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# Sexual Abuse of Girls and Adult Couple Relationships: Risk and Protective Factors


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# Sexual Abuse of Girls and Adult Couple Relationships: Risk and Protective Factors

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Submitted in fulfilment of the requirements of the degree of Doctor of Philosophy in

Clinical Psychology, 2007

Abstract

Child sexual abuse (CSA) of girls is common and associated with a range of negative adult outcomes, especially difficulties in intimate relationships. However, CSA does not inevitably result in these outcomes. Aspects of the abuse and the family environment, and several mediating variables influence the association between CSA and adult relationship outcomes. However, researchers have been unable to reliably determine which CSA survivors will experience negative relationship outcomes in adulthood. This thesis sought to describe the abuse and family-of-origin characteristics which account for the variability in adult relationship functioning of CSA survivors. This thesis also sought to examine variables that mediate the association between CSA and adult relationship functioning. Five thousand women (18 to 41 years) were randomly selected from the electoral roll and sent a questionnaire examining childhood experiences and adult relationship functioning: 1,335 responses were received. CSA was reported by 45% of the sample and was associated with a range of negative adult relationship outcomes. Using latent class analysis of their abuse characteristics CSA survivors were divided into three meaningfully different classes: the family, friend, and stranger abuse classes. Women in the family abuse class compared to other CSA survivors experienced the most severe abuse, the highest rate of family-of-origin dysfunction, the lowest rate of adult relationship satisfaction, and the highest rate of separation and divorce. CSA survivors, particularly those abused by a family member or friend, compared to nonabused women were more likely to develop an insecure attachment to their adult partner and extreme gender role beliefs. An insecure adult attachment and extreme gender role beliefs predicted the use of more destructive and fewer constructive coping strategies, which was associated with negative relationship outcomes including relationship and sexual dissatisfaction and partner sexual coercion. The classification of CSA used in the current study provides greater specificity in

identifying those CSA survivors most at risk of experiencing relationship difficulties in adulthood. The findings of the current study also suggest that increasing CSA survivors' use of constructive coping skills and decreasing their use of destructive strategies would assist them to have more positive experiences in their adult intimate relationships.

# Declaration

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

______________________________

Bronwyn Watson

January 2007

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# CHAPTER ONE

## The Prevalence and Nature of Child Sexual Abuse

Sally was 10 when it began. She was getting ready for bed one night when her stepfather came into her room and watched her undress. Soon Sally's stepfather began touching her genitals and making her touch his. Within a year Sally's stepfather was forcing her to have intercourse with him. Sally did not like or understand this. All she knew was that it hurt and felt very wrong. Her stepfather threatened that if she told anyone he would hurt her and her sister. The sexual abuse had been going on for several years when Sally told her mother. Her mother became angry and demanded to know why Sally would make up such horrible things about her stepfather. When Sally was 14 she ran away from home. Sally had several boyfriends during this time and fell pregnant. Sally's partner Greg often drank too much, and sometimes hit her. Sally did not like sex, it hurt and made her feel dirty, but she felt she should have sex with her partner. Sally often thought of what her stepfather had done to her and drank alcohol to block out these memories. She thought about telling someone about the abuse, but worried no one would believe her.

Unfortunately experiences like Sally's are common. Childhood sexual abuse (CSA) is experienced by many young people and can have an enduring negative effect on their lives, particularly on their adult intimate relationships. However, as underscored by this thesis, CSA does not inevitably lead to negative relationship outcomes in adulthood. The outcomes CSA survivors[1] experience are influenced by several moderating and mediating variables. However, researchers have been unable to reliably determine which CSA survivors will experience negative relationship outcomes in adulthood. Therefore, this thesis examined risk and protective factors that influence

[1] The term CSA survivor is used throughout this dissertation to avoid the awkwardness of the phrase 'women with a history of CSA' and when the term 'victim' would convey a pejorative inference. The use of the term CSA survivor is not intended to imply that all women who experience CSA have negative outcomes or that some women do not 'survive' this form of abuse.

the association between CSA and difficulties in adult intimate relationships to identify those CSA survivors most likely to experience these difficulties and to inform the development of treatment interventions.

This thesis is divided into six chapters. Chapter 1 provides a critical review of the research concerning the prevalence and nature of CSA. Chapter 2 analyses the research concerning the long-term effects of CSA and moderators of the association between CSA and adult outcomes. Chapter 3 examines the research concerning mediators of the association between CSA and adult relationship functioning. Chapter 4 outlines the first section of the current study concerning classes of CSA and adult relationship outcomes. Chapter 5 outlines the second section of the current study concerning mediators of the association between CSA and adult relationship outcomes. Chapter 6 discusses the treatment implications, limitations, and suggestions for future research arising from the current study.

### *The Prevalence of Child Sexual Abuse*

There are two sources of data concerning the occurrence of CSA; police and child protection records of the number of cases reported to the authorities in a given year and epidemiological research of the prevalence of CSA in the wider population. In Australia, during 2004, 45,154 cases of child abuse and 4,386 cases of CSA were substantiated by child protection services (Australian Institute of Health and Welfare, 2006). In the same period, 872,000 cases of child abuse and 84,584 cases of CSA were substantiated by child protection services in the US (US Department of Health and Human Services, 2006). It is difficult to extrapolate the lifetime prevalence of CSA from these incident figures. Therefore it has been argued that the best way to determine the lifetime prevalence of CSA is to ask adults about their childhood experiences (Finkelhor, 1994a). Studies which have asked adults about their childhood experiences

across Australia, America, New Zealand, and Britain reported that approximately 30% to 60% of women and 10% to 20% of males have experienced CSA (Finkelhor, 1994b; Goldman & Padayachi, 1997; Messman-Moore & Long, 2000; Russell, 1999). The prevalence estimates from these studies are substantially higher than levels of CSA reported by official authorities. However, the CSA prevalence estimates obtained from these studies are equivocal, providing estimates ranging from 3% to 71%.

The variability in prevalence estimates reported across studies could reflect genuine differences in the occurrence of CSA in different regions or countries. Poverty and other indicators of social disadvantage are moderately positively correlated with CSA (Drake & Pandey, 1996; Paveza, 1988). Therefore studies sampling individuals from lower socio-economic areas may report higher genuine CSA prevalence estimates than studies conducted in higher socio-economic areas. However, the prevalence of CSA does not appear to differ greatly from one Western country to another when national random samples are used (Finkelhor, 1994b). Finkelhor (1994b) found when methodological characteristics were taken into account there were few differences in CSA prevalence estimates from studies from America, Australia, Europe, Canada, Great Britain, New Zealand, and South Africa. However, the prevalence of CSA in non western regions including North Africa, the Middle East, and Asia has not been established (Finkelhor, 1994b), and might vary from Western countries. Therefore, the variability in CSA prevalence estimates, at least within Western countries, appears to be largely the product of methodological factors (Anderson, Martin, Mullen, Romans, & Herbison, 1993; Fassler, Amodeo, Griffin, Clay, & Ellis, 2005; Femina, Yeager, & Lewis, 1990; Finkelhor, Moore, Hamby, & Straus, 1997; Leventhal, 1990; Martin, Anderson, Romans, Mullen, & O'Shea, 1993; Rind, Tromovitch, & Bauserman, 1998; Wyatt & Peters, 1986a, 1986b).

*The Reliability and Validity of Retrospective Reports of Child Sexual Abuse*

A major methodological concern when assessing the prevalence of CSA has been the use of retrospective rather than prospective research designs (Anderson et al., 1993; Andrews, Gould, & Corry, 2002). Although the use of prospective studies would be beneficial in obtaining an accurate CSA prevalence estimate, there are ethical and legal barriers which have prevented them from being conducted. An example of such an ethical barrier is that once researchers are aware of ongoing CSA they are required by law to report it to authorities (Haverkamp & Daniluk, 1993). However, disclosing CSA to authorities could have a negative impact on victims, placing them at risk of retaliation by the offender and causing physical, emotional, and financial disruptions to their families: an ethical dilemma a researcher needs to consider when designing their methodology (Haverkamp & Daniluk, 1993). Furthermore parental consent is required for children to be involved in research (Anderson et al., 1993; Finkelhor, Ormrod, Turner, & Hamby, 2005), which would likely reduce those who had experienced CSA from participating, resulting CSA being underrepresented in the sample. The use of prospective designs when researching CSA has also been hampered by several pragmatic concerns. One such concern is that to adequately assess the prevalence of CSA prospective research would need to be conducted over a long period of time, require extensive training and supervision of research staff, and require the use of different assessment techniques commensurate with the age of the child, and as a result would be expensive to conduct (Briere, 1992; Finkelhor et al., 2005; Roy & Perry, 2004). It would also be difficult to preserve a random sample throughout a long prospective study as participant characteristics would be associated with attrition in a systematic way (Briere, 1992; Roy & Perry, 2004), resulting in CSA prevalence estimates being influenced by self-selection biases. Therefore, although prospective

research designs would be beneficial in obtaining an accurate CSA prevalence estimate, there are several barriers that have prevented their use.

The predominant concern regarding the use of retrospective reports of CSA is that if adults do not disclose actual cases of abuse or report false memories they will be misclassified and prevalence estimates will not be accurate (Williams, 1994b). The false / recovered memory debate has a long history and has had a strong influence on the study of CSA (Courtois, 1999). This debate was first ignited by Freud (1953) who, after acknowledging the widespread prevalence of CSA, completely revised his seduction theory stating that adult-child sexual contact was merely a fantasy of the child. Although Freud's oedipal theory was challenged at the time (Ferenczi, 1988; Janet, 1925), it was not until Kinsey, Pomeroy, Martin, and Gebhard’s (1953) landmark study that CSA was acknowledged as a genuine and common experience.

The contemporary study of CSA began in the 1970s, largely as a result of the Women's Liberation Movement and the study of trauma in response to the Vietnam War (Courtois, 1999; Kaplan & Manicavasagar, 2001). These influences led to the recognition of the occurrence of child abuse and numerous studies were conducted to examine the prevalence of CSA (Bagley & Ramsey, 1985; Baker & Duncan, 1985; Finkelhor, 1984; Kercher & McShane, 1984; Russell, 1983; Siegel, Sorenson, Golding, Burnham, & Stein, 1987; Wyatt, 1985). During the 1980s the media popularised the view that many difficulties in adulthood could be traced to CSA and many treatments were offered to abuse survivors (Bass & Davis, 1994; Courtois, 1999; Kaplan & Manicavasagar, 2001). Some of the techniques used to treat CSA survivors such as hypnosis became contentious as they were found to produce false and elaborated memories of abuse (Ceci & Bruck, 1993; Goodman, Quas, Batterman-Faunce, Riddlesberger, & Kuhn, 1996; McConkey, 1997; Widom & Morris, 1997); as a result

the credibility of the research documenting the prevalence of CSA was seriously questioned (Courtois, 1999).

