA, although family conflict contributed significantly to prediction of risk of abuse.

The finding that parental absence due to maternal employment was risk factor for CSA, was contrary to the earlier findings of Finkelhor (1984). Benedict and Zautra (1993) believed that this variable and not living with one or both parents posed a strong risk factor for CSA because it led to creation of particular environments which are conducive to CSA occurring. For example, a lack of supervision means it is not possible to ensure children are protected from exploitative adults (Finkelhor, & Baron, 1986). In addition, a poor marital relationship has been found to be characteristic of such families (Finkelhor, 1984). The finding by Benedict and Zautra that a higher level of family organization increased the risk of CSA is consistent with the view that abused children come from families with an authoritarian structure, as found by Alexander and Lupfer (1987), and those families with conservative values.

In a further investigation of patterns of family functioning, Long and Jackson (1994) sought to compare a group of college students with a history of CSA (n = 80) with a control group without such a history (n = 92). As was expected, greater
numbers of CSA survivors came from the disorganized family type and fewer survivors were found to be from the support-oriented family type. No significant relationships were found between family type and sexual abuse characteristics, including the relationship of the perpetrator to the victim, whether intercourse occurred and whether coercion or violence was used.

In an Australian study, Higgins and McCabe (1994) sought to assess the relationship between CSA, family violence and other family characteristics, and later adult adjustment, using an integrated risk-sequelae model. A group of university students were surveyed (n = 199) and 23.6% (n = 47) women were found to have a history of CSA. Compared to nonabused women, CSA survivors reported significantly higher rates of both fathers and mothers being sexually punitive and having more traditional family values, family violence, parental separation or divorce, maternal separation and drunkenness in mothers. Abused women reported a higher level of family violence, their fathers as having more traditional values and both parents as having higher levels of sexual punitiveness, than was the case for the nonabused women. The only three variables found to contribute significantly to prediction of trauma symptoms, were the level of family violence, parental separation/divorce and traditional family values of the mother. The level of family violence was found to provide the best discrimination between survivors and nonabused women, and to be a significant predictor of adult adjustment, independent of sexual abuse history.

In an attempt to evaluate whether family functioning predicted psychological distress in a range of sexually abused groups, Koverola, Proulx, Battle, & Hanna (1996) undertook a complex study. Of the 833 female students studied, 253 women indicated they had been sexually abused and were subsequently classified into the child sexual abuse (CSA) group (n = 83), the peer sexual abuse (PSA) group (n = 78), or the revictimization group (n = 44). It was found that the abused groups differed significantly from the nonabused control group on cohesion and conflict, and the CSA group differed from the nonabused group on control. However, although the abused groups differed significantly on these dimensions of family functioning from the nonabused control group, they did not differ from each other.
Further analyses were conducted, which indicated conflict and control were significant predictors of distress in the abused group, and cohesion was a significant predictor of distress in the nonabused group. Abused groups tended to perceive their families as low in the degree of commitment, help and support which members offered each other. Families of abused groups were also perceived as very controlling of their members, with a high degree of openly expressed anger, aggression, and conflict among family members. The presence of these family characteristics was predictive of distress in the abused group. In contrast, for the nonabused group, low cohesion or the perception of family members as generally unhelpful and unsupportive of other family members, was predictive of distress. Thus, Koverola et al. concluded there may be a difference in the way perceived family functioning influences the individual’s level of distress, depending upon whether they have been sexually victimized or not.

Despite Finkelhor’s (1984) finding that family violence was not a risk factor for CSA, others have found a higher rate of family violence in the families of CSA survivors compared to nonabused controls (Higgins, & McCabe, 1994). Given these findings, Maker, Kemmelmeier and Peterson (1998) sought to investigate differences between those who had/had not witnessed domestic violence in childhood, whilst controlling for a CSA history. The participants were college women (n = 131), with 35.1% (n = 45) indicating they had witnessed either moderate/severe/extreme domestic violence between their parents, and a control group (n = 85) indicating they had not witnessed domestic violence. No significant differences were found between the three domestic violence exposure groups in terms of a history of CSA. However, when these groups were combined, a significant difference was found between the survivors group and the nonabused group in terms of witnessing domestic violence during childhood. Furthermore, trauma symptoms and antisocial behaviours reported by those who had witnessed domestic violence were related to a history of CSA, rather than witnessing marital violence.

Family conflict and impact on later dating relationships was explored in a study by Banyard, Arnold, & Smith (2000) of a group of college women (n = 219), 47 of whom reported experience of CSA. These CSA survivors reported a trend
towards higher levels of family conflict, but there were no differences between the CSA group and nonabused controls in terms of cohesion and expressiveness in the family-of-origin. It was also proposed that a history of CSA would continue to account for significant variance in dating relationship outcome measures, after controlling for negative family environment. Banyard et al. found a history of CSA significantly increased the likelihood of experiencing physical and psychological aggression in a recent dating relationship, even when conflict in the family-of-origin was controlled for. CSA survivors were more than twice as likely as nonabused women to experience physical dating aggression and three times as likely to experience psychological aggression in a dating relationship.

**Summary**

There are a number of consistent themes in the findings from this empirical research, which echo those discussed in the previous section. Those women from families with traditional family values, an authoritarian structure, sexually punitive parents, marital discord or separation and divorce, parental absence or illness or simple ineffectiveness were found to have an increased risk of being subjected to sexual abuse during childhood. Alcohol abuse by parents, and particularly the mother, also increased the risk of sexual abuse, but it was suggested this may simply be an accompanying factor signifying the presence of other issues such as a lack of inhibition or marital unhappiness. A history of CSA rather than witnessing domestic violence between the parents was found to account for the later trauma symptoms and antisocial behaviours observed in survivors. Although there appeared to be contradictory findings in relation to family size and crowdedness, it would appear that increased family size may increase the potential for sibling sexual abuse.

Those families in which CSA had taken place were described as being higher in conflict, generally exhibiting higher control and being more rigid and unresponsive to change and therefore less adaptable. Abusive families were also reported to be low in cohesion, although there has been some discussion as to the actual nature of the concept being measured. Parents were characterized as lacking empathy and physical affection and were seemingly disengaged. Whilst the family was perceived to fit
within the disorganized family type, the family environment was classified as having a low intellectual-cultural orientation and a low active-recreational orientation.

**Clinical Studies**

Clinical studies examining family functioning in those families where CSA has occurred have primarily focused on describing the attributes of the families and the roles of individual family members. These descriptions provide some understanding of the underlying family dynamics which allow intrafamilial abuse, including sibling incest, to occur. Comparison of functioning in the survivors’ current family with that of their family-of-origin provides the opportunity to explore how intergenerational transmission of abuse may continue.

In an early clinical study of 15 survivors of father-daughter incest who were receiving psychotherapy, Herman and Hirschman (1977) observed the severity of the women’s difficulties appeared to be related to the degree of family disorganization and deprivation in their histories, rather than their incest history itself. Unlike in other studies, the families were not of predominantly lower socioeconomic status, two fathers were white-collar workers and six were professionals. All of the mothers were houseworkers, which would have been relatively common at that time, particularly if they had young children. Five of the 15 families were classified as disorganized with histories of poverty, unemployment, frequent moves, alcoholism, violence, abandonment and foster care, and the women from these families reported the most severe distress. In almost all of the families, there was an estrangement between the mother and daughter, which preceded the overt incest. Over half of the mothers were partially incapacitated by physical or mental illness or alcoholism and took on an invalid role in the home or were regularly absent due to hospitalization.

Mothers were perceived by their daughters as helpless, frail, downtrodden victims, who could not care for themselves, let alone protect their children (Herman, & Hirschman, 1977). Some mothers habitually confided in their daughters, yet the daughters felt unable to confide in their mothers. Five of the women suspected that their mothers knew of the incest, but tacitly condoned it. Two of this group attempted to disclose, but were put off by their mothers’ denial or indifference and
two others who did disclose received very negative reactions. Some of the mother-daughter relationships were characterized by frank and open hostility.

In contrast, incest survivors described their fathers as having at least some warmth. Herman and Hirschman (1977) claimed this phenomenon could be partially explained by such authoritarian fathers presenting to society as likable and respected community members. The daughters responded to their father’s social status and power and gained satisfaction from being their fathers’ favourites, especially given they were often not special to anyone else. The daughters also felt sorry for fathers who had lost social status, and rarely expressed anger at them, unless they had also experienced physical abuse, and tended to be ambivalent regarding the sexual abuse. When mothers were somehow incapacitated, the daughter was perceived to have replaced the mother in her traditional role, both in domestic and sexual services for the father.

Whilst this work by Herman and Hirschman (1977) provided a valuable description of the family dynamics of women who had experienced father-daughter incest, it should be kept in mind that the study was based on a very small group of incest survivors (n = 15). The researchers acknowledged that no systematic case finding procedure was employed, the participants were selected from those attending psychotherapy with therapists known to the researchers. The therapists approached participants and established their willingness to be involved. The women were all survivors of intrafamilial abuse, therefore no suggestions could be made regarding the family dynamics which may have existed for survivors of extrafamilial abuse. The lack of a matched control group for comparison purposes, means it is not possible to ascertain whether the family dynamics observed were unique effects associated with incest, or were related to some other variable/s.

Herman (1981) subsequently conducted a further study of 40 women who had experienced incestuous relationships with their fathers and were currently receiving psychotherapy. However, similar methodological issues applied to this study as the former one. Recruitment of participants was restricted to those currently in psychotherapy, who might be expected to have poorer psychological functioning than
CSA survivors in the general community. However, therapists approached only those patients whom they believed capable of participating, leading the researchers to conclude the participants were relatively psychologically healthy due to having dealt with the trauma of their experience to a large extent. Patients participated in semi-structured interviews conducted by their own therapists or the researchers, suggesting their may have been some variability related to differences between interviewers. The researchers acknowledged that the interview material was subject to the retrospective distortion of memories of childhood, but claimed that the similarity in accounts of survivors gave some credence to their validity. The researchers also acknowledged that the material gained was from the survivor’s perspective only and would have been strengthened with the addition of material sought from other family members.

In this second study, Herman (1981) expanded her previous research with additional findings. In the second study, about half of the women were judged to come from working-class families, with all of the families appearing to be quite conventional, with most being financially stable and involved in regular church attendance. Generally, they did not have involvement with mental health services, social agencies or the police. Households were quite patriarchal, with fathers having absolute authority, which was often maintained by force, but never to the degree of inflicting injuries requiring outside intervention. More than a third of the fathers were described as problem drinkers, yet very few received any medical or psychiatric treatment. The fathers determined the family’s social life and frequently secluded the women in the family. The mothers had much lower status than the fathers, which was reflected in the preferred status of sons over daughters, with boys receiving greater freedom and privileges including education. In addition, just as fathers exercised complete control over wives and daughters, often they also enlisted their sons in this role.

Herman (1981) observed that 55% of respondents described their mothers as having periods of disabling illness, which resulted in frequent hospitalizations, or being an invalid at home. Maternal disability resulted from depression, alcoholism and psychosis, which was rarely diagnosed or treated. The daughters described their
mothers as withdrawn, peculiar and unavailable. In 38% of families, daughters had been separated from their mothers for some period during childhood, either due to maternal hospitalization or an inability to cope with childcare, resulting in placement in alternative care. Three mothers died during the daughters’ childhood, one by suicide and one suicided after her daughter left home. The researcher observed that in these families, there was an average of 3.6 children, much higher than the national average of 2.2 children. Seventeen of the mothers had four children or more and five had eight or more children. In many cases it seemed that pregnancies were simply enforced upon the women, who were relatively unable to prevent them. Often the mothers suffered physically from these multiple pregnancies and the burden of caring for a number of young children, and in four cases the mothers also had the extra needs of a severely handicapped child to deal with. Herman believed the mothers conveyed the message to their daughters that a woman was defenceless against a man and it was her duty to serve and endure.

Herman (1981) found 80% of the participants were the oldest or the only daughters in their families and before the age of ten, 45% were in the role of “little mothers” in the family. These daughters cared for younger siblings and took responsibility for major household tasks. Most daughters were also assigned the role of mediating between their parents and particularly being their father’s confidant. Daughters viewed their mothers at best ambivalently, and at worst were actively hostile towards them, due to strong perceptions of rejection. Daughters were unable to disclose to their mothers, given the expectation that protection would not be provided in any case. The attention offered by fathers provided some compensation for the deficits in their relations with their mothers.

Herman (1981) observed that daughters attempted to escape the family via various methods, with thirteen running away at least once, three requesting alternative care placements and many becoming pregnant (45% in adolescence) or marrying prematurely. However, in 28% of families, the incest was repeated with younger sisters, in a further 25% of families the daughters believed their younger sisters were molested, but they were unsure. In a third of families this did not occur, because there were no available sisters. The daughters’ belief that they were
responsible for holding their families together was reinforced by the fact that in several families the fathers deserted once the daughters had left home.

Herman (1981) considered these 40 families to have demonstrated overt incest and conducted a comparison with 20 families which had exhibited covert incest, which was defined as fathers who displayed sexually motivated behaviour towards their daughters, which did not involve physical contact or a requirement for secrecy. It was hoped that differences between the samples would indicate which family characteristics may prevent the development of overt incest, in the belief that this formed part of a continuum. However, Herman did not advance any evidence to support the existence of such a continuum. Furthermore, it was unclear how the covert incest group of families might relate to families in the general population. Traditional sex role types and the fathers were similar in the two groups of families, with Herman concluding that the main difference between the overt and covert incest groups seemed to lie in the descriptions of the mothers. The daughters with covertly incestuous fathers described their mothers as healthier, more assertive, more competent, more socially active and less isolated than those in overtly incestuous families. This group also had fewer pregnancies, meaning the mothers were less overburdened and only one daughter out of the twenty families was placed in the maternal role. The mothers with covertly incestuous husbands seemed to refuse to tolerate the same extremes of abuse, not putting up with beatings, seclusion in their homes or enforced pregnancies, that women with overtly incestuous husbands endured. Thus, although the mother-daughter relationships were still very strained, mothers seemed better able to protect themselves and their daughters from overt sexual abuse.

In an examination of the family circumstances associated with sibling incest, de Young (1982) found only five cases of sibling incest in her clinical sample of 80 incest survivors. Weinberg (1955) had proposed that the fathers in such families typically failed to serve as “restraining agents” by not using their intrafamilial power to prevent incest. This may have been due to being absent from the home or due to physical or mental incapacitation, or those who were in the home may have had weak personalities and lacked the assertiveness required. This view was supported by de
Young’s (1982) sample in which one father was dead, one separated from his family, one incapacitated by mental illness and two were emotionally absent despite their physical presence in the home. Mothers also tended to be viewed as psychologically absent, due to being so passive and ineffectual that they lacked the assertiveness to adequately supervise their children. Thus the mother may have been physically absent or so overwhelmed with responsibilities that adequate supervision was not provided. Mothers were also characterized as having rigid, puritanical attitudes towards sex, which meant sex education of the children at home was unlikely, paradoxically resulting in increased curiosity and experimentation.

Paternal absence or incapacitation may place the son into playing the role of the father in the family. Given household responsibilities beyond his age, the individual attempts to carry them out using his available skills such as arguing, demanding and exercising power, resulting in bullying behaviour with siblings. Thus de Young (1982) found two brothers used incest as “punishment” for their misbehaving sisters. Although in all five cases of sibling incest, the brothers initiated the incest, it may have been consummated through mutual consent. Only one sister was found to be of lower intelligence and in all five cases the sisters were younger than their brothers.

In an attempt to investigate the procedure underlying intergenerational transmission of abuse, Carson, Gertz, Donaldson and Wonderlich (1990) studied a group of women who were CSA survivors (n = 40) receiving psychotherapy, comparing their current family relationships with characteristics of their family-of-origin. The researchers were limited in that the family-of-procreation (current family) could only be examined for those 25 women who were married or single with at least one child. Carson et al. found participants indicated that during childhood, in addition to sexual abuse, they had also experienced physical abuse (48%), psychological abuse (80%) and emotional neglect (35%). Alcohol abuse/chemical dependency of a father/stepfather was an issue for 70% of the women, compared to 22.5% for a mother/stepmother, 57.5% for a brother/stepbrother, 30% for a sister/stepsister and 42% for at least one grandparent. In terms of their current family, 45% of survivors reported concerns about their own
alcohol use, 37.5% had concerns about their spouse’s alcohol use and 10% had concerns about their child’s usage.

Although current families were not found to fall into the enmeshed category, and participants were not rigid in terms of their adaptability, they tended not to rate their current families as emotionally close and cohesive, perhaps due to the lack of trust inherent in their family-of-origin. Rather than using a comparison group, Carson et al. (1990) compared incest survivors with a normative group (n=100) for the measures used and cautioned that it was unknown whether there may have been some incest survivors within these normative groups. Current families were found to have significantly less emphasis on social activity participation and expressiveness, resulting in social isolation and an inability to openly express thoughts and feelings with their own children, compared to a normative group. The incest survivors were significantly lower than the normative group on intellectual/cultural orientation, cohesion, independence, and organization and higher on conflict and control.

The families-of-origin of incest survivors were also found to be significantly lower than the normative group in terms of perceived overall family health (Carson et al., 1990). Such findings suggest a lack of trust, empathy, and respect for others in the family system, difficulties with the assertive expression of feelings and inappropriate coping skills for grief and conflict resolution. In addition, incest survivors had significantly lower overall perceived family health in regard to autonomy and intimacy, suggesting the families-of-origin did not encourage these attributes, compared to the normative group. In terms of psychological adjustment, compared to the normative group the incest survivors were significantly higher on alienation, social nonconformity and discomfort and lower on defensiveness.

Carson et al. (1990) found in comparison to the normative group, the incest survivors demonstrated significantly greater intergenerational triangulation (third person involvement in interactions between two others, which prevents healthy interactions in the dyadic relationship) and intergenerational intimidation. Thus it appears that experiences in the family-of-origin of incest survivors may have influenced their perceptions and performance in their current families. The survivors’
current relationships with their nuclear family members were perceived to be significantly higher in triangulation and lower in spousal intimacy than for the normative group. Carson et al. believed these findings supported the intergenerational theory espoused by Williamson and Bray (1988), in that the dynamics of incestuous families and the potentially negative effects on survivors are carried over into the next generation of family relationships, making them less intimate and more conflictual.

Nash, Hulsey, Sexton, Harralson, and Lambert (1993) compared four groups of women to attempt to establish the unique effects of CSA on psychological adjustment, by separating out the impact of family pathology. The four groups consisted of a clinical CSA group (n = 24), a nonclinical CSA group (n = 32), no abuse (other psychological problems, no history of sexual abuse) clinical group (n = 23) and a no abuse nonclinical group (normals) (n = 26). Although main effects for abuse status were found for psychopathology and dissociation measures, when family pathology was controlled, abuse status was no longer significant for either psychopathology or dissociation. However, significantly greater impairment on some psychological measures was evident among CSA survivors, including excessive preoccupation with bodily functions and soma-based, stress-related difficulties, a damaged sense of self, painful self-introspection and egocentricity. Thus, the researchers concluded that although much of the observed adult pathology associated with CSA may result from a pathogenic family environment, CSA may make the individual feel that her body is fundamentally damaged and inadequate.

**Summary**

The available clinical studies confirm the empirical findings of those studies utilizing community and college student groups, and provide some clarification of the family dynamics underlying these findings. Maternal absence due to a variety of causes was linked to a difficult mother-daughter relationship and a role reversal which placed the maternal family responsibilities upon the daughter. Although mothers were perceived to be very dependent upon their daughters, the daughters could not expect any support or protection in return. It was suggested daughters had
a slightly better relationship with their fathers, who at least exhibited some warmth towards them and commanded social status within their family and community. Again, the families were characterized as being quite patriarchal with fathers using force to maintain dominance if required. Within the family, members occupied traditional roles, with females being subordinate to males and socially isolated by them. Adolescent daughters would attempt to physically run away from their families or achieve this by early marriage and pregnancy. The belief that it was the daughter’s responsibility to hold the family together was borne out by instances of family disintegration when she left home.

Once again, abusive families were characterized by parental alcohol abuse. Sibling incest seemed to occur in situations of paternal absence or ineffectiveness. Although family functioning was not described as enmeshed or rigid and had reasonable adaptability, it was not perceived to be close or cohesive. Families-of-origin were classified as low in terms of their overall family health, with poor development of autonomy and intimacy and high intergenerational triangulation and intergenerational intimidation. Examination of the family functioning of the CSA survivors’ current families strongly suggested these patterns of difficulties were being repeated with another generation. In addition, it appeared CSA survivors’ beliefs that their bodies were damaged and inadequate was a consequence of their CSA experience, rather than being subjected to a pathological family environment.

**Concomitant Psychological and Physical Abuse**

A small number of researchers have attempted to disentangle the effects of various types of abuse during childhood, including psychological and physical abuse. In particular, some efforts have focussed on determining the specific effects of various types of abuse and the degree of overlap of their effects. In the following sections, the relationships between the experience of various types of childhood abuse and their impact on later psychological functioning will be discussed in terms of research employing community and college participants.
Community Studies

The findings of Wind and Silvern (1992) did not provide support for specific effects being related to particular types of abuse. A sample of women working at a university (n=259) were assessed to find that 137 women had not experienced either sexual or physical abuse. A comparison was conducted between women who had been sexually abused, or physically abused, both sexually and physically abused, and not abused during childhood. No significant differences were found between women who were physically abused versus sexually abused in terms of depression, trauma symptomatology or negative life events. Those who experienced more severe sexual or physical abuse also demonstrated more negative outcomes. Women in the dual abuse group (physical and sexual) exhibited poorer outcomes than either of the sole physical or sole sexual abuse groups. The incest (parent/parent-surrogate) group, the severe physical abuse group and the dual abuse group evidenced similar symptomatology. Thus it was concluded that physical and sexual abuse had common long-term effects, indicating a generalized response to abuse types, but that concomitant physical abuse amplified the consequences of CSA.

Hall, Sachs, Rayens, and Lutenbacher (1993) assessed the prevalence of childhood physical and sexual abuse among low-income single mothers (n=206) to investigate the relationship between abuse and current maternal depression. Of this sample, 70% experienced some kind of childhood abuse with 36% experiencing severe physical abuse and 22% reporting sexual abuse (including 11% who described it as violent). Only 2% of the women experienced sexual abuse alone and 83% of those who had been violently sexually abused had also experienced severe physical abuse. There was a significant difference in depression between those who had experienced severe physical abuse and those who had not experienced physical abuse. Furthermore, those women who had experienced violent sexual abuse were significantly more depressed than either those who had been sexually abused without violence, or those who had not been sexually abused. Level of sexual abuse was a significant predictor of high depressive symptoms, with depression increasing to being 4.5 times more likely in the case of those experiencing violent sexual abuse.
As part of a larger study, Mullen et al. (1994) interviewed women who reported a history of CSA (n=248), along with an equal number of nonabused controls. Those women who had experienced physical abuse as children were also more likely to have experienced sexual abuse (13.5%) compared to controls (2.2%), and particularly when compared to survivors of abuse involving intercourse (31.3%). In terms of physical punishment after the age of 12 years, these figures rose to 14.3% for controls, 32.5% of CSA survivors and over 50% of survivors of abuse including intercourse.

**College Studies**

Briere and Runtz (1990) examined three types of child abuse histories: sexual, physical and psychological abuse in a group sample of female college students (n=277). The students were questioned about the effects of family experiences on their self-concept, maladaptive sexual activity and aggression. Psychological abuse was found to be related to subsequent low self-esteem, sexual abuse to dysfunctional sexual behaviour and physical abuse to later anger/aggression. When psychological abuse was accounted for, a history of physical or sexual abuse usually implied the absence of the other abuse type. On the other hand, physical and psychological abuse tended to occur together and result in all three kinds of effects.

**Summary**

Few studies have addressed the issue of concomitant physical, psychological and sexual abuse in childhood, and a clear link has not been shown between a particular type of abuse and specific effects. However, it would appear that the likelihood of experiencing multiple forms of abuse is linked to greater severity of a type of abuse and that both of these factors may contribute to subsequent psychological difficulties in the survivor.

**Overall Summary**

In summary, it is difficult to assess the unique effects of CSA and family dysfunction on the later psychological adjustment of survivors, given their strong interrelationship. The findings from community studies suggest a number of factors...
such as the presence of a stepfather, maternal absence, a lack of parental support and family stressors including isolation may increase the child’s vulnerability to CSA. These findings were largely confirmed in studies of college students which also generally used nonabused control groups for comparison. In addition, families where CSA occurred were characterized as high in conflict and control, and less adaptable. Despite some major methodological issues, clinical studies provided an insight into the family dynamics which allowed CSA to occur and continue into another generation. Overall, there would appear to be empirical evidence for the suggestion that CSA may exert a unique negative influence upon the developing sense of self and later psychological adjustment, over and above more general family dysfunction and a maltreating environment.
CHAPTER 3

INTRAPERSONAL FUNCTIONING

The focus of research in recent times into the psychological impact of CSA has primarily focussed on the effects on the survivor’s intrapersonal functioning. However there has been criticism by Beitchman, Zucker, Hood, DaCosta, & Akman (1991) of the methodology of studies included in the significant reviews by Browne and Finkelhor (1986) and Alter- Reid, Gibbs, Lachenmeyer, Sigal, and Massoth (1986), for very few included the use of a control group or a comparison group. The research participants were generally obtained from clinical samples who were presenting for treatment with psychiatric or psychological symptoms, and who were exhibiting psychopathological symptoms, such as family disruption, parental illness, alcoholism, etc. Therefore, without control groups, the unique effects of CSA could not be ascertained. In the same way, only limited generalizations could be made in relation to studies using nonclinical samples, for random representative surveys represent the only method that fully reduces the effect of sampling bias. Briere and Runtz (1988b) have also claimed a significant proportion of the research in this area consists of summarized case reports and is methodologically flawed through the use of small sample sizes and inadequate measures.

In their landmark review of the albeit methodologically flawed literature, Browne and Finkelhor (1986) found the most commonly reported long-term effects of CSA were depression, feelings of isolation and stigma, poor self-esteem, anxiety, self-destructive behaviour, difficulty in trusting others, substance abuse, sexual maladjustment and a tendency towards revictimization. In their follow up review, Beitchman et al. (1992) supplemented this list with the characteristics of homosexuality and personality disorders. Similarly, Lipovsky and Kilpatrick (1992) included the symptoms of dissociation, PTSD and anger. In the following chapters, more comprehensive discussion of the nature of these long-term effects of CSA will be provided. These effects are classified into areas relating to intrapersonal
functioning, interpersonal functioning and cognitive responses to the abuse experience.

This chapter discusses the long-term impact of CSA on the survivor’s intrapersonal functioning, which researchers have sometimes categorized as mental health symptoms. Areas of functioning to be discussed include self-esteem, fear and anxiety, depression, suicidality and self-mutilation, anger, substance abuse, eating disorders, somatization, dissociation, memory impairment, borderline personality disorder, and post traumatic stress disorder (PTSD).

**Self-Esteem**

Although it would be expected CSA survivors would have lower self-esteem, there is little empirical evidence of this as an initial effect. However, evidence of a negative self-concept as a longer-term effect of CSA is much stronger. Research relating to the impact of CSA on self-esteem will be reviewed in the following sections, with studies classified according to whether participants were recruited from the community, colleges or clinical services.

**Community Studies**

In their random community sample of CSA survivors (n = 82) compared to non-abused women (n = 285), Bagley and Ramsay (1986) found in adulthood 19% of the survivors, compared to 5% of the controls, scored in the “very poor” category of a self-esteem inventory. Conversely, only 9% of the survivors compared to 20% of the controls, demonstrated “very good” levels of self-esteem on this measure. The results demonstrated that those women with very poor self-esteem were nearly four times as likely to report having been abused. Gold (1986) also found CSA survivors (n = 91) in a community sample (n = 191) were more likely than nonvictims (n = 76) to report lower self-esteem.

Greenwald, Leitenberg, Cado and Tarran (1990) achieved similar results to those of Fromuth (1986), using a nonclinical and nonstudent sample to assess the impact of a history of CSA on self-esteem. They found no significant differences
between the survivors’ group (n = 54) and matched nonabused controls (n = 54) in the level of self-esteem. Again, the differing findings may reflect differences in the construct that various self-esteem measures are evaluating.

Hunter (1991) also found a community sample of adult survivors of CSA (n = 28) had significantly lower self-esteem than a group of matched nonabused controls (n = 28). However, this finding needs to be considered in the context that the survivors were selected on the basis they had experienced abuse involving physical contact, placing them within the more severe abuse category.

Using a convenience sample of university staff (n = 259), Wind and Silvern (1992) sought to investigate whether there were specific effects of childhood sexual versus physical abuse given the apparently high incidence of dual abuse and consequent potential for effects to overlap. When compared to the nonabused group, the relationship between parental incest and/or physical abuse and various measures of adult adjustment, including self-esteem, was found to be quite strong. However, the ability of self-esteem to discriminate the high risk from nonabused groups was relatively weak and not independent of other symptoms in discriminant analyses.

**College Studies**

Jackson, Calhoun, Amick, Maddever and Habif (1990) found significantly lower self-esteem in a college student sample with a history of intrafamilial CSA (n = 22) compared to nonabused controls (n = 18). However, these researchers cautioned the findings may not be related simply to the sexual abuse experience, as significant differences in family characteristics were observed between the two groups. In contrast to these findings, Fromuth (1986), found a history of CSA among a sample of college students (n = 383) was not significantly related to scores on self-esteem. The difference between these findings may be attributable to Fromuth’s use of a very broad definition of sexual abuse, which led to the inclusion of relatively mild forms of non-contact abuse. In addition, the use of a variety of measures of self-esteem makes assessment of the comparability of findings difficult.
Clinical Studies

As might be expected, within clinical samples of CSA survivors, self-esteem problems have been noted to be greater than in non-clinical populations. For example, Courtois (1979) found 87% of CSA survivors (n = 31), recruited from public advertisements, mental health agencies and private therapists, reported their sense of self had been moderately to severely affected by the experience of sexual abuse by a family member. Herman (1981) also found that 60% of the incest survivors in her clinical sample (n = 40) were reported to have a “predominantly negative self-image” (p.119) compared to only 10% of the comparison group who had seductive but not incestuous fathers. The “seductive fathers” group (p.109) were defined as those who demonstrated behaviour towards their daughters which was clearly sexually motivated, but which did not involve physical contact or a requirement for secrecy. Given the nature of the control group, the generalizability of these findings is unclear.

Summary

Although the above studies would seem to indicate a history of CSA is linked to low self-esteem, particularly for clinical samples and in cases of greater abuse severity, further research is required. The development of more comprehensive measures of self-esteem, specifically designed for sexual abuse survivors, which have been standardized across a range of age groups, and community and clinical samples would certainly be of assistance in resolving this issue. In addition, the importance of evaluating family characteristics associated with sexual abuse has been underscored. The possible role of other types of childhood abuse in influencing self-esteem also needs to be established.

Fear and Anxiety

There is some evidence that CSA survivors demonstrate generalized emotional symptoms such as fear and anxiety to a greater degree than women who have not been sexually abused. However, there may be a number of other factors involved, such as the survivor’s perceptions regarding parental support during
childhood, the threat or use of force during the abuse, the relationship of the offender to the survivor. In addition, the survivor’s current relationship functioning and whether general versus specific phobias or anxiety are being assessed, may have some bearing on findings.

In the following sections, the relationship between the experience of CSA and subsequent fear and anxiety in survivors will be discussed in terms of research employing community, college and clinical participants.

**Community Studies**

Stein, Golding, Siegel, Burnam and Sorenson (1988) reported findings from the Los Angeles Epidemiologic Catchment Area (ECA) study whose aim was to estimate the prevalence of specific health issues, including lifetime sexual abuse among a community sample. Stein et al. (1988) reported a prevalence of 24% for anxiety disorders among sexual abuse survivors (n = 51) compared to 9% of women who had not been sexually abused (n = 1,307). The lifetime prevalence rate for anxiety disorders was 37% for the CSA survivors compared to 14% for the controls.

These findings were borne out by another study (Murphy et al., 1988) using an adult community sample, composed of child and adolescent sexual abuse survivors (n = 86) and nonabused controls (n = 184). The sexual abuse survivors demonstrated significantly higher anxiety scores and two-thirds of the survivors indicated that they had been subjected to force or the threat of force. Murphy et al. (1988) argued these findings were consistent with the research by Girelli, Resick, Marhoefer-Dvorak, and Hutter (1986) who found that among adult rape survivors, the victim’s perception of the degree of threat involved during a sexual assault may have a closer relationship to the degree of distress suffered later, compared to an objective measure of the severity of the assault.

A significantly higher rate of anxiety among CSA survivors (n = 54) compared to a matched control group of nonabused women (n = 54) was also found by Greenwald, Leitenberg, Cado, and Tarran (1990). Furthermore, this significant
difference remained, when subjects’ perceptions of parental emotional support were controlled for.

**College Studies**

College students who were intrafamilial CSA survivors (n = 51) were found to be significantly more likely to demonstrate anxiety compared to a matched nonabused control group (n = 51) in a study by Sedney and Brooks (1984). However, when the intrafamilial and extrafamilial abuse groups were combined, they were not differentiated from the controls on anxiety. Thus, anxiety was significantly associated with a history of intrafamilial, but not extrafamilial abuse. In addition, CSA survivors seemed to experience anxiety as a more serious problem than the controls. This was particularly evident in the finding that although 26% of CSA survivors saw a doctor or were hospitalized for this problem, only 9% of the women in the control group experienced anxiety problems as severely.

Among college women (n = 383), Fromuth (1986) found phobic anxiety was the only symptom significantly associated with CSA after controlling for the effects of parental support, although this was a relatively weak relationship. Thus, it was suggested it may not necessarily be the sexual abuse which is related to later negative adjustment, but rather a lack of parental supportiveness which characterized the abused child’s family environment. However, Greenwald et al.’s (1990) findings suggested a lack of parental support was insufficient to account for the increased anxiety demonstrated by CSA survivors. The seeming difference in the findings from these two studies may result from measuring slightly different constructs, Fromuth (1986) investigated phobic anxiety, whereas Greenwald et al. (1990) examined general anxiety.

Briere and Runtz (1988a), who also studied undergraduate students, found a significantly higher level of chronic anxiety among CSA survivors (n = 33) compared to nonabused controls (n = 191). Briere and Runtz found greater anxiety was reported by women who experienced parental incest, a higher number of perpetrators, older abusers, and a longer period of abuse. The researchers suggested such anxiety
symptoms “…may represent conditioned responses to sexual victimization that persist into later life in a manner similar to chronic rape trauma” (p.55). Through this process, aspects of the assault would subsequently trigger anxiety reactions in other situations and may explain the higher lifetime prevalence rate of anxiety disorders found among CSA survivors by Stein et al. (1988).

Yama, Tovey, and Fogas (1993) also found nonclinical undergraduate CSA survivors (n = 46) demonstrated significantly higher levels of anxiety than nonabused controls (n = 93). However, contrary to the findings of other researchers (Briere, & Runtz, 1988a; Sedney, & Brooks, 1984), no differences were found between the intrafamilial and extrafamilial CSA survivors. The researchers proposed this result may have been due to the intrafamilial abuse group containing a relatively small number of cases of abuse by a father/stepfather (n = 5). It was thought that a higher incidence of this type of perpetrator would have resulted in a greater impact for this group, given the results of previous research (e.g. Briere, & Runtz, 1988a; Herman, & Schatzow, 1987; Sedney, & Brooks, 1984).

In contrast to the previous studies, Jackson et al. (1990), who also used a university sample, found those with a history of CSA (n = 22) did not demonstrate higher levels of specific fears compared to nonabused controls (n = 18). The researchers questioned whether these findings resulted from inadequate measurement, the extinction of such responses since the cessation of abuse and before the time of measurement, or whether the conditions associated with CSA simply are not conducive to the development of specific fears. Some support for the latter explanation comes from Fromuth’s (1986) finding that phobic anxiety was only weakly related to the experience of CSA.

**Clinical Studies**

A variety of clinical studies have examined the nature of fear and anxiety in women who had experienced CSA. Lundberg-Love, Marmion, Ford, Geffner, and Peacock (1981) compared a group of CSA survivors (n = 29) with a psychological treatment control group (n = 22), an exercise control group (n = 31) and a no
treatment control group (n = 15). Survivors were entering treatment for a range of clinical conditions, those in the psychological treatment group were without a history of sexual abuse and the other two groups were part of a physiological research study. The CSA group was found to score significantly higher than all other groups on anxiety.

Briere (1984) gathered participants from a community counselling service, and found CSA survivors were significantly more likely than nonabused controls to report a fear of men, anxiety attacks and problems with anger. However, given that 49% of the sexually abused participants had also been battered in an adult relationship, it was not clear whether these symptoms related to the CSA, the more recent physical abuse, or a combination of both.

In another clinical study, Gorcey, Santiago, and McCall-Perez (1986) recruited more broadly through public advertisements and approaches to mental health agencies and private therapists. Consistent with the findings of previous studies, adult survivors of CSA (n = 41) reported higher levels of anxiety and more generalized anxiety than the control group (n = 56). Similarly, adult survivors of CSA also had significantly higher levels of fear. Using a sample of psychotherapy patients, Herman and Schatzow (1987) found among CSA survivors (n = 53), 14 of the women (26%) had chronic, severe anxiety. In the majority of these cases, the abuse had been associated with force (21%) or the threat of force (38%), consistent with the findings of Murphy et al. (1988). The additional finding by Herman and Schatzow that 75% of the women had been abused by a father or stepfather was consistent with the findings of Briere and Runtz (1988a).

Summary

In summary, higher rates of anxiety and fear appear to be present in CSA survivors compared to the general population, regardless of whether community or clinical samples are used. It is difficult to define the type of fear and anxiety experienced, given the use of various measures by different researchers. This practise indicates standard usage of a specific measure would be beneficial. There is an
indication that if the abuse is intrafamilial rather than extrafamilial, it may have a more detrimental effect upon the survivor and this factor needs further exploration. It would also be helpful to compare the type and levels of fear and anxiety at different time periods, to assess whether the nature of this changes following cessation of the abuse.

Although there seems to be a positive relationship between the experience of CSA and the presence of fear and anxiety symptoms in adulthood, this was not shown to be independent of the use of force or threat of force. Whilst a few studies have reported on this factor, other researchers did not separate out the effects, and some did not evaluate the factor at all. In addition, recent research suggests the victim’s perception of the degree of threat involved may be more important in predicting the level of subsequent distress, than an objective measure of the sexual assault’s severity. Therefore, future research should focus on measures that evaluate the victim’s subjective experience of the assault. For example, it may be important to determine whether the survivor feared for her life during the assault, was fearful of physical injury, or was threatened with undesirable consequences, such as the breakup of the family if she told of the abuse. These circumstances may more accurately predict long-term functioning than quantitatively determining the actual violence involved in the assault. As Koverola et al. (1996) put it “…an individual’s perception of reality becomes the individual’s reality” (p.277).

**Depression**

Research into the impact of CSA on the later development of depression in survivors has considered a number of factors, such as the incidence of major depressive episodes, characteristics of the abuse, and family background variables, including perceptions of parental support. In the following sections, the relationship between the experience of CSA and later depression in survivors will be discussed in terms of research employing community, college and clinical participants.
Community Studies

Depression in adulthood has been found to be associated with CSA in a wide range of community studies. In a random community sample, Bagley and Ramsay (1986) found survivors of CSA (n = 82) were significantly more depressed compared to a nonabused group (n = 285). In addition, current depression was found to be significantly associated with a prior history of sexual abuse. Four individuals were identified as acutely depressed and all reported a prior history of sexual abuse. However, the small number of individuals involved suggests caution should be exercised in relation to interpretation of this data.

Both Gold (1986) and Greenwald et al. (1990) in comparing CSA survivors with nonabused control groups, found significantly higher rates of depression among survivors. A community survey conducted in New Zealand found similar results (Mullen et al., 1988). These researchers found compared to nonabused controls (n = 273), women reporting experience of CSA (n = 41) were more frequently identified as having psychiatric disorders which were predominantly of a depressive type (6.3% compared to 20.0%). Furthermore, Peters (1988) found women with a history of contact CSA (85%) (n = 54) were significantly more likely than survivors of noncontact CSA (59%) (n = 17), or nonabused controls (66%) (n = 48) to have experienced a major depressive episode and to have had more depressive episodes. The relationship between CSA and depression was still significant after controlling for the influence of maternal warmth. Consistent with the findings of Peters (1988), Stein et al. (1988) found a significantly higher current prevalence of major depression among sexually abused women compared to nonabused controls, (17% and 3% respectively). The lifetime prevalence of major depression followed a similar pattern, with 22% of women who were CSA survivors (n = 51) suffering depression compared to 6% of nonabused women (n = 1,307).

In contrast to the findings of the studies previously discussed, Murphy et al. (1988), found CSA survivors (n = 38) did not demonstrate greater depression compared to nonvictims (n = 184). Beitchman et al. (1992) suggested this lack of a relationship may have been due to a long time delay since the last incident of abuse.
and testing for depression. However, in a comparison of sexual abuse type groups (child n = 38, adolescent n = 48 or adult n = 81), Murphy et al. found women who had experienced multiple abuse experiences (prior to the age of 18 years and a subsequent assault at 18 years or older, n = 34) were significantly more depressed than all groups of CSA survivors, and nonabused controls. Adult survivors of sexual assault also had significantly higher depression scores than nonabused women. In a follow-up study, these participants completed structural interviews to determine the extent to which survivors of three types of CSA (rape, molestation, and noncontact assault) were at an increased risk of developing major mental disorders (Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992). Child rape survivors (n = 39) were found to be significantly more likely than nonvictims (n = 260) to have met the DSM-III criteria (American Psychiatric Association, 1980) for a major depressive episode. Furthermore, the lifetime prevalence risk ratio for a major depressive episode was 1.5 for child rape and molestation survivors versus nonvictims.

A significantly higher level of depression among intrafamilial CSA survivors (n = 22) compared to a matched group of nonabused controls (n = 18) was found by Jackson et al. (1990) using a standard inventory of depression. These results were expanded upon with the survivor group being found to have a greater ratio of negative to positive affect, and a lower mean total on positive affect, although there was no difference between the groups on negative affect. Furthermore, survivors were found to have experienced greater depression and/or suicidal behaviour in the past compared to controls, as measured through a structured interview. However, when the researchers examined mood separated from other aspects of depression, the survivors did not report a greater negative affect, simply less positive affect than nonvictims. This finding suggested future research should take into consideration the various components of depression (such as mood, cognitive distortions, somatic symptoms, etc). Jackson et al.’s findings indicated survivors had an inability to experience pleasure, rather than an intensely negative affect, as the basis for their mood disturbance.

Alexander (1993) also used a standard inventory to assess depression in a community sample of adult survivors of CSA (n = 112). Current depression was
found to be significantly predicted by abuse characteristics and in particular early age of onset of abuse.

Roosa, Reinholtz and Angelini (1999) sought to compare whether this relationship between CSA and depression varied by ethnicity, using four groups of African American (n = 277), Mexican American (n = 539), Native American (n = 312) and non-Hispanic white women (n = 782). After controlling for background characteristics identified as risk factors for CSA and depression, it was found that severity of CSA was significantly related to depressive symptoms only for non-Hispanic white and Mexican Americans. Furthermore, CSA variables accounted for more variance in depression than background variables for Mexican American women only. However, child physical abuse was the strongest predictor of depression in adulthood and the only significant predictor for each ethnic group.

**College Studies**

Sedney and Brooks (1984) found among college women (n = 301), that CSA survivors (n = 51) reported a significantly higher rate of depression than nonabused controls. In contrast, Fromuth (1986) did not find a significant association between depression and a history CSA among college students (n = 383), which Beitchman et al. (1992) thought was perhaps due to including cases of less severe forms of sexual abuse. Fromuth (1986) found depression was correlated with the level of parental support present in the family, in contrast with the findings of Peters (1988) that the relationship between CSA and depression remained significant when the influence of maternal warmth was controlled. It would appear that it may be difficult to disentangle the relative influences of CSA and a lack of parental support in the later development of depression.

Given their belief that measures of acute symptomatology may not be sufficiently sensitive to adequately assess a relatively low incidence of chronic symptomatology, Briere and Runtz (1988a) examined both types of symptomatology. They found college students with a history of CSA (n = 33) demonstrated significantly higher levels of chronic, but not acute depression, compared to
nonabused women (n = 191). Using a standard inventory for assessment of
depression, Yama et al. (1993) also found significantly higher rates of depression
among CSA survivors (n = 46) compared to a nonabused control group (n = 93).
However, contrary to the researchers’ expectations, no differences were found
between the intrafamilial and extrafamilial CSA survivor groups in terms of
depressive symptoms. It was suggested this finding may have resulted from a low
incidence of father/stepfather abuse (n = 5), as this factor was thought to be
associated an increased likelihood of depression.

Clinical Studies

Few studies have examined the relationship between the experience of CSA
and later depression using clinical samples. Lundberg-Love et al. (1981) compared a
group of CSA survivors (n = 29) with a psychological treatment control group (n =
22), an exercise control group (n = 31) and a no treatment control group (n = 15).
Survivors were entering treatment for a range of clinical conditions, those in the
psychological treatment group were without a history of sexual abuse and the other
two groups were part of a physiological research study. The CSA group was found to
be more depressed than the exercise and no treatment control groups. However, the
psychological treatment control group was also significantly different from the no
treatment control group in terms of depression. Therefore, the difference in rates of
depression cannot simply be attributed to the presence of a CSA history rather than
other background factors.

Summary

The results of these studies are consistent in suggesting there is a greater
prevalence of depression among women who have experienced CSA compared to
nonabused controls. However, it would appear that the measure of depression used,
including whether it assesses a chronic or acute condition may have a significant
bearing on the findings. In addition, whether depression is divided into its various
components, such as mood, cognitive distortions and somatic symptoms may
determine the nature of relationships found. A complex relationship between
depression and the experience of CSA may exist, with revictimized and adult
survivors, and those with other psychological conditions demonstrating greater depression. It may be concluded that the role of the child’s family, and in particular the child’s perception of the mother’s response to the abuse, and the degree of parental support, may be important mediating factors between the experience of CSA and a depressive response in adulthood.

Depression in adulthood has been found to be associated with CSA, particularly when the abusive experience has commenced at an early age, or has been severe, such as involving physical contact or multiple abusive experiences. However, the provision of social support and the survivor’s perception of the abusive experience, including the influence of cultural beliefs, may be important mediating factors for later functioning. It is obviously important to control for family background factors such as disruption, dysfunction and violence, given that these factors may increase both the likelihood of CSA and depression.

**Suicidality and Self-Mutilation**

A review of the research literature suggests consistent findings of a link between a history of CSA and self-harm (Beitchman et al., 1992). Although there have been no studies investigating the prevalence of self-mutilation behaviour in community or college samples of CSA survivors, a few clinical studies have indicated an association between CSA and self-mutilation. Different researchers have defined the concept of self-harm in a variety of ways, with the continuum ranging from self-mutilation to suicidal ideation and actual suicide attempts. Briere in particular has endeavoured to explore the relationship between CSA and self-harm in a range of studies (Briere, 1988; Briere, & Runtz, 1986, 1988b; Briere, & Zaidi, 1989).

In the following sections, the relationship between a history of CSA and self-harming behaviour in survivors will be discussed in terms of research employing community, college and clinical participants.
Community Studies

A small but significant relationship between suicidal ideation and sexual abuse (11% for survivors compared to 3% for the nonabused controls) was found by and Ramsay (1986) in a community sample of women (n = 377). In addition, the four (5%) cases of suicide attempts and/or deliberate self-harm occurred among women who had experienced CSA, compared to none among the controls.

Using structured interviews with a community sample of women who had experienced intrafamilial CSA (n = 22), Jackson et al. (1990) sought to explore past history of suicide attempts. Survivors reported significantly higher rates of suicidal behaviour in the past compared to nonabused matched controls (n = 18). Whereas, Saunders et al. (1992) evaluated whether abuse severity might also play a role in determining suicidality, both in terms of suicidal ideation and suicide attempts. Adult survivors of child rape (n = 39) and molestation (n = 157), were more likely than nonvictims (n = 260) to have thought about suicide and to have attempted suicide. Thus, the rape group and molestation survivors demonstrated significantly higher prevalence rates than the nonvictim group for suicidal ideation (35.9% and 31.6% respectively compared to 19.6%) and suicide attempts (17.9% and 15.8% respectively compared to 5.8%). There were no significant differences in lifetime prevalence rates of suicide attempts between the noncontact CSA and nonvictims groups, suggesting severity of the abuse may play a major role in determining suicidality.

College Studies

Among college students (n = 301), Sedney and Brooks (1984) had also found a high rate of suicide attempts. Of the CSA survivors (n = 51), 16% had made at least one suicide attempt in the past, compared to only 6% of matched nonabused controls.

Clinical Studies

Clinical studies have tended to demonstrate an even stronger link between a history of CSA and suicidality, in comparison to community and college studies. The lack of empirical studies in relation to self-mutilatory behaviour confirms Courtois’ (1988) observation that the extent of self-mutilatory behaviour among CSA survivors
may be greatly underestimated, given it is often “…a hidden, solitary practice of which the survivor is afraid and ashamed” (p.303).

An early study by Carroll, Schaffer, Spensley and Abramowitz (1981) matched 14 self-mutilating patients with 14 nonabused controls from the same psychiatric population. Self-mutilators were defined as self-inflicting at least one injury resulting in physical damage, but which was nonsuicidal in intent. In-depth interviews indicated that although the trend was in the expected direction, self-mutilators were not significantly more likely than controls to have experienced some sexual abuse. However, a strong association was found between physical abuse and a family prohibition on the expression of anger and self-mutilation. These findings and the results from a pilot study of eleven CSA survivors led Shapiro (1987) to suggest that incestuous sexual abuse accompanied by physical force is psychically linked to self-blame in the survivor, resulting in acts of self-mutilation. Shapiro (1987) found six of the CSA survivors had undertaken self-mutilatory behaviour and all the survivors reported suicidal ideation.

Briere and Runtz (1986) found that within a group of clinical patients seeking crisis counselling (n = 195), those presenting with suicidal ideation were more likely to report a history of CSA (35.6%) compared to nonsuicidal patients (22.6%). In addition, CSA survivors were much more likely to have made at least one suicide attempt in the past (55%), compared to the nonabused clients (23%). Furthermore, the researchers found that the age at the first suicide attempt was strongly associated with a history of CSA. For those women who had made a first suicide attempt prior to the age of 13 years (n = 14), 92.9% had experienced CSA, as had 87% of women who had made their first suicide attempt during adolescence (n = 39). On the other hand, a first attempt during adulthood (n = 30) was statistically independent of abuse status. Briere and Runtz acknowledged that although interpretation of the childhood data must be qualified by the small sample size, there was an indication of support for a “diminishing effects” model of abuse-related suicidality. In particular, perhaps the effects of CSA on suicidality were most significant during childhood and adolescence, becoming less relevant for first incidents of suicidality in adulthood.
An attempt was made to examine the relationship between suicidality and a history of CSA from another perspective, in a subsequent study by Briere and Runtz (1988b). In this study, 44% of the female clients (n = 152) in a community health centre crisis intervention service were found to have had a history of sexual abuse prior to the age of 15 years. Of these individuals, 51% had made at least one suicide attempt in the past, compared to 34% of those without such a history. Further analysis of this data suggested self-mutilation behaviour was significantly predicted by a history of CSA, and a history of concurrent physical abuse and sexual penetration by the perpetrator was significantly related to suicidal behaviour (Briere, 1988).

Bryer, Nelson, Miller and Krol (1987) took into consideration the abuse history (sexually, physically or both) of women demonstrating suicidality among a sample of psychiatric inpatients (n=66). Women with a history of suicidal ideation, gestures and/or attempts, were three times as likely to have experienced childhood abuse (sexually, physically or both, n = 48) than patients without these symptoms. However, the researchers did not specify the relationship to suicidality for each of the abuse groups separately. Therefore, the unique impact of sexual abuse could not be established.

In a further study of clinical patients, Briere and Zaidi (1989) examined the psychiatric records of 50 women who presented to an emergency room. Of this group, 17% of those with a history of CSA (n = 35) and none of the controls (n = 15) had a documented history of self-mutilation. CSA survivors were also found to be significantly more likely than controls to have a history of suicide attempts (23% compared to 5%) and suicidal ideation (current or past) (27% compared to 5%).

Summary

In spite of limited empirical research, clinical studies have demonstrated a stronger link between CSA and suicidality compared to community and college samples. Both suicidal ideation and suicide attempts have consistently been found to be associated with a history of CSA. CSA has also been linked to previous suicide
attempts, and in particular the age of the first suicide attempt during childhood or adolescence. The risk of suicidality appears to increase with increased severity of CSA. Although suicidality seemed linked to concurrent physical and sexual abuse during childhood, the role of the physical abuse cannot be distinguished. However, exploration of self-mutilatory behaviour indicates sexual abuse accompanied by physical force may provide a trigger for self-harming behaviour through self-blaming attributions.

**Anger**

Although no empirical studies have specifically examined the relationship between a history of CSA and the development and expression of anger in survivors, a number of clinical studies have indicated CSA survivors may display a significant degree of anger towards others in adulthood. In the following section, the relationship between a history of CSA and expression of anger will be discussed in terms of clinical research.

**Clinical Studies**

Tsai and Wagner (1978) observed that CSA survivors participating in therapy groups (n = 50) sometimes expressed greater anger towards their mother for not protecting them, than the person who actually carried out the molestation. In her investigation of psychotherapy outpatients (n = 40), Herman (1981) also confirmed this observation and suggested that some survivors saw their fathers as the only source of caring and affection in their lives. Tsai and Wagner (1978) noted that in cases of incest, mothers were accused of colluding with the father, ranging from active collusion to either obliviousness or denial, including passive acceptance. Thus, survivors believed their mothers had either consciously or inadvertently perpetuated the pathological sexual relationship, and their own welfare was sacrificed in their mother’s attempts to keep the family together.

In conducting a study with a small sample of psychiatric inpatients (n = 3) and a self-help outpatient group (n = 7), Haller and Alter-Reid (1986) made similar
observations. They also proposed that survivors’ anger was related to their mother’s lack of protection and their father’s exploitation and lack of accountability. Furthermore, the survivor’s anger was thought to emanate from seeing herself in the role of the sexually abused child carrying the burden of being the “victim”, while the offender received no punishment. Thus, Briere (1988) found CSA survivors seeking crisis counselling (n = 133) reported greater anger than nonabused women (n = 61). In addition, bizarre abuse was found to be significantly related to anger, as might be expected. In conducting a further study of women seeking crisis counselling (n = 152), Briere and Runtz (1988b) again found CSA survivors (n = 67) had greater difficulty in controlling their temper and reported higher levels of anger than nonabused women (n = 86). The researchers proposed that the effect resulted from the betrayal, powerlessness and stigmatization intrinsic to many situations of CSA, leading to the experience of chronic rage. The anger may be directed towards the self, as in the case of self-mutilation or suicidality. Alternatively, the anger may be directed towards others, such as in aggression, criminal acts or acting out behaviour in response to a range of interpersonal situations. This seems uncharacteristic of CSA survivors in general, perhaps due to their experience of a prohibition on the expression of anger in their family-of-origin, as noted by Carroll et al. (1981).

**Summary**

In conclusion, there appears to be fairly consistent clinical support for the view that CSA survivors exhibit greater anger as adults, compared to nonabused controls. The anger of survivors is often directed at their mothers for not protecting them, rather than at the offenders themselves. Such anger may be exhibited as chronic rage, which may be expressed in a broad range of ways and situations. Comprehensive research is required to test proposals regarding how this anger forms and generalizes, the methods of expression used and their adaptability over the longer term.

**Substance Abuse**

There are equivocal findings in relation to the association between substance abuse and a history of CSA, which can be understood when differences in
methodology are taken into consideration. In the following sections, the relationship between a history of CSA and subsequent substance abuse will be discussed in terms of research employing community, college and clinical participants.

**Community Studies**

Few studies of alcohol or drug abuse among women in the community have focussed on the relationship between substance abuse and a history of CSA. Using a community sample (n = 119), Peters (1988) found survivors of contact abuse (n = 54) were more likely than survivors of noncontact abuse (n = 17) or nonvictims (n = 48), to have definite alcohol abuse or probable drug abuse. These results suggested the severity of the abuse, for example, contact versus noncontact abuse, may have an influence on whether the individual goes on to develop substance abuse problems. These results were confirmed by the findings of Stein et al. (1988) who analyzed a large, representative community sample (n = 1,358). Stein et al. found a higher prevalence of lifetime alcohol abuse/dependence among CSA survivors (21% of n = 51) compared to nonabused women (4% of n = 1,307). They also found a higher prevalence of lifetime drug abuse/dependence among survivors of CSA (14% of n = 51) compared to nonabused women (3% of n = 1,307).

**College Studies**

In contrast to community studies, mixed findings have resulted from studies of college students. In a study of female college students (n = 301), Sedney and Brooks (1984) found no differences between abused (n = 51) and a matched group of nonabused women (n = 51) in terms of their drug or alcohol abuse. Women who were CSA survivors and had serious difficulties with drug or alcohol abuse may be less likely to continue on at college and therefore be under-represented in such a sample. However Zierler et al. (1991) also investigated a college sample and found female CSA survivors (n = 21) were more than twice as likely as nonabused women (n = 54) to undertake heavy alcohol consumption at some period in their lives. In addition, the abuse survivors used tranquilizers more frequently than those who had not been assaulted.
Clinical Studies

In a sample of psychotherapy patients, Meiselman (1978) found no difference in rates of alcohol addiction for incest survivors (n = 26) compared to a control group (n = 50). However, it should be noted that a very small number of patients were involved. Similarly, Carmen, Rieker and Mills (1984) found no differences in the percentages of drug and alcohol abusers among abused (n = 65) compared to nonabused psychiatric inpatients (n = 58). These patients also did not differ in their substance abuse at the time of admission. Given their psychiatric inpatient status, it is possible that these women chose not to reveal details of their substance history.

However, Briere and Runtz (1988b) found among a clinical sample (n = 152), a much higher percentage of abused women (n = 67) compared to nonabused women (n = 86) reported a history of drug addiction (20.9% compared to 2.3%) and a history of alcoholism (26.9% compared to 10.5%). This difference in findings may be due to the nature of the sample. These individuals had sought appointments at a crisis counselling centre, suggesting difficulties in their daily coping, which may have been precipitated or exacerbated by CSA and substance abuse. In a further study, Briere (1988) investigated a clinical sample (n = 195) of women attending a crisis intervention service. A comparison between CSA survivors (n = 133) and nonabused women (n = 61), found survivors were significantly more likely to report a history of alcoholism and drug addiction. Furthermore, indicators of abuse severity including longer periods of sexual abuse, forced participation in bizarre sexual acts, abuse by multiple perpetrators and the co-occurrence of physical abuse, were related to the development of drug and alcohol addiction.

In their study of alcoholic inpatients, Windle, Windle, Scheidt and Miller (1995) found 59% of the women reported a history of childhood abuse. Of these women, 49% reported a history of sexual abuse (with or without physical abuse), 33% reported physical abuse (with or without sexual abuse) and 23% reported dual abuse. Furthermore, a family history of alcoholism was associated with a higher prevalence of childhood sexual or physical abuse, although there was little difference in the rates of abuse type (sexual only, physical only or dual abuse). Therefore,
factors from the survivor’s family-of-origin, including the presence of concomitant physical abuse and a family history of alcoholism appeared to predispose the CSA survivor to alcoholism.

Jarvis, Copeland and Walton (1998) sought to assess whether CSA was associated with either substance abuse at an earlier age and/or greater severity of substance dependence. They also questioned what aspects of the CSA may predict substance abuse. The sample consisted of women in drug and alcohol treatment (n = 100) with and without a history of CSA, and CSA survivors who were not receiving drug and alcohol treatment (n = 80) who did or did not have current substance abuse. There was no difference found in severity of substance dependence between CSA survivors and other drug and alcohol treatment clients. However, those women with a history of CSA, even after controlling for maternal substance abuse, reported a younger age at first intoxication, an earlier use of inhalants and more frequently identified stimulants as their main problem drug.

For CSA survivors not undertaking drug and alcohol treatment, those who had current substance abuse had typically been abused during adolescence by a person outside the family. Jarvis et al. (1998) suggested substance abuse may have been used as a coping method by these adolescents, given their greater accessibility to alcohol and other drugs. Adolescent substance abuse may actually have precipitated the sexual abuse by increasing the young woman’s vulnerability through incapacitation. Women without current substance abuse were typically found to have been abused by family members before adolescence. The researchers proposed that women abused at a younger age may have developed alternative methods of coping by the time they were old enough to experiment with alcohol and other substances. On the other hand, given the characterization of survivors’ families as having very conservative values, it seems likely there was an accompanying prohibition on the use of alcohol or other substances.
Summary

The few community studies to focus on the relationship between CSA and later substance abuse suggested abuse severity may increase the development of substance abuse in survivors. Survivors were found to have a higher lifetime prevalence rate for both alcohol abuse/dependence and drug abuse/dependence. However, college studies produced more equivocal findings, as was the case among clinical studies. These differences may have been attributable to a variety of methodological factors. As a first step in understanding this relationship further, standardized measures of sexual abuse and substance abuse should be employed to enable comparisons between studies. It seems there may be a link between the relationship of the offender (intrafamilial or extrafamilial), increased severity of the sexual abuse and family characteristics such as a family history of alcoholism, which may predict an increased likelihood of later substance abuse.

Eating Disorders

The general acknowledgement of a possible relationship between sexual abuse and the development of an eating disorder has led to a number of investigatory research studies being undertaken, particularly within the clinical field. In the following sections, the relationship between a history of CSA and development of eating disorders will be discussed in terms of research employing college and clinical participants.

College Studies

Calam and Slade (1989) sought to investigate the relationship between eating disorders and unwanted sexual experiences in a college sample (n = 130). Overall, 58% of the students reported some type of unwanted sexual experience, with 20% of the unwanted events being experienced by the age of 14 years and 13% reporting intrafamilial abuse. A history of CSA was associated with a diagnosis of eating disorder based on global measures. Intrafamilial abuse was significantly associated with dieting, whilst CSA involving force was related to eating difficulties and sexual intercourse correlated with eating problems.
An assessment of college students (n = 294) against the DSM-III criteria for bulimia, in addition to information regarding weekly binges, was used by Bailey and Gibbons (1989) to evaluate the likelihood of a relationship between physical victimization and bulimia. Although 13% of the students reported a history of CSA, this was not significantly associated with a diagnosis of bulimia. However, the experience of child physical abuse was significantly associated with both a diagnosis of bulimia and severity of this disorder. Beckman and Burns (1990) also sought to assess college students (n = 340) on a questionnaire operationalizing the DSM-III criteria for bulimia, and found a prevalence rate of CSA of 65.9% within the total sample. Those classified as bulimic (n = 44) were significantly more likely to have reported experiencing forced extrafamilial abuse after the age of twelve (48.7%) compared to 27.4% of those classified as nonbulimic (n = 170). In contrast, intrafamilial abuse rates were not significantly different between bulimic and nonbulimic groups after the age of twelve years. The researchers were surprised by the relatively low overall rates of intrafamilial CSA (8.3% bulimics and 4.8% of nonbulimics) and extrafamilial CSA (7.5% bulimics and 10.8% nonbulimics) reported.

The possible mediation by abuse characteristics, personality variables, and levels of family support of a relationship between CSA and later development of eating disorders was explored by Smolak, Levine and Sullins (1990). Excluding experiences with peers, 23.0% of the college sample (n = 298) reported experience of CSA. Overall, the CSA group were found to have a higher rate of eating disorders, although this rate was not linked to abuse severity (type and frequency), type of contact (no physical contact, physical contact but not penetration, penetration) or the familiarity of the offender (strangers, known others, relatives). However, CSA survivors who rated their parents as unreliable appeared to experience greater difficulties compared to those women reporting they had reliable parents. Thus, Smolak et al. concluded family characteristics may play an important role in determining whether CSA survivors develop disturbed eating behaviours and attitudes.
Clinical Studies

Given the nature of eating disorders, the majority of research studies addressing the existence of a relationship between a history of CSA and development of eating disorders has been conducted with clinical populations. In a study of outpatients (n = 78), Oppenheimer, Howells, Palmer, and Chaloner (1985) used DSM-III criteria to classify participants as having anorexia (n = 36), bulimia (n = 33), or both anorexia and bulimia (n = 9). Among the total group, 29.5% had experienced sexual events in childhood and adolescence, and a further 34.6% were classified as experiencing a coercive sexual event, with a total of 51.3% of patients experiencing CSA. However, there was no relationship found between CSA history and the type of eating disorder diagnosed.

In a study employing structured interviews, Finn, Hartman, Leon and Lawson (1986) found 18.3% of the group psychotherapy patients (n = 87) could be classified as bulimic, whilst none were anorexic. There were no significant differences between those reporting a CSA history (n = 61) and the nonabused controls (n = 26) in terms of prevalence of bulimia or other eating disturbances, with approximately 48% of the women in both groups exhibiting abnormal eating. Finn et al. acknowledged that the high base rates of both lifetime eating disturbance (82%) and/or a history of CSA (70%) meant many participants would have a history of both, yet the findings indicated a lack of a meaningful relationship between them.

In an attempt to assess the prevalence of CSA among those diagnosed and being treated for bulimia (n = 172), Root and Fallon (1988) conducted structured interviews incorporating the DSM-III diagnostic criteria and issues related to physical victimization. Overall, consistent with similar research (Bailey, & Gibbons, 1989), 65.7% of the participants had been physically victimized, whilst 28.5% of participants reported experiencing CSA. The researchers proposed physical victimization may lead to the development of bulimia, as a method of coping with physical invasion. Such physical invasion could also include experience of CSA. Semistructured interviews were also utilized by Bulik, Sullivan and Rorty (1989) to examine family environment variables and CSA history among women classified as
bulimic (n = 35) according to DSM-III criteria. In addition to ten women who described a history of CSA, two women whose siblings experienced intrafamilial CSA were included in a familial sexual abuse group (34.3%). No differences were found between this familial sexual abuse group and those without an abuse history. In contrast, bulimic women coming from families in which CSA occurred were more likely than women from families without a familial sexual abuse history, to have experienced major depression, relatives who abused drugs and a disturbed family environment. Bulik et al. observed that although the prevalence rate of CSA within their study was similar to that of Oppenheimer et al. (1985), it appeared the severity of abuse was greater within their group.

Hall, Tice, Beresford, Wooley, and Hall (1989) sought to investigate the extent and nature of CSA among women subsequently being treated for anorexia nervosa or bulimia. Following clinical interviews, patients were classified as having bulimia or anorexia (n = 72) or other types of eating disorders (n = 86). In all, 50.0% of the anorexic or bulimic group had experienced CSA, which was significantly different to the 27.9% of the other eating disorders group who reported experiencing CSA.

In a more sophisticated study employing two nonabused control groups, Steiger and Zanko (1990) compared the prevalence of CSA among eating disordered women (n = 73), with the control groups of women being treated for anxiety or affective disorders (n = 21) and normal women not exhibiting eating disorders (n = 24). A history of CSA was reported by 29.7% of the eating disordered group, 33.3% of the anxiety/affective disorders group and 8.7% of controls. There was a wide variation in prevalence of CSA among the eating disordered group, with anorexic restrictors demonstrating the lowest rate (6.3%), followed by bulimics with a history of anorexia (25.0%), bulimics without a history of anorexia (41.7%) and finally, anorexic bingers (41.7%).

In a follow up of their previous study (Oppenheimer et al., 1985), Palmer, Oppenheimer, Dignon, Chaloner, and Howells (1990) classified eating disordered outpatients (n = 158) as anorexic (n = 80) or bulimic (n = 78) according to DSM-III criteria. Overall, 31.0% of the outpatients reported experience of CSA and a further
26.6% indicated experience of unpleasant or coercive sexual events. However, no significant association was found between rates of abuse and specific eating disorder type, or between the age at abuse and subsequent diagnosis.

**Summary**

Overall, it would appear that a history of CSA increases the survivor’s vulnerability to the later development of eating disorders, particularly when accompanied by physical force. However, the research to date has provided a range of highly discrepant results. It has been proposed that some variability could be accounted for by methodological issues, such as differing diagnostic criteria, study design and assessment techniques. Furthermore, the heterogeneity of the eating disordered population and the comorbidity of eating pathology and personality disorders are factors which need to be taken into consideration. Overall, results suggested that approximately 30% of eating disordered patients had experienced CSA, which is a figure equivalent to that for the general population, although it may be possible to establish a direct link between a history of CSA and development of eating disorders in some individuals.

**Somatization**

There has been very limited empirical research into the link between a history of CSA and the long-term effect of somatization in adulthood, with a few studies incorporating this issue when considering the survivors’ psychological adjustment. Somatization has been defined by Derogatis, Lipman, Rickels, Uhlenhuth and Covi (1974) as “…distress arising from perceptions of bodily dysfunction” and as including “…somatic equivalents of anxiety” (p.4). Thus, somatization relates to a preoccupation with bodily processes and their vulnerability to disease or dysfunction. Briere and Runtz (1988a) argued that this heightened concern may result from the experience of physical invasion and vulnerability, characteristics usually involved in sexual victimization. The sexual locus of such victimization may result in increased awareness and sensitivity to pain or sensation in the primary or secondary sexual regions, which may account for the chronic pelvic pain found among some incest survivors (Gross, Doerr, Caldirola, Guzinski, & Ripley, 1980).
In the following sections, the relationship between a history of CSA and development of somatization symptoms will be discussed in terms of research employing community and college participants.

**Community Studies**

Using a community sample (n = 391), Murphy et al. (1988) compared survivors of child (n = 38), adolescent (n = 48), and adult (n = 81) and both child/adult (multiple) (n = 34) sexual assault, with nonabused controls (n = 184). The multiple sexual assault group was found to have significantly higher somatization than all of the other sexual assault groups. Consistent with these findings, using a nonclinical sample of adult women, Briere and Runtz (1988b) also found CSA survivors (n = 33) reported higher levels of somatization than nonabused controls (n = 191). Assessment of symptoms over the last week (acute) and within the last year (chronic) indicated that somatization appeared to discriminate abuse history, at both acute and chronic levels of occurrence. This finding suggested a generalized elevation of somatization for survivors. The abuse variables of parental incest and total duration of abuse were correlated with higher chronic somatization, whereas the use or threat of force was related to higher acute somatization. These findings may be explained by the nature of the abuse experience, parental incest and abuse over an extended period is highly likely to be chronic in nature, leading to the parallel development of chronic somatization symptoms. Similarly, the use or threat of force is likely to provoke a crisis in the survivor’s functioning, precipitating the development of acute symptoms of distress. Consistent with these findings, Greenwald et al. (1990) found a higher rate of somatization among CSA survivors (n = 54) compared to matched nonabused controls (n = 54).

Hyman (2000) investigated the relationship between a history of CSA and later health and mental health problems in a large community sample of lesbian women (n = 1,889). The survivors of CSA (n = 814) were classified into four groups: intrafamilial without coercion (n = 365), intrafamilial with coercion (n = 135), extraracial known perpetrator (n = 182) and extrafamilial unknown perpetrator (n = 132). A history of CSA was found to be a significant predictor of the number of physical health problems a
woman reported, particularly for women who experienced intrafamilial CSA without coercion, and women who experienced extrafamilial CSA (known or unknown perpetrator). Hyman (2000) found women who experienced intrafamilial CSA with coercion were the most likely to report mental health problems. It appeared that intrafamilial CSA with coercion did not factor into the prediction of physical health problems, as it was more powerful in predicting mental health issues. It might be expected that this would be the case, as the experience of intrafamilial CSA represents betrayal of trust by a family member, which when combined with the use of coercion, doubly jeopardizes the survivor’s capacity to trust others and may lead to self-blaming attributions.

**Clinical Studies**

Lundberg-Love et al. (1981) compared a group of CSA survivors (n = 29) with a psychological treatment control group (n = 22), an exercise control group (n = 31) and a no treatment control group (n = 15). Survivors were entering treatment for a range of clinical conditions, those in the psychological treatment group were without a history of sexual abuse and the other two groups were part of a physiological research study. The CSA group was found to be significantly higher on somatization than the exercise and no treatment control groups, but not the psychological treatment group, suggesting a range of clinical disorders may result in an elevation of symptoms of somatization.

**Summary**

The limited research available suggests that there is a positive relationship between CSA and somatization. However, to assess this accurately, the type and chronicity of abuse needs to be carefully defined. It appears abuse characteristics including parental incest and longer duration of abuse may be associated with chronic somatization and the use or threat of force may be associated with acute somatization. However, further research is required with a range of samples and comparison time frames to both validate and expand on current research.
Dissociation

There has been acknowledgement that data are lacking on dissociation as a sequel of CSA (Briere and Runtz, 1988a, 1988b). However, this may be partially due to a lack of reliable measures of this symptom. In the following section, the relationship between a history of CSA and development of symptoms of dissociation will be discussed in terms of research employing clinical participants and a college study.

Clinical Studies

Blake-White and Kline (1985), on the basis of their work with adult incest survivors, argued that the experience of incest, and particularly the initial assault, is associated with a range of emotions which the child finds overwhelming, leading to a dissociative process. These emotions result from facing a situation which evokes enormous grief, despair or anxiety and the individual may respond by a total repression of the memories of the disturbing events for a prolonged period, which is accompanied by a disappearance of painful affect.

Similarly, Briere (1988) proposed that dissociation may be seen as an extreme form of denial or avoidance, which may be adaptive for coping with the discomfort of the abuse. For example, an abused child may learn to dissociate from her/his body as an adaptive means of escaping sensory input during victimization. However, this coping response may persist and become a generalized automatic response to any anxiety-producing or noxious event, which may result in amnesic periods or misinterpretations of situations because of a dissociation from reality. Furthermore, Briere and Runtz (1988b) argued that this defense has voluntary and involuntary components, the latter being experienced by the individual as a serious mental health problem.

Briere (1988) and Briere and Runtz (1988b) assessed the symptoms of dissociation in clinical samples of adult survivors of CSA. These survivors were more likely to report problems related to dissociation such as “spacing out”, derealization and out of body experiences, than nonvictims. In one clinical sample (n
including CSA survivors (n = 133) and nonabused women (n = 61), dissociation was linked to abuse which involved sexual intercourse (Briere, 1988). In another clinical sample (n = 152) of CSA survivors (n = 67) and nonabused women (n = 86) seeking crisis counselling appointments, dissociation was again demonstrated to be relatively common among CSA survivors (Briere, & Runtz, 1988b).

**College Studies**

In a sample of female college students (n = 224) including 33 CSA survivors, dissociation was positively related to the age of the oldest abuser, parental incest and duration of abuse (Briere, & Runtz, 1988a). It may be hypothesized that these circumstances represented the most severe forms of abuse, promoting the use of dissociation as a coping response.

**Summary**

In summary, it has been proposed that the observed symptoms of dissociation, which seem to be associated with the more severe forms of sexual abuse, may be adaptive as a coping response at the time of abuse. However, if this behaviour develops into a more generalized response to anxiety provoking situations, it becomes detrimental for the individual, which would seem to be the case for at least some CSA survivors.

**Memory Impairment**

Although there has been much debate regarding the validity and accuracy of adults’ memories of CSA, very few studies have attempted empirical investigation of this issue given the practical difficulties involved. In the following section, the relationship between CSA and memory impairment will be discussed in terms of research employing clinical participants.
Clinical Studies

Using a sample of women who participated in a time-limited therapy group for incest survivors (n = 53), Herman and Schatzow (1987) investigated the recovery of previously repressed traumatic memories. “Severe memory deficits” were reported by 28% of the women, whereas 64% reported “…at least some degree of amnesia” for the sexual abuse (Herman and Schatzow, 1987, p.4). Furthermore, increasing memory deficits were associated with an earlier age at onset of abuse, lengthier duration of the abuse and a greater degree of violence involved in the abuse. The majority of patients were able to validate their memories through obtaining corroborating evidence from other sources.

In one of the few studies to measure memory impairment in CSA survivors, Jarvis et al. (1998) compared women who were and were not attending drug and alcohol residential programs. The groups were divided into drug and alcohol program attendees with a history of CSA (D & A treatment with CSA, n = 50) and those without such a history (D & A treatment only, n = 50). These groups were compared with a second group of women with a CSA history who had no drug and alcohol problems (CSA only, n = 50) and those who were abusing substances but not attending drug and alcohol treatment (CSA with D & A no treatment, n = 30). The majority of CSA survivors (66%) had experienced a memory loss about CSA at some time, with memory disturbances ranging from forgotten details to total amnesia until recent recollection. Significantly more of the CSA only group reported memory loss compared to the other two CSA groups, who had drug and alcohol problems for which they were, or were not receiving treatment. Furthermore, memory loss was associated with abuse at a younger age, which may be explained as part of the dissociative process.

Summary

From the very limited clinical research available, it would appear that memory impairment is linked to dissociative processes which occur during experience of CSA. Memory loss is particularly profound when severity of abuse increases, such as
an earlier age of onset, longer duration of abuse, and accompaniment by physical force.

**Borderline Personality Disorder**

A number of researchers have also suggested that there is an association between CSA and Borderline Personality Disorder (BPD). In the following section, the association between CSA and development of BPD will be discussed in terms of research employing clinical participants.

**Clinical Studies**

Barnard and Hirsch (1985) reported that 57% of the 30 incest survivors in their study had received a primary diagnosis of BPD. Similarly, Bryer et al. (1987) also found that among 14 psychiatric inpatients with BPD, 86% were survivors of early sexual abuse. In contrast, only 14% of patients who had not been abused were diagnosed as having BPD.

However, Dahl (1985) argued that the diagnosis of BPD and its differentiation from other personality disorders is subject to wide variability, depending upon the specific theoretical notion held about the diagnosis. Kolb and Gunderson (1980) suggested that BPD may be overdiagnosed. Beitchman et al. (1992) believed a disturbed relationship between the child and parents, which is characteristic of the borderline disorder, may be a more significant predictor of BPD than the sexual abuse itself.

**Summary**

As is the case for other psychological disorders, there are methodological problems inherent in the study of BPD, primarily relating to variations in the operationalization of the diagnosis. This makes it difficult to evaluate the validity of an association between CSA and later development of BPD. Further research is required to evaluate the association between BPD and CSA, separated from the impact of familial relationships.
Post Traumatic Stress Disorder

A number of clinicians (Blake-White, & Kline, 1985; Cole, & Barney, 1987; Rodriguez, Kemp, & Foy, 1998) have proposed that survivors of CSA may manifest symptoms consistent with Post Traumatic Stress Disorder (PTSD) in adulthood. The symptoms cluster into a stress response syndrome and cycle predictably in two major phases of denial and intrusive thinking. In the denial phase, over-controlling defenses are operating, with symptoms including amnesia (partial or full), forgetfulness, minimizing, dissociation, fatigue, headaches and selective inattention. In the intrusive phase, under-controlling defences are operating, with symptoms including hypervigilance, repetitive thoughts and imagery, hallucination-like phenomena, confusion, waves of intense emotions, tremors, sweating and nightmares (Cole, & Barney, 1987).

This psychiatric disorder is characterized by symptoms of intrusive re-experiencing of the traumatic event and avoidance. The trauma survivor moves between these two phases of denial and intrusive thinking, and symptom intensity and change are observed or reported during the move from one phase to another. Based on their work with CSA survivors, Cole and Barney (1987) proposed that there is a “therapeutic window” between the extremes of the phases. This is when the symptoms are still present, but the level of distress is more moderate and the symptoms sufficiently manageable to enable reworking of the traumatic material.

Blake-White and Kline (1985) also observed that women who experienced CSA have symptom patterns which fit the diagnosis of PTSD. Although the abuse has been buried and supposedly forgotten, a delayed disorder is often observed. The survivor wants to avoid the anxiety of remembering, by forgetting the trauma and pushing it into the past. Methods which may be used include total denial, abuse of alcohol or excessive use of prescription or illegal drugs. However, a number of situations may trigger vivid recollections. These include the complete emotional context and visual and tactile memories of the actual abuse. For example, sexual contact with a male, being in bed alone at night, and hearing a male breathing heavily may bring back these memories. Being touched by another person may also elicit an
exaggerated startle response. Individuals have often described a feeling of detachment from their emotions or feeling outside their body.

Furthermore, Blake-White and Kline (1985) argued that conflicting realities play a major role in this disorder for the sexually abused child becomes a "complier". Compliance is required to ensure survival, as the abused child who denies her reality may often identify with the aggressor. Although told by the abuser what she was doing was acceptable, the child suspected it was wrong. The psychosocial stress of the abuse may have become so severe that the child found it easiest to cope by either denying that the abuse occurred, or denying that it had been traumatic. Unlike adult trauma survivors, the CSA survivors are unlikely to have had much life experience, including control over their environment. Blake-White and Kline proposed that children are therefore less likely to have had the opportunity to develop an awareness that the situation could be better. The child’s personality would still be at an early stage of formation and as the abuse continued and the stress intensified, the only method of coping may be for the child to dissociate from the painful events of their reality.

Finkelhor (1988) suggested that the PTSD model focuses too much on the affective experience and does not take into consideration the cognitive changes which are common following CSA. Finkelhor and Browne (1985) outlined an alternative model, which proposes there are four traumagenic dynamics of abuse: (1) traumatic sexualization, (2) betrayal, (3) stigmatization and (4) powerlessness. Each dynamic is hypothesized to relate to specific symptoms observed following experience of CSA. Finkelhor (1990) has argued that a PTSD conceptualization of the impact of CSA is inadequate for a number of reasons. In particular, survivors demonstrate additional symptoms such as sexualization and cognitive distortions, and may exhibit symptoms such as depression and sexual adjustment difficulties but not be diagnosed as having PTSD. Finkelhor also argues that PTSD theory is not as applicable in situations where abuse does not occur in violent circumstances, such as in the case of chronic abuse. The trauma results from the distorted socialization arising from the relationship or situation.
In the following sections, the association between CSA and development of PTSD will be discussed in terms of research employing community and clinical participants.

**Community Studies**

In their community sample of randomly selected female CSA survivors (n = 131), Saunders et al. (1992) reported a PTSD rate of 11.4% for the noncontact group (n = 35), 33.3% for the molestation group (n = 57) and 64.1% for the penetration group (n = 39). These data indicated a 46% lifetime PTSD rate for participants who experienced contact CSA. However, there were no significant differences found between the noncontact, molestation or penetration groups on current PTSD rates, with the current PTSD rate being 12.5% for those who had experienced contact abuse. Rape survivors (17.9%) were twice as likely as those experiencing molestation (8.8%) to have met the PTSD diagnostic criteria.

Hazzard (1993) piloted a measure of trauma-related beliefs with a group of CSA survivors (n = 59). This measure was developed on the basis of four internally consistent subscales reflecting Finkelhor and Browne’s (1985) traumagenics model: Self-Blame, Stigmatization, Betrayal/Powerlessness and Traumatic Sexualization. Multiple regression analyses were used to investigate the relationships between these trauma-related beliefs and other psychological/behavioural outcomes. Self-Blame/Stigmatization beliefs predicted lower self-esteem, interpersonal problems, depression, anxiety and overall psychological distress. Betrayal beliefs predicted interpersonal problems, an external locus of control and sexual problems. Powerlessness beliefs predicted lower self-esteem, depression and an external locus of control. Traumatic Sexualization beliefs predicted anxiety and sexual avoidance. These findings did provide support for Finkelhor and Browne’s (1985) model, with the exceptions that Betrayal beliefs did not predict depression, and Self-Blame beliefs predicted anxiety, but anxiety seemed unrelated to Powerlessness beliefs.

A study by Coffey, Leitenberg, Henning, Turner, and Bennett (1996) attempted to empirically partially test Finkelhor and Browne’s (1985) model using a
community sample of adult survivors of CSA (n = 192). Although this sample was ultimately subject to self-selection, it was taken from a larger pool (n = 666) which appeared representative of the general population. Perceived stigma, betrayal, powerlessness and self-blame were hypothesized to mediate the long-term effects of CSA. A path analysis suggested that the level of psychological distress currently experienced by these adult survivors was mediated by feelings of stigma and self-blame. It was also noted that broader societal factors may additionally contribute to an individual’s thoughts and feelings about the abuse, including stigmatization by others.

Clinical Studies

Briere and Runtz (1988b) and Finkelhor (1988), among others, have argued that the symptoms associated with CSA do not neatly fit the diagnosis for PTSD. Finkelhor (1988) suggested that PTSD does not account for all of the symptoms associated with CSA and it only accurately applies to some CSA survivors. For example, CSA survivors (n = 67) were more likely than nonabused respondents (n = 86) to report previous suicide attempts and drug addiction, alcoholism and revictimization in an adult relationship (Briere, & Runtz, 1988b). Finkelhor and Browne (1985) suggested that such difficulties related to the low self-esteem and interpersonal vulnerability that arose from perceived powerlessness and stigmatization, dynamics which are intrinsic to the abuse process.

Rowan, Foy, Rodriguez, and Ryan (1994) sought to investigate current rates of PTSD using an outpatient clinical sample (n = 47) of CSA survivors (females n = 44, males n = 3). The researchers found 69% of survivors met the full diagnostic criteria for PTSD and a further 19% met the criteria for partial PTSD. Use of a measure of PTSD symptoms provided consistent findings, as 64% of survivors met the full criteria for PTSD and 19% met the criteria for partial PTSD. However, the researchers felt a lack of heterogeneity in the sample in terms of severe abuse exposure, limited the applicability of the results to the general population of CSA survivors. Research is required which utilizes survivors with a range of abuse severity, with classifications carefully documented.
Summary

In summary, there continues to be dispute about whether CSA survivors demonstrate the characteristics of PTSD in adulthood. It would appear that further examination of the role of abuse severity and adoption of a multiple trauma perspective, with a particular focus on the influence of childhood physical abuse, offers promise. An alternative traumagenic model has been proposed by Finkelhor and Browne (1986), however due to the lack of measures available to assess internalized beliefs, it has been difficult to operationalize it, ensuring there has not been comprehensive empirical testing of the model to date. Initial investigation suggests it does provide a promising avenue for future research, although the role of broader societal factors also needs incorporation.
CHAPTER 4
INTERPERSONAL FUNCTIONING

Not surprisingly, survivors of CSA have been found to have difficulties with interpersonal relationships, ranging from marital and other intimate relationships to parental relationships and friendships. This chapter discusses the long-term impact of CSA on the survivor’s interpersonal functioning, including the broad areas of relationships with partners and parenting. In regard to relationships with partners, the areas of functioning to be discussed include relationship functioning, relationship stability, intimacy functioning, partner characteristics, homosexuality, sexual adjustment, high-risk sexual behaviour, relationship difficulties, and revictimization in terms of adult sexual assault, adult physical assault and adult psychological maltreatment. Aspects of parenting to be discussed include child-bearing patterns, parenting attitudes and abilities, and abuse of children.

Relationship Functioning

There is limited empirical research which compares the relationship functioning of nonvictims and individuals with a history of CSA. In the following sections, the impact of CSA on the relationship functioning of survivors will be discussed in terms of research employing community, college and clinical participants.

Community Studies

Studies using community samples have found that CSA survivors may experience greater problems in their interpersonal relationships. For example, Bagley and Ramsay (1986) found an increased frequency of divorce (12% for survivors compared to 5% for nonabused controls) and poorer marital satisfaction for survivors (n = 82) compared to those who had not been abused (n = 285) (8% compared to 0% reporting at least some problems, 20% compared to 40% reporting very happy, no
problems). Furthermore, Murphy et al. (1988) established that survivors of sexual abuse during adolescence (n = 48) had higher interpersonal sensitivity than those without an abuse history (n = 184). This finding suggested survivors experienced significantly more problems related to feelings of personal inadequacy in relation to others, clear discomfort in interpersonal situations, self-consciousness, general uneasiness and negative expectations in relation to interpersonal interactions.

In contrast, Russell (1986) studied a community sample of women with an abuse history (n = 152), and only 12% indicated the abuse had a negative impact on their relationships with others. Some women actually noted some positive long-term effects on their relationships as a result of the recovery process. These effects included becoming more assertive, more independent and having improved relationships with men as a result of seeking more equal relationships. Therefore, it is important that researchers do not make the assumption that all women will only report negative effects of CSA on their interpersonal relationships.

**College Studies**

DiLillo and Long (1999) compared a sample of college women who were CSA survivors (n = 51) with a control group lacking a sexual abuse history (n = 91). The aim was to compare the relationship between victimization history and survivors’ self-reports of functioning in adult intimate relationships. As expected, survivors reported significantly less relationship satisfaction, poorer communication, and lower levels of trust in their partners than the control group. As the researchers pointed out, the results indicated that CSA negatively affected adult couple functioning, or at least the survivors’ perception of this functioning.

Taking the research a step further, Roche, Runtz and Hunter (1999) sought to improve understanding of the nature of the relationship between CSA and later psychological adjustment, through consideration of the role of mediating variables. In particular, they focussed on the impact of attachment style, using female college students with (n = 85) and without a history of CSA (n = 222). As expected, a history of CSA predicted both psychological adjustment and attachment style, and adult
attachment style predicted psychological adjustment. Furthermore, when the effects of CSA were controlled, attachment style continued to predict adjustment, whereas CSA no longer predicted adjustment when the effects of attachment were controlled. This finding indicated that adult attachment style mediated the relationship between CSA and psychological adjustment.

**Clinical Studies**

Using a clinical sample (n=153), Briere and Runtz (1988b) did not find support for the hypothesis that CSA survivors (n = 67) would demonstrate greater relationship difficulties compared to those women without an abuse history (n = 86). Although survivors were more likely to report social isolation, the difference was not significant, and an equivalent rate of problems related to loneliness were reported by both the CSA and nonabused groups.

In contrast, Jehu (1988) reported on a clinical sample consisting of women who sought treatment for abuse-related difficulties (n = 51), and observed that many had significant difficulties in their interpersonal relationships. All of the married women reported discord, oppression or abuse within their marriage. Ninety percent had relationship problems with men and 49% had relationship problems with women. Predictably, 78% of the women reported significant mistrust of others, 88% felt different from others and 62% felt isolated or alienated from interpersonal relationships. It appeared that many of the problems related to a lack of communication skills and assertiveness. However, this sample consisted of women seeking treatment and there was no comparison group, so findings cannot be seen as strictly abuse-specific relationship problems.

**Summary**

In summary, further research is required to determine how a history of CSA may impact upon the later interpersonal relationships of survivors. More complex investigation which examines the role of various mediating variables is obviously an important area for future research. It would also be useful to determine levels of relationship functioning as perceived by survivors, using self-report measures and
measures completed by the significant others in their lives. In this way, more comprehensive measures of the survivors’ communications skills, assertiveness and sources of relationship discord could be obtained. This may also allow measurement of any discrepancy present between survivors’ beliefs about themselves and the actuality of their relationship functioning.

**Relationship Stability**

DiLillo (2001) suggested that couple relationships may provide some of the most challenging interpersonal interactions for sexual abuse survivors. Support for this suggestion is provided by consistent findings of increased rates of separation and divorce in community samples of CSA survivors (Bagley, & Ramsay, 1986; Bifulco, Brown, , & Adler, 1991; Finkelhor, 1990; Hunter, 1991; Mullen, Romans-Clarkson, Walton, , & Herbison, 1988; Mullen et al, 1994; Russell, 1986).

In the following section, the impact of CSA on the relationship stability of survivors will be discussed in terms of research employing community participants.

**Community Studies**

Russell (1986) found that incest survivors who reported the most severe trauma were the most likely to marry (78%) compared to those who reported only some or no trauma (62%). It would seem that marriage may have been a method of escape from the abuse, as had been observed by Herman (1981). However, those who reported only some trauma were the most likely never to marry (47%). A linear relationship was found between the degree of trauma reported and the outcome of the marriage. Of those who reported extreme trauma, 37% were divorced or separated, compared to 31% who reported considerable trauma, 22% who reported some trauma, and only 7% of those who reported no trauma.

In a random community sample, Bagley and Ramsay (1986) found that those with a history of CSA (n = 82) were less likely to marry than those without such a history (n = 285) (13% compared to 6%) and were more likely to divorce or separate
Consistent with these findings, using a random community sample of 2,000 women, Mullen et al. (1988) found that although the CSA survivors had a similar rate of marriage to the general population, significantly more marriages (20%) ended in separation or divorce.

In a large, random sample (n=1,476), Finkelhor et al. (1989) also found that a history of CSA (n = 416) was positively associated with marital disruption. CSA survivors who experienced intercourse had higher rates of marital disruption (35%), compared to those who did not experience intercourse (23%), and nonvictims (17%). Furthermore, this relationship remained when other background factors such as age, race, geographic region, father’s education, family structure (e.g. single parent or step-parent family), number of children in the family, happiness of family life, closeness to mother, adequacy of sex education, and strictness of parental authority were controlled. In addition, a study of a community sample by Hunter (1991) found that CSA survivors’ (n = 28) evaluations of their own partner relationships demonstrated significantly less relationship satisfaction than was true for the nonabused controls (n = 26).

Bifulco et al.’s (1991) findings from a longitudinal study of a community sample, indicated that CSA was positively associated with an increased risk of marital problems in the form of divorce or separation, or never having married or cohabited, despite having children. On the other hand, Mullen et al. (1994) found, in a random community sample of CSA survivors (n = 248) compared to matched nonabused controls, there were not significant differences in relation to the proportion currently either in a close relationship (81.3% versus 80.3%), or married or cohabiting (68.3% versus 73.3%). However, those who had experienced abuse involving intercourse were less likely to be currently living with a partner (53.1% versus 73.3%). Separation and divorce were also significantly more common among those with a history of CSA (11.9%) compared to nonabused controls (4.0%), although the proportion who had never married or were widowed did not differ significantly.
Summary

It can be seen from these community studies that there appears to be a relationship between abuse severity and likelihood of marriage. Survivors of the most severe forms of sexual abuse may be the most likely to marry and survivors of some trauma were the most likely to never marry. Those experiencing severe trauma may marry in order to escape from the abuse. In addition, compared to the general population, survivors of sexual abuse, and particularly those who experienced more severe abuse, were more likely to experience marital disruption resulting in separation or divorce. However, these studies have not controlled for other types of abuse and family stressors in the survivors’ family-of-origin, which may have an impact on their later relationship stability. Further research is required which controls for these factors, in order for the unique effects of CSA to be ascertained.

Intimacy Functioning

A number of researchers have developed theories to explain the difficulties observed in the intimate relationships of survivors of CSA. Gelines (1983) focussed on a generational transmission model, whereby discord in the marital relationship developed due to overdependence of the partner on the incest survivor. Two patterns of difficulty in intimacy functioning have been described, including a fear of intimacy and an avoidance of intimacy. Jehu (1989) suggested survivors exhibit a fear of intimacy which does not necessarily appear in casual or impersonal sexual relationships, but may become obvious in a more committed relationship. Davis and Petretic-Jackson (2000) proposed a second pattern of difficulty in intimacy functioning whereby the survivors avoid intimacy by complete avoidance of all intimate and sexual relationships. Holmes and Rempel (1989) suggested intimacy implies increased closeness and increased dependency, with higher dependency being associated with increased risk.

These proposed patterns of difficulties in intimacy were consistent with clinical observations that survivors had little faith that others could be trusted, higher dependency needs and greater communication difficulties with partners. Banyard et al. (2000) sought to explain these observations in relation to gender socialization
resulting in a silencing of the female’s sense of self, although this proposal did not receive empirical support. Follette (1992) discussed a dynamic labelled as “benevolent blame” in which her partner blames the survivor for marital problems in what appears superficially to be a supportive relationship. Mullen et al. (1994) also reported CSA survivors as perceiving their partners to be uncaring and overcontrolling.

In the following sections, the impact of CSA on the intimacy functioning of survivors will be discussed in terms of research employing community, college and clinical participants.

**Community Studies**

Mullen et al. (1994) examined the nature of partner relationships between adult survivors of CSA (n=248) compared to matched nonabused controls. It was found that significantly more CSA survivors (26.2%) reported their partners to be uncaring and overcontrolling, than did the controls (9.8%).

**College Studies**

In a sample of college women with a CSA history (n = 51), compared to a control group without such a history (n = 91), DiLillo and Long (1999) found survivors demonstrated less belief in the reliability of others. This finding suggested survivors believed others would break promises or fail to uphold commitments. Survivors also differed from controls in terms of emotional trust, which indicated difficulties with confiding in others and believing that others are credible and honest. The CSA survivors also reported poorer communication in their couple relationships than nonabused women. The findings were thought to demonstrate a range of communication difficulties between partners, low levels of self-disclosure, in addition to a higher frequency of aversive interactions, and poor conflict management skills.

Banyard et al. (2000) went further in suggesting that women’s gender socialization may lead them to “silence themselves”, to conform to social rules about female roles in relationships. Thus, it was proposed that the experience of CSA may
lead to greater levels of silencing the self and therefore mediate the relationship between abuse and revictimization. A tendency to silence the self may prevent the woman from putting her needs first and questioning the viability of an abusive relationship. Silencing the self was also thought to be associated with nonverbal cues which may attract an abusive partner, who believes he has found a target for his abusive behaviour. However, in a sample of 258 female college students, there were no significant differences between the abused and nonabused groups on the Silencing the Self Scale (Jack, & Dill, 1992). Banyard et al. proposed that the lack of difference between groups may have been due to the high homogeneity of the sample used. The students were very similar in demographic terms and might be assumed to be relatively high functioning given their college participation.

**Clinical Studies**

Jehu (1989) proposed that some CSA survivors may experience a fear of intimacy, as demonstrated by 81% of CSA survivors in a clinical sample (n=22) (Jehu, Gazan, & Klassen, 1985). In a subsequent psychotherapy sample of CSA survivors (n = 51), Jehu (1988) found 68% stated they feared men and 90% agreed that “No man can be trusted”. Furthermore, 45% of the women reported that they avoided long-term relationships with men.

Hill, Gold, and Bornstein (2000) found that a sample of female psychotherapy outpatients who had experienced CSA (n = 85) demonstrated significantly higher dependency than had been established in research with psychiatric patients, non-clinical adults, and college students. However, dependency was not found to be related to abuse characteristics such as relationship to perpetrator, age of abuse at onset or number of perpetrators. It is possible that factors such as accessibility to social or family support may have had a greater bearing on the development of dependency.

Follette (1992) had also observed a damaging, but subtle dynamic, whereby “benevolent blame” occurs in the marriage of CSA survivors. This phenomenon results when a well-meaning partner is outwardly supportive of the survivor, but
simultaneously holds her completely responsible for the couple’s marital problems, thus perpetuating feelings of shame and stigmatization which she may already be experiencing. Herman (1981) has also suggested that some survivors feel obliged to their partner for marrying them at all, knowing that they had already been used by the offender during their childhood. Furthermore, possession of this knowledge gave the partner the power to put down and shame the victim (Russell, 1982).

**Summary**

Although clinical observations have led to the development of theories in regarding the relationship functioning of CSA survivors, comprehensive empirical studies have not yet been undertaken in this area. Despite this, there is some limited clinical evidence to support two patterns of difficulties in intimacy functioning and general difficulties relating to trust, dependency and communication in relationships. A theory relating to the influence of gender socialization was not supported. The proposal regarding occurrence of relationships characterized by an attitude of benevolent blame requires empirical investigation. The limited research conducted to date provides support for the proposal that CSA survivors have greater difficulties in intimacy functioning than others without an abuse history.

**Partner Characteristics**

Very little research to date has investigated the characteristics of male partners of CSA survivors, although a number of observations have been made about the negative characteristics of this group. Researchers had found that rape victims, including marital rape victims, were more likely to have been sexually abused as children than nonabused controls (Fromuth, 1986; Russell, 1982). Such findings lead to the question of why survivors would tend to get involved and to remain involved in exploitative relationships. Jehu and Gazan (1983) hypothesized that relationship choices may be related to three components, which are seemingly directly influenced by CSA. These components are low self-esteem, the desire to justify moral superiority and hostility directed towards men, and a failure to learn assertion and protective skills (which may have been modelled by the mother).
In the following sections, the relationship between CSA and the characteristics of partners of survivors will be discussed in terms of research employing community, college and clinical participants.

**Community Studies**

Researchers have found that rape survivors, including marital rape survivors, were more likely to have been sexually abused as children than nonabused controls (Fromuth, 1986; Russell, 1982). Russell (1982) found the mean number of sexual abuse experiences with different people reported by 87 survivors of wife rape (excluding the experience of wife rape) was 3.01, which was almost twice as high as the rate of 1.69 for women who were beaten by a husband but not raped by him (n = 75). This rate was also over three times higher than for all other women who had ever been married (n = 482) suggesting CSA survivors had a greater risk of becoming involved with abusive partners.

**College Studies**

In Fromuth’s (1986) study of female college students (n = 383), a significant relationship was found between a history of CSA and being raped and having other nonconsensual experiences, even when parental support was controlled for.

The issue of partner choice by women sexually abused during childhood would seem to be an important determinant of the likelihood of their revictimization and the safety of their children. Fox and Gilbert (1994) found limited support for the “…specificity model of trauma” (p.854). This model suggested that the specific childhood traumas of incest, physical abuse and parental alcoholism would be particularly positively predictive of adult involvement with sexually assaultative/coercive, physically assaultative and chemically dependent partners respectively. However, using a sample of female college students (n = 253), Fox and Gilbert found sexual assault rates were highest for women who had experienced physical abuse, rather than incest, in childhood. Furthermore, these researchers found the relationship remained when social desirability effects were controlled for.
Clinical Studies

Consistent with Tsai and Wagner’s (1978) and Herman’s (1981) findings that CSA survivors chose unsuitable partners, Jehu and Gazan (1983) suggested that a primary component of relationship choice is the fact that survivor’s self-esteem is often so low that she selects and retains abusive partners because they do not embody high standards. The survivor feels she could not live up to high standards. There is some evidence to support this theory, as 58% of the CSA survivors (n = 24) in psychotherapy endorsed as partly, mostly or absolutely true, the Belief Inventory item that “…Only bad, worthless guys would be interested in me” (Jehu, 1988, p.137).

In relation to the second component of relationship choice, Meiselman (1978) observed that complaints by many women about being “used” by men were accompanied by a degree of self-righteousness that suggested the woman obtained some satisfaction from her victim role. It seemed that her mistreatment by men demonstrated to her that she was morally superior and justified in her increasing expressions of hostility towards them.

On the other hand, the victim may never have learned the skills required to protect herself and assert her rights in a relationship, and she may have acquired only very limited or inaccurate expectations of what she might be entitled to demand from a partner. Jehu (1988) suggested such deficiencies in skills or expectations could have resulted from the survivor’s modelling of her mother’s passivity and misuse by a dominant father-figure. This situation had been observed to be typical in the families-of-origin of many survivors (Herman, 1981; Meiselman, 1981). Gelinas (1983) concurred with this view, suggesting that incest survivors tended to repeat their mother’s pattern, marrying and meekly submitting to men who were immature, needy and demanding. By choosing or being chosen by such exploitative men, the women had difficulty recognizing that such qualities are not necessarily part of a relationship. However, there has been little empirical research attempting to explore these clinical observations in greater detail.
Jehu and Gazan (1983) suggested that there is a tendency for CSA survivors to oversexualize all relationships with men, to become involved repeatedly in relationships that are punitive and where the partners are ill-matched, as well as with men who misuse women. Based on their work with running therapy groups for women sexually abused as children, Tsai and Wagner (1978) also commented that survivors seem to have a “…compulsion in getting involved with unworthy men” (p. 422). These women also frequently reported that the personal characteristics of the men they became involved with often resembled those of their molesters. This observation was borne out by Van Buskirk and Cole’s (1983) psychotherapy sample of incest survivors who described their lovers/spouses as being very similar to their fathers, in that they were cold, self-centred, dominant and exploitive. In addition, the incest survivors described ideal lovers/spouses as being either forceful and self-seeking like their father, or as being relatively passive, touchy, and sensitive.

Jehu (1988) observed that some partners show a complete lack of respect for the survivor and will dominate and exploit her, sometimes to the extent of physical abuse. The reaction of some survivors to such exploitation appeared to be to take a generally masochistic stance. They were not usually perceived as actively inviting the abuse, but “…their willingness to tolerate mistreatment allowed them to endure relationships that a more mature, assertive woman would have ended or never begun at all” (p. 137). Although there was no indication that the woman gained pleasure from such abuse, the therapists used the term “masochistic” to highlight the patient’s inability to avoid or terminate such relationships. Informally, the therapists also used such terms as “doormat”, “punching bag” and “dish rag” to describe the “…passive, dependent woman who would suffer almost anything to be attached to a man” (Meiselman, 1978, p. 215).

A clue to the impact of mothers’ adjustment on partner choice is provided by the work of Friedrich (1991), who compared mothers of sexually abused children (n = 37), with mothers receiving outpatient psychotherapy (n = 41) and women with no history of psychiatric disturbance (n = 76), in terms of personality profiles. The findings indicated the personality profiles characteristic of parents of sexually abused children, may have contributed to mate selection and parenting problems. The same
personality features were thought to contribute to immature, impulsive and egocentric behaviour, which could increase the likelihood that the mother would choose a partner who would molest her child. However, empirical research has not been undertaken to evaluate this assertion.

Friedrich (1991) also claimed the mothers’ personality profile features reflected more anger, familial discord, alienation and depression, which would place the child at risk for significantly more severe abuse and of a longer duration. The greater pathology evidenced by mothers in terms of personality profile was related to the duration of abuse experienced by the child. It was theorized that compromised parents seemed to have greater difficulties in providing appropriate parental supervision and may raise their children in less protected environments. However, there was some acknowledgment that these were broad generalizations which had not been empirically tested. The heterogeneity of the mothers was quite dramatic and it appeared from the data that many of the mothers did not contribute to their child’s sexual molestation nor were they aware of it, at the time it was occurring.

Cohen (1988) observed that in a therapy group for male partners of sexual abuse survivors, the theme emerged that the men had liked being in an emotionally distant relationship. In a similar therapy group conducted by Brittain and Merriam (1988), the majority of the men (n = 31) were described as individuals who tended to be confused about their sexual identity, to feel chronically incompetent, to have poor impulse control, and to participate in battering or sexual abuse.

DiLillo (2001) noted that male partners of sexually abused women were often characterized as less well adjusted and less supportive when compared to partners of nonabused women. Courtois (1988) also observed that partner choice and subsequent interactions appeared to reflect abuse dynamics. Although men were feared, they were often also idealized and overvalued. Incest survivors may seek out a dominant and/or older man who can take care of her and provide her with protection. On the other hand, the incest survivor may continue in her caretaking patterns and find an immature partner who demands her attention, but is incapable of giving attention in
return. Rather predictably, some incest survivors ended up in abusive relationships with others who were also subjected to abuse during childhood (Courtois, 1988).

A study by Lambourn-Kavcic and Day (1995) was the only one located that compared partners of incest survivors (n = 30) with a nonabused control group (n = 30). The aim of the study was to assess whether partners of incest survivors exhibited greater dependency needs in interpersonal relationships, exhibited a greater tendency to be exploitive in relationships, and demonstrated a greater sense of entitlement in interpersonal relationships. It was also proposed that a large proportion of these men would have been abused in childhood. The men were assessed in terms of dependency, self-criticism and efficacy. Although no significant differences were found between partners of incest survivors and controls, the method of recruitment and relatively small sample size (DiLillo, 2000) must be taken into consideration. The partners of incest survivors were aware of the purpose of the study, were volunteers recruited via clinical groups and had often participated in their own counselling. Under these conditions, it is unlikely that partners with a tendency to be exploitive or abusive in relationships would demonstrate such attitudes in the study, or even participate, therefore a selection bias may have been operating.

**Summary**

Clinical observations have led to a generally negative characterization of the partners of CSA survivors, which is borne out by reflections of the survivors themselves. However, empirical investigation of this apparent phenomenon is almost completely lacking. Furthermore, support was not found for a specificity model of trauma linking a history of CSA to particular partner characteristics. However, previous research had found that rape survivors, including marital rape survivors, had an increased likelihood of a prior CSA history. There would also appear to be initial support for a proposal that relationship choices are related to three components directly influenced by CSA. In addition, there was some limited support relating the pathology demonstrated by personality profiles of mothers of abused children, to the duration of the child’s abuse.
Overall Summary

In summary, survivors of CSA would appear to marry at different rates compared to the general population and their marriages are prone to higher rates of separation and divorce. Although a number of theories have been proposed regarding the relationship functioning of CSA survivors, empirical investigation of this is largely non-existent. However, clinical evidence offers support for difficulties in intimacy functioning and more general difficulties with trust, dependency, communication and benevolent blame in the relationships of CSA survivors in adulthood. Despite initial support for theories and observations that a history of CSA may have a negative impact on partner choice, these ideas have not been empirically tested to any great extent. This is surprising, given the serious impact that partner choice could have on the likelihood of revictimization of the woman, and potentially her children.

Homosexuality

Based on a review of the research literature, Beitchman et al. (1992) concluded that there appears to be a small but significantly increased rate of homosexual activity among women who have experienced CSA. The conclusion was tentative, for only a small number of studies have considered this issue and the majority relied on the use of clinical samples. In the following sections, the relationship between CSA and homosexuality will be discussed in terms of research employing community, college and clinical participants.

Community Studies

Employing a community sample, Gundlach (1977) found a significantly higher proportion of reported childhood rape or molestation among homosexual women (n = 225) compared to a matched control group of heterosexual women (n = 233). Of the 17 women reporting molestation in childhood (ages 4 to 15) by a relative or close family friend, 16 became homosexuals. The researchers suggested this very high incidence may have been due to the perceived severity of the abuse these women experienced, compared to females who later became heterosexual.
adults. The individuals who became lesbians had experienced molestation over a prolonged period, or attempted rape or actual rape. Thus it may be suggested that the severity of the abuse is a factor in the later development of a homosexual orientation.

On the other hand, a study by Bell, Weinberg and Hammersmith (1981) in which 200 lesbians and 200 heterosexual women were subjected to intensive interviews, indicated that lesbians were no more likely to report a history of CSA than the heterosexual women. Thus there was no association found between a history of CSA and the later development of a lesbian sexual preference. However, given that the researchers did not adequately define the abusive experiences, it is difficult to draw conclusions from the findings.

In a community study of CSA within homosexual populations, Simari and Baskin (1982) found 38% of the lesbian adults (n = 29) had experienced incest. Of this group, 9% had experienced nuclear family incest compared to 91% who had experienced extended family incest. Of the total population of incest survivors, 64% had experienced heterosexual incest and of this group only 29% described themselves as homosexual before the incestuous event. In contrast, in relation to the 36% who had experienced homosexual incest, 75% of them described themselves as actively homosexual before the incestuous event. These findings suggest that, particularly in the case of heterosexual incestuous abuse, given that relatively few females were homosexual beforehand, the abuse may have had some role in determining their sexual orientation.

Hall (1999) used a phenomenological approach in an exploratory study of a non-clinical sample of lesbian women who were survivors of CSA. As a result of lengthy interviews, it was found that all of the eight women, with one exception, reported experiencing problems in their adult sexual relationships. These issues included “negotiated sex”, a lack of spontaneity in relationships where both women were CSA survivors, the concept of a double secret: CSA and lesbianism, and “woman-to-woman” sexual assault (i.e. further sexual victimization perpetrated by an adult female partner).
College Studies

Fromuth (1986) found a very weak but significant relationship between CSA and homosexual experiences in a sample of college students (n=383) \( (r = .12) \), which was independent of parental support. However, as stated previously, this study employed a very broad definition of sexual abuse, including noncontact experiences, which may explain these findings. Runtz and Briere (1986) reported a significantly higher incidence of homosexual contact among abused female students (n=39) compared to nonabused controls (n=11), although the obvious difference in sample sizes needs to be considered.

Clinical Studies

Using a sample of psychotherapy clients, Meiselman (1978) found that 7 out of the 23 women abused by their fathers were lesbian or had significant conflicts about homosexual feelings, whereas homosexual behaviour was rare in the nonabused control group. On the other hand, Herman (1981) found that the majority of the 40 incest survivors in her study were exclusively heterosexual, with only two having a confirmed lesbian identity and three others considering themselves to be bisexual. Therefore, a minimum of five out of 40 incest survivors would appear to have been involved in homosexual activities, which is not insubstantial. However, it was not possible to compare the relative rates of homosexual experiences for a control group, as comparison data were not provided. Herman noted that the two women who did become lesbians felt strongly that their incest experience had influenced their sexual orientation and that in developing their lesbian identity, they had mastered their childhood traumas to some degree and achieved a healthier and more rewarding personal life. Thus the development of a lesbian identity seemed to be an adaptive and positive way of coming to terms with the incest trauma.

Summary

In summary, there appears to be quite a significant increase in the rate of homosexual activity among those women who are survivors of CSA. It would appear that the two factors of severity of the abuse, and whether the abuse was heterosexual rather than homosexual in nature, may be associated with an increased likelihood of
development of a homosexual orientation. However, to confirm these conclusions, further empirical research employing nonabused control groups is necessary.

**Sexual Adjustment**

In their review of empirical studies on the short-term effects of CSA, Beitchman, Zucker, Hood, Da Costa and Akman (1991) found that sexualized behaviour is the only short-term effect consistently associated with CSA, rather than being characteristic of child clinical samples in general. It would therefore be expected that adults who had been sexually abused as children would also display sexual disturbance or dysfunction. This proposal has been supported by studies using clinical samples of CSA survivors (Browne, & Finkelhor, 1986). Sexual disturbance may include symptoms such as difficulties developing sexual intimacy, lack of sexual response, lack of enjoyment of sex, sexual dissatisfaction, difficulties differentiating between sex and affection and flashbacks to the abusive experiences (Lipovsky, & Kilpatrick, 1992).

When considering the impact of CSA on later sexual adjustment in survivors, it should be kept in mind that there would appear to be a high base rate of sexual disturbance in the general population, as demonstrated by Frank, Anderson and Rubinstein (1978). These researchers found that in 100 couples, 50% of the men and 77% of the women reported sexual dissatisfaction, with specific concerns including a lack of interest or an inability to relax.

In the following sections, the relationship between CSA and later sexual adjustment will be discussed in terms of research employing community, college and clinical participants.

**Community Studies**

Courtois (1979) observed that 80% of the former incest survivors in her community sample (n = 31) reported an inability to relax and enjoy sexual activity, avoidance or abstention from sex, or alternatively a compulsive desire for sex. These findings were consistent with those of Gold (1986) who found that CSA survivors (n
compared to controls (n = 76), reported more negative sexual symptoms, fewer positive responses to sexual invitations and less satisfaction with sexual relationships. Investigation of a community sample by Brunngraber (1986) also found more severe long-term effects in the sexual and relation-to-men life spheres among respondents who had experienced CSA (n = 21). As the women in her study began to enter into emotionally and sexually intimate relationships with men, numerous problems arose, which these survivors of pubescent incest attributed to their experience of CSA. For these women, voluntary sexual activities became frightening and relationships with men were avoided. However, a control group for comparison was not incorporated into the design of this study given its exploratory nature.

In a large community study, it was found that 20% of the 45 women who had a history of CSA, reported one or more symptoms of sexual disturbance during the previous six months (Stein et al., 1988). These women also reported a lifetime prevalence of specific sexual disturbance, with 35% having a fear of sex, 32% had “less sexual interest” and 36% had “less sexual pleasure” (p.138). However, details of the type of abuse experienced by the women were not provided, and neither were data on the percentage of women without a history of CSA who experienced symptoms of sexual disturbance.

Saunders et al. (1992) conducted clinical interviews with a sample from this parent study and found those with a history of CSA (n = 131) exhibited significantly higher rates of current and past sexual disorders compared to women without an abuse history (n = 260). The estimated lifetime prevalence for sexual disorders was 63% for participants who experienced molestation (n = 57) and 67% for those raped in childhood (n = 39), which was significantly greater than the 54% for those experiencing noncontact CSA (n = 35) and 44% of those with no abuse history (n = 260). Thus the rape group had a 50% greater risk for sexual disorders compared to the nonabused group. Furthermore, 32% of those who had experienced molestation, compared to only 16% of nonabused women, met the diagnostic criteria for a sexual disorder at the time of the interview. It would appear that the severity of the sexual assault may be related to increased difficulties in sexual functioning, but further research is required to confirm this.
Finkelhor et al. (1989) examined data from a large, random representative community sample who were contacted by phone and interviewed anonymously. Of the 1,485 women questioned, 27% indicated a history of CSA (n = 416), and of this abused group, 49% indicated experience of actual or attempted intercourse or similar events (n = 213). It was found that CSA survivors who had experienced abuse involving attempted or actual intercourse reported more marital disruption in adulthood, and a lower level of satisfaction with their heterosexual relationships, than either the no intercourse group or the nonvictims.

Jackson et al. (1990) compared a community sample of women who had experienced familial sexual molestation (n = 22) with a group of women who had not experienced CSA (n = 18). CSA survivors demonstrated lower sexual satisfaction than women lacking an abuse history. Interview data, which were only obtained from the abused group suggested that 65% of survivors met the DSM-III criteria for one or more sexual dysfunctions. However, given interviews were not conducted with the comparison group, it is unclear how this prevalence rate of sexual dysfunction may compare with that of the general population.

Greenwald et al. (1990) used a sample of 1,500 nurses to examine sexual satisfaction and sexual dysfunction. However, no differences were observed between the CSA survivor group (n = 54) and a group of matched nonabused controls (n = 54) on these measures. It was thought the findings may have been a reflection of the poor response rate and subsequently limited sample. Hunter (1991) also sought to compare a nonclinical sample of women with a history of CSA (n = 28) and a matched control group (n = 26). The abused group reported significantly less satisfaction in their intimate relationships and more symptoms of sexual dysfunction compared to the control group.

Mullen et al. (1994) sent a random community sample of 2,250 women a questionnaire and then requested the 248 women reporting a history of CSA to undertake an interview, together with an equal number of nonabused controls. The CSA survivor group were found to be as sexually active as the controls, but were
more likely to express dissatisfaction with their sex life and to experience difficulties with their own sexuality. Although survivors were no more or less likely to be engaging in a particular frequency of intercourse, they were more likely to see it as either too often or not enough. Therefore CSA would seem to be most disruptive of attitudes to sexual activity and attributions the individual makes regarding their own sexuality.

**College Studies**

Finkelhor (1979) conducted a study with female college students (n = 530) and found CSA survivors (n = 102) reported significantly lower levels of sexual self-esteem than their nonabused counterparts (n = 428). However, in another study of a college student sample (n = 383), Fromuth (1986) found there was no correlation between sexual abuse and sexual self-esteem, desire for intercourse, or students’ self-ratings of their sexual adjustment. In this study, 96% of the respondents were unmarried and their average age was 19 years, so it was possible that some of the long-term sexual adjustment problems evident in samples in other studies were not yet obvious in this younger population. However, this would not explain the discrepancy with the findings of Finkelhor (1979), although Fromuth (1986) questioned whether women who were more sensitive to sexual issues may have been less likely to volunteer to participate in her study. In addition, Fromuth (1986) used a very broad definition of CSA, whereas Finkelhor (1979) referred to abuse involving contact.

Fritz, Stoll and Wagner (1981) also used a college student sample (n = 952) to examine differences in the rates of sexual problems for those with a CSA history (n = 42) and those without such a history (n = 498). Interestingly, only 23% of the molested women reported having difficulties with current sexual adjustment. However, it is not clear how this rate compared to that of the nonabused population, for the data were not provided in relation to this group. The only significant difference found between molested women with sexual problems (n = 10) and the group of molested women without sexual problems (n = 22) was that positive rather than negative coercion appeared to be correlated with self-perceived adult sexual
maladjustment. However, the small number of cases involved should be kept in mind when interpreting these findings.

Alexander and Lupfer (1987) assessed a sample of female college students (n=586) using a questionnaire designed to evaluate current sexual satisfaction and current sexual functioning. However, no significant relationship was found between a history of CSA (n = 149) or relationship to the offender (perpetrator was a nuclear family member/extended family member/not a relative) and sexual adjustment. The researchers suggested that the questionnaire may not have been sufficiently sensitive to detect any differences in sexual satisfaction or sexual functioning in this population.

Kinzl et al. (1995) studied a group of 202 university students and found significant differences in sexual disorders exhibited by the groups, categorized as: women without CSA (n = 158), single-incident survivors (n = 18) and multiple-incident survivors (n = 26). Multiple CSA incident survivors (30.8%) significantly more frequently reported sexual desire/arousal disorders than women with single CSA experiences (11.1%) or those without a CSA history (12.0%). Similarly, those with multiple CSA experiences (42.3%) more frequently reported orgasm disorders than women with single CSA experiences (27.8%), and women without a history of CSA (14.6%). There were no significant differences between the groups in terms of sexual pain disorders, or between the single incident group and the no abuse group for any type of sexual dysfunction. In addition, it was found that a generally negative family background had a significant impact on the development of any kind of sexual disorder.

Matorin and Lynn (1998) attempted to develop an instrument, the Traumatic Sexualization Survey, suitable to test the traumatic sexualization component of Finkelhor and Browne’s (1986) traumagenic dynamics model of sexual abuse. In an effort to address a common drawback of previous studies, the college student participants (n = 451) were classified into groups according to whether they had experienced sexual abuse only 22% (n = 99), physical abuse only 10% (n = 44), both sexual and physical abuse 10% (n = 43) and an absence of abuse 59% (n = 265). It
was found that sexually abused women scored higher than nonabused women on three Traumatic Sexualization Survey factors: thoughts about sex, role of sex in relationships and attraction/interest and sexuality. Physically abused women differed from nonabused women only on the factor of thoughts about sex. Sexually abused women did not score significantly higher than physically abused women on any factors. The finding that sexually abused women did not score differently from nonabused women on the factor of avoidance and fear of sexual and physical intimacy contrasts with the findings from other studies (Charmoli, & Athelstan, 1988; Courtois, 1988; Kinzl, Traweger, & Biebl, 1995).

Matorin and Lynn (1988) suggested this discrepancy resulted from using a sample of college students who were not patients or survivors of parental incest. College women may have been a relatively well educated and adapted group, who felt strong peer pressure to endorse positive statements about sex, which may also account for the findings of Fromuth (1986). The researchers aimed to conduct further research to assess if this factor was mediated by abuse severity, with incest or repeated abuse hypothesized to lead to the greatest avoidance and fears of sexual intimacy.

Bartoi and Kinder (1998) used a college sample of 201 students to evaluate a measure of sexual satisfaction. Of the 175 students retained in the study, 40% had been abused in childhood, 20% were sexually abused in adulthood only, and 45% had no sexual abuse history. Although it was predicted the CSA survivors would show higher rates of specific sexual dysfunctions including anorgasmia, vaginismus, sexual avoidance, sexual noncommunication and nonsensuality than adult sexual abuse survivors or nonabused women, this was not the case. CSA survivors and adult sexual abuse survivors did not differ from each other on any of these variables. It had also been predicted that the CSA survivor group would be less satisfied with the overall quality of their most recent sexual relationship than adult sexual abuse survivors or the nonabused women. However, both child and adult survivor groups did not differ from each other, although together they differed from the comparison group. This finding suggested that women who have been abused at some time in their lives tend to have less satisfying sexual relationships with their partners than
women who have never been abused. Women sexually abused in childhood or adulthood were also considered more likely to rate their ability to communicate interpersonally as lower than for those women who had not been abused. However, the abused groups did not differ from the nonabused group in terms of their ability to communicate interpersonally.

Bartoi, Kinder and Tomianovic (2000) used a college student sample (n = 200) to assess the interaction effects between “emotional status” and sexual abuse history on adult sexuality. Emotional status included the factors of general anxiety, anxiety-related disorders, depression and alcoholism. Several aspects of sexuality were also examined including anorgasmia, sexual avoidance, sexual dissatisfaction, sexual infrequency, sexual noncommunication, nonsensuality and vaginismus. Contrary to expectations, “emotional status” and a history of CSA were not found to have an additive interacting association with the participants’ sexual functioning. However there was a significant association between high anxiety scores and both sexual avoidance and vaginismus for the CSA survivor group. There was also a significant association between high scores on anxiety-related disorders (i.e. Obsessive Compulsive Disorder, phobias and traumatic stress disorders) and both sexual infrequency and sexual avoidance. However, it should be kept in mind that these researchers combined survivors of child and adult sexual abuse into a single group, based on a lack of differences between these groups in a previous study (Bartoi, & Kinder, 1998).

Clinical Studies

Meiselman (1978) found 87% of the 23 CSA survivors in psychotherapy in adulthood reported having a current sexual problem, or had had a serious problem in sexual adjustment some time after experiencing incest. The specific problems related to being frigid, confused about their sexual orientation or promiscuous and were not mutually exclusive. Meiselman conducted a comparison to a nonabused control group and found a rate of only 20% for sexual problems, indicating this issue alone was not a reflection of what prompted women to seek psychotherapy. Similarly, Langmade (1983) compared a group of female incest survivors (n = 68) who were in
therapy with a matched control group of women who had not been victimized. Consistent with the above research, the incest survivors were found to be more sexually anxious, experienced more sexual guilt and reported greater dissatisfaction with their sexual relationships than the control group members.

A study by Tsai, Feldman-Summers and Edgar (1979) consisted of comparison of three groups of 30 women on sexual adjustment measures: sexual abuse survivors seeking therapy, sexual abuse survivors who considered themselves to be well-adjusted and had not sought therapy, and a nonabused control group. The results indicated that the “well-adjusted” survivors were not significantly different from the control group on measures of overall adjustment or sexual adjustment, but those survivors seeking therapy did demonstrate a difference. This group experienced orgasm less often, reported themselves to be less sexually responsive, obtained less satisfaction from their sexual relationships, were less satisfied with the quality of their close relationships with men, and reported having a greater number of sexual partners.

It is difficult to know how to interpret findings from the survivor group in the above study, as these survivors were recruited on the basis of believing they were well-adjusted. Thus, it is difficult to know how such a group compares with survivors in the general population who were not in therapy. However, it was found that women in the clinical group had experienced molestation at an older age (adolescence), reported stronger negative feelings associated with the molestation and a higher frequency and duration of molestation than women in the nonclinical group (Tsai et al., 1979).

Herman (1981) found that 55% of incest survivors (n = 40) reported later sexual problems, with many stating that their pleasure in sex was minimal or even entirely absent. However, this group was not significantly different from those with seductive fathers (n = 20) on this measure. Herman (1981) used the latter group for comparison purposes as they were relatively matched in relation to class, ethnic and religious background and like the incest survivors, were all patients in psychotherapy. Seductive fathers were defined as those who demonstrated behaviour towards their
daughters “…that was clearly sexually motivated, but which did not involve physical contact or a requirement for secrecy” (p.109). Given the nature of this comparison group, the validity of the conclusions drawn is questionable.

Gorcey et al. (1986) compared a sample of CSA survivors (n = 41) obtained through advertising and mental health agencies, with a control group of nonabused women (n = 56). In terms of sexual functioning and intimacy, 85% of the sexually abused group reported problems in sexual relationships. The survivors reported a variety of sexual problems including fear of sex (43%) and flashbacks to the original victimization during sexual activities (11%). In addition, 11% of the CSA survivor group reported that they were not engaging in any sexual intimacy.

Briere (1988) studied female clients of an outpatient crisis intervention service (n = 195), and also found CSA survivors (n = 133) reported a higher rate of sexual problems compared to those without a CSA history (n = 61). Furthermore, bizarre abuse and abuse involving intercourse were correlated with sexual problems in this abused population. In research with incest survivors who were currently in therapy (n = 35), Maltz and Holman (1987) found the women experienced a variety of sexual problems, particularly a lack of arousal and a lack of orgasm. In addition, abused women aged under 35 had significantly more painful intercourse and felt more concern about the reaction of partners to incest, than women aged 35 or older. However, the lack of a control group makes it difficult to interpret these findings.

Jehu (1988, 1989) took a more comprehensive approach to classifying the specific areas of sexual dysfunction. He found 78% of an adult clinical sample (n = 51) who had experienced CSA reported at least one sexual dysfunction which included sexual phobias or aversions (59%), sexual dissatisfaction (59%), impaired sexual motivation (57%), impaired sexual arousal (49%), impaired orgasm (45%), dyspareunia (27%) and vaginismus (8%). However, given that a nonabused control group was not available for comparison, it is unclear how these rates may compare with those in the general population.
Charmoli and Athelstan (1988) recruited a mixed sample (n = 601) of women who were college students (n = 181) and those attending outpatient psychotherapy (n = 420) and found 377 reported childhood and adolescent incest experiences. It should be noted that incest was defined as “…being looked at, talked to, or touched by a family member in a way that felt sexual to the women” (p.57). Individuals who had experienced incest were more likely than the comparison group to report vaginal problems, negative reactions to sex, compulsive sexual behaviour (defined as out-of-control, compulsive sexual activity that was associated with feelings of guilt) and a higher number of total sexual problems. No significant differences between the groups were found for problems with orgasm.

Vaginal problems were found to increase with low ages of onset of abuse and large age discrepancies between survivors and perpetrators, and decrease with longer held incest secrets and positive responses to incest disclosure (Charmoli, & Athelstan, 1988). It was suggested that the negative relationship between vaginal problems and keeping the incest secret may have been a consequence of negative reactions from others being associated with sexual problems, which could be avoided by not disclosing the experience. Negative emotional reactions to sex corresponded to large age discrepancies between participants and offenders, and a high frequency of incest. Compulsive sexual behaviour was associated with parents as partners, high frequency of incest and negative reactions of others to the disclosure of incest. In terms of total sexual problems, four specific aspects of incest were significantly related: large age discrepancies between the victim and perpetrator, negative reactions of others to the disclosure of incest, high frequency of incest, and a low age of onset for the women.

Mackey et al. (1991) studied a subsample of currently sexually active women (n = 37) from a larger sample of women who had recently experienced a sexual assault as an adult. It was found that 16 members of this sample also had a history of CSA. This group were the only ones who reported orgasmic difficulty, guilt, the greatest number of fears about and requirements for intercourse to be satisfying. The CSA survivors also reported twice as many anxiety-related responses as other groups (no prior sexual abuse n = 16 and prior sexual assault as an adult n = 5).
Summary

In summary, it is difficult to draw conclusions about the relationship between CSA and later sexual adjustment due to a number of methodological issues in the studies available. In particular, there has been use of a variety of definitions of sexual problems and a lack of comparable nonabused control groups. This has precluded the impact of CSA on sexual adjustment being separated from other factors.

It appears that the highest rates of sexual disturbance were associated with father-daughter incest, or abuse involving penetration and what was termed “bizarre” sexual abuse. For those studies which included only a small proportion of women victimized by their fathers, or where the type of abuse was unlikely to include intercourse or oral-genital contact, sexual disturbance was less definitely linked with CSA or there were weak effects only. The suggestion that women suffering more severe abuse may be more likely to seek help, was supported. Survivors seeking therapy were molested at an older age (adolescence), had more negative feelings regarding the incest and had a greater frequency and duration of molestation.

Obviously, more research is required to build an understanding of the complex processes involved in the development of attitudes towards sexuality and how CSA impacts upon these attitudes. The research to date has defined sexual functioning generally in terms of behavioural descriptors, rather than also considering the important affective and interpersonal aspects of sexual functioning. There has been little focus upon survivors’ feelings about their own sexuality and communication with partners about sexual issues, yet these factors may operate independently of behavioural or physiological descriptors of sexual functioning. Furthermore, the role of relationship satisfaction as a potential confounding factor in sexual functioning has not been fully assessed.
High-Risk Sexual Behaviour

The literature in relation to CSA has previously labelled observed patterns of sexual behaviour by survivors as “promiscuous” (de Young, 1982; Herman, 1981; Meiselman, 1978). The term “promiscuity” was later replaced with “indiscriminate sexual behaviour” to describe the observed pattern of frequent, short-term sexual activity with numerous sexual partners by CSA survivors. Courtois (1988) suggested that whilst some CSA survivors were sexually abstinent and phobic, others were compulsively and indiscriminately sexual with early and/or repeated pregnancies being characteristic of some survivors.

In the following sections, the relationship between CSA and high-risk sexual behaviour will be discussed in terms of research employing community, college and clinical participants.

Community Studies

In a study of sex among siblings, using a community sample (n = 796), Finkelhor (1980) found 15% of females had experienced this type of CSA. These women were more sexually active as young adults than those without a history of sibling sexual abuse, regardless of whether they had rated the experience as positive or negative, and whether or not it was with a peer partner or a nonpeer partner (greater than 5 year age disparity).

In their community sample (n = 248), Wyatt, Guthrie and Notgrass (1992) found that women who had experienced CSA and were then revictimized in adulthood (n = 65) were more likely than women without an abuse history (n = 72) to report higher rates of unintended and aborted pregnancies. These researchers suggested that this finding indicated the sexual act was perhaps perceived in isolation from the consequences of sexual activity, such as pregnancy. The CSA survivor’s perception of herself as powerless (Finkelhor, 1988) may reduce awareness of the need to plan pregnancies and initiate discussions regarding contraception with sexual partners. Consequently, women may spontaneously engage in unprotected sex
because they did not feel they could communicate their sexual and contraceptive needs to their partners (Wyatt, & Lyons-Rowe, 1990). Alternatively, given their low self-esteem and propensity for relationship difficulties, CSA survivors may have been coerced into having sex by abusive partners, with unintended pregnancy being a consequence.

**College Studies**

Fromuth (1986), using a sample of female college students (n = 383), found those who had been sexually abused tended to experience a wider range of sexual activity and were more sexually active than those who had not been sexually abused. Although these women were more likely to have experienced intercourse, they were not more likely to have become pregnant nor were they more likely to have had an abortion. However, survivors were more likely to have engaged in a higher rate of non-coital sexual behaviour and to describe themselves as promiscuous. But the increased sexual activity was not sufficiently excessive that they would have been considered “promiscuous” or deviant. Fromuth suggested that perhaps the woman’s self-concept, rather than her actual behaviour, was being influenced by the sexual abuse. However, there was a lack of relationship found between a history of sexual abuse and sexual self-esteem, suggesting that the apparent contradiction may have been due to the small size of the relationships.

Alexander and Lupfer (1987) investigated a sample of college students (n = 586) and found 149 had a history of CSA. Women who had an abuse history were significantly more likely to have had sexual intercourse (aside from the abuse) than those who had not been abused, regardless of the relationship of the offender (perpetrator was a nuclear family member/extended family member/not a relative). In addition, the occurrence of abuse seemed related to the present frequency of sexual behaviour, with a higher frequency of sexual behaviour among abused women, again regardless of the relationship of the offender.

Zierler et al. (1991) also found that CSA survivors (n = 29) were much more likely to participate in sex with casual acquaintances, and to have multiple sexual
partners on an average yearly basis, compared to those without a history of CSA (n = 54). Although no differences in reports of condom use during the previous year were found between CSA survivors and those without a CSA history, survivors were three times as likely to become pregnant before 18 years of age. Wyatt and Lyons-Rowe (1990) believed that CSA survivors may avoid discussing issues related to contraceptive use and their partners’ sexual history.

Bartoi and Kinder (1998) argued that increased sexuality may not be considered dysfunctional, and it was therefore more appropriate to measure “sexual irresponsibility”. This concept was operationalized as the number of unwanted pregnancies and the number of unsafe sexual partners, as these measures were felt to reflect a lack of contraceptive use. A group of 175 students classified as CSA survivors (n = 66), adult sexual abuse survivors (n = 29) and not abused (n = 80) were assessed in terms of unplanned pregnancies. However, abuse was not found to be significantly associated with the women’s number of unplanned pregnancies. Yet, it was found that those women with either an adult or CSA history had a engaged a significantly greater number of unsafe sexual practices with partners.

Bartoi et al. (2000) used a sample of college students (n = 200) to conduct further evaluation of sexual irresponsibility. It was found that women who had high anxiety and a history of sexual abuse also reported higher numbers of unwanted pregnancies. In contrast, sexual abuse history was not associated with numbers of unwanted pregnancies for women with lower levels of anxiety. The number of unsafe sexual practices engaged in with partners was not found to be associated with sexual abuse history. In addition, depression and alcoholism were not found to have a mediating effect on the association between sexual abuse history and any of the sexuality variables tested.

The preliminary nature of the research by Bartoi et al. (2000) was acknowledged, including a lack of reliability and validity assessments for the measure of sexual responsibility developed. Bartoi et al. proposed that more comprehensive measures of sexual responsibility, such as a measure of women’s consistency of contraceptive use and willingness to be tested for sexually transmitted diseases.
should be formulated. Furthermore, it was suggested that use of a clinical sample rather than a college sample may have increased the number of participants who demonstrated clinically significant levels of depression, anxiety, alcoholism and substance abuse. It would have been preferable if Bartoi et al.’s (2000) study had not combined groups of women who had been abused during childhood, with those who had been abused during adulthood. This was done in order to compare all sexual abuse survivors with the nonabused group, but resulted in a consequent loss of ability to compare findings with those of other studies.