Since the 1990s common ground in the false / recovered memory debate has been sought in order to ascertain the genuine prevalence of CSA (Courtois, 1999). A number of professional bodies have evaluated the validity and reliability of adult recollections of CSA (American Psychiatric Association, 1993; American Psychological Association, 1992; American Psychological Association Working Group on Investigation of Memories of Childhood Abuse, 1994; Australian Psychological Society, 1994; British Psychological Society, 1995; Canadian Psychiatric Association, 1996; National Association of Social Workers, 1996). The conclusions of these professional bodies were remarkably similar. First, they agreed that CSA is common. Second, they proposed that CSA continuously remembered largely reflects an accurate recall. Third, they concluded that CSA not remembered for a period of time and recalled later (so called "recovered memories") can reflect that either CSA occurred or inaccurate memories.

The core issue of the recovered / false memory debate is whether an individual can forget a genuine experience of CSA and successfully recall it during adulthood (Courtois, 1999; Ornstein, Ceci, & Loftus, 1998). Research examining independently corroborated cases of CSA found that most CSA survivors (approximately 60%) reported continuous memories of the abuse and a significant subset of CSA survivors (approximately 30%) reported being unaware of the abuse for some period of time (Albach & Everaerd, 1992; Cameron, 1994; Feldman-Summers & Pope, 1994; Herman & Harvey, 1997; Herman & Schatzow, 1987; Widom & Morris, 1997; Williams, 1994b). As demonstrated by these findings, which show underreporting of substantiated cases of CSA, when retrospective reports are erroneous the inaccuracy is usually in the false negative rather than the false positive direction (Andrews et al.,

2002; Baker & Duncan, 1985). These findings suggest that an individual can forget a genuine experience of CSA and successfully recall it in adulthood, and that when retrospective reports are inaccurate they usually reflect underreporting of abuse rather than false reports of CSA.

Memory processes have been extensively studied for the last 100 years. From this research, guidelines concerning how to reliably retrospectively assess CSA can be outlined (Alessi & Ballard, 2001; Courtois, 1999; Ornstein et al., 1998). Memory recall is affected by suggestion, especially by someone in a position of authority, such as a therapist (Ceci & Bruck, 1993; Flavell, Flavell, & Green, 1987; McConkey, 1997; Ornstein et al., 1998). The use of repeated questioning and the presentation of misleading information were found to result in the elaboration of a memory with fictional elements accompanied by a conviction about having experienced these elements (Ceci & Bruck, 1993; Ceci, Huffman, Smith, & Loftus, 1994). Young children were found to be more suggestible than older children and adults (Ceci & Bruck, 1993; Ceci, Huffman et al., 1994). However, studies of real-life events have indicated that both children's and adults' suggestibility is greater for peripheral aspects of a situation (e.g., the physical characteristics of the person or place, or the date or time of the event) than for the central activity that occurred (Ghetti, Goodman, Eisen, Qin, & Davis, 2002; Goodman, Batterman-Faunce, Schaaf, & Kenney, 2002; Goodman, Quas, Batterman-Fauce, Riddlesberger, & Kuhn, 1994; Goodman et al., 1996; Goodman, Rudy, Bottoms, & Aman, 1990). In these studies, when children were asked in a direct and concrete manner whether specific events had taken place, false memories of child abuse were rarely reported, even when questions were asked that might foster such reports (Ghetti et al., 2002; Goodman et al., 2002; Goodman et al., 1994; Goodman et al., 1996; Goodman et al., 1990). As the use of direct and concrete forms of questioning were found to elicit more accurate memory recall, it is argued that to reliably assess

CSA behaviourally specific questions should be used and hypnosis and other suggestion techniques should be avoided.

*The Impact of Gender on Child Sexual Abuse Prevalence Estimates*

The participants' gender is another methodological variable that has a great impact on CSA prevalence estimates. The current study focused exclusively on CSA in females for two reasons. First, CSA is substantially more common in females than males and therefore could be argued to have more ubiquitous public health implications for women. Second, CSA has been found to result in different types of adult sequelae for males and females, especially in regards to relationship functioning, which is the focus of this dissertation, and these sequelae appear to be more proximal to the abuse experience for females than males.

CSA is substantially more common in girls than boys. CSA prevalence estimates for females ranged from 7% to 62% with an average of 29% across studies. In comparison, CSA prevalence estimates for males ranged from 3% to 16% with an average of 9% across studies (Baker & Duncan, 1985; Finkelhor, 1984, 1990; Kercher & McShane, 1984; Siegel et al., 1987). Within Australia during 2002, 80% of CSA cases reported to police involved female victims (Australian Bureau of Statistics, 2003). In the US, females were three times more likely than males to be recorded as victims of CSA (National Association for Prevention of Child Abuse and Neglect, 2003; Snyder & Sickmund, 1999). The gender difference in CSA prevalence estimates may reflect that this form of abuse is more common in girls than boys or could be the result of underreporting of abuse by boys. Males were found to be less likely to disclose CSA than females (Finkelhor, 1980, 1994a; Pierce & Pierce, 1985). However, even if the gender discrepancy in the occurrence of CSA is influenced by underreporting by males,

it is argued that females are still substantially more likely to experience this form of abuse than males (Finkelhor, 1994a).

CSA is associated with different types of adult sequelae for males and females, especially in regards to relationship functioning, and these sequelae appear to be more proximal to the abuse experience for females than males. Confusion regarding gender identity and sexual preference and an increased risk for perpetrating sexual abuse, are common relationship outcomes of male CSA survivors that occur less frequently in females (Beitchman et al., 1992; Cahill, Llewelyn, & Pearson, 1991). In addition, the association between CSA and adult sequelae has been found to be weaker for males than females, and therefore these outcomes appear less proximal to the abuse experience for males than females (Kinzl, Mangweth, Traweger, & Biebl, 1996; Rind et al., 1998).

*The Impact of Sample Type on Child Sexual Abuse Prevalence Estimates*

The type of sampling strategy used to recruit participants is another methodological variable which influences CSA prevalence estimates. Three types of samples have been used within CSA research: student, clinical and community. To obtain a clear estimate of the prevalence of CSA a wide cross-section of studies were reviewed. The databases of Psych Info, Science Direct, and Psych Articles were searched for English language articles using combinations of the keywords child sexual abuse, child abuse, sexual abuse, incest, and early sexual experiences. All studies of female participants located and published from the late 1950s onwards were included in this review, except those that identified abuse status in participants prior to recruitment and those that did not clearly specify how they defined or assessed CSA. Sixty-eight studies were found: 28 used student samples, 15 used clinical samples, and 25 used community samples.

Studies using student samples reported lower CSA prevalence estimates than those using community samples and it is argued that they may underrepresent women who have experienced CSA. CSA prevalence estimates obtained from student samples ranged from 6% to 71% with an average of 25% (Arata, 1998; Bendixen, Muus, & Schei, 1994; Breitenbecher, 1999; Briere & Runtz, 1988c, 1990; Davis, Petretic-Jackson, & Ting, 2001; Everill & Waller, 1995; Filipas & Ullman, 2006; Finkelhor, 1979; Fromuth, 1986; Goldman & Padayachi, 1997; Harter, Alexander, & Neimeyer, 1988; Himelein & McElrath, 1996; Kessler & Bieschke, 1999; Kinzl, Traweger, & Biebl, 1995; Long & Jackson, 1991; Maker, Kemmelmeier, & Peterson, 2001; Messman-Moore, Long, & Siegfried, 2000; Meston, Heiman, & Trapnell, 1999; Roche, Runtz, & Hunter, 1999; Runtz & Briere, 1986; Sandberg, Matorin, & Lynn, 1999; Schaaf & McCanne, 1998; Smith, Davis, & Fricker-Elhai, 2004; Styron & Janoff-Bulman, 1997; Swanson & Mallinckrodt, 2001; Van Bruggen, Runtz, & Kadlec, 2006; Wilson, Calhoun, & Bernat, 1999). The low prevalence estimates found in student samples may be due to CSA survivors being less likely to attend university than their nonabused peers. CSA survivors were found to be significantly more likely to have low-income families in which their parents did not complete high school, were unemployed, or worked in blue-collar positions than women without a history of CSA (Drake & Pandey, 1996; Finkelhor et al., 1997; Manion et al., 1996; Paveza, 1988; Sedlak, 1997), which would reduce their likelihood of attending university. In addition, CSA survivors were found to have significantly lower levels of academic performance than their nonabused peers (Manion et al., 1996; Paradise, Rose, Sleeper, & Nathanson, 1994), which would also reduce their likelihood of attending university. Therefore CSA is likely to be underrepresented in student samples.

In contrast, studies using clinical samples have reported higher CSA prevalence estimates than those using community samples and it is argued that they may

overrepresent women who have experienced CSA. CSA prevalence estimates from clinical samples ranged from 16% to 65% with an average of 39% (Bryer, Nelson, Miller, & Krol, 1987; Carlin & Ward, 1992; Chu & Dill, 1990; Herman, Perry, & van der Kolk, 1989; Hill et al., 2001; Katerndahl & Burge, 2005; McCauley et al., 1997; Moeller, Bachmann, & Moeller, 1993; Sarwer & Durlak, 1996; Senn, Carey, Vanable, Coury-Doniger, & Urban, 2006; Silbert & Pines, 1981; Surrey, Swett, Michaels, & Levin, 1990; Zierler et al., 1991). There are several reasons for the high CSA prevalence estimates found in clinical samples. First, many clinical samples are recruited from counselling services specifically designed for CSA survivors (Briere & Runtz, 1988a; Conte & Schuerman, 1988; Friedrich, Beilke, & Urquiza, 1988). Second, there is strong evidence of an association between CSA and adult psychopathology (Scott, 1992; Surrey et al., 1990). Third, clinical samples often consist of individuals from low socio-economic backgrounds, which is a risk factor for experiencing CSA (Drake & Pandey, 1996; Paveza, 1988; Sedlak, 1997). Therefore CSA is likely to be overrepresented within clinical samples.