**Clinical Studies**

Meiselman (1978) found that 25% of the women seeking psychotherapy following a history of incest (n = 47), were sexually promiscuous as adolescents compared to a group of women who had not been abused (n = 50). However, this number was reduced to 19% when a stricter definition of promiscuity was employed. For a couple of individuals at the extreme end of the continuum, it seemed that the compulsive, self-destructive quality of their relationships indicated they were at least partially motivated by non-sexual needs. Generally, the women seemed to grow out of sexually acting out by their twenties. For those who continued, their therapists believed the women had a tendency to sexualize all of their relationships and were unable to differentiate sex and affection due to a confusion of parental love and overt sexuality in their childhood. There was also a tendency to describe the women as masochistic in their relationships with men and question if they were using their sexual adventures as further proof that men only want to “use” women and that they were helpless to prevent this.

Herman (1981) described how women who had been sexually abused by their fathers had learned from this experience that sexualized behaviour was a way of obtaining attention. Many of the women had developed a repertoire of sexually stylized behaviours which appealed to their fathers and which subsequently worked on other men. Continuance of this behaviour resulted in a series of brief, unsatisfying sexual relationships, with 35% of the women in the sample (n = 60) indicating that they had had periods in their lives when they were sexually promiscuous, by their
own definition. Many women fluctuated between periods of compulsive sexual activity and periods of asceticism and abstinence. Consistent with these observations, de Young (1982) reported that 28% of the CSA survivors in her mixed clinical and community sample (n = 72) engaged in activities which could be classified as promiscuous. However, as there was no comparison group, it is difficult to interpret these findings.

Summary

From the above literature, it can be tentatively concluded that a history of CSA is likely to result in a higher likelihood of sexually active behaviour, particularly during adolescence. In general, it was found that a history of CSA seemed to predispose women to a higher rate of early and unwanted pregnancies and subsequent terminations, indicating a higher rate of unsafe sex. However, future research needs to make a careful comparison between the self-reported promiscuous behaviour of women who have been sexually abused and those without a history of abuse, in combination with using more objective measures of actual sexual behaviour, self-concept and measures of sexual irresponsibility.

Revictimization

The observation that some women with a history of CSA seem vulnerable to further abuse during adulthood, has led to investigation of the concept of revictimization. Messman and Long (1996) reviewed the literature examining the relationship between CSA and later adult revictimization in the form of either sexual or physical assaults, and the impact on the women’s later adjustment. They concluded that women who were sexually abused as children were significantly more likely to experience abuse as adults, compared to women who had not had such a childhood experience. When the results were combined for the college, clinical and community samples, it was found that 16% to 72% of women who had experienced sexual abuse as children were likely to be revictimized later in life. The large discrepancy in this range is due to variations in the way abuse was defined. There were also limitations on the generalizability of the findings, particularly given that the
participants were predominantly, white, single, middle class, educated and aged 18 - 30 years.

**Adult Sexual Assault**

A number of studies have investigated the relationship between CSA and experiences of sexual assault in adulthood using a range of participants and definitions of definitions of both CSA and adult assault. In the following sections, the relationship between CSA and adult sexual assault will be discussed in terms of research employing community, college and clinical participants.

**Community Studies**

Revictimization was analyzed by Russell (1986) in a community sample (n = 930), through conducting assessments of contact abuse experiences prior to age 14 and completed or attempted rape by a nonrelative after age 14. It was found 65% of the incest survivors (n = 152) were victimized after age 14 by rape or attempted rape, not including incestuous rape, compared to 61% of women with a history of extrafamilial abuse (n = 172) and 35% of women without a sexual abuse history (n = 743). In addition, Russell (1986) assessed revictimization in the form of marital rape. In this sample, 19% of incest survivors reported having been raped by their spouse during marriage, as compared to only 7% of women without a history of sexual abuse. Further assessment was conducted with those who were currently married and it was found 27% of incest survivors were raped by their current husbands, as opposed to only 11% of women who had not experienced incest. Thus it would seem from these findings that women who experienced CSA were at a higher risk of sexual revictimization in adulthood, particularly if they had experienced intrafamilial abuse. CSA survivors were also more likely to have experienced marital rape than nonabused women, including among those who were currently married.

As part of a larger study of a randomly selected community sample, Murphy et al. (1988) examined a subgroup of 391 women. The participants were classified into groups based on their victimization: CSA only; adolescent sexual assault only;
adult sexual assault only; multiple sexual assault; assault both before and after age 18; and nonvictims. It was established that 207 women (52.9%) reported at least one lifetime incident of sexual abuse, with 126 women (32.2%) reporting a sexual abuse incident prior to the age of 18 years. Overall, 34 women (8.7%) reported being sexually abused both in childhood and adulthood. It was found that the revictimized women (i.e. the multiple assault group) differed significantly from the other survivor groups and the nonvictim group on a range of symptoms of psychological distress. However, the researchers did not provide sufficient information regarding adult sexual assault rates for women without a history of CSA, which would have allowed comparison with those who did have a CSA history.

Wyatt et al. (1992) studied sexual revictimization in a community sample of 248 women using extensive individual interviews. Of the 161 women who reported a history of CSA, 40% had experienced at least one incident of sexual abuse both in childhood and after the age of 18 years. CSA included both contact and noncontact sexual abuse. If the perpetrator was less than 5 years older, the incident was only included if it was not desired or it involved coercion. Similarly, adult sexual assault was defined as observing someone exposing his or her genitals, observing someone masturbating, attempted rape or rape. There was a significant finding that women with a history of CSA were 2.4 times more likely to be revictimized as adults, compared to women who did not have such a history.

Wind and Silvern (1992) studied a community sample of women working at a university (n = 259) and found those with a history of child abuse (both sexual and physical), were significantly more likely to report negative adult experiences than those without an abuse history (n = 137). The adult negative experiences included sexual assault, physical assault and force in adult relationships. It was also found that characteristics of the sexual abuse such as frequency, duration, use of force and abuse by a father figure were associated with negative adult outcomes. However, no differences were found in rates of adult sexual assault for women who had not been abused, those physically abused only or those sexually abused only during childhood. Thus it would seem that those women who had experienced childhood abuse, either
West, Williams and Siegel (2000) conducted a prospective study of adult sexual revictimization using a sample of women who had documented histories of CSA. The women had attended the emergency room at a large hospital between 1973-1975 and according to the records had experienced contact sexual abuse. Then in 1990-1991, 136 of the now adult females were reinterviewed, with analyses focussing on the 113 black women (86% of the reinterviewed sample). Of this group, 62% recalled the CSA incident in the records (index abuse) and 68% reported additional CSA experiences. CSA was defined as any sexual abuse prior to the age of 18, including the index incident. Adult sexual revictimization was defined as sexual abuse incidents occurring after the age of 18 years.

In this study by West at al. (2000), 30% of participants reported adult sexual revictimization, with the number of sexual assault incidents ranging from 1 to 6. The majority of participants reported 1 incident (79%) or 2 incidents (18%). In terms of abuse characteristics which predicted subsequent victimization, only physical force was a significant predictor, increasing the probability of sexual revictimization by a factor of 4.30. The abuse characteristics of age at onset of abuse, penetration and abuse by a family member did not vary by revictimization status. Because a comparison group was not used, it is unclear how the rates of adult sexual assault may compare to those without a CSA history.

**College Studies**

Fromuth (1986) used a sample of college students (n = 383) and asked the women if they had ever been raped. A weak but significant relationship was found between a history of CSA and rape, compared to women without an abuse history, even when parental supportiveness was controlled. The issue of nonconsensual sexual experience was also explored by examining the relationship between sexual abuse before the age of 13 years and having any nonconsensual sexual experience after the age of 12 years. A nonconsensual sexual experience was defined as “…any
reported experience that involved the other person using force or threat” (p.12). This relationship was also found to be significant for those with a CSA history, as opposed to those without such a history, again even when parental support was controlled. Thus Fromuth (1986) concluded that early sexual abuse was related to being a victim of coercive sex in adulthood.

Alexander and Lupfer (1987) studied a sample of college students (n = 586) and also found a significantly higher rate of experience of subsequent sexual assault among women with a CSA history (n = 149), compared to those women without such a history (n = 407). This association was evident, regardless of the relationship of the offender (nuclear family abuse/extended family abuse/abuse by outsiders). However, as Messman and Long (1996) pointed out, there was no specification as to how adult victimization was assessed or the age criterion used to differentiate childhood versus adult experiences.

In contrast to the previous findings (Alexander, & Lupfer, 1987; Fromuth, 1986), Mandoki and Burkhart (1989) did not find support for the proposition that there is a link between CSA and later sexual revictimization in adulthood among college student samples. Using a sample of 282 women, only 13% (n = 37) reported CSA prior to the age of 14 years, and only 6% (n = 16) reported sexual victimization both as a child and as an adult. Thus individuals victimized as children were not more likely than those without a sexual abuse history to be sexually assaulted as adult. Messman and Long (1996) have suggested that these findings were a product of the methodology used, for the survey employed is generally used to assess sexual assaults after the age of 14 rather than prior to 14. Furthermore, the use of the survey of sexual experiences in this case demonstrated a very low prevalence rate for CSA of only 7%. As adult sexual assault was confined to the more severe attempted or completed rape, the range of experiences classified as revictimization was also reduced.

A prospective analysis of the relationship between various sexual assault experiences in a sample of college students (n = 796) was undertaken by Gidcyz, Hanson and Layman (1995). Initially, two groups of women were surveyed
regarding their histories of CSA prior to the age of 14 years. The women were then surveyed to assess experiences of sexual assault between the age of 14 and the initial point in the study, with these experiences labelled adolescent victimization. After a period of three months, each of these two groups of women were surveyed for a second time regarding their experiences of sexual assault during the intervening three month period, with the results labelled as adult sexual victimization Time 1. After a further three months, both groups were surveyed again to provide an adult sexual victimization Time 2 figure (6 month follow-up). After a subsequent three month period, the first group only were surveyed again, to provide an adult sexual victimization Time 3 figure (9 month follow-up).

Gidcyz et al. (1995) conducted analyses which indicated that women with a history of child or adolescent sexual abuse were more likely than women without such a history to report sexual assault at Adult Time 1 (63.6% compared to 26.6%). Women who reported sexual abuse at Adult Time 1 were in turn more likely than women without an abuse history to report sexual abuse at Adult Time 2 (43.8% compared to 14.8%). Once again, women who reported sexual abuse at Adult Time 2 were more likely than those women without such a history to report sexual abuse at Adult Time 3 (50% compared to 2.4%). Thus, victimization status at each time period was dependent upon victimization status in the preceding time period, indicating that a history of sexual victimization is a risk factor for subsequent victimization. Furthermore, it was found increasing levels of severity of victimization in the preceding time period led to an increased chance of being victimized generally in the successive time period.

Gidcyz et al. (1995) also conducted an analysis assessing the mediating effects of the variables of family adjustment, alcohol use, psychological adjustment, interpersonal functioning and sexual behaviour on victimization experiences. However, although family adjustment initially predicted adjustment, it did not predict child victimization as had been hypothesized. In addition, although adolescent victimization experience significantly predicted interpersonal problems, the number of sexual partners and alcohol use at the time of initial assessment, these mediating variables did not predict victimization status during the 3 month follow-up period.
None of the mediating variables significantly directly predicted victimization status during the subsequent time periods, with the only exception being psychological adjustment measured at the 6 month follow-up period directly predicting victimization status at the 9 month follow-up period. This finding suggests that perhaps the survivor’s poor psychological adjustment makes her more vulnerable to being in circumstances where she has a higher risk of victimization. Gidcyz et al. (1995) found the indirect effects of the mediating variables on victimization statuses were all negligible.

In a complex study of sexual revictimization among college students, Koverola, Proulx, Battle and Hanna (1996) divided their sample of 833 students into a nonabused group (n = 378) and the remaining 253 students were classified into three abuse groups based on their age at abuse. The first group consisted of those students who had been sexually abused at 16 years or younger (CSA group, n = 83). The second group consisted of those students aged over 16 and who had been sexually abused by a peer aged less than 5 years older than the survivor (PSA group, n = 78). The third group were the revictimized group who reported either an incident of CSA or peer sexual assault, as well as at least one incident of unwanted sexual contact that occurred when the subject was aged 17 or older (REV group, n = 44). Those individuals who reported no unwanted sexual contacts of any kind during either childhood or adulthood were placed in the nonabused group.

Koverola et al. (1996) found that the revictimized group reported the most severe forms of sexual assault including increased severity, frequency and force compared to the other sexual assault groups. Furthermore, the sexual assault groups were all significantly more distressed than the nonabused control group on measures of depression, anxiety, somatization and global distress. In addition, the revictimization group demonstrated significantly higher levels of PTSD symptomatology than either the CSA or the peer sexual abuse group. However, when abuse characteristics of severity, frequency and force were controlled for, the sexual abuse groups did not differ significantly on PTSD. Therefore PTSD symptomatology would seem to be determined by characteristics of the abuse rather than
revictimization status, with greater abuse severity being associated with increased PTSD symptomatology.

Using a college sample of 648 women, Messman-Moore and Long (2000) assessed CSA history prior to the age of 17 and adult sexual assaults after the age of 17. It was found that 127 women (20.1%) reported a history of CSA, whereas 506 women reported no such history. All of the women were then classified into five groups based on abusive experiences: (a) revictimization – CSA and adult sexual assault or adult physical assault or both (n = 71); (b) multiple adult victimizations – both adult sexual assault and adult physical assault (but not CSA) (n = 65); (c) CSA only (n = 56); (d) adult assault only – sexual assault or physical assault (n = 159); and (e) no abuse experience (n = 282). Although the results supported the concept of a cumulative effect of trauma, differential effects for child to adult revictimization compared to multiple adult victimizations were not found. Both women who had been revictimized and those who experienced multiple adult assaults demonstrated similar levels of psychological functioning, and reported greater difficulties than women with only one form of adult abuse or no victimization. Women with CSA only reported similar symptoms to revictimized women.

In further analyses of these study data, Messman-Moore and Long (2000) found CSA survivors were more likely than nonvictims to report unwanted fondling with an acquaintance due to misuse of authority, unwanted oral-genital contact with an acquaintance due to drug use, unwanted intercourse with an acquaintance due to misuse of authority and due to the use of physical force (date rape). CSA survivors were also more likely than nonvictims to report unwanted intercourse by a stranger due to misuse of authority. Overall, 52.3% of the women reported some form of unwanted sexual contact, with 26.4% reporting unwanted sexual intercourse.

Banyard, Arnold and Smith (2000) also sought to examine the relationship between CSA history and sexual coercion, through examination of coercion in a dating relationship in the previous year for a sample of college students (n = 219). Forty seven women (25.1%) reported a history of CSA and 24.7% reported having experienced sexual coercion. However, no significant differences were found in
terms of sexual coercion between the group of CSA survivors and those without a CSA history. The researchers suggested this finding may have resulted from the actual sample used, as very low rates of sexual coercion were reported, making it difficult to establish consistent patterns. In addition, it may have been quite limiting to restrict sexual coercion to that within dating relationships, rather than encompassing a broader range of relationships. Consideration of various characteristics of the sexual abuse may also assist in this investigation.

**Clinical Studies**

Using a clinical sample of women who had an incest history and were receiving psychotherapy, Herman and Hirschman (1977) reported that four (27%) of the fifteen women had also been raped in adulthood. CSA was defined as overt sexual contact between a parent and child. In a later clinical study of forty women who had experienced father-daughter incest, Herman and Hirschman (1981) found that six (15%) also reported being raped, with three individuals having been raped more than once. In some of these cases, the increased risk of rape could be traced directly to the incestuous abuse, for two women had been raped during a run-away episode resulting from the childhood abuse. However, neither of these studies details how adult rape was defined and assessed and limiting of the sample to only father-daughter incest survivors means the generalizability of the findings is quite limited.

Gorcey et al. (1986) used a combined community and clinical sample of women with a CSA history (n = 41) to compare revictimization rates with a control group (n = 56) of women without a history of CSA. Although CSA was not specifically defined, interview responses elicited related to contact abuse prior to the age of 14 years. It was reported that 37% of the CSA survivors had been later raped as teenagers or adults. However, tests for statistical significance and the adult rape criteria were not provided, and neither were the relevant statistics for the control group.

Briere and Runtz (1987) examined the relationship between a history of CSA and later rape among a clinical sample of 152 women seeking appointments at a crisis
counselling centre. CSA was defined as any self-reported sexual contact experienced before the age of 15 years and initiated by a person aged 5 or more years older. A nonsignificant difference in the rate of rape between those with a history of CSA (n = 67) and those without such a history (n = 86) was found. However, it is unclear how rape was assessed and it appears other forms of sexual revictimization such as attempted rape may have been excluded, which may help to account for these findings of a lack of evidence of revictimization. In contrast to the findings in the previous study, in another clinical study of outpatients of a crisis intervention service (n=195), Briere (1988) found a significant association between a history of CSA (n = 133) and subsequent rape or sexual assault during adulthood. Adult sexual assault referred to experiences over the age of 16, whereas CSA was defined as those events occurring prior to the age of 16 with someone 5 or more years older.

In a study of psychiatric inpatients (n = 98), Chu and Dill (1990) found a history of CSA (n = 35) doubled the risk of experiencing sexual abuse in adulthood (2.20:1). However, these results are difficult to interpret given that no comparison group of nonabused controls was used.

A research study by Follette, Polusny, Bechtle and Naugle (1996) used a mixed sample of clinical/community participants recruited from psychology clinics and community advocacy agencies (n = 72), who were compared with nonclinical university student participants (n = 138). CSA was defined as any forced or pressured sexual contact between the individual and someone older, before the age of 18. Adult sexual assault was defined as forced or pressured sexual contact involving penetration that occurred when the individual was over 18 years. Of the clinical/community group, 65% reported a history of CSA compared to 40% of the nonclinical student group. In terms of adult sexual assault, 40% of the clinical/community group reported having this experience compared to only 5% of the nonclinical/student group. However, this finding may have been a result of an age difference between the two groups, with the likelihood being that the student group were younger, reducing the opportunity for them to have experienced adult sexual assault. The clinical/community participants were found to report significantly higher rates of trauma symptoms including anxiety, depression,
dissociation, sexual abuse trauma, sexual problems and sleep disturbance, than the nonclinical/student women. Furthermore, when the groups were partitioned according to the number of different types of trauma experienced (0-3), a significant overall effect was found, indicating a cumulative impact for multiple types of trauma experiences.

**Summary**

It can be concluded that individuals who have experienced CSA are at a much greater risk of adult sexual assault than their nonabused peers. In addition, those who experienced adult sexual assault as well as CSA, were found to be at increased risk of the greatest level of distress following the recent sexual assault. Women who have been revictimized appear more likely to experience feelings of depression, anxiety, hostility and other difficulties (Messman, & Long, 1996). In addition, the severity of the sexual abuse, particularly in terms of whether it involved rape and the level of force used, appears to have a significant relationship with the individual’s later functioning. Increased severity of the previous CSA experience also appears to indicate an increased likelihood of more severe adult sexual assault. The results of the studies provide support for a cumulative model of trauma, with multiple trauma experiences indicating a poorer prognosis for the individual.

Future research should incorporate clear definitions of what constitutes an adult sexual assault, and preferably inclusion of a broad range of revictimization behaviours, to enable comparison between studies. Furthermore, studies of revictimization should ideally be conducted on a longitudinal and prospective basis. It is important that substantial time periods have elapsed between measurements of victimization to ensure events occurring in the intervening period are captured, and provide an accurate assessment of revictimization across the lifespan.

**Adult Physical Assault**

It would appear that many women who have been sexually abused in childhood have been subjected to a range of abuses in adulthood as well. Consequently, a few studies have examined revictimization in the form of adult
physical assault. In each of these studies, adult physical assault has been measured using the Conflict Tactics Scale (CTS; Straus, 1979). In the following sections, the relationship between CSA and adult physical assault will be discussed in terms of research employing community, college and clinical participants.

**Community Studies**

An investigation of revictimization in terms of physical abuse within marriage in a community sample (n = 930) by Russell (1986), indicated 27% of the incest survivors reported ever having a physically violent husband, compared to only 12% of women without an incest history. When only those women who were currently married were considered, it was found that 38% of incest survivors were physically abused by their current husband, compared to 18% of women without an incest history.

**College Studies**

As outlined in the previous section, Messman-Moore and Long (2000) found that in their college sample of 648 women, 127 (20.1%) reported a history of CSA and 506 women reported no such history. The four abuse groups (revictimization, multiple adult victimizations, CSA only, adult assault only) and a nonvictims group were then compared in terms of psychological functioning. Although the concept of a cumulative effect of trauma received support, no differential effects for child to adult revictimization compared to multiple adult victimizations were found. Furthermore, women with revictimization and women with multiple adult assaults displayed similar levels of psychological functioning. Both of these groups consistently reported more difficulties in a number of areas of functioning, compared to women with only one form of adult abuse, or women without an abuse history. In a further analysis of the data from this study, Messman-Moore and Long (2000) found CSA survivors experienced more physical violence in adulthood than those without a history of CSA. Furthermore, when the physical violence episodes were broken down into minor physical violence and severe physical violence, CSA survivors were found to experience more episodes of both types of violence.
Also using a college sample (n = 219), Banyard et al. (2000) found 25.1% of women reported a history of CSA and 24.2% reported experience of physical aggression in a dating relationship. Women with a history of CSA were significantly more likely to experience physical aggression in dating relationships (40.4%), compared to women without a CSA history (19.8%). Furthermore, this relationship remained even when the presence of conflict in the family-of-origin was controlled for.

Clinical Studies

Using a clinical sample of women incestuously abused in childhood (n = 40), Herman and Hirschman (1981) found that 11 of the women (27.5%) reported enduring regular beatings from husbands or lovers. In addition, the women seemed to feel that they deserved to be beaten, believing that this was to be expected after witnessing their own mothers being beaten. A number of the women tolerated extremes of abuse in their marriages and made efforts to protect themselves only when their lives were clearly in danger. In their previous study of father-daughter incest survivors, Herman and Hirschman (1977) also indicated that in many cases the women became intensely involved with men who were cruel, abusive or neglectful and they tolerated extremes of mistreatment. However, the report of this research did not incorporate clear empirical findings in relation to this issue of physical assault. Furthermore, a lack of comparison groups of nonabused women made the findings of both studies difficult to interpret.

Consistent with the observations of Herman (1981), Briere and Runtz (1987) using a clinical sample of women seeking crisis counselling appointments (n = 152), found that of the 44.1% of women with a history of CSA, 48.9% also reported a history of adult battery. This figure was significantly higher when compared to only 17.6% of women without a CSA history who had experienced battery as an adult. However, a description of how adult battery was assessed was lacking. As outlined in the previous section, Follette et al. (1996) conducted a comparison of clinical/community participants (n = 72) with nonclinical/student participants (n = 138). It was found that 65% of the clinical/community group reported a history of
CSA compared to 40% of the nonclinical/student group. In addition, 79% of the clinical group reported experiencing physical abuse by a partner compared to 43% of the nonclinical group.

**Summary**

In summary, there would appear to be a consistent finding, across a range of sample types, that CSA survivors are more likely to experience physical abuse as an adult than their nonabused counterparts. This relationship would seem to hold even when the role of conflict in the family-of-origin has been accounted for. However, it is clear that more empirical work is required to confirm these findings, particularly given the lack of detailed definitions of adult physical assault, and how it is assessed, and the insufficient use of nonabused control groups, which severely limits the generalizability of the findings.

**Adult Psychological Maltreatment**

In addition to an increased risk for revictimization in the form of sexual assault or physical abuse, it has been proposed that CSA survivors may be at greater risk of psychological maltreatment by their partners. The few studies that have attempted to assess this proposition by investigating dating relationships in college students will be discussed in the following section.

**College Studies**

Messman-Moore and Long (2000) used the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1989) to measure this factor among a sample of college women (n = 633). The measure contains two subscales: the dominance-isolation subscale includes items on isolation from resources, demands for subservience and rigid observance of traditional sex roles; the emotional-verbal subscale has items describing verbal attacks, demeaning behaviour and the withholding of emotional resources. It was found that 127 women (20.1%) reported a history of CSA and 506 women did not report such a history. CSA survivors reported significantly more psychological maltreatment than women without such a history,
with survivors reporting more acts of dominance-isolation and more acts of emotional-verbal abuse by partners, than nonvictims.

Banyard et al. (2000) assessed psychological aggression in the dating relationships of students (n = 219). It was found that 25.1% of the women (n = 47) reported a history of CSA and 87.2% of this group reported experiencing psychological aggression in dating relationships, compared to 66.3% of women without a CSA history. The relationship between psychological aggression and a history of CSA remained, even after controlling for conflict in the family-of-origin, with CSA survivors three times more likely to experience psychological aggression in a dating relationship.

**Summary**

In summary, although relatively few studies have investigated revictimization in terms of adult psychological maltreatment, findings to date suggest CSA survivors are more likely to experience this form of victimization than those without an abuse history. However, it should be noted that to date studies have examined psychological maltreatment only in college populations and only in the context of dating relationships. Obviously, future research which looks at this phenomenon in a range of populations and a variety of types of relationships is essential.

**Overall Summary**

Although it has been established that revictimization exists, there has been limited systematic investigation of this phenomenon and thus inadequate testing of the circumstances leading to vulnerability for revictimization. There have also been a number of methodological difficulties with the studies that have been conducted, such as possible alternative ways of defining revictimization and limitations on generalizability, as sampling has not been representative of the broader population. Furthermore, the age of study participants is important, for many samples have involved adults aged under 30 years, which provides a limited time in which abuse in adulthood could have occurred. There has also been variability in how childhood and adulthood experiences are differentiated (e.g. at what age?), and in definitions and
assessment of childhood and adulthood assaults. Because much of the information on revictimization has been obtained from studies looking at other issues, many studies did not report statistical comparisons between CSA survivors and nonvictims concerning experiences of adult abuse, nor did they include appropriate control groups to allow such comparisons.

Despite this lack of empirical investigation, various researchers have suggested a number of factors may play a role in the occurrence of revictimization, including low self-esteem, learned helplessness, causal attributions (internal, global and stable), relationship choices, learned behaviour patterns and expectations.

**Parenting**

To date, there has been little consideration of the impact of CSA on later parenting. Yet general research on parenting and parenting under stress suggests that early family experiences are very influential upon development of future parenting skills (Main, & Goldwyn, 1984; Zuravin et al., 1996). Those adopting a developmental approach focus on attachment and internal working models. Early models of parenting experienced as a child become a template for the development of the individual’s own cognitive models of parenting and impact on later interactions with their own children (Crowell, & Feldman, 1988; Main, & Goldwyn, 1984; Ricks, 1987).

There are a number of areas in which a history of CSA may impact upon later parenting including: child-bearing patterns, parenting attitudes and abilities and . These aspects of parenting will be considered in the following sections.

**Child-bearing Patterns**

As discussed previously, CSA survivors have frequently reported being involved in high-risk sexual behaviours. In addition, a study by Herman-Giddens, Sandler, and Friedman (1988) produced initial data suggesting a link between CSA and early onset of puberty among some girls. Although such a proposal clearly needs
further empirical investigation, the combination of these factors suggests there may be altered child-bearing patterns among CSA survivors.

In comparing CSA survivors (n = 29) and nonabused women (n = 54), from a college sample, Zierler et al. (1991) found the survivors were 2.6 times more likely to become pregnant before the age of 18. These findings are consistent with those from Russell’s (1986) large probability community sample, which indicated that incestuously abused females (n = 152) had their first child on average 18 months earlier than their nonabused peers (n = 778). Mullen et al. (1994) also found, from a large community sample, that CSA survivors (n = 248) were more likely than nonabused controls to have been pregnant under the age of 19. Furthermore, early pregnancy was most highly associated with increased severity of abuse, with a rate of 31.3% for the intercourse group. In contrast, Widom and Kuhns (1996), using a prospective design, also matched respondents on the basis of age, race, gender and social class but found that those who had experienced CSA (n = 76) did not differ from the nonabused controls (n = 244) on age at pregnancy.

Similarly, a study by Herman-Giddens et al. (1998), which also investigated whether there was a higher risk of teenage pregnancy among CSA survivors (n = 231) compared to nonabused controls (n = 503), found no differences when demographic characteristics (poverty, status, race, maternal education, marital status, and age) were controlled. These findings suggested teenage pregnancy may have been a function of family issues such as poverty, or other factors that were not controlled, rather than being associated with a history of CSA. On the other hand, Herman et al. found CSA survivors had more children at an earlier age than their nonabused peers, even when demographic characteristics had been taken into consideration. Parity (more than one child) was also found to be increased among survivors who were married, probably due to the support for increased fertility offered by marriage. This finding was consistent with those of Mullen et al. (1994), who also found that although equally likely to have had children, survivors on average had a larger family than those women without a history of CSA.
However, Steele and Alexander (1981) and Gelinas (1983) also observed that some CSA survivors stated they had not dared to have children and did not intend to become parents at all, in case their children also had similar negative experiences.

**Summary**

There is some inconsistency in the findings, but generally it appears those women who are survivors of CSA are more likely to become pregnant earlier than their nonabused peers, particularly when they have experienced more severe abuse. However, the differences between CSA survivors and nonabused groups seem to disappear when demographic characteristics are controlled. Further empirical investigation is required using nonabused control groups and controlling for family background factors to ascertain the role of CSA in later child-bearing patterns among survivors. CSA survivors have been found to have greater parity than their nonabused peers and a number of factors have been proposed to account for this finding. Concerns have been expressed about how the lack of resources associated with decreased maturity may increase the risk of inadequate parenting in survivors. In contrast, some CSA survivors choose to avoid a parenting role altogether. Thus, further investigation of the overall child-bearing pattern of CSA survivors, including reasons for voluntary childlessness, age at first pregnancy, number of children and spacing between children may provide a better understanding of the link between CSA and child-bearing.

**Parenting Attitudes and Abilities**

Steele and Alexander (1981) have reported that based on their memories of inadequate and unreliable parental care, many CSA survivors are ambivalent about their ability to be good parents and the parenting methods they use. It seemed that sometimes the survivors believed that they were doing exactly the right thing and at other times they were sure they were doing the wrong thing. This leads to survivors having difficulty in providing consistent, adequate, general parenting of their children. For example, clinical observations by Gelinas (1983) indicated CSA survivors had difficulty maintaining a balance between discipline and affection with their children.
DiLillo (2001) has more specifically suggested that there are a number of reasons underlying the parenting difficulties of CSA survivors. Firstly, high levels of dysfunction in the family-of-origin may prevent survivors from receiving sufficient exposure to effective parental role modelling. Secondly, the abuse experience and subsequent intrapersonal problems such as anger, low self-esteem and depression, may undermine the survivor’s confidence and competencies in their parenting abilities. Thirdly, parenting abilities may be hampered by interpersonal relationship difficulties, including the marital relationship. Furthermore, Courtois (1988) suggested early and/or repeated pregnancies increased the risk of poor parenting for young mothers who lacked the knowledge, skills, patience or support to cope with the demands of young children. This is particularly the case when the mother’s own immaturity and emotional deprivation are considered.

The survivor’s own unresolved abuse experience may prevent the development of emotional and physical closeness with her children, potentially providing an opportunity for abuse of them (Courtois, 1988). In addition, survivors may experience gender-related parenting issues with fears about their sons’ development as they mature. On the other hand, survivors may fear for their daughters or feel rivalry with them. Individuals may cope with such feelings by being overly protective or overly distant with their children, potentially providing the opportunity for child abuse. Consistent with these views, Steele and Alexander (1981) reported CSA survivors expressed anxiety about concerns that their daughters, either actual children or those they may bear in future, may also be abused by their fathers (maternal grandfathers). The survivors also expressed concern that their husbands may engage in abusive behaviour with their daughters.

Very few empirical studies have investigated the parenting attitudes and behaviours of women who have experienced CSA. Cole and Woolger (1989) compared the perceptions of families-of-origin and current child-rearing attitudes of 21 incest survivors and 19 women who had experienced extrafamilial sexual abuse. It was found incest survivors, and especially those with negative perceptions of their mothers, had significantly higher expectations of autonomy for their children than did
other CSA survivors. Incest survivors were also resistant to their children’s dependency upon them and more highly valued children’s self-sufficiency compared to the extrafamilial sexual abuse survivors. Both groups of sexual abuse survivors had similar attitudes regarding the nurturance and control of their children.

Given the high prevalence of sexual abuse by fathers with alcohol problems, which had previously been observed (Herman, 1981; Russell, 1986), a subsequent study attempted to control for alcoholism (Cole, Woolger, Power, & Smith, 1992). The main research group consisted of women with incestuous and alcoholic fathers (n = 20) and those with alcoholic fathers only (n = 25), who were compared to women whose fathers presented no known problems (n = 39). Incest survivors were found to have greater difficulties in feeling adequate as a parent, they described being less confident and less emotionally controlled than the mothers from the nonabused control group. Incest survivors also reported greater loss of control and less consistency with their children compared to nonabused controls, with the adult children of alcoholics group falling between these groups. The finding that there were no significant differences in loss of control and consistency between mothers with alcoholic fathers only and those who experienced incest, was proposed to be due to such a high prevalence of alcoholism in the incest survivors’ families-of-origin. Parenting attitudes relating to the nurturance and discipline of children did not differ between the nonabused control and incestuously abused parent groups.

It would appear that CSA survivors’ perception of themselves as having parenting difficulties has some basis. In a study by Cohen (1995), comparison of a clinical sample of female incest survivors (n = 26) with a group of matched nonabused controls (n = 28) who had not experienced abuse, found significant differences between the groups on an assessment of parenting skills, with the incest survivors demonstrating poorer functioning. Survivors were more likely to view themselves negatively and as inadequate parents, to have unreasonable, rigid and unrealistic expectations of their children and to have rejecting attitudes. The largest differences were found in the areas of role support and communication. Small differences found relation to objectivity, expectations of children and limit setting may have been due to measurement of parenting skills that are more clearly defined.
by community standards and social expectations. Such parenting skills were proposed by Cohen to be easier to learn and internalize than some of the other skills measured.

Banyard (1997), in an examination of low-income mothers (N = 430), sought to more specifically investigate whether CSA had a negative impact on parenting in the areas of parenting attitudes and behaviours. The areas covered were the frequency with which the respondent worried about problems related to her children, how satisfied she was with her parenting, and how much she wished to change the parent she was and strategies for dealing with parent-child conflict. Furthermore, the study sought to remove the influence of other negative family-of-origin experiences such as neglect, physical abuse and perceived negative relationships with parental figures. CSA was found to be associated with more negative views of self as a parent and greater use of physical punishment strategies, even after accounting for differences in family-of-origin relationship quality.

Zuravin and Fontanella (1999) sought to replicate Banyard’s (1997) investigation into the relationship between CSA and subsequent parenting attitudes and behaviours and further examine the role of other childhood experiences rather than CSA. Given the impact of maternal depression on parenting ability, it was also proposed that the effect of CSA on parenting may be mediated by maternal depression. Using a community sample of low–income mothers (n = 516), contrary findings to those of Banyard (1997) were reported. Severely violent methods for handling conflict and perceived parenting competence, which discriminated between CSA survivors and victims, were completely accounted for by other childhood experiences. Experience of physical neglect in childhood increased the risk of poor parenting and perceived parental support, and the experience of physical abuse decreased the probability of poor parenting.

The researchers concluded that the contradictory findings to those of Banyard (1997) were due to sample composition. Whilst Zuravin and Fontanella (1999) used a sample of nonmaltreating mothers, Banyard (1997) compared mothers with/without a maltreated child and the rate of CSA was significantly higher among the former
group. Therefore, it seemed that for mothers with a maltreated child, CSA was associated with greater parenting problems, over and above other adverse childhood experiences.

Hiebert-Murphy (2000) sought to assess whether parenting satisfaction or efficacy was related to a maternal history of CSA, following the disclosure of sexual abuse by their children. Therefore, a sample of 102 mothers were recruited from community sexual assault support services. It was found that neither parenting satisfaction nor parenting efficacy were predicted by maternal child/adolescent sexual abuse. The researchers questioned if this lack of a relationship was due to the sample only containing a small number of father-daughter incest examples compared to previous studies (Cole, & Woolger, 1989; Cole et al, 1992). Potentially, other types of sexual abuse and particularly extrafamilial abuse may not have such an impact on the survivor’s views about parenting. Furthermore, intervening variables such as disclosure and receiving social support may mediate the relationship between a maternal history of CSA and subsequent parenting.

Qualitative data relating to survivors’ parenting was provided by Burkett (1991) who used a circumplex model of human behaviour developed from interpersonal theory, to evaluate CSA survivor mother and child interactions in videotaped sessions. These observational analyses indicated that the twenty mothers who had experienced CSA were more self-focused than child-focused, than the comparison group of twenty nonabused mothers. The survivors were also more likely to give messages to their children communicating belittling and blame and fewer messages that communicated affirmation and understanding. The qualitative analyses suggested CSA survivor mothers were more likely to view their child as a close friend or primary companion and to depend upon their child for emotional support, indicating a pattern of role reversal.

Using qualitative research methods, Westerlund (1992) obtained questionnaires (n = 43) and interviews (n = 10) with women who had experienced childhood incest. For the 40% of respondents who had children, all believed that the incest had affected their parenting in some way. Over a third of the women believed
they were more sensitive and responsive to their children’s needs as a consequence of their incest experience. However, almost half of the respondents with children described themselves as too troubled, anxious or depressed as a result of the incest, to be as energetic and generous towards their children as they would have liked.

Almost all of Westerlund’s (1992) respondents described having to fight a tendency to be overprotective, to prevent their “terror”, “pessimism” or “mistrust” being transmitted to their children. Respondents found it difficult to leave their children in the care of others and worried about the nature and adequacy of their children’s sexual abuse prevention training, general sex education and gender socialization. A quarter of the respondents indicated that their children had been sexually abused. A few respondents had a continual concern that their children would perceive them as helpless or ineffective in the same way as they perceived their own mothers. These women also blamed themselves when something painful occurred in their children’s lives.

A third of respondents (Westerlund, 1992) reported feeling discomfort with handling the genitals of children during changing and/or bathing and in being physically demonstrative with their children. This discomfort was generally experienced in association with feelings of confusion about the boundaries between nonerotic/erotic touch and nonexploitative/exploitative touch. Due to a fear of being “intrusive”, “inappropriate”, “seductive”, or “stimulating”, some respondents felt unable to express affection spontaneously with their children. In addition, respondents raised parenting issues related to contact with or estrangement from the respondent’s family-of-origin, and the offender.

In an exploratory study, Voth and Tutty (1999) used a phenomenological approach to the narratives of six women who were daughters of incest survivors to gain an understanding of perceived parenting competency of CSA survivors from the child’s perspective. Three major themes emerged: that daughters of incest survivors experienced their mothers as failing to “grow up”, they experienced difficulties in dynamics in the mother-daughter interactions during childhood and these daughters experienced relational difficulties as adults. In addition, two of the daughters were
incest survivors and one suspected that she might be a survivor. Issues in the lives of daughters which were attributed to her mother’s abuse history were accepted as such, despite the possibility they could also be linked to her own abuse. This can be explained by the daughters’ abuse being associated with her survivor mother’s inability to protect her. Keeping in mind the small sample size, this study appears to offer some support for the apparent parenting difficulties of CSA survivors observed by clinicians and the few empirical investigations to address this issue.

Summary

In general, mothers who have experienced CSA appear to have less confidence in their parenting ability, demonstrate lower emotional control and greater inconsistency in parenting. Although mothers with an abuse history were found to have negative views of their parenting ability and had increased utilization of physical punishment, an attempt to replicate these findings was not successful. Survivor mothers were found to discourage dependency in their children, encourage self-sufficiency and have higher expectations of their child’s autonomy. Thus, it would appear that a major difficulty in the parenting of CSA survivors relates to a pattern of role reversal, with survivors focusing on their own needs rather than those of their children. In addition, the quality of parenting may be mediated by the nature of the marital relationship, intrapersonal difficulties of the survivor, concerns about the potential for repetition of abuse, age and gender of the child.

Qualitative data in the form of self-reports of mothers with a history of CSA suggest they believed the experience had affected their parenting, although sometimes this had been in a positive way. General parenting issues had become heightened as a consequence of their experience, whereas some special concerns had also arisen as a direct consequence of the abuse. The childhood experiences of adult children parented by CSA survivors would seem to be consistent with the survivor mothers’ reports regarding their own parenting difficulties.
Abuse of Children

Some researchers have described a phenomenon known as the transmission of abuse status, when children whose mothers have experienced CSA, are found to be at higher risk of child maltreatment. Zuravin and DiBlasio (1992) found that CSA was one factor which discriminated adolescent mothers who had been reported for neglect of their children (n = 22), from those who had not (n = 80) in a community sample of low-income mothers (n = 518). Using a subset of respondents from the same sample who had experienced childhood maltreatment (n = 213), Zuravin et al. (1996) found that severity of CSA was associated with an increased likelihood of having a child who experienced some type of maltreatment.

Similarly, in a study comparing a group of mothers of abused children (n = 100) with a control group of normal women (n = 500), it was found by Goodwin et al. (1981), that 24% of the abusing mothers had a history of CSA, in contrast to only 3% of the nonabused controls. Interestingly, significantly more incest survivors in the normal group had successfully reported the incident to a parent, the survivors from the abusive parent group were more likely to have been under 13 when the abuse began, and the survivors who were nonabusive parents had slightly more education.

In a sample of 118 mothers whose children had been reported for intrafamilial sexual abuse, Heriot (1996) did not find that a maternal history of CSA was a risk factor for nonprotection following the child’s disclosure of sexual abuse. Similarly, Deblinger, Stauffer, and Landsberg (1994) compared nonoffending mothers with (n = 83) and without (n = 100) a history of CSA, whose child was alleged to have been sexually abused. The survivor mothers demonstrated significantly higher levels of general distress and felt more alone, but believed the allegations concerning their children and advocated for their children to the same degree as those mothers without such an abuse history.
Summary

It would appear that a history of childhood maltreatment such as sexual abuse increases the risk of child abuse for the survivor mother’s children, particularly if the abuse she experienced was severe. However, it has not been demonstrated empirically that survivor mothers have lower levels of belief in allegations concerning sexual abuse of their children or advocate for them any less, despite heightened general distress. Thus, there do appear to be some protective factors, which may hinder the transmission of abuse, including successful disclosure by the survivor, a later age at onset of the abuse and increased education.

Overall Summary

In summary, despite some inconsistency in the findings, mothers with a CSA history have generally been found to be at higher risk of having teenage pregnancy and a greater number of children than their nonabused peers. CSA survivors also expressed a range of parenting concerns, including for some a wish to avoid motherhood. A pattern of role reversal between the CSA survivor mother and her children, and intrapersonal difficulties impacting upon the parenting of the survivor has also been observed. Although the children of survivor mothers were at higher risk of child abuse, this was reduced if the mother had successfully disclosed, her age at onset of abuse was later and she had achieved more education. Contrary to expectation, survivor mothers were not less likely than their nonabused peers to believe allegations of sexual abuse regarding their children or to advocate for them any less, despite their heightened distress.

Survivors of CSA reported lower confidence in parenting and higher rates of feeling a lack of control in parenting situations. Sexually abused mothers were also more likely to rely on their children for emotional support and to be more self-focussed in their parenting. CSA was also found to be associated with lower esteem as a parent and greater use of physical punishment. Further research in this area should carefully compare samples based on the severity of sexual abuse, for it has been demonstrated that this may have a significant effect on results. It is also important that differences in the quality of the family-of-origin be controlled for.
CHAPTER 5

RISK AND RESILIENCE FACTORS IN THE SURVIVORS’ RESPONSE TO CSA

An examination of the long-term effects of CSA on psychological adjustment raises the question as to why some survivors seem to recover from the immediate negative impact, whilst others continue to experience negative consequences (Gold, Sinclair, & Balge, 1999). Factors that may play a role in determining the outcome of abuse include attributions made regarding the abuse and the coping strategies, including the provision of family and social support, used to manage the experience. The notion of resilience would seem to offer a way of conceptualizing the factors which may play a role in minimizing the impact of CSA on the survivor’s later psychological adjustment. One indicator of resilience is the CSA survivor’s ability to regain personal autonomy, with some achieving this through reframing of their experience as having had some positive aspects or perceived benefit to them.

In this chapter, the role of cognitive attributions regarding the CSA will be discussed in terms of attributional approach including attributions of self-blame and other blame, and the search for meaning and world assumptions. In addition, locus of control, coping strategies, family support and social support will be discussed in the context of examining factors which may predispose the survivor to risk of, or resilience against, negative impact on their adult psychological functioning.

Attributional Approach to CSA

Gold (1986) emphasized the importance of factors associated with the individual’s response to CSA, arguing that an examination of the interaction between the person and the situation is a more accurate conceptualization of behaviour, than either observing the person or situation separately. Gold used the learned
helplessness model of depression (Abramson et al., 1978), to construct the proposition that an individual’s causal attributions and expectancies mediate their response to uncontrollable situations.Attributions are classified according to three dimensions: internal-external, stable-unstable, and global-specific.

Therefore, if CSA is conceptualized as a helplessness experience (an uncontrollable event), then learned helplessness theory suggests that the symptoms observed in many survivors may result from internal, stable, global attributions for bad events. Survivors would have expectations of having no control over their environment. Thus, Gold proposed that the psychological distress observed in CSA survivors results from internal, stable, global attributions for bad events and an expectation of having no control over their environment.

A number of researchers have sought to investigate how attributional style may mediate the relationship between the experience of CSA and survivors’ later psychological adjustment. The implications of attributions of self-blame and blaming others including the offender, have also been explored in relation to survivors’ psychological functioning in adulthood. Some researchers have sought to investigate the relationship between attributions of blame and the search for meaning in abuse and the role of the individual’s basic assumptions or beliefs about oneself and the world. All of these areas will be discussed in the following subsections.

Attributional Style

The relationship between attributional style and later psychological functioning following a history of CSA was investigated by Gold (1986) using a mixed college/clinical/community sample of CSA survivors (n = 103), compared with a control group of women who did not have a CSA history (n = 88). As predicted, women with a history of CSA who tended to make internal, stable and global attributions for negative events were more likely to report psychological distress and low self-esteem. Thus survivors were more likely than those without a CSA history to attribute bad events to global factors, to attribute good events to
external factors, to blame their own character for bad events and were less likely to blame other people for bad events.

The relationship between attributional style, abuse characteristics and nondisclosure was also investigated by Wyatt and Mickey (1987) using a random community sample (n = 248), of whom 61 women reported experiencing CSA involving contact abuse exclusively (rather than contact and noncontact abuse). It was found that self (internal) attributions were associated with aspects of the abuse, the severity of the abuse and nondisclosure, whereas external attributions were associated with “overall lasting effects” of the abuse. The researchers suggested responses relating to external attributions indicated some survivors had become aware of their inability to fend off powerful perpetrators or their inability to control chance events (world, others). However, there were some obvious methodological difficulties with this research, for the participants were scored on the variables via a clinical interview only. This clearly raises questions regarding standardization across participants and raters, as demonstrated in the rating of the variable of lasting effects of each childhood abuse experience being classified as “positive, negative, cognitive or none at all” (p.408).

Mandoki and Burkhart (1989) theorized that multiple victimization would be associated with decreased assertiveness, low self-esteem and an internal, global and stable attributional style. However, this was not supported by their findings when using a college sample of 282 women. The sample was divided into groups of CSA survivors (n = 21), child nonvictims (n = 170), survivors of adult sexual assault involving attempted/completed sexual intercourse (n = 75) and both child and adult survivors (n = 16). This finding may provide support for Koss’s (1985b) proposal that sexual victimization is not predictable based simply on the survivor’s personality characteristics, the social context of the survivor must also be considered.

Wenninger and Ehlers (1998) sought to replicate and expand on previous research by investigating the relationship between a history of CSA, attributional style, dysfunctional cognitions and posttrauma symptoms. In their first study, a sample of American CSA survivors (n = 43), the majority of whom were receiving
treatment, were compared to a group of women without a CSA history (n = 29). Consistent with the findings of Gold (1986), survivors’ attributions for negative events in everyday life were found to be more internal, stable and global, than for those without a CSA history. However, Wenninger and Ehlers (1998) found only the globality scale was significantly related to the severity of long-term symptoms. They proposed that this finding was a reflection of the overaccommodation of cognitive schemas, as described by Resick, Schnicke, and Markway (1991, as cited by Wenninger, & Ehlers, 1998). The stability dimension only demonstrated the predicted relationship with Trauma Symptom Checklist (TSC) subscales of depression and post-sexual abuse trauma symptoms, providing alternative replication of Gold’s (1986) findings.

Wenninger and Ehlers (1998) suggested their findings failed to replicate Gold’s (1986) finding of a significant relationship between the internality attributional dimension and psychological functioning due to methodological differences between the two studies. However, high correlations were found between dysfunctional beliefs regarding safety, trust, esteem, or intimacy and posttrauma symptoms. Wenninger and Ehlers (1998) suggested that although general assault survivors may also develop maladaptive cognitions in relation to safety, dysfunctional beliefs about intimacy may be specific to sexual abuse survivors.

Wenninger and Ehlers (1998) advocated a model showing the link between dysfunctional cognitions and posttrauma symptoms, suggested by McCann, Sakheim and Abrahamson (1988). This model proposed a reciprocal interaction between an individual’s negative schemas, her/his behaviour resulting from such cognitions and her/his life experiences. Consistent with this model, dysfunctional beliefs about the self and others may function as self-fulfilling prophecies. In an attempt to replicate their findings, Wenninger and Ehlers (1998) conducted a second study using a German sample of 35 CSA survivors, who were evaluated using the same measures (PTSD Symptom Scale, Trauma Symptom Checklist (TSC)) as the American sample. Support was found for the previous finding that dysfunctional beliefs were strongly associated with post-trauma symptoms, even when the frequency of abuse was controlled for, as a relevant abuse characteristic.
Self-Blame and Other-Blame

Hoagwood (1990) used a clinical sample of CSA survivors (n = 31) to assess the intensity, direction and type of self- and other-blame in relation to adjustment. It was found there were significant differences in the direction and types of blame experienced as children (measured retrospectively) and as adults. The women blamed themselves more as children and less as adults in terms of overall self-blame, and in terms of both characterological self-blame (a stable, internal attribution for being a particular type of person) and behavioural self-blame (an unstable, internal attribution for engaging in particular behaviours) (Janoff-Bulman, 1979). In terms of direction of blame, as children the survivors blamed the abuser, their mother and their father less than they did as adults. There were no differences between behavioural and characterological self-blame experienced as a child, but for adults characterological self-blame was significantly more intense than behavioural self-blame. Thus, as adults the survivors blamed themselves more for being a “bad” person than for being involved in “bad” behaviour.

Whilst self-blame was associated with poorer adjustment, other-blame was associated with healthier adjustment in Hoagwood’s (1990) study. Women who blamed themselves more as children, were more depressed as adults and had lower self-esteem. Similarly, women who blamed themselves as adults were more depressed and had a lower self-concept. In contrast, women who blamed their abuser more as adults were less depressed and had higher self-esteem, and a higher self-concept. Significant relationships were also found between blame and characteristics of the abuse, including age at abuse and duration of the abuse. Firstly, the younger the women were when first abused, the less they blamed the abuser. Secondly, the longer the time that the abuse continued, the more self-blame the women experienced, both as children and as adults.

McMillen and Zuravin (1997) acknowledged this study by Hoagwood (1990) was the only one to attempt to measure blaming of family members for the abuse, but criticized Hoagwood (1990) for not reporting sufficient descriptive information on
the blame measures developed for the study. They also argued single-item indicators of blame, such as those used by Hoagwood (1990), do not reflect the many different ways in which individuals may blame themselves or others.

Lalor (1994) found a significant relationship between attributional blaming style and self-esteem, with negative self-blaming attributions (i.e., negative beliefs about the self such as believing the abuse was her fault) being associated with low self-esteem, using a clinical sample of CSA survivors (n = 36). Furthermore, low support from the mother at the time of and after disclosure of abuse was related to negative (self-blaming) attributional style. It had been theorized that self-blame may provide a coping mechanism, by giving a sense of control to CSA survivors (Morrow, 1991). However, although participants tended to blame themselves for the abuse, they also felt personally unable to control it. Yet, they appeared to believe that it was possible for someone else to take responsibility and control the abuse. This would fit with the model proposed by Abramson et al. (1978), which suggested a difference between personal helplessness where outcomes are potentially controllable, and universal helplessness where outcomes are intrinsically uncontrollable. Survivors demonstrated the perception that their abuse fell within the category of universal helplessness, for although they had been personally helpless to control the abuse, they believed this was within the power of others.

Peters and Range (1996) addressed this issue through use of the Belief Inventory (BI; Jehu, 1988) to measure the general factor of pervasive or characterological self-blame in both a clinical sample and a college sample of CSA survivors. In the clinical sample (n = 57), 35% of participants had engaged in self-mutilation, 91% had experienced suicidal ideation, 53% had threatened suicide, 37% had attempted suicide at least once and 39% conceded at least a slight possibility they would commit suicide in the future. The sample was classified as high self-blamers (n = 43) or low self-blamers (n = 14) and these two groups compared. High self-blamers were found to be more depressed, suicidal, more likely to have self-mutilated and have weaker survival and coping beliefs (as measured using the Reasons for Living Inventory, RFL; Linehan, Goodstein, Neilson, & Chiles, 1983) than low self-blamers.
In the college sample of CSA survivors (n = 101), Peters and Range (1996) found 13% of participants had engaged in self-mutilation, 56% had experienced suicidal ideation, 31% had threatened suicide, 5% had attempted suicide at least once and 13% conceded at least a slight possibility they would commit suicide in the future. Again, the sample was divided into high self-blamers (n = 58) and low self-blamers (n = 42) and these two groups compared. The results were consistent with those found for the clinical sample. Women who were high self-blamers were more depressed and suicidal, had weaker survival and coping beliefs, and had more fear of suicide and fear of social disapproval than low self-blamers. In addition, depression, self-blame and reasons for living were significant predictors of suicidality. However, high self-blamers were not more likely to have engaged in self-mutilation. Peters and Range (1996) proposed the differing findings for the college sample for this behaviour are a result of nonclinical samples participating in less obvious self-destructive behaviour.

In order to explore this issue further, McMillen and Zuravin (1997, 1998) sought to examine three types of attributions: self-blame, family blame and perpetrator blame, and the relationships between these attributions and adjustment. Their community sample consisted of a combined group of 154 women, drawn from a case-comparison study of low-income mothers who did or did not have a confirmed history of a maltreated child (n = 93 and n = 61 respectively). The researchers developed Attributions of Responsibility and Blame Scales and used the Benevolent World Scale (Janoff-Bulman, 1989) to assess views of others and the world in general. This method attempted to evaluate how the women may try to resolve the attributional dilemma, for blaming oneself may have negative consequences for how one views the self. On the other hand, blaming oneself may allow one to continue to believe in a just world and the goodness of others (Lerner, & Miller, 1978; Miller, & Porter, 1983; Tennen, & Affleck, 1990). Alternatively, blaming others, such as the abuser or nonprotective adults, may have negative consequences for views of others, whilst allowing favourable views of the self.
McMillen and Zuravin (1997) found self-blame and family-blame were skewed in comparison to perpetrator-blame scores, which were distributed fairly evenly. A high degree of self-blame was found to be rare among these CSA survivors. Given this was an adult CSA survivor sample, it is consistent with Hoagwood’s (1990) finding that self-blame was less likely as survivors grew into adulthood (at least as retrospectively measured). McMillen and Zuravin (1997) found attribution of blame variables as a group were related to self-esteem, relationship anxiety, comfortableness with closeness and having a maltreated child. The attribution of blame measures as a group accounted for 29% of the variance in self-esteem, 8% of the variance in comfort with closeness and 17% of the variance in relationship anxiety, when demographic and sexual abuse characteristics were accounted for. As a group, the attribution of blame measures were not related to views of others and comfort depending on others. As would be expected, those who were high on self-blame tended to have lower self-esteem, less comfort with closeness and more relationship anxiety, compared to those with lower self-blame.

Among this sample of survivors, McMillen and Zuravin (1997) found family blame was positively associated with relationship anxiety and an increased likelihood of having a maltreated child, but not other measures of adjustment (self-esteem, views of others, comfort with closeness, comfort with depending on others, and degree of relationship anxiety). These results are therefore partially consistent with Hoagwood’s (1990) findings that mother blame was not related to depression or self-esteem. The results suggest family blame was related to relationship anxiety because individuals whose relatives in childhood failed to protect and support them, may become anxious about their own adult intimate relationships. However, it would also be expected that these adults would experience decreased comfort in depending on others and getting close to others, which the data did not support. The relationship between family blame and having a maltreated child is potentially due to dysfunctionality in the family-of-origin. Survivors coming from dysfunctional families may be more likely to blame their families and to have received more dysfunctional parenting within such families, which, in turn, may make it more difficult for them to parent effectively.
In contrast to the findings of both Wyatt and Newcomb (1990) and Hoagwood (1990), McMillen and Zuravin (1997) found there were no main-effect relationships between perpetrator blame and adjustment. McMillen and Zuravin suggested the lack of a relationship may have been due to a lower variability and lower reliability of this attribution subscale compared to the other blame subscales. An examination of the interaction patterns between blame attributions and adjustment suggested that those women who had the lowest blame in all three categories (self/family/perpetrator), had the highest (most positive) views of others. Conversely, those with highest degrees of blame for all three categories, had the lowest (most negative) views of others. These results suggest that a possible healthy resolution of the attributional dilemma enables the individual to have the highest (most positive) views of others.

In a follow up study to compare attributions of blame in adulthood to those of childhood, McMillen and Zuravin (1998) used a group of 154 women with. the CSA survivors being drawn from a case-comparison study of low-income mothers who did or did not have a confirmed history of a maltreated child (n = 93 and n = 61 respectively). It was found that recollected childhood self-blame, family blame and perpetrator blame were all higher than the their equivalents for adulthood. The highest level of blame was childhood self-blame, which dropped the most dramatically in comparison to survivors’ current self-blame. Most women reported high perpetrator blame both as adults and children. A lower level of family-blame was maintained for both childhood and adulthood, with little decrease.

Attribution changes perceived by the CSA survivors were largest for self-blame and smallest for perpetrator blame, although changes in both directions were common. Overall, 79.1% of the women reported higher self-blame as children than as adults and 15.6% had lower self-blame as children than as adults. Overall, 58.4% of the CSA survivors had a higher family blame score for childhood than they reported as adults, and 28.6% had a lower childhood family blame score than adult family blame score. Perpetrator blame scores changed little, with most women reporting high levels of perpetrator blame, both as adults and as recollected for childhood.
The abuse characteristics of relationship to perpetrator, force and abuse frequency were not found by McMillen and Zuravin (1998) to be related to perceived changes in attributions. However, a number of other sexual abuse characteristics were found to relate to blame (self/family/perpetrator) change rates. In general, the more blame an individual recalled assigning to a source during childhood, the more a decrease in blame toward that source was reported. Age at first abuse, coitus and race were also related to blame change. The older the individual was when first abused, the greater the decrease in family blame and perpetrator blame over time. A smaller decrease in perpetrator blame was found for those whose abuse involved coitus, compared to those whose abuse did not. Race was related to both self-blame and perpetrator blame change, with African Americans reporting a lower reduction in self-blame and a greater reduction in perpetrator blame than others.

McMillen and Zuravin (1998) also investigated the relationship between changes in self-blame and changes in blame towards others. Self-blame change was found to be highly positively associated with family blame change over time, but was not related to perpetrator blame change. Furthermore, individuals with higher perceived support from family and friends reported a greater reduction in self-blame and family blame. In addition, of those women who told their mothers about their abuse, the more specific support they received from their mothers, the more family blame decreased. However, neither support from family and friends nor mothers, was related to a perceived change in perpetrator blame. These findings may be due to supportive others directly discouraging self-blame, or those with supportive relatives being more able to convince themselves they are good people and not deserving of negative experiences. Given that a general perception of support was related to self-blame change, but abuse specific support from mothers was not, the latter explanation appears more likely. The presence of a positive relationship between support and family blame change is also consistent with this view, for it would be difficult to blame family members for the abuse if they responded supportively following disclosure (McMillen, & Zuravin, 1998).

Although McMillen and Zuravin (1998) did not seek to recruit a clinical sample, 26.6% (n = 41) of the women were participating in therapy. However,
therapy did not appear to be related to attribution changes, with decreases in self-blame occurring regardless of therapy status. However, the exception was the finding of an unexpected relationship between therapy and attribution change. Those who went to therapy, but did not tell the therapist about their CSA, had an increase in family blame 3.8 points higher than those who did not go to therapy. This finding suggests therapists may potentially increase the CSA survivor’s blame of family members for her abuse, during the course of trying to shift attributions of blame from the self and/or to the perpetrator.

Search for Meaning and World Assumptions

McMillen and Zuravin (1997) concluded that their study would have benefited from examination of the relationship between attributions of blame and a wider range of adjustment measures. Two other potential measures of adjustment are the search for meaning in a traumatic experience, and the individual’s basic assumptions or beliefs about oneself and the world.

Silver, Boon and Stones (1983) sought to evaluate whether the search for meaning is a common and adaptive process for CSA survivors. They studied a community sample of women who were intrafamilial incest survivors (n = 77). Women able to make sense of their incest experience reported significantly less psychological symptomatology, higher self-esteem and better social adjustment. However, even this group of women reported significantly more frequent and intense psychopathological symptoms than a population of nonpatient “normals”, and significantly poorer social functioning than a community sample of women. Finding meaning in the abusive experience was associated with fewer recurrent, intrusive, disruptive and upsetting ruminations about the incest. For those who searched for meaning unsuccessfully, 65% of the group still reported these symptoms occurring at least sometimes. Furthermore, ruminations accompanying the search for meaning in the abusive experience were not adaptive in terms of psychological distress and poorer social functioning, if such ruminations failed to lead to a better understanding over a prolonged period.
According to Janoff-Bulman (1989), basic assumptions about oneself and the world may be shattered by sexual abuse. This theorist proposed three basic assumptions make up the individual’s “assumptive worlds” or fundamental beliefs about the world, other people and themselves. These basic assumptions are: the world is benevolent (the extent to which the world is viewed positively or negatively), the world is meaningful (the extent to which the distribution of outcomes are just, controllable, or due to chance), and worthiness of the self (the extent to which one holds positive or negative views of oneself). Janoff-Bulman argued that the severity of the trauma resulting from traumatization relates to the degree that the person’s basic assumptions are shattered. Therefore, the process of recovery from trauma involves rebuilding the survivors’ assumptive worlds.

Ullman (1997) sought to build on Silver et al.’s (1983) work by examining both the search for meaning and world assumptions in relation to CSA. This study aimed to evaluate how CSA and attributions of blame related to measures of recovery from, and cognitive adaptation to trauma. A convenience sample of CSA survivors from the community were recruited and assessed using Silver et al.’s (1983) items reflecting the search for meaning and the World Assumptions Scale (Janoff-Bulman, 1989). It was found attributions of blame were related to assumptions about the self and the world, but were not related to self-rated recovery. Self-blame was related to less searching for meaning in one’s victimization and greater meaningfulness of the world, but unrelated to other measures of adjustment.

Ullman (1997) suggested although blaming oneself may be harmful for adjustment, it may remove the need to find meaning in one’s experience. This is because determining the explanation for the assault as being intrinsic to one’s character or behaviour, eliminates any further need to search for meaning in the experience, or to question the meaningfulness of the world. On the other hand, external attributions of blame were related to perceiving the world as less benevolent and perceiving oneself as less worthy, consistent with research on the maladaptiveness of blaming others (Tennen, & Affleck, 1990).
Ullman’s (1997) finding that women who were still searching for meaning in their victimization reported poorer recovery, is consistent with the results of Silver et al. (1983). Silver et al.’s research suggested finding such meaning is essential for successful healing from sexual abuse trauma. Ullman’s additional finding that self-blaming attributions were related to a poorer prognosis for women sexually victimized as children and adults, compared to those assaulted in adulthood only, suggests such attributions may be more harmful for CSA survivors. This finding raised concern as Gold’s (1986) research had indicated CSA survivors were more likely to make self-blaming attributions than nonvictimized controls. Thus, low self-worth associated with blaming oneself may develop at an earlier age in CSA survivors, and these self-blame attributions may be more difficult to change than for women who have been assaulted in adulthood, who may more readily accept that an assault was not their fault (Ullman, 1997). Furthermore, those women who were sexually revictimized in adulthood reported more psychological symptoms in response to assault, and were more likely to make external attributions of blame, than women abused in adulthood only. In addition, women who were sexually revictimized in adulthood with high self-blame also had poorer self-rated recovery, than women who were sexually assaulted in adulthood only. Thus, it would seem that negative, self-blaming attributions formed as a result of CSA were simply reinforced by revictimization in adulthood.

Lev-Wiesel (2000) also sought to extend evaluation of attributions regarding CSA, through examination of their relationship to survivors’ quality of life. Accordingly, a clinical sample (n = 37) of female paternal incest survivors in Israel, were interviewed regarding their past and current life. Survivors were asked about their parents’ abusive behaviour in terms of “…the father who was the abuser and the mother who sometimes was perceived as the father’s accomplice” (p.5). Qualitative data from the interviews suggested three types of explanation for the offenders’ abusive behaviour: characteristics of the offender-parent (incestuous father) (21.6%), characteristics of the victim (18.9%), and circumstantial conditions (24.3%). Of the total group, 35.2% of women attributed blame for the abuse to both themselves and the abuser’s personality, or the circumstances. Those women who attributed blame for the abuse to the offender’s characteristics retained their self-esteem and had a
higher quality of life (family/professional/social), than survivors who blamed themselves or situational factors. None of those who attributed blame for the abuse to their own personality reported a high or moderate level of satisfaction in their family life. In contrast, 30.7% of the women who attributed blame for the abuse to combined explanations reported being moderately or highly satisfied in their family life.

**Overall Summary**

In summary, research consistently supports the view that CSA survivors who hold internal, stable and global attributions regarding their abuse experience are the ones who will demonstrate greater psychological distress and lower self-esteem. The exception was Mandoki and Burkhart’s (1989) findings, which suggested the social context may play a more important role than personality characteristics in sexual revictimization. Attributions of blame for the abusive experience appear to change over time, with greater self-blame occurring in children and decreasing as the survivors progress into adulthood. In addition, this change in blame appears related to the abuse characteristics of age at first abuse, coitus and race. As long as the search for meaning in the abusive experience was somewhat successful, it appeared to result in improved psychological and social functioning. However, the opposite was true if this search for meaning did not improve understanding over a prolonged period.

There appears to be support for the proposal that a healthy resolution of the attributional dilemma involves the lowest degree of blame directed towards the self/other/world and this is related to higher quality of life. A model of reciprocal interaction between the individual’s schemas, the behaviour resulting from these cognitions and life experiences, reflected how dysfunctional core beliefs can be confirmed as self-fulfilling prophecies.
Locus of Control

Given the importance of attributional style in determining the ability of CSA survivors to achieve better psychosocial adjustment following their abuse, it would seem that locus of control may be similarly important. Locus of control is broadly defined as a generalized expectancy of reinforcement, which is most active in situations that are novel or ambiguous (Rotter, 1966). This generalized expectancy develops a control orientation that becomes a relatively stable characteristic of the individual. Although locus of control can be situation-specific, it is generally perceived as a personality variable (Carlisle–Frank, 1991). Individual differences occur to the degree that a person attributes event outcomes either to her/his own relatively permanent, internal characteristics versus attributing outcomes to external factors including luck, fate, chance, or powerful others. An external locus of control, rather than an internal locus of control, has been linked to a range of psychological difficulties and poorer efficacy of treatment (Porter, & Long, 1999).

In general, studies of the relationship between locus of control and later adjustment of CSA survivors have used college student samples and the Rotter Internal-External Locus of Control Scale (I-E Scale or LOC; Rotter, 1966) as the standardized measure (Gold, 1986; Jackson et al., 1990; Porter, & Long, 1999). In the following sections, the relationship between locus of control and the impact of CSA on later psychological functioning will be discussed in terms of research employing community and college participants.

Community Studies

Gold (1986) investigated the relationship between CSA and later adult functioning using a mixed community and clinical sample of CSA survivors (n = 103), who were compared with a nonabused control group (n = 88). Locus of control was measured using the I-E Scale and the CSA survivors were found to be more likely to attribute good events to external factors. Thus, survivors demonstrated an external locus of control orientation, which has been associated with greater psychological difficulties.
Valentine and Feinauer (1993) recruited a community sample of 22 female CSA survivors to participate in a study on the effects of CSA. All of the survivors stated that they were functioning well, and this appeared to be borne out by the fact they were currently employed and/or living in the community, without needing state or welfare assistance. None of the survivors were or had been institutionalized in hospitals, prisons, or shelters for the homeless or battered. The survivors participated in an in-depth interview designed to elicit the factors they perceived as important in assisting them to survive their CSA experience. One of the prevalent resiliency themes extracted, related to an inner-directed locus of control which seemed to emanate from internal values rather than from expectations and directions of others, and was thus described as recognizing personal power.