The best means for accurately assessing the prevalence of CSA are community samples because they are more representative of the general population than student or clinical samples and less likely to either under or overrepresent the occurrence CSA. However, community studies vary in their recruitment strategies (Beitchman et al., 1992). Some community studies used random sampling of electoral or telephone records, while others recruited participants through community advertisements (Beitchman et al., 1992). CSA prevalence estimates for community samples ranged from 4% to 47% for nonrandom samples with an average of 27% (Andrews, Valentine, & Valentine, 1995; Bifulco, Brown, & Adler, 1991; Dong, Anda, Dube, Giles, & Felitti, 2003; Fassler et al., 2005; Finkelhor, Hotaling, Lewis, & Smith, 1990; Greenwald, Lettenberg, Cado, & Tarran, 1990; Herman-Giddens et al., 1998; Kallstrom-Fuqua,

Weston, & Marshall, 2004; Merrill, Guimond, Thomsen, & Milner, 2003; Merrill et al., 2005; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Messman-Moore & Long, 2002; Nelson et al., 2002; Schloredt & Heiman, 2003; Stander, Olson, & Merrill, 2002; Whiffen, Judd, & Aube, 1999), and from 5% to 62% for random community samples with an average of 26% (Anderson et al., 1993; Bagley & McDonald, 1984; Baker & Duncan, 1985; Coffey, Leitenberg, Henning, Turner, & Bennett, 1996b; Dunne, Purdie, Cook, Boyle, & Najman, 2003; Finkelhor, 1984; Fleming, 1997; Kercher & McShane, 1984; Kinsey et al., 1953; Lipman, MacMillan, & Boyle, 2001; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Russell, 1983; Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992; Siegel et al., 1987; Testa, VanZile-Tamsen, & Livingston, 2005; Wyatt, 1985). Although the occurrence of CSA reported by random and nonrandom community samples does not differ greatly it is argued that random samples provide the most accurate CSA prevalence estimates by reducing the impact of self-selection bias. Therefore, this review used random community samples. The CSA prevalence estimates and methodological characteristics of these studies are presented in Table 1.

*The Impact of the Use of Interviews and Questionnaires and Type of Questions on Child Sexual Abuse Prevalence Estimates*

The way in which CSA is assessed, that is, whether interviews or questionnaires are used and the types of questions asked, also has a strong influence on prevalence estimates. As shown in Table 1, studies that used face-to-face interviews to assess CSA reported higher prevalence estimates ($M$ = 27%, range 3% to 62%) than those that used self-administered questionnaires ($M$ = 16%, range 5% to 29%). There is considerable variability in the types of questions used to assess CSA and this variability has a large impact on prevalence estimates (Bifulco et al., 1991; Femina et al., 1990; Wyatt & Peters, 1986a). Some studies asked participants brief general questions, for example:

"As a child, were you ever sexually abused?" (Kercher & McShane, 1984, p. 497), or "When you were a child, were you ever forced to have sexual intercourse against your will?" (DiLillo, DeGue, Kras, Di Loreto-Colgan, & Nash, 2006, p. 410); or provided participants with their definition of CSA and asked them if they have experienced this (Bagley & McDonald, 1984; Baker & Duncan, 1985; Boney-McCoy & Finkelhor, 1996), as illustrated in this example:

> A child (anyone under 16 years) is sexually abused when another person who is sexually mature involves the child in any activity which the other person expects leads to their sexual arousal. This might involve intercourse, touching, exposure of sexual organs, showing pornographic material or talking about sexual things in an erotic way (Baker & Duncan, 1985, p. 458).

Other studies have used behaviourally-specific questions to assess CSA (Anderson et al., 1993; Finkelhor, 1984; Kinsey et al., 1953; Russell, 1983; Saunders et al., 1992; Siegel et al., 1987; Wyatt, 1985), for example:

> Before the age of 16 did someone (X) when you did not want them to? (a) masturbate in front of you; (b) try to sexually arouse you; (c) touch or fondle your body, including genitals OR make you touch or fondle their body; (d) rub their genitals against your body in a sexual way; (e) touch your genitals with their mouth OR make you touch their genitals with your mouth; (f) try to have vaginal intercourse with you; (g) have vaginal intercourse with you; (h) try to have anal intercourse with you; (i) or have anal intercourse with you (Dunne et al., 2003, p. 144).

Typically when using behaviourally specific questions, the participant is also asked questions regarding their relationship to the perpetrator, their age and that of the perpetrator at the time the abuse occurred, and the frequency and duration of the abuse (Russell, 1983; Whiffen et al., 1999; Wyatt, 1985). As shown in Table 1, studies that

used behaviourally specific questions to assess CSA reported higher prevalence rates (*M* = 26%, range 3% to 62%) than those that used brief general questions to assess CSA (*M* = 16%, range 5% to 27%), when using either questionnaires or interviews.

There are several potential explanations for the differential reporting of CSA in response to different assessment techniques and it is argued that questionnaires with behaviourally specific questions provide the most accurate and reliable CSA prevalence estimates (Anderson et al., 1993; Fricker, Smith, Davis, & Hanson, 2003; Wyatt, 1985). First, it is possible that the higher rates of CSA reported in interviews, particularly when using multiple questions, may be due to the effects of suggestion leading to false or elaborated memories of CSA (Ceci & Bruck, 1993; Ceci, Loftus, Leitchtman, & Bruck, 1994; Ornstein et al., 1998). However, most retrospective reports of CSA where assessed for their veracity were found to be accurate, and when inaccuracy occurs it is generally the product of underreporting rather than overreporting of abuse (Albach & Everaerd, 1992; Cameron, 1994; Feldman-Summers & Pope, 1994; Herman & Harvey, 1997; Herman & Schatzow, 1987; Widom & Morris, 1997; Williams, 1994b). An alternative explanation is that the increased CSA prevalence rate found in studies using interviews could reflect underreporting when using questionnaires. Some studies have found that individuals with corroborating evidence for CSA who did not report the abuse in questionnaires did so in interviews (Femina et al., 1990). Other studies have found that most CSA cases are reported in both questionnaires and interviews (DiLillo et al., 2006; Martin et al., 1993). Studies reporting equivalent prevalence estimates from questionnaires and interviews are those which use behaviourally specific questions to assess CSA (DiLillo et al., 2006; Martin et al., 1993). Therefore, it is argued that the low CSA prevalence estimates found in studies using questionnaires are most likely due to their reliance on brief general questions (Martin et al., 1993).

The failure to report a CSA incident in response to brief general questions may occur for several reasons including that individuals do not think what happened to them would be considered by others to be abusive, they have not reconciled in their own minds whether they have experienced abuse, they wish to forget the abuse, or they want to protect the perpetrator/s of the abuse (Femina et al., 1990; Lanktree, Briere, & Zaidi, 1991). Using behaviourally specific questions to assess CSA is less likely to lead to underreporting because participants are not required to specify whether an act was *abusive*, which is a highly subjective judgement, rather they are simply required to state whether a particular sexual act had occurred and whether that act was *unwanted* (Anderson et al., 1993; Wyatt, 1985). Therefore, although researchers have proposed that the use of questionnaires leads to underreporting of CSA this appears to only apply to those questionnaires that use brief general questions. Due to the possibility of iatrogenic effects of the researcher occurring when using interviews, it is proposed that assessing CSA using questionnaires with specific behavioural questions results in the most accurate and reliable prevalence estimates (Anderson et al., 1993; Fricker et al., 2003; Wyatt, 1985).

*The Impact of Differential Definitions on Child Sexual Abuse Prevalence Estimates*

There is a lack of consensus regarding the definition of CSA, which has contributed greatly to the variability in prevalence estimates (Gorey & Leslie, 1997; Haugaard, 2000; Trickett, Noll, Reiffman, & Putnam, 2001). As Haugaard (2000) stated:

> Each word in the term *child sexual abuse* has been operationalized differently by different researchers, lawmakers, and clinicians, and there is no consensus about the definition of any of the words within the context of the term *child sexual abuse* (p. 1036).

Four major distinctions concerning the definition of CSA have been found to have a substantial impact on prevalence estimates: these distinctions are whether extrafamilial and intrafamilial perpetrated abuse and contact and noncontact sexual acts are included, the limits placed on the victim's age and on the difference in age between the perpetrator and victim, and whether the act is required to involve physical violence or force to be included (Fassler et al., 2005; Finkelhor, 1994a).

Studies have varied as to whether they consider both extrafamilial and intrafamilial abuse within their definition of CSA. Extrafamilial CSA refers to abuse that occurs outside the family, while intrafamilial CSA refers to abuse that occurs within the family (Finkelhor, 1979; Russell, 1983). As shown in Table 1, only one random community study excluded extrafamilial acts from their definition of CSA and reported a prevalence estimate of 5%. In contrast, studies that assessed both types of abuse reported much higher CSA prevalence estimates ranging from 6% to 62% with an average of 27%. Although it was once common practice for studies to focus exclusively on intrafamilial abuse, those researchers using more methodologically rigorous studies have recognised the importance of examining both intrafamilial and extrafamilial CSA.

The second distinction concerning the definition of CSA has been between contact and noncontact abuse (Anderson et al., 1993; Femina et al., 1990; Finkelhor et al., 1997; Leventhal, 1990; Martin et al., 1993; Rind et al., 1998; Wyatt & Peters, 1986a, 1986b). Contact CSA acts refer to those that involve physical contact between the perpetrator and victim. Noncontact CSA acts refer to sexual behaviours that do not involve physical contact between perpetrator and victim (Wyatt & Peters, 1986b). As shown in Table 1, studies that included only contact acts in their definition of CSA reported lower prevalence estimates (*M* = 21%, range 5% to 35%) than studies that included both contact and noncontact acts in their definition of CSA (*M* = 28%, range 6% to 62%).

Although agreement on the inclusion of most contact acts within the definition of CSA has been attained, there is little consensus regarding whether noncontact acts should also be included (Haugaard, 2000). It has been argued that in order for a particular behaviour to be defined as CSA it must be *abusive*, that is, the behaviour must be demonstrated to cause harm to the individual (Rind et al., 1998). However, there are several problems with this approach to defining CSA. First, there is no consensual definition of what *harm* resulting from the CSA would constitute, for example what types of outcomes would be considered *harmful* and what magnitude of effect would be required to establish evidence of *harm* (Ondersma et al., 2001). Second, symptoms associated with CSA were found to vary with the age of the victim and can be delayed in onset (Briere, 1992). Therefore, the age at which the *harm* caused by CSA would become apparent would need to be specified (Ondersma et al., 2001). Third, there is insufficient evidence that particular sexual acts do not cause harm to a child (Baker & Duncan, 1985; Finkelhor, 1980). In addition, in some cases even if a child described a sexual experience with an adult as positive, it would be difficult to exclude it from a definition of CSA, as Ondersma et al. (2001) clearly illustrated:

> A stranger who provides a willing child with heroin may not cause short- or even long-term harm; further, the child could report the experience as positive… In our opinion, that adult's act would still be child endangerment, would still be corrupt, and could not be either profitably or appropriately labelled *adult-child drug sharing* (p. 711).

Given that there is no evidence to justify excluding particular sexual acts on the basis of the level of harm they cause, it is argued that all forms of CSA need to be assessed and a broad definition including noncontact acts by all types of perpetrators should be used.

Although virtually all studies of CSA provided an upper age limit for the victim, these do not appear to have strongly influenced prevalence estimates. These age limits

ranged from 12 to 18 years of age, with the most common age limit used being 16 years of age (Anderson et al., 1993; Femina et al., 1990; Finkelhor et al., 1997; Leventhal, 1990; Martin et al., 1993; Rind et al., 1998; Wyatt & Peters, 1986a, 1986b). As shown in Table 1, studies that used an age limit of 15 years resulted in CSA prevalence estimates (*M* = 29%, range 24% to 34%) similar to those found when an age limit of 16 years is used (*M* = 22%, range 6% to 35%), and those found when an age limit of 18 years is used (*M* = 32%, range 5% to 62%). The use of an age limit of 15 years or above has not substantially affected CSA prevalence estimates, because as shown in Table 2, most girls are abused in their prepubescent years (Baker & Duncan, 1985; Coffey et al., 1996b; Russell, 1983; Testa et al., 2005).

The choice of a limit on the victim's age when defining CSA is argued to be somewhat arbitrary and has resulted from different perspectives regarding the age at which children become adults (Haugaard, 2000). The age of legal sexual consent has varied from 13 to 18 years across countries, has differed across time, and is often higher for homosexual than heterosexual sex (Muehlenhard, Highby, Lee, Bryan, & Dodrill, 1998; Posner & Silbaugh, 1996). It has been argued that when defining CSA the victim's perspective of their *willingness* in the act should be considered (Constantine, 1981; Rind et al., 1998). *Willingness* suggests a capacity of informed consent for sexual activities which is influenced by an individual's age and maturity (Muehlenhard et al., 1998). However, setting an age for informed sexual consent is by its nature arbitrary because same-age children vary in their capabilities to make such judgements (Muehlenhard et al., 1998; Ondersma et al., 2001). Many countries, including most states and territories Australia, define the age of legal sexual consent as 16 years (Gay & Lesbian Rights Lobby, 2001). Therefore, lacking a more precise manner in which to define informed sexual consent an age limit of 16 years was used in the current study.

Many studies not only specified an age limit for the victim when defining CSA, but also placed a limit on the age difference between the victim and the perpetrator (Femina et al., 1990; Finkelhor et al., 1997; Rind et al., 1998; Wyatt & Peters, 1986b). As shown in Table 1, when no restriction was placed on the age difference between victims and perpetrators CSA prevalence estimates (*M* = 21%, range 5% to 35%) are lower that those found when using a 5-year age difference limit (*M* = 37%, range 20% to 62%). One study used a 10-year age difference limit between the victim and perpetrator and found a CSA prevalence estimate of 15%.

Placing a restriction on the age difference between the victim and perpetrator, especially a large age difference, substantially reduces CSA prevalence estimates and it is argued that there is no evidence to suggest that the age difference between the victim and perpetrator is associated with the outcomes of CSA survivors. Preadolescent children often engage in sex-play with their peers, which is a normal part of sexual development. However, some children engage in sexually aggressive behaviours that are comparable to those of adults (Araji, 1997; Cantwell, 1995; Friedrich, 2000; Gil & Johnson, 1993; Horton, 1996; Shaw, Lewis, Loeb, Rosado, & Rodriguez, 2000; Sperry & Gilbert, 2005). Children who were sexually abused by their peers reported their experiences as equally negative and as having equally pervasive outcomes as the experiences reported by children abused by adults (Finkelhor et al., 2005; Sperry & Gilbert, 2005). Therefore, it is argued that there is no evidence to exclude CSA perpetrators on the basis of their age difference to the victim.

Some studies required physical force to be present during sexual acts in order for them to be considered CSA. However, it is argued that excluding cases of abuse that do not involve physical violence artificially lowers CSA prevalence estimates. As shown in Table 1, studies requiring force in their definition of CSA reported substantially lower prevalence estimates (*M* = 17%, range 7% to 29%) than studies not requiring

force in their definition of CSA (*M* = 28%, range 5% to 62%). As shown in Table 2, a substantial proportion of CSA cases did not involve the use of force by the perpetrator. Therefore, the use of physical force by perpetrators is not common and therefore should not be used as a criterion by which to define CSA.

Although the use of physical force by the perpetrator was not found to be typical, as shown in Table 2, the majority of CSA cases involved some form of psychological coercion. The presence of psychological coercion may assist in determining whether cases such as that of a 16-year-old girl having wanted sexual intercourse with her 18-year-old boyfriend represent CSA. The term *want* is defined as "… desire; wish for possession of… need or desire." (Oxford University Press, 1990, p. 1382). In contrast, the term *willing* is defined as "ready to consent or undertake…" (Oxford University Press, 1990, p.1403). *Willingness* on behalf of the recipient requires an understanding of the nature and ramifications of the sexual acts involved (Muehlenhard et al., 1998). In cases where a victim has surpassed the age of legal sexual consent or where the victim and perpetrator are the same age, the criteria of whether the experience was *wanted* would be more useful than the criteria of whether the victim was *willing,* as it takes into account the use of psychological coercion by the perpetrator and does not exclude victims of the basis of their age (Muehlenhard et al., 1998). Therefore, it is argued that it is beneficial to determine if the experience was *unwanted* and therefore exclude from the definition of CSA cases where the individual clearly desired the sexual activity.

The way in which researchers define CSA has substantial consequences for prevalence estimates and abuse-related sequelae reported across studies, and therefore it is argued that one must be cognisant of the purpose of the research when choosing a definition. General agreement has been attained that certain acts, for example a father having intercourse with his 10-year-old daughter, represent CSA. However, other

cases, for example a parent appearing nude in front of a 12-year-old child, or a 15-year-old girl reporting wanted sexual activity with her 18-year-old boyfriend, are less clear as to whether they represent CSA (Haugaard, 2000). Definitions of CSA within a legal context are rigid as they have significant consequences for both the victim and perpetrator. The cultural context also strongly influences a society's definition of CSA. In some cultures sex with young girls by adults is considered acceptable and marriage in early teenage years still occurs in some countries (Chang & Myers, 1997; Dion & Dion, 1993). It is important to recognise that *abuse* as a violation of legal or social norms often differs markedly from *abuse* as harm done to the child or as it is defined in research (Kilpatrick, 1987; Ondersma et al., 2001). The current study used a broad and inclusive definition of CSA, that is, any unwanted sexual act occurring at or prior to 16 years, for two reasons. First, there is insufficient evidence to justify excluding from the definition of CSA certain sexual experiences on the basis of the *abusiveness* or the *harm* caused by the experience. Second, in order to ascertain if aspects of the abuse do indeed differentially influence adult outcomes they must be assessed.

Table 1

*Prevalence Estimates of CSA From Random Community Samples*

| | | Definition of CSA | | | | | Measurement of CSA | |
|---|---|---|---|---|---|---|---|---|
| Author / year | CSA Prevalence | Extrafamilial abuse included | Non contact abuse included | Limit on victim's age or on age difference [a] | Physical force required | Sample Size | Interview vs. questionnaire | Types of questions |
| Kinsey et al. (1953) | 24% | Yes | No | Victim < 15 years 5 year age difference | No | N = 4,441 | Interview | Behaviourally specific |
| Sapp & Carter (1978) | 5% | No | No | Victim < 18 years | No | N = 2,000 | Questionnaire | Brief general |
| Russell (1983, 1984) | 54% | Yes | Yes | Victim < 18 years 5 year age difference | No | N = 930 | Interview | Behaviourally specific |
| Finkelhor (1984) | 15% | Yes | Yes | Victim < 16 years 10 year age difference | No | N = 334 | Questionnaire | Behaviourally specific |

| | | Definition of CSA | | | | Measurement of CSA | | |
|---|---|---|---|---|---|---|---|---|
| Author / year | CSA Prevalence | Extrafamilial abuse included | Non contact abuse included | Limit on victim's age or on age difference [a] | Physical force required | Sample size | Interview vs. questionnaire | Types of questions |
| Kercher & McShane (1984) | 12% | Yes | Yes | Victim < 18 Years | No | N = 593 | Questionnaire | Brief general |
| Baker & Duncan (1985) | 6% | Yes | Yes | Victim < 16 Years | No | N = 1,050 | Questionnaire and interview | Brief general |
| Timnick (1985) | 27% | Yes | Yes | Victim < 18 years | No | N = 1,252 | Questionnaire | Brief general |
| Wyatt (1985) Wyatt, Guthrie, & Notgrass (1992) | 62% | Yes | Yes | Victim < 18 years 5 year age Difference | No | N = 248 | Interview | Behaviourally specific |
| Bagley & McDonald (1984) Bagley & Ramsey (1985) | 22% | Yes | No | Victim < 16 years 3 year age difference | No | N = 377 | Interview | Brief general |

| | | Definition of CSA | | | | Measurement of CSA | | |
|---|---|---|---|---|---|---|---|---|
| Author / year | CSA Prevalence | Extrafamilial abuse included | Non contact abuse included | Limit on victim's age or on age difference [a] | Physical force required | Sample size | Interview vs. questionnaire | Types of questions |
| Siegel et al. (1987)<br>Scott (1992) | 7% | Yes | No | Victim < 16 years | Yes | N = 1,645 | Interview | Behaviourally specific |
| Saunders et al. (1992) | 34% | Yes | Yes | Victim < 18 years | No | N = 391 | Interview | Behaviourally specific |
| Anderson et al. (1993)<br>Martin et al. (1993) | 32% | Yes | Yes | Victim < 16 years | No | N = 3,000 | Questionnaire and interview | Behaviourally specific |
| Coffey et al. (1996b) | 29% | Yes | No | Victim < 16 years<br>5 year age difference | Yes | N = 666 | Questionnaire | Behaviourally specific |
| Fleming (1997)<br>Fleming, Mullen, Sibthorpe, & Bammer (1999) | 20% | Yes | No | Victim < 16 years<br>5 year age difference | No | N = 710 | Interview | Behaviourally specific |

| | | Definition of CSA | | | | Measurement of CSA | | |
|---|---|---|---|---|---|---|---|---|
| Author / year | CSA Prevalence | Extrafamilial abuse included | Non contact abuse included | Limit on victim's age or on age difference [a] | Physical force required | Sample size | Interview vs. questionnaire | Types of questions |
| Lipman et al. (2001) | 15% | Yes | Yes | Not specified | Yes | N = 1,471 | Questionnaire and interview | Brief general |
| Dunne et al. (2003) | 35% | Yes | Yes | Victim < 16 years | No | N = 908 | Interview | Behaviourally specific |
| Najman et al. (2005) | 35% | Yes | No | Victim < 16 years<br>5 year age difference | No | N = 908 | Interview | Behaviourally specific |
| Testa et al. (2005) | 34% | Yes | No | Victim < 14 years | No | N = 732 | Interview | Behaviourally specific |

*Note*. [a] Refers to age difference between the perpetrator and victim at the onset of CSA.