Valentine and Feinauer (1993) observed that it appeared some survivors had recognized their personal power early in life, whereas others developed it later and were then able to achieve steps toward independence. The survivors particularly emphasized the importance of learning to be more self-directed, assume responsibility for oneself, make one’s own decisions, and look out for oneself first. This sense of control and power seemed to assist the participants to study, overcome fears and achieve other successes.

**College Student Studies**

In an early investigation into the relationship between CSA and later psychological and sexual adjustment, Fromuth (1986) used a college sample of 383 females. One measure of psychological adjustment included was the Locus of Control Scale developed by Coleman et al. (1966). No differences in locus of control were found between survivors of CSA and those without an abuse history. However, a very broad definition of sexual abuse was used in this study and there was no attempt to categorize survivors on the basis of abuse severity. In addition, the particular locus of control scale used was a very brief measure with quite a limited level of standardization.
In a comparison of young women at college who had a history of intrafamilial CSA (n = 22) with those who did not have a CSA history (n = 18), Jackson et al. (1990) used the Rotter Internal - External Locus of Control Scale (I-E Scale; Rotter, 1966). It was expected CSA survivors would perceive themselves as having little control over other people and events. However, this was not the case, the results did not suggest this group had a greater external locus of control. The researchers did not offer any explanation for this finding, which contradicted their other findings that survivors experienced greater adjustment difficulties than their nonabused counterparts (Jackson et al., 1990).

Porter and Long (1999) made a more sophisticated attempt to examine whether locus of control was a factor that might explain the relationship between the experience of CSA and later psychological adjustment difficulties. They used a sample of college students (n = 369), which included CSA survivors (n = 84) and those who had not experienced CSA (n = 285). Locus of control was measured using the I-E Scale (Rotter, 1966). CSA was clearly defined and the severity of the abuse was taken into consideration. Consistent with the other findings, Porter and Long (1999) failed to detect differences between the locus of control of CSA survivors and those without a CSA history. Furthermore, no relationship was found between a survivor’s perception of control over the abuse experience and her later locus of control. However, the results demonstrated locus of control and abuse status interacted in predicting the survivor’s symptom severity and psychological problems including depression, anxiety and hostility. Porter and Long found those survivors with a severe abuse history and an internal locus of control reported relatively lower distress levels. In contrast, survivors with a severe abuse history and an external locus of control, reported extremely elevated distress levels, which were greater than in any other group of survivors. Thus, it was suggested locus of control may play a buffering role, protecting survivors of severe abuse from psychological maladjustment. Survivors who maintained an internal locus of control, despite severe abuse, experienced limited difficulties in adulthood compared to those who believed they were not in control of their lives or environments (external locus).
Porter and Long’s (1999) research revealed the complexity of the relationship between locus of control and abuse severity. On the surface, survivors of less severe abuse were found to be less distressed than those survivors with a more severe abuse history, and no different from those lacking an abuse history. Those survivors with less severe abuse, regardless of locus of control, were less distressed than survivors with more severe abuse and an external locus of control. However, survivors of less severe abuse with an internal locus of control demonstrated similar functioning to survivors of more severe abuse who also had an internal locus of control.

Porter and Long (1999) found a similarly complex relationship when considering the findings of survivors of less severe abuse compared to those without an abuse history. Survivors of less severe abuse with an external locus of control reported poorer functioning than nonvictims with an internal locus of control. Nonvictims with an external locus of control and survivors of less severe abuse with an internal locus of control did not differ in terms of psychological adjustment. Similarly, survivors of less severe abuse with an external locus of control did not demonstrate differences in psychological distress compared to nonvictims (regardless of their locus of control). Overall, these findings suggested survivors of less severe abuse may be more similar to those without an abuse history, than those with a more severe abuse history. Only survivors of less severe abuse who had an external locus of control reported similar levels of distress to survivors of more severe abuse. Thus, it would appear that whether the survivor perceives the abuse as outside their control is as important a factor to take into consideration of their emotional distress, as the actual severity of the abuse itself.

**Summary**

Studies employing college samples have generally failed to detect a relationship between an external locus of control and a history of CSA. Despite a similar finding, Porter and Long (1999) sought to explore this relationship more fully and found locus of control and abuse severity interacted in predicting the survivors’ symptom severity. This was despite their additional finding that a survivor’s perception of control over the abuse experience was not related to her later locus of
control. These findings raise questions about the timing of formation of locus of control in the individual’s development and its relationship to abuse severity, which will require further research for clarification. Potentially, the unidimensional nature of the Rotter Locus of Control Scale may have been unable to evaluate the complex nature of the relationship between locus of control and the experience of CSA. Valentine and Feinauer’s (1993) study explores a number of themes underlying locus of control and recognition of personal power of survivors, which may offer a more effective way of conceptualizing the relationship between these factors.

**Coping Strategies**

Draucker (1996) defined successful coping in incest survivors as having been able to find meaning in the incest experience, development of a belief in one’s ability to avoid further sexual assault and comparing oneself favourably with other women who had similar abuse experiences. Furthermore, Draucker (1996) found successful coping was associated with higher self-esteem, better social adjustment, and less depression than unsuccessful coping. A coping scale for rape survivors developed by Burt and Katz (1987, as described in Gold, Milan, Mayall, & Johnson, 1994, the original Burt & Katz article was not published.) was adapted by Gold et al. (1994) for measurement of reactions to CSA. Results from the use of this scale demonstrated expressive coping, such as talking the issue over with friends or family, was associated with a better recovery. In contrast, nonexpressive coping (avoidance or self-destructive thoughts) was associated with greater dissociation, anxiety, and depression (Gold et al., 1994).

Leitenberg et al. (1992) used a random community sample of CSA survivors (n = 54) to explore the long term coping strategies used by these women to cope with their childhood abuse. It was believed differential use of the nine coping methods may influence the psychological effects of abuse. The methods most likely to be employed were “denial” and “emotional suppression”, and the least likely to be used were “spiritual and religious support”, and “direct action related to the offender”. The participants rated the methods of “social support”, “avoidance”, “emotional suppression” and “denial” as being the most helpful strategies. In terms of abuse
characteristics, abuse of greater severity (father-daughter incest, longer duration, higher level of sexual intimacy-up to penetration, and greater force) led to a higher use of “social support”, “action related to the offender”, “spiritual comfort” and “emotional suppression” strategies. In addition, if the abuse occurred at a younger age, the coping strategy of “denial” was used more often, than if the victim was older.

Leitenberg et al.’s (1992) comparison of the use of particular coping strategies and current psychological adjustment indicated higher use of “denial”, “emotional suppression”, “cognitive rumination” and “avoidance” were associated with greater psychological distress, even after controlling for abuse characteristics. None of the coping methods were significantly related to less psychological distress. Unfortunately, although participants frequently used “denial” and “avoidance” coping methods and rated them as helpful, they were actually associated with poorer adult psychological adjustment. Spaccarelli (1994) questioned these findings, as it appeared some of the coping items may have been confounded with social withdrawal or anxiety items on the outcome measure. However, it would seem quite understandable that survivors would seek to use coping methods which offer escape from the negative feelings, painful memories and lack of control inherent in the circumstances surrounding CSA. Furthermore, it may be expected those survivors experiencing the greatest distress would be the most likely to use such strategies, in order to avoid their emotional pain.

Sinclair and Gold (1997) found CSA survivors also used another method of avoidant or nonexpressive coping, by not disclosing to others. Withholding of disclosure, even when the survivor wanted to tell, was associated with more trauma symptoms. In addition, withholding of disclosure was associated with more severe CSA.

In a sample of nonclinical, college CSA survivors (n = 180), Himeline and McElrath (1996) investigated the relationship between self-enhancing cognitive distortions of reality (positive illusions), psychological adjustment (affective well-being, life satisfaction, and the absence of psychological distress) and CSA history (n = 45). Positive illusions were made up of the two components of internal control
believing in one’s personal ability to control future events), and unrealistic optimism (believing future events will be more positive than negative). It was found CSA survivors and nonvictimized women were equally likely to adopt cognitive styles characterized by positive illusions, which proved to be highly adaptive in terms of better psychological adjustment.

In a second, qualitative study by Himelein and McElrath (1996), 20 of the CSA survivors were interviewed and subsequently divided into a high adjustment group (n = 13) and a low adjustment group (n = 7), based on their adjustment index scores. In terms of process comparisons, the high adjustment group provided a greater quantity of information, both about their CSA experiences and their attempts to cope with this, than did the low adjustment group. The interviewers also observed the high adjustment group seemed more comfortable and confident when discussing their CSA history, compared to the low adjustment group. In terms of strategies that helped them deal with their CSA history, 57% of the low adjustment group felt they had not yet dealt with the CSA, compared to only 15% of the high adjustment group.

A content analysis by Himelein and McElrath (1996) of the coping processes used by the survivors with high adjustment, revealed the four main methods as: disclosure and discussion of CSA, minimizing the impact of CSA, positive reframing and refusing to dwell on the experience. These findings are consistent with those of previous researchers, who described the benefits of expressive coping rather than avoidant coping methods (Draucker, 1996; Gold et al., 1999; Leitenberg et al., 1992; Sinclair, & Gold, 1997). It would seem successful resolution of CSA involves a component of cognitively confronting and reflecting on the abuse experience. Those survivors who attempted to suppress memories of CSA, without having ever thought through the experience, tended to find their healing was incomplete. In comparison, the well-adjusted group seemed to indicate the “working through” process did not require formal therapy, though the presence of a supportive other was important.

Hiebert-Murphy (1998) examined the relationship between having their own history of contact CSA (n = 75) versus no CSA history (n = 27), and coping strategies used by mothers whose children disclosed sexual abuse (n = 102). It was found the
level of emotional distress following the child’s disclosure was related to a history of maternal child/adolescent sexual abuse and a higher frequency of avoidance coping strategies. The use of such coping strategies was found to predict levels of maternal distress even after controlling for maternal CSA history and social support. Consistent with the findings of Himelein and McElrath (1996), Hiebert-Murphy found survivors who used active behavioural and/or cognitive coping strategies to deal with the situation experienced less emotional distress, than survivors who used more avoidance strategies.

Hiebert-Murphy (1998) argued her findings provided support for a resources model of coping, whereby coping is a mechanism by which social resources relate to functioning. In these circumstances, coping contributed to the prediction of emotional distress, after controlling for both maternal history of sexual abuse (a stressor) and social support (a social resource).

Summary

In summary, although there would seem to be a natural tendency for CSA survivors to use avoidant coping strategies (including nondisclosure) to escape painful feelings, those methods have been found to be associated with greater psychological distress. Positive illusions were found to be highly adaptive, regardless of whether or not the individual had experienced CSA. Expressive coping methods relating to the CSA, such as disclosure and discussion, minimization of impact, positive reframing and a refusal to dwell on the issue were related to survivors having the highest adjustment. Thus, successful resolution of CSA seems to require a cognitive confrontation and reflection on the experience. Survivors who seek to simply suppress the memories tend to be unable to recover as fully.

Family Support and Social Support

In their review of the CSA literature, Kendall-Tackett et al. (1993) found family support was an important variable in the recovery of abused children. Maternal support, as shown by belief in the child and acting protectively towards him or her, was found to assist the child to recover more rapidly. The least symptomatic
children had the most assertive mothers. Although parent-child relationships are likely to be very important to younger children, support from peers and current ways of coping may become increasingly significant for adjustment in adulthood. Social support and coping appear to have an interactive effect on adjustment and well-being (Heller, Swindle, & Dusenbury, 1986). This is to be expected, as the effective use of a social support system can also be viewed as a coping strategy. In addition, given that many measures of coping include social support aspects such as sharing feelings with friends, or discussing problems with others, there is potentially some conceptual overlap between the two constructs. This may partially account for similarities in their functions (Runtz, & Schallow. 1997).

This section will consider a number of studies, using both community and clinical samples, which have examined the role of social and family support in the later adjustment of women who have experienced CSA.

**Community Studies**

From a large, random community sample, 248 women were interviewed by Wyatt and Mickey (1987) regarding their history of CSA. Subsequently 61 women were found to have a history of contact CSA only (those who had experienced noncontact abuse only or both noncontact and contact abuse were excluded). The survivors were asked to rate support by parents and others as either: support, mixed (support and nonsupport), nonsupport or told no-one. The effect of abuse was defined as “attitudes towards men”, with the intervening variable being “level of support” by parents and others. Survivors’ attitudes towards men were not related to severity of the abuse experience, if nonabusing parents and others supported the survivors upon disclosure of the incidents. These findings suggested the harmful effects of abuse may be mediated by the support of nonabusing parents and others. However, these findings should be considered with caution, as it would seem crucial to conduct further research using a more comprehensive measure of abuse effects than simply the survivors’ attitudes towards men, which could potentially be influenced by a wide range of other issues.
Bagley and Ramsay (1986) also used a random community sample of 377 women to assess psychosocial outcomes of CSA (n = 82). Memories of parental rearing behaviour were measured, and recollection of parental punitiveness, coldness, and control without support was the factor found to be most strongly linked to a history of CSA. Furthermore, within the CSA survivors group, parental separation, and parental coldness and lack of support were found to be independent predictors of mental health outcome, even when sexual abuse variables were controlled. Thus, the researchers concluded although CSA occurs more frequently in homes disrupted by separation from either or both parents, and notable for parental coldness or lack of support, CSA is not a direct function of the family variables. This was also true for intrafamilial abuse to a lesser extent, as children from families demonstrating coldness and lack of support and separation from a parent, reported sexual abuse by immediate or extended family members or family friends in 49% of cases.

In a complex study of perceived parental warmth as a mediator of the long-term impacts of CSA, Wind and Silvern (1994) utilized a community sample of women working at a university (n = 259). The sample was classified into those without a childhood abuse history (n = 137), nonincestuous (extrafamilial) sexual abuse (n = 56), parental (intrafamilial) incest (n = 17) and parental (intrafamilial) physical abuse (n = 24). Perceived parental emotional support and acceptance was assessed using in terms of parenting styles. Parental support was rated as significantly higher among the nonabused women, than by those who had experienced intrafamilial abuse (sexual or physical). In addition, extrafamilial abuse was not related to unfavourable ratings of either parent when compared to the nonabused group. Unsupportive parenting was found to mediate the relationship of childhood abuse (sexual and physical) to adult depression and low self-esteem. The findings of increased depression and low self-esteem among survivors compared to nonvictims was statistically dependent upon the survivor’s perceptions of low parental support and acceptance. Parental support was not found to mediate the relationship between abuse and trauma symptoms, but was found to be directly associated with PTSD symptoms. Wind and Silvern (1994) proposed the findings indicated parenting and abuse constitute two independent contributions to variations in PTSD symptomatology. It was suggested this relationship may be a product of
parental support being linked to the more general items on the TSC (Trauma Symptom Checklist) such as sleep disturbance and depressed mood, rather than more PTSD specific items such as dissociation and flashbacks.

Wind and Silvern (1994) acknowledged it is not possible to verify the accuracy of retrospective reports of parenting. However, it is proposed the experience of parental warmth, support and acceptance is more important than specific parenting acts. The perception of such an environment is essential, regardless of the actual parenting behaviour. Furthermore, the way respondents rated their experiences reflected a wide variability, both within survivor and nonvictim groups, refuting the presence of a response bias. Finally, the finding that extrafamilial abuse survivors did not rate their parents differently from nonabused women indicates the abuse itself did not result in a pervasive negative view of childhood or parents.

McMillen and Zuravin (1998) assessed whether social support from family and friends was related to perceived attribution change in a community sample of CSA survivors who did/did not have a maltreated child (n = 93/n = 61). Perceived support from family and friends was assessed using the Provisions of Social Relations Scale (PSR; Turner, Frankel, & Levin, 1983). Survivors with higher perceived support from family and friends had greater decreases in self-blame and greater decreases in family blame, as retrospectively reported for childhood compared to adulthood. Abuse specific support from others was assessed by asking survivors who had told their mothers of the abuse (n = 64), to rate how helpful their mothers were on a 7-point scale from “made things a lot worse” to “helped a lot” (p.6). For those individuals who told their mothers, the more abuse specific support they received from their mothers, the more family blame reportedly decreased. Neither of the support measures were related to perceived changes in perpetrator blame. The researchers concluded the presence of support may result in decreases in self-blame due to either the supportive others directly discouraging self-blame, or because those with supportive relationships may convince themselves they are good people and not deserving of bad things happening to them. Given general perceived support was related to reports of self-blame change, but abuse specific support from mothers was
not, weight is added to the proposal that supportive relationships reaffirm the survivors’ self-worth. Similarly, an apparent relationship between support and family blame change makes sense, for survivors would find it hard to continue blaming family members for the abuse, if these same family members were supportive following disclosure.

**Clinical Studies**

A mixed clinical and community sample was used by Gold (1986) to evaluate the influence of social support on the later adjustment of women who were CSA survivors (n = 103), compared to a control group (n = 88). Social support was measured using two dimensions of the Social Relationship Scale (SRS; McFarlane, Neale, Norman, Roy, & Streiner, 1981). Two aspects of social support were found to be related to the survivors’ adult functioning, specifically in terms of their sexual functioning. Those women who reported good quality adult relationships (helpful and reciprocal) also tended to report satisfactory sexual relationships. Consequently, Gold (1986) proposed the quality of the support reported by these survivors might reflect their ability to have close relationships with others, including sexual relationships. Girls who were close to mothers who had been abused themselves, and therefore had difficulties with sexual functioning and mothering skills, may have been at increased risk. These mothers may have had difficulty in both allowing their daughters to separate from them, and providing an appropriate role model for positive sexual functioning.

Lalor (1994) used a clinical sample of CSA survivors (n = 36) to evaluate the role of maternal social support at the time of and after disclosure. Social support was measured using three items reflecting belief, blame and willingness to discuss (the abuse). It was found 29 of the survivors had disclosed to their mothers, and low social support from the mother was related to a self-blaming attributional style. Unfortunately, the proportion of mothers who consistently supported their daughters (ie, believed, did not blame, were willing to discuss), during and after disclosure was only 10%. Although the proportion of mothers who believed their daughters at disclosure was 62%, this reduced to 31% of mothers who were non-blaming and only
10% of mothers were willing to discuss the abuse. However, Janoff-Bulman and Frieze (1983) indicated availability to listen, to enable the survivor to express a range of emotions is crucial to support, and such support may be needed for months or even years after a trauma. Thus it seems simple verbal expression of belief is insufficient and maternal behaviour which indicates a non-blaming attitude and a willingness to be available for discussion is what is required to ensure the survivor is less likely to make negative self-attributions. Lalor (1994) argued the mother as gender role model may also contribute to the association between a lack of maternal support and a negative attributional style in the survivor. Given a daughter is likely to identify with her mother, if the daughter is denied positive support, she is likely to adopt her mother’s negative appraisal.

Lalor (1994) found a relationship between maternal support and the abuse characteristics of number of perpetrators, duration of abuse and age at cessation of abuse. It was found 90% of mothers were considered to be non-supportive, with 76% classified as ambivalent and 24% as consistently negative. In terms of the latter group, the abuse involved multiple perpetrators and 93% of these cases involved family members. Lalor (1994) proposed this lack of maternal support may be an indication of role conflict, with the mother unable to adequately support her daughter due to divided loyalties when the perpetrator was a family member. Lalor (1994) suggested these findings support the notion that multiple perpetrators and abuse over an extended duration may be difficult for mothers to understand and accept. This is because such scenarios challenge the mothers’ beliefs about their awareness of the situation and their ability to protect their child (Sirles, & Franke, 1989). In addition, the finding that the older the child was at the cessation of abuse, the less likely the mother was to support her daughter, was thought by Lalor (1994) to be due to belief an older child possesses sufficient sexual knowledge to falsify a report. In contrast, younger children were generally assumed not to have the knowledge or ability to describe sexual experiences without actually experiencing them according to Sirles and Franke.

Unexpectedly, Lalor (1994) found maternal support was not related to self-esteem in the survivor. However, the trend was in the expected direction, despite not
reaching statistical significance. The findings suggested degree of maternal blame of the daughter was closely linked to the daughter’s level of self-esteem. Lalor sought to investigate the reasons underlying a lack of maternal disclosure by seven of the women. Although these individuals were concerned about fears of rejection and abandonment, they were more worried about their mother’s emotional welfare. Lalor suggested such beliefs may reflect a role reversal between mother and daughter, which Sirles and Franke (1989) had observed in sexually abusive families.

Lalor (1994) proposed a lack of maternal support may also be a reflection of intergenerational sexual abuse, with the mother having also experienced CSA. Hiebert-Murphy (1998) sought to assess this proposition, using a clinical sample of mothers (n = 102) whose children had disclosed sexual abuse. Of this sample, 75 mothers (74%) reported a history of contact CSA, with 22 (22%) experiencing contact sexual abuse during childhood only, 22 (22%) experiencing sexual abuse during adolescence only and 31(30%) experiencing contact sexual abuse during both childhood and adolescence. Lack of support from friends and family predicted emotional distress in mothers whose children had disclosed sexual abuse. A lack of support from friends accounted for 7% of the variability of emotional distress, and a lack of support from family accounted for 4% of the variability. Both variables combined contributed a further 2.2% in shared variability, with a total of 13.2% (adjusted) of the variability in emotional distress being accounted for. A further analysis indicated social support added to the prediction of emotional distress after accounting for a maternal history of CSA.

Hiebert-Murphy (1998) advocated a number of theories to explain why a maternal CSA history may make it more difficult for a woman to deal with a sexual abuse disclosure by her child. One theory was the mother’s memories of abuse may be triggered by her child’s abuse (Courtois, & Sprei, 1988), leading her to re-experience her own abuse. Alternatively, the greater distress exhibited by mothers with a history of CSA may reflect the long-term effects of their own abuse. Thus, the differences between mothers with/without a history of CSA may have predated their child’s disclosure of abuse and may not be related to it (Hiebert-Murphy, 1998). Hiebert-Murphy’s (1998) findings are consistent with those of Manion et al. (1996)
who found social support was related to emotional distress among mothers following their children’s disclosures of sexual abuse. Hiebert-Murphy (1998) suggested those women who have a strong support network may be better able to deal with the stress resulting from a sexual abuse disclosure. On the other hand, women who are less distressed may be better able to maintain or develop satisfying relationships and so perceive their social networks as more supportive.

In order to assess which forms of social support mediate the relationship between CSA and psychological adjustment, Hyman, Gold and Cott (2003) evaluated a group of CSA survivors (n = 172) seeking outpatient psychotherapy at a community centre. Social support was assessed in terms of four separate functions defined as “tangible”, “appraisal”, “self-esteem”, and “belonging”. “Tangible” referred to the perceived availability of material aid, whilst “appraisal” assessed the perceived availability of someone to talk to about one’s problems. “Self-esteem” measured the perceived availability of a positive image when comparing oneself to others, and “belonging” was defined as the perceived availability of companions that one can enjoy activities with. As predicted, self-esteem support was found to be the perceived support type most strongly related to reduced psychological adjustment difficulties, although appraisal support was also found to be a significant factor. Thus, CSA survivors who perceived themselves to be valued and who felt they had the ability to access support in coping with problems were the least likely to demonstrate psychological difficulties. In considering these findings, however, it should be kept in mind that a nonabused control group was not used and therefore it cannot be ascertained whether the perceived importance of such forms of social support may be applicable to psychotherapy patients in general.

**Summary**

In summary, it has been consistently found that a high level of social support, and particularly maternal support, is crucial in recovery of survivors of CSA. This remains the case, regardless of the severity of the abuse experience, and is accompanied by proportional decreases in family and self-blame attributions. Parental support during childhood was consistently rated more negatively by those
who had experienced intrafamilial sexual abuse, compared to those who had experienced extrafamilial abuse. However, parental separation and a lack of support were independent predictors of mental health outcome, even when sexual abuse variables were controlled for. A lack of parental support was associated with increased depression and low self-esteem, and similar general symptoms associated with PTSD, but not trauma symptoms specific to PTSD. The difference in findings would seem to be dependent upon the measure of mental health used, with parental support being associated with more general difficulties rather than specific trauma symptoms.

Those CSA survivors who reported good quality adult relationships, also tended to report satisfactory sexual relationships. In addition, a lack of social support from friends and family was a predictor of greater emotional distress in mothers with a CSA history, whose children disclosed sexual abuse. Thus, it was proposed mothers with a CSA history may have been able to deal with stress more effectively if they had a strong support network. Alternatively, those who were less distressed may be more capable of building satisfying relationships and so perceiving their social networks as more supportive. Future research utilizing prospective designs and addressing the perceptions of survivors regarding the forms of social support available to them may assist in addressing these issues.

The proposition that mothers who had experienced CSA would have greater difficulty in providing support to their daughters was borne out by Hiebert-Murphy’s (1998) findings. It would appear there are a number of complex reasons which may help to explain this phenomenon. Such mothers may have their own memories of abuse triggered by the disclosure or there may be continuing long-term effects of their own abuse on their psychosocial adjustment. Potentially, daughters who identified with their mothers would have difficulty separating from them and receiving appropriate role modelling, both in terms of mothering and sexual functioning and would be more likely to develop negative self-attributions.
Resilience

To understand more fully the determinants of the long-term adjustment of those who have suffered CSA, consideration should be given to the concept of resilience. This involves an evaluation of the characteristics of survivors of sexual abuse who do not experience the same high level of symptomatology (Conte, 1985). It is important to learn more about individuals who have apparently coped successfully with sexual abuse, to determine what they did or did not do, which enabled them to recover or adjust more effectively than other survivors (Feinauer, & Stuart, 1996). Summit (1983) believed for incest survivors, “The healthy, normal, emotionally resilient child will learn to accommodate to the reality of continuing sexual abuse…Much of what is eventually labelled as adolescent or adult psychopathology can be traced to the natural reactions of a healthy child to a profoundly unnatural and unhealthy parental environment” (p.184).

The two major factors which have been thought to determine resilience are abuse severity and how the child made sense of, or attributed meaning to her experiences, which affected how the experiences were dealt with over time (Conte, 1985; Finkelhor, & Browne, 1985; Newberger, & De Vos, 1988; Roth, & Newman, 1991). Following a traumatic experience, many survivors will ask “Why me?”. The attributions of responsibility they make may determine the progress of their recovery. Conte (1985) disputed the conventional wisdom that survivors who demonstrate internal attributions or blame themselves will have more serious problems than those who make external attributions, blaming others or nature. At the time there were no empirical data to support this concept.

Thus, Conte (1985) proposed it is important for survivors to have some sense of control over an otherwise uncontrollable situation. By placing the total blame on an external source, any sense of personal efficacy the victim may have had is removed. This proposal is consistent with Finkelhor and Browne’s (1985) traumagenic dynamics model, which suggested powerlessness, learned helplessness, and sense of entrapment impedes recovery, whereas increased feelings of control improve recovery. Thus, when the survivor feels increased levels of power and
control over recovery, negative effects are reduced. Lamb (1986) argued the potential therapeutic impact of telling a sexually abused child it was not their fault may be quite harmful. This is because although such a position does not relieve the perpetrator of responsibility, by relieving the child of any responsibility and control over their situation, a victim status is conferred upon the child. Such a status reduces feelings of power, which are important to recovery, and undermines the child’s belief in their ability to effect their own life, protect themselves or change their world.

In an exploratory study of factors associated with healthy adjustment in CSA survivors, Valentine and Feinauer (1993) interviewed 22 survivors from a self-selected community sample of 75 survivors. This subgroup believed they had survived the experience and were functioning well, which was borne out by their claims of healthy personalities, stable careers and strong interpersonal relationships. Resiliency themes which emerged from the interviews were classified as: the ability to find emotional support outside the family, self-regard or the ability to think well of oneself, religion or spirituality, external attributions of blame and cognitive style, and an inner locus of control which resulted from internal values rather than the expectations and directions of others.

Valentine and Feinauer (1993) observed resilient survivors seemed to have qualities which enabled them to elicit positive responses from others. In general, the women indicated they could find a strong support system outside the family, and had at least one caregiving adult with whom they could establish a close bond. School and college were vital in providing a refuge from a painful environment, and involvement in school activities and competency in schoolwork provided an important source of self-esteem. Similarly, church groups provided opportunities for friendship, role models, mentors and confidants. Support networks assisted in developing meaning in survivors’ lives and a belief they could control their own fate. Active participation in a church group often marked a critical turning point in their lives and influenced their self-perceptions of being worthy and valuable individuals.

Valentine and Feinauer (1993) reported resilient survivors were able to both form a good marriage or to remove themselves from a bad marriage. They were also
able to keep their distance from noxious family situations and substitute healthier social interactions. Resilient survivors were capable of reframing their situations and rather than viewing their abuse experience as an insurmountable obstacle, they could see it as a challenge and develop skills for their own survival. The resilient survivors also believed their situation would get better. In addition, these survivors did not see themselves as responsible for their abuse and over time were able to see that they were survivors. However, they did not perceive themselves as powerless survivors, many had a “gut” belief in themselves as being valuable, having a sense of purpose and being able to set goals which would help them achieve happiness. This was consistent with Cohler’s (1987) proposal that stressful childhood experiences may not inevitably lead to an abnormal outcome, if the child can develop a sense of purpose and a satisfying life task which matches their nature.

In a further study, Feinauer and Stuart (1996) sought to investigate the nature of causal attributions of CSA and how this related to the recovery process of survivors. Blaming self, fate or both self and fate for the CSA was quite debilitating, with these individuals experiencing more symptoms of distress than those who blamed the perpetrator. Thus, it seemed internal attributions were not necessarily more empowering than external attributions. The greatest difficulties were reported by those survivors who blamed themselves and fate or bad luck. This suggested these individuals were potentially still confused about the abuse experience and had not been able to make sense of it. Instead, blaming the perpetrator appeared to be the attribution which most enabled survivors to find a way of making sense of their abuse experience. However, it was noted survivors were not asked specifically whether they blamed the perpetrator, this was simply assumed. This assumption ignores the possibility survivors did not blame anything, but had managed to make sense of their abuse and so had an improved recovery. It was proposed the vital element is blame for the event being placed outside the self and separated from responsibility for recovery, which needs to be within the control of the survivor.
Summary

In summary, the two major factors which would seem to underlie resilience in CSA survivors are sexual abuse severity and attributional style of the survivor. However, further studies of resiliency in this survivor group need to focus on more specific measures of cognitive coping styles, the precise nature of the attribution of blame, locus of control, self-perceptions and the presence of a social support network.

Perceived Benefit

Some researchers have questioned the assumption that CSA can be considered only as a negative and harmful experience. When asking women about how their incest experiences had affected their lives, Russell (1986) had expected responses describing perceived harm. Therefore, she was surprised when a number of women also described positive long-term effects as a result of the recovery process. These effects included social justice concerns, such as developing greater awareness of the problem of sexual assault or sexism in general, developing greater sympathy for sexual assault survivors, and becoming motivated to take action against sexual assault. On a more personal level, the women described getting their lives in order, taking better care of themselves, feeling like a stronger person, improving their relations with men by seeking more equal relationships, and becoming more in charge of, or more independent in relationships (Russell, 1986).

Brunngraber (1986) argued his study was the first to document positive outcomes of paternal incest in each of the eight life-spheres. It was claimed that despite their incestuous experiences, or possibly because of them, many women seemed to have gained valuable qualities of self-reliance, autonomy, independence, accountability, and sensitivity toward others. However, this study used a convenience sample of CSA survivors (n = 21) and no further information was provided about the nature and effects of these positive outcomes of paternal incest.

In an examination of incestuous experiences in homosexual populations, Simari and Baskin (1982) found 64% of their group of 29 female homosexuals reported the experience as negative. This group contained all cases of heterosexual
incest, whereas none of the females who had experienced homosexual incest reported it as negative. Thus, it was concluded women were less traumatized when both members of the incestuous dyad were female. This conclusion suggests research findings from heterosexual populations, that incest seems more traumatic for the female than for the male, may not necessarily apply to homosexual populations.

Haugaard and Emery (1989) observed in a sample of 1,089 female and male college students, three females and seven males rated both their current memory of their childhood or adolescent sexual experience, and their response at the time it occurred, as very positive. These positive responders (n = 10) differed significantly from the group of nonpositive responders (n = 91), on the three variables of pressure to participate, guilt felt then and type of impact. Thus it was concluded those people who had reported “positive” childhood or adolescent intergenerational sexual contacts appeared to have had “a different experience from the others” (p. 95).

There has recently been more systematic examination of the perceived benefit from CSA (Kilpatrick, 1986; Himelein, & McElrath, 1996; Laviola, 1992; McMillen et al., 1995; Okami, 1991). Okami (1991) studied the perceptions of participants who had experienced childhood or adolescent intergenerational sexual contact and its impact on their adult life. This exploratory, descriptive study examined “positive” feelings regarding these experiences, using a self-selected sample of CSA survivors from the community (n = 26) and a comparison group of seven survivors receiving psychotherapy. The presence of gross adult pathology in the participants was measured using the General Life Attitudes Scale (GLAS) developed by the researcher. The study included investigation of the mediating variables of gender of the older participant, age of the minor participant at the time of onset, age discrepancy between participants, intrafamilial versus extrafamilial contacts, coercion, duration or frequency of contacts, types of sexual behaviours reported, use of clinical samples in outcome studies, parental attitudes towards sexuality, familial and societal responses to disclosure and overall childhood functioning.

Okami (1991) specified that in order for an experience to be classified as positive, the participant had to report having assessed it in a positive manner, both at
the time it occurred and in retrospect. In contrast, an experience was judged as negative if the participant considered it to have been negative either at the time of its occurrence or in retrospect. It was found positive responders’ descriptions of affect included expressions of warmth, pleasure, affection, humour and lustiness. They did not label the experiences as sexual abuse and these could not be labelled as abusive in the maltreatment sense. In contrast, negative responders expressed helplessness, rage, guilt or numbness, and particularly those in the clinical sample described experiences that were clearly abusive. The experiences were often coercive, unpleasant, unwanted, frequently traumatizing, often psychologically brutal and sometimes physically brutal, and subjects tended to label their experiences as sexual abuse. Therefore, the perception of whether an experience was positive or negative (abusive) would seem to depend upon whether any type of coercion was used, and other factors.

However, Okami’s (1991) study had a number of limitations. The participants were intentionally recruited on the basis they had at least partially positive feelings regarding their early sexual experience, therefore limiting the generalizability of the findings. Positive responders appear to represent a small group in the nonclinical population of CSA survivors and Okami (1991) acknowledged this study was not attempting to realistically assess prevalence in the overall population of survivors. Okami also accepted there had not been rigorous psychometric testing of the outcome measures used, and these were reliant upon self-assessments of functioning in adulthood, rather than being standardized measures of functioning. Such measures could not evaluate if subjects had been adversely affected in some way that they did not recognize.

Okami’s (1991) finding that a difference in perception between positive and negative experiences was dependent on whether any type of coercion was employed, was supported by Laviola’s (1992) work. This study of older brother – younger sister incest used a sample of 17 survivors who participated in in-depth semi-structured interviews. Approximately half of the sisters felt both positive and negative about the sexual activity and their brothers at the time. Such mixed feelings were usually reported when the incest was maintained through coercion. In contrast, the other half
of the group of survivors felt completely negative about the sexual activity and their brothers at the time, with these negative feelings usually reported when the incest was maintained through force. None of the women were completely positive toward the activity or their brothers, and the majority of women felt completely negative about themselves in relation to the activity at the time. Laviola (1992) observed when the less invasive activity of fondling was employed, coercion (rather than force) was used to maintain it, and the sisters experienced some positive feelings towards their brothers and the activity at the time. It was proposed that the sisters’ emotional needs may have been partially met by the attention from their brothers, which led the survivors to have felt some closeness or enjoyment.

McMillen et al. (1995) attempted to comprehensively assess perception of benefit from the experience of CSA using a sample of 154 survivors. The survivors were a subset of participants in a larger case-comparison study of low-income mothers. McMillen et al. reported almost half (46.8%) of the women indicated some perceived benefit from their experience of CSA, although 88.9% of those who reported perceived benefit also reported perceptions of harm. Qualitative analyses revealed the four main categories of perceived benefit were: protecting children from abuse, self-protection, increased knowledge of CSA, and having a stronger personality.

The nature of the relationship between perception of benefit and abuse characteristics of the survivor, survivor mother’s age currently, age at first abuse, race, force, coitus, relationship to perpetrator and abuse frequency were also assessed by McMillen et al. (1995). Only the mother's age (currently) was related to the perceived benefit rating, with those who perceived some benefit being a little older than those who perceived no benefit. Furthermore, none of the abuse characteristics were related to any of the four main perceived benefit types. The degree of perceived benefit was positively associated with several indicators of adult adjustment including self-esteem, relationship anxiety and comfort with depending on others. In addition, those who perceived themselves as stronger had higher self-esteem and those who perceived increased sexual abuse knowledge viewed others more favourably and were comfortable with getting close to others, compared to other respondents.
This study by McMillen et al. (1995) limited investigation to those who had experienced unwanted sexual contact, which is in contrast to Okami’s (1991) broader definition of those who had experienced at least partially “positive” feelings in relation to childhood or adolescent intergenerational sexual contact. McMillen et al. expressed some concern regarding any influence the sensitization statement, which was used prior to the rating question, may have had on rates of reported benefit. It was concluded however, that although it may be useful to test the effect of different wording on benefit response, the evidence of perceived benefit in different samples with different biases suggested overall some women sexually abused as children perceive benefit from the experience. The finding that the perceived benefit type of being better able to protect children from CSA was not related to adult adjustment indicators, was attributed to potentially too few domains of adult adjustment being measured. However, it was also proposed future research should incorporate objective measures of self-protection and protection of children, to assess whether the perceptions of benefit actually translated into increased safety.

It is interesting that in a qualitative study of cognitive coping and illusion among CSA survivors, Himelein and McElrath (1996) found similar themes of perceived benefit emerged, when compared to those found by McMillen et al. (1995). In a subsample of 20 from a larger sample of college women (n = 180), a majority of well-adjusted women (n = 13) who were CSA survivors, described at least some positive or self-enhancing perceptions of the abuse. This was despite the fact the women were not asked directly about whether they felt CSA had had any beneficial consequences. This positive reframing was observed to take many forms, including viewing CSA as a vehicle for personal change or growth, believing they had learned from the experience, and finding meaning in adversity. The common theme among the perceptions was a sense of hope and optimism.

Himelein and McElrath (1996) described some consequences that were more specifically related to the abuse experience, such as greater caution towards men (a change viewed as an asset), engaging in more self-protective behaviours, and refusal to give in to pressures to conform. On the other hand, there were also more general
consequences, such as the strengthening of religious faith, developing clearer ideas about the nature of healthy relationships, becoming a more introspective person, and growing up more quickly than their peers. Only one woman from the low adjustment group (n = 7) provided a positive reframing of CSA, which she suggested had helped her “become stronger as a person”.

Himelein and McElrath (1996) proposed that like positive illusions, positive reframing is an indication of a self-enhancing style of thought. Furthermore, both types of illusion were associated with better psychological adjustment, and the survivors themselves provided accurate assessments of their own level of adjustment. Rather than illusion being harmful, those utilizing this strategy appeared to be thriving.

There are a number of difficulties inherent in an investigation of perception of benefit from the experience of CSA. Abramson (1990) has argued data obtained through retrospective investigation of sexual behaviour is intrinsically flawed. Factors which may influence recall include the participants’ variable memory capabilities, and willingness or motivation to disclose potentially stigmatizing information. In addition, the impact of researcher related variables such as gender interaction, demand characteristics and personality style need to be considered in assessing the reliability of the data. Linton (1982) conducted a prospective study examining the natural history of emotional memory. Over time, changes and distortions in the memory of emotions associated with an event were found, suggesting retrieval of emotional memory may not be a reliable source of data.

**Summary**

In summary, the degree of perceived benefit experienced by CSA survivors seems to be related to adult adjustment in the areas of self-esteem, relationship anxiety and comfort with depending on others. However, given the use of retrospective research methods, a direct causal association between perceived benefit and adjustment cannot be established. The generalizability of the findings to date has been quite limited, given the specific nature of the samples used and concerns about
the reliability of data obtained from the retrieval of emotional memory, considering the potential for cognitive distortion. Furthermore, the link between perception of benefit, such as improved self protection and protection of children from CSA and actual behaviour demonstrating this, has not been tested. However, the emergence of similar themes regarding perceived benefit in a range of studies suggested further exploration of these would be valuable.
HYPOTHESES

Study 1

Hypothesis 1
Women who have experienced CSA will also have experienced a range of psychosocial problems in their family-of-origin.

Hypothesis 2
That there will be a positive association between perception of benefit and current age of the CSA survivor, but there will be no association between perception of benefit type and current age, age at commencement of abuse and abuse frequency.

Hypothesis 3.1
That age of the participant at the commencement of CSA will be negatively associated with the duration of abuse and the severity of the abusive acts.

Hypothesis 3.2
That age of the participant at the commencement of CSA will be positively associated with the father figure (father/stepfather) being the perpetrator.

Hypothesis 3.3
That the duration of CSA will be positively associated with the number of perpetrators and the severity of the abusive acts involved.

Hypothesis 3.4
That the number of perpetrators of CSA will be positively associated with the severity of the acts involved in the abuse and the presence of coercion.

Hypothesis 3.5
That the severity of abusive acts involved in the CSA will be positively associated with the presence of coercion.

Hypothesis 4
That there will be an association between coping methods and current psychological adjustment in terms of the level of psychological symptoms.
**Hypothesis 5**
That there will an association between coping methods, parenting competency, and relationship satisfaction.

**Hypothesis 6**
That there will be an association between attributional style and current psychological adjustment in terms of level of psychological symptoms.

**Hypothesis 7**
That there will be an association between attributional style, parenting competence and relationship satisfaction.

**Hypothesis 8**
That there will be an association between beliefs regarding the abuse and current psychological adjustment, in terms of level of psychological symptoms.

**Hypothesis 9**
That there will be an association between beliefs regarding the abuse and parenting competence, and relationship satisfaction.

**Hypothesis 10**
That higher severity of CSA, as indicated by:
- a younger age at commencement
- longer duration
- higher number of perpetrators
- greater degree of familiarity of perpetrator (father/stepfather)
- higher degree of severity of abusive acts
- greater use of force or coercion

will be associated with poor adult adjustment in the following areas:
- current psychological adjustment – in terms of level of psychological symptoms
- negative perceptions of parenting competency
- lack of relationship satisfaction
Study 2

*Hypothesis 1.1*
That there will be a positive association between increased abuse severity and lowered self-esteem, and self-reporting of mental health issues.

*Hypothesis 1.2*
That there will be a positive association between increased abuse chronicity (duration) and sexual relationship difficulties, and difficulty with trusting others.

*Hypothesis 1.3*
That there will be a positive association between abuse perpetrated by a father figure (father/stepfather) and adult sexual adjustment difficulties.

*Hypothesis 2*
That higher severity of CSA, as indicated by:
- Increased degree of physical invasiveness
- Greater duration
- Whether the father/stepfather was the perpetrator
- Will be associated with poor adult adjustment in the following areas:
  - Lower self-esteem
  - Higher external locus of control orientation

*Hypothesis 3*
That self-esteem will be negatively associated with less adaptive features of disclosure of CSA.

*Hypothesis 4*
That locus of control and severity of sexual abuse characteristics will be positively associated with less adaptive features of disclosure of CSA.

*Hypothesis 5*
That self-esteem will be positively associated with characteristics of the search for meaning in abuse.
Hypothesis 6
That locus of control will be negatively associated with characteristics of the search for meaning in abuse.

Hypothesis 7
That severity of abuse characteristics will be positively associated with search for meaning in abuse characteristics.

Hypothesis 8
That disclosure of abuse characteristics will be negatively associated with search for meaning in abuse characteristics.

Hypothesis 9
That a perception that partners are caring will be negatively correlated with the perception that the partner is controlling.

Hypothesis 10
That perceptions of a partner as caring will be negatively associated with less adaptive features of characteristics of disclosure. Perceptions of a partner as controlling will be positively correlated with less adaptive features of characteristics of disclosure.
CHAPTER 6

Study 1: Profile Of Women Who Experienced Childhood Sexual Abuse

The aim of Study 1 was to construct a profile of a sample of Australian women who defined themselves as having experienced CSA. The four demographic variables of relationship status, number of children, age at birth of first child and average spacing between children, were investigated on the basis of research findings by Mullen et al. (1994). To enable comparison with Jehu’s (1988) data, information was gathered in relation to the family of origin of participants, including the family type, father and mother figures and the presence of particular psychosocial problems. The relationship between actual characteristics of the CSA and the women’s later psychological functioning in a range of domains was also investigated. Particular abuse characteristics were selected on the basis of the research literature indicating that these characteristics potentially have a link to adult functioning.

Jehu (1988) proposed that crucial characteristics which were associated with a CSA survivor’s later adjustment included the age of the child at the commencement of abuse, the number of occasions and duration of abuse. These characteristics provide a measure of chronicity. Jehu investigated the relationship between the offender and the CSA survivor, the types of sexual activities that occurred, and the methods of inducement used by the offender. In addition, Jehu gathered data in relation to the number of perpetrators who had sexually abused the woman when she was a child. To obtain a comprehensive picture of the nature of the CSA, all of these variables were investigated for the current participants.

A number of measures were selected to enable assessment of the participants’ psychological functioning. The Brief Symptom Inventory (BSI) (Derogatis, & Spencer, 1982) has been used by a number of researchers, including Silver et al. (1983), to evaluate the current psychological functioning of women who had experienced CSA. The Belief Inventory (Jehu, 1988) was specifically developed for use with women who
had experienced CSA, with the aim of establishing the presence of distorted beliefs in relation to self-esteem, guilt and self-blame. A measure of women’s Attributional Style in Relation to the Abuse (ASRA) was developed by Lalor (1994), to assess adult survivors’ attributional style regarding the causality and controllability of CSA. The Ways of Coping Questionnaire (WCQ) developed by Folkman and Lazarus (1988) provides an evaluation of the thoughts and actions that underlie an individual’s choice of coping method. A measure of parenting developed by Banyard (1997) allows an assessment by the individual of their own perceived parenting competency. The Kansas Marital Satisfaction Scale (KMS) developed by Schumm et al. (1986) provides a robust measure of marital satisfaction. Finally, a measure of perceived benefit from the abusive experience was utilized, based on the perceived benefit rating and interview data gathered by McMillen et al. (1995).

METHOD

Participants

A non random convenience sample of 118 adult women who had experienced sexual abuse as children participated in this research. The women were recruited through advertising at participating Centres Against Sexual Assault (CASAs) within the state of Victoria, Australia. Information posters advertising the survey were displayed in the waiting rooms of the CASAs and counselling staff were briefed on the nature of the survey and requested to facilitate the participation of any clients who were interested in doing this. Recruitment was also facilitated through a brief article about the research study in a range of small, local newspapers and a daily, metropolitan newspaper, which included an invitation to participate and a contact telephone number. The only requirement was that participants be aged over 18 years and have experienced CSA as defined by themselves. Participants ranged in age from 19 to 65 years and whilst over a third were married, more than a quarter did not have a partner. On average, participants had 2.56 children, with the most frequent age at the birth of the first child being 22 years. However, over a third of the participants had no children. For further demographic details of the sample, see Table 7.1.
Measures

A 13-page questionnaire was developed to obtain demographic information, information about the family of origin, characteristics of the abuse and to assess the participant’s current level of functioning (see Appendix A). The demographic data obtained included the age of the participant in years, her relationship status, which was to be selected from a range of four options, the gender and date of birth of her children. Participants were also asked whether their children had ever been notified to the Department of Human Services or its equivalent interstate, and if so, what type of abuse was alleged (of the four options provided), and what was their relationship to the alleged perpetrator(s). The composition of the participant’s family-of-origin and the presence of psychosocial issues within that family were also probed, based on a protocol for initial assessment interviews developed by Jehu (1988). In relation to characteristics of the CSA, the respondents were asked their age in years at the onset of the abuse, the duration of the abuse (days, months, years), the number of occasions on which the abuse occurred, and the number of perpetrators. The nature of the perpetrator’s relationship to the participant (e.g. father), the type of sexual abuse in terms of the sexual activities that occurred (e.g. manual stimulation of victim’s genitals by offender) and the methods used by the perpetrator to induce participation (e.g. bribery) were also investigated, based on a protocol for initial assessment interviews developed by Jehu.

Seven quantitative measures were also incorporated into the questionnaire: Brief Symptom Inventory (BSI) (Derogatis, & Spencer, 1982), Belief Inventory (Revised) (Jehu, 1988), Attributional Style in Relation to the Abuse (ASRA) (Lalor, 1994), Ways of Coping Questionnaire (WCQ) (Folkman, & Lazarus, 1988), perceived Parenting Competency (Banyard, 1997), Kansas Marital Satisfaction Scale (KMS) (Schumm et al., 1986) and Perceived Benefit from Child Sexual Abuse (McMillen et al., 1995). Each of these measures are described in detail below.
Brief Symptom Inventory (BSI)

The BSI was developed as a shorter form of the parent instrument, the SCL-90-R, a self-report psychological symptom inventory which had been developed and used in a range of settings (Derogatis, 1977; Derogatis, Rickels, & Rock, 1976). The BSI consists of 53 items chosen to form a brief measurement scale, which most accurately reflects the nine primary symptom dimensions of the SCL-90-R. The primary symptom dimensions, including the number of items in each, are: Somatization (seven items), Obsessive-Compulsive (six items), Interpersonal Sensitivity (four items), Depression (six items), Anxiety (six items), Hostility (five items), Phobic Anxiety (five items), Paranoid Ideation (five items), and Psychoticism (five items). There are an additional four items, which do not form a dimension and are not scored collectively. These items are included because they possess clinical significance and contribute to the global scores. In addition to the nine primary symptom dimensions, there are three global indices of distress calculated from responses to the BSI: the Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST).

Both test-retest and internal consistency reliabilities for the BSI primary symptom dimensions have been shown to be very good (Derogatis, & Meliseratos, 1983). In the current sample, Cronbach’s alpha was .94 for the total scale, with alphas ranging from .78 to .92 for the nine subscales. The BSI’s correlations with the comparable dimensions of the SCL-90-R are quite high (Derogatis, & Meliseratos, 1983). With respect to validity, high convergence between BSI scales and similar dimensions of the MMPI indicate convergent validity, and factor analytic studies of the internal structure of the scale suggest construct validity. A number of criterion-oriented validity studies have also been completed with the measure (Derogatis, & Meliseratos, 1983).

For each item on the BSI, the respondent rates the degree of distress on a five-point Likert scale from (0 - 4), ranging from ‘Not at All’ to ‘Extremely’. Symptoms are briefly described, for example “Nervousness or shakiness inside”. The instructions accompanying the inventory are brief and worded in simple language, as are the items.
themselves, to ensure even those respondents with only a basic reading knowledge are able to understand and complete the task.

Raw scores for each dimension are derived by summing the values for each item in the dimension, and then dividing this summed score by the number of items endorsed for that dimension. For example, the Somatization dimension has seven items, therefore if a participant responded to only six items, the sum should be divided by six rather than seven. By endorsing more items for the dimension, and at a higher level, the participant indicates a higher level of the symptom dimension being measured. Each of the primary symptom dimensions are described in greater detail below:

**Somatization (SOM)**

This dimension is a reflection of distress arising from perceptions of bodily dysfunction. The items focus on cardiovascular, gastrointestinal, and respiratory complaints; and other systems with strong autonomic mediation. Pain and discomfort of the gross musculature and additional somatic equivalents of anxiety are also components of somatization. Averaged scores range from 0-4, with higher scores indicating higher levels of somatization.

**Obsessive – Compulsive (O-C)**

This dimension includes symptoms often identified with the standard clinical syndrome of the same name. The measure focuses on thoughts, impulses, and actions that are experienced as unremitting and irresistible by the individual, but are of an ego-alien or unwanted nature. Behaviour and experiences of a more general cognitive performance deficit are also included in the measure. Averaged scores range from 0-4, with higher scores indicating higher levels of obsessive-compulsive symptoms.

**Interpersonal Sensitivity (I-S)**

This dimension focuses on feelings of personal inadequacy and inferiority, particularly in comparison with others. Self-deprecation, self-doubt, and marked discomfort during interpersonal interactions are characteristic of high scores on this
dimension. Averaged scores range from 0-4, with higher scores indicating higher levels of interpersonal sensitivity.

**Depression (DEP)**

The symptoms of this dimension reflect a representative range of the indications of clinical depression. Symptoms of dysphoric mood and affect are represented, as well as a lack of motivation and loss of interest in life. Averaged scores range from 0-4, with higher scores indicating higher levels of depression.

**Anxiety (ANX)**

General signs such as nervousness and tension are included in this dimension, as are panic attacks and feelings of terror. Cognitive components involving feelings of apprehension and some somatic correlates of anxiety are also included in the dimension. Averaged scores range from 0-4, with higher scores indicating higher levels of anxiety.

**Hostility (HOS)**

This dimension includes thoughts, feelings, or actions that are characteristic of the negative affect state of anger. Averaged scores range from 0-4, with higher scores indicating higher levels of hostility.

**Phobic Anxiety (PHOB)**

This dimension is defined as a persistent fear response – to a specific person, place, object, or situation – that is irrational and disproportionate to the stimulus and leads to avoidance or escape behaviour. The items focus on the more pathognomonic and disruptive manifestations of phobic behaviour. Phobic anxiety is very similar to agoraphobia or phobic anxiety depersonalization syndrome. Averaged scores range from 0-4, with higher scores indicating higher levels of phobic anxiety.

**Paranoid Ideation (PAR)**

This dimension represents paranoid behaviour fundamentally as a disordered mode of thinking. The important characteristics of projective thought, hostility, suspiciousness, grandiosity, centrality, fear of loss of autonomy, and delusions are seen
as primary aspects of this disorder. Averaged scores range from 0-4, with higher scores indicating higher levels of paranoid ideation.

**Psychoticism (PSY)**

This scale represents the construct of psychoticism, with items representative of a withdrawn, isolated, schizoid lifestyle included, in addition to primary symptoms of schizophrenia, such as thought control. The scale provides for a range from mild interpersonal alienation to dramatic psychosis. Averaged scores range from 0-4, with higher scores indicating higher levels of psychoticism.

In order to calculate the three global indices, the four additional items are totalled. Thus the three global indices comprise:

**Global Severity Index (GSI)**

This index is calculated by adding the sums of the nine symptom dimensions and the additional items and then dividing by the total number of responses (for example, divide by 53 when there are no missing items). Averaged scores range from 0-4, with higher scores indicating the presence of severe, global symptoms of distress.

**Positive Symptom Total (PST)**

This total is derived by counting up the number of items endorsed with a positive (nonzero) response. Therefore, scores range from 0-53, with a high score on this scale indicating the presence of a large number of symptoms in total.

**Positive Symptom Distress Index (PSDI)**

This index is calculated by dividing the sum of the item values by the PST. Averaged scores range from 0-4, with higher scores indicating the presence of a high level of distress through a range of symptoms.

**Belief Inventory (Revised)**

The Belief Inventory was developed in the University of Manitoba Program to measure common distorted beliefs associated with child sexual abuse (Jehu, Gazan, &
Klassen, 1985; Jehu, Klassen, & Gazan, 1986). The revised form of the inventory contains an extra nine items from categories related to self-blaming and self-denigratory beliefs, producing a 26-item scale (Jehu, 1988). Some items relate specifically to a history of CSA, for example, “I must have been responsible for the sex when I was young because it went on for so long.” The participant is asked to respond according to how strongly she believes each statement is true in her case. A five-point Likert scale is provided with responses ranging from 0 = ‘Absolutely Untrue’, to 4 = ‘Absolutely True’. Within the Belief Inventory there are four items that are of clinical significance and used in the calculation of the total score, but which do not form part of any of the three subscales.

Scores for each of the three subscales of Self-Esteem (nine items), Guilt (four items) and Self-Blaming (nine items) are calculated by recoding those responses which were endorsed ‘Partly True’ ‘Mostly True’ or ‘Absolutely True’ to the respective values of 1, 2 and 3 and then adding these scores. The highest possible score for each of the nine-item subscales of Self-Esteem and Self-Blaming is 27 and for the four-item Guilt subscale, the highest possible score is 12. The higher the score on each of these subscales, the greater the level of symptomatology. A total score on the Belief Inventory is obtained by adding the recoded scores for each item, with the possible range being 0-78.

For the current sample, an alpha coefficient of .71 for the Belief Inventory was obtained, with subscale alpha coefficients of .84 for Self-Esteem, .63 for Self-Blame, and .75 for Guilt. Jehu (1988) indicated that psychometric data were available only for the original 17-item version of the inventory and not the revised 26-item measure used in this study. The test-retest reliability for the original inventory had been gathered from the responses of 25 previously sexually abused women, over an interval of one week, during their initial assessment. A total score of 15 or above was classified as a clinically significant level of distorted beliefs on the original inventory. The Pearson correlation was .93, indicating a very high level of reliability. Peters and Range (1996) reported results of a factor analysis of the original inventory that indicated the scale primarily measured one factor defined as pervasive or characterological self-blame, and that it was internally consistent (Cronbach’s alpha = .91). The inventory has face validity and
given the claimed link between distorted beliefs and mood disturbances, it was expected to have reasonable concurrent validity with the Beck Depression Inventory (BDI). This was supported by a Pearson correlation of .55, between the BDI and the Belief Inventory for a group of 25 previously sexually abused women (Jehu).

**Attributional Style in Relation to the Abuse (ASRA)**

The ASRA is a six-item measure for assessing attributional style regarding the causality and controllability of abuse, for participants who had experienced CSA (Lalor, 1994). For the first four items relating to causality, participants were asked to select from a five-point scale ranging from ‘In no way my fault’ (1) to ‘All my fault’ (5). For example, participants were asked about their perspective at the time of the abuse, “At the time of the abuse, I felt that the abuse was”. For the final two items relating to the controllability of the abuse, respondents were asked to select from a five-point scale from ‘Controllable by you’ (1) to ‘Controllable by others’ (5) (this item needs to be reverse scored), and ‘Someone is responsible’ (1) to ‘No-one is responsible’ (5) respectively. The highest possible score on the scale was therefore 30, with a higher score indicating a self-blaming or internal attributional style.

The internal reliability coefficient (Cronbach’s alpha) was calculated for the whole scale by Lalor (1994) and found to be .76, compared to .60 in the current study.

**Ways of Coping Questionnaire (WCQ)**

The 66-item Ways of Coping Questionnaire was designed by Folkman and Lazarus (1988) using a process-oriented approach to coping, which is directed towards what an individual actually thinks and does within the context of a specific encounter, and how the thoughts and actions change as the encounter unfolds. The WCQ consists of 16 filler items and 50 items that evaluate the eight Coping subscales: Confrontive Coping, Distancing, Self-Controlling, Seeking Social Support, Accepting Responsibility, Escape-Avoidance, Planful Problem Solving, and Positive Reappraisal.

Folkman and Lazarus (1988) argued that given the variable nature of coping processes, test-retest estimates of reliability are inappropriate. Folkman and Lazarus
Folkman and Lazarus (1988) also argued that the Ways of Coping Questionnaire demonstrated construct validity, for the results from their research studies are consistent with the theoretical predictions that coping consists of both problem-focussed and emotion-focussed strategies and that coping is a process.

The response format for the Ways of Coping Questionnaire comprises a four-point Likert scale, allowing participants to indicate the frequency with which they use each strategy, with the options being ‘Does not apply or not used’ (0) to “Used a great deal” (3). The items are designed to be quite general in order to be applied to a stressful situation that the participant had experienced in the previous week. For example, “I tried to analyze the problem in order to understand it better”. High scores on a subscale indicate that the participant often used the behaviours described by that subscale, to cope with the stressful event. Coping subscales are described in greater detail below:

**Confrontive Coping (six items)**

This subscale describes aggressive efforts to alter the situation and suggests some degree of hostility and risk-taking. Scores range from 0-18, with higher scores indicating the individual often used confrontation to cope with the stressful event.

**Distancing (six items)**

This subscale describes cognitive efforts to detach oneself and to minimize the significance of the situation. Scores range from 0-18, with higher scores indicating the individual often used distancing to cope with the stressful event.
Self-Controlling (seven items)

This subscale describes efforts to regulate one’s feelings and actions. Scores range from 0-21, with higher scores indicating the individual often used self-control to cope with the stressful event.

Seeking Social Support (six items)

This subscale describes efforts to seek informational support, tangible support, and emotional support. Scores range from 0-18, with higher scores indicating the individual often sought social support to cope with the stressful event.

Accepting Responsibility (four items)

This subscale acknowledges the individual’s role in the problem, with a concomitant theme of trying to put things right. Scores range from 0-12, with higher scores indicating the individual often accepted responsibility for the stressful event, to assist in coping with it.

Escape-Avoidance (eight items)

This subscale describes wishful thinking and behavioural efforts to escape or avoid the problem. Items on this subscale contrast with those of the Distancing subscale, which suggest detachment. Scores range from 0-24, with higher scores indicating the individual often sought to escape or avoid the problem, to cope with the stressful event.

Planful Problem Solving (six items)

This subscale describes deliberate problem-focused efforts to alter the situation, combined with an analytic approach to solving the problem. Scores range from 0-18, with higher scores indicating the individual often used problem solving, to cope with the stressful event.
Positive Reappraisal (seven items)

This subscale describes efforts to create positive meaning by focusing on personal growth. It also includes a religious dimension. Scores range from 0-21, with higher scores indicating the individual often used positive reappraisal, to cope with the stressful event.

Relative scores, which describe the proportion of effort represented for each type of coping, are expressed as a percentage ranging from 0 to 100. Therefore, a high relative score on a particular Coping subscale means that the individual used those coping behaviours more often than they used other behaviours. To calculate the relative scores, the average response per subscale is calculated by dividing the total raw score by the number of items in the subscale. The average responses per subscale are then summed across all the subscales. The average score for each subscale is then divided by the sum of the averages for all 8 subscales, and this is the relative score for the subscale.

Parenting

The perceived Parenting Scale provided a measure of maternal feelings regarding parenting competency using three separate questions (Banyard, 1997). The first question asked about the frequency with which the participant worried about problems related to her children (Worry About Child). The response format consisted of a five-point Likert scale with options from ‘Never’ (1) to ‘All of the time’ (5). The mean score for the sample of 518 mothers was 4.01 (SD = 1.29), with higher scores indicating a greater degree of worry (Banyard, 1997). The second question evaluated satisfaction with self as a parent, and asked how much the participant wanted to change the kind of parent she was (Parent Self-Esteem). The response format consisted of a five-point Likert scale with options from ‘No change’ (1) to ‘A complete change’ (5). The mean for the sample of 518 mothers was 1.98 (SD = 1.19) (Banyard, 1997). The third question asked the participant about her expectations regarding future parenting, “In the next 2 years do you feel your situation as a parent will:” (Future Parenting). The response format consisted of a three-point Likert scale, with the options being: ‘Get better’ (1), ‘Stay the same’ (2), or ‘Get worse’ (3). The mean for the sample of 518 mothers was 1.23 (SD = .50) (Banyard. 1997).
Investigation by Banyard (1997) of the correlations between these measures of parenting indicated that none were highly correlated with one another (see Table 6.1), suggesting that to some extent they were assessing somewhat different constructs. Therefore, each was treated separately as an outcome variable. This was also the case with the current sample, where the correlations between items are shown in brackets in Table 6.1.

Table 6.1 Correlations Between Measures of Parenting

<table>
<thead>
<tr>
<th>Variables</th>
<th>Worry About Child</th>
<th>Parent Self-esteem</th>
<th>Future Parenting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry About Child</td>
<td>-----</td>
<td>.14** (0.18)</td>
<td>.10* (0.06)</td>
</tr>
<tr>
<td>Parent Self-esteem</td>
<td>-----</td>
<td>.09 (0.01)</td>
<td></td>
</tr>
<tr>
<td>Future Parenting</td>
<td>-----</td>
<td></td>
<td>.09 (-01)</td>
</tr>
</tbody>
</table>

*p ≤ .05, **p ≤ .01.

Kansas Marital Satisfaction Scale (KMS)

The Kansas Marital Satisfaction Scale (KMS) (Schumm et al., 1986) is a 3-item scale used as a measure of marital satisfaction. Participants were asked to select from a seven-point Likert scale whose options ranged from ‘Extremely Dissatisfied’ (1) to ‘Extremely satisfied’ (7). The items were designed to examine different facets of marital satisfaction, for example, “How satisfied are you with your relationship with your husband?” The KMS is scored by summing the individual item scores to achieve a possible range of 3 to 21, with higher scores reflecting greater satisfaction.

The KMS was normed using a group of 61 wives randomly selected from a large U.S. research project on stress and coping (Schumm et al., 1986). Item means were 6.21 (SD = .84), 6.11 (SD = .84), and 5.95 (SD = 1.04) for satisfaction with husband as a spouse, with the marriage, and with the relationship with the husband, respectively. No test-retest data were reported by Schumm et al. The KMS has excellent internal consistency, with an alpha of .93 (Schumm et al). In the current sample, the alpha coefficient was .96. The KMS has excellent concurrent validity, demonstrating significant correlations with the Dyadic Adjustment Scale and the Quality of Marriage.
Perceived Benefit from Child Sexual Abuse

The Perceived Benefit Rating (McMillen et al., 1995) was developed as a single item measure of participants’ perception of benefit following the experience of CSA. Given that this question may have been threatening to some participants, the following statement was used to precede the items: “Even though some people think that the unwanted sexual contact has had no effect or a negative effect on their lives, some people have found some ways that they feel they have benefited from the unwanted sexual contact”. Interviewees were then asked to rate how much benefit they felt they had received from the unwanted sexual contact they had experienced, using a five-point Likert scale. The rating options on the scale were ‘No benefit’ (0) to ‘A lot of benefit’ (4). For the statistical analyses, the ratings were recoded to 0 (no benefit), 1 (a little or some benefit), and 2 (quite a bit or a lot of benefit). The resulting trichotomous variable was referred to as perceived benefit rating.

McMillen et al. (1995) assessed the actual benefit type using qualitative analyses. Those participants who reported perceiving some level of benefit, were asked to describe in what ways they felt they might have benefited from the unwanted sexual contact. Their verbal answers were written down and analyzed independently by two of the researchers to assess reported benefit types. Four thematic categories were developed, based on the general themes which emerged. Kappa coefficients ranged from .68 (Increased knowledge of sexual abuse), .79 (Stronger), .89 (Self-Protection) to .91 (Protection of Children), for the main categories of benefit type.

The findings from the study by McMillen et al. (1995), informed the procedure for the present study. The participants were asked whether they perceived any benefit arising from their CSA. They were then asked about in which areas they believed they may have benefited, but rather than this being an open-ended question, the participants were provided with the four main thematic categories developed by McMillen et al.
Participants were asked to circle categories if they were appropriate to their experience, and to add any comments for each category that they might wish to.

**Procedure**

Ethics approval for the study was obtained from the Ethics Committee at Deakin University (see Appendix B). There were no specific requirements for individuals to be eligible to participate in the study, other than they needed to be women who reported that they had experienced CSA and were now aged over 18 years. Due to the sensitive nature of the research subject, it was felt that an indirect method of recruiting participants would be most appropriate. Thus respondents were recruited for the study by advertising at participating Centres Against Sexual Assault (CASAs), in small, local papers and in a daily, metropolitan newspaper. The fifteen CASAs in the state of Victoria, Australia, were approached via their co-ordinators and the purpose and requirements of the research outlined. For various reasons, a number of CASAs declined to participate and eventually only a small number of CASAs in rural areas were involved. The CASAs were supplied with advertising flyers (Appendix C) to put up in waiting rooms and a box of packs containing a questionnaire (see Appendix A), consent form (see Appendix D), plain language statement (see Appendix E) and request form for a summary of the research results (see Appendix F). The intention was for the agency to simply provide a means for clients to be aware of the research and for participants to volunteer to participate by taking a questionnaire pack.

Given the initial slow uptake rate of under ten questionnaires using this method, and the concern that participants would be limited to those seeking support from such a centre, alternative recruitment methods were implemented. It was decided to request local newspapers (see Appendix G) to print a brief outline of the research and a request for readers to volunteer to participate (see Appendix H). This method generated some enquiries to the contact telephone number supplied, which was linked to an answering machine. Questionnaire packs were then sent to participants who had left their contact details. A large metropolitan newspaper then agreed to a request to print the same invitation for research participants, with the same contact methods. A substantial number of enquiries were received, questionnaire packs distributed and completed...
questionnaires returned over an extended period. In total, 126 requests for questionnaires were received and approximately 100 (from this source) were returned, giving a response rate of approximately 79%. Following completion of the initial analysis of results, a summary sheet of these results was distributed to those participants who had requested this on the original results request form (see Appendix F).
CHAPTER 7

STUDY 1: RESULTS

Descriptive Statistics

Demographic Data

Basic demographic data were obtained from the 118 participants who returned questionnaires. There was an even distribution of ages between 19 and 65 years among participants, as shown in Figure 7.1.