## *The Nature of Child Sexual Abuse*

To obtain a clear picture of the nature of CSA a wide cross-section of studies were reviewed. The databases Psych Info, Science Direct and Psych Articles were searched for English language articles using the keywords child sexual abuse, child abuse, sexual abuse, incest, and early sexual experiences. All studies using female participants located and published from the late 1950s onwards were included in this review, except those that provided little information concerning CSA characteristics. Seventy studies were found; 16 used student samples, 23 used clinical samples, and 31 used community samples.

### *The Impact of Sample Type on the Nature of Child Sexual Abuse*

Similar to the findings concerning the prevalence of CSA, differences in the nature of CSA were found across sample types: Women in student samples reported a lower prevalence of severe CSA, and those from clinical samples reported a higher prevalence of severe CSA than those in community samples. CSA survivors from student samples were less likely to have experienced CSA involving intercourse, and more likely to have experienced abuse for a shorter frequency and duration by younger perpetrators than women from community samples (Arata, 1998; Bendixen et al., 1994; Briere & Runtz, 1988c; Everill & Waller, 1995; Filipas & Ullman, 2006; Finkelhor, 1984; Fromuth, 1986; Goldman & Padayachi, 1997; Kessler & Bieschke, 1999; Madu & Peltzer, 2001; Messman-Moore et al., 2000; Roche et al., 1999; Runtz & Briere, 1986; Schaaf & McCanne, 1998; Sperry & Gilbert, 2005; Van Bruggen et al., 2006). In contrast, CSA survivors from clinical samples were more likely to have experienced CSA involving a family member, multiple perpetrators, intercourse, and psychological coercion, and were less likely to have disclosed their abuse experiences than women from community samples (Briggs & Joyce, 1997; Chu & Dill, 1990; Conte &

Schuerman, 1988; Denov, 2004; Draucker, 1995; Feiring, Taska, & Lewis, 1998; Friedrich et al., 1988; Herman, Russell, & Trocki, 1986; Jonzon & Lindblad, 2004; Katerndahl & Burge, 2005; Lanktree et al., 1991; Moeller et al., 1993; Nash & West, 1985; Pierce & Pierce, 1985; Pistorello & Follette, 1998; Pribor & Dinwiddle, 1992; Roesler & McKenzie, 1994; Rowan, Foy, Rodriguez, & Ryan, 1994; Sarwer & Durlak, 1996; Silbert & Pines, 1981; Wenninger & Ehlers, 1998). As studies using student samples reported a lower prevalence of severe CSA and those using clinical samples reported a higher prevalence of severe CSA, studies using random community samples, which are also more representative of the general population, are argued to provide the most accurate description of the nature of CSA. The findings from these studies are presented in Table 2.

*The Impact of Differential Definitions on the Nature of Child Sexual Abuse*

Similar to the findings concerning the prevalence of CSA, the nature of abuse reported by participants varied in accordance with the way it was measured and defined. First, studies using brief general questions to assess CSA reported higher rates of less severe abuse; that is, they reported fewer intrafamilial perpetrators, less intercourse, fewer contact acts, and less chronic abuse (Baker & Duncan, 1985) than those using behaviourally specific questions (Anderson et al., 1993; Coffey et al., 1996b; Finkelhor, 1984; Fleming, 1997; Najman et al., 2005; Russell, 1983; Siegel et al., 1987; Testa et al., 2005; Wyatt, 1985). Second, studies including only contact acts within their definition of CSA reported higher levels of CSA involving intercourse (Fleming, 1997; Najman et al., 2005; Russell, 1983; Siegel et al., 1987; Testa et al., 2005) than those which included noncontact CSA acts (Anderson et al., 1993; Coffey et al., 1996b; Finkelhor, 1984; Russell, 1983; Wyatt, 1985).

*The Nature of Child Sexual Abuse*

*The relationship of the perpetrator and victim.* It was once believed that most CSA perpetrators were strangers to the victim (Finkelhor, 1980). However, as shown in Table 2, contrary to this stereotype research found most perpetrators (approximately 80%) are known to the victim. Nonetheless, family members are not the most common CSA perpetrators. Rather, friends of the victim or her family and acquaintances were found to be the most common CSA perpetrators. Studies found 48% (range 30% to 71%) of CSA cases involved a perpetrator who was a friend or acquaintance, 31% involved a family member (range 14% to 43%), and 22% involved a stranger (range 3% to 56%). However, approximately one third of CSA cases involved more than one perpetrator ($M$ = 28%, range 3% to 37%). In regards to incest, studies found CSA to be most commonly perpetrated by stepfathers and secondly by biological fathers (Finkelhor, et al., 1990; Russell, 1984; Wyatt, 1985). Most CSA perpetrators were male. In Table 2, it is shown that males made up an average of 92% of CSA perpetrators (range 64% to 100%). Cases of female-perpetrated CSA were scarce, which may be due to the rarity of these occurrences or a lack of disclosure of these offences (Tardif, Auclair, Jacob, & Carpentier, 2005). Several researchers argued that the rate of female perpetrated CSA is underestimated (Denov, 2004; Grayston & De Luca, 1999; Rudin, Zalewski, & Bodmer-Turner, 1995; Tardif et al., 2005).

*The age of victims and perpetrators at the onset of child sexual abuse.* As shown in Table 2, CSA typically occurred during girls' prepubescent years, with an average age of onset of 10 years (range 10 to 11 years). Traditionally CSA perpetrators were portrayed as "dirty old men". However contrary to this stereotype most CSA perpetrators were young adults, with a mean age of 29 years (range 21 to 34 years).

*The type of sexual acts involved in child sexual abuse.* It is also shown in Table 2, that most CSA acts involved physical contact between the victim and perpetrator but

not intercourse. Studies found contact CSA acts not involving intercourse occurred on average in 60% of cases (range 40% to 91%). The most common types of contact CSA acts included the perpetrator fondling the child's genitals or the child being forced to touch the perpetrator's genitals; touching the child's other body parts including the breasts, buttocks and legs; and oral sex between the perpetrator and child. However, vaginal and anal intercourse during CSA was not unusual, it occurred on average in 32% of cases (range 5% to 54%). Noncontact CSA acts occurring in isolation were uncommon, they comprised on average 11% of CSA cases (range 0% to 55%). The most common noncontact CSA acts included the perpetrator exposing his or her genitals or masturbating in front of the child, forcibly watching the child undress or engaging in pornography, and making unwanted verbal sexual requests (Bendixen et al., 1994; Finkelhor et al., 1990; Friedrich et al., 1988; Goldman & Padayachi, 1997; Moeller et al., 1993; Rowan, et al., 1994; Wyatt, 1985).

*The use of physical force and psychological coercion by child sexual abuse perpetrators.* As shown in Table 2, the use of physical force by perpetrators during CSA acts was uncommon, it occurred on average in 25% of cases (range 7% to 41%). The use of methods of psychological coercion by perpetrators during CSA acts was more prevalent than the use of physical force, it occurred on average in 41% of cases (range 10% to 72%).

*The duration and frequency of child sexual abuse.* As shown in Table 2, many CSA victims (*M* = 52%, range 37% to 76%) experienced abuse on only one occasion. Despite many CSA experiences occurring only once, the average duration of abuse reported by random community samples was 4 years (range 10 to 91 months), which suggests that the chronicity of CSA is heterogeneous.

*Disclosure of child sexual abuse and its impact on victims.* As shown in Table 2, many women (*M* = 63%, range 36% to 89%) disclosed their abuse experiences.

However, few women (*M* = 8%, range 5% to 14%) disclosed CSA to police or child protection services. Few studies asked women directly about the impact of their abuse experiences. In the studies which examined the impact of CSA from the victim's perspective, two thirds of all CSA survivors (57% to 99%) reported their abuse experiences as harmful, terrible, very negative, or extremely upsetting at the time they occurred (Baker & Duncan, 1985; Finkelhor, 1984; Herman et al., 1986; Herman-Giddens et al., 1998; Silbert & Pines, 1981; Testa et al., 2005). However, more discrepancy concerning the effect of CSA over a longer period was found. For example in one community study less than one third (13% to 27%) of CSA survivors reported that their abuse experiences caused them permanent damage or had a great effect on their lives (Baker & Duncan, 1985), while one clinical study found 93% of CSA survivors reported that the abuse was highly damaging and difficult to recover from (Denov, 2004). In addition very few studies have documented the rate at which women with a history of CSA seek professional help for their abuse experiences. One community study found 62% of CSA survivors had sought therapy for their abuse experiences (Lamb & Edgar-Smith, 1994), while 41% of women with a history of CSA reported seeing a therapist in a student study (Arata, 1998). Although clinical studies reported high rates of CSA, the proportion of CSA survivors who seek professional help for their abuse experiences is unclear.