![Figure 7.1 Age of Participants](attachment:image.png)

Data in relation to age cohorts, relationship status, number of children, age at birth of first child and average spacing between children are presented in Table 7.1. Just over half of the participants were married or in a de-facto relationship, whilst nearly a third did not have a partner. A third of the sample did not have children. However, this figure cannot be compared to the general population given the varied age range in the sample.
It is unclear whether some women may have children in the future, while an unknown number of others may be beyond child-bearing age. Of those women who did have children, the average number of children was 2.42 per woman. Participants who
had had children, tended to do so at a fairly young age. The average age of the mother at the birth of her first child was 23.8 years. The average spacing between sibling children did not show any particular pattern.

**Family-of-**Origin

Participants were asked for information about their family-of-origin, including the type of family in which they grew up (between the ages of 0-15 years) and which person they had as a father/mother figure during this period. Data relating to the family-of-origin of participants are presented in Table 7.2. Many women indicated they had experienced a range of family types. Some indicated they had experienced moving between parental households following parental separation, or regular reconfigurations of their family household due to changing relationships or circumstances.

<table>
<thead>
<tr>
<th>Table 7.2 Family-of-Origin Family Type Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type Family</strong></td>
</tr>
<tr>
<td>Both Parents</td>
</tr>
<tr>
<td>Single Mother</td>
</tr>
<tr>
<td>Mother/Stepfather</td>
</tr>
<tr>
<td>Stepmother/Father</td>
</tr>
<tr>
<td>Single Father</td>
</tr>
<tr>
<td>Grandparents</td>
</tr>
<tr>
<td>Mother/Boyfriend</td>
</tr>
<tr>
<td>Relatives</td>
</tr>
</tbody>
</table>

**Alternative Care**

| Foster Parents | .9% Foster Father | .9% Foster Mother | .9% |
| Children’s Home/Institution | 2.6% Male Guardian | .9% Female Guardian | .8% |
| | | Babies Home/Nurses | 1.7% |
| | | Boarding School/Nuns | 1.7% |
Percentages add to more than 100%, as respondents could mark more than one selection per category.

A number of participants indicated that they had more than one type of father/mother relationship during this period, with 26.6% reporting a father figure in addition to, or as an alternative to their natural father. Conversely, only 16.1% of participants reported having a mother figure in addition to, or as an alternative to their natural mother. However, the vast majority of participants grew up, at least some of the time, in families consisting of both natural parents, a single mother, or mother and stepfather combination. Respondents rarely reported being in the care of a mother figure who was not their natural mother, although it was over three times as common for them to report being in the care of a father figure who was not their natural father.

**Hypothesis 1**

Women who have experienced CSA will also have experienced a range of psychosocial problems in their family-of-origin.

Participants were asked whether other psychosocial problems had been present in their family during their childhood (0-15 years). The data relating to psychosocial issues in the participants’ family-of-origin are presented in Table 7.3. A majority of participants indicated that marital conflict was present in their family-of-origin. Nearly half of the participants perceived their father was dominant. A large number of participants also believed they had a restrictive upbringing and were exposed to domestic violence and alcohol abuse.

**Table 7.3 Family-of-Origin Psychosocial Issues**

<table>
<thead>
<tr>
<th>Psychosocial Family Issues</th>
<th>Percentage of Participants%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Conflict</td>
<td>58.7%</td>
</tr>
<tr>
<td>Dominant Father</td>
<td>47.7%</td>
</tr>
<tr>
<td>Restrictive Upbringing</td>
<td>43.1%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>41.3%</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>38.5%</td>
</tr>
<tr>
<td>Parental Absence</td>
<td>38.3%</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>36.7%</td>
</tr>
<tr>
<td>Victimized Mother</td>
<td>33.0%</td>
</tr>
<tr>
<td>Sexual Punitiveness</td>
<td>18.3%</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>7.3%</td>
</tr>
<tr>
<td>Dominant Mother</td>
<td>1.8%</td>
</tr>
</tbody>
</table>
Parental absence due to a range of factors including jail or mental illness, and social isolation were features present in many participants’ families. Nearly a third of participants felt their mothers had been victimized and nearly a fifth of participants believed they had experienced sexual punitiveness by their parents. Drug abuse was an issue for only a small number of families, perhaps reflecting the general age cohort of participants. In the ‘Other’ category, the only response provided, by a couple of participants, was ‘Dominant Mother’. Only a handful of participants did not nominate any of the psychosocial issues as being present in their family-of-origin. Therefore, it would appear that the hypothesis that those women who have experienced CSA will also have experienced a range of psychosocial problems in their family-of-origin, is largely supported.

**Childhood Sexual Abuse Data**

To enable investigation of the impact of abuse severity, participants were asked about a number of characteristics relating to the abuse experience itself, including the age when the abuse first began, the duration of the abuse, on how many occasions the abuse occurred and the number of perpetrators involved. In order to assess the nature of the CSA, three factors were considered. Firstly, the relationship between the perpetrator and participant was evaluated, to assess the degree of familiarity, including the degree of biological relationship between the perpetrator and participant. Secondly, the actual nature of the sexually abusive activities was explored, including a scale of increasing severity. Thirdly, the methods utilized by the offender to induce participation in the sexually abusive experience were established. Each of these characteristics of CSA are explored in the following sections.

**Age When Abuse Began**

From Figure 7.2, it can be seen that the majority of participants believed that their abuse began during the middle childhood years. Some participants believed that their abuse had commenced at a very early age and cited various sources for this belief, including recovered memories, family discussions and formal reports. Overall, 40.7% of

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a Percentages add to more than 100%, as participants could mark more than one selection per category.
participants experienced the commencement of sexual abuse before the age of 6 years, 74.6% by the age of 10 years and 100% by the age of 15 years.

![Figure 7.2 Age When Abuse First Began](image)

Occasions and Duration of Abuse

It can be seen from Figure 7.3 that for a number of participants, the experience of CSA occurred on just one occasion, or over a relatively short period of time. A smaller group experienced sexual abuse over a period of months, with the majority of respondents experiencing sexual abuse for a number of years. Many participants appeared to have great difficulty in being able to define on how many occasions they had experienced sexual abuse. This led to a large number of participants providing written comments regarding time periods, with less than half providing actual numbers, making comparisons between the two groups of comments and numbers difficult.

The majority of participants indicated that they had experienced abuse over a period of years, suggesting it was chronic in nature. This indication was supported by the additional information that participants generally experienced abuse on a high number of occasions.
Figure 7.3 Duration of Child Sexual Abuse (days)

It can be seen from Table 7.4 that the CSA survivors generally experienced abuse of up to a six-year duration, which is consistent with the abuse ceasing as they reached puberty. Of these abuse survivors, 7.6% were abused on a single occasion only.

<table>
<thead>
<tr>
<th>Years of Abuse</th>
<th>Percentage of CSA Survivors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>20.7%</td>
</tr>
<tr>
<td>1-3</td>
<td>20.9%</td>
</tr>
<tr>
<td>4-6</td>
<td>24.4%</td>
</tr>
<tr>
<td>7-9</td>
<td>9.3%</td>
</tr>
<tr>
<td>10-12</td>
<td>6.7%</td>
</tr>
<tr>
<td>13 or more</td>
<td>8.2%</td>
</tr>
<tr>
<td>Missing data</td>
<td>8.5%</td>
</tr>
</tbody>
</table>
Number of Perpetrators

Participants were also asked how many perpetrators had sexually abused them. The number of perpetrators per participant can be seen in Figure 7.4. Nearly half of all participants had experienced sexual abuse that involved just one perpetrator. Sexual abuse by multiple perpetrators tended to occur as either a series of victimizations by different individuals over time, or was due to a number of perpetrators conducting the abuse on a particular occasion.

![Number of Sexual Abuse Perpetrators per Participant](image)

**Figure 7.4 Number of Sexual Abuse Perpetrators per Participant**

Basic information relating to characteristics of the CSA of participants is summarized in Table 7.5.

Nature of Relationship Between Perpetrator and Participant

To assess the nature of the relationship between the perpetrator and participant, the participants were asked to nominate from a range of relative types, acquaintances and strangers, or to suggest another category, regarding who had abused them. Data concerning the nature of the relationship between the perpetrator and the participant are shown in Table 7.6. There are two methods of investigating the nature of the relationship
between the perpetrator and the participant. The first method relies on combining the responses from all participants and then apportioning the responses belonging to each perpetrator type. There were 117 respondents who supplied this information, with a total of 224 responses. The percentages presented in the first column of Table 7.6 are therefore the percentage of the total offender group nominated within each offender category.

Table 7.5 Summary of Characteristics of CSA

<table>
<thead>
<tr>
<th>Duration of Abuse</th>
<th>Occasions of Abuse</th>
<th>Number of Perpetrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days (14.4%)</td>
<td>Range: 1-100 occasions</td>
<td>1 perpetrator 46.6%</td>
</tr>
<tr>
<td>Range: 1-28 days</td>
<td></td>
<td>2 perpetrators 19.5%</td>
</tr>
<tr>
<td>Average: 5.5 days</td>
<td></td>
<td>3 perpetrators 16.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4-9 perpetrators 11.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-15 perpetrators 5.8%</td>
</tr>
<tr>
<td>Months (10.2%)</td>
<td>Average: 20.2 occasions</td>
<td>Average 2.6 perpetrators</td>
</tr>
<tr>
<td>Range: 2-14 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average: 6.5 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years (69.5%)</td>
<td>One Occasion: 6.8%</td>
<td>46.6% One perpetrator</td>
</tr>
<tr>
<td>Range: 1-43 years</td>
<td></td>
<td>53.4% Multiple perpetrators</td>
</tr>
<tr>
<td>Average: 6.7 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The majority of participants reported CSA perpetrated by a family member (intrafamilial abuse), rather than by someone outside the family (extrafamilial abuse). Overall, the rate of intrafamilial abuse was 54.2%, compared to a rate of extrafamilial abuse of 44.8%. A minority of participants (24.6%) were abused by extrafamilial offenders only, with many participants abused by both extrafamilial offenders and at least one intrafamilial offender. It is also evident that fathers and brothers made up over a quarter of the perpetrator group, whereas grandfathers and uncles were also well represented. Although only 18.8% of participants indicated that they had had a stepfather whilst growing up, 10.3% of participants cited their stepfather as perpetrating sexual abuse against them. Therefore, more than half of the stepfathers were sexually abusive. In comparison, 82.9% of participants reported having their natural father as
their father figure whilst growing up, and only 29.9% reported being abused by their natural father, which is substantially less than half. Step relatives made up another 3% of abusers. Of those perpetrators from outside the family, participants were nearly twice as likely to report sexual abuse by a male acquaintance, or someone who they knew, rather than a male stranger.

### Table 7.6 Nature of Relationship Between Perpetrator and Participant

<table>
<thead>
<tr>
<th>Type of Relationship to Perpetrator</th>
<th>Percentage of Total Offenders (N=224)</th>
<th>Percentage of Participants (N=117)(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrafamilial (within the family)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>15.6%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Brother</td>
<td>9.8%</td>
<td>18.8%</td>
</tr>
<tr>
<td>Grandfather</td>
<td>6.3%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Uncle</td>
<td>5.8%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Stepfather</td>
<td>5.4%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Male Cousin</td>
<td>4.5%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Female Relatives</td>
<td>2.1%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>4.7%</td>
<td>9.6%</td>
</tr>
<tr>
<td><strong>Extrafamilial (outside the family)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male Acquaintance</td>
<td>16.1%</td>
<td>30.8%</td>
</tr>
<tr>
<td>Male Stranger</td>
<td>8.5%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Friend of the Family</td>
<td>4.5%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Others</td>
<td>15.8%</td>
<td>32.3%</td>
</tr>
</tbody>
</table>

\(^a\) Percentages do not add to 100% as they indicate the number of participants who nominated a particular offender type and many participants experienced abuse by multiple perpetrators.

The second column in Table 7.6 indicates the percentage of the total number of participants who nominated a particular perpetrator category. Given these categories are not mutually exclusive, the percentages do not add up to one hundred percent. It can be seen that almost a third of the participants reported being sexually abused by their father and nearly a fifth of participants reported being abused by their brother. Nearly a third of participants reported being abused by a male acquaintance.
The type of relationship that the participant had with the perpetrator was further categorized according to the degree of familial relationship or familiarity with the perpetrator. Biological relatives comprised nearly half of all the perpetrators identified by participants. When this group is combined with non-biological relatives, it can be seen that over half of the perpetrators were relatives. Overall, the overwhelming majority of participants experienced CSA perpetrated by an individual who was known to them, rather than by a stranger.

Types of Sexual Activities

Participants were also asked about the types of sexual activities that occurred, in relation to all perpetrators. The types of sexually abusive activities experienced are summarized by the four categories of: noncontact activity, sexual stimulation activity, attempted/actual sexual penetration or other activities, as shown in Table 7.7. The majority of participants experienced sexual abuse involving physical contact, but this did not necessarily include attempted or actual penetration.

Table 7.7 Categories of Sexually Abusive Activities

<table>
<thead>
<tr>
<th>Sexually Abusive Activities</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncontact</td>
<td>21.0%</td>
</tr>
<tr>
<td>Kiss/Fondling/Stimulation</td>
<td>55.4%</td>
</tr>
<tr>
<td>Attempted/Penetration</td>
<td>22.4%</td>
</tr>
<tr>
<td>Other</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Participants were asked to circle from an extensive list, the sexual activities they had experienced, or to nominate any that were not covered, as seen in Table 7.8. The majority of participants reported experiencing a range of sexually abusive activities that included those involving no physical contact to attempted or actual penetration. The second column in Table 7.8 indicates for each sexual activity, the percentage of the total responses that related to that particular activity. From the 117 participants who provided information relating to this question, there were 671 responses received. Given that these categories are not mutually exclusive, the percentages do not add up to one
hundred percent. The third column in Table 7.8 indicates the percentage of the total number of participants who nominated a particular activity.

Table 7.8 Sexual Activities Experienced During CSA

<table>
<thead>
<tr>
<th>Type of Sexual Activity</th>
<th>Percentage of Total Sexual Activities (N = 671)</th>
<th>Percentage of Participants (N = 117)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Noncontact Activity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exhibitionistic display of the offender’s genitals to victim</td>
<td>7.6%</td>
<td>43.6%</td>
</tr>
<tr>
<td>Peering at the victim by offender</td>
<td>7.3%</td>
<td>41.9%</td>
</tr>
<tr>
<td>Victim observes offender masturbating</td>
<td>5.5%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Offender observes victim masturbating</td>
<td>.6%</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21.0%</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Stimulation Activity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erotic kissing</td>
<td>5.4%</td>
<td>30.8%</td>
</tr>
<tr>
<td>Erotic fondling of victim’s body by offender</td>
<td>13.3%</td>
<td>76.1%</td>
</tr>
<tr>
<td>Erotic fondling of offender’s body by victim</td>
<td>6.3%</td>
<td>35.9%</td>
</tr>
<tr>
<td>Manual stimulation of victim’s genitals by offender</td>
<td>13.3%</td>
<td>76.1%</td>
</tr>
<tr>
<td>Manual stimulation offender’s genitals by victim</td>
<td>6.4%</td>
<td>36.8%</td>
</tr>
<tr>
<td>Oral stimulation of victim’s genitals by offender</td>
<td>4.9%</td>
<td>28.2%</td>
</tr>
<tr>
<td>Oral stimulation of offender’s genitals by victim</td>
<td>5.8%</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>55.4%</td>
<td></td>
</tr>
<tr>
<td><strong>Attempted/Actual Sexual Penetration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simulated/&quot;dry&quot; intercourse</td>
<td>8.0%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Attempted penile penetration</td>
<td>.3%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Digital vaginal penetration</td>
<td>1.2%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Digital penetration of victim’s anus by offender</td>
<td>2.4%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Penile penetration of victim’s vagina by offender</td>
<td>8.3%</td>
<td>47.9%</td>
</tr>
<tr>
<td>Penile penetration of offender’s anus by offender</td>
<td>1.8%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Insertion of foreign objects into victim’s vagina</td>
<td>.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>22.4%</td>
<td></td>
</tr>
<tr>
<td><strong>Other Activity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1.2%</td>
<td></td>
</tr>
</tbody>
</table>

a The percentages do not add up to 100%, as most participants reported experiencing a range of sexually abusive activities.

It can be seen from Table 7.8 that over half of the sexual activities experienced by participants fell within the category of sexual stimulation, with the remaining activities equally divided between the less severe noncontact abuse and the more severe
attempted or actual sexual penetration activities. Three-quarters of participants reported being fondled or manually stimulated by the offender, whereas only half that number reported fondling or manually stimulating the offender. Almost half of the participants reported experiencing vaginal rape or simulated/‘dry’ intercourse, with slightly fewer indicating that they had experienced exhibitionism or voyeurism by the offender. A third of the participants indicated that they had orally stimulated the offender, with a similar number observing the offender masturbating or being involved in erotic kissing with the offender. Fewer participants reported being orally stimulated by the offender and very few indicated that they had experienced other forms of penetration or been observed masturbating.

**Inducement to Participate**

In recognition of the existence of a range of motivations for participating in sexually abusive activities, participants were asked to select from a comprehensive list what methods had been used by the offender to induce them to participate in the activity. Data regarding the frequency of use of different methods of inducing participation in the abusive activity are shown in Table 7.9. The second column in Table 7.9 provides a percentage figure for each particular method, based on the total of 353 responses received from 113 participants. The most common methods relied on the power imbalance between the adult and child, with the most likely methods of inducement utilizing authority, threats or physical force. To a lesser degree, offenders also preyed on the participant child’s needs for affection, attention or other emotional needs. This can be summarized as methods generally used to induce participation in sexual activities involving coercion (67.1%), or exploitation of the child’s emotional needs (17.6%).

The percentages in the third column of Table 7.9 indicate the percentage of the participants who nominated a particular method of inducement. Given these categories are not mutually exclusive, the percentages add to more than one hundred percent. It can be seen from Table 7.9 that a majority of participants indicated that they felt they had been induced to participate through the use of adult authority. Half of the participants believed they had been subjected to threats, with nearly as many induced through physical force. A slightly lower number of participants perceived the
inducement as an opportunity for attention and affection, and nearly as many were bribed. A minority of participants felt the activities were misrepresented as sex education or a proclamation of romantic love.

Some participants were induced through being told it was their duty to replace their mother and a few through the promise of sexual gratification, or the activity being misrepresented as a game. A range of other methods of inducement were reported (see Table 7.9).

### Table 7.9 Methods of Inducement to Participate in Sexual Activity

<table>
<thead>
<tr>
<th>Method to Induce Participation in Sexual Activity</th>
<th>Percentage of Total Responses (N = 353)</th>
<th>Percentage of Participants (N = 113) a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise of adult authority</td>
<td>22.4%</td>
<td>69.9%</td>
</tr>
<tr>
<td>Threats</td>
<td>16.1%</td>
<td>50.4%</td>
</tr>
<tr>
<td>Physical force</td>
<td>14.2%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Opportunity for attention and affection</td>
<td>12.5%</td>
<td>38.9%</td>
</tr>
<tr>
<td>Bribery</td>
<td>11.0%</td>
<td>34.5%</td>
</tr>
<tr>
<td>Misrepresenting activities as sex education</td>
<td>5.7%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Proclamation of romantic love</td>
<td>5.1%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Duty to replace mother</td>
<td>3.4%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Promise of sexual gratification</td>
<td>1.7%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Misrepresenting activities as a game, fun, ‘something special’ or ‘fooling around’</td>
<td>.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Other</td>
<td>7.7%</td>
<td>23.4%</td>
</tr>
</tbody>
</table>

a Percentages add to more than 100% as participants could nominate any number of methods by which they were induced to participate in sexually abusive activities.

### Summary of Descriptive Statistics

It can be seen that there was a wide age range among participants, and approximately a third did not have a partner or children, although this was not necessarily the same women. Many participants had complex family arrangements in terms of their mother and father figures. As predicted, participants reported a high prevalence and extensive range of psychosocial issues in their families of origin. Although the majority of respondents believed their sexual abuse had begun during their middle childhood years, some believed their abuse had commenced at a very early age. Some participants reported experiencing abuse on just one occasion or for a relatively
short period of time, whereas the majority reported experiencing abuse for a number of years. Nearly half of the participants experienced abuse involving just one perpetrator. In contrast, some participants reported abuse by a large number of perpetrators, either as a series of victimizations by different individuals over time, or a number of perpetrators on a particular occasion.

Perpetrators were more likely to be family members (intrafamilial abuse), with fathers, brothers, grandfathers and uncles being most highly represented within this group. Stepfathers were over-represented as perpetrators when compared to their representation among participants’ families of origin. In terms of the sexual activities forming the abuse, over half were within the category of sexual stimulation, whereas the remainder were equally divided between the less severe noncontact abuse and the more severe attempted or actual sexual penetration activities. Participants reported that the most common methods employed to induce their participation in the sexually abusive activities utilized authority, threats or physical force. To a lesser degree, offenders preyed on the participant child’s needs for affection, attention or other emotional needs.

Quantitative Statistics

Psychological Adjustment

As indicated in Table 7.10, psychological adjustment in relation to the experience of CSA was evaluated using three measures. The Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982) was used to evaluate the participants’ current psychological functioning. The Belief Inventory (Jehu, 1988) was used to assess participants’ self-esteem, guilt and self-blame in relation to their sexually abusive experience. The Attributional Style in Relation to the Abuse (ASRA) (Lalor, 1994) sought to explore attributional style regarding causality of the abuse. Each of these three measures will be explored in the following sections.

Current Psychological Functioning – BSI

Current psychological functioning was evaluated using the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982) (see Table 7.10). Participants were found
to have higher levels of symptoms than nonpatient adult female norms, in terms of interpersonal sensitivity, obsessive-compulsiveness, depression, paranoid ideation, anxiety, psychoticism, hostility, phobic anxiety and somatization. The findings in relation to the Global Severity Index, the Positive Symptom Total and the Positive Symptom Index suggest the participants as a group were experiencing significant difficulties in psychological adjustment compared to adult nonpatient female norms (see Appendix I).

**Attributional Style**

Results from the Attributional Style in Relation to the Abuse (ASRA) (Lalor, 1994) measure, (see Table 7.10), demonstrated that over a third of participants felt that at the time of the abuse it was their fault. In comparison, over two thirds of participants now perceived the abuse as being in no way their fault. This would suggest that participants shifted the blame for the abuse away from themselves. Participants tended to exhibit a non self-blaming attributional style, with nearly a third of participants believing the cause of the abuse related to an aspect of the situation, compared to less than half this number who perceived the abuse cause as related to an aspect of themselves. In addition, almost double the number of participants perceived the abuse was reflective of others, rather than themselves. Three-quarters of the participants believed the abuse was controllable by others, compared to very few participants who believed the abuse was controllable by themselves. There was a clear belief expressed by the majority of participants that someone was responsible for the abuse, rather than the perception of only a few participants that no-one was responsible for the abuse.
### Table 7.10 Measures of Current Psychological Adjustment

<table>
<thead>
<tr>
<th>Brief Symptom Inventory</th>
<th>Belief Inventory</th>
<th>Attributional Style in Relation to the Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential range of 0-4 for each subscale, with higher scores indicating a higher level of the symptom.</td>
<td>Self-esteem Possible Range 0-27 (Low – High)</td>
<td>Now, I feel that the abuse is:</td>
</tr>
<tr>
<td></td>
<td>Average 6.1 13.7% - 67.8% (average 38.4%)</td>
<td>In no way my fault 68.6% (1)</td>
</tr>
<tr>
<td></td>
<td>Endorsed item as at least partly true.</td>
<td>All my fault 1.7% (5)</td>
</tr>
<tr>
<td>Somatization</td>
<td>Self-blaming Possible Range 0-27 (Low – High)</td>
<td>At the time of the abuse, I felt the abuse was:</td>
</tr>
<tr>
<td>Average 1.2</td>
<td>Average 3.3 6.0% - 61.0% (average 21.5%)</td>
<td>In no way my fault 12.7% (1)</td>
</tr>
<tr>
<td></td>
<td>Endorsed item as at least partly true.</td>
<td>All my fault 34.7% (5)</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>Self-esteem Possible Range 0-27 (Low – High)</td>
<td>Was the cause of the abuse something that reflected on:</td>
</tr>
<tr>
<td>Average 1.9</td>
<td>Average 2.1 24.1% - 40.5% (average 32.1%)</td>
<td>An aspect of the situation 28.0% (1)</td>
</tr>
<tr>
<td></td>
<td>Endorsed item as at least partly true.</td>
<td>An aspect of yourself 13.6% (5)</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>Depression Average 1.8</td>
<td>Did the abuse say something about: (reflective of)</td>
</tr>
<tr>
<td>Average 2.1</td>
<td>Anxiety Average 1.7</td>
<td>Others 33.9% (1)</td>
</tr>
<tr>
<td></td>
<td>Hostility Average 1.4</td>
<td>Yourself 17.8% (5)</td>
</tr>
<tr>
<td></td>
<td>Phobic Anxiety Average 1.2</td>
<td>Average 2.6</td>
</tr>
<tr>
<td></td>
<td>Paranoid Ideation Average 1.8</td>
<td>Psychoticism Average 1.7</td>
</tr>
<tr>
<td></td>
<td>Global Symptom Index Average 1.6</td>
<td>Did the abuse say something for which:</td>
</tr>
<tr>
<td></td>
<td>Positive Symptom Distress Index Average 2.3</td>
<td>Controllable by you 4.2% (1)</td>
</tr>
<tr>
<td></td>
<td>Positive Symptom Total Range 0-53 Average 33.3</td>
<td>Controllable by others 73.7% (5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average 4.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Was the abuse:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Someone is responsible 78.8% (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No-one is responsible 4.2% (5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average 1.4</td>
</tr>
</tbody>
</table>
Beliefs

Based on the original 17-item version of the Belief Inventory, 28.2% of participants were classified as having high self-blame according to Jehu’s (1988) criteria for clinical significance (score \( \geq 15 \)). It can be seen from Table 7.11, that in general participants did not report a high degree of cognitive distortion in beliefs relating to self-esteem. In particular, few participants endorsed a belief that “I don’t have the right to deny my body to any man who demands it”. However, over two-thirds of participants did believe “I will never be able to lead a normal life, the damage is permanent” (see Table 7.11). In general, participants did not demonstrate strong feelings of guilt in relation to their abuse, suggesting a low level of cognitive distortions relating to guilt. In particular, only a quarter of participants endorsed as at least partly true the distorted belief that “I must have been responsible for the sex when I was young because it went on so long”. In contrast, nearly half the participants believed “It must be unnatural to feel any pleasure during molestation”. The extent of self-blaming by participants in relation to their abuse was quite small, suggesting a low degree of cognitive distortion in beliefs relating to self-blame. Very few participants believed “I was responsible for the abuse because I asked the offender about sexual matters”, however nearly two-thirds of participants believed “The offender abused me because he was sexually frustrated”.
### Table 7.11 Belief Inventory

<table>
<thead>
<tr>
<th>Item</th>
<th>Belief</th>
<th>Participants Responding as Partly, Mostly or Absolutely True (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I must be an extremely rare woman to have experienced sex with an older person when I was a child.</td>
<td>19.1</td>
</tr>
<tr>
<td>2</td>
<td>I am worthless and bad.</td>
<td>45.2</td>
</tr>
<tr>
<td>3</td>
<td>You can’t depend on women, they are all weak and useless creatures.</td>
<td>16.2</td>
</tr>
<tr>
<td>4</td>
<td>No man can be trusted.</td>
<td>56.8</td>
</tr>
<tr>
<td>5</td>
<td>I must have permitted sex to happen because I wasn’t forced into it.</td>
<td>32.8</td>
</tr>
<tr>
<td>6</td>
<td>I don’t have the right to deny my body to any man who demands it.</td>
<td>13.7</td>
</tr>
<tr>
<td>7</td>
<td>Anyone who knows what happened to me sexually will not want anything to do with me.</td>
<td>44.1</td>
</tr>
<tr>
<td>8</td>
<td>I must have been seductive and provocative when I was young.</td>
<td>31.0</td>
</tr>
<tr>
<td>9</td>
<td>It doesn’t matter what happens to me in my life.</td>
<td>33.3</td>
</tr>
<tr>
<td>10</td>
<td>No man could care for me without a sexual relationship.</td>
<td>49.1</td>
</tr>
<tr>
<td>11</td>
<td>It is dangerous to get close to anyone because they always betray, hurt, or exploit you.</td>
<td>59.8</td>
</tr>
<tr>
<td>12</td>
<td>I must have been responsible for the sex when I was young because it went on so long.</td>
<td>24.1</td>
</tr>
<tr>
<td>13</td>
<td>I will never be able to lead a normal life, the damage is permanent.</td>
<td>67.8</td>
</tr>
<tr>
<td>14</td>
<td>Only bad, worthless guys would be interested in me.</td>
<td>25.2</td>
</tr>
<tr>
<td>15</td>
<td>It must be unnatural to feel any pleasure during molestation.</td>
<td>40.5</td>
</tr>
<tr>
<td>16</td>
<td>I am inferior to other people because I did not have normal experiences.</td>
<td>44.3</td>
</tr>
<tr>
<td>17</td>
<td>I’ve already been used so it doesn’t matter if other men use me.</td>
<td>23.1</td>
</tr>
<tr>
<td>18</td>
<td>I was responsible for the abuse because I asked the offender about sexual matters.</td>
<td>6.0</td>
</tr>
<tr>
<td>19</td>
<td>The offender abused me because he was ‘sick’ and therefore not responsible for his actions.</td>
<td>39.1</td>
</tr>
<tr>
<td>20</td>
<td>The abuse was my own fault because I used it to obtain attention and/or affection from the offender.</td>
<td>13.8</td>
</tr>
<tr>
<td>21</td>
<td>The offender abused me because he was drunk at the time.</td>
<td>16.1</td>
</tr>
<tr>
<td>22</td>
<td>I was to blame for the abuse because I used it to obtain favours and rewards from the offender.</td>
<td>15.7</td>
</tr>
<tr>
<td>23</td>
<td>The offender abused me because he was sexually frustrated.</td>
<td>61.0</td>
</tr>
<tr>
<td>24</td>
<td>The offender engaged me in sexual activities in order to teach me about sex and to make me a better sexual partner.</td>
<td>12.2</td>
</tr>
<tr>
<td>25</td>
<td>The offender engaged in sexual activities with me so that our relationship would be closer and better.</td>
<td>14.0</td>
</tr>
<tr>
<td>26</td>
<td>The offender engaged in sexual activities with me to give me physical pleasure.</td>
<td>15.9</td>
</tr>
</tbody>
</table>

### Current Functioning

The current functioning of participants was evaluated using measures of specific areas of functioning applicable in daily life. The areas covered included coping,
Coping Methods

High raw scores on subscales of the Ways of Coping Questionnaire (Folkman, & Lazarus, 1988) indicate that the person often used this particular type of coping in dealing with stressful situations. The results in Table 7.12 demonstrate that participants favoured coping strategies utilizing self-control (average 52%) or escape-avoidance (average 49%), followed by planful problem solving (average 42%), accepting responsibility (40%), seeking social support (average 38%), confrontive coping (average 36%), distancing (35%), and were least likely to use positive reappraisal (average 26%).

Parenting

Of the 118 participants, almost a third did not have children. For those participants who were parents, their own perceptions of their parenting competence were assessed using Banyard’s (1997) basic measure. As can be seen in Table 7.12, most participants reported that they worried about problems related to their children nearly all of the time. In addition, most participants also wished to achieve at least some change in their parenting. However, over the next two years the vast majority of participants believed their situation would stay the same or get better.

Pearson correlations were conducted to evaluate the impact on parenting of a range of demographic variables. The three demographic variables of relationship status, age and number of children were used. The number of children of participants was not found to be correlated with any of the parenting competence measures. However, participants with more formal relationships (e.g., married) (r = .35, p < .01) and with increasing age were found to have had more concerns about their future parenting (r = .25, p < .05).

Relationship satisfaction

Of the 118 participants, a third indicated they did not currently have a partner. For those who did have a partner, their degree of relationship satisfaction was assessed.
It can be seen from Table 7.12, from responses to the Kansas Marital Satisfaction Scale (KMS) (Schumm et al., 1986), that the majority of participants reported being somewhat to extremely satisfied with their marriage, although a quarter of participants were somewhat to extremely dissatisfied with their marriage. Similarly, most participants indicated they were somewhat to extremely satisfied with their husband as a spouse, although again a quarter of participants were somewhat to extremely dissatisfied with their husband as a spouse. In a similar fashion, a majority of participants indicated they were somewhat to extremely satisfied with their relationship with their husband, but a quarter of participants were somewhat to extremely dissatisfied with their relationship with their husband. Overall, it can be seen that most participants indicated a reasonably high level of satisfaction in relation their marriage/relationship.

**Perception of Benefit**

The perception of benefit from the experience of CSA was assessed using a question developed by McMillen et al. (1995). Participants were asked to rate how much benefit they felt they had received, to produce a perceived benefit rating. As can be seen from Table 7.12, although just over a third of the participants felt there was no benefit from the unwanted sexual contact, a majority of participants felt there had been at least a little benefit (61.3%), and 23.4% of survivors believed they had received quite a bit or a lot of benefit. The great majority of participants indicated they perceived benefit in the areas of an increased knowledge of sexual abuse, followed equally by protection of children and becoming a stronger person, and lastly by self-protection.

**Hypothesis 2**

That there will be a positive association between perception of benefit and current age of the CSA survivor, but there will be no association between perception of benefit type and current age, age at commencement of abuse and abuse frequency.

Older CSA survivors were found to be less likely to perceive benefit from their CSA than younger survivors ($r = -.20$, $p < .05$). However, no relationships were found between particular perception of benefit types and current age, age at commencement of abuse and abuse frequency, with the exception of current age being significantly negatively correlated with the perceived benefit of becoming a stronger person ($r = -.30$, 217
Thus, older participants were less likely than their younger counterparts to perceive they had become a stronger person as a result of their experience of CSA.

**Table 7.12 Measures of Coping Methods, Parenting, Relationship Satisfaction and Perceived Benefit from Childhood Sexual Abuse**

<table>
<thead>
<tr>
<th>Ways of Coping Questionnaire</th>
<th>Parenting</th>
<th>Kansas Marital Satisfaction Scale</th>
<th>Perceived Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Confrontive Coping</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible Range 0-18</td>
<td>No children</td>
<td>No partner</td>
<td></td>
</tr>
<tr>
<td>Average 6.5</td>
<td>31.4%</td>
<td>33.1%</td>
<td></td>
</tr>
<tr>
<td><strong>Distancing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible Range 0-18</td>
<td>Worry About Child</td>
<td>Marriage Satisfaction: 58.6% Somewhat to extremely satisfied (5-7) 18.7% Mixed (4)</td>
<td></td>
</tr>
<tr>
<td>Average 6.3</td>
<td>How often do you worry about problems related to your children?</td>
<td>22.7% Somewhat to extremely dissatisfied (1-3) Possible range 1-7 Average 1.5</td>
<td></td>
</tr>
<tr>
<td><strong>Self-Controlling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible Range 0-18</td>
<td>Never 2.5% (1)</td>
<td>Spouse Satisfaction: 61.1% Somewhat to extremely satisfied (5-7) 16.9% Mixed (4)</td>
<td></td>
</tr>
<tr>
<td>Average 9.4</td>
<td>All of the time 40.7% (5)</td>
<td>22.1% Somewhat to extremely dissatisfied (1-3) Possible Range 1-7 Average 4.7</td>
<td></td>
</tr>
<tr>
<td><strong>Seeking Social Support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible Range 0-18</td>
<td>Parent Self-Esteem How much do you want to change the type of parent you are?</td>
<td>Relation Satisfaction: 55.3% Somewhat to extremely satisfied (5-7) 19.7% Mixed (4)</td>
<td></td>
</tr>
<tr>
<td>Average 6.8</td>
<td></td>
<td></td>
<td>25.0% Somewhat to extremely dissatisfied (1-3) Possible range 1-7 Average 4.6</td>
</tr>
<tr>
<td><strong>Accepting Responsibility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible Range 0-12</td>
<td>No change 10.3% (1)</td>
<td>Self-Protection 77.5%</td>
<td></td>
</tr>
<tr>
<td>Average 4.8</td>
<td>A complete change 15.4% (5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Escape-Avoidance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible Range 0-21</td>
<td>Future Parenting In the next two years do you feel your situation as a parent will:</td>
<td>Overall Satisfaction Possible Range 3-21 Average 13.7</td>
<td></td>
</tr>
<tr>
<td>Average 10.3</td>
<td>Get better 46.2% (1)</td>
<td>Get worse 3.8% (3) Average 1.6</td>
<td></td>
</tr>
<tr>
<td><strong>Planful Problem Solving</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible Range 0-17</td>
<td>Get better 46.2% (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average 7.1</td>
<td>Get worse 3.8% (3) Average 1.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Positive Reappraisal</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible Range 0-21</td>
<td>Overall Satisfaction Possible Range 3-21 Average 13.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average 5.5</td>
<td>Stronger Person 72.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Summary of Quantitative Statistics

Participants demonstrated high levels of symptoms in terms of interpersonal sensitivity, obsessive-compulsiveness, depression, paranoid ideation, anxiety, psychoticism, hostility, phobic anxiety and somatization. Relatively high ratings on the GSI, PST and PSI suggested that the participants as a group were also experiencing significant difficulties in psychological adjustment. Most participants had fairly high self-esteem, few had a high level of guilt and most did not blame themselves in relation to the abuse. Attributions regarding causality of the abuse appeared to change over time. One third of participants reported believing at the time of the abuse that it was their fault, compared to two-thirds of participants who now felt the abuse was definitely not their fault. A third of participants also demonstrated non self-blaming attributions by indicating a belief that the cause of the abuse related to an aspect of the situation rather than themselves, and was a reflection upon others rather than on themselves. Similarly, the majority of participants believed the abuse was controllable by others and that someone was responsible for the abuse.

The coping methods most frequently utilized by participants were self-control, escape-avoidance, planful problem solving, seeking social support, confrontive coping, and distancing, with the least likely to be used being positive reappraisal. The third of participants who were parents reported a high degree of worry about problems related to their children, wished to achieve at least some change in their parenting, but also believed their situation would stay the same or get better. The majority of participants who were in a relationship, indicated that they were satisfied with their marriage/husband/relationship. A majority of participants felt there had been at least a little benefit resulting from their experience of abuse, particularly in the area of an increased knowledge of sexual abuse.
Analyses Related to Severity of Sexual Abuse

Based on the research literature, a number of hypotheses were generated at the end of the Introductory chapters, regarding the relationships between various measures of severity of CSA. To test these hypotheses, Pearson correlations were calculated between the abuse measures of: age at commencement of sexual abuse (in years), duration of abuse (in days), number of perpetrators, whether a father figure (father/stepfather) was a perpetrator, severity of the abusive acts and whether coercion was used.

Hypothesis 3.1
That age of the participant at the commencement of CSA will be negatively associated with the duration of abuse and the severity of the abusive acts.

As expected, age at commencement of CSA was negatively correlated with duration of the abuse and severity of the abusive acts (see Table 7.13). These findings indicated that the younger the age of the child when the abuse began, the more likely the abuse was to be of a longer duration and more severe in terms of the sexual activities involved.

Hypothesis 3.2
That age of the participant at the commencement of CSA will be positively associated with the father figure (father/stepfather) being the perpetrator.

It would be expected that given a father figure would have greater accessibility to the child to perpetrate abuse, the age of the child at the commencement of abuse would be lower in those situations where the father figure was the perpetrator. However, age at commencement of sexual abuse was not correlated with the father figure (father/stepfather), rather than someone else, being the perpetrator (see Table 7.13).

Hypothesis 3.3
That the duration of CSA will be positively associated with the number of perpetrators and the severity of the abusive acts involved.
As predicted, the duration of abuse was positively correlated with the number of perpetrators and the severity of the abusive acts involved (see Table 7.13). This prediction was made on the basis that abuse of a longer duration may reflect the presence of a number of perpetrators and increase the opportunity for participation in a range of abusive acts of potentially increasing severity.

**Hypothesis 3.4**

That the number of perpetrators of CSA will be positively associated with the severity of the acts involved in the abuse and the presence of coercion.

As expected, the number of perpetrators was positively correlated with the severity of the acts involved in the abuse and coercion being present (see Table 7.13). This expectation was based on an increased number of perpetrators leading to a higher likelihood of abusive acts of greater severity and coercion accompanying this.

<table>
<thead>
<tr>
<th>Table 7.13 Correlations between Severity of Abuse Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age at sexual abuse (in years)</strong></td>
</tr>
<tr>
<td>Age at sexual abuse (in years)</td>
</tr>
<tr>
<td>Duration of abuse (in days)</td>
</tr>
<tr>
<td>Number of perpetrators</td>
</tr>
<tr>
<td>Father figure perpetrator</td>
</tr>
<tr>
<td>Severity of abusive acts</td>
</tr>
<tr>
<td>Coercion</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01
Hypothesis 3.5
That the severity of abusive acts involved in the CSA will be positively associated with the presence of coercion.

It was found that the severity of abusive acts was positively correlated with the presence of coercion (see Table 7.13). It seemed reasonable to expect that sexually abusive acts of increasing severity might be accompanied by increasing levels of coercion, to ensure compliance by the participant child.

Summary of Analyses Related to Severity of Sexual Abuse
All of the hypotheses regarding the relationships between particular severity of abuse measures were supported by findings of significant correlations, with one exception. The age at commencement of CSA was not correlated with the presence of a father figure (father/stepfather) rather than someone else, as the perpetrator. The presence of a father figure as the perpetrator did not show an association with any of the other abuse severity measures.

Relationships Between Coping, Attributions, Beliefs and Current Psychological Adjustment
In order to assess the nature of the relationships between the participants’ preferred methods of coping, their attributions relating to the abuse, beliefs in relation to the abuse and their current psychological functioning in terms of psychological symptoms, perceived parenting competency and relationship satisfaction, a number of hypotheses were developed at the end of the Introductory chapters. The following analyses evaluate these hypotheses.
Hypothesis 4
That there will be an association between coping methods and current psychological adjustment in terms of the level of psychological symptoms.

To test this hypothesis, coping methods were assessed using the Ways of Coping Questionnaire (WCQ) (Folkman, & Lazarus, 1988) and current psychological adjustment was measured using the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982).

Pearson correlations were calculated between the WCQ and the BSI, with only three of the WCQ subscales demonstrating significant correlations with any of the BSI subscales (see Table 7.14). The Escape-Avoidance subscale of the WCQ was significantly positively correlated with all the BSI subscales of Paranoid Ideation, Depression, Psychoticism, Interpersonal Sensitivity, Obsessive-Compulsive, Anxiety, Hostility, Somatization, Phobic Anxiety and the Global Severity Index (GSI). These findings suggest participants who favour the escape-avoidance method of coping are those with the highest rates of psychological symptoms, suggesting this is not an effective coping method. The Accepting Responsibility subscale of the Ways of Coping Questionnaire was significantly positively correlated with the BSI subscales of Psychoticism, Depression, Paranoid Ideation, Obsessive – Compulsive, Interpersonal Sensitivity, Anxiety and Hostility. These results suggest that those participants who accepted responsibility as their method of coping still have elevated rates of psychological symptoms, but not to the same degree, and in fewer domains, than those seeking to escape or avoid problems.

The Distancing subscale of the Ways of Coping Questionnaire was significantly positively correlated with the BSI subscales of Psychoticism, Anxiety, Paranoid Ideation, Somatization, Obsessive – Compulsive and the Global Severity Index (GSI). Therefore, those participants adopting distancing as their method of coping appear to also have an increased level of negative psychological symptoms, but to a lesser degree than those seeking to avoid or escape the problem altogether. Overall, it would seem that those participants who can detach themselves from problems fare much better psychologically than those who seek to cope through avoidance of issues.
Hypothesis 5
That there will an association between coping methods, parenting competency, and relationship satisfaction.

To test this hypothesis, coping methods were assessed using the Ways of Coping Questionnaire (WCQ) (Folkman & Lazarus, 1988), parenting competency was assessed using a measure developed by Banyard (1997) and relationship satisfaction was assessed using the Kansas Marital Satisfaction Scale (KMS) (Schumm et al., 1986).

Table 7.14 Correlations Between Coping (WCQ) and Psychological Adjustment (BSI)

<table>
<thead>
<tr>
<th></th>
<th>WCQ – Escape-Avoidance</th>
<th>WCQ – Accepting Responsibility</th>
<th>WCQ – Distancing</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSI – Somatization</td>
<td>.33**</td>
<td>.11</td>
<td>.22*</td>
</tr>
<tr>
<td>BSI – Obsessive-Compulsive</td>
<td>.44**</td>
<td>.22*</td>
<td>.19*</td>
</tr>
<tr>
<td>BSI – Interpersonal Sensitivity</td>
<td>.44*</td>
<td>.21*</td>
<td>.21*</td>
</tr>
<tr>
<td>BSI – Depression</td>
<td>.46**</td>
<td>.23*</td>
<td>.17</td>
</tr>
<tr>
<td>BSI – Anxiety</td>
<td>.41**</td>
<td>.19*</td>
<td>.24**</td>
</tr>
<tr>
<td>BSI – Hostility</td>
<td>.40**</td>
<td>.18</td>
<td>.15</td>
</tr>
<tr>
<td>BSI – Phobic Anxiety</td>
<td>.35**</td>
<td>.16</td>
<td>.21*</td>
</tr>
<tr>
<td>BSI – Paranoid Ideation</td>
<td>.50**</td>
<td>.24*</td>
<td>.22*</td>
</tr>
<tr>
<td>BSI – Psychoticism</td>
<td>.45**</td>
<td>.30**</td>
<td>.24**</td>
</tr>
<tr>
<td>BSI – Global Symptom Index (GSI)</td>
<td>.51**</td>
<td>.21*</td>
<td>.27**</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01

Only four of the eight Ways of Coping Questionnaire subscales demonstrated any significant correlation with the perceived parenting competence or relationship satisfaction measures when Pearson correlations were calculated (see Table 7.15). There were significant positive correlations between the WCQ Distancing subscale and Worry About Child, Parent Self-Esteem and the Husband Satisfaction (KMS3) item of the
KMS. These findings suggest that participants who use distancing from problems as their way of coping, tended to worry about problems related to their children to a greater degree, strongly wished to change the type of parent they perceived themselves to be, but were satisfied with their relationship with their partner. The Escape – Avoidance subscale was significantly correlated with Worry About Child and Parent Self-Esteem. Therefore, those participants coping with problems by avoiding them, also worried about problems related to their children to a high degree and wished to change the type of parent they perceived themselves to be.

The Positive Reappraisal subscale was significantly positively correlated with the Husband Satisfaction (KMS3) item on the KMS. Thus, participants who sought to create positive meaning through personal growth were quite satisfied in their relationship with their partner. The Accepting Responsibility subscale was significantly positively correlated with Parent Change. Therefore, participants who accepted responsibility for their own role in problems and tried to resolve them, were also seeking to change the type of parent they perceived themselves to be.

Table 7.15 Correlations between Coping (WCQ), Parenting and Relationship Satisfaction (KMS)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry About Child</td>
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<td>.28*</td>
<td>-.20</td>
<td>.16</td>
</tr>
<tr>
<td>Parent Self-Esteem</td>
<td>.28*</td>
<td>.23*</td>
<td>-.04</td>
<td>.25*</td>
</tr>
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<td>Future Parenting</td>
<td>-.15</td>
<td>-.12</td>
<td>-.21</td>
<td>-.14</td>
</tr>
<tr>
<td>KMS1 – Marriage</td>
<td>.20</td>
<td>.07</td>
<td>.21</td>
<td>-.02</td>
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<tr>
<td>Satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KMS2 – Spouse</td>
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<td>.09</td>
<td>.19</td>
<td>-.01</td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KMS3 – Husband</td>
<td>.16</td>
<td>.16</td>
<td>.24*</td>
<td>.07</td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KMS Total</td>
<td>.19</td>
<td>.09</td>
<td>.20</td>
<td>-.06</td>
</tr>
</tbody>
</table>

*p < .05
Hypothesis 6
That there will be an association between attributional style and current psychological adjustment in terms of level of psychological symptoms.

To test this hypothesis, attributional style was measured using the Attributional Style in Relation to Abuse (ASRA) (Lalor, 1994) measure and current psychological adjustment was measured using the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982). Given that the various items on the ASRA appeared to be assessing somewhat different constructs, individual items were treated as separate outcome variables (ASRA1-Current fault, ASRA2-Past fault, ASRA3-Abuse cause, ASRA4-Abuse reflective, ASRA5-Abuse controllable, ASRA6-Abuse responsibility). Correlations were calculated between these ASRA variables and the BSI subscales.

Only three of the six ASRA items were significantly correlated with the BSI subscales (see Table 7.16). The Current fault (ASRA1) item of the ASRA measure was found to be significantly positively correlated with all of the BSI subscales: Psychoticism, Paranoid Ideation, Anxiety, Phobic Anxiety, Interpersonal Sensitivity, Depression, Somatization, Obsessive – Compulsive, Hostility and the Global Symptom Index (GSI). These findings indicate that those participants who currently blame themselves for the abuse also had a higher level of negative psychological symptoms in each domain on the BSI. The Abuse cause (ASRA3) item of the ASRA measure was found to be significantly positively correlated with the BSI subscales of Interpersonal Sensitivity, Obsessive-Compulsive, Somatization and Phobic Anxiety. These results suggest participants who attributed the cause of the abuse to an aspect of themselves were likely to have elevated symptoms relating to feelings of inferiority, phobias, obsessive-compulsive behaviours and somatic symptoms. The Abuse reflective (ASRA4) item of the ASRA was found to be significantly positively correlated with the BSI subscales of Phobic Anxiety and Psychoticism. Therefore, participants who believed the abuse was reflective of themselves tended to also be phobic, withdrawn and isolated. Participants with a tendency to blame themselves for the abuse demonstrated a higher level of psychological symptomatology in general, and social withdrawal in particular.
Table 7.16 Correlations between Attributional Style (ASRA) and Current Psychological Adjustment (BSI)

<table>
<thead>
<tr>
<th></th>
<th>ASRA1 - Current fault</th>
<th>ASRA3 – Abuse cause</th>
<th>ASRA4 – Abuse reflective</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSI – Somatization</td>
<td>.28**</td>
<td>.19*</td>
<td>.17</td>
</tr>
<tr>
<td>BSI – Obsessive – Compulsive</td>
<td>.25**</td>
<td>.20*</td>
<td>.09</td>
</tr>
<tr>
<td>BSI – Interpersonal Sensitivity</td>
<td>.35**</td>
<td>.25**</td>
<td>.16</td>
</tr>
<tr>
<td>BSI – Depression</td>
<td>.29**</td>
<td>.11</td>
<td>.10</td>
</tr>
<tr>
<td>BSI – Anxiety</td>
<td>.33**</td>
<td>.07</td>
<td>.13</td>
</tr>
<tr>
<td>BSI – Hostility</td>
<td>.21*</td>
<td>.11</td>
<td>.02</td>
</tr>
<tr>
<td>BSI – Phobic Anxiety</td>
<td>.41**</td>
<td>.19*</td>
<td>.21*</td>
</tr>
<tr>
<td>BSI – Paranoid Ideation</td>
<td>.35**</td>
<td>.13</td>
<td>.14</td>
</tr>
<tr>
<td>BSI – Psychoticism</td>
<td>.39**</td>
<td>.14</td>
<td>.20*</td>
</tr>
<tr>
<td>BSI – Global Symptom Index (GSI)</td>
<td>.40**</td>
<td>.18</td>
<td>.17</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01

**Hypothesis 7**

That there will be an association between attributional style, parenting competence and relationship satisfaction.

To assess this hypothesis, attributional style was measured using the Attributional Style in Relation to Abuse (ASRA) measure developed by Lalor (1994), parenting competency was assessed using a measure developed by Banyard (1997), and relationship satisfaction was assessed using the Kansas Marital Satisfaction Scale (KMS) (Schumm et al., 1986).

No significant correlations were found between attributional style, parenting competence, or relationship satisfaction.

**Hypothesis 8**

That there will be an association between beliefs regarding the abuse and current psychological adjustment, in terms of level of psychological symptoms.
To test this hypothesis, beliefs were measured using the Belief Inventory developed by Jehu (1988) and current psychological adjustment was assessed using the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982).

It can be seen from the correlation matrix in Table 7.17 that all three of the Belief Inventory subscales of Self-Esteem, Guilt, and Self-Blame were significantly positively correlated with all of the BSI subscales and the Global Symptom Index (GSI). These findings suggest participants with low self-esteem, strong feelings of guilt and a high degree of self-blame in relation to their sexual abuse, had concomitantly a high level of negative psychological symptoms across all domains.

<table>
<thead>
<tr>
<th></th>
<th>BI – Self-Esteem</th>
<th>BI – Guilt</th>
<th>BI – Self-Blame</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSI – Somatization</td>
<td>.52**</td>
<td>.21*</td>
<td>.36*</td>
</tr>
<tr>
<td>BSI – Obsessive – Compulsive</td>
<td>.42**</td>
<td>.25**</td>
<td>.22*</td>
</tr>
<tr>
<td>BSI – Interpersonal Sensitivity</td>
<td>.55**</td>
<td>.30**</td>
<td>.38**</td>
</tr>
<tr>
<td>BSI – Depression</td>
<td>.61**</td>
<td>.23*</td>
<td>.32**</td>
</tr>
<tr>
<td>BSI – Anxiety</td>
<td>.59**</td>
<td>.25**</td>
<td>.29**</td>
</tr>
<tr>
<td>BSI – Hostility</td>
<td>.42**</td>
<td>.27**</td>
<td>.37**</td>
</tr>
<tr>
<td>BSI – Phobic Anxiety</td>
<td>.51**</td>
<td>.26**</td>
<td>.27**</td>
</tr>
<tr>
<td>BSI – Paranoid Ideation</td>
<td>.59**</td>
<td>.38**</td>
<td>.40**</td>
</tr>
<tr>
<td>BSI – Psychoticism</td>
<td>.59**</td>
<td>.36**</td>
<td>.45**</td>
</tr>
<tr>
<td>BSI – Global Symptom Index (GSI)</td>
<td>.64**</td>
<td>.34**</td>
<td>.45**</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01

**Hypothesis 9**
That there will be an association between beliefs regarding the abuse and parenting competence, and relationship satisfaction.
To test this hypothesis, beliefs regarding the abuse were measured using the Belief Inventory developed by Jehu (1988), and parenting competency using a measure developed by Banyard (1997), and relationship satisfaction using the Kansas Marital Satisfaction Scale (KMS) (Schumm et al, 1986).

Table 7.18 Correlations Between Beliefs Regarding Abuse (BI) and Parenting Competence, and Relationship Satisfaction (KMS)

<table>
<thead>
<tr>
<th></th>
<th>BI – Self-Esteem</th>
<th>BI – Guilt</th>
<th>BI – Self-Blame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry About Child</td>
<td>.21</td>
<td>.02</td>
<td>.17</td>
</tr>
<tr>
<td>Parent Self-Esteem</td>
<td>.27*</td>
<td>.23*</td>
<td>.24*</td>
</tr>
<tr>
<td>Future Parenting</td>
<td>.02</td>
<td>-.00</td>
<td>-.05</td>
</tr>
<tr>
<td>KMS1 – Marriage Satisfaction</td>
<td>-.10</td>
<td>-.03</td>
<td>.03</td>
</tr>
<tr>
<td>KMS2 – Spouse Satisfaction</td>
<td>-.09</td>
<td>-.02</td>
<td>.04</td>
</tr>
<tr>
<td>KMS3 – Husband Satisfaction</td>
<td>-.18</td>
<td>-.04</td>
<td>.01</td>
</tr>
<tr>
<td>KMS Total</td>
<td>-.11</td>
<td>-.01</td>
<td>.02</td>
</tr>
</tbody>
</table>

*p < .05

It can be seen from the correlation matrix in Table 7.18 that each of the three Beliefs Inventory subscales of Self-Esteem, Guilt and Self-Blame demonstrated a significant positive correlation with only the Parent Self-Esteem item of parenting competence and none of the KMS items. These results indicate participants who wished to change the type of parent they perceived themselves to be, also had low self-esteem, strong guilt feelings and high self-blame in relation to their sexual abuse.

Summary of the Relationships between Coping, Attributions, Beliefs and Current Psychological Adjustment

Three of the coping methods were strongly positively correlated with all of the BSI subscales. It would appear that utilizing coping strategies that rely upon escaping or avoiding the problem, accepting responsibility for the problem or distancing oneself
from the issue, are associated with a greater degree of psychological distress. The same coping methods were linked to negative perceptions of parenting competency, whilst positive reappraisal as a method of coping was related to the participant’s relationship with her husband receiving a high satisfaction rating. Attributional style in relation to the abuse was primarily related to symptoms involving phobias, feelings of inferiority and social withdrawal. In contrast, no relationship was found between attributional style and either parenting competency or relationship satisfaction. Beliefs about the abuse relating to self-esteem, guilt, and self-blame were associated with a higher level of psychological symptoms across all the domains. This finding suggests that those who continue to blame themselves for the abuse also have a high level of psychological difficulties. These individuals also strongly wished to change the type of parent they perceived themselves to be. There was no relationship between beliefs about the abuse and relationship satisfaction.

**Relationship Between Sexual Abuse Characteristics and Current Psychological Adjustment**

A number of hypotheses were generated, at the end of the Introductory chapters, regarding the characteristics and nature of sexually abusive activities which may play a role in determining the long-term psychological adjustment of CSA survivors:

**Hypothesis 10**

That higher severity of CSA, as indicated by:
- a younger age at commencement
- longer duration
- higher number of perpetrators
- greater degree of familiarity of perpetrator (father/stepfather)
  - higher degree of severity of abusive acts
- greater use of force or coercion

will be associated with poor adult adjustment in the following areas:
- current psychological adjustment – in terms of level of psychological symptoms
- negative perceptions of parenting competency
- lack of relationship satisfaction
In order to test these hypotheses, a series of correlational analyses were conducted. Severity of abuse was operationalized using six measures: age at the commencement of abuse (in years), the duration of sexual abuse (in days), the number of perpetrators, whether the father/stepfather was the perpetrator, severity of sexually abusive acts, and the use of force or coercion.

Current psychological adjustment was evaluated using three measures: the BSI, parenting competency, and relationship satisfaction (KMS). Results of the correlations are summarized in Table 7.19. Only three of the six measures of sexual abuse severity were significantly correlated with measures of current psychological adjustment.

Firstly, the presence of a father/stepfather, rather than someone else, as perpetrator was significantly negatively correlated with all three items of the KMS: marriage, spouse, relationship and the KMS total. These findings suggest that those participants who were abused by a father/stepfather experienced strong dissatisfaction with their marriages, their husband as a spouse and their relationship with their husband, and accordingly their marital relationship in general. It should be noted that many participants were not married and were referring to their partners from long-term relationships.

Secondly, the degree of severity of sexual acts was significantly positively correlated with the Hostility, Somatization, Anxiety, and Paranoid Ideation subscales of the BSI. These results indicate that participants who experienced abuse involving more severe sexual acts demonstrated higher levels of symptoms relating to anger, bodily dysfunction, general anxiety and paranoid thinking.

Thirdly, the presence of the use of force or coercion to induce participation in sexual activities was significantly positively correlated with the Somatization, Paranoid Ideation, and Phobic Anxiety subscales of the BSI. Those participants who had been forced into participating in the sexual abuse reported higher levels of symptoms relating to bodily dysfunction, paranoid thinking and phobias.
| Table 7.19 Correlations between Sexual Abuse Characteristics and Current Psychological Adjustment |
|-----------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                                   | Age at onset of abuse (years) | Duration of abuse (days) | Number of perpetrators | Father/ Stepfather as perpetrator | Severity of sexually abusive acts | Use of force/ Coercion |
| BSI – Somatization                | -.16             | .17             | .07             | -.05             | .22*             | .22*             |
| BSI – Obsessive – Compulsive      | -.06             | .05             | .02             | .14             | .18             | .14             |
| BSI – Interpersonal Sensitivity   | .03              | -.00            | -.09            | .09             | .10             | .06             |
| BSI – Depression                  | -.08             | -.02            | -.04            | .11             | .09             | .07             |
| BSI – Anxiety                     | -.11             | .01             | .02             | .09             | .20*             | .13             |
| BSI – Hostility                   | -.10             | .10             | .10             | .14             | .37**            | .18             |
| BSI – Phobic Anxiety              | -.04             | .08             | .14             | .12             | .17             | .20*             |
| BSI – Paranoid Ideation           | .00              | .17             | .08             | .08             | .20*             | .21*             |
| BSI – Psychoticism                | .02              | .04             | -.00            | .09             | .11             | .18             |
| BSI – Global Symptom Index (GSI)  | -.09             | .09             | .07             | .10             | .18             | .17             |
| Worry About Child                 | -.10             | -.03            | -.11            | -.22            | .00             | -.04            |
| Parent Self-Esteem                | .03              | .02             | .11             | .20             | .16             | .17             |
| Future Parenting                  | .00              | -.03            | -.10            | -.08            | -.17            | -.16            |
| KMS1 – Marriage Satisfaction      | -.04             | .06             | .02             | -.43*            | .07             | .09             |
| KMS2 – Spouse Satisfaction        | .00              | .16             | .02             | -.51**           | .06             | .05             |
| KMS3 – Husband Satisfaction       | .03              | .12             | -.02            | -.50**           | -.02            | -.02            |
| KMS Total                         | .03              | .05             | -.06            | -.53**           | .05             | .04             |

*p < .05, **p < .01
Summary of the Relationship Between Sexual Abuse Characteristics and Current Psychological Adjustment

In terms of the relationships between sexual abuse characteristics and current psychological adjustment, three of the measures of sexual abuse characteristics demonstrated no associations with current adjustment. Thus, the age at the commencement of the abuse, the duration of the abuse and number of perpetrators demonstrated no relationship to current psychological adjustment in terms of level of psychological symptoms, parenting competency or relationship satisfaction. However, having a father/stepfather as the perpetrator was associated with dissatisfaction in all facets of the individual’s relationship with her partner. Those participants who had experienced more severe sexual acts during their abuse displayed greater anger, somatization, anxiety and paranoid thinking. Similarly, the use of force or coercion to induce participation in the abusive activities was associated with higher levels of symptoms relating to somatization, paranoid thinking and phobias.

Multiple Regression Analyses to Predict Adult Psychological Adjustment

Five standard multiple linear regression analyses were conducted to evaluate the contributions of the thirteen predictor (independent) variables to the prediction of the five outcome (dependent) variables of current psychological adjustment (BSI scores), marital satisfaction (KMS scores) and perceived parenting competency (Worry About Child, Parent Self-Esteem, Future Parenting). Selection of the thirteen independent variables was based on the correlational analyses outlined previously. The variables selected comprised Ways of Coping (WCQ) subscales of Escape-Avoidance, Distancing, Accepting Responsibility, Positive Reappraisal; Attributions in Relation to Abuse (ASRA) items of Current fault, Abuse cause, Abuse reflective; Belief Inventory (BI) subscales of Self-Esteem, Guilt, Self-Blame; and sexual abuse severity measures of father figure as perpetrator, coercion and severity of sexual acts. It can be seen from Table 7.20, that the predictor variables significantly predicted current psychological adjustment (BSI scores) and perceived parenting competency in terms of Parent Self-Esteem.
When current psychological adjustment, as measured by the BSI total score (GSI), was used as the dependent variable, $R$ for regression was significant, $F(13, 104) = 9.85, p = .00, R^2 = .55$. There were four independent variables which uniquely contributed significantly to prediction of current psychological adjustment: escape-avoidance method of coping ($sr^2 = .04$), distancing method of coping ($sr^2 = .01$), father figure as perpetrator ($sr^2 = .01$), and beliefs relating to guilt about the abuse ($sr^2 = .01$). All thirteen of the predictor variables in combination accounted for 55% of the variance in current psychological adjustment (see Table 7.20).

When Marital Satisfaction was used as the dependent variable, $R$ for regression was not significant, $F(13, 104) = 1.56, p = .11$. Therefore, the combination of the thirteen predictor variables did not significantly predict marital satisfaction (see Table 7.20).

The three items of Worry about Child, Parent Self-Esteem and Future Parenting, from the perceived parenting competency measure by Banyard (1997) were treated as separate variables in these regression analyses given their low intercorrelations. When Worry About Child was used as the dependent variable, $R$ for regression was not significant, $F(13, 104) = 1.73, p = .07$. Therefore, the combination of the thirteen predictor variables did not significantly predict the level of worry about problems in relation to the participant’s children (see Table 7.20).

When Parent Self-Esteem was used as the dependent variable, $R$ for regression was significant, $F(13, 104) = 1.95, p < .03, R^2 = .20$. Therefore, the combination of the thirteen predictor variables accounted for 20% of the variance in how much the participant wished to change the type of parent she perceived herself to be (see Table 7.20).

Nine of the independent variables uniquely contributed significantly to prediction of the participant’s parenting self-esteem: distancing method of coping ($sr^2 = .03$), accepting responsibility method of coping ($sr^2 = .02$), father figure as perpetrator ($sr^2 = .01$), positive reappraisal as a method of coping ($sr^2 = .01$), current attributions that the abuse was the participant’s fault ($sr^2 = .01$), attributions that the abuse was reflective of
the participant ($sr^2 = .01$), that coercion occurred ($sr^2 = .01$), beliefs relating to guilt about the abuse ($sr^2 = .01$) and beliefs relating to self-blame for the abuse ($sr^2 = .01$).

Table 7.20 Regression Equations Predicting Current Psychological Adjustment, Marital Satisfaction and Perceived Parenting Competency

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>$R^2$</th>
<th>$R$</th>
<th>$F$</th>
<th>$Sr^2$</th>
<th>Unique Predictors</th>
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<td>.74</td>
<td>9.85</td>
<td>.04</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>.01</td>
<td>WCQ: Distancing</td>
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<td>.01</td>
<td>Father figure as perpetrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.01</td>
<td>BI: Guilt</td>
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<tr>
<td>KMS Total Score</td>
<td>Ns</td>
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<tr>
<td>Worry About Child</td>
<td>Ns</td>
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<tr>
<td>Parent Self-Esteem</td>
<td>20%</td>
<td>.32</td>
<td>.92</td>
<td></td>
<td>WCQ: Distancing</td>
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<td>.03</td>
<td>WCQ: Accepting</td>
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<td>Responsibility</td>
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<td>Father figure perpetrator</td>
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<td>.01</td>
<td>WCQ: Positive</td>
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<td>Reappraisal</td>
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<td>ASRA1: Current Fault</td>
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<td>.01</td>
<td>ASRA4: Abuse Reflective</td>
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<td>.01</td>
<td>Coercion</td>
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<td>BI: Guilt</td>
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<td></td>
<td>BI: Self-Blame</td>
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<tr>
<td>Future Parenting</td>
<td>Ns</td>
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When Future Parenting was used as the dependent variable, $R$ for regression was not significant, $F (13, 104) = .92, p = .54$. Therefore, the combination of the thirteen predictor variables did not significantly predict the participant’s feelings regarding her future parenting capacity (see Table 7.20).

**Qualitative Data**

**Perception of Benefit**

Content analysis of the qualitative data relating to perception of benefit was carried out by careful reading of the material, followed by categorization, synthesis and interpretation of the responses. Following a question regarding how much benefit they felt they had received from the unwanted sexual contact they had experienced, the participants were asked to comment further regarding in which areas they believed they had benefited. The participants were then provided with a listing of the four areas which had emerged when participants in McMillen et al.’s (1995) study were provided with an open-ended question regarding this topic. In addition to comments regarding the specific themes, a number of participants wrote comments relating to the whole question of perceived benefit. The following sections will outline these general comments, followed by comments relating to the specific benefit types of protection of children, self-protection, increased knowledge of sexual abuse, and becoming a stronger person. A total of 100 participants (85%) wrote additional comments relating to this part of the questionnaire.

**General Comments**

In all, nine of the participants wrote general comments in relation to the question of perceived benefit from sexual abuse. Understandably, some participants objected to the notion of perceived benefit from what is universally regarded as a negative experience:

“Stupid question – why would you get any benefit??”

“I haven’t benefited at all my perpetrator has.”
“I have a problem, with the word “benefit”.”

However, even those who felt ambivalent about whether it was really of benefit, acknowledged that benefit existed in some form:

“The only benefit is that I understand what people in my situation might be experiencing.”

“At least I was given food.”

“I 1st Time = No benefit. Later – it shocked me – woke me from a sexually promiscuous stupor.”

“Once I dealt with the situation I resolved not to be made worthless by anyone again. I learn’t to look for benefits in anything.”

Protection of Children

A total of 82 (69%) participants wrote comments in relation to whether they felt their experience of CSA had led to the benefit type of protection of children. The vast majority of participants commented on perceptions of how their experience had led them to be very protective of their own children:

“My children always tell me I am over-protective. I watch them like a hawk and was very strict on who babysat or let alone with (them).”

“Very careful with my own children – yet very aware of not isolating them because of my fears – have good communication with them.”

“As a mother I have been paranoid about my children’s safety in male company. I didn’t even trust my husband. I hated to see anyone cuddling or kissing them.”
“It has taken a long time for me to let my children sleep-over – even within close family. I’m forever amazed how parents have just dropped kids at my door without even knowing me and who is in the house, who stays here etc.”

Other participants took the view that they had a particular understanding of children experiencing sexual abuse and felt a responsibility to campaign for greater public awareness of the issue:

“I am a strong advocate for the safety and welfare of children.”

“I’m more aware of what can happen and take steps to protect my own children. Also writing books to help protect other children. And speaking out about abuse when I can.”

“A greater understanding of how vulnerable children are, and how childhood experience can mould a person’s personality. Children have rights too.”

“My own situation has allowed me to realise the vital importance discussing sexual abuse is with children. Having discussed my situation with several of my friends I have enlightened them and assisted them with tips on how to broach the subject of sexual abuse with their children.”

“One day any ‘knowledge’ may help to save a child from similar experience & minimize damage that years of non disclosure can cause. I see this as a positive.”

Some participants were quite aware of a cycle of abuse, with some lamenting its continuation for another generation amongst their own children:

“I have broken the chain and protected my daughter.”

“I followed the same pattern my parents had set and did not protect my children from abuse.”
“Had I realized that my gut instincts were correct and that my sister had confirmed my suspicions earlier other members of the family might have believed me and helped me to protect my children from my belief that my father has sexually abused either one or both of my 2 children from an early age.”

“I get very upset if I hear about abuse of any type to kids. I failed myself to protect my kids from this same man. I just never thought he’d touch them.”

“I could not protect my own children until after I had my own counselling.”

“Besides the 1 incident when my daughter was 11 months, I have learned. My children have enjoyed their childhood because I never put them or myself in situations where they can be abused. I know constantly where they are and who they are with, most of all they know they are loved and wanted.”

Alternatively, for a number of participants, their experience of CSA profoundly impacted upon their decision to remain childless:

“Choosing not to have them.”

“I was too scared to have a child.”

“I have benefited from the abuse by seeing it through new eyes and being honest about my feelings to do with it. Like excitement rather than living in my parents judgements which ultimately become my own self judgements. I have not had children as I am still terrified that I cannot look after them properly. That I am damaged.”

“I have not had children as I believe I could never protect them from abuse. ie would be afraid for them.”
“Paramount, of course. I was not able to conceive because my insides were so ruined.”

**Self-Protection**

A total of 70 (59%) of participants commented in relation to whether their experience of CSA had been of benefit in the area of self-protection. This perception appeared to be closely linked to the participant’s level of self-esteem. A few participants reported experience of behaviour which they later viewed as inappropriate:

“I didn’t really understand that I needed to protect myself until I was much older, as a young adult/teenager my self esteem let me do more damage to myself which is hard to come to terms with now.”

“I have been provocative in many relationships since the abuse.”

“I am able to choose the people I associate with and avoid abusive relationships that were once part of my life. I listen to my gut instead of my head.”

“It has not helped me. I got sexually involved frequently through my life – maybe as self punishment.”

Participants in general were characterized by a lack of trust in others and men in particular:

“I don’t trust anyone – not even my husband sometimes.”

“I put up barriers so don’t allow men to get too close or see my vulnerability.”

“Unable to have a sexual relationship ie. penetration (self protection).”

“My barriers are still up. I will not allow anyone to become close to me. I don’t trust anyone, especially men.”
“Have doubts about my judgement of people. Doubts about capabilities of handling people contact at work. Probably affects forming of close relationships.”

Some participants spoke of developing a façade to cope with the outside world:

“I try & protect myself by giving the image of myself being extremely strong but I am very vulnerable & scared inside.”

“Not that many people really know me.”

“I never let anyone, pass my barriers. Also, they will never see the real me. I put up facade (façade) who I am.”

“Yes by journeying façade, scared of intimacy take strength and allowing finally vulnerability and fragility in my feelings, and opening up to love and affection and trust.”

On a more positive note, some participants were able to describe how they had become more assertive or self-reliant:

“Taken self-defence course.”

“I still have a way to go with this one but am definitely getting better each year as I become more assertive.”

“Not be a victim or seen as a victim.”

“No friendships – have become self reliant.”

“Realize that I am the only person who is going to protect me. Made me very self reliant.”
One participant provided a comprehensive summary of her views, which seemed to reflect the sentiments of many others:

“I don’t know if I benefited – looking back on my life I think I suffered from generalized anxiety until 4 years ago (after a year of therapy). I think I was frightened of everything & everyone (although I had a brave front and even hid these feelings from myself). Because I was who I was I didn’t acknowledge my underlying anxiety. I didn’t even realize that I lacked self-esteem because I hid behind alcohol, marijuana (smoked nearly every day for 15 years) occasional speed & heroin.”

**Increased Knowledge of Sexual Abuse.**

In total, 78 (66%) of participants commented in regards to having an increased knowledge of sexual abuse as a result of their CSA experience. Only a few participants provided comments that had a guarded tone:

“Don’t talk about it and I don’t like hearing about it.”

“No – I don’t understand why people abuse. It has made me a very angry person inside. It has made me believe situations are not as they seem to be.” “I am not a fool, everywhere these events occur. I have no answers, and choose to stick to myself, my ears work and that I can offer, but not much else.”

“I have only told people close to me about what happened.”

A great number of the participants commented upon how they believed their abuse experience had made them perceptive of the universality of the issue:

“My own abuse has made me more self aware & compassionate. Everyone has a story to tell……sexual abuse is very common, people just don’t talk about family secrets!”
“Friends have later discussed their own abuse, or abuse of those close to them.”

“As an adult I have become aware of how widespread sexual abuse of minors is.”

“I now know that anyone is capable of being an offender.”

“I understand many aspects of sexual abuse now & can relate to so many experiences of other women and know what they are feeling & what to say to them.”

“I feel I have a greater understanding of how common sexual abuse is and how much it can really screw up someone’s life.”

For some participants, researching the nature of sexual abuse seemed to provide a way of regaining some control:

“At the age of 14 I found out that incest was what was happening to me, I stopped my attacker and told him not to touch me again – later I learned the power dynamics involved, I have gone out of my way to learn the mechanisms and how to dissolve his power.”

“Counselling & literature….I have read what I can find & been to counselling (very helpful).”

“I have receive a lot of help from social workers I move a lot trying to find true peace. Read lots of books.”

“I have learn’t a great deal about this – especially from books like ‘The Courage to Heal’. I feel very wise, although being immersed in this issue can be depressing & overwhelming & definitely affects my happiness.”

“Ive done a bit of reading on it. What are the signs, side affect, physical & mental & I volunteer for Lifeline on the phones. So I hear other people in similar
situation.”

“As an adult I have an obsession about learning all I can about sexual abuse to children.”

Whilst some participants made a clear link between their experience of CSA and their vocational choices, many sought to raise public awareness of the issue:

“I’ve been in groups, talked & meat (met) with many people due to sexual abuse.”

“Facilitator of support group.”

“I was partially instrumental in the starting of an open group for sexually abused women. I write to the newspapers about sexual abuse frequently. Some letters were printed.”

“It’s out there – people should be educated about sexual abuse.”

“Children should be told to tell an adult if sexual abuse occurs.”

“Needs to be more “Awareness” campaigns publicly.”

**Stronger Person**

A total of 86 (73%) of participants commented on whether they believed their experience of CSA had made them a stronger person. The comments ranged across the continuum, from negative or defiant through ambivalence to the development of inner strength. Those comments which were characterized as negative included:

“No, it’s made me a nervous, emotionless adult, not to mention overweight.”
“I was already strong – I feel weakened & self-conscious by abuse – damaged but not stronger because of it.”

“Only after 2 nervous breakdowns, 2 times 2 years of counselling. I think I would have been better off without the abuse in the first place.”

“I would love to feel strong & confident within myself but I feel I have carried this for too long.”

“No I’ve gone through sh…..Despite counselling.”

“Other crises in my life have left me a much stronger person in some areas but certainly not in the area discussed here.”

A couple of the participants expressed defiance as a result of their abusive experience:

“Has made me a ‘little over the top’ when it comes to being defiant or direct.”

“Have a ‘don’t fuck with me!’ outlook.”

Some participants held quite an ambivalent attitude regarding perceived benefit from their abusive experience:

“Stronger in some areas and not others. Stronger can be good and bad.”

“It’s hard to say if I am a stronger person because I didn’t get to experience the adult I would’ve been if I hadn’t been abused.”

“I think I am a stronger person but still have too many fears.”
“In some ways I can see I am a stronger person however I know that the abuse has seriously affected my life (drug & alcohol abuse from ages 15-30) & I see it effecting me still today with my inability to get a job which reflects my abilities. I get cognitive disfunction in interviews & on one hand I know I could do a particular job on the other hand I doubt myself.”

“Yes BUT who would I have been and at times, not often anymore, I grieve for not having been allowed to be that person.”

A sizeable number of participants credited their abusive experience with leading to development of an inner strength:

“Definitely feel stronger as a result of my experiences. That’s the positive that came out of a very negative situation.”

“I would not be the person I am today had this not happened to me. I have done much more personal growth than most people I know.”

“I am a stronger person, I don’t believe that I could have achieved as much, without the experience, as I have to this day, I’m a very determined person.”

“I am stronger & for this time & age that is a good thing. (e.g. the rise in crime/abuse & generally the world as a whole).”

“Not stronger from knowledge but knowing I can endure & successfully operate despite what was done to me.”

Many participants described a long road to recovery following their abusive experience:

“Definitely, after nearly 3 years with a good supportive man, 12 weeks of councilling at the Rape Crisis Centre & a few months with a phschiatrist (bad spelling) and a lot of soul searching, tears & tantrums. At least now I can
see a light at the end of the tunnel.”

“Once I stopped trying to kill myself, I’ve grown. Many have said they don’t know how I cope with what I cope with.”

“Proud of myself that I’m still alive and highly respected in my work – even though I have a nervous breakdown almost every 4-5 years.”

“I’m stronger for the experience coming through the flashbacks, depression & alcohol abuse (now 7 1/2 years sober) & living life & enjoying life. Providing my own needs and able to talk about without shame or embarrassment.”

“After finally accepting/recognizing what had happened many years ago – I faced my demons, all the things that I had hidden – I feel happier, lighter, yet stronger emotionally. I am more aware of what type of person I am – and I am O.K. I am a lovely, wonderful strong woman.”

**Participants’ Additional Comments**

Although qualitative data were not sought for any other sections of the questionnaire, 89 (75%) of participants wrote comments in relation to particular sections, questions or issues regarding CSA in general. Many of the participants provided comments on the relationship status question and characteristics of their family-of-origin, which were coded and added into the main analyses of results. Comments relating to the characteristics of the CSA were treated similarly, although a number of these comments related to the participants’ memory difficulties, which made answering the questions difficult. The following sections cover comments relating to the quantitative measures of the Brief Symptom Inventory (BSI), Belief Inventory (BI), Attributions in Relation to the Abuse (ASRA) measure, Ways of Coping Questionnaire (WCQ), Parenting, and Kansas Marital Satisfaction Scale (KMS). The final section deals with general comments relating to the research study.
Brief Symptom Inventory (BSI)

A few participants made general comments in reference to the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982), indicating that they perceived some of the physical symptoms they experienced as being due to other causes such as menopause. One participant marked the questionnaire twice, from the perspective of before and after counselling. Participants placed a particular emphasis on providing extra information in relation to the item “Thoughts of ending your life” (9), suggesting this was a salient issue for them. A number of participants also reinforced their difficulties with anxiety related behaviours such as checking, and suggestions that they might have a mental condition.

Belief Inventory (BI)

Participants comments in relation to the Belief Inventory (Jehu, 1988) particularly focussed on two items, “The offender abused me because he was sexually frustrated” (23) and “The offender engaged in sexual activities with me to give me physical pleasure” (26). Participants expressed difficulty in being able to answer these questions because they were unaware of the offender’s underlying motivations, which is understandable given their young age and lack of discussion with the offender in many cases. Participants were clear, however, that in relation to the item “The offender abused me because he was ‘sick’ and therefore not responsible for his actions” (19), although the offender may have been sick, he should definitely be held responsible for his actions.

Attributional Style in Relation to the Abuse (ASRA)

Quite a number of participants expressed difficulty in being able to answer the second item, “At the time of the abuse, I felt that the abuse was…In no way my fault - all my fault” (ASRA2), on the Attribution in Relation to the Abuse (ASRA) measure (Lalor, 1994). The participants’ difficulties seemed to primarily relate to their developmental stage at the time of the abuse, with the typical comment being “I didn’t realise it was abuse”. A few participants also expressed difficulty in understanding the third item of the scale, “Was the cause of the abuse something that reflected on: An
aspect of the situation – an aspect of yourself” (ASRA3). This difficulty led to participants being unable to answer the question.

Ways of Coping Questionnaire (WCQ)

A number of participants provided comments clarifying their answer to the item “I tried to make myself feel better by eating, drinking, smoking, using drugs, or medications, etc.” (33), on the Ways of Coping Questionnaire (WCQ) (Folkman & Lazarus, 1988). Given the range of options provided, participants were keen to confirm which of the behaviours they had used as a way to cope. For the item relating to religious faith, “I found new faith” (36), a couple of participants wished to establish that their faith had been maintained rather than being new.

Parenting

A few comments were expressed in relation to the perceived parenting competency measure (Banyard, 1997), with some participants simply observing their ambivalence about having children as a consequence of their abusive experience.

Kansas Marital Satisfaction Scale (KMS)

The Kansas Marital Satisfaction Scale (KMS) evoked a large range of comments from participants, with many expressing that it was not appropriate to them, as the scale assumes that the participant is currently married. A number of participants outlined current relationship arrangements and complex histories, which they felt did not fall within the scope of the scale. In particular, a couple of participants commented that they were in same sex relationships, and felt these should have been covered “What happened to lesbian relationships!! Your survey is presumptuous as MANY lesbians in relationships have suffered sexual abuse”.

General Comments

Quite a number of participants volunteered narrative comments at the end of the questionnaire, seemingly because they were keen to provide a fuller account of their life experiences following childhood exposure to sexual abuse. Many participants spoke about their experience of counselling and their belief that this had made very significant
improvements to their quality of life. All participants were keen to offer any support they could, despite the obvious pain the issue caused them, to prevent the further abuse of children. Some participants were grappling with current issues relating to their abuse and appeared to use the questionnaire as a method for exploring their feelings.
CHAPTER 8

Study 2: Exploration Of Themes From The Experience Of Childhood Sexual Abuse Survivors

The aim of Study 2 was to explore in greater depth, through the use of telephone interviews and an open-ended method of questioning, themes which emerged from Study 1. Topics were selected on the basis that they related to the impact of CSA on women’s psychological adjustment in adulthood. To provide a marker of the severity of the sexual abuse experienced, three questions were asked regarding the nature of the abuse, its duration, and the nature of the offender’s relationship to the participant. A lack of self-esteem was often mentioned by participants in Study 1 as a major difficulty for them, and this was supported by the literature (Bagley, & Ramsay, 1986; Courtois, 1979; Gold, 1986; Herman, 1981; Hunter, 1991; Jackson et al., 1990). Therefore, it was decided to incorporate Rosenberg’s Self-Esteem Scale (Rosenberg, 1965) into the interview, as this was the measure of self-esteem most commonly used by previous researchers in the field of sexual abuse (Fromuth, 1986; Greenwald et al., 1990; Hunter, 1991; Jackson et al., 1990; Lalor, 1994; McMillen et al., 1995; McMillen, & Zuravin, 1997; Silver et al., 1983). Given the concerns raised about the participants’ lack of control over their environment which had allowed the abuse to occur, it was considered important to investigate the sense of control of women who had experienced CSA. Rotter’s Locus of Control Scale (Rotter, 1966) was used for this purpose, given its extensive prior use in research (Gold, 1986; Jackson et al., 1990; Porter, & Long, 1999) and relative ease of adaptability to an interview format.

Issues which had arisen in relation to parenting in Study 1 were further explored using two questions. These questions were formulated to address whether the participant’s decision to have children or not had been influenced by her experience of abuse, and whether she believed her experience had had an impact on her parenting. The major topic of disclosure of abuse was addressed using Jehu’s (1988) protocol for initial assessment interviews of women who had experienced CSA. The format of this section allowed participants to explain the characteristics of their abuse disclosure as a
narrative. In addition to subsections relating to disclosure in general, during childhood and in adulthood, a final section evaluated disclosure of the abuse to partners. This was followed up with the Intimate Bond Measure (Wilhelm, & Parker, 1988), which had been successfully employed by Mullen et al. (1994) to assess how participants perceived their partners, as caring and/or controlling. The aim was to evaluate whether participants viewed their partners as a source of emotional support and someone in whom they could confide.

The extent to which participants may be searching for meaning in their abuse was investigated using questions adapted from research by Silver et al. (1983). These questions also examined whether participants believed they had been able to resolve feelings about the abuse, deal with it and accept it. An extra question from Mullen et al.’s (1994) study, which sought to explore the participant’s degree of social isolation was also added to this section. Participants were asked their own views on what they believed were the long-term effects of abuse and what would enable them to reduce these effects. This section was based on questions from Mullen et al.’s study, which provided very interesting data on the participant’s own perceptions of their functioning and what was actually attributable to their abuse experience. This questioning had the added benefit of inviting the participant to be actively involved in discussion of the debate surrounding the impact of CSA. It also allowed a transfer into the final interview question regarding whether there were any other issues the participant wished to cover or which she felt had been omitted. This was felt to be very important to determine if there were any other salient topics related to the abuse that had not previously been explored in the research literature and therefore the interview.

**METHOD**

**Participants**

Of the 118 women who completed questionnaires in the first stage of the research, 106 requested to be sent a copy of the summary of results. Six of these results
summaries were returned to sender, so 100 respondents received the invitation to participate in a telephone interview. Thirty-three women indicated their willingness to participate, and all were subsequently interviewed by phone. All women were aged over 18 years and had experienced CSA, as they formed a self-selected subsample of the participants from Study 1. Of the thirty-three participants who were interviewed, 22 (67%) had children and 21 (64%) were currently in a relationship with a male partner.

Measures

Prior to the telephone interviews, a structured interview format was developed, based on the findings from Study 1. This proforma comprised eight sections covering abuse characteristics, self-esteem, locus of control, parenting, disclosure, intimate bonds, the search for meaning and attributions (see Appendix J). Each of these sections will be discussed in detail below.

Abuse Characteristics

It was explained to the participants that three questions would be asked about their actual CSA experience, in order to establish a marker for the remaining sections. This was necessary given that the original questionnaires had been anonymous and so could not be matched with the interview proformas. Participants were asked to indicate which of the three abuse categories of noncontact, fondling, or penetration would cover their abuse. When more than one type was mentioned, the most severe type of abuse was the one used in analyses. Participants were also asked about the duration of their CSA, which was estimated in years. The nature of the offender’s relationship to the participant, being intrafamilial or extrafamilial, was also sought. If a participant indicated that there had been more than one offender, the primary or original offender was used in relationship analyses. The nature of the offender’s relationship to the participant was collapsed into the categories of ‘Nuclear family’ (1), ‘Extended family’ (2), ‘Known other’ (3) or ‘Stranger’ (4).
Rosenberg Self-Esteem Scale

Self-esteem was assessed using the Rosenberg Self-Esteem Scale (Rosenberg, 1965). This is a ten-item scale designed to measure global self-esteem (Wylie, 1979). Each item contains a statement of belief or attitude regarding self-worth. For example, “At times I think I am no good at all”. Items are rated on a four-point Likert scale, with the response options being ‘Strongly agree’ (4) to ‘Strongly disagree’ (1). Scores for each item are summed to obtain a total score, ranging from 10 to 40. Reliability for the scale ranges from .85 on test-retest administrations to .92 using the coefficient of reproducibility (Wylie, 1979). Validity has been found to be acceptable (Demo, 1985).

Rotter’s Locus of Control Scale.

The Internal-External (I-E) Locus of Control Scale developed by Rotter (1966) is a 29 item, forced-choice test which includes six filler items, designed to make the purpose of the test more ambiguous. The scale seeks to measure the participant’s expectations about how reinforcement is controlled and is therefore considered to be a measure of generalized expectancy.

Given the length of the I-E Scale and its self-administration design, it was decided to use a sample of seven items in the telephone interview proforma, to provide an indication only of the participant’s locus of control. The seven items were selected on the basis of being quite general and easily comprehensible given the interview process. An item consists of a pair of statements, with each statement representing alternate beliefs about the nature of the world, being either internal or external. The items were read to the participant, who was asked to select which of the two statements best described her views. The scale is scored by summing the total number of external choices made by the participant, with a possible range from 0 to 7.

Parenting

To explore the issue of parenting, which had arisen as a theme during the first stage of research, participants were asked two questions. The first question sought to establish how, if at all, the interviewee’s decision to have children had been influenced by her experience of CSA. For those who had children, the second question focussed on
the impact, if any, that the CSA had had on their parenting. Aside from a clear indication of whether the decision to have children had been influenced or not and whether there had been an impact on parenting, qualitative responses were reported for these questions.

**Disclosure**

The issue of disclosure was addressed using a protocol for initial assessment interviews developed by Jehu (1988), with minor modifications. The initial questions related to general characteristics of disclosure, with another three subsections being allocated to disclosure during childhood, adulthood, and to partners respectively. These subsections are discussed in more detail below:

**General**

Participants were asked if they had disclosed their experience of abuse, whether they had kept the experience of abuse secret for a period of time and if so, for how long. If participants had kept their abuse secret, they were asked what factors had contributed to this secrecy. The proforma included a range of possible responses for the interviewer’s benefit, but participants simply articulated their own thoughts on this. Participants were also asked to rate to what extent they would have liked to tell others but held themselves back from doing this. Answers ranged on a five-point Likert scale from ‘I have not wanted to tell anyone’ (1) to ‘I have very much wanted to tell others but did not’ (5).

**Childhood Disclosure**

In the second subsection, participants were asked if they had disclosed their experience of abuse before reaching the age of 17 years and if so, what age were they at the time. Participants were also asked who they had told, and if they had told a third party, what factors had led to this. Participants were also questioned regarding the reactions of significant others and the consequences of the disclosure of abuse prior to the age of 17 years. Lists of possible responses were provided on the proforma, for the interviewer’s benefit, in relation to the two questions about factors and the two questions about reactions and consequences respectively. Aside from the first two questions
whose responses could be quantitatively analyzed, the remaining responses were qualitative in nature.

**Adult Disclosure**

In the third subsection, participants were asked what factors led to their disclosure as an adult and who they told. Participants were also questioned as to reactions of significant others to the disclosure and what were the consequences of the disclosure. For the three questions relating to factors, reactions and consequences, the proforma provided a list of possible responses for the interviewer’s benefit. For all of the questions in this section, the participants provided qualitative responses.

**Partner Disclosure**

In the final subsection, participants were asked whether they were in a relationship, and if so, whether their current partner knew about their experience of CSA and their reactions to this. Participants were also asked whether they had informed previous partners about their experience of abuse and their reactions to this. Aside from the quantitative data obtained regarding the participant’s past and present relationship status and whether disclosure occurred, qualitative responses were provided by participants in relation to current and previous partner’s reactions.

**Intimate Bond Measure (IBM)**

The Intimate Bond Measure (IBM) is a 24-item self-report measure developed by Wilhelm and Parker (1988), as an instrument for assessing the nature of intimate relationships. The two key underlying dimensions of care and control are reflected in division of the scale into the Care and Control subscales, each comprised of 12 items. Given the length of the IBM and its design for use as a self-report measure, it was decided to select eight items, comprised of four items from each of the Care and Control Scales, for use in the interview proforma. Items were selected on the basis of being general in nature, for example, “Is a good companion” (Care subscale) and “Seeks to dominate me” (Control subscale). Participants were read each item and asked to rate their partner’s attitudes and behaviour towards them in recent times on a four-point Likert scale, with response options ranging from ‘Very true’ (4), to or ‘Not at all (1).
These scores were then collapsed down to ‘Very true’ (3), ‘Moderately true’ (2), ‘Somewhat true’ (1) and ‘Not at all’ (0). The scores are summed for each of the two subscales, with a possible range from 0 to 12, given the selection of four items from each subscale.

**Searching for Meaning**

Silver et al. (1983) provided a method for assessing the extent to which participants may search for meaning following experience of an abusive experience. The researchers operationalized this search for meaning using two closed response questions. The first question related to “why me?” and the second question asked participants how often they found themselves “searching for some reason, meaning, or way to make sense out of their incest experience”. Participants were asked to rate on a five-point Likert scale ranging from ‘Never’ (1) to ‘Always’ (5). The two items were found to be highly correlated ($r = .56, p < .00$) and were thus combined into an index of the frequency with which respondents engaged in a search for meaning.

Five other questions were developed based on the findings from Silver et al.’s (1983) research. These questions focussed on whether the participants had been able to find meaning in their abusive experience and the degree to which they had resolved their feelings about the abusive experience. Participants were also asked whether they had dealt with it and whether they had accepted it. An extra question regarding whether they had at least one person they could confide in about the experience, was adapted from Mullen et al.’s (1994) research which sought to assess degree of social isolation. For each of these questions, a quantitative response indicating the presence or absence of the phenomena was followed by qualitative responses, with the exception of the final one.

**Participants’ Attritions**

It was decided that an important step in this second stage of the research was to build on the investigation conducted by Mullen et al. (1994), which asked women their opinions on how their experience of CSA had affected their lives. The participants were asked what they believed had been the long-term effects of experiencing CSA. In addition, participants were asked what they believed might enable them to reduce the
long-term effects of the abusive experience. Although some possible responses to the first question were developed from the findings of Mullen et al. (1994), these were simply listed on the proforma for the interviewer’s benefit. Participants provided qualitative responses to both questions.

**Additional Comments**

At the conclusion of the interview, participants were questioned as to whether there were any additional comments they wished to make or whether there was any issue that they felt had not been covered. The aim was to elicit any other topics which were important to participants, but which had not yet appeared in the research literature.

**Procedure**

The results summary sheet included an invitation for participants to take part in a second stage of the research, which aimed to explore in greater depth some of the themes which had arisen during the first stage. Participants were informed that this would be performed via a telephone interview, scheduled to last for approximately half an hour. If they were interested in taking part in such an interview, participants were requested to again contact the original telephone number and leave a message. This message should contain contact details, preferred times to be interviewed, and whether they would be interested in receiving a summary of the results of the second stage of the research.

Ethics approval for the extension and modification of the study was obtained from the Ethics Committee at Deakin University (see Appendix K). Thirty-three of the participant women provided contact details and interviews with all of these participants were subsequently arranged at a mutually convenient time. Interviews were then held over a one month period, with each interview ranging in duration from half an hour to two and a half hours. The length of the interview was dependent upon the amount of discussion that the participant wished to have regarding issues that arose. At the conclusion of the interview, participants were asked if there were any issues that they felt had been overlooked or that they wished to raise.
CHAPTER 9

STUDY 2: RESULTS

Descriptive Statistics

Demographic Data

Of the 118 women who returned questionnaires, 33 subsequently volunteered to participate in a phone interview. Of this group, 22 had children and 21 were currently in a relationship with a male partner, although the same participants were not necessarily in both of these groups. No other demographic information was sought, given the sensitive nature of the interview issues and the fact that the participants had provided their names and contact details to the researcher to arrange the interview.

Quantitative and Qualitative Statistics

Childhood Abuse Characteristics

Basic data relating to the degree of severity of CSA for the 33 phone participants are presented in Table 9.1. Participants were provided with the three severity of abuse categories and asked which category would best describe their abuse. The degree of severity of abuse was based on the most severe form of abuse that the participant mentioned, if more than one type was provided. Participants were asked to provide the duration of the abuse that they had experienced in terms of years. Participants were also asked what was the nature of the offender’s relationship to themselves, in order to establish whether this was intrafamilial or extrafamilial sexual abuse. When multiple offenders were cited, the primary offender was the one used in analyses. Sixteen of the participants (48%) indicated that they had experienced CSA perpetrated by their father (and in some cases others), and one reported abuse by her stepfather (3%).
Table 9.1 Childhood Sexual Abuse Severity (n = 33)

<table>
<thead>
<tr>
<th>Degree of Severity of Abuse</th>
<th>Duration of Abuse in Years</th>
<th>Relationship to Offender</th>
<th>Noncontact</th>
<th>0%</th>
<th>&lt;1 year</th>
<th>30.0%</th>
<th>Nuclear Family</th>
<th>63.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondling</td>
<td>42.4%</td>
<td>2-7 years</td>
<td>50.0%</td>
<td></td>
<td></td>
<td></td>
<td>Extended Family</td>
<td>18.2%</td>
</tr>
<tr>
<td>Penetration</td>
<td>57.6%</td>
<td>8-14 years</td>
<td>20.0%</td>
<td></td>
<td></td>
<td></td>
<td>Known Other</td>
<td>18.2%</td>
</tr>
</tbody>
</table>

**Self-Esteem**

It can be seen from Table 9.2 that participants in general had low self-esteem, based on their scores on Rosenberg’s Self-Esteem Scale (Rosenberg, 1965), given that they needed to score above two on each item to register positive self-esteem. In particular, participants felt unable to “respect” themselves, felt “useless” and “no good” at times. In contrast, participants generally believed they had some good qualities and were a worthy person, at least on an equal plane with others.

Table 9.2 Scores on Rosenberg’s Self-Esteem Scale (n = 33)

<table>
<thead>
<tr>
<th>Item</th>
<th>Average (Possible Range 1-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 On the whole I am satisfied with myself.</td>
<td>2.4</td>
</tr>
<tr>
<td>2 At times I think I am no good at all.</td>
<td>1.9</td>
</tr>
<tr>
<td>3 I feel that I have a number of good qualities.</td>
<td>3.3</td>
</tr>
<tr>
<td>4 I am able to do things as well as most people.</td>
<td>2.0</td>
</tr>
<tr>
<td>5 I feel I do not have much to be proud of.</td>
<td>2.4</td>
</tr>
<tr>
<td>6 I certainly feel useless at times.</td>
<td>1.9</td>
</tr>
<tr>
<td>7 I feel that I am a person of worth, at least on an equal plane with others.</td>
<td>2.8</td>
</tr>
<tr>
<td>8 I wish I could have more respect for myself.</td>
<td>1.8</td>
</tr>
<tr>
<td>9 All in all, I am inclined to feel that I am a failure.</td>
<td>2.6</td>
</tr>
<tr>
<td>10 I take a positive attitude toward myself.</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23.5</strong></td>
</tr>
</tbody>
</table>

When it is considered that Rosenberg’s Self-Esteem Scale (Rosenberg, 1965) provides a global measure of quite modest self-esteem as the highest possible total
score, it can be seen from Figure 9.1 that the participants demonstrated depleted self-esteem. This was acknowledged by participants themselves, with sighs and wry comments when it was mentioned that the next part of the interview examined the issue of self-esteem. One participant believed her situation had changed as she now had a new partner and so was more positive. Other participants acknowledged the assistance they had received from counselling, reflected in the comment, “Different position before having counselling and dealt with it. Felt overcome something”.

![Figure 9.1 Participants’ Total Scores on Rosenberg’s Self-Esteem Scale](image)

**Locus of Control**

It can be seen from Table 9.3, based on seven items selected from Rotter’s Locus of Control Scale (Rotter, 1966), that participants tended to score closer to one than zero. This scoring demonstrated an expectation that reinforcement is controlled externally rather than internally. Although participants believed that getting a good job was the result of hard work rather than luck, they also believed they were not in control of their own destiny.
Table 9.3 Scores on Rotter’s Locus of Control Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Average (Possible Range 0-1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many of the unhappy things in people’s lives are partly due to bad luck. People’s misfortunes result from the mistakes they make.</td>
<td>.43</td>
</tr>
<tr>
<td><em>No matter how hard you try some people just don’t like you.</em> People whom can’t get others to like them don’t understand how to get along with others.</td>
<td>.67</td>
</tr>
<tr>
<td>I have often found that what is going to happen will happen. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.</td>
<td>.45</td>
</tr>
<tr>
<td>Becoming a success is a matter of hard work, luck has little or nothing to do with it. Getting a good job depends mainly on being in the right place at the right time.</td>
<td>.30</td>
</tr>
<tr>
<td>Many times I feel I have little influence over the things that happen to me. It is impossible for me to believe that chance or luck plays an important role in my life.</td>
<td>.66</td>
</tr>
<tr>
<td>People are lonely because they don’t try to be friendly. There’s not much use in trying too hard to please people, if they like you, they like you.</td>
<td>.63</td>
</tr>
<tr>
<td>What happens to me is my own doing. Sometimes I don’t feel that I have enough control over the direction my life is taking.</td>
<td>.69</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3.71</strong></td>
</tr>
</tbody>
</table>

In Figure 9.2, it can be seen that a majority of participants displayed an external locus of control orientation, based on their total scores for the seven items selected from the Rotter Locus of Control Scale (Rotter, 1966).
From Table 9.4 it can be seen that just under half of the participants believed that their experience of CSA had had an impact on their decision to have children. Further exploration of their comments in relation to this question indicated this influence had been overwhelmingly negative. The very few participants who stated that their abusive experience had positively influenced their decision to have children, expressed a wish to do things differently for their own children. For example, “Definitely, that’s why (I) had children, to prove that I could look after them. Did it all, partner no support.”.

In contrast, the majority of participants explained that their experience of CSA had negatively influenced their decision to have children. Some participants who had had children, had done so reluctantly or reduced the number of children they felt able to manage. For example, “Strongly influenced – not want to have children. But now do want children due to dealt with abuse.”. For other participants, their abusive experience had played a major role in deciding not to have children at all. For example, “Greatly,
not had any children. Childhood sexual abuse – that has been major reason. Engaged twice, not married, fear of bringing children into situation.”.

This fear regarding the impact of the abuse on their parenting capacity would seem to be justified, given the belief of all participants who had children, with only one exception, that there had been an impact on their parenting. Nearly all participants spoke of being overly protective towards their children and the conflict with allowing their children to develop independence. For some participants, their abusive experience raised particular issues relating to the gender of their children. For example, “It effects me that he is a boy and (the) same age as when my abuse began – sometimes it makes it difficult for me with him” and “Has a lot to do with self-esteem as a parent. Wary, more protective of her, suspicious of men figures in her life”. One participant believed that her abusive experience had simply been repeated in another generation, “Not been able to protect my children in same way my parents weren’t able to protect me. Because I had bad role models”.

### Table 9.4 Impact of Childhood Sexual Abuse on Parenting

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the decision to have children been influenced by experience of childhood sexual abuse?</td>
<td>48.48%</td>
<td>51.52%</td>
<td></td>
</tr>
<tr>
<td>How has the decision to have children been influenced?</td>
<td>Not to have children</td>
<td>To have children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>81.25%</td>
<td>18.75%</td>
<td></td>
</tr>
<tr>
<td>Do you believe the childhood sexual abuse has had an impact on your parenting?</td>
<td>63.64%</td>
<td>.03%</td>
<td>33.33%</td>
</tr>
</tbody>
</table>
Abuse Disclosure

General Disclosure

As can be seen in Table 9.5, all of the participants, except one (who did not perceive later discussions as disclosure), stated that they had disclosed their childhood abuse. In addition, all of the participants except one (who was unable to hide the emotional impact at the time) had kept the experience of abuse secret for a period of time. The secret was generally kept for a very lengthy period of time, averaging over 20 years, see Figure 9.3. Participants were evenly split between wanting to tell others at the time, not wanting to tell anyone and halfway in between wanting to and not wanting to.

Table 9.5 Characteristics of General Disclosure of Abuse

<table>
<thead>
<tr>
<th>General Disclosure</th>
<th>Yes</th>
<th>97.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secret:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>97.0%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How long before told?</th>
<th>Range 1.5 – 53 years</th>
<th>Average 21.5 years</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Like to tell?</th>
<th>(1) No - (5) Very Much</th>
<th>Average 3.1</th>
</tr>
</thead>
</table>

The reasons for the participants’ secrecy can be classified into general themes (see Table 9.6), including fear, which was often associated with threats from the offender – both physical threats and of family disruption. Shame and embarrassment, concern that they would not be believed, and difficulty in being able to deal with the abuse themselves were also reasons cited by participants. For those participants whose family life was often turbulent, they did not perceive that there was anyone whom they could tell. For example, “Denial. Difficulty in having to deal with something like that. Lack of appropriate person to assist” and “Ashamed. Not want anyone to know. Not think anyone would believe me. Felt like I deserved it, it was my fault”.

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For some participants, their secrecy resulted from a strong sense of loyalty to other family members. For example, “Death threats to parents. Worrying about grandmother - when she is gone I will be free. Knowing would kill her because she thinks a lot of the person who did it”. In some cases, participants were stunned to find that because they had taken so long to disclose, their disclosure was not taken seriously. For example, “When started telling people. People’s attitude: That happened long ago. People didn’t take it seriously”.

Figure 9.3 How Long it took for Participants to Disclose
Table 9.6 Factors Contributing to Secrecy Regarding Abuse Disclosure

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashamed, blaming self, guilt</td>
<td>46.9%</td>
</tr>
<tr>
<td>Fear of disbelief, or anger by third party, eg. mother</td>
<td>43.8%</td>
</tr>
<tr>
<td>Fear of physical violence from offender</td>
<td>37.5%</td>
</tr>
<tr>
<td>Fear of offender harming someone else</td>
<td>18.8%</td>
</tr>
<tr>
<td>Denial, difficult to deal with</td>
<td>18.8%</td>
</tr>
<tr>
<td>Lack of appropriate person to assist</td>
<td>12.5%</td>
</tr>
<tr>
<td>Manipulation, aware not to blame</td>
<td>9.4%</td>
</tr>
<tr>
<td>Memory loss, survival required forgetting</td>
<td>9.4%</td>
</tr>
<tr>
<td>Innocence, naivete</td>
<td>6.3%</td>
</tr>
<tr>
<td>Mistrust of people</td>
<td>6.3%</td>
</tr>
<tr>
<td>Loyalty to offender</td>
<td>3.1%</td>
</tr>
<tr>
<td>Fear of being taken away from home</td>
<td>3.1%</td>
</tr>
<tr>
<td>Lack of ability to communicate</td>
<td>3.1%</td>
</tr>
<tr>
<td>Didn’t think of it</td>
<td>3.1%</td>
</tr>
<tr>
<td>Years gone by, too late</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

* Percentages add to more than 100% as participants could select more than one reason for not disclosing.

Childhood Disclosure

Only one third of the participants disclosed their experience of abuse before the age of 17 years (see Table 9.7), but again this was generally years after the abuse first began. The age of the participants at the time of their disclosure was evenly spread within the range of 9 to 16 years. In a number of these cases, the disclosure was outside the control of the participant. In two cases, the participants’ mother observed the abusive behaviour and in another two cases the participant child was unable to emotionally contain herself following abuse. This did not necessarily lead to support for the participant though, for example, “Neighbour attempted to assault (rape) me, told mother what happened. She was horrified. Said it was nothing to what had been going
on. Disbelieved”. In only one case was disclosure pre-empted by the confession of the perpetrator.

**Table 9.7 Characteristics of Childhood Disclosure of Abuse**

<table>
<thead>
<tr>
<th>Disclosure in Childhood</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33.3%</td>
</tr>
<tr>
<td>No</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

**Age at Disclosure (n=11)**

<table>
<thead>
<tr>
<th>Range</th>
<th>9-16 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>13.2 years</td>
</tr>
</tbody>
</table>

All of the participants told female relatives, with their mother being the most likely person, followed by a sister who was in the role of substitute mother, a grandmother or aunt. It appears that in a couple of these cases, this was where the information stayed, with it being questionable as to whether the participant was believed. In approximately half of the cases where the participant disclosed as a child, a third party was told. However, this was similarly ineffective, with the only case where the child was in institutional care proceeding on to a police investigation and medical examination. In another case, the child was seen by a doctor, and a priest was consulted by family members, but there was no further follow up. One participant suggested that such a lack of support was potentially partially due to a lack of support services available at the time. In one instance, the child disclosed to an aunt in order to protect the younger children in her care and, uncharacteristically compared to the other responses, the news was greeted positively.

The reactions of significant others to the participant’s disclosure in childhood were primarily ones of disbelief and stunned shock and in one case focussed on concern about what others would think of the family, see Table 9.8. In the three cases where the participant was believed, at best the news was accepted positively, or simply not spoken about again. At worst, following a confrontation about the disclosure, the participant was cast out of the family. In one case, the participant was subjected to subsequent
victimizations by family members “Mother acted surprised but I didn’t believe her. Kids picked on me. Some police supportive, others not. Brother (11) tried too when I was 14 – thought no one would believe me because he was so young. Share bed in mother’s flat. Uncle when I was under 5, sit on lap and touch me up. Brother-in-law attempted rape following knowledge of abortion following rape. If you tell, no one will believe you”.

Table 9.8 Reactions of Significant Others to Disclosure Prior to Age 17 Years (N=10)

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Percentage of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive reactions e.g., belief in victim</td>
<td>40.0%</td>
</tr>
<tr>
<td>Shock/horror</td>
<td>30.0%</td>
</tr>
<tr>
<td>Anger/hostility towards victim</td>
<td>30.0%</td>
</tr>
<tr>
<td>Disbelief of victim</td>
<td>30.0%</td>
</tr>
<tr>
<td>Denial of victimization</td>
<td>20.0%</td>
</tr>
<tr>
<td>Withdrawal from crisis of disclosure</td>
<td>10.0%</td>
</tr>
<tr>
<td>Anxiety concerning disruption of family</td>
<td>10.0%</td>
</tr>
<tr>
<td>Self-interest/self-defence</td>
<td>10.0%</td>
</tr>
<tr>
<td>Positive Reactions e.g., belief in victim</td>
<td>40.0%</td>
</tr>
<tr>
<td>Other negative reactions. Eg. revictimization by others</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

* Percentages add to more than 100% as participants could indicate more than one type of reaction of significant others to disclosure.

In general, the consequences of the disclosure were not beneficial for the participants, ranging from no consequences except discussion, to an ineffectual attempt by a parent to warn another parent of a vulnerable child, a police investigation which was filed, and leaving home to live on the street. In only one case did the participant receive counselling on a regular basis. Although two offenders were jailed as a result of the abuse, in one case the participant was also sent to a children’s home. In the small number of cases where the police were involved, they were perceived to have supported the offender. For example, in one case the participant implied that her father improperly influenced police processes, “Sell piano accordion to support myself. Not social
security. Police checking paid board. Father employed at court – not recorded on (police) file”.

**Disclosure in Adulthood**

The disclosure of CSA when the participant had reached adulthood was generally prompted by overwhelming emotional distress, often accompanied by the surfacing of repressed memories, a trigger provided by significant life events or relationship problems. In many cases, the participant had simply blocked the abuse out and it took a while for them to realize that it was the underlying cause for their emotional distress. For example, “Not tell, because it seemed too late. Why didn’t you tell? Anger, I was becoming irrational. It was affecting everything I did. I was becoming a hostile person. Neil Mitchell (radio show) focussing on issue for a week, with callers telling their stories. Rang Lifeline, had just wrecked another Mother’s Day.”

Repressed memories also appeared to lead to gradually increased pressure, for example, “Memories which came back more and more and could not be pushed aside. Becoming more and more depressed, became suicidal”. Significant life events included a range of incidents, for example, “Death of my brother – then had to deal with my own issues or suicide” and “Getting married at 18, he wanted children. I thought I could not have them, I had to tell him why”. Relationship issues could prompt disclosure for a variety of reasons, for example, “Ex-fiancé. Relationship not going well, told him, thought it might help relationship” and “Having trouble with relationships, trusting. Became very promiscuous. Being in a violent relationship for 4 years, when he left I had to get help”.

As an adult, participants disclosed to a range of others, with the most frequent category being their current husband/partner or previous partners (36.4%). In some cases their partner suggested the participant seek professional help and in others they went directly to professionals such as GPs, CASA (Centre Against Sexual Assault) counsellors, other counsellors, psychologists and psychiatrists (30.3%). In other cases, the participants sought the support of their mother (15.2%) or close friends, church members, family members or the governess of the jail. In a couple of instances,
participants contacted Operation Paradox, a police phone line for reporting cases of sexual abuse. Reactions of significant others to the disclosure by the participant ranged from being positive, supportive and understanding (57.6%) and suggesting that she seek professional help (15.2%) to shock, disbelief and rejection (33.3%).

Unfortunately, in two cases professionals acknowledged that they were unable to help the participant due to a lack of experience, whilst in one case the psychiatrist avoided the issue, seemingly due to not knowing how to deal with it. However, of more concern were reports that, in at least five cases, professionals acted inappropriately, “Did you enjoy it?” (Psychiatrist, following referral for a professional experienced in sexual abuse cases, over 20 years ago), “This doesn’t really happen” (male GP, 20 years ago), “Go home and make love to husband on kitchen table and forget about it” (GP, 15 years ago), “Christmas, time to forgive” (Dr), and “...when on the second visit she said ‘Stop – Stop! It is all too horrible’. I didn’t bother to return. I put the lid back on and I guess that is where it will stay”(Psychiatrist, recently). Some participants detected that family members felt guilty over their failure to provide protection, felt a conflict in loyalty between the victim and the offender and expressed a desire that the participant should simply move on. For example, (Husband) “Brushed it aside. Not tell anyone else. Only others who have had it happen understand, others tell to forget about it – long ago. Brothers and sister: All got problems, re: self-esteem. Not told mother, father dead. Older brother close to parents, so not told. Sister talked a lot, then changed sides when father dying of cancer, not spoken.” Following disclosure by some participants, there was no further discussion of the topic. For example, “Husband told to go to doctor. Doctor gave tablets and referred to social worker. Daughter knew, not discuss. Mother not want to discuss”. In a couple of cases, the participants had not disclosed to their family members.

Although there were often major consequences as a result of the participant’s disclosure in adulthood of their childhood abuse, most appeared to feel it had been worthwhile and sometimes inevitable. Assistance was sought by participants from psychologists/therapists (27.3%), psychiatrists (9.1%) and sources of self-help (15.2%). Participants reported that they had eventually emotionally healed (12%), their health had improved, they were able to talk more freely, how they saw themselves had changed,
they were able to protect others, received sympathy and developed allies within the family. However, a number of participants reported that their family had split (21.2%), they had moved interstate, their family’s denial had increased their frustration (9.1%) and they felt disillusioned, horrible and painful, were still dissociating, experienced more stress and were worried about family confrontations. Formal investigation was rarely undertaken, with two cases reported to the police, two cases where an investigation was explored and one case where the participant decided against a police investigation. In one case, there was no prosecution given that the matter was investigated by the church and not the police. In three cases the offender was jailed, whilst in one of these cases the participant was placed in care.

Partner Disclosure

For the two thirds of participants who were currently in a relationship, all had told their partners of their abuse experience, see Table 9.9. The reactions of current partners were generally supportive (47.6%), angry at the offender (33.3%), difficulty in understanding (19.0%) and in some cases the abuse had caused difficulties with intimacy (14.3%). Participants also reported that their partners expressed shock, were sorry and angry at men, wanting to compensate, upset and feeling powerless. One partner indicated that he had been abused himself and the participant believed did not say much because he had not healed. In fact, participants found that some partners simply did not say anything much (19.0%), making it difficult to know their beliefs regarding the abuse.

<table>
<thead>
<tr>
<th>Table 9.9 Characteristics of Disclosure to Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your current partner know about your CSA?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Have you informed previous partners about your experience of sexual abuse?</td>
</tr>
</tbody>
</table>
Nearly half of the participants who had been in previous relationships had not told their partners about their abuse experience, see Table 9.9. Of those participants who had disclosed, their partner’s reactions were generally supportive (50.0%), they were angry at the offender (18.8%), and they experienced difficulties with intimacy (18.8%). Participants also described their partners as being shocked, bewildered and disclosed that a previous partner had the same issue. In some cases the relationship broke down (18.8%), with other participants believing the abuse was used as an excuse for different problems within the relationship (12.5%). In one case, the partner was angry that the participant had taken so long to tell him, another claimed the participant was “leading him on” by disclosing, whilst two partners thought the participants should “get over it”. One partner confronted the offender, whilst another prevented their children from seeing the offender.

Intimate Bonds

Of the 33 participants, 21 indicated that they were currently involved in a relationship with a male partner. None of the participants indicated that they were currently involved in a lesbian relationship. The data shown in Table 9.10 indicate that participants believed their partners were very caring towards them, as shown by their high scores on the four items selected from the Care subscale of the Intimate Bond Measure (Wilhelm, & Parker, 1988). The highest possible care score was achieved by 45.5% of partners of the participants. In contrast, participants rated their partners as not at all controlling, as shown by their very low scores on the four items selected from the Control subscale of the same measure. Nearly two-thirds (63.6%) of participants did not consider their partners controlling at all. None of the participants agreed with the statement that their partner “Insists I do exactly as I’m told”. Two of the participants saw it as a positive thing that their partner “Tends to try and change me” given their low self-esteem. They stated “How I see myself” and “For the better. He gave me the wings, to fly, soar”. Partners were rated by 86.4% of participants as being above the median for care, and none of the partners were rated above the median for control. The average total score for these selected items from the Intimate Bond Measure (Wilhelm, & Parker, 1988) was raised by high scores on the Care subscale, but then lowered by very low scores on the Control subscale.
### Table 9.10 Scores on the Intimate Bond Measure

<table>
<thead>
<tr>
<th>Item</th>
<th>Care subscale</th>
<th>Control subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Item</td>
<td>Average</td>
</tr>
<tr>
<td>1</td>
<td>2.5</td>
<td>0 – 3</td>
</tr>
<tr>
<td>4</td>
<td>2.5</td>
<td>0 – 3</td>
</tr>
<tr>
<td>5</td>
<td>2.4</td>
<td>0 – 3</td>
</tr>
<tr>
<td>16</td>
<td>2.4</td>
<td>0 – 3</td>
</tr>
<tr>
<td>Total</td>
<td>9.9</td>
<td>0 – 12</td>
</tr>
</tbody>
</table>

#### Average Total Score for selected 8 items: 11.2

#### Possible Range: 0 – 24

---

**Searching for Meaning in Childhood Sexual Abuse**

As can be seen in Table 9.11, participants had a tendency towards frequently wondering why they had been abused (item 1) and searching for a reason or way to make sense out of their sexual abuse experience (item 2). Over 80% of participants reported searching at least sometimes for some reason, meaning or way to make sense of their abuse experience. A high correlation between these two items (r = .60, p < .001) provided support for their combination as an index for measuring the frequency with which participants engaged in a search for meaning. Participants appeared to believe that they had to try to make some sense out of their abuse. Their comments included, “Cause it won’t go away”, and “I went through it and it has made me a stronger person. I had to turn it into a positive”. Nearly half of the participants had been unable to find meaning in their abusive experience nor felt that they had dealt with it, but nearly two thirds believed they had accepted it. A number of participants commented that the meaning they had been able to find related to the intergenerational nature of abuse and could be used to achieve positive things, “I was part of an ongoing cycle of abuse, generational. Because quiet, shy nature as a child, was vulnerable. Deal with it, understand, turn it into something I can use to assist others”. Other participants simply felt angry and believed they would never be able to find meaning in their abuse, “Excluded me from society. Adverse meaning – useless, to be used, worth nothing, different from others. Now, isolated and confined me.”
Table 9.11 Searching for Meaning in Abuse

<table>
<thead>
<tr>
<th>Question</th>
<th>Never (1)</th>
<th>Always (5)</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you find yourself wondering why me?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you find yourself searching for some reason, meaning, or way to make sense out of your sexual abuse experience?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>3.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been able to find meaning in your abusive experience?</td>
<td>48.5%</td>
<td>48.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Have you dealt with it?</td>
<td>39.4%</td>
<td>39.4%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Have you accepted it?</td>
<td>60.6%</td>
<td>30.3%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Currently, do you have at least one person that you can confide in about your childhood sexually abusive experience?</td>
<td>90.9%</td>
<td>9.1%</td>
<td></td>
</tr>
</tbody>
</table>

This anger was echoed by the majority of participants, who indicated their feelings about the abusive experience remained largely unresolved, see Table 9.12. Participants’ comments reflected a range of views on whether feelings about the abusive experience could be resolved. Some participants appeared to have found ways to make living with their abuse more manageable, “To move forward in life, need to sort it and file it, for your own peace of mind. Achieve with age”, “This may not be appropriate, this is an ongoing thing. 10-20 years ago I was a total emotional mess. Not resolved, never is, find a way of managing it in your life” and “I don’t think I will ever have anything to do with my family or Italians again. I can’t believe they didn’t know. Never be resolved. But my life is okay - just don’t deal with it”. Some participants perceived that dealing with the abuse was reflected in their contact with the offender, for example, “Because he is dad too”. Almost all participants (90.9%) confirmed that they have at least one person they could confide in about their childhood sexually abusive experience.
Table 9.12 Degree of Resolution of Abuse (n=31)

<table>
<thead>
<tr>
<th>Degree to which resolved feelings about abuse?</th>
<th>Percentage of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution not possible</td>
<td>16.1%</td>
</tr>
<tr>
<td>No</td>
<td>16.1%</td>
</tr>
<tr>
<td>Slightly</td>
<td>6.5%</td>
</tr>
<tr>
<td>Sting gone out, not in denial</td>
<td>6.5%</td>
</tr>
<tr>
<td>Halfway</td>
<td>6.5%</td>
</tr>
<tr>
<td>Still in process</td>
<td>16.1%</td>
</tr>
<tr>
<td>Majority reconciled</td>
<td>25.8%</td>
</tr>
<tr>
<td>Almost totally</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

Participants’ Attributions

Participants provided a very wide range of answers when asked what they believed had been the long-term effects of experiencing CSA. These responses were grouped into six broad categories of relationship issues, emotional or psychological health issues, lifestyle and financial issues, physical health issues, and positive impacts, as outlined in Table 9.13. Most participants provided more than one response.

All participants believed there had been at least some long-term effects as a result of their experience of CSA. Furthermore, nearly half of the participants described themselves as suffering from mental health issues, which they attributed to their CSA.
**Table 9.13 Comments Regarding Long-Term Effects of Childhood Sexual Abuse**

<table>
<thead>
<tr>
<th>Comments on the Long-Term Effects of Childhood Sexual Abuse</th>
<th>Percentage of Participant Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship Issues</strong></td>
<td>39.4%</td>
</tr>
<tr>
<td>(Ranging from strained family relationships to abusive partner relationships)</td>
<td></td>
</tr>
<tr>
<td>Trust issues</td>
<td></td>
</tr>
<tr>
<td>Think can trust father and if can’t....</td>
<td></td>
</tr>
<tr>
<td>Not let anyone close, protect yourself</td>
<td></td>
</tr>
<tr>
<td>Isolation from family members</td>
<td></td>
</tr>
<tr>
<td>Single – never married, had children, now too old, past it</td>
<td></td>
</tr>
<tr>
<td>No family relationships – husband, kids</td>
<td></td>
</tr>
<tr>
<td>Relationships with men</td>
<td></td>
</tr>
<tr>
<td>Promiscuity</td>
<td></td>
</tr>
<tr>
<td>Not like intimacy</td>
<td></td>
</tr>
<tr>
<td>Push myself at the gym not to move away from men</td>
<td></td>
</tr>
<tr>
<td>Hard to commit to someone</td>
<td></td>
</tr>
<tr>
<td>Let partner bash me</td>
<td></td>
</tr>
<tr>
<td>Abusive relationships</td>
<td></td>
</tr>
<tr>
<td><strong>Emotional or Psychological Health Issues</strong></td>
<td>38.6%</td>
</tr>
<tr>
<td>(Ranging from self-image concerns to anxiety disorders)</td>
<td></td>
</tr>
<tr>
<td>Self hatred</td>
<td></td>
</tr>
<tr>
<td>Perfectionist</td>
<td></td>
</tr>
<tr>
<td>Feel insecure</td>
<td></td>
</tr>
<tr>
<td>Inability to function as an adult</td>
<td></td>
</tr>
<tr>
<td>Find it very hard to be happy – doing what someone else wants you to</td>
<td></td>
</tr>
<tr>
<td>Fear huge amount</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts, 11 suicide attempts</td>
<td></td>
</tr>
<tr>
<td>Turning to alcohol and drugs</td>
<td></td>
</tr>
</tbody>
</table>
**Lifestyle and Financial Issues**  
Ruined my childhood, grew up without one  
A life of hell  
Not a normal life  
Lost opportunities  
Total destruction of chance in life  
Took job to get away from home  
Did not reach my full academic potential  
Irrevocably in personal and professional life  
Nomadic, gone place to place, many homes, move around  
Fucked me up completely

<table>
<thead>
<tr>
<th><strong>Physical Health</strong></th>
<th>3.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight gain, back injury (200kgs)</td>
<td></td>
</tr>
<tr>
<td>Eating disorders</td>
<td></td>
</tr>
<tr>
<td>Put on lots of weight</td>
<td></td>
</tr>
<tr>
<td>Diagnosed with ovarian cancer, out of remission, wonder how much attributable to abuse, same region</td>
<td></td>
</tr>
<tr>
<td>Suffering migraines and high blood pressure since 16,17</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Positive Impacts</strong></th>
<th>3.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent, been by myself, honed survival skills</td>
<td></td>
</tr>
<tr>
<td>It has made me self-reliant</td>
<td></td>
</tr>
<tr>
<td>Awareness of humanity’s imperfection</td>
<td></td>
</tr>
<tr>
<td>Desire to help people who are stuck</td>
<td></td>
</tr>
<tr>
<td>Made me a better person, I was able to turn it into a positive thing</td>
<td></td>
</tr>
</tbody>
</table>

**Hypothesis 1.1**  
That there will be a positive association between increased abuse severity and lowered self-esteem, and self-reporting of mental health issues.

Participants reporting more severe abuse (penetration) were the least likely to suggest their abuse had a negative impact on their self-esteem ($r = -.37, p < .05$) and no relationship was found between increased abuse severity and self-reporting of mental health issues.

**Hypothesis 1.2**  
That there will be a positive association between increased abuse chronicity (duration) and sexual relationship difficulties, and difficulty with trusting others.
No significant relationships were found between the duration of abuse and either sexual relationship difficulties or difficulty in trusting others.

**Hypothesis 1.3**

That there will be a positive association between abuse perpetrated by a father figure (father/stepfather) and adult sexual adjustment difficulties.

Participants who expressed difficulties in their sexual relationship were found to be those whose perpetrator was not their father or stepfather ($r=-.44$, $p<.05$).

Participants provided a very diverse set of responses when asked what they believed would reduce the effects of their sexually abusive experience. The responses were grouped into six broad categories of social support, self-improvement, offender related, community activity, acceptance, and nothing, don’t know, as outlined in Table 9.14. Most participants provided more than one response.

**Table 9.14 Comments Regarding Reduction of Effects of Childhood Sexual Abuse**

<table>
<thead>
<tr>
<th>Comments on Reduction of Effects of Sexually Abusive Experience</th>
<th>Percentage of Participant Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Support (Ranging from improved relationships to professional support)</td>
<td>31.6%</td>
</tr>
<tr>
<td>An understanding from my mother and father that it happened (cold and quiet) = acknowledgement</td>
<td></td>
</tr>
<tr>
<td>Interested in father’s reaction, had been unaware that he had not been told</td>
<td></td>
</tr>
<tr>
<td>Within family, victim confronted and family members supported perpetrator</td>
<td></td>
</tr>
<tr>
<td>Quality, good times with men</td>
<td></td>
</tr>
<tr>
<td>Being a secondary victim with daughter’s experience was very beneficial</td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Psychiatrist says when I am 70, I should forget about it by then</td>
<td></td>
</tr>
</tbody>
</table>
Self-Improvement Strategies  27.6%
So now want to maintain control, not be put in that position again
Working on weight loss
Use a lot of wisdom in dealing with partner, kids
Positive attitude: Be happy in myself, have fun with the rest of my life
Remove shame, read book which helped
Keep in touch with yourself, nurturing yourself (massage therapist)
Put more hard work into dealing with it
That I can understand why it happens, hints on how to survive, what are the impact, symptoms, where are they coming from

Offender Related  19.4%
Perpetrator to be punished
Hurting him, not necessarily physically, revenge
I would love to confront him and ask why? Face-to-face
If he was not around, not seen for 8 years
Try not to see him, because it brings it up for me
To see him dead
Or for him to die, because my torment would end, I could get on with my life
Would like to see brother obliterated – all paedophiles

Community Activity  9.2%
Like to do talks at schools and encourage kids to tell
Have them made responsible
Want a mandatory prison term for paedophiles in Victoria, writing about this
Doing something like this survey
Prevent any further abuse of other kids
Counselling, more availability of places like CASA. Don’t feel embarrassed with them

Acceptance  6.1%
So put up with life as it is
I get on with my life, I don’t take it to my grave, they will take it to theirs
Stop looking for answers I am never going to get
Trying to get on with life and not think about it

Nothing, Don’t Know  6.1%
Don’t know, if I did know I would do it
It is too ingrained
I don’t think anything could ever alleviate it
Additional Comments

At the completion of the telephone interview, when participants were asked if there was anything that they wished to add, or that they felt had not been covered, a number provided additional comments. These comments principally related to narratives regarding the individual participant’s own abusive situation or their general view of the impact of CSA, and support services.

Analyses Related to Self-Esteem, Locus of Control, Disclosure Characteristics and the Search for Meaning

CSA Severity, Self-Esteem and Locus of Control

Based on the research literature, a number of hypotheses were generated at the end of the Introductory chapters, regarding the relationships between various measures of the severity of CSA. To test these hypotheses, Pearson correlations were calculated between the abuse measures of: severity of abuse in terms of the degree of physical invasiveness of the abuse, the duration of the abuse (in years) and whether a father/stepfather was the perpetrator. In addition, correlations were conducted between abuse measures, self-esteem and locus of control.

Hypothesis 2
That higher severity of childhood sexual abuse, as indicated by:
-Increased degree of physical invasiveness
-Greater duration
-Whether the father/stepfather was the perpetrator
-Will be associated with poor adult adjustment in the following areas:
-Lower self-esteem
-Higher external locus of control orientation

It can be seen from Table 9.15, that there were no significant relationships between self-esteem, locus of control, and severity of sexual abuse characteristics. In contrast to the findings of Study 1, a relationship was found between the duration of abuse, in years, and whether the perpetrator was a father/stepfather. This finding suggests that those participants experiencing CSA of a long duration, perpetrated by a father/stepfather may have been more likely to volunteer to participate in the second stage of this research.
Table 9.15 Correlations between Severity of Abuse Measures

<table>
<thead>
<tr>
<th></th>
<th>Severity of Abuse</th>
<th>Duration of Abuse (years)</th>
<th>Father/Stepfather Perpetrator</th>
<th>Self-Esteem</th>
<th>Locus of Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of Abuse</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Abuse (years)</td>
<td></td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father/Stepfather Perpetrator</td>
<td></td>
<td></td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Esteem</td>
<td></td>
<td></td>
<td></td>
<td>-0.26</td>
<td></td>
</tr>
<tr>
<td>Locus of Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

*p < .05

Self-Esteem and Characteristics of Disclosure

Based on the research literature, a number of hypotheses were generated and described at the end of the Introductory chapters, concerning the relationship between disclosure of CSA, the search for meaning in abuse and self-esteem.

Hypothesis 3
That self-esteem will be negatively associated with less adaptive features of disclosure of CSA.

Self-esteem was found to be significantly negatively correlated with three of the characteristics of disclosure of CSA, see Table 9.16. Self-esteem was negatively correlated with whether the participant kept their experience of abuse secret, indicating that their self-esteem decreased if they kept their experience secret. Self-esteem was also negatively correlated with whether the participant had wanted to tell others about her abuse, but had held herself back from doing so. This finding indicates that the participants’ self-esteem increased if they had not wanted to tell anyone rather than wanting to do this, but being unable to. Self-esteem was also negatively correlated with
whether the participant had informed previous partners about her experience of sexual abuse. Thus, this finding suggests that participants had higher self-esteem if they had not disclosed to previous partners, perhaps as a result of consequences arising from the disclosure.

Table 9.16 Correlations Between Self-Esteem and Characteristics of Disclosure

<table>
<thead>
<tr>
<th></th>
<th>Self-Esteem</th>
<th>Gen. Disclosure</th>
<th>Secret</th>
<th>How Long to Tell?</th>
<th>Like to Tell?</th>
<th>Childhood Disclosure</th>
<th>Age (in years) when Disclosed</th>
<th>Told Previous Partner/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem</td>
<td>1.00</td>
<td>.14</td>
<td>-.42*</td>
<td>-.21</td>
<td>-.47**</td>
<td>.20</td>
<td>.14</td>
<td>-.41*</td>
</tr>
<tr>
<td>General Disclosure</td>
<td>1.00</td>
<td>-.03</td>
<td>-.14</td>
<td>.21</td>
<td>.13</td>
<td>.12</td>
<td>-.16</td>
<td></td>
</tr>
<tr>
<td>Secret</td>
<td>1.00</td>
<td>-</td>
<td>-</td>
<td>-.25</td>
<td>-.14</td>
<td>.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How Long?</td>
<td>1.00</td>
<td>.00</td>
<td>-.31</td>
<td>-.47**</td>
<td>.29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Like to Tell?</td>
<td>1.00</td>
<td>-.02</td>
<td>-.03</td>
<td>.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Disclosure</td>
<td>1.00</td>
<td>.98**</td>
<td></td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (in years)</td>
<td>1.00</td>
<td>-.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Told Previous Partner/s</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01

The other significant correlations depicted in Table 9.16 would be expected, for the age of the participant when disclosing as a child was directly related to how long she has kept her abuse a secret and whether it is classified as a childhood disclosure. No
other significant correlations were found between self-esteem and characteristics of disclosure.

**Hypothesis 4**
That locus of control and severity of sexual abuse characteristics will be positively associated with less adaptive features of disclosure of CSA.

No significant correlations were found between locus of control, severity of sexual abuse characteristics and features of disclosure of CSA.

**Self-Esteem, Locus of Control, Severity of Abuse Characteristics and the Search for Meaning**

Based on the research literature, a number of hypotheses were generated and described at the end of the Introductory chapters, concerning the relationship between self-esteem, locus of control and the search for meaning in abuse.

**Hypothesis 5**
That self-esteem will be positively associated with characteristics of the search for meaning in abuse.

It can be seen from Table 9.17 that self-esteem was not significantly correlated with any of the characteristics of searching for meaning in abuse. The degree to which participants asked themselves “Why me?” was significantly positively correlated with how often they found themselves searching for a way to make sense out of their abuse. Therefore, the degree to which participants questioned why they had been subjected to abuse was associated with their search for meaning in this abuse. In addition, the degree to which participants asked themselves “Why me?” was significantly negatively correlated with the degree to which they believed they had both dealt with the abuse and accepted it. Those participants who questioned why they had been abused were less likely to feel that they had dealt with the abuse or accepted it. There was a significant positive correlation between believing that the abuse had been dealt with and accepting it.
Hypothesis 6
That locus of control will be negatively associated with characteristics of the search for meaning in abuse.

There was a significant negative correlation between believing that the abuse was dealt with and locus of control, see Table 9.17. Those who believed they had dealt with their abuse demonstrated an internal locus of control orientation. There were no other significant correlations between characteristics of the search for meaning in abuse and locus of control.