Table 2

*The Nature of CSA as Reported by Random Community Samples*

| Author / year | Relationship of victim and perpetrator | Victim's age at the onset of CSA | Perpetrator's age or age difference / [a] Number of perpetrators | Type of CSA act | Duration and frequency of CSA | Use of physical force and psychological coercion [b] | Rate of CSA disclosure | Victim's level of distress / Help sought [c] |
|---|---|---|---|---|---|---|---|---|
| Russell (1983, 1984) | 29% family<br>60% friend / acquaintance<br>11% stranger<br>98% male | 11 years | 97% of cases involved one perpetrator | 53% intercourse<br>100% contact | 43% once<br>31% < 2 years | 41% force | 8% told police | |
| Finkelhor (1984) | 33% family<br>67% extrafamilial (friends and strangers) | | | | | | | |
| Baker & Duncan (1985) | 14% family<br>30% friend / acquaintance<br>56% stranger | 11 years | 84% of cases involved one perpetrator | 5% intercourse<br>40% contact<br>55% non-contact | 63% once | | | 57% CSA was harmful at time it occurred<br>13% permanent damage had been caused by CSA |

| Author / year | Relationship of victim and perpetrator | Victim's age at the onset of CSA | Perpetrator's age or age difference [a] / Number of perpetrators | Type of CSA act | Duration and frequency of CSA | Use of physical force and psychological coercion [b] | Rate of CSA disclosure | Victim's level of distress / Help sought [c] |
|---|---|---|---|---|---|---|---|---|
| Wyatt (1985) | 19% family<br>30% friend / acquaintance<br>51% stranger<br>100% male | 6-8 years | 61% of perpetrators between 25-55yrs | 27% intercourse<br>49% contact<br>24% non-contact | 76% once | 25% force<br>10% coercion | | |
| Siegel et al. (1987) | 23% family<br>71% friend / acquaintance<br>21% stranger<br>93% male | 10 years | | 30% intercourse<br>70% contact | $M = 3.9$ incidents<br>54% once | 25% force | | |
| Saunders et al. (1992) | 35% family<br>50% friend / acquaintance<br>15% stranger | 11 years | | 28% intercourse<br>68% contact | 81% once | 12% thought would be killed or seriously injured | 6% told police | |

| Author / year | Relationship of victim and perpetrator | Victim's age at the onset of CSA | Perpetrator's age or age difference / [a] Number of perpetrators | Type of CSA act | Duration and frequency of CSA | Use of physical force and psychological coercion [b] | Rate of CSA disclosure | Victim's level of distress / Help sought [c] |
|---|---|---|---|---|---|---|---|---|
| Anderson et al. (1993) | 38% family<br>47% friend / acquaintance<br>15% stranger<br>98% male | 11 years | | 19% intercourse<br>59% contact<br>22% non-contact | 58% once<br>20% < 1 year | | 72% disclosed<br>8% told police or authorities | |
| Coffey et al. (1996b) | 43% family<br>47% friend / acquaintance<br>10% stranger | 10 years | | 54% intercourse<br>46% contact | 46% once<br>27% < 1 year | | | |
| Fleming (1997) | 41% family<br>51% friend / acquaintance<br>8% stranger<br>99% male | 10 years | $M = 34$ years<br>$M = 24$ years age difference | 10% intercourse<br>90% contact | 57% < 1 year | 7% force<br>72% coercion | 52% disclosed<br>10% told police | |
| Najman et al. (2005) | | | | 38% intercourse<br>72% contact | | | | |

| Author / year | Relationship of victim and perpetrator | Victim's age at the onset of CSA | Perpetrator's age or age difference / [a] Number of perpetrators | Type of CSA act | Duration and frequency of CSA | Use of physical force and psychological coercion [b] | Rate of CSA disclosure | Victim's level of distress / Help sought [c] |
|---|---|---|---|---|---|---|---|---|
| Testa et al. (2005) | 40% family<br>45% friends acquaintance<br>3% stranger<br>8% not specified | 10 years | | 49% intercourse<br>51% contact | | 25% force | | CSA self-reported trauma 5.6 out of 7 at time occurred and 3.8 currently |

*Note*. [a] Refers to difference in age between the perpetrator and victim at onset of CSA. [b] Refers to the use of physical force or psychological coercion by the perpetrator during the CSA act. [C] Refers to the victim's level of distress in response to the CSA act/s and whether they sought professional help explicitly for the abuse.

*Conclusions Concerning the Prevalence and Nature of Child Sexual Abuse*

In conclusion, CSA of girls is common. The mean estimate in methodologically rigorous studies is that 43% of girls experience CSA, defined as an unwanted sexual experience prior to 18 years of age. The CSA experienced varies greatly on many dimensions including the specific nature of the abuse, ranging from unwanted noncontact abuse to sexual penetration, the chronicity and frequency of CSA, the extent of the use of coercion and force by the perpetrator, the relationship and age difference between the perpetrator and victim, and the age of the victim. The vast majority of cases of CSA are not reported to police or child protection services.

# CHAPTER TWO

## The Long-Term Effects of Childhood Sexual Abuse

This chapter provides a critical analysis of the research concerning the long-term effects of CSA. First a brief review of the methodological limitations of this research is provided. The association between CSA with a range of negative adult outcomes is then examined. This is followed by a review of the impact of abuse and family-of-origin characteristics on the association between CSA and adult functioning.

### *Methodological Limitations of the Research Concerning the Long-Term Effects of Childhood Sexual Abuse*

There have been several methodological limitations of the research regarding the long-effects of CSA (Baker, 2002; Briere & Runtz, 1988b; DiLillo, 2001). As demonstrated in chapter 1, the use of retrospective reports, brief general questions, and restrictive definitions of CSA has led to underreporting of CSA (Anderson et al., 1993; Andrews et al., 2002; Wyatt, 1985). These methodological characteristics have not only influenced CSA prevalence estimates but have resulted in individuals with histories of abuse being falsely classified into the comparison or *nonabused* group, and in doing so have reduced the ability to accurately detect the effects of CSA (Briere, 1992). Similarly, as outlined in chapter 1, the use of biased samples has not only influenced CSA prevalence estimates but has also resulted in discrepant findings concerning the effects of CSA on adult functioning. Studies using clinical samples reported more severe abuse and considerably poorer adult outcomes in CSA survivors than those using community samples (Beitchman et al., 1992; DiLillo, 2001; Muehlenhard et al., 1998; Rumstein-McKean & Hunsley, 2001). In contrast, women recruited from student samples were younger and thus had less opportunity to experience adult outcomes (i.e., divorce, adult sexual assault), experienced less severe forms of CSA, and were better

adjusted than women from community samples (Beitchman et al., 1992; DiLillo, 2001; Muehlenhard et al., 1998; Rumstein-McKean & Hunsley, 2001). Random community samples were found to be more representative of the general population than clinical or student samples and less likely to under or overrepresent the prevalence and severity of CSA (Beitchman et al., 1992; DiLillo, 2001; Muehlenhard et al., 1998; Rumstein-McKean & Hunsley, 2001). Therefore to gain a clear understanding of the association between CSA and adult functioning, this chapter focused on findings from studies using random community samples.

The use of cross-sectional designs, and several measurement and statistical issues have also been methodological limitations of the research examining the long-term effects of CSA (Briere & Runtz, 1988b; Davis & Petretic-Jackson, 2000; Rind et al., 1998; Rumstein-McKean & Hunsley, 2001). The use of cross-sectional designs has prevented causal inferences from being made about the effects of CSA (Briere, 1992; Rumstein-McKean & Hunsley, 2001). Cross-sectional studies also suffer from a lack of independence in the assessment of CSA and long-term outcomes. When child and adult experiences are assessed concurrently, an individual's perception of their CSA experiences will be influenced by their current perception of their adult functioning (Briere, 1992). Cross-sectional studies may also misrepresent the long-term effects of CSA, as symptomatology associated with this form of abuse has been found to differ across time and be commensurate with the individual's developmental stage (Briere, 1992). Furthermore the temporal sequence of events assumed in cross-sectional research cannot be verified, as these studies are incapable of determining whether the symptoms experienced by an individual occurred prior to, during, or after the CSA experience (Briere, 1992). Ideally to prevent these methodological issues from obscuring the long-term effects of CSA prospective research designs should be used.

However, as outlined in chapter 1, ethical, legal and pragmatic issues have prevented prospective studies of CSA from being conducted.

The research concerning the long-term effects of CSA has also been compromised by the use of inadequate measures of adult adjustment (Briere, 1992; Davis et al., 2001; Rumstein-McKean & Hunsley, 2001). Rather than using existing instruments with good psychometric properties a number of researchers have developed their own measures of adult adjustment with unknown reliability and validity; a problem which has been compounded by researchers not reporting psychometric data for these instruments. As a consequence of using inadequate measures of adult adjustment, findings concerning the long-term effects of CSA cannot be compared across studies and are difficult to interpret (Briere, 1992; Briere & Elliott, 1993). Another methodological problem is the use of global or generic measures of psychopathology to assess adult functioning such as the Millon Multiaxial Personality Inventory (MMPI) (Millon, 1994) and the Rosenberg Self-Esteem Scale (Rosenberg, 1965), which may be less sensitive to, and underestimate the effects of CSA (Briere, 1992; Briere & Elliott, 1993), than more specific measures, such as using instruments like the Beck Depression Inventory (Beck, Rial, & Rickets, 1974) to assess depression, or the Alcohol Use Disorders Identification Test (Saunders, Aasland, Babor, De La Fuente, & Grant, 1993) to assess alcohol use.

Several statistical issues have limited the research concerning the long-term effects of CSA. There has been a lack of attention to the relative magnitude of the association between CSA and adult outcomes. Researchers have typically not reported the proportion of women with and without a history of CSA who experienced different outcomes (Baker, 2002; Briere & Runtz, 1988b). Moreover, most studies have used small sample sizes that result in low statistical power to detect effects of CSA. In addition, several studies have included many variables in their designs and used

multivariate statistical analyses, which can result in spurious findings or decrease the ability to detect relationships which are present (Briere, 1992; Briere & Elliott, 1993). Many studies have also not used comparison groups, making it impossible to estimate the effects of CSA (Davis & Petretic-Jackson, 2000; Muehlenhard et al., 1998; Rumstein-McKean & Hunsley, 2001; Sarwer & Durlak, 1996). In addition when comparison groups have been used they have often not been equivalent to CSA survivors on other variables (Briere, 1992; Briere & Elliott, 1993). CSA is not randomly distributed in the population and coincides with other forms of family-of-origin dysfunction and child maltreatment (Briere & Elliott, 1993; Nash, Neimeyer, Hulsey, & Lambert, 1998). In order to infer a direct relationship between CSA and adult outcomes using retrospective data, factors that are correlated with CSA must be examined in order to rule out alternative explanations (DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). In summary, a number of methodological issues have obscured the ability of studies to determine the effect of CSA on adult functioning. These methodological issues include the use of unrepresentative samples, inadequate instruments to assess CSA and adult adjustment, cross-sectional research designs, unequal comparison groups, and a lack of attention to the magnitude of the association between CSA and adult outcomes.

*The Impact of Childhood Sexual Abuse on Adult Psychological Functioning*

Associations have been found between CSA and a number of psychological conditions, including depression; suicide; posttraumatic stress disorder (PTSD); other anxiety disorders; alcohol and substance abuse; eating disorders; personality disorders, especially borderline personality disorder (BPD); and other symptoms of psychopathology. However, the magnitude of the association between CSA and these psychological outcomes has generally been only of a small to moderate size (Jumper,

1995; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Neumann, Houskamp, Pollock, & Briere, 1996; Paolucci, Genuis, & Violato, 2001).

*The Association Between Child Sexual Abuse and Depression*

One of the psychological outcomes most strongly associated with CSA is depression. Women with a history of CSA were significantly more likely to experience a major depressive episode or a diagnosis of major depressive disorder than women with no history of CSA (Andrews et al., 1995; Bifulco et al., 1991; Hill et al., 2001; Hunter, 1991; McCauley et al., 1997; Mullen et al., 1996; Nelson et al., 2002; Saunders et al., 1992; Scott, 1992; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Thompson et al., 2003; Wenninger & Ehlers, 1998). Studies found 5% to 29% of CSA survivors met diagnostic criteria for major depressive disorder compared with 3% to 10% of their nonabused peers (Andrews et al., 1995; Bagley & Ramsey, 1985; Fleming et al., 1999; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Saunders et al., 1992). In addition, 49% to 85% of CSA survivors received a lifetime diagnosis of depression compared with 26% to 66% of women without a history of CSA (Bifulco et al., 1991; Mullen et al., 1996; Nelson et al., 2002; Peters, 1988; Saunders et al., 1992; Thompson et al., 2003). Meta-analyses examining the relationship between CSA and depression found a robust, but only small to moderate size association ($d$ = 0.22 and 0.44) (Jumper, 1995; Paolucci et al., 2001).

*The Association Between Child Sexual Abuse and Suicide*

CSA survivors were also found to be significantly more likely to experience suicide ideation and attempt suicide than women with no history of CSA (Bagley & Ramsey, 1985; Briere & Runtz, 1988a; Bryer et al., 1987; McCauley et al., 1997; Mullen et al., 1996; Nelson et al., 2002; Saunders et al., 1992). Studies found 18% to

27% of CSA survivors reported having attempted suicide at some point in their lives compared with 3% to 16% of women without a history of CSA (Mullen et al., 1996; Nelson et al., 2002; Saunders et al., 1992). A meta-analysis found a moderate effect of CSA on suicide ($d$ = 0.44) (Paolucci et al., 2001).

*The Association Between Child Sexual Abuse and PTSD and Other Anxiety Disorders*

CSA survivors were also found to be significantly more likely to experience PTSD than women with no history of CSA (Anderson et al., 1993; Briggs & Joyce, 1997; Filipas & Ullman, 2006; Saunders et al., 1992; Spataro et al., 2004; Thompson et al., 2003; Wenninger & Ehlers, 1998). Studies reported 64% to 85% of CSA survivors had been diagnosed with PTSD at some point during their lives compared with 11% to 12% of their nonabused peers (Saunders et al., 1992; Thompson et al., 2003). Meta-analyses found a medium effect of CSA on PTSD ($d$ = 0.40 to 0.52) (Neumann et al., 1996; Paolucci et al., 2001). Studies also found that CSA survivors had significantly higher levels of agoraphobia, obsessive compulsive disorder, social phobia, and generalised symptoms of anxiety than their nonabused peers (Greenwald et al., 1990; Herman et al., 1986; Lipman et al., 2001; McCauley et al., 1997; Nelson et al., 2002; Saunders et al., 1992; Scott, 1992; Stein, Golding, Siegel, Burnam, & Sorenson, 1988). A lifetime prevalence estimate for any anxiety disorder of 69% was reported for CSA survivors compared with 24% for their nonabused peers (Nelson et al., 2002; Saunders et al., 1992). A meta-analysis found a small to medium effect of CSA on anxiety ($d$ = 0.40) (Neumann et al., 1996).

*The Association Between Child Sexual Abuse and Alcohol and Substance Abuse*

Alcohol and substance abuse were also found to be strongly associated with a history of CSA (Lipman et al., 2001; McCauley et al., 1997; Messman-Moore & Long,

2002; Mullen et al., 1996; Nelson et al., 2002; Scott, 1992; Thompson et al., 2003; Zierler et al., 1991). Studies found the lifetime prevalence for alcohol or substance abuse or dependence was 23% to 36% for CSA survivors compared with 8% to 25% for women without a history of CSA (Messman-Moore & Long, 2002; Nelson et al., 2002; Thompson et al., 2003).

*The Association Between Child Sexual Abuse and Eating and Personality Disorders*

CSA is also associated with the development of eating disorders (Fleming et al., 1999; Kinzl & Biebl, 1992; Mullen et al., 1996; Thompson et al., 2003; Vize & Cooper, 1995). The lifetime prevalence for eating disorders was 17% to 35% for CSA survivors compared with 5% to 8% for their nonabused peers (Andrews et al., 1995; Fleming et al., 1999; Thompson et al., 2003). In addition, an association between CSA and the development of personality disorders (Spataro et al., 2004), particularly BPD was found in some clinical studies (Bradley, Jenei, & Westen, 2005; Bryer et al., 1987; Herman & Schatzow, 1987; Katerndahl & Burge, 2005).

*The Impact of Childhood Sexual Abuse on Adult Relationship and Sexual Functioning*

The literature has primarily focused on intrapsychic symptomatology when considering the adult outcomes of CSA survivors (Rumstein-McKean & Hunsley, 2001). However, as CSA represents a violation of an intimate bond and is sexual in nature it seems likely that CSA survivors would experience difficulties in their adult intimate relationships (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). The intimate relationships of women with a history of CSA differ quite consistently from those of nonabused women in terms of stability and quality (Davis & Petretic-Jackson, 2000; DiLillo, 2001).

*The Association Between Child Sexual Abuse and Early Sexual Activity and Number of Sexual Partners*

CSA survivors were found to be significantly more likely to have begun having consensual intercourse at an earlier age than women without a history of CSA (Brown, Cohen, Chen, Smailes, & Johnson, 2004; Noll, Trickett, & Putnam, 2003; Testa et al., 2005; Vigil, Geary, & Byrd-Craven, 2005). A mean age of onset for consensual intercourse was 15 to 16 years for CSA survivors compared to 17 years or older for their nonabused counterparts (Brown et al., 2004; Fergusson, Horwood, & Lynskey, 1997; Noll et al., 2003; Testa et al., 2005; Vigil et al., 2005). CSA survivors were also found to have more lifetime sexual partners than their nonabused peers (Fergusson et al., 1997; Krahe, Scheinberger-Olwig, Waizenhofer, & Kolpin, 1999; Najman et al., 2005; Schloredt & Heiman, 2003; Senn et al., 2006; Testa et al., 2005; Wenninger & Heiman, 1998). On average CSA survivors were found to have seven lifetime sexual partners, compared with five lifetime sexual partners for their nonabused peers (Testa et al., 2005).

*The Association Between Child Sexual Abuse and Risky Sexual Activity*

CSA survivors were found to engage in more risky sexual behaviours than women with no history of CSA. CSA survivors were found to engage in higher rates of prostitution (Earls & David, 1990; Silbert & Pines, 1981; Widom & Kuhns, 1996; Zierler et al., 1991), trading sex for money or drugs (Arriola, Louden, Doldren, & Fortenberry, 2005; Senn et al., 2006), anonymous sex (Fergusson & Mullen, 1999; Zierler et al., 1991), sex with multiple partners (Arriola et al., 2005; Meston, Heiman, & Trapnell, 1999; Paolucci et al., 2001; Wyatt et al., 1992; Zierler et al., 1991), and infidelity (Colman & Spatz Widom, 2004) than their nonabused peers. Women with a history of CSA were found to experience higher rates of sexually transmitted infections

(STI) (Testa et al., 2005), and poorer birth and STI control efficacy than women without a history of CSA (Arriola et al., 2005; Fergusson & Mullen, 1999; Noll et al., 2003; Senn et al., 2006).

*The Association Between Child Sexual Abuse and Teenage Pregnancy*

In addition, CSA survivors were found to have their first child at a younger age than their nonabused counterparts (Fergusson et al., 1997; Mullen et al., 1996; Noll et al., 2003; Zierler et al., 1991). CSA survivors were found to be more likely to have had their first child prior to 19 years of age than women without a history of CSA (Mullen et al., 1996; Noll et al., 2003; Zierler et al., 1991). Some studies found that women with a history of CSA had their first pregnancy at an absolute younger age than women without a history of CSA (Brown et al., 2004; Russell, 1983; Vigil et al., 2005), though others did not (Herman-Giddens et al., 1998). Although the mean age of first pregnancy for women with and without a history of CSA may not differ, it appears the proportion of women who become pregnant as a teenager is greater amongst abused women. CSA survivors were also found to have more unintended and aborted pregnancies than women with no history of CSA (Fleming et al., 1999; Herman-Giddens et al., 1998; Mullen et al., 1996; Russell, 1983, 1984; Wyatt et al., 1992; Zierler et al., 1991).

*The Association Between Child Sexual Abuse and Multiple Short-Term Relationships*

The high number of lifetime sexual partners and sexual risk taking behaviours seen in CSA survivors may be more a product of their inability to maintain an intimate relationship than of their sexual permissiveness. Having many lifetime sexual partners may coincide with having multiple short-term relationships. Prior studies found a higher rate of short-term cohabitation in CSA survivors compared to women without a history of CSA (Bifulco et al., 1991; Cherlin, Burton, Hurt, & Purvin, 2004; Colman &

Spatz Widom, 2004; Messman-Moore & Long, 2000). Cherlin et al. (2004) found that CSA survivors often had a “transitory union pattern” (p. 780) which involved forming cohabiting relationships very quickly after meeting a new partner and exiting these relationships after a short duration.

*The Association Between Child Sexual Abuse and Separation and Divorce*

CSA survivors were found to be significantly more likely to separate or divorce than women without a history of CSA (Anderson et al., 1993; Bagley & Ramsey, 1985; Bifulco et al., 1991; Colman & Spatz Widom, 2004; DiLillo, 2001; Fleming et al., 1999; McCauley et al., 1997; Nelson et al., 2002). Studies found 11% to 20% of CSA survivors to be divorced compared with 5% to 10% of their nonabused peers (Bagley & Ramsey, 1985; DiLillo, 2001; Fleming et al., 1999; Nelson et al., 2002).

However, this increased rate of separation does not appear to be the result of women with a history of CSA marrying at higher rates than nonabused women. Some studies found CSA survivors to be less likely than their nonabused peers to marry (Bagley & Ramsey, 1985; Bifulco et al., 1991; DiLillo, 2001), though others found the opposite pattern (Fleming et al., 1999; Messman-Moore & Long, 2000). However, the difference in the rate of marriage between women with and without a history of CSA in these studies was small. Most studies found CSA survivors were no more likely to marry or to be married more than once than women without a history of CSA (Cherlin et al., 2004; Colman & Spatz Widom, 2004; Russell, 1983). These findings add weight to the proposition that the high number of lifetime sexual partners of CSA survivors is not the product of entering relationships at a higher rate but rather a difficulty in maintaining them.