Table 9.17 Correlations between Self-Esteem, Search for Meaning in Abuse Characteristics and Locus of Control

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<td>Self-Esteem</td>
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<td>-.31</td>
<td>.12</td>
<td>.19</td>
<td>.29</td>
<td>.07</td>
<td>.02</td>
<td>-.26</td>
</tr>
<tr>
<td>SFM Why me?</td>
<td>1.00</td>
<td>.60**</td>
<td>-.14</td>
<td>-.52**</td>
<td>-.66**</td>
<td>-.16</td>
<td>.25</td>
<td></td>
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<tr>
<td>SFM How often?</td>
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<td>.01</td>
<td>-.31</td>
<td>-.32</td>
<td>-.19</td>
<td>.05</td>
<td></td>
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<tr>
<td>SFM Find meaning</td>
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<td>.28</td>
<td>.24</td>
<td>-.11</td>
<td>-.21</td>
<td></td>
<td></td>
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<tr>
<td>SFM Dealt with it?</td>
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<td>.40*</td>
<td>.36</td>
<td>-.46*</td>
<td></td>
<td></td>
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<tr>
<td>SFM Accepted it?</td>
<td>1.00</td>
<td>-.01</td>
<td>-.22</td>
<td></td>
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<tr>
<td>Confident</td>
<td>1.00</td>
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<tr>
<td>Locus of Control</td>
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<td>1.00</td>
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*p < .05, **p < .01
Hypothesis 7
That severity of abuse characteristics will be positively associated with search for meaning in abuse characteristics.

There was only one significant positive correlation between search for meaning in abuse characteristics and severity of abuse characteristics. Whether the participant had someone to confide in regarding her abuse was correlated with duration of her abuse (r = .40, p < .05). Therefore the longer the abusive experience the more likely the participant was to have someone in which to confide about it.

Disclosure of Abuse Characteristics and Search for Meaning Characteristics

It would be expected that there would be a relationship between disclosure of abuse characteristics and search for meaning in abuse characteristics.

Hypothesis 8
That disclosure of abuse characteristics will be negatively associated with search for meaning in abuse characteristics.

When Pearson correlations were conducted between the disclosure of abuse characteristics and the search for meaning in abuse characteristics, only two significant correlations were found. The degree to which the participant questioned “Why me?” was positively correlated with whether she had wanted to tell others about her abuse but did not (r = .38, p < .05). Therefore those who questioned why they in particular had been abused, had also wanted to disclose to others but had been unable to. In addition, being able to find meaning in their abusive experience was positively correlated with age at childhood disclosure (r = .41, p < .05). Therefore participants who had been more successful in being able find meaning in their abusive experience, were more likely to have disclosed their abuse later during their childhood.
Characteristics of Disclosure and Intimate Bond Measure

Based on the research literature, a number of hypotheses were generated and described at the end of the Introductory chapters, concerning the relationship between characteristics of disclosure and perceptions of partners in terms of care and control.

_Hypothesis 9_
That a perception that partners are caring will be negatively correlated with the perception that the partner is controlling.

It can be seen from Table 9.18, that Care and Control subscales of the Intimate Bond Measure were significantly negatively correlated with each other. This indicates that those participants who perceived their partners as caring were also likely to perceive them as being less controlling and vice versa.

_Hypothesis 10_
That perceptions of a partner as caring will be negatively associated with less adaptive features of characteristics of disclosure. Perceptions of a partner as controlling will be positively correlated with less adaptive features of characteristics of disclosure.

It can be seen from Table 9.18, that the Care subscale was negatively correlated with the age at which the participant disclosed as a child, whilst this age of disclosure was significantly positively correlated with the Control subscale. This suggests that the participant was more likely to perceive her current partner as more caring and less controlling, the lower her age at the time of disclosure. In addition, the Control subscale was significantly negatively correlated with the length of time that the participant had taken to disclose her abusive experience. Thus, those participants who perceived their partners as less controlling, were more likely to have taken longer to disclose, which would appear to be counterintuitive. However, some participants indicated that they had disclosed to their partners in the context of experiencing relationship difficulties, when the disclosure appeared to be somewhat involuntary.
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<td>.12</td>
<td>-.16</td>
<td>-</td>
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<tr>
<td>Secret?</td>
<td>.10</td>
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<td>-</td>
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<td>-.14</td>
<td>.24</td>
<td>.13</td>
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<td>How Long to Tell?</td>
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<td>.00</td>
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<td>-.47**</td>
<td>.21</td>
<td>.34</td>
<td>-.53*</td>
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<tr>
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<td>.03</td>
<td>.13</td>
<td>.33</td>
<td>-.22</td>
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<td>Age (in years)</td>
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<td>.47*</td>
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<tr>
<td>When Told Told Previous Partner/s?</td>
<td>1.00</td>
<td>.00</td>
<td>-.34</td>
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<tr>
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<td>IBM Control</td>
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CHAPTER 10

CONCLUSIONS AND IMPLICATIONS

This chapter provides a comprehensive discussion and integration of the findings from both Study 1 and Study 2. The role of issues associated with the childhood family-of-origin will be considered as the starting point for the impact of CSA on the survivor’s later psychological adjustment. This is followed by a discussion of the characteristics of the CSA itself and the motivations preventing and prompting disclosure of the abuse during childhood. The long-term impact of CSA on adult psychological functioning is then explored in detail, including difficulties in the relationship functioning of survivors. This is followed by a discussion of the influence of CSA on the decision of whether or not to have children and parenting issues. This material is then sued to explain the factors which may confer resilience or risk, in terms of the survivor’s long-term psychological adjustment. The thesis concludes with a discussion of limitations of the current research, implications for practice/policy directions and suggestions for future research.

Childhood Family-of-Origin

There has long been a recognition that CSA is not an event that occurs in isolation, but is one of a range of negative life experiences of children growing up in a dysfunctional family environment. The children in such families are at a higher risk of experiencing all forms of abuse, in a family whose composition has a higher likelihood of being unstable. Therefore, when investigating the impact of CSA on adult psychosocial functioning, consideration must be given to the influence of family environmental factors including psychosocial issues and the possibility of concomitant physical or psychological abuse. These areas of concern will be discussed in the following sections.
Family Composition

The degree of family disruption and reconfiguration experienced within the family-of-origin by these participants appeared to be substantially less than that reported in previous research (Jehu, 1988). This may be attributable to the fact that previous studies have generally relied on recruitment of participants through sources such as counselling centres, which is likely to skew the sample towards women exhibiting a greater degree of clinical symptomatology, which would be expected if their family background was highly dysfunctional. In contrast, the majority of participants in the current research indicated they had grown up with both of their parents at least some of the time and relatively few had had stepparents, which may also be reflective of the older age of the cohort.

Despite only a small number of participants in the current study reporting that they had a stepfather whilst growing up, over half of these men were reported to be sexual abuse perpetrators. This finding is consistent with data from previous research which demonstrates stepfathers are much more sexually predatory towards their daughters than natural fathers (Finkelhor, 1984; Jehu, 1988; Mullen et al., 1994; Russell, 1986). Finkelhor (1984) found that the stepfathers themselves only represented part of the increased risk, the remainder was due to abuse by friends of the family. It was suggested that these men were actually friends of the stepfather’s who may not experience the same level of restraint towards the stepchild than if she was their friend’s biological daughter. A similar scenario has been proposed to explain the increased risk for girls who have stepbrothers (Finkelhor, 1979). Yet some of the stepdaughters were abused prior to even meeting their stepfather, leading Finkelhor to suggest their abuse was perpetrated by their mother’s friends, who were opportunistic men exploiting a daughter if she was accessible. Participants in the current study seemed to support the view that their vulnerability was increased by their mother bringing into the home sexually predatory men, with a number citing abuse by “mother’s boyfriends”. There was also a view that mothers would become consumed by a new relationship with a stepfather, making it impossible for daughters to criticize even sexually abusive behaviour.
Psychosocial Issues

As predicted, the majority of participants reported experiencing an extensive range of psychosocial issues in their family-of-origin. The prevalence rates of particular psychosocial issues follows the same pattern as found previously (Jehu, 1988). It would appear that the presence of these psychosocial issues is an indication that the environment within the family may make the children vulnerable to sexual assault, either by family members or by those outside of the family (Bagley & Ramsay, 1986).

Marital conflict was the issue most frequently reported to occur in the families of origin of CSA survivors in the current study and previous research (Jehu, 1988). It is difficult to assess to what extent this conflict may precede or emanate from the presence of CSA and intrafamilial abuse in particular. There has been little empirical research exploring the mechanism by which marital conflict is related to CSA (Finkelhor, 1979). However, Jehu (1988) has suggested that children with discordant parents may lack sufficient attention, support, affection, and love, which makes them vulnerable to exploitation by any adult who seems to meet these needs. Qualitative data from the current study suggested that parents involved in marital conflict were much less emotionally available to their children, with their energies being absorbed by participation in the conflict. Participants painted a picture of families where communication was poor and cohesiveness low, so that when abuse occurred, they did not have a path to disclosure.

The presence of a dominant father, restrictive upbringing and domestic violence was reported by almost half the participants in the current study, a finding consistent with previous research, especially in cases of intrafamilial abuse (Alexander & Lupfer, 1987; Finkelhor, 1984; Higgins & McCabe, 1994; Jehu, 1988). It has been proposed that when a father holds very traditional family values, which espouse that children should be obedient to adults and women are subservient to males, daughters are at greater risk of CSA (Alexander & Lupfer, 1987; Finkelhor, 1984). Such fathers often maintain absolute control through the use of coercion and force, which increases the daughter’s vulnerability, because other family members lack the capacity to protect her. Aside from being unable to protect their daughters, victimized mothers do not model or
teach self-protective and assertive skills to their daughters (Jehu, 1988). This view was borne out by comments from participants in the current study, which indicate the strength of their fathers within the family structure and the powerlessness of other family members, including themselves, in being able to undermine this. Participants often did not view their mothers as capable of being protective given their own oppression, leaving daughters to develop self-reliance. The two participants that nominated their mothers as being dominant did not experience sexual abuse perpetrated by these females, although a couple of participants did allege abuse by female perpetrators.

Reports by participants in the current study of sexual punitiveness towards them by their parents are consistent with the findings of Finkelhor (1984), that sexually punitive mothers were linked with much higher rates of CSA. The mothers warned and reprimanded daughters for asking questions and participating in any activities related to sex. Whilst the mechanism leading to this connection was unclear, daughters in this situation may find it difficult to develop a realistic understanding of what represents a danger, they may become rebellious and engage in risk taking, particularly if being encouraged by an authority figure seeking to exploit them. Social isolation is another feature of families where daughters have an increased risk of CSA (Finkelhor, 1984; Herman, 1981; Jehu, 1988; Sgroi, 1982), which was confirmed in the current study with over a third of participants reporting it to be an issue in their family-of-origin. Social isolation means the family maintains an insular view that the outside world is hostile and only family members can be relied upon. This style of family functioning supports intrafamilial abuse by encouraging dependency on family members to meet all needs whilst preventing scrutiny and interference by the general community (Jehu, 1988). Social isolation also removes opportunities to develop social support networks, which prevents disclosure of the abuse, ensuring its continuation.

The current finding of alcohol abuse, and to a lesser degree drug abuse, by parents has often been connected with daughters having an increased vulnerability to experiencing CSA (Cole et al., 1992; Goldman & Goldman, 1988; Jehu, 1988; Mullen et al., 1994). However, Goldman and Goldman (1988) argued that alcohol abuse may simply be an accompanying factor, indicating a lack of inhibition when it relates to the father. Alternatively, alcohol abuse may be suggestive of marital unhappiness, which
may also apply in cases where daughters report their mothers as abusing alcohol. The incapacitation of parents through alcohol abuse may lead to increased vulnerability of daughters due to a lack of supervision and protection. The same argument may be made in cases where parents are physically or psychologically absent due to being emotionally distant, lacking in affection or ill, making it difficult for daughters to develop a close, confiding relationship with them.

**Characteristics of the CSA**

It can be difficult for survivors to be precise about the details of the nature of their CSA, for reasons which primarily relate to their developmental stage, including concepts of time and morality, and memory processing. The capacity to remember details of the abuse may be further compromised by the impact of emotional trauma on memory functioning. Therefore, when asked for details relating to their abuse experiences, many participants had difficulties recalling the age at which the abuse commenced, the duration of the abuse and particularly on how many occasions the abuse took place. In situations where the abuse was perpetrated by a number of people, possibly in a range of situations, participants understandably had difficulties specifying how many perpetrators may have been involved.

**Age at Onset and Frequency of Abuse**

Some participants believed that their abuse had commenced at a very early age and cited a range of sources as support for this information, including recovered memories, family discussions and formal reports. The majority of participants in the current study believed that their sexual abuse commenced during middle childhood years, which is consistent with the findings of other researchers (Jehu, 1988; Lalor, 1994; Silver et al., 1983). A few participants reported abuse on a single occasion only, or a small number of occasions, suggesting a greater likelihood that the activity involved penetration or attempted penetration, without the gradual grooming process that accompanies CSA occurring over a longer duration. Other participants spoke of abuse occurring sporadically when the perpetrator was a more distant relative or babysitter. The majority of participants indicated they had experienced CSA over a period of years,
suggesting it was chronic in nature, which was supported by the additional information that the abuse had occurred on a high number of occasions.

The duration of abuse of participants in the current study is broadly similar to that found in previous research (Jehu, 1988; Lalor, 1994). On average, participants in the current study experienced abuse of a shorter duration than those participating in Jehu’s (1988) study. However, this may be explained in that the selection criteria for that study specified survivors must have been abused on more than one occasion, skewing the data to reflect abuse on multiple occasions compared to the current study. Participants in Lalor’s (1994) study had experienced abuse for a longer duration than those participating in the current study, which may be explained by the nature of the sample, as Lalor recruited women who had been referred to a counselling service for therapeutic intervention. The lack of rigid selection criteria and such a narrow recruitment source for participants, means that CSA survivors in the current study presented with a broader range of experiences.

**Relationship of Offender**

The nature of the relationship between CSA survivors and offenders in the current study shows a similar profile to that found by Lalor (1994) and Messman-Moore et al. (2000), with a greater proportion of abuse being intrafamilial rather than extrafamilial. Fathers, followed by brothers, grandfathers and uncles were the most highly represented offenders in the intrafamilial abuse category in the current study. Jehu (1988) focussed on intrafamilial abusers and in comparison to the current study found a higher proportion of perpetrators were brothers and, as discussed previously, stepfathers were over represented amongst the nominated perpetrators.

Males who reside with the female child obviously have greater access to her, which may facilitate abuse, yet as discussed previously, there are a range of family environmental circumstances which may leave the child more vulnerable to sexual exploitation. The comments of participants in the current study certainly supported the view that the betrayal of trust when a father figure sexually abuses his daughter exacerbates the trauma of CSA. Male acquaintances, followed by strangers and friends
of the family were the most highly represented in the extrafamilial abuse category. Clearly, there may be some differences in interpretation by participants regarding who was a friend of the family compared to merely an acquaintance. Participants were twice as likely to report abuse by a male they knew rather than a male stranger.

The majority of participants in the current study reported experiencing a range of sexually abusive activities that included those involving no physical contact ranging to attempted or actual penetration. In comparison, the selection criteria for Jehu’s (1988) program required that the abuse must have included manual or oral stimulation of the victim’s and/or the offender’s genitals or penile penetration of the victim’s vagina. Broad trends in types of sexually abusive activities are similar across studies including the current one (Jehu, 1988; Messman-Moore et al., 2000). Nearly half the participants in the current study and nearly two-thirds from Jehu’s study, reported experience of penile-vaginal intercourse. Some participants in the current study reported more customized sexual activities, which seemed to meet the needs of the perpetrator, with only one participant reporting participation with a group of other children in abusive activity supervised by an adult.

**Methods of Inducement**

Although the participants in Jehu’s (1988) study reported a higher number of methods of inducement to participate in the abuse on average (4.53), compared to the current study (3.12), the ranking of usage of methods was very similar. The most common methods of inducement relied on the power imbalance between the perpetrator and the child, with a majority of participants in both studies exercising adult authority or threats to ensure participation. Aside from such coercion, nearly half of the participants reported the use of physical force to make them comply, a finding similar to that of Messman-Moore et al. (2000). Over a third of participants perceived the abuse as an opportunity for attention and affection or were bribed to participate. Only a small number of participants in the current study were lured into participation through the activities being misrepresented as sex education, a proclamation of romantic love on the part of the perpetrator or their duty to replace their mother.
Compared to Jehu’s (1988) findings, a much lower number of participants in the current study believed they were induced to participate on the promise of sexual gratification. Only a small number of participants in the current study believed they participated as a result of the activity being misrepresented as a game, compared to nearly two-thirds of the Manitoba study participants (Jehu, 1988). The comments of participants in the current study reflected concern as to whether they experienced some pleasure from the abuse, and questioning as to whether this might explain their behaviour in voluntarily returning to the situation. However, most participants were simply angry that they had been manipulated, which could happen in a range of ways, as demonstrated by the following comment, “One guy pretended he was blind and asked me if there was a nearby phone box (I was 7 and on the way to school). He said he couldn’t dial the numbers and would I do it for him if he picked me up. He digitally penetrated me.” Participants were frustrated that they were powerless and this vulnerability had been exploited, many mourned their childhood loss of innocence and harboured revenge fantasies.

### Number of Perpetrators

In the current research, nearly half of the participants had experienced sexual abuse involving just one perpetrator. Sexual abuse by multiple perpetrators tended to occur as either a series of victimizations by different individuals over time, or was due to a number of perpetrators conducting the abuse on a particular occasion. These findings are consistent with those of Jehu (1988), who found a substantial proportion of sexual abuse survivors were abused by more than one offender. Similarly, Lalor (1994) found nearly half of the CSA survivors had been subjected to sexual abuse by multiple perpetrators. Reports of CSA survivors in the current study that had experienced revictimization in a range of contexts are consistent with research literature on revictimization.

Although the rate of sexual revictimization was not formally measured in the current study, many participants provided qualitative data regarding CSA by a range of relatives and others, “gang bangs” during adolescence, and sexual assault in adulthood. Participants provided their own explanations for these occurrences, seemingly as a way
to make sense of them. For example, one participant abused by her father, strangers on one occasion, her brother and uncle, believed that she was so scared, anyone could do anything to her and she would not say a word. This set of circumstances may be explained by Herman’s (1981) proposal that perhaps a father’s breach of the incest taboo may give other family members tacit permission to do the same. A participant’s description of “innumerable rapes after became homeless at 16, including gang bangs” paints a picture of high vulnerability to sexual exploitation when young women leave home as a consequence of CSA.

**Disclosure During Childhood**

It has long been recognized that a precondition for the occurrence of CSA is secrecy. Usually abuse occurs when the child is alone with an adult and the child comes to understand that the activity is not to be discussed with others (Summit, 1983). Regardless of the child’s age when the abuse commences, she comes to the realization something negative will occur unless she maintains her secrecy. Therefore, despite general expectations that the victim would seek help, the abused child usually would not ask or tell anything about her abusive experience during childhood (Summit, 1983).

**Why No Disclosure?**

In retrospective surveys such as the current study, the majority of abuse survivors indicated that during their childhood they had never told anyone about their abuse (Jehu, 1988). Therefore the question must be posed as to why victims do not tell. Different researchers have proposed many underlying causes for this silence by survivors (Finkelhor, 1980; Hubbard, 1989; Jehu, 1988; Summit, 1983), including fear of punishment, rejection and abandonment, and disruption of the family. Lalor (1994) found non-disclosers were most concerned about their mothers’ emotional welfare. All participants in the current study acknowledged keeping their abuse secret for a period of time, with the exception of one participant who simply could not hide the emotional impact of the abuse when it occurred, and consequently had to indicate the source of her distress.
Nearly half of the participants in the current study cited reasons for not disclosing which related to their own feelings of shame, guilt and blaming themselves, with nearly as many participants concerned that a disclosure would be met with a negative reaction. Such findings suggest participants had low self-esteem, lacked social support and as children had taken on responsibility for the abusive behaviour occurring. Over a third of participants were afraid of physical harm from the offender as a consequence of disclosing, which may have been quite a realistic fear, particularly if the CSA occurred in a context of violence. Many participants were also concerned that the offender might physically harm someone else if a disclosure was made, this belief may have formed as a result of threats by the offender. A number of participants also pointed out that they were having difficulty processing the abuse for themselves and therefore had little prospect of being able to explain what had occurred to someone else. One participant highlighted how the child’s developmental stage and consequent abilities impacted on their capacity to make a disclosure, they may simply have lacked the verbal skills to do so.

Quite a few participants indicated the lack of an appropriate person who would be able to assist them if a disclosure was made. This absence of adequate social support is not surprising when the impact of a range of psychosocial issues on the family’s functioning is considered. Some participants painted a picture of growing up in a chaotic family, where a range of abuse types were inflicted on family members, and there was no significant adult who could be trusted and relied upon to provide protection. All of these issues tend to focus on immediate practical problems which prevented disclosure. In the current study, none of the participants mentioned positive factors such as attention or affection, enhanced self-esteem or favours/rewards being reasons for maintaining their secrecy about the CSA, all major reasons reported to Jehu (1988). Only one participant in the current study mentioned loyalty to the offender as a reason for non-disclosure, which is in stark contrast to Jehu’s finding that half the participants cited this reason. In addition, only one participant in the current study mentioned a fear of being taken away from home and none were concerned about the offender being jailed or harming himself/herself, compared to quite a few participants in Jehu’s study. Given that participants in Jehu’s research were attending for counselling, they may have intellectually worked through reasons why they had not disclosed during
childhood. In comparison, participants in the current study included a broader cross-section of CSA survivors, many of whom did not appear to have undertaken formal counselling.

Who is Told?

Interestingly, in the current study all of the participants who disclosed told a female relative, with their mother being the most likely person, followed by a sister who acted as a mother substitute, a grandmother or aunt. The decision to tell a relative is quite salient, given that the majority of participants experienced abuse perpetrated by a nuclear family member or extended family member. The choice of a female relative may have been made by the participant due to a lack of other options, with children generally having a limited social support network and those from dysfunctional families even more likely to have restricted access to supportive others. From the descriptions of some participants it appeared that the information provided to the relative simply stayed with them, with doubts about whether the participant was even believed. Unfortunately, in other cases when a third party was told, it was similarly ineffective. In one case, the child was seen by a doctor and the family consulted a priest, but there was no further follow up. In only one situation, where the child was in institutional care, did the disclosure lead to a police investigation and medical examination. It was most unfortunate that in other situations where children did disclose their abuse, these procedures did not take place as a matter of course, thus potentially allowing the abuse to continue and reinforcing to the child that she was powerless. One participant was able to recognize the impact of historical context and suggest that the lack of support offered was reflective of the lack of services available at the time.

Responses to Disclosure

The rate of disclosure before the age of 17 years was even lower in the current study than the half of participants in Jehu’s (1988) study. The reticence of participants to disclose sexual abuse during their childhood would seem to be well founded. Those participants who did venture a disclosure were often met with quite a negative response such as disbelief, denial of their victimization, anger or hostility directed towards them. In the worst case, following disclosure the participant was revictimized by another
family member, apparently in the belief that her credibility was so damaged it would not matter if she did disclose this further abuse. These findings are reflective of those of Jehu (1988), who noted the consistency in negative responses received by his participants. In comparison, Russell (1986) found a wider variability, including positive reactions, by mothers to the disclosure of their daughter’s abuse. However, Lalor (1994) found that although nearly two thirds of mothers believed their daughter at disclosure, only half this number held a non-blaming attitude and only 10% of mothers were willing to discuss the abuse. The few participants in the current study who reported positive reactions described responses that might reasonably be taken for granted in other scenarios when a victim outlines experience of a trauma. These positive reactions consisted of belief of the victim, valuing an attempt to protect others and in only one case obtaining outside assistance for the victim. Browne and Finkelhor’s (1986) conclusion that negative reactions to disclosure may aggravate trauma for sexually abused children may be true, but this needs to be considered in the context that reactions to disclosure may be different for the current generation. Many of the participants in the current study were from a previous generation and the reactions to disclosure they encountered may have been more positive if they were children disclosing today.

**Intrapersonal Functioning**

Participants in the current study exhibited higher levels of symptoms than the norms for nonpatient adult females on all scales of the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982), despite being a self-selected community sample with few participants currently receiving clinical support.

**Somatization**

Previous researchers have found CSA survivors to have a higher rate of somatization compared to controls (Briere & Runtz, 1988a; Greenwald et al., 1990; Lundberg-Love et al., 1981), particularly when the CSA is part of the abuse experienced by individuals who are later revictimized as adults (Murphy et al., 1988). In the current study, participant reports of somatic symptoms were found to increase as the severity of sexually abusive acts increased. These findings reflect greater preoccupation with bodily processes and their vulnerability to disease or dysfunction when there is a greater
degree of physical invasion of the victim (Briere & Runtz, 1988a). This perception of connection between abuse and ill health is illustrated by a survivor’s questioning of a possible link between her CSA and development of ovarian cancer. In the current study, it was also found that rates of somatic symptoms increased if force or coercion had been used to induce participation, perhaps as a result of participants experiencing greater levels of stress in such circumstances. The current findings are consistent with those of Briere and Runtz (1988a), who found that CSA involving the threat or use of force was related to a higher rate of acute somatization.

**Fear and Anxiety**

Consistent with previous research (Briere & Runtz, 1988a; Fromuth, 1986; Gorcey et al., 1986; Greenwald et al., 1990; Lundberg-Love et al., 1981; Murphy et al., 1988; Stein et al., 1988; Yama et al., 1993), participants were found to have elevated levels of symptoms relating to anxiety and persistent fear or phobic anxiety, compared to norms. Although some researchers (Sedney & Brooks, 1984) have found a significant association between anxiety and intrafamilial CSA, but not extrafamilial CSA, there was no difference in anxiety levels found between these groups of CSA survivors in the current study. This may have been due to the fact that over three-quarters of the participants in the current study had been abused by at least one family member and of those abused exclusively by individuals from outside their families, most were abused by a number of perpetrators. Murphy et al. (1988) argued that findings of increased anxiety could be connected to participants’ experience of being subjected to force or the threat of force. Murphy et al. claimed their findings were consistent with Girelli et al.’s (1986) research, which found that an adult rape victim’s perception of the degree of threat involved, rather than an objective measure of the assault’s severity, may have a closer relationship with the degree of distress experienced. The comments of participants in the current research appeared to support this view.

Only half of the participants in the current study, compared to two-thirds of participants in Murphy et al.’s (1988) study, indicated they had been subjected to force or coercion to induce them to participate in the abuse. In the current study, the use of force or coercion, but not the severity of the sexually abusive activities, was related to
increased phobic anxiety. Thus, it would appear that the use of force or coercion is linked with the development of specific fears rather than more general anxiety. The specific fears may be related to particular threats that have been made or certain objects associated with the abuse. It would appear that more physically invasive abuse, and not the use of force or coercion at the time, may increase the likelihood of chronic anxiety.

Consistent with Briere’s (1984) finding that CSA survivors were more likely than controls to report a fear of men, quite a number of participants in the current study indicated that they hated men or had difficulties in relationships with men. However, in the present study some participants indicated, as had been the case in Briere’s study, that they had also experienced abusive adult relationships. Therefore, it is not possible to ascertain whether the participants’ negative views towards men may have been related to their CSA, experience of physical abuse as an adult, or a combination of both. Some participants in the current study also attributed their feelings of fear or anxiety, or the development of specific phobias or panic disorder, to long-term effects of their CSA experience.

**Depression**

Participants in the current study demonstrated higher levels of depressive symptomatology than norms, consistent with the findings of previous researchers (e.g., Bagley, & Ramsay, 1986; Briere, & Runtz, 1988a; Gold, 1986; Greenwald et al., 1990; Jackson et al., 1990; Lundberg-Love et al., 1981; Mullen et al., 1990; Peters, 1988; Saunders et al., 1992; Sedney, & Brooks, 1984; Stein et al., 1988; Yam et al., 1993). Findings from the current study were consistent with those of Yam et al. (1993), in that there were no differences between the intrafamilial and extrafamilial CSA survivor groups in terms of depressive symptoms. Yam et al. suggested this result may have been due to there being only a small number of cases in their study where the perpetrator was a father/stepfather, but that was not the case in the current study. Furthermore, participants in the current study abused by a father/stepfather were not significantly more likely to demonstrate increased depression. Yam et al.’s contention that family environment characteristics may act as an important mediating variable between CSA
and later depression would seem quite salient and plausible given the high rate of psychosocial issues reported.

Peters (1988) found women who had experienced contact CSA were significantly more likely to have experienced a major depressive episode and a greater number of depressive episodes, than those who had experienced noncontact CSA. However, a comparison between these groups was not possible within the current study, as none of the participants had experienced solely noncontact abuse. Despite this, results from the current study are consistent with the proposal that contact CSA may increase depression, given participants in the current study exhibited elevated depression compared to norms. It was possible to compare the results from the current study with the findings of Alexander (1993) given that the same abuse characteristics were employed. Alexander found that age at onset of abuse in particular, severity of abusive activities and whether the perpetrator was a father figure or not, were predictive of current depression among participants. Yet none of these same abuse characteristics were significantly associated with current depression in this study. A possible explanation for the difference in findings may lie in the use by Alexander of a specific, comprehensive measure of depression. The sample of community participants utilized in each study would appear to be broadly similar.

Findings from the current study do not support those of Murphy et al. (1988) who found those women who had been revictimized had higher depression scores than other groups of CSA victims or controls. Although revictimization was not measured directly, participants in the current study who reported abuse by multiple perpetrators did not report higher levels of depression. Overall, these findings suggest there may be a complex relationship between experience of CSA and later depression. Development of depression in CSA survivors may be mediated by a range of factors, including the survivor’s perception of the abusive experience, concomitant physical abuse (Roosa et al., 1999), a lack of social support and other factors reflective of family functioning in the family-of-origin (Beitchman et al., 1992).
Suicidality

Findings from the current study support the existence of a relationship between a history of CSA and suicidal behaviours which has been found by other researchers (Bagley & Ramsay, 1986; Briere, 1988; Briere & Runtz, 1986; Briere & Runtz, 1988b; Bryer et al., 1987; Jackson et al., 1990; Sedney & Brooks, 1984). The issue of suicidal ideation is addressed by one item in the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982), which asks participants about “Thoughts of ending your life”. Nearly half the participants in the current study responded that they had had these thoughts and a few participants had been extremely distressed or bothered by this in the previous week. This item was not associated with severity of the sexual abuse, which was consistent with the findings of Saunders et al. (1992) of no significant differences in lifetime prevalence rates for suicide attempts between noncontact CSA survivors and nonabused controls. The responses to the item were not associated with other sexual abuse characteristics, such as age at commencement of abuse, duration of the abuse, the number of perpetrators or the use of force or coercion. Neither was the item associated with the relationship of the offender to the survivor, contradicting Jackson et al.’s (1990) finding that those experiencing intrafamilial CSA had reported significantly higher rates of suicidal behaviour in the past compared to matched nonabused controls. Previous researchers have found an association between CSA and suicide attempts (Bagley, & Ramsay, 1986; Briere, 1988; Briere, & Runtz, 1986; Briere, & Runtz, 1988b; Bryer et al., 1987; Jackson et al., 1990; Saunders et al., 1992), with two studies highlighting that concomitant physical abuse also occurred in childhood (Briere, 1988; Bryer et al., 1987). The findings suggest suicidal behaviour in CSA survivors may be mediated by a range of family environment characteristics, including concomitant physical abuse in particular.

Participants in the current study were not directly asked about a history of suicide attempts, although in the qualitative data many women indicated they had previously had suicidal thoughts or did not care if they were to die. A couple of participants perceived suicidal thoughts to be a long-term effect of CSA and one observed that she had undertaken 11 suicide attempts and was not afraid of dying, as she perceived death as providing peace. Another participant reported how her abuse issues had resurfaced
and she had become suicidal and wanted to take her children with her, as she believed at the time that it was the only way to protect them. She had undertaken counselling and wished to ensure that she was never like that again. Thus, it would appear that suicidal thoughts and attempts were of great concern to the participants in the current research.

**Self-Mutilation**

Although self-mutilatory behaviour may be seen as associated with suicidal behaviour, Carroll et al. (1981) argued participants describe their actions differently in terms of the stated intent, type of tension felt and their subsequent emotional state. The small number of clinical studies which have focussed on the link between CSA and self-mutilation have provided support for an association between them (Briere, 1988; Briere & Zaidi, 1989; Carroll et al., 1981; Shapiro, 1987; van der Kolk et al., 1991). However, three studies were exploratory and the findings did not reach statistical significance (Briere & Zaidi, 1989; Carroll et al., 1981; Shapiro, 1987). Carroll et al. (1981) proposed that because most CSA survivors were not allowed to express angry feelings, they sought other coping methods for managing intense feelings and this led to self-mutilatory behaviour. Shapiro (1987) posits that self-blame is the mechanism through which intense feelings relating to the CSA are linked to self-mutilatory behaviour. In the current study, one participant spoke about self-harm as a strategy for dealing with the long-term effects of CSA and slowly finding other strategies. Another participant who was in jail at the time of disclosing her CSA, felt a keenness to subsequently self-harm, in an environment which is notable for its high incidence of self-harming behaviour (Bach-y-Rita, 1974). Despite not being directly questioned about self-harming behaviour, some participants in the current study volunteered that they had employed this behaviour as a coping strategy on previous occasions. However, the participants confirmed the secretive nature of participation in such behaviour.

**Eating Disorders**

Even though detailed information about their histories of eating disorders or substance abuse was not sought from participants in the current study, some observations can be made. Three participants attributed their history of eating disorders, including obesity, to the experience of CSA. A couple of participants characterized
themselves as having abused drugs and alcohol as a long-term effect of their CSA and one spoke of overdosing. One item on the Ways of Coping Scale (WCQ; Folkman & Lazarus, 1988) aimed to establish if participants engaged in behaviours such as eating, drinking, smoking, use of drugs or medications as methods of coping. Nearly half of the participants admitted using these methods a great deal. This is consistent with the findings of some researchers that CSA survivors reported much higher levels of alcoholism and drug abuse than controls (Briere, 1988; Briere, & Runtz, 1988b; Peters, 1988; Stein et al., 1988; Windle et al., 1995; Zierler et al., 1991). However, in the current study no significant association was found between engaging in substance abuse and those abuse characteristics which have been shown to be indicators of an increased likelihood of later substance abuse. For example, number of perpetrators, age at the onset of abuse, severity of the abuse, intrafamilial versus extrafamilial offenders and use of coercion were not associated with engaging in eating and substance abuse behaviours. This finding may be explained by the lack of a detailed exploration of substance abuse history in the current study.

**Anger**

Participants in the current study demonstrated higher levels of hostility than norms, as would be expected on the basis of previous research findings in relation to anger among CSA survivors receiving clinical services (Briere, 1988; Briere, & Runtz, 1988b; Haller, & Alter-Reid, 1986; Herman, 1981; Tsai, & Wagner, 1978). Briere and Runtz (1988b) suggested that these feelings of anger resulted from the betrayal, powerlessness and stigmatization inherent in CSA, which can lead to chronic rage. The researchers observed that survivors’ anger may be directed towards themselves, being expressed as self-mutilation or suicidality, as discussed previously. Alternatively, the anger may be directed towards others, as aggression, criminal acts or acting out behaviour in a range of interpersonal situations (Briere, & Runtz, 1988b).

In the current study, although many participants had difficulties with interpersonal relationships and distrusted others, only a few described anger, frustration or rebellion as long-term effects of their CSA. Only one participant spoke of having a criminal offending history, whilst another participant described perpetrating frequent
physical violence towards her male partner. A number of researchers (Haller, & Alter-Reid, 1986; Herman, 1981; Lipovsky, & Kilpatrick, 1992; Tsai, & Wagner, 1978) have commented on the finding that CSA survivors may feel even greater rage towards mothers who they perceive as not having protected them, compared to the offender who actually perpetrated the abuse. Some participants in the current study expressed great anger towards mothers who they perceived as showing more support for the perpetrator at their daughter’s expense. Survivors were especially angry at mothers who blamed them for the abuse, or wished to deny its occurrence. Some participants believed their mothers had been aware of the abuse but took no action to prevent its continuance. One participant continued to be extremely angry about her mother’s role, “He did it in front of mum and she turned her back. Not seen her for 4 years since father died.” In a couple of cases, participants were angry at mothers who used discussion of their daughter’s abuse to focus attention on themselves and their needs. Of course, participants also expressed very strong anger at their abusers, indicating disbelief at the degree of betrayal of trust that occurred. Many participants spoke of the need to protect other family members and so were waiting for these family members to die before they could launch police investigations and prosecutions. A couple of participants had confronted the offender in different ways and some had come to see their abusers as quite pitiful. A number of participants were heavily focussed on revenge, fantasizing about seriously harming the offender, with one not using a firearm at the last minute.

**Psychiatric Health**

Given their experiences of betrayal of trust, by those that should have ensured their care and protection, it is hardly surprising that CSA survivors would exhibit feelings of paranoia. Participants in the current study demonstrated significantly elevated symptoms of paranoid ideation compared to norms. Furthermore, the level of paranoia heightened as the severity of the sexually abusive acts and use of force or coercion increased. It seemed that participants developed greater paranoia in response to their powerlessness in the face of physical invasion associated with force or coercion.

In the current study, participants demonstrated higher levels of symptoms of psychosis compared to norms. In fact, these symptoms were elevated to a greater degree
than all other symptom scales on the BSI (Derogatis, & Spencer, 1982). This was despite the fact that participants were a self-selected community sample whose level of functioning was adequate to enable them to remain in the community. Although a couple of participants reported receiving inpatient psychiatric care, most had received therapeutic counselling only in relation to their abusive experiences. One participant indicated she had been diagnosed with Borderline Personality Disorder (BPD), which a couple of researchers have proposed is associated with experience of CSA (Barnard, & Hirsch, 1985; Bryer et al., 1987).

**Interpersonal Functioning**

**Relationship Stability**

Although it was expected that participants in the current study would demonstrate a high degree of relationship difficulties with partners, as found in previous research (Bagley, & Ramsay, 1986; DiLillo, & Long, 1999; Jehu, 1988; Roche et al., 1999), the quantitative data suggested this was not the case. A third of the participants in the first stage of this research did not have a current partner. Of the two-thirds of participants who did have a current partner, most were somewhat to extremely satisfied with their marriage, husband as a spouse and relationship with their husband. However, a quarter of the participants were quite dissatisfied with these aspects of their relationship, although it seemed that a number of participants were commenting on previous relationships which had already broken down. Many participants wrote additional comments relating to the Kansas Marital Satisfaction Scale (KMS; Schumm et al., 1986) and this qualitative data detailed a number of issues, suggesting the assessment of relationship functioning was much more complex than a simple analysis of relationship satisfaction. Some participants pointed out that they interpreted the scale as applying to them, even though it referred to a “marriage” and “husband”. In some cases, participants were in defacto or long-term relationships.

Other comments written by participants on the questionnaire, in the first stage of the research, indicated that they were not intending to get married and some were widows. Quite a number of participants noted their marriages had broken down and a few of these participants indicated they had completed the questionnaire in relation to...
their ex-partner. Furthermore, some participants implied their relationship breakdown was influenced by their experience of CSA. For example, one participant stated “Recently separated. Had an affair with secretary, she’s more trusting”. Another participant explained “My husband and I have been separated for 5 years now and yes my own problems with sexual abuse didn’t help our marriage at all. Sometimes my ex husband reminded me of my stepfather”. Whereas another participant demonstrated the complexity that can occur, “I am in a de facto relationship. I am married, to be divorced. And living with someone else”. Some participants suggested there had been an improvement in their second marriage, with one participant indicating great dissatisfaction with her first marriage, but she had found her second marriage to be very happy, which was assisted by receiving some counselling which had helped her. One participant was very positive about her partner, observing that “I have had a lot of loving support from my husband – I doubt that I would have come as far as I have without him”.

The additional finding that participants in the first stage of the current study demonstrated higher scores on the Interpersonal Sensitivity subscale (BSI, Derogatis, & Spencer, 1982) compared to norms, is consistent with research by Murphy et al. (1988). High scores on this subscale indicate the participants had difficulties with feelings of personal inadequacy in relation to others, discomfort in interpersonal situations, self-consciousness, general uneasiness and negative expectations in relation to interpersonal interactions. To explore the issue of relationship difficulties in greater depth, participants in the second stage of the research were interviewed regarding the nature of their disclosure of CSA to current and previous partners and the nature of their relationship with a current partner. The ratio of one-third of participants who did not have a current partner was reflected in the subsample of participants interviewed in the second stage of the research. All of these participants were involved with a male partner, who was almost universally perceived to be highly caring and not controlling, the ideal combination for perception of partners.

Significant associations were not found between the degree of sexual abuse severity and the likelihood the participant would negatively perceive her partner as low on care and high on control in the current study. These findings are in contrast to those
of Mullen et al. (1994), who found the ideal combination reported by only a third of CSA survivors, with a positive link to those who had not experienced intercourse. It is possible that women in the current study experiencing relationship difficulties may have been less likely to volunteer to participate in the second stage of the research. Alternatively, those relationships outlined in the first research stage, where the degree of dissatisfaction was high, had perhaps already broken down and participants had been simply reflecting on what they had been like.

**Disclosure to Partner**

In the second stage of the research, all of those participants who currently had a partner had told this partner of their CSA experience. The generally supportive reactions of partners and their anger at the offender is congruent with the participants’ perception of their relationship and satisfaction with it. However, many participants felt their partners had problems understanding their CSA and it had caused difficulties with intimacy in their relationship. Some partners did not say anything following the disclosure of CSA, leaving participants unsure of what their feelings were. Participants often found this apparent lack of reaction to be an anti-climax after the emotional release of finally disclosing.

In contrast to current relationships, only half of the participants had told previous partners of their CSA. However, these partners had also been generally supportive and angry at the offender. Some participants were met with negative and even hostile reactions, and again the CSA had caused difficulties with intimacy in the relationship, with a number of relationships breaking down. However, some participants believed their abuse was used as an excuse for other problems within the relationship. Understandably, such reactions might make participants reticent to attempt disclosure again with future partners.

**Intimacy Functioning**

Even though participants generally reported a reasonably high level of satisfaction in their relationships with current partners, qualitative data relating to their perception of the long-term effects of CSA placed a strong emphasis on interpersonal
relationship difficulties. Consistent with the findings of Jehu (1988) and DiLillo and Long (1999), nearly half the participants described distrust of others as a long-term effect of CSA. Some participants described feeling insecure, being isolated from their family and experiencing social difficulties. One participant observed, “It has made me a little aloof with people, I don’t trust people”. These difficulties were experienced in all types of relationships, including the ability to form friendships. In particular, many participants reported difficulties in relationships with men, especially in relation to trust issues. One participant commented “Developing a new relationship. Sometimes people are not prepared to stick around to get to know you. Need 6 months to do this, go through hoops first”. Another participant was thankful she had been able to develop strong, long-term friendships, but lamented that she had “rarely had a decent relationship with men”. Whilst one participant reported her disclosure of CSA to a partner had led to accusations that she was leading him on, another indicated some men had become sexually excited by her revelation of previous sexual abuse or wished to prove they could get her over her sexual difficulties.

**Partner Characteristics**

The observation made by a couple of clinicians (Tsai, & Wagner, 1978; Van Buskirk, & Cole, 1983) that the personal characteristics of survivors’ partners were reminiscent of their fathers, was also made by one participant. This survivor observed “Partners chosen are similar to father: workaholics, fighting for attention or love….Traits which are very similar – scary”. This observation might also help to explain the negative association found between each aspect of marital relationship satisfaction and the survivor’s father/stepfather being the perpetrator. Those survivors abused by their father/stepfather were the least satisfied with their marriage, spousal relationship and relationship with their husband. This finding is consistent with those of Russell (1986) who found survivors of father/stepfather abuse reported the greatest degree of trauma, whereas Meiselman (1978) and Courtois (1979) found incest survivors were particularly likely to experience difficulties in intimate relationships and a large proportion of the group had never married.
Homosexuality

A couple of participants pointed out that the scale did not accommodate same sex relationships, but completed the items as though it did. The angry comment of one participant “What happened to lesbian relationships!! Your survey is presumptuous as MANY lesbians in relationships have suffered sexual abuse” would seem to be quite accurate in light of the findings of the few research studies available (Bell et al., 1981; Fromuth, 1986; Gundlach, 1977; Hall, 1999; Herman, 1981; Meiselman, 1978; Runtz, & Briere, 1986; Simari, & Baskin, 1982). Almost all of these studies found a significant positive association between CSA and having a homosexual orientation. Furthermore, the lesbians in Herman’s (1981) study felt their incest experience influenced the development of their lesbian identity, which they felt required mastery of childhood traumas to a degree and resulted in a healthier and more rewarding personal life. In the current study, one participant commented that she believed her CSA had led to the long-term effect of ambiguity about her sexual orientation, but laughed when recounting that this was until she told her mother she was gay and her mother responded “Oh dear, no you are not”, twice. There were insufficient participants in the current study who identified themselves as lesbians, to assess whether the factors of severity of abuse and heterosexual versus homosexual abuse may increase the likelihood of development of a homosexual orientation, as found by Gundlach (1977) and Simari and Baskin (1982) respectively.

Sexual Adjustment

A number of participants spoke of their difficulties with intimacy and being able to commit to a relationship, as long-term effects of their CSA. These feelings were manifested as finding it difficult to be around people, not being able to be close to men and dislike of being touched. Abuse experiences could be very closely linked to later attitudes, for as one participant wrote “My first sexual experience with my husband was horrendous cause I knew it would hurt as the other time had. It is only recently I have started to enjoy my body down there but unfortunately it is not with my husband. I struggle to enjoy sex with him.” Participants were sometimes aware of their methods of coping with intimacy difficulties, such as the woman suffering obesity who commented that intimacy with her husband was hard and she was aware she had used her weight as
an excuse to push him away. Another participant summed up her attitude as “Afraid to love, don’t ever want to be touched. Lost my sexuality, no feeling towards love”. It is clear from these comments that participants’ relationship difficulties ranged across the spectrum from emotional and interpersonal aspects to behavioural components of sexual functioning, consistent with Di Lillo’s (2001) argument that all of these aspects are salient.

**High-Risk Sexual Behaviour**

As part of their difficulties with relationships and sexuality as a consequence of abuse, a number of participants in the current study described a history of sexual abuse that led into sexually promiscuous behaviour, including experience of sexual assaults. These findings are consistent with previous research literature on the relationship between a history of CSA and subsequent high-risk sexual behaviour (Alexander, & Lupfer, 1987; Bartoi, & Kinder, 1998; de Young, 1982; Finkelhor, 1980; Fromuth, 1986; Herman, 1981; Meiselman, 1978; Zierler et al., 1991). For example, one participant wrote about sexual molestation at five different ages during childhood, a rape at age 14, promiscuous behaviour until marriage at age 18, a rape including death threats at age 17 and seduction by a friend during a bad marriage, which lasted for four years. Yet this participant had been remarried for 18 years and was working on issues in her relationship and her own issues constantly.

Evaluation of self-reports of promiscuity need to take into consideration research findings suggesting that although CSA survivors were equally as sexually active as controls, they expressed greater difficulties with their sex life, sexuality and perceived frequency of intercourse, being either too often or not sufficiently often (Mullen et al., 1994). This research echoed the earlier findings of Fromuth (1986) that self-described “promiscuous” behaviour, would not be formally classified as such, and potentially the woman’s self-concept rather than her actual behaviour was influenced by her experience of CSA. Whilst this may have been the case for some participants, to varying degrees, it would seem that some women in the current study were very sexually active. An insightful participant explored how her promiscuous behaviour had led to a gang rape, which had changed her whole perspective on the meaning of sex. This pattern reflects
Meiselman’s (1978) observation that most CSA survivors seemed to grow out of sexually acting out behaviour by their twenties. For other survivors, there was a tendency to sexualize all of their relationships and an inability to differentiate sex and affection, due to confusion between parental love and overt sexuality during childhood. One participant simply suggested “Not intentionally promiscuous, looking for love”. This issue was eloquently summed up by a participant thus, “I feel it is important to point out the distorted viewpoint I’ve held throughout my life due to sexual abuse – the idea that SEX = LOVE. The only affection I had known as a child was sex and any male who showed an interest in me, was offered sex automatically. I still query if I understand love between an adult man and woman in a ‘normal’ way”.

Consistent with the fairly extensive research literature available (e.g., Brunngraber, 1986; Charmoli, & Athelstan, 1988; Maltz, & Holman, 1987; Meiselman, 1978; Mullen et al., 1994; Saunders et al., 1992), quite a number of participants in the current study identified themselves as having difficult sexual relationships. However, given the qualitative nature of the data and the small number of individuals involved, it was not possible to assess whether difficulties in sexual functioning, as found by previous researchers, were associated with father-daughter incest (Herman, 1981; Meiselman, 1978), a higher frequency of CSA, or a younger age at onset (Greenwald et al., 1990), being an adolescent at the onset of molestation, negative feelings associated with the molestation, or a higher frequency and duration of molestation (Tsai et al., 1979), or more severe sexually abusive activities (Finkelhor et al., 1989). In the current study, one participant stated she had “never had any sexual enjoyment”, a comment reminiscent of survivor accounts obtained by Herman (1981). Participants described how flashbacks to the CSA could be elicited by particular places, smells or sexual activities, “with intimacy it comes back”, which heavily impacted upon their partner relationships. One participant very candidly outlined her beliefs about how CSA had affected her adult life, making her different from her peers, “Physical sex is easy, pleasurable but low in significance. I like SEX but if I don’t feel like it I can still participate & at worst pretend I am a slab of meat & the real me is elsewhere. Sometimes I use mental images of child/adult sexual abuse as erotic stimuli”.

Revictimization

The experiences of participants in the current study would certainly lend support to the phenomenon of revictimization, despite a lack of formal exploration of this issue. Revictimization has been observed in the course of studies into the long-term impact of CSA (e.g., Chu, & Dill, 1990; Follette et al., 1996; Fromuth, 1986; Gorcey et al., 1986; Herman, 1981; Herman, & Hirschman, 1977; Murphy et al., 1988; Russell, 1986). There have also been a few studies which have focussed specifically on this issue (Gidcyz et al., 1995; Koverola et al., 1996; Messman-Moore, & Long, 2000; West et al., 2000; Wyatt et al., 1992). As one participant wrote in despair in relation to the number of perpetrators of abuse against her, there had been “one more recently so what have I learnt?” Other participants had gained insight over time, “As a result of the abuse I was very promiscuous in my 20s, had no self esteem, believed I had no right to say no to a man, and attracted very abusive partners. Through a great deal of personal development, I have turned my life around, I now study and have quite a healthy minded husband”. However, sometimes this insight was too late to prevent another generation from experiencing abuse, “…the biggest impact of these experiences on me has been attracting the wrong types of men, who re-damaged me & my children.”

Revictimization in adulthood is not necessarily in the form of further sexual abuse, CSA survivors have also been found to experience higher rates of physical assault (Banyard et al., 2000; Briere, & Runtz, 1987; Follette et al., 1996; Herman, 1981; Herman, & Hirschman, 1977; Messman-Moore, & Long, 2000; Russell, 1986). A few participants offered comments confirming this was their experience too, “Used and abused – the old cliché”, “Husband addicted to pornography – increasingly violent”, “Married (year) to abusive, violent, alcoholic ex-cop. Widowed (6 years later). Forever guilt-ridden that I am pleased that my husband died! However, must accept responsibility for my acceptance of destructive relationship – and my contribution to it!”

Children and Parenting

For the two-thirds of participants in the current study who had children, the average number of children (2.42 per woman) was greater than that found by Mullen et al. (1994), whose research participants had an average of 2.24 children for those who
had experienced abuse, and 1.79 children for controls. The finding that participants would seem to have a greater number of children than their counterparts who had not experienced CSA, was supported by the work of Herman-Giddens et al. (1998). The findings from the first stage of the research would seem to be explained by a number of factors, which became more apparent during the telephone interviews of the second stage. Consistent with Finkelhor’s (1984) account of the circumstances of CSA survivors, some women indicated a clear plan to leave their dysfunctional family homes as soon as possible. The most practical way to achieve this in the absence of social welfare support, particularly in earlier times, was to marry the first eligible male. This scenario is consistent with Russell’s (1986) finding that those CSA survivors reporting the most severe trauma were the most likely to marry.

Thus, consistent with previous findings (Mullen et al., 1994; Zierler et al., 1991) that women with a CSA history had a tendency to have their first pregnancy earlier than controls, some women in the current study became teenage brides who rapidly acquired the responsibilities of motherhood. This scenario may also underpin Herman-Giddens et al.’s (1998) finding that married CSA survivors in particular, had a higher number of children. Given the circumstances of an opportunistic marriage, it seems unsurprising that some of the husbands in the current study turned out to be abusive, whilst a couple of women were extremely thankful that they had been so lucky in landing a supportive partner. As one participant commented “Married at 18…Was boss at work, could have been worse”. However, one participant described in detail the alternative of running away from home and living on the street, where she was subjected to sexual exploitation resulting in a few abortions and illegitimate children, who were removed from her care by welfare authorities. This life pattern description is quite reminiscent of the exploration of circumstances of female street hustlers conducted by Miller (1986).

A number of participants in the first stage of the research indicated their ambivalence about having children as a consequence of their experience of abuse. This issue was subsequently explored further in the second stage of the research, with participants questioned as to whether their decision to have children had been influenced by their experience of CSA. Almost half of the participants agreed the decision had been influenced by their experience, with only a few indicating a positive impact of...
encouraging them to have children. Comments from these individuals articulated a desire to have children to prove they were capable of good parenting. For example, some participants who viewed their child rearing as compensatory stated “I had 4 children because I wanted to be a good mother and give the children the happy family I never had – we’re doing a good job too!”, “Compensated with own children, would have been happy to have more”. Such comments provide support for Courtois’ (1988) argument that some CSA survivors were potentially good and even exceptional parents, who were determined to ensure their children have different experiences. In contrast, the vast majority of individuals who indicated they had decided not to have children as a result of their abusive experience would seem to fit the pattern described by other researchers (Gelinas, 1983; Herman, 1981; Steele, & Alexander, 1981).

One participant’s belief she could not have children led to disclosure of her CSA, “Getting married at 18, he wanted children. I thought I could not have them (for no apparent reason), and I had to tell him why”. It seemed that a lack of sexual knowledge had led this participant to believe she could not have children as a result of CSA involving penetration. Some participants who had had children had done so reluctantly, or reduced the number of children they felt able to manage, which was a sentiment echoed by those who elected not to have children at all. The participants provided support for Herman’s (1981) assertion that many CSA survivors were afraid they would be bad mothers to their children, with one indicating she had been afraid she would hurt them. This particularly frank participant claimed “Through counselling I have discovered that I have chosen not to have children because I was afraid that I would hurt them. I had so much anger inside me that I was unsure if I could control it. (I married a man who didn’t want any more children, he has 2 teenage children.)”. Many participants had specific concerns relating to their ability to protect their own children from abuse, perhaps reflecting their firsthand knowledge of the vulnerability of children.

The concern of participants that their CSA experience may have an impact on their parenting would seem to be justified given that all those women with children, with only one exception, believed that CSA had had an impact on their parenting. Almost all of the participants spoke about being overly protective of their children and some participants perceived the conflict this caused with allowing their children to
develop independence. This theme of increased protection of children was commented on extensively in the context of perception of benefit from the abuse explored in the first stage of the research. For some participants, their CSA experience raised particular gender-related issues in parenting their children, a potential problem flagged by Courtois (1988). One participant outlined how her son’s gender and age being the same as when her abuse commenced had sometimes made it difficult for her to parent him. Such a comment echoes Courtois’ (1988) point that survivors may hold fears regarding their son’s development as he matures. On the other hand, participants in the current study were also worried about their ability to protect their daughters from males, a concern highlighted by Steele and Alexander (1981).

**Parenting Difficulties**

The results from the current study provide some support for DiLillo’s (2001) proposal that there are three main reasons which may explain the parenting difficulties of CSA survivors. The first reason, that highly dysfunctional families of origin do not allow survivors sufficient exposure to effective parental role modelling, would seem to be supported by survivors in the current study. These women described very chaotic families, which did not even provide access to social support, which would have allowed disclosure of the abuse. One survivor whose children had been abused, blamed herself for being unable to protect them, because she had had bad role models in her parents. Another participant appeared to recite a mantra to herself, “I am good. I am a good mother. I will be a good person.” A few participants described themselves as child-like, lacking the knowledge and emotional skills to parent children, just as Courtois (1988) had described. For example, one participant described herself thus, “When married mentally 10 years, 18 years physically”. Some participants believed that a role reversal had occurred, with their children coming to parent them, providing support for the observations of Burkett (1991).

The second reason proposed to underlie parenting difficulties, was the impact of the abuse experience itself and subsequent intrapersonal problems. Such problems as anger, low self-esteem and depression, were thought to result in undermining of the survivor’s confidence and belief in their parenting competency (DiLillo, 2001).
Banyard’s (1997) measure of perceptions of parenting competence suggested nearly half of the participants were very worried about their children and most participants had relatively low parenting self-esteem. This finding fits with the positive association found between parent self-esteem and survivors’ distorted beliefs in relation to self-esteem, feelings of guilt and self-blame in relation to their CSA. However, the majority of participants believed their future parenting would remain the same or get better. Although Banyard (1997) found women with greater numbers of children had more concerns about their future parenting, this was not the case among the participants in the current study. This finding might be explained by the reluctance of many of the current participants to have children at all, which would be influenced by their ability to form stable relationships, leaving others to have as many children as their confidence in parenting allowed. The finding in the current study that those participants with more formal relationships (eg. married) and with increasing age, had more concerns about their future parenting, may simply reflect the fact that these were the participants more likely to have children.

DiLillo’s (2001) third reason for explaining the parenting difficulties of CSA survivors focussed on the hampering of parenting abilities by interpersonal relationship difficulties, and especially the marital relationship. The current study provides some indirect support for this proposition in that many of the participants with children indicated that their relationships had broken down. Most participants who currently had a partner, but did not necessarily have children, reported a reasonably high level of relationship satisfaction. For the subgroup of a quarter of participants who expressed high levels of dissatisfaction with their relationship, many of the relationships appeared to have already broken down or were destined to break down.

**Risk and Resilience Factors**

The concept of resilience has been used to describe those survivors of CSA who do not exhibit the same high level of symptomatology as their counterparts (Conte, 1985). It is important to know more about the characteristics of these survivors and what they did or did not do, which has enabled them to apparently cope successfully with their abusive experience (Feinauer, & Stuart, 1996). The two major factors which
appear to determine resilience are abuse severity and how the survivor made sense of, or attributed meaning to her experience, and therefore dealt with it over time (Conte, 1985; Finkelhor, & Browne, 1985; Newberger, & De Vos, 1988; Roth, & Newman, 1991).

**Self-Esteem**

A pervasive theme that emerged from the first stage of the current research study was the survivors’ low self-esteem and primarily negative self-concept. Yet, participant scores on the Self-Esteem subscale of the Belief Inventory (Jehu, 1988) generally did not reflect low self-esteem. However, the vast majority of participants endorsed at least one item, suggesting they held a distorted belief in relation to self-esteem. For example, over two-thirds of participants believed it was at least partially true they would never be able to lead a normal life due to the damage from CSA being permanent. The finding that self-esteem was significantly positively associated with a high level of negative psychological symptoms across all domains suggests those participants with low self-esteem also experienced a range of psychological difficulties. Overall, the participants tended not to strongly endorse items that suggested their experience of CSA had decreased their value as a person. This finding can be explained by the context in which most participants completed the questionnaire. The Belief Inventory was designed for use as a clinical measure of pre and post intervention outcome, to enable clinicians to specifically target distorted beliefs and correct them through cognitive restructuring. Jehu (1989) found almost all participants enrolled in a therapy program had low self-esteem, indicative of a clinically significant level of distorted beliefs. However, it appears that most of the participants in the current study had undertaken counselling at some point in their lives, and counselling would generally attempt to address such beliefs. Therefore, it may be expected that participants would be inhibited from endorsing such statements, even if they continued to have low self-esteem.

The pervasive theme of low self-esteem which emerged from the first stage of the research led to the second stage of the research incorporating a formal measure of self-esteem. The use of the Rosenberg Self-Esteem Scale (Rosenberg, 1965) was prompted by the scale’s design as a global self-esteem measure. This scale had the advantage that it has been used by a wide range of researchers in the sexual abuse field.
Participants were confirmed to generally have low self-esteem, with particular difficulty in being able to respect themselves, feeling useless and thinking they were no good. In contrast, participants generally believed they had a number of good qualities. Although Hunter’s (1991) research suggested lower self-esteem may be associated with increased severity of abuse, findings from the current study do not confirm this. Many participants in the current study recognized a long-term effect of their experience of CSA was a lack of self-esteem, as demonstrated by comments such as “No self worth”, “Absolutely zero self-esteem”, “Low self-esteem which can be overcome, with a lot of soul searching” to “Don’t even like people looking at me” and “Self hatred”. Interestingly, only three participants mentioned self-esteem in relation to what might reduce the long-term effects of CSA. The range of views expressed by these participants provides an indication of the difficulty confronting survivors and perhaps different stages of resolution, “Don’t know given it is a lack of self-esteem, despite wonderful children and great partner”, “Build up self-esteem and confidence”, “Now, got better self-esteem than those who had a comparatively better childhood….I am worth doing that (nurturing) for, keep self-esteem high”.

Self-esteem was found to be correlated with three characteristics of disclosure of CSA. Participants’ self-esteem decreased if they kept their experience of CSA a secret, or if they had wanted to tell others about the abuse, but had held themselves back from doing so. This decrease in self-esteem associated with an inability to disclose abuse may have been reflective of a lack of a suitable person within the child’s family or social network who she could disclose to. A finding that participants had higher self-esteem, if they had not disclosed to previous partners, may be linked to the predominantly negative reactions participants received if they disclosed in childhood. Participants who were met with negative responses to previously disclosing abuse may have been protecting themselves from further harm. Therefore, they did not disclose their abuse history until they had resolved trust issues in the context of a long-term relationship.
Attributional Style

The attributions that CSA survivors make about the causes of their abuse appear to have an important role in their later adjustment (Gold, 1986; Gold, Sinclair, & Balge, 1999; Hoagwood, 1990; McMillen, & Zuravin, 1997; Wyatt, & Mickey, 1987). Consistent with the findings of Hoagwood (1990), participants in the current study demonstrated decreased self-blame, blaming themselves more as children (measured retrospectively) and less as adults for the abuse. Morrow (1991) suggested self-blame may function as a coping mechanism through provision of a sense of control for the victim. However, consistent with the findings of Lalor (1994), the great majority of participants in the current study believed the abuse was controllable by others but not by themselves. Furthermore, the majority of participants in the current study perceived someone was responsible for the abuse, rather than no-one being responsible for it, again consistent with the findings of Lalor.

Lalor (1994) argued self-blame may provide a way of finding meaning in a negative life event for participants who are developmentally immature. This view was supported by some participants in the current study, who indicated they blamed themselves for the abuse when they were children, but as they grew older they recognized the offender was responsible. In addition, participants reported this belief the offender was responsible, was thoroughly reinforced during the course of therapy. No relationship was found between attributional style and either perceived parenting competency or marital satisfaction. This lack of relationship may be explained by the measurement of attributional style being focussed on attributions associated with the abuse experience, whereas current parenting competence and marital satisfaction were being investigated.

Those participants in the current study who continued to blame themselves for their CSA had poorer adjustment, as evidenced by a higher level of negative psychological symptoms in all domains, consistent with the findings of Hoagwood (1990). Participants who attributed the cause of the abuse to an aspect of themselves exhibited symptoms relating to feelings of inferiority, phobias, obsessive-compulsive behaviours and somatic difficulties, suggesting development of a negative self-concept.
This theme seems to have been perpetuated by those participants who attributed the abuse as being reflective of themselves, for they tended to be phobic, withdrawn and isolated. Overall, these findings would suggest the more a survivor perceives her experience of CSA as intrinsic to her concept of self, whereby she is responsible for it occurring due to her flawed nature, the greater the detrimental effect on her long-term adjustment.

**Cognitive Distortions**

The Belief Inventory (Jehu, 1988) provides a method for measuring the specific cognitive distortions which underlie self-blame. A comparison between the participants in the current study and the clinical and college student samples studies by Peters and Range (1996) suggests CSA survivors in the current study demonstrated a much lower rate of self-blame overall. Less than a third of participants in the current study met the criteria for having clinically significant self-blame, as defined by Jehu (1988), compared to three-quarters of the clinical sample and almost two-thirds of the college sample studied by Peters and Range (1996).

Significant associations were found between the Belief Inventory’s (Jehu, 1988) three subscales of self-esteem, guilt and self-blame and all domains of psychological symptoms measured. However, participants in the current study demonstrated cognitive distortions to varying degrees in relation to particular beliefs, consistent with the findings of Jehu (1988). Participants in the current study provided strong endorsement for the belief they would be unable to lead a normal life due to permanent damage and the belief they were inferior to others due to not having normal experiences. When commenting on their attributions concerning the long-term impact of CSA, many participants reinforced this belief regarding their inferiority, with one describing it as “Total destruction of chance in life”. These distorted beliefs relate to a sense of personal inadequacy and inferiority in survivors, which Jehu (1988) argued can be countered by discussion of the prevalence of CSA and how many survivors do successfully overcome its effects. Participants in the current study also provided strong endorsement of the distorted belief, “It is dangerous to get close to anyone because they always betray, hurt, or exploit you” indicating a fear of intimate relationships. Participants provided
similarly strong endorsement of the distorted belief “No man can be trusted”, apparently fearing a repeat of their abusive experience. The insecurity and need for control expressed by survivors comes from their experience of being betrayed by someone they loved and trusted, that exploited the survivor for their own gratification (Jehu, 1988). Jehu, Gazan and Klassen (1985) suggested such beliefs reflect why some women have difficulty in maintaining a longer-term relationship with a man, because of the increasing closeness and intimacy involved, which is not such an integral part of shorter, more superficial relationships. A number of participants in the current study described a pattern of behaviour, particularly as young adults, which would provide support for this view.

Almost half the participants in the current study endorsed the distorted belief that “No man could care for me without a sexual relationship”, which Jehu (1988) argued was a result of survivors being socialized to believe their rights were subordinate to those of others, with associated low self-esteem. This lack of self-esteem was reflected in participants’ equally strong endorsement of the distorted belief, “I am worthless and bad”. Jehu (1988) argued that to the degree this attitude comes from self-blame for the abuse, it can be addressed by reattribution of responsibility to the offender. Therefore, the survivor’s self-esteem would be expected to improve as self-blaming attributions are transferred to offender-blame.

Many participants in the current study felt stigmatized by their experience of CSA, as shown by the strong endorsement of the distorted belief, “Anyone who knows what happened to me sexually will not want anything to do with me”. This sense of stigmatization may result from self-blame for the abuse, pressure from the offender to keep the abuse secret, and the negative responses of others to disclosure, according to Jehu (1988). The generally long duration of secrecy regarding abuse and the predominantly negative reactions to childhood disclosure of abuse in particular reported by participants provide support for these areas as sources of stigmatization. Strong endorsement by participants in the current study of the distorted belief “It must be unnatural to feel any pleasure during molestation”, suggests strong guilt feelings rather than a recognition that sexual arousal is a reflex response (Jehu, 1988). Few participants in the current study directly addressed the issue of physical pleasure during sexual
abuse, although one concluded she must have enjoyed it, to have continued voluntary participation for an extended period of years.

When it came to the section of the Belief Inventory (Jehu, 1988) which examined offender blame, participants in the current study expressed a range of views. Although nearly two-thirds of participants endorsed the distorted belief “The offender abused me because he was sexually frustrated”, potentially this was an assumption made by many of the survivors, which may have been fostered by offenders. When discussing the methods used to induce participation in abuse, one participant who felt her duty was to replace her mother commented “Father. He would just get in bed and fondle me. Not one word was ever spoken”. Many other participants noted that they did not know what the offender’s motivations were, which may be explained by the survivor being a child at the time of abuse, who consequently lacked the cognitive capacity to ascribe motivations for behaviour to others. In addition, the circumstances of the abuse may have provided the child with few clues, for example one participant noted her parents had been totally unaware of the CSA as she was removed from her bedroom with the offender’s hand over her mouth, and later returned the same way, ensuring she was the only person who knew about the abuse. Although many participants endorsed the distorted belief that “The offender abused me because he was ‘sick’ and therefore not responsible for his actions”, a number qualified this by confirming that although they believed the offender was sick, he should most definitely still be held responsible for his actions. Using the explanation the offender was sick and this accounted for his actions would seem to be more acceptable to survivors than the alternative that offenders were quite rational and aware of the unacceptability of their behaviour. Many survivors found it incomprehensible that an adult could be sexually abusive towards a child.