*The Association Between Child Sexual Abuse and Relationship Functioning*

As well as experiencing instability in their relationships, CSA survivors were found to be more likely to have poorer quality relationships than nonabused women. CSA survivors reported less relationship satisfaction and intimacy (Colman & Spatz Widom, 2004; Davis et al., 2001; DiLillo & Long, 1999; Feinauer, Callahan & Hilton, 1996; Fleming et al., 1999; Gold, 1986; Hunter, 1991; Jackson, Calhoun, Amick, Maddever & Habif, 1990; Jehu, 1988; Liang, Williams, & Siegel, 2006; Testa et al., 2005; Westurlund, 1992), and were more anxious about their relationships (Pistorello & Follette, 1998; Whiffen et al., 1999) than their nonabused peers.

*The Association Between Child Sexual Abuse and Sexual Functioning*

CSA survivors also reported lower levels of sexual satisfaction than their nonabused peers (Fleming et al., 1999; Gold, 1986; Jackson et al., 1990; Jehu, 1988; Schloredt & Heiman, 2003; Stein et al., 1988; Van Bruggen et al., 2006). CSA survivors also described having more sexual problems (Fleming et al., 1999; Laumann, Paik, & Rosen, 1999; Mullen et al., 1996), experiencing more emotional difficulties interfering with sex (Laumann et al., 1999; Wenninger & Heiman, 1998), finding sex to be more unpleasant (Laumann et al., 1999; Stein et al., 1988), and being more anxious about sex (Stein et al., 1988), than their nonabused peers. Women with a history of CSA were found to display fewer positive responses to sexual invitations than women with no history of CSA (Gold, 1986; Gorcey, Santiago, & McCal-Perez, 1986; Herman et al., 1986; Hunter, 1991; Mullen et al., 1996; Pistorello & Follette, 1998). Studies found approximately 40% of CSA survivors in community samples reported having sexual problems compared with less than 20% of their nonabused peers (Laumann et al., 1999; Mullen et al., 1996; Stein et al., 1988).

There is also a strong relationship between CSA and adult sexual dysfunction. Briere and Runtz (1988a) found that CSA had a large effect on sexual difficulties (*d* = 0.80), while Neumann et al. (1996) in a meta-analysis found a moderate effect size (*d* = 0.40). Approximately one quarter of the general population will experience a sexual dysfunction at some point during their lives (Kinzl et al., 1996; Rosen & Leiblum, 1995b), in comparison to three quarters of CSA survivors (Jehu, 1988; Maker et al., 2001; Sarwer & Durlak, 1996; Saunders et al., 1992). Sexual desire disorders, sexual aversion disorders or sexual phobias, sexual arousal disorders, orgasmic disorders, dyspareunia and vaginismus have all been found to occur at elevated rates in women with CSA histories (Jackson et al., 1990; Jehu, 1988; Kinzl et al., 1995).

*The Association Between Child Sexual Abuse and Relationship Violence*

CSA survivors were also found to be at a greater risk for experiencing violence in their intimate relationships than their nonabused peers (DiLillo, Giuffre, Tremblay, & Peterson, 2001; Lang, Stein, Kennedy, & Foy, 2004; Messman-Moore & Long, 2000). For example, DiLillo et al. (2001) found more than a third of CSA survivors' relationships were violent compared to less than one fifth of nonabused women. Women with a history of CSA were more likely to experience physical assault by their male partners in adulthood than women without a history of CSA (DiLillo et al., 2001; Fromuth, 1986; Herman & Hirschman, 1981; Maker et al., 2001; Messman-Moore & Long, 2000; Russell, 1984; Testa et al., 2005; Whiffen et al., 1999). Previous studies found one third to a half of CSA survivors had experienced violence by an intimate partner compared with one tenth to a quarter of nonabused women (Banyard, Arnold, & Smith, 2000; Briere & Runtz, 1988c; Cyr, McDuff, & Wright, 2006; Messman-Moore & Long, 2000; Russell, 1983).

In contrast, the perpetration of physical violence by CSA survivors towards their partners has been relatively unexamined. General couple research found comparable amounts of violence committed by male and female partners or that women were slightly more likely than men to engage in physical aggression in their intimate relationships (Dutton & Nichols, 2005; Gelles & Conte, 1990; Holtzworth-Munroe, 2005; Kwong, Bartholomew, & Dutton, 1999; Straus & Gelles, 1986). The few studies that have examined violence by female survivors of CSA found that these women are more likely to physically assault their partners than their nonabused counterparts (DiLillo et al., 2001; Maker et al., 2001), but have not provided rates of female perpetrated violence. The higher levels of partner violence being committed by CSA survivors is consistent with the findings that as children these women are more aggressive than their nonabused peers (Cosentino, Meyer-Bahlburg, Albert, & Gaines, 1993; Dubowitz, Black, Harrington, & Verschoore, 1993; Gomes-Schwartz, Horowitz, & Cardarelli, 1990), that female prisoners who have committed violent crimes have a high rate of CSA (Baskin & Sommers, 1998), and that CSA survivors are more likely to be arrested for violent offences than their nonabused peers (Siegel & Williams, 2003).

*The Association Between Child Sexual Abuse and Adult Sexual Coercion*

Several studies found that women with a history of CSA are more likely than their nonabused peers to experience sexual coercion or assault in adulthood (Alvarez, Kimerling, Pavao, & Baumrind, 2005; Banyard, Williams, & Siegal, 2001; Chu & Dill, 1990; Fergusson et al., 1997; Fleming et al., 1999; Fromuth, 1986; Gold, Sinclair, & Balge, 1999; Koss & Dinero, 1989; Maker et al., 2001; Messman-Moore & Long, 2000, 2002; Messman-Moore et al., 2000; Muehlenhard et al., 1998; Roodman & Clum, 2001; Russell, 1983; Stevenson & Gajarsky, 1991; Testa et al., 2005; Urquiza & Goodlin-Jones, 1994; West, Williams, & Siegel, 2000; Wyatt et al., 1992). Meta-analyses found

CSA to have a large effect on sexual revictimisation (*d* = 0.63 to 0.67) (Koss & Dinero, 1989; Neumann et al., 1996; Roodman & Clum, 2001), with more than two thirds of CSA survivors having experienced sexual assault as an adult in comparison to less than one third of women without a history of CSA (Filipas & Ullman, 2006; Gold et al., 1999; Maker et al., 2001; Messman-Moore & Long, 2003; Nelson et al., 2002; Russell, 1983; Stevenson & Gajarsky, 1991; Urquiza & Goodlin-Jones, 1994; Van Bruggen et al., 2006; West et al., 2000; Wyatt et al., 1992). CSA survivors were also found to experience rape and sexual coercion by their husbands at twice the rate of their nonabused peers (Messman-Moore & Long, 2003).

Similar to the perpetration of physical violence by CSA survivors, sexual coercion committed by women with a history of CSA on their intimate partners has been unexamined. Studies found about a fifth of women in the general population use methods of coercion to engage their partner in sexual activity (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). There is some research to suggest that CSA survivors may be more likely than their nonabused peers to act in a sexually coercive manner towards their partners. CSA survivors were found to be more likely to be sexually aggressive as children and adolescents than their nonabused peers (Gil & Johnson, 1993; Kisiel & Lyons, 2001). However, similar to the research concerning the perpetration of physical violence by CSA survivors on their male partners, the use of sexual coercion by these women clearly warrants further study.

### *A Summary of the Long-Term Effects of Childhood Sexual Abuse*

In summary CSA is associated with a range of negative adult outcomes. CSA is reliably associated with adult psychopathology. However, this association is of a small to moderate size. In contrast, CSA has a strong effect on adult relationship functioning. CSA survivors enter sexual relationships and motherhood at an earlier age, find it more

difficult to maintain intimate relationships, and have more sexual partners and short-term relationships than their nonabused peers. CSA survivors compared to their nonabused peers experience higher levels of separation, divorce, and violence in their intimate relationships, and are more dissatisfied with their relationships and sex lives. However, CSA does not inevitably result in these negative relationship outcomes in adulthood. Prior research suggests at least one third of CSA survivors have good quality adult intimate relationships (Colman & Spatz Widom, 2004; Davis & Petretic-Jackson, 2000; Liem, James, O'Toole, & Boudewyn, 1997). Therefore, to ascertain why some CSA survivors experience these relationship difficulties and others do not researchers explored factors that influence the association between CSA and adult outcomes.

*The Impact of the Nature of the Abuse on Adult Outcomes of Child Sexual Abuse Survivors*

Due to the heterogeneous outcomes of CSA survivors, researchers have sought to distinguish those women who have difficulties in adulthood from those who do not. This work began by conceptualising CSA on a severity continuum. Researchers used characteristics of the abuse that were found to impact on the association between CSA and adult functioning to demarcate increasing levels of severity of abuse. To create an index of severity of CSA, researchers summed varying combinations of these abuse characteristics (DiLillo, 2001; Fassler et al., 2005; Merrill et al., 2003).

*The Impact of the Level of Physical Contact Involved in the Abuse on Adult Outcomes of Child Sexual Abuse Survivors*

One of the most robust indicators of adult functioning in CSA survivors is the level of physical contact involved in the CSA act/s. Increasing levels of physical

contact between the perpetrator and victim, particularly abuse involving penetration, was found to be associated with higher rates of a range of negative outcomes in adulthood, including several psychological disorders, sexual problems, risky sexual behaviour, and relationship instability and violence (Bifulco et al., 1991; Cyr et al., 2006; Feinauer, et al., 1996; Fergusson et al., 1997; Fleming et al., 1999; Jonzon & Lindblad, 2005; Najman et al., 2005; Sarwer & Durlak, 1996; Saunders et al., 1992). Those studies that did not report an association between increasing levels of physical contact during CSA and adult outcomes were those in which invasive abuse (i.e., intercourse) was uncommon (Finkelhor, 1979; Fromuth, 1986). There appears to be a linear relationship between increasing levels of physical contact during CSA and worse adult outcomes.

*The Impact of the Relationship of the Victim and Perpetrator on Adult Outcomes of Child Sexual Abuse Survivors*

Another strong predictor of adult functioning in CSA survivors is the proximity of the relationship between the victim and perpetrator. Studies found that abuse committed by an intrafamilial perpetrator was associated with poorer adult outcomes including several psychological disorders, sexual problems, sexual coercion, and relationship violence, than that committed by an extrafamilial perpetrator (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Browne & Finkelhor, 1986; Herman et al., 1986; McLean & Gallop, 2003; Noll et al., 2003; Russell