Locus of Control

As would be expected given their negative life experiences, most participants in the current study demonstrated an external locus of control orientation. Participants generally believed they were not in control of their own destiny, which had been reinforced to them through being in a position of powerlessness with regard to the offender’s actions. The belief that getting a good job was the result of hard work rather
than luck, demonstrating an internal versus external locus of control orientation, may have been coloured by participants’ low self-esteem. Participants did not perceive themselves as lucky people and may have identified with the notion that they would only get a good job through hard work, as demonstrated by the comment “Got to prove yourself”. The locus of control of participants in the current study did not demonstrate an association with severity of abuse, consistent with the findings of Porter and Long (1999). These researchers argued locus of control may act as a dispositional foundation for the development of adjustment difficulties, whereby psychological and emotional adjustment is mediated by locus of control orientation following experience of negative life events such as CSA. This view is supported by the lack of a relationship between locus of control and self-esteem in participants in the current study.

Valentine and Feinauer (1993), through the study of resiliency in CSA survivors, offered an alternative view of locus of control, which focussed on an inner directed locus of control. Beliefs of survivors were thought to derive from internal values rather than expectations or directions of others, leading to the label of personal power. Valentine and Feinauer observed some survivors recognized their personal power early in life, whereas others developed it later and used it to work towards independence, a pattern also observed among participants in the current study. A number of participants in the current study were quite focussed on the concept of personal power, highly valuing their development of self-reliance, independence and overcoming of challenges. One participant outlined how she had retrieved her power from the offender by confronting him by letter, making him aware of the effects of his abuse of her and threatening to go to court, although she had made the decision this would not be in her interests. As a consequence of the letter and revelation of his behaviour to other family members, he left the country and threatened suicide. However, the survivor’s emotional adjustment was greatly improved with a disappearance of many symptoms of distress.

Searching for Meaning

It has been proposed the search for meaning may be a common and adaptive process assisting in the long-term adjustment of CSA survivors (Silver et al., 1983). An equivalent number of participants in the current study to that of Silver et al. (1983),
reported they were not presently asking the question “Why me?” in terms of their abuse. On the other hand, the majority of participants did ask themselves this question, and quite frequently, with over a third of participants asking the question “always”. The association between this questioning of “Why me?” and how often the search for meaning was conducted was even higher than found by Silver et al. (1983). Those participants in the current study who frequently questioned why they had been abused, were less likely to believe they had dealt with the abuse or accepted it, consistent with the findings of Silver et al. (1983). It seems likely this lack of resolution of the abuse, may be prompting the continued search for meaning.

Participants seemed to feel they had to try to make sense out of their abuse, although one acknowledged she was searching for answers that she may or may not get. This participant’s belief was borne out by the results of the group, with half the participants reporting they were unable to find meaning in their abusive experience. This level of success was seemingly lower than that of the participants in Silver et al.’s (1983) study, however many of those participants reported continuing to search for meaning, despite being somewhat satisfied with the answer they had devised. Participants in the current study tended to either perceive they would never be successful in finding meaning in their abuse, or they had been able to turn it into a positive in some way. The latter sentiment was echoed in the comments of participants relating to resolution of the abuse.

The majority of participants reported their feelings about the abuse remained largely unresolved, with many reflecting that this was an ongoing process. Silver et al. (1983) warned an unsuccessful search for meaning in abuse seemed quite detrimental to survivors. One participant, who had not been able to achieve resolution of her abuse, reflected this in her comment “His face is still in my wedding photo. Why don’t/can’t I cut it out?”. Although equal numbers of participants believed they had or had not dealt with the abuse, two-thirds stated they had been able to accept it. A positive association was found between having dealt with the abuse and having accepted it, which provides support for a link between these two processes. Furthermore, those participants who believed they had dealt with their abuse demonstrated an internal locus of control orientation. This finding is consistent with the proposal that locus of control mediates.
between the experience of negative life events such as CSA and later adjustment (Porter, & Long, 1999). Individuals who perceive themselves as self-reliant and independent would also be expected to perceive themselves as having dealt with their abuse issues. Those participants who indicated they had not dealt with the abuse, but had accepted it, explained the difference as being due to having no choice but to accept the abuse had happened. Some participants indicated an unwillingness to deal with the abuse, “Put in a little part and lock it up, don’t”, although most participants adopted a practical attitude of learning to manage it as a part of their lives, “No, I have not yet. I am working on this – it is a long process. Not want to fall in deep hole in road anymore, want to get shallower”.

The findings from the current study of a lack of relationship between the frequency of search for meaning in abuse, and whether the abuse had involved penetration, and the duration of the abuse, were consistent with those of Silver et al. (1983). It seemed that such characteristics of the abuse, along with whether the perpetrator was a stepfather/father had no bearing on whether the survivor continued to search for meaning in her abuse or was successful in this quest. Similarly, no relationship was found between self-esteem and more active searching for meaning, and being able to make sense of the abuse, for participants in the current study, contrary to the findings of Silver et al. (1983). The reasons for such contradictory findings in relation to self-esteem are unclear, given that both studies employed the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and participant groups with a similar profile.

**Participant Attributions**

In response to questioning about their own attributions regarding the long-term impact of their CSA, participants in the current study demonstrated a great diversity in their degree of introspection. Some participants had clearly thought about the impact of CSA on their adjustment and life course. All of the participants in the second stage of the research believed there had been at least some long-term effects as a result of their experience of CSA, compared to just over half of the participants in the study by Mullen al. (1994). In addition, almost half of the participants in the current study described themselves as suffering from mental health issues which they attributed to their CSA.
experiences, a much higher rate than the small percentage of participants reporting mental health issues in Mullen et al.’s (1994) research. When considering these findings, it should be kept in mind the participants in the second stage of this research study were a self-selected subset of under of third of participants from the first stage of the research.

The finding in the current study that those participants reporting more severe abuse (penetration) were the least likely to suggest their abuse had a negative impact on their self-esteem, was quite the opposite to findings obtained by Mullen et al. (1994). A possible explanation for the current findings may be the greater likelihood that those who experienced abuse of greater severity potentially had access to more comprehensive support services. Similarly, those who experienced abuse of greater severity may not necessarily develop mental health problems given the apparently important role of social support in mediating the relationship between CSA and psychological adjustment. Social support may also play an important role in mediating the relationship between CSA and interpersonal relationship functioning, thus explaining a lack of significant relationship between abuse duration and either sexual relationship difficulties or difficulty in trusting others.

Findings from the current study do not support those of Mullen et al. (1994), who reported participants who indicated their father or stepfather was their abuser were especially likely to perceive this as having affected their sexual adjustment as adults. None of the participants in the current study who reported sexual difficulties had been abused by a father/stepfather. This finding provides support for the observation there is not a linear relationship between abuse severity and subsequent adjustment difficulties. Close examination of the nature of the CSA of the participants concerned indicates some had not experienced abuse involving penetration or abuse of extended duration. It would appear that other factors in combination, such as the use of force or coercion and provision of adequate social support, may play an important role in adjustment rather than considering any abuse characteristic on its own.
Perception of Benefit

The reports from a variety of researchers (Brunngraber, 1986; Haugaard, & Emery, 1989; Himelein, & McElrath, 1996; Laviola, 1992; McMillen et al., 1995; Okami, 1991; Russell, 1986; Simari, & Baskin, 1982), have indicated a perception among some survivors of CSA, of having received some benefit arising from their abusive experience. These findings were borne out by the results from the current study. In the original exploratory study of perceived benefit from CSA conducted by McMillen et al. (1995), almost half the participants reported perceiving at least a little benefit from their experience of abuse. In the current study, nearly two-thirds of participants reported perceiving at least a little benefit. The number of participants who perceived they had received quite a bit or a lot of benefit, were similar in both studies. However, whilst McMillen et al. (1995) found older participants were more likely to perceive some benefit from their abuse, in the current study younger participants were more likely to perceive some benefit from their abuse. The reason for this difference may lie in the age of the survivors at the time of participating in the research. The average age of participants in McMillen et al.’s (1995) study was 31 years compared to the 41 years for participants in the current study. Participants who perceived the greatest benefit would be of a similar age in each study. Based on their comments, this age group appeared primarily focussed on the role of caring for children and how their abuse experience impacted upon this. Those participants who were younger did not have this focus. Participants who were older may have been reflecting on a lifetime of adjustment difficulties and inability to ensure self-protection leading to revictimization, for older participants were less likely to perceive they had become a stronger person. The results of this study and recent research are consistent with the notion that perceived benefit is related to adjustment, for it provides an indicator of successful coping.

Coping

In terms of measurement of methods for coping with stressful situations, it would appear many participants in the current study focussed on their experience of CSA, rather than a more recent stressful event, as specified in the instructions accompanying the measure. Participants demonstrated a strong reliance on use of escape-avoidance coping methods, which were defined as wishful thinking and behavioural efforts to
escape or avoid the problem. A number of participants focussed on their heavy reliance on behaviours such as eating, drinking, smoking, using drugs, or medications. These responses were consistent with subsequent revelations of eating disorders and substance abuse issues among some participants. However, reliance on escape-avoidance coping methods was associated with poor psychological adjustment in all domains measured by the Brief Symptom Inventory (BSI, Derogatis, & Spencer, 1982). This finding of an association between use of escape-avoidance coping strategies and poor psychological adjustment was consistent with the findings of previous researchers (Gold et al., 1999; Hiebert-Murphy, 1998; Leitenberg et al., 1992; Sinclair, & Gold, 1997). Yet, it seems understandable survivors would seek to employ coping strategies which offer escape from negative feelings and respite from painful memories, particularly given their inherent lack of control in the circumstances surrounding CSA. Potentially, those survivors experiencing the greatest distress would be the most likely to adopt escape-avoidance coping strategies in order to avoid their emotional pain. Participants using escape-avoidance as their preferred method of coping, were also found to be worried about their children to a high degree and had low parenting self-esteem. Parenting methods which rely on avoidance of issues would seem likely to lead to behavioural issues in children, generating worry for parents and a belief they had a lack of parenting capacity.

Participants in the current study also indicated a strong reliance on self-controlling coping strategies, which are defined as efforts to regulate one’s feelings and actions. The behaviours included within this category emphasize self-reliance rather than seeking support from others and not acting impulsively. Participants may have learned as a consequence of their experience of CSA, they have only themselves to rely upon and it may be risky to disclose to others or act impulsively. Participants also relied upon planful problem solving coping strategies, which are defined as deliberate problem-focussed efforts to alter the situation, combined with an analytic approach to solving the problem. Findings from the current study are consistent with those of Leitenberg et al. (1992), who found no coping methods were related to lower psychological distress, although coping methods which do not significantly heighten distress may be more adaptive for survivors.
Reliance by participants who are CSA survivors on the coping strategy of accepting responsibility, which is defined as acknowledging one’s own role in the problem with a concomitant theme of trying to put things right, is especially concerning if they were referring to the CSA as the stressful event. In this context, accepting responsibility for the problem is making self-blaming attributions. Accordingly, an association was found between accepting responsibility coping methods and poorer psychological adjustment in terms of increased symptoms of obsessive-compulsivity, interpersonal sensitivity, depression, anxiety, paranoid ideation, psychoticism and a global symptom index. In addition, participants who accepted responsibility for their own issues demonstrated low parenting self-esteem.

Participants in the current study reported weaker reliance on seeking social support coping methods, which are defined as efforts to seek informational support, tangible support, and emotional support. Use of these coping methods would indicate a higher likelihood the survivor would disclose her CSA, which according to Sinclair and Gold (1997) and Himelein and McElrath (1996) is associated with better psychological adjustment. To a lower degree, participants in the current study were reliant on confrontive coping methods, which are defined as aggressive efforts to alter the situation which involve some degree of hostility and risk taking. These coping behaviours might be expected to be quite difficult for CSA survivors to employ given the apparent assertiveness and belief in self required. However, Himelein and McElrath (1996) have argued successful resolution of CSA involves a component of cognitively confronting and reflecting on the abuse experience.

The use by participants in the current study of distancing coping methods, which are defined as cognitive efforts to detach oneself and to minimize the significance of the situation, was associated with poorer psychological adjustment. This finding is consistent with the research literature which indicates that such avoidant coping methods are linked with poorer adjustment (Draucker, 1996; Gold et al., 1994; Leitenberg et al., 1992; Sinclair, & Gold, 1997). Participants using distancing as their method of coping displayed increased symptoms of somatization, obsessive-compulsivity, interpersonal sensitivity, anxiety, phobic anxiety, paranoid ideation, psychoticism and on the global index of symptoms. Furthermore, participants using distancing as a coping method
worried about their children to a great degree and had low parenting self-esteem, but were satisfied in their relationship with their partner. This finding may be explained by the difficulties CSA survivors often experience in intimate relationships. Participants may have been comfortable maintaining distance within the relationship itself and minimizing such issues.

Positive reappraisal was the coping strategy least likely to be used by participants in the current study. Positive reappraisal is defined as efforts to create positive meaning by focussing on personal growth, it also has a religious aspect. It is understandable that CSA survivors who have grown up in a context of negative life experiences may have difficulty in finding positive outcomes from their experiences. However, Himlelein and McElrath (1996) have found use of positive reframing to be important in the coping of CSA survivors demonstrating a high degree of adjustment. Participants in the current study using positive reappraisal coping strategies were quite satisfied in their relationship with their partner, suggesting they were able to focus on the positives within the relationship.

Dissociation and Memory Impairment

CSA survivors have been commonly observed to experience dissociation as a response to their abuse experience (Briere, 1988; Briere, & Runtz, 1988a, 1988b). Blake-White and Kline (1985) suggested this process occurs because during the assault the child becomes overwhelmed by a range of emotions. Facing a situation evoking powerful grief, despair or anxiety may lead the individual to respond by totally repressing the memories of the incident for a prolonged period, which has the benefit of removing the painful affect. Whilst this extreme form of denial or avoidance may be adaptive for coping with the difficulties associated with abuse in the short term, mental health problems may arise in the longer term (Briere, 1988). Consistent with the findings of other research (Herman, & Schatzow, 1987; Jarvis et al., 1998; West et al., 2000), many of the participants in the current study acknowledged memory difficulties in relation to their abuse. Participants described experiencing a gradual surfacing of memory fragments, which may have been triggered by particular events or flashbacks. For example, participants commented “It was blocked out for many years”, “Earlier
years blocked out as are most of my school-age years (incl. High school and up to & incl. my mid 30’s.) bits and pieces pop up”, and “I was aware of having been sexually abused but somehow forgot about it to the point that I made some comment in my early 30’s about ‘those poor children who are treated like that’. It wasn’t until my late 30’s that it all resurfaced (after my mother’s death)”.

Participants’ memory difficulties appeared to relate particularly to characteristics of the abuse such as the age at which it commenced, frequency and duration of the abuse, and the actual sexual activities involved. For example, “Unsure of time span as much of my childhood is still blocked, but it was a number of years”. Although the lack of some of these details may be accounted for by the young age of the child at the time, the absence of many others appears to result from an adaptive coping response. Some participants were aware of the existence of an abusive experience through other corroborating information. For example, participants apologized “I have blocked out a lot of it… so I can’t give too much detail, I’m sorry. - part of my “safety” blockage – won’t remember but was treated for sexually transmitted disease at 12” and “I don’t remember everything, because I blocked everything out till I got court papers everything came to the surface, but I still don’t see clear”.

**Social Support**

Heller et al. (1986) have argued social support and coping appear to have an interactive effect on adjustment and well-being, which makes sense as the effective use of a social support system is considered an adaptive coping strategy. Although a couple of participants in the first stage of this research wrote comments on their questionnaire indicating they had not disclosed their experience of CSA before, this was not the case for participants in the second stage telephone interviews. Very few of the participants in these interviews indicated they did not have at least one person they could confide in about their CSA. However, the finding by Silver et al. (1983) that participants without a confidant were significantly less likely to have been able to make sense of their abuse, was not replicated in the current study. Given that almost all participants in the current study did have a confidant, the restriction in the range of responses may have prevented the identification of a relationship between these factors. Despite the major
consequences that often followed disclosure in adulthood of CSA, the participants did not appear to have regretted their decision to disclose. However, some participants had not told particular family members, due to concerns for their relatives’ emotional welfare. Comments from participants included “Other younger sister – not really supportive. Will tell when mother dies.” Lalor (1994) had commented on this tendency of survivors to demonstrate greater concern about the emotional welfare of their mothers than fears of rejection and abandonment, which were quite justified.

Participants sought support from a range of professionals, self-help resources, friends and other family members. Many participants indicated disclosure had provided a release, which enabled them to begin a healing process during which their psychological health improved, which is a view consistent with research findings (Himelein, & McElrath, 1996; Sinclair, & Gold, 1997). Participants spoke positively about building up a social support network of family members, friends and professionals. Some participants completed sections of the questionnaire in the first stage of this research from the perspective of pre- and post- counselling to demonstrate how much they believed their psychological functioning had improved, whilst others noted comments to this effect. A number of participants indicated the necessity to attend counselling for a period of years on an episodic basis determined by triggers in their environment.

Aside from a lack of professionalism exhibited by some practitioners, participants expressed a wish professionals had been more proactive in exploring their abuse issues. Participants recalled “Panic disorder = saw psychiatrist for 2 years, didn’t tell until near end. He finally asked ‘Want to talk’, she said No. ‘Wish at the time, wish he had pushed me’” and “Been treated by psychologists and anti-depressants, never discussed real issue”. One participant offered a number of insights regarding the impact of counselling, “Disclosure empowered mother, changed parental relationship. Biggest help – psychologist who agreed with me, (normalize) what others have experienced. Impact destroy or push to succeed. Family friend of mother’s, significant other, makes the difference. Motivation for going into helping professions. Previously could not borrow a book, someone would see and know”. This finding has implications for the
CONCLUSIONS

CSA is a negative experience, that generally occurs in the context of a range of other psychosocial issues in the survivor’s childhood family-of-origin. This makes it difficult to untangle what long-term impact the CSA itself may have on the survivor’s adult psychological functioning, especially as there does not appear to be a simple linear relationship between severity of abuse and later difficulties. Although the CSA survivors participating in this research were a self-selected sample from the general community, they demonstrated significantly higher rates of symptoms of psychological distress in all the domains measured, than would be expected for a group of nonclinical adult women. Furthermore, the CSA survivors indicated they had experienced great difficulties in interpersonal functioning. As expected, many survivors acknowledged a history of relationship difficulties, which some attributed directly to their experience of CSA. Sadly, many participants believed they would not have children or had decided not to, for a range of reasons associated with their abuse. For those CSA survivors who did have children, there was universal acknowledgement of the impact of abuse experiences on their parenting.

Importantly, there are a number of factors that are markers of resilience in CSA survivors, particularly in relation to attributions and access to social support. Survivors exhibiting high self-esteem, are less burdened by the range of psychological adjustment difficulties, than their counterparts reporting low self-worth. Self-esteem is linked to the CSA survivor’s view of herself; the more she blames herself for the abuse experience, the more the CSA becomes integral to her concept of self. Therefore, external attribution of blame, an inner directed locus of control and reduction of cognitive distortions appears to hold the key to the survivor’s psychological health. CSA survivors who have been successful in their search for meaning in their abuse experience are more likely to report satisfactory resolution of the abuse. A majority of survivors reported perceiving at least a little benefit from their abuse experience, with the main focus being a wish to ensure improved protection for children. Whilst use of avoidant
coping strategies, dissociation and consequent memory impairment may be functional at the time of abuse, there are negative consequences for later psychological adjustment. Therefore, provision of social support that facilitates the disclosure of abuse during childhood may offer the best prognosis for the CSA survivor.

**Limitations**

**Sampling**

A number of concerns have been expressed regarding the sampling methods employed in previous studies of the impact of experience of CSA on adult psychological adjustment (Meiselman, 1978; Silver et al., 1983; Vander Mey, & Neff, 1982). Given the sensitive nature of the topic, researchers have been constrained in how they can advertise studies to recruit participants. This has led to a reliance on accessing participants through formal relationships with institutions such as psychiatric services or correctional facilities, court, police or child protection service records or counselling programs. Less formal methods have utilized self-help groups or contacts between networks of professionals working in the area. If the only method which had been pursued in the current study was recruitment through the CASAs (Centres Against Sexual Assault), participants would have come from a narrow range of women who were currently receiving counselling.

However, the decision to advertise the research in a number of local, weekly newspapers followed by a brief mention in a large metropolitan daily newspaper greatly enhanced the range of potential participants who were made aware of the research. Requests to participate in the research were received from a diverse range of areas within the metropolitan area, some rural areas and even interstate. The broad age range of participants also reflects this diversity, and is quite important given the tendency of previous research to focus on participants within a narrow age range. Interestingly, a number of potential participants were quite hesitant about whether they would be suitable to volunteer given their older age, generally being over 60 years. They had apparently formed a perception that because their abuse had been so long ago, they would be unsuitable for participation. Yet the reassurance that their contribution would
be greatly valued led to keen participation and valuable information about the impact of CSA across the lifespan and upon following generations.

Participants in the current study demonstrated higher levels of symptoms of psychological distress than nonpatient adult female norms, as shown by their results on the Brief Symptom Inventory (BSI) (Derogatis, & Spencer, 1982). This finding suggests that the participants may have had a profile similar to that of clinical patients, although few reported currently undertaking counselling or therapy. All of the participants were living in the community and seemingly had an adequate level of functioning, although a couple spoke about being in custodial and psychiatric care on previous occasions. Importantly, participants defined themselves as having experienced CSA, and so the group represents a wide range of experiences, rather than being biased by the categorization of CSA of a researcher. Despite this range of diversity amongst participants, as Silver et al. (1983) pointed out, it is not possible to know the extent to which the participant group is representative of the population of adult survivors of CSA.

It was decided not to employ a control group for use in the current research, despite the obvious benefit of being able to compare results with the CSA survivors. The majority of questions participants were asked to respond to in the present study related to details of their CSA and attributions regarding this experience. This subject matter is clearly not relevant to control group members, removing the advantage of comparability and making the use of such a group not especially relevant.

**Procedure**

By employing a retrospective design, the current research is vulnerable to the vagaries of memory recall of adults, reflecting on their experiences as young children in a situation invoking emotional crisis. Thus, there are a number of factors likely to result in memory impairment, including the developmental immaturity of the child impacting on her ability to cognitively process the experience, dissociation as a coping response and the length of time since the incident occurred. However, retrospective designs have a range of advantages compared to prospective research studies. Obvious ethical
constraints prevent the detailed exploration of CSA experiences among child survivors, other than during the course of therapeutic interventions. The alternative of employing a prospective research design, such as that utilized by West et al. (2000), requires the investment of extensive resources to follow up CSA survivors as they reach adulthood. This method is reliant on comprehensive records being kept of the abuse experience and is necessarily restricted to those CSA survivors whose abuse was reported contemporaneously. It can be seen from the current research that this is a small subsample of the abused population, seemingly biased towards those in less dysfunctional families, who receive a greater degree of social support. Research which tracks a general sample of children, including those who disclose experience of CSA during childhood, has the difficulty that a number of individuals in the comparison group may have experienced CSA but did not disclose this abuse until much later in adulthood.

The design of the current study prevented the linking of survivors’ questionnaire and interview data due to the anonymity of participants submitting questionnaires. Whilst this was recognized as a constraint in building an even more detailed profile of survivors’ current functioning, the importance of maintaining confidentiality was paramount. Prospective participants undertook to complete the questionnaire on the basis that it was anonymous and confidential; it was felt likely any suggestion this could change if they volunteered to participate in telephone interviews would have negatively affected the response rate. Furthermore, identifying data was kept separately from the interview records to ensure the researcher did not associate the participant’s identity with the content of the interviews.

The questionnaire employed in the first stage of the research initially appeared as though it may be somewhat lengthy for survivors to complete. However, the majority seemed to indicate they would have been comfortable with extra information being sought. In particular, provision of qualitative data in the form of comments written in various sections suggested survivors were keen to provide more detailed explanation of their views. In terms of the data sought during telephone interviews, participants were invited to provide any additional comments they wished to and most participants accepted this invitation. In general, the telephone interviews were a manageable length,
suggesting the further formal measures could have been incorporated. In particular, it may have been useful to expand measurement of partner relationships by incorporating all of the items from the Intimate Bond Measure (Wilhelm, & Parker, 1988). Whilst a single interview question was asked regarding the survivor’s social support accessibility, it may have been informative to include a section on this topic in the questionnaire. In addition, further exploration in the interview of who provided this support, how available it was and whether it met the survivor’s needs would assist in planning informal and formal support services. Inclusion of a measure focusing on an inner directed locus of control and sense of personal power may have facilitated integration of findings relating to attributional style, psychological adjustment and daily functioning, and a greater understanding of the characteristics underlying resiliency.
CHAPTER 11

IMPLICATIONS FOR PRACTICE/POLICY

A number of recommendations have arisen from the findings of the current research study. These recommendations and the arguments in support of them are discussed below.

Recommendation 1
A public education campaign targeted at primary school age children to encourage the disclosure of CSA.

The current research confirms the view that children are more likely to experience CSA perpetrated by a close family member, than someone whom they do not know. Generally, children who are subjected to CSA have a range of other negative experiences whilst growing up in a dysfunctional family-of-origin. In addition to making the child more vulnerable to abuse by family members, such dysfunctional families offer little protection from offenders outside the family. Thus, greater attention should be focussed on the increased risk of CSA for children in families exhibiting psychosocial issues such as substance abuse, mental illness, family violence and marital disruption. Until now, support for child survivors of CSA has usually relied upon the child making a disclosure of abuse, and a mandatory report made to the Child Protection Service as a notification. An investigation ensues and the child is referred to a sexual assault support service if this is deemed warranted.

However, it is clear few children disclose their experience of abuse at the time it is occurring, or even during their later childhood. The reasons for this lack of disclosure are varied, but may include threats from the offender, negative impact on the child’s self-concept, uncertainty about how a disclosure would be responded to and a lack of a suitable person to disclose to. Many of these issues could be overcome by a clear message reaching the children concerned, that they are not responsible for the abuse, what the consequences of disclosure to a professional are likely to be and how to go about doing this. Clearly, a strong emphasis on prevention and early detection of CSA is
required, to avoid the long-term impact on psychological adjustment, which is so much worse when chronic abuse continues unchecked. Previous campaigns have focussed on provision of protective behaviours programs in primary schools to encourage children to identify and report inappropriate touching by others. Whilst such programs have resulted in many reports of CSA subsequently being investigated, a comprehensive, well-coordinated campaign would seem to be necessary. Given the almost universal attendance of children at primary school, this setting offers the best opportunity to target information campaigns at children. The school environment is also conducive to interactive discussion and longer-term follow-up.

Recommendation 2

Increased community awareness that children are most likely to be subjected to intrafamilial abuse, that sibling sexual abuse is CSA, and that many children are abused by multiple perpetrators.

Children and the general community need to be aware that family members are the most likely offenders against children, and the implications of that betrayal of trust by a person whose role it is to provide care and nurturing for the child. There should also be greater articulation of the message that sibling abuse is child sexual assault and needs to be treated accordingly, for the impact on survivors appears equivalent to that for other intrafamilial perpetrators. There has tended to be an assumption within Child Protection Services that if a child reports CSA, then there has been only one offender, yet almost half the participants in the current research indicated abuse by multiple perpetrators. Therefore, wider dissemination of research findings and incorporation of these into training of relevant professionals may assist in the breakdown of myths regarding CSA which currently persist.

Recommendation 3

That training be provided to the general community on how to respond of a child discloses CSA.

The second step following disclosure by a child that CSA is currently occurring or has previously occurred, is to have an effective intervention plan developed. Because children may not disclose to a mandated professional, members of the general community need to be aware of what to do if a disclosure is made to them. Their role is
to support the child, the child has placed a great deal of trust in them by disclosing, but they do not have the responsibility of conducting an investigation. The person to whom the CSA has been disclosed must report the abuse either to a mandated professional or to the Child Protection Service, and continue providing support to the child throughout the process.

Recommendation 4

Improvement in the prosecution of sexual offence cases within the criminal justice system to encourage CSA survivors that this is a course that should be pursued. Very few participants in the current research had sought or succeeded in instigating police investigation of their abuse, with the majority perceiving the criminal justice process as irrelevant to them. An alarming finding from the current research was the extent to which survivors had considered revenge involving violence against their offender, seemingly a result of feeling powerless with no access to an appropriate alternative. A few participants who had pursued legal redress found the process to be gruelling and very frustrating. Therefore, there is little wonder that reporting rates to police of sexual offences are very low (ABS, 1996) and the rate of prosecution of sexual offences is extremely small. This scenario leaves the majority of sex offenders facing no formal consequences for their behaviour and continued opportunity for offending behaviour. As a result of recognition the criminal justice system was potentially not meeting the needs of complainants in sexual offence cases, the Victorian Law Reform Commission was asked to review the current legislative provisions relating to sexual offences. It is to be hoped that recommendations made in the Interim Report (VLRC, May 2003), will institute reforms that encourage sexual assault survivors to perceive the criminal justice system as offering them an effective service that ensures offenders are held accountable for their behaviour.

Recommendation 5

Improvement in the capacity of health professionals regarding how to best respond to patients who disclose CSA.

A number of participants in the current research recounted very concerning behaviour by medical and mental health professionals when they disclosed or attempted to disclose experience of CSA. This reflects very poorly on these professions given the
evidence that perhaps a majority of the patients in mental health services have a history of CSA. It might be expected these professionals would be especially skilled in addressing the issues emanating from CSA given their level of professional qualification, yet there is a tendency to refer patients to the nearest Centre Against Sexual Assault (CASA) to deal with the issue. Such a lack of a holistic approach to case management of patients means the linkage between their history of CSA and current presenting issues is not explored in the context of mental health treatment. It seems many mental health professionals were lacking confidence in how to provide treatment if a patient did disclose CSA, and patients were attuned to this and so did not feel comfortable with raising the issue. However, it is unrealistic of mental health professionals to expect patients to initiate discussion of CSA issues given the associated issues of a lack of self-esteem, negative self-concept, anxiety and isolation which may lead to the belief that experience of sexual abuse is a very rare event. Many participants would have preferred the mental health clinician to ask them directly about any history of abuse and use probing questions to explore the issue, as participants did not know how to tackle such a discussion.

Improvements in the treatment of survivors could be made by ensuring appropriate material on treatment of sexual abuse issues was incorporated in the training of medical professionals. Ideally, this would include interaction with sexual abuse survivors themselves, to provide their perspective on what approaches are of assistance. Professionals need to ask about sexual abuse and abuse issues in general when taking a history from clients whose health care is their responsibility. The current reticence to do this, on the basis the client may be offended, seems unfounded. The use of such an approach in the past seems more likely to be related to the professional’s discomfort with the issue. The ensure improvement in health care for CSA survivors, the professional involved needs to feel confident they can provide appropriate treatment to address the issues raised, or at least support a suitably qualified professional following a referral for specialist service. The traditionally poor linkages between Mental Health Services and CASAs have been recognized with the development of a Victorian government project examining liaison between the three sectors of sexual assault, family violence and mental health. As part of this project it is hoped barriers between the
sectors may be overcome as networking improves and joint training is developed to exchange specialist knowledge.

Recommendation 6

That interventions with CSA survivors focus on addressing the distorted cognitions which are associated with the experience of abuse.

Findings from the current research suggest the key to resiliency in survivors of CSA may lie in the attributional style adopted by the survivor. The minimization of distorted beliefs arising from the abuse experience may offer the survivor the opportunity to develop healthy psychological adjustment. Positive reframing of an abusive experience by a survivor, to extract any perceived benefit, seems to be associated with improved adjustment. In addition, encouragement of external attribution of blame whilst maintaining an inner directed locus of control enhances the survivor’s sense of personal power. The practical approach of identifying and then intervening to cognitively restructure distorted beliefs, as advocated by Jehu (1988), would seem to provide a very effective way to improve psychological adjustment. This approach has the advantage that pre- and post- measures of the intervention can be easily facilitated. Furthermore, by examining the beliefs underlying their behaviour, participants are offered a level of insight that may prevent continuation of self-harming behaviour and reduce the potential for revictimization.

Recommendation 7

That the community as a whole take responsibility for providing social support to survivors of CSA.

An important component of a survivor’s recovery from abuse is the degree of social support she receives at the time of the abuse and subsequently. The presence of social support, which may be simply one significant other outside the family, bodes well for the survivor’s later adjustment. Whilst professionals can clearly provide an important source of support, they are not available to the CSA survivor on an unlimited basis. Survivors need to have informal support service networks who can provide ongoing support throughout their lives, particularly in light of their vulnerability to problems in psychological adjustment. The potential benefits to the community of
investing in assistance for those survivors having difficulty in building and maintaining such informal social support networks would seem to outweigh the costs.

The continuing high profile of CSA in the Australian media may be cause for optimism among survivors of CSA. It seems very doubtful that a return would be possible to past attitudes regarding CSA, even from the recent past. Intense media scrutiny and discussion has focussed the community’s attention on the offender’s responsibility for their behaviour, the secretive nature of abuse, the impact on CSA survivors’ long-term functioning and the failure of the criminal justice system to respond adequately to the needs of abuse survivors. The reason the full extent of CSA within the community has remained hidden lies in the stigmatization of both survivors and offenders. Survivors have been unable to achieve credibility with allegations that a “pillar of society” is actually capable of sexual offending. Overall, survivors have been an invisible group, leaving the professionals who work closely with them to advocate for improved services. Yet, this scenario is changing, with some participants in the current research being pro-active in organizing their own support groups and undertaking public speaking. A number of other participants were more than willing to be part of media campaigns with the aims of presenting issues from a survivor’s perspective and encouraging children to speak out about experience of abuse.

**Future Research**

The current research has examined the long-term impact of CSA on survivors’ later functioning in relation to psychological adjustment, perceived parenting and relationship satisfaction. There has been an attempt to investigate the role of abuse severity, as defined by a range of abuse characteristics, attributional style and beliefs in relation to the abuse, coping methods and perception of benefit. This approach to research with CSA survivors is a departure from earlier work, which primarily concentrated on defining individual areas of difficulty experienced by survivors, without attempting to integrate findings to provide a comprehensive picture of survivors’ overall functioning. This single focus approach has prevented identification of gaps in the research literature in essential areas such as the impact of CSA on parenting, partner choice and relationship functioning.
There is more work to be done in the investigation of parenting difficulties among CSA survivors, including assessment of the role of CSA, separated from other negative experiences which the survivor may have exposed to. Many participants in the current research have articulated strategies for protecting their children, whilst some reported their own children had been abused. There is a lack of research examining what strategies parents employ in practice, and under what circumstances abuse of CSA survivors’ children occurs. Findings from such research could form the basis for developing strategies to improve the parenting capacity of CSA survivors. The importance of such work should not be underestimated given the high incidence of intergenerational transmission of abuse. Another important ingredient in breaking this cycle of abuse is closer examination of the relationship functioning of CSA survivors, particularly given the high rates of revictimization of survivors. Potentially, entry into and continuance in abusive relationships could be reduced among survivors if intervention was targeted towards their self-esteem and attributional style, including distorted beliefs. To date, there has been little research based on therapeutic interventions with partners of CSA survivors, providing clinicians with limited guidance on appropriate strategies and their effectiveness.

The main question that arises from observations made in the current research, is whether resilience to CSA can be instilled. Whilst it would seem that some individuals possess a disposition and attributional style which makes them quite resilient to even very adverse negative experiences, many others do not. However, perhaps through targeted interventions which have been rigorously researched, an outcome of improved resiliency may be achieved. The invisibility of CSA has meant the difficulties experienced by many survivors have not been attributed to this issue, thus the true social and economic costs remain unknown. Only by gathering data in relation to these costs will arguments for resourcing early detection, prevention and support services become more persuasive.
References


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* Please note that a complete transcription of the qualitative data is available from the author upon request.
APPENDIX A

QUESTIONNAIRE

A. Demographic Information
Please provide some basic biographical details so that I can develop a general description of the participants in this research:

1. Age ______ years

2. Relationship Status (Please circle)
   I do not have a partner.
   I have a partner and we live separately.
   I am in a de facto relationship.
   I am married.

3. Children
   Gender .................................. DOB..............
   Gender .................................. DOB..............
   Gender .................................. DOB..............
   Gender .................................. DOB..............
   Gender .................................. DOB..............
   Gender .................................. DOB..............

4. Have your children ever been notified to the Department of Human Services or an equivalent Department interstate? Please circle.
   Yes       No

What type of abuse was alleged and what relationship was/were the alleged perpetrator(s)? eg. Stepfather
Please circle. (You may circle more than one type.)

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<tr>
<th>Abuse Type</th>
<th>Alleged perpetrator(s)</th>
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<td>Neglect</td>
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<td>Emotional abuse</td>
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<tr>
<td>Physical abuse</td>
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5. FAMILY OF ORIGIN

Please circle the type of family in which you grew up (between the ages of 0 – 15):
(You may circle more than one category.)

**Family**
- Single parent – mother
- Single parent – father
- Two parents – mother & father
- Two parents – mother and stepfather
- Two parents – stepmother and father
- Two parents – same sex couple – female
- Two parents – same sex couple - male

**Father Figure**
Please circle the type of father relationship you had during the majority of your childhood (0-15 years):

- Natural Father
- Adoptive Father
- Stepfather
- Foster Father
- Other __________________
  (Please specify)

**Mother Figure**
Please circle the type of mother relationship you had during the majority of your childhood (0-15 years):

- Natural Mother
- Adoptive Mother
- Stepmother
- Foster Mother
- Other __________________
  (Please specify)

Please circle which of the following were issues in your family during your childhood (0-15 years):
(You may circle more than one issue.)

- Alcohol abuse
- Domestic violence
- Dominant father
- Drug abuse
Marital conflict/disruption
Parental absence
Restrictive upbringing
Sexual punitiveness (eg. Parents angry at adolescent sexual behaviour)
Social isolation
Victimized mother

6. **CHILDHOOD SEXUAL ABUSE**
(a) What age were you when the sexual abuse first began?

------------------------years

(b) What was the duration of the abuse?

------------------------days
------------------------months
------------------------years

(c) On approximately how many occasions did the abuse occur?

------------------------occasions

(d) How many individuals have sexually abused you?

------------------------perpetrators

(e) **Please circle** the relationship of the offender:
(You may circle more than one offender.)
Male stranger
Female stranger
Male acquaintance
Female acquaintance
Father
Stepfather
Mother
Stepmother
Uncle
Aunt
Grandfather
Grandmother
Brother
Stepbrother
Sister
Stepsister
Male cousin
Female cousin
Brother – in – law
Sister – in – law
Others (please specify) ____________________

(f) **Please circle** the sexual activities that occurred in relation to all perpetrators:
(You may circle more than one activity.)

Exhibitionistic display of the offender’s genitals to victim
Peering at the victim by offender
Erotic kissing
Erotic fondling of victim’s body by offender
Erotic fondling of offender’s body by victim
Victim observes offender masturbating
Offender observes victim masturbating
Manual stimulation of victim’s genitals by offender
Manual stimulation of offender’s genitals by victim
Oral stimulation of victim’s genitals by offender
Oral stimulation of offender’s genitals by victim
Digital (finger or thumb) penetration of victim’s anus by offender
Penile penetration of victim’s anus by offender
Simulated/"dry" intercourse
Penile penetration of victim’s vagina by offender
Other __________________________(Please describe.)

(g) **Please circle** the methods used by the offender to induce participation in sexual activities:

Misrepresenting activities as a game, fun, “something special” or “fooling around”
Misrepresenting activities as sex education
Opportunity for attention and affection
Proclamation of romantic love
Bribery
Promise of sexual gratification
Exercise of adult authority
Threats
Physical force
Duty to replace mother
Other methods (please specify)________________________
**BRIEF SYMPTOM INVENTORY**

Below is a list of problems people sometimes have. Please read each one carefully and circle the number that best describes **HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOthered YOU DURING THE PAST 7 DAYS INCLUDING TODAY.**

Not at All = 0, A little bit = 1, Moderately = 2, Quite a bit = 3, Extremely = 4

1) Nervousness or shakiness inside 0 1 2 3 4
2) Faintness or dizziness 0 1 2 3 4
3) The idea that someone else can control your thoughts 0 1 2 3 4
4) Feeling others are to blame for most of your troubles 0 1 2 3 4
5) Trouble remembering things 0 1 2 3 4
6) Feeling easily annoyed or irritated 0 1 2 3 4
7) Pains in heart or chest 0 1 2 3 4
8) Feeling afraid in open spaces or on the streets 0 1 2 3 4
9) Thoughts of ending your life 0 1 2 3 4
10) Feeling that most people cannot be trusted 0 1 2 3 4
11) Poor appetite 0 1 2 3 4
12) Suddenly scared for no reason 0 1 2 3 4
13) Temper outbursts that you could not control 0 1 2 3 4
14) Feeling lonely even when you are with people 0 1 2 3 4
15) Feeling blocked in getting things done 0 1 2 3 4
16) Feeling lonely 0 1 2 3 4
17) Feeling blue 0 1 2 3 4
18) Feeling no interest in things 0 1 2 3 4
19) Feeling fearful 0 1 2 3 4
20) Your feelings being easily hurt 0 1 2 3 4
21) Feeling that people are unfriendly or dislike you 0 1 2 3 4
22) Feeling inferior to others 0 1 2 3 4
23) Nausea or upset stomach 0 1 2 3 4
24) Feeling that you are watched or talked about by others 0 1 2 3 4
25) Trouble falling asleep 0 1 2 3 4
26) Having to check and double-check what you do 0 1 2 3 4
27) Difficulty making decisions 0 1 2 3 4
28) Feeling afraid to travel on buses, subways, or trains 0 1 2 3 4
29) Trouble getting your breath 0 1 2 3 4
30) Hot or cold spells 0 1 2 3 4
31) Having to avoid certain things, places, or activities because they frighten you
32) Your mind going blank
33) Numbness or tingling in parts of your body
34) The idea that you should be punished for your sins
35) Feeling hopeless about the future
36) Trouble concentrating
37) Feeling weak in parts of your body
38) Feeling tense or keyed up
39) Thoughts of death or dying
40) Having urges to beat, injure or harm someone
41) Having urges to break or smash things
42) Feeling very self-conscious with others
43) Feeling uneasy in crowds, such as shopping or at a movie
44) Never feeling close to another person
45) Spells of terror or panic
46) Getting into frequent arguments
47) Feeling nervous when you are left alone
48) Others not giving you proper credit for your achievements
49) Feeling so restless you couldn’t sit still
50) Feelings of worthlessness
51) Feeling that people will take advantage of you if you let them
52) Feelings of guilt
53) The idea that something is wrong with your mind

BELIEF INVENTORY (Revised)
Please circle the response which indicates how strongly you believe each statement to be true in your own case. Please answer according to what you really believe yourself, not what you think you should believe.

0 = Absolutely Untrue, 1 = Mostly True, 2 = Partly True Partly Untrue, 3 = Mostly True, 4 = Absolutely True

1. I must be an extremely rare woman to have experienced sex with an older person when I was a child.
2. I am worthless and bad.
3. You can’t depend on women, they are all weak and useless creatures. 0 1 2 3 4

4. No man can be trusted. 0 1 2 3 4

5. I must have permitted sex to happen because I wasn’t forced into it. 0 1 2 3 4

6. I don’t have the right to deny my body to any man who demands it. 0 1 2 3 4

7. Anyone who knows what happened to me sexually will not want anything to do with me. 0 1 2 3 4

8. I must have been seductive and provocative when I was young. 0 1 2 3 4

9. It doesn’t matter what happens to me in my life. 0 1 2 3 4

10. No man could care for me without a sexual relationship. 0 1 2 3 4

11. It is dangerous to get close to anyone because they always betray, hurt, or exploit you. 0 1 2 3 4

12. I must have been responsible for the sex when I was young because it went on so long. 0 1 2 3 4

13. I will never be able to lead a normal life, the damage is permanent. 0 1 2 3 4

14. Only bad, worthless guys would be interested in me. 0 1 2 3 4

15. It must be unnatural to feel any pleasure during molestation. 0 1 2 3 4

16. I am inferior to other people because I did not have normal experiences. 0 1 2 3 4

17. I’ve already been used so it doesn’t matter if other men use me. 0 1 2 3 4

18. I was responsible for the abuse because I asked the offender about sexual matters. 0 1 2 3 4
19. The offender abused me because he was 'sick' and therefore not responsible for his actions. 0 1 2 3 4

20. The abuse was my own fault because I used sexual activities to obtain attention and/or affection from the offender. 0 1 2 3 4

21. The offender abused me because he was drunk at the time. 0 1 2 3 4

22. I was to blame for the abuse because I used it to obtain favours and rewards from the offender. 0 1 2 3 4

23. The offender abused me because he was sexually frustrated. 0 1 2 3 4

24. The offender engaged me in sexual activities in order to teach me about sex and to make me a better sexual partner. 0 1 2 3 4

25. The offender engaged in sexual activities with me so that our relationship would be closer and better. 0 1 2 3 4

26. The offender engaged in sexual activities with me to give me physical pleasure. 0 1 2 3 4

**ATTRIBUTIONAL STYLE IN RELATION TO THE ABUSE**

Please circle.

1) Now, I feel that the abuse is:

   In no way my fault all my fault
   
   1 2 3 4 5

2) At the time of the abuse, I felt that the abuse was

   In no way my fault all my fault
   
   1 2 3 4 5

3) Was the cause of the abuse something that reflected on:

   An aspect of the situation an aspect of yourself
   
   1 2 3 4 5
4) Did the abuse say something about:

<table>
<thead>
<tr>
<th>Others</th>
<th>or</th>
<th>something about yourself</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

5) Was the abuse:

<table>
<thead>
<tr>
<th>Controllable by you</th>
<th>controllable by others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

6) Was the abuse something for which:

<table>
<thead>
<tr>
<th>Someone is responsible</th>
<th>no-one is responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

WAYS OF COPING QUESTIONNAIRE

To respond to the statements in this questionnaire, you must have a specific stressful situation in mind. Take a few moments and think about the most stressful situation that you have experienced in the past week.

By “stressful” I mean a situation that was difficult or troubling for you, either because you felt distressed about what happened, or because you had to use considerable effort to deal with the situation. The situation may have involved your family, your job, your friends, or something else important to you. Before responding to the statements, think about the details of this stressful situation, such as where it happened, who was involved, how you acted, and why it was important to you. While you may still be involved in the situation, or it could have already happened, it should be the most stressful situation that you experienced during the week.

As you respond to each of the statements, please keep this stressful situation in mind. Read each statement carefully and indicate, by circling 1, 2, or 3, to what extent you used it in the situation.

**Key:** 0=Does not apply or not used 1=Used somewhat 2=Used quite a bit 3=Used a great deal

Please try to respond to every question.

1. I just concentrated on what I had to do next—the next step. 0 1 2 3
2. I tried to analyze the problem in order to understand it better. 0 1 2 3
3. I turned to work or another activity to take my mind off things. 0 1 2 3
4. I felt that time would have made a difference—the only thing was To wait. 0 1 2 3
5. I bargained or compromised to get something positive from the situation.
6. I did something that I didn’t think would work, but at least I was doing something.
7. I tried to get the person responsible to change his or her mind.
8. I talked to someone to find out more about the situation.
9. I criticized or lectured myself.
10. I tried not to burn my bridges, but leave things open somewhat.
11. I hoped for a miracle.
12. I went along with fate: sometimes I just have bad luck.
13. I went along as if nothing had happened.
14. I tried to keep my feelings to myself.
15. I looked for the silver lining, so to speak; I tried to look on the bright side of things.
16. I slept more than usual.
17. I expressed anger to the person(s) who caused the problem.
18. I accepted sympathy and understanding from someone.
19. I told myself that things helped me feel better.
20. I was inspired to do something creative about the problem.
21. I tried to forget the whole thing.
22. I got professional help.
23. I changed or grew as a person.
24. I waited to see what would happen before doing anything.
25. I apologized or did something to make up.
26. I made a plan of action and followed it.
27. I accepted the next best thing to what I wanted.
28. I let my feelings out somehow.
29. I realized that I had brought the problem on myself.
30. I came out of the experience better than when I went in.
31. I talked to someone who could do something concrete about the problem.
32. I tried to get away from it for a while by resting or taking a vacation.
33. I tried to make myself feel better by eating, drinking, smoking, using drugs, or medications, etc.
34. I took a big chance or did something very risky to solve the problem.
35. I tried not to act too hastily or follow my first hunch.
36. I found new faith.
37. I maintained my pride and kept a stiff upper lip.
38. I rediscovered what is important in life.
39. I changed something so things would turn out all right.
40. I generally avoided being with people.
41. I didn’t let it get to me; I refused to think too much about it.
42. I asked advice from a relative or friend I respected.
43. I kept others from knowing how bad things were. 0 1 2 3
44. I made light of the situation; I refused to get too serious about it. 0 1 2 3
45. I talked to someone about how I was feeling. 0 1 2 3
46. I stood my ground and fought for what I wanted. 0 1 2 3
47. I took it out on other people. 0 1 2 3
48. I drew on my past experiences; I was in a similar situation before. 0 1 2 3
49. I knew what had to be done, so I doubled my efforts to make things work. 0 1 2 3
50. I refused to believe that it had happened. 0 1 2 3
51. I promised myself that things would be different next time. 0 1 2 3
52. I came up with a couple of different solutions to the problem. 0 1 2 3
53. I accepted the situation, since nothing could be done. 0 1 2 3
54. I tried to keep my feeling about the problem from interfering with other things. 0 1 2 3
55. I wished that I could change what had happened or how I felt. 0 1 2 3
56. I changed something about myself. 0 1 2 3
57. I daydreamed or imagined a better time or place than the one I was in. 0 1 2 3
58. I wished that the situation would go away or somehow be over with. 0 1 2 3
59. I had fantasies or wishes about how things might turn out. 0 1 2 3
60. I prayed. 0 1 2 3
61. I prepared myself for the worst. 0 1 2 3
62. I went over in my mind what I would say or do. 0 1 2 3
63. I thought about how a person I admire would handle this situation and used it as a model. 0 1 2 3
64. I tried to see things from the other person’s point of view. 0 1 2 3
65. I reminded myself how much worse things could be. 0 1 2 3
66. I jogged or exercised. 0 1 2 3

**PERCEIVED BENEFIT FROM CHILD SEXUAL ABUSE**

Even though some people think that the unwanted sexual contact has had no effect or a negative effect on their lives, some people have found some ways that they feel they have benefited from the unwanted sexual contact.

Please circle how much benefit you feel you have received from the unwanted sexual contact you experienced:

<table>
<thead>
<tr>
<th>No benefit</th>
<th>A little benefit</th>
<th>Some benefit</th>
<th>Quite a bit of benefit</th>
<th>A lot of benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

In which areas do you believe you have benefited, please circle, if any:
Please add any comments you wish.
Protection of children
Comment

Self-protection
Comment

Increased knowledge of sexual abuse
Comment

Stronger person
Comment

<table>
<thead>
<tr>
<th>PARENTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you worry about problems related to your children?</td>
</tr>
<tr>
<td><strong>Please circle.</strong></td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>How much do you want to change the kind of parent you are?</td>
</tr>
<tr>
<td><strong>Please circle.</strong></td>
</tr>
<tr>
<td>No change</td>
</tr>
<tr>
<td>In the next 2 years do you feel that your situation as a parent will:</td>
</tr>
<tr>
<td><strong>Please circle.</strong></td>
</tr>
<tr>
<td>Get better</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>KANSAS MARITAL SATISFACTION SCALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How satisfied are you with your marriage?</td>
</tr>
<tr>
<td><strong>Please circle.</strong></td>
</tr>
<tr>
<td>Extremely Dissatisfied</td>
</tr>
<tr>
<td>Very Dissatisfied</td>
</tr>
<tr>
<td>Somewhat Dissatisfied</td>
</tr>
<tr>
<td>Somewhat Satisfied</td>
</tr>
<tr>
<td>Mixed Satisfied</td>
</tr>
<tr>
<td>Satisfied</td>
</tr>
<tr>
<td>Satisfied</td>
</tr>
</tbody>
</table>
How satisfied are you with your husband as a spouse?

**Please circle.**

<table>
<thead>
<tr>
<th>Extremely Dissatisfied</th>
<th>Very Dissatisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Mixed</th>
<th>Somewhat Satisfied</th>
<th>Very Satisfied</th>
<th>Extremely Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

How satisfied are you with your relationship with your husband?

**Please circle.**

<table>
<thead>
<tr>
<th>Extremely Dissatisfied</th>
<th>Very Dissatisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Mixed</th>
<th>Somewhat Satisfied</th>
<th>Very Satisfied</th>
<th>Extremely Satisfied</th>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Thank you very much for your participation in this research, it is greatly appreciated.

If you would like a copy of the summary of the research results, please complete the attached form.
MEMORANDUM

TO: Ms Virginia Dods Psychology

FROM: Secretary, Deakin University Human Research Ethics Committee (DUHREC)

DATE: 24 November 2000

SUBJECT: PROJECT: EC 229-2000 (Please quote this project number in future communication.)
The relationship between childhood sexual abuse and partner choice

The above project was considered at Meeting 6/00 held on 20 November 2000. The Ethics Committee decision and explanation are given below.

THAT APPROVAL BE GIVEN FOR MS VIRGINIA DODS, UNDER THE SUPERVISION OF PROF MARITA MCCABE, PSYCHOLOGY, TO UNDERTAKE THIS PROJECT FROM 1 DECEMBER 2000 TO 31 DECEMBER 2001.

Standard on-going ethics clearance has been given for the above project as submitted, the conditions listed on the accompanying page.

In arriving at its decision, the Ethics Committee noted a revised plain language statement for use with the questionnaire faxed through by you on 9/11/00.

Please contact my office if you have any concerns or queries about the above decision. The project reference number should be quoted in any communication.

Keith Wilkins
Secretary, Ethics Committee
Tel: (03) 9251 7123 (or ext 17123)
Email: keithwil@deakin.edu.au
APPENDIX C

IF YOU ARE FEMALE AND OVER 18 YEARS 
AND EXPERIENCED

CHILDHOOD SEXUAL ABUSE

ARE YOU INTERESTED IN BEING PART OF RESEARCH

TO UNDERSTAND THE IMPACT OF 
CHILD SEXUAL ABUSE

ON ADULT WOMEN

AND THEIR RELATIONSHIPS

If you are a female aged over 18 and have experienced childhood sexual abuse, please support this important Deakin University research project. The questionnaire on beliefs and methods of coping will take approximately 40 minutes in total to complete. Your answers will be anonymous and confidential. To find out more please contact:

Professor Marita McCabe or
Virginia Dods
School of Psychology
Deakin University
221 Burwood Highway
BURWOOD VIC 3125

ph 9244 6856
Fax 9244 6858
APPENDIX D

DEAKIN UNIVERSITY ETHICS COMMITTEE
CONSENT FORM: SURVEYS, QUESTIONNAIRES

I, of

Hereby consent to be a subject of a human research study to be undertaken

By Virginia Dods under the supervision of Professor Marita McCabe

and I understand that the purpose of the research is to gather information about the relationships of women who have experienced sexual abuse as children.

I acknowledge that

1. Upon receipt, my questionnaire will be coded and my name and address kept separately from it.
2. Any information that I provide will not be made public in any form that could reveal my identity to an outside party ie. I will remain fully anonymous.
3. Aggregated results will be used for research purposes and may be reported in scientific and academic journals.
4. Individual results will not be released to any person except at my request and on my authorisation.
5. That I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used.

Signature: Date:

NOTE:
In the event of a minor's consent, or person under legal liability, please complete the Ethics Committee's "Form of Consent on Behalf of a Minor or Dependent Person".
Dear Madam:

This letter is designed to introduce you to my research and to help you to decide if you would like to participate in this Deakin University research project. This project is being carried out by myself, Virginia Dods, under the supervision of Professor Marita McCabe in the School of Psychology. This project is part of my Doctor of Psychology (Forensic) degree.

This project aims to provide information to enable a better understanding of the impact of childhood sexual abuse on adult women and their relationships.

If you have experienced sexual abuse during your childhood, I would like to invite you to participate in this study.

If you agree to participate, you will be provided with:
1) Consent form
2) Copy of the Questionnaire
3) Small Envelope
4) Large Envelope

The first step is to complete a consent form and place this in the small envelope and seal it. When you have completed the questionnaire, you need to place this and the small envelope inside the large envelope and seal it. This large envelope should then be returned.

This process ensures that your answers remain anonymous and confidential. The consent form will be kept separately from the questionnaire, therefore there will be no identifying information stored with the questionnaires.

Completion of this questionnaire is expected to take about 40 minutes.

The questionnaire consists generally of multiple choice questions, but there is the opportunity for you to add comments if you wish. Examples of questions include "The offender abused me because he was sexually frustrated", "Never feeling close to another person" or "I tried to keep my feelings to myself".

Naturally, it is understood that information about your feelings and experiences is extremely personal and thinking about it may cause you distress. You are free to withdraw from participating in this research at any time and a referral to counselling at the appropriate CASA (Centre Against Sexual Assault) will be made if you need this.

For more information about this project, or if you would like to participate, please call Virginia Dods or Marita McCabe on 9244 6856.

Yours sincerely,

Virginia Dods
Doctor of Psychology (Forensic) Student – School of Psychology

Should you have any concerns about the conduct of this research project, please contact the Secretary, Ethics Committee, Research Services, Deakin University, 221 Burrowed Highway, BURWOOD VIC 3125. Tel (03) 9251 7123 (International +61 3 9251 7123).
APPENDIX F

SUMMARY OF RESEARCH RESULTS

If you would like to receive a summary of the results of this research upon its completion, please provide the necessary postal contact details below:

Name...........................................................................................................

Address.......................................................................................................  

*Please note that this form will be kept separately from questionnaire data and any interview notes, it is simply to be used for postal purposes.

If you have any queries, please contact:

Professor Marita McCabe or Virginia Dods
School of Psychology
Deakin University
221 Burwood Highway
BURWOOD VIC 3125

ph 9244 6856
Fax 9244 6858
APPENDIX G

Chief of Staff
The Herald Sun
40 City Road
Southbank

23.11.01

Dear Sir/Madam,

I am a student currently undertaking research as part of my Forensic Psychology Doctoral degree at Deakin University. My research focuses on the experiences of women who have been sexually abused during childhood. Given that this is naturally a very sensitive subject, it is difficult to recruit participants, which leads to such research not being conducted. I feel this is very unfortunate and so I am endeavouring to conduct research which will have practical applications. I have received positive feedback from current participants which is very encouraging.

In an attempt to recruit a wider sample of participants I have completed a brief article about my research and would ask if you might consider publishing this. I have also included a flyer outlining the nature of the research.

I would be very happy to discuss any queries you might have or wish for further information and I can be contacted any time on 9419 0314.

Yours sincerely,

Virginia Dods
The Editor
The Age
250 Spencer Street
Melbourne 3000

23.11.01

Dear Sir/Madam,
I am a student currently undertaking research as part of my Forensic Psychology Doctoral degree at Deakin University. My research focuses on the experiences of women who have been sexually abused during childhood. Given that this is naturally a very sensitive subject, it is difficult to recruit participants, which leads to such research not being conducted. I feel this is very unfortunate and so I am endeavouring to conduct research which will have practical applications. I have received positive feedback from current participants which is very encouraging.

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I would be very happy to discuss any queries you might have or wish for further information and I can be contacted any time on 9419 0314,
Yours sincerely,

Virginia Dods
Moving beyond Childhood Sexual Abuse

Research is being conducted to look at the issues for women who are the adult survivors of childhood sexual abuse. Virginia Dods, a Deakin University student, decided after nearly ten years of work in the welfare field, that a practical approach was called for. As a result, a project was born which aims to ask women to reflect on their experiences and how these have come to shape their adult lives and relationships now.

Ms Dods is working with Professor Marita McCabe as the project forms part of her Doctorate in Forensic Psychology. Virginia recognizes that the subject matter is naturally very sensitive and this is why participants complete an anonymous, confidential questionnaire.

Ms Dods has been really pleased by comments from the participants so far, such as “I could not have done this survey three months ago, but now it has really helped to see how far I have come” and “I really want to let people know what happened and how I now have a new life”.

The project focuses on women, currently aged over 18, who have experienced sexual abuse during their childhood. There will be a further follow-up study looking at the issues that stand out from the initial questionnaire information.

For more information, or to take part in the survey, phone Ms Dods or Professor McCabe on 9251 7061.
APPENDIX J

Interview Proforma for Study 2

Abuse Characteristics
1. Please indicate based on these three categories, what was the nature of your childhood sexual abuse?
   Noncontact
   Fondling
   Penetration
2. What was the duration of your childhood sexual abuse?
3. What was the nature of the offender's relationship to you?
   (Intrafamilial to Extrafamilial)

Self-Esteem
(Rosenberg, 1965, 10 item scale)

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

1) On the whole I am satisfied with myself.
2) At times I think I am no good at all.
3) I feel that I have a number of good qualities.
4) I am able to do things as well as most people.
5) I feel I do not have much to be proud of.
6) I certainly feel useless at times.
7) I feel that I am a person of worth, at least on an equal plane with others.
8) I wish I could have more respect for myself.
9) All in all, I am inclined to feel that I am a failure.
10) I take a positive attitude toward myself.

Locus of Control
(Rotter, 1966)

2.a. Many of the unhappy things in people's lives are partly due to bad luck.
    b. People's misfortunes result from the mistakes they make.

7.a. No matter how hard you try some people just don't like you.
    b. People whom can't get others to like them don't understand how to get along with others.

9.a. I have often found that what is going to happen will happen.
    b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
11a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
   b. Getting a good job depends mainly on being in the right place at the right time.

25a. Many times I feel that I have little influence over the things that happen to me.
   b. It is impossible for me to believe that chance or luck plays an important role in my life.

26a. People are lonely because they don’t try to be friendly.
   b. There’s not much use in trying too hard to please people, if they like you, they like you.

28a. What happens to me is my own doing.
   b. Sometimes I don’t feel that I have enough control over the direction my life is taking.

**Parenting**

1. *How has your decision to have children been influenced by your experience of childhood sexual abuse, if at all?*

2. *What impact do you believe your childhood sexual abuse has had on your parenting, if any?*

**Disclosure**

1. *Have you disclosed to anyone that you were sexually abused during childhood?*
   - Yes
   - No

2. a) *Did you keep your experience of sexual abuse secret for a period of time?*
   - Yes
   - No

   b) *If yes, how long?*

   c) *If yes, what factors contributed to your secrecy?*

   **Possible Answers:**
   - Favours/rewards
   - Attention/affection
   - Sexual pleasure
   - Enhanced self-esteem
   - Loyalty to offender
   - Fear of disbelief, blame or anger by a third party (e.g., mother)
   - Fear of offender being jailed
   - Fear of offender harming himself/herself
   - Fear of offender harming someone else
   - Fear of victim being taken away from home
   - Fear of physical violence from offender
   - Actual physical violence from offender
   - Other ..................................................
3. Please rate to what extent would you have liked to tell others but held yourself back from doing so?
(1) I have not wanted to tell anyone TO (5) I have very much wanted to tell others but did not

Childhood Disclosure
4. a) Did you disclose your experience of abuse before reaching the age of 17 years?
Yes
No

b) If so, what age were you?

c) If so, what factors led to disclosure?
Possible Answers:
Observation by third party
Physical injury to victim
Venereal disease in victim
Pregnancy of victim
Precocious sexual activity initiated by victim
Victim telling third party
Other factor


d) Who did you tell?

e) If the respondent told a third party, what factors led to this?
Possible Answers:
To obtain protection for herself
To obtain protection for other children
Relief of guilt/shame
Desire for more freedom from offender
Resentment/anger/hostility towards offender
Reaching puberty
Fear of pregnancy
Other

f) What were the reactions of significant others to disclosure prior to age 17 years?
Possible Answers:
Shock/horror
Anger/hostility towards victim
Anger/hostility towards offender
Guilt over previous failure to protect victim
Denial of victimization
Denial of impact on victim
Anxiety concerning impact on victim
Anxiety concerning disruption of family
Anxiety concerning physical violence from offender
Conflict of loyalties between victim and offender
Self-interest/self-defence/self-protection
Withdrawal from crisis of disclosure
Disbelief of victim
Attempts to undermine victim’s credibility
Pressure on victim to suppress allegations
Blaming victim
Protective towards victim
Obtained outside assistance
Co-operative with outside authorities
Other
g) Consequences of disclosure prior to age 17 years?
Possible Answers:
Investigation by social agency
Investigation by police
Medical examination of the victim
Removal of victim from the home
Removal of offender from the home
Prosecution of offender
Conviction of offender
Jailing of offender
Therapy for victim
Therapy for other family members
Therapy for offender
Other consequences..........................

Adult Disclosure
5.a) For those respondents who disclosed as an adult, what factors led to disclosure?
Possible Answers:
To obtain protection for herself
To obtain protection for other children
Relief of guilt/shame
Desire for more freedom from offender
Resentment/anger/hostility towards offender

b) Who did you tell?

c) What were the reactions of significant others to disclosure?
Possible Answers:
Shock/horror
Anger/hostility towards victim
Anger/hostility towards offender
Guilt over previous failure to protect victim
Denial of victimization
Denial of impact on victim
Anxiety concerning impact on victim
Anxiety concerning disruption of family
Anxiety concerning physical violence from offender
Conflict of loyalties between victim and offender
Self-interest/self-defence/self-protection
Withdrawal from crisis of disclosure
Disbelief of victim
Attempts to undermine victim's credibility
Pressure on victim to suppress allegations
Blaming victim
Protective towards victim
Obtained outside assistance
Co-operative with outside authorities
Other...............................
Therapy for victim
Therapy for other family members
Therapy for offender
Other consequences.................................

Partner
6. a) If in a relationship, does your current partner know about your childhood sexual abuse experience?
Yes
No

b) If so, what are his/her reactions to it?

c) Have you informed previous partners about your experience of sexual abuse?
Yes
No

d) If so, what were their reactions to it?

Possible Answers:
Anger/hostility towards victim
Anger/hostility towards offender
Guilt over previous failure to protect victim
Denial of victimization
Denial of impact on victim
Anxiety concerning impact on victim
Anxiety concerning disruption of family
Anxiety concerning physical violence from offender
Self-interest/self-defence/self-protection
Withdrawal from crisis of disclosure
Disbelief of victim
Attempts to undermine victim’s credibility
Pressure on victim to suppress allegations
Blaming victim
Protective towards victim
Obtained outside assistance
Co-operative with outside authorities
Others..................................................

Intimate Bond Measure
(Willm & Parker, 1988)

Very True  Moderately True  Somewhat True  Not at all
4  3  2  1

1. Is very considerate of me.

2. Is a good companion.

3. Is affectionate to me.

4. Tends to try and change me.

5. Tends to order me about.

6. Insists I do exactly as I’m told.
7. Is very loving to me.

8. Seeks to dominate me.

(Correlated with severity of abuse, ability to confide in partner)

Searching for Meaning

Never - Always
1 5

1) How often do you find yourself wondering why me?

2) How often do you find yourself searching for some reason, meaning, or way to make sense out of your sexual abuse experience?

3) Have you been able to find meaning in your abusive experience?
   Yes - What
   No
   Other

4) To what degree have you resolved your feelings about the abusive experience?
   Have you dealt with it?
   Yes
   No
   Other

   Have you accepted it?
   Yes
   No
   Other

5) Currently, do you have at least one person that you can confide in about your childhood sexually abusive experience?
   Yes
   No
   Other

(Correlated with Social Adjustment (SAS), Self-Esteem(Rosenberg))

Respondent's Attributions
1) What do you believe have been the long-term effects of experiencing childhood sexual abuse? (Mullen et al., 1994)
   Possible answers:
   Fear of men
   Lack of trust affecting close relationships for men and women
   Damage to self-esteem and self-confidence
   Sexual problems
   Promiscuous behaviour as adolescents
   Anger towards abuser
   Active hatred towards abuser
Mental health problems
- Depressive disorders
- Substance abuse
Fears of contact with men = phobia

(Correlated with severity of abuse, chronicity of abuse, relationship to offender (intrafamilial vs extrafamilial))

2) What would enable you to reduce the long-term effects of your sexually abusive experience?
APPENDIX K

Research Services
Office of the Pro Vice-Chancellor (Research) (Melbourne Campus)

MEMORANDUM

TO: Ms Virginia Dods
   Psychology
   Melbourne

FROM: Secretary, Deakin University Human Research Ethics Committee (DUHREC)

DATE: 28 November 2001

SUBJECT: PROJECT: EC 229-2000 (Please quote this project number in future communication)
THE RELATIONSHIP BETWEEN CHILDHOOD SEXUAL ABUSE AND PARTNER CHOICE

This application was considered by DU-HREC at the meeting of 29 October 2001.

APPROVAL HAS BEEN GIVEN FOR MS VIRGINIA DODS, UNDER THE SUPERVISION OF PROF MARITA MCCABE, PSYCHOLOGY, TO CONTINUE THIS PROJECT TO 31 DECEMBER 2002.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the application and approval. It is your responsibility to contact the Secretary immediately should any of the following occur:
- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

[Signature Redacted by Library]

Victoria Emery
Secretary, DU-HREC
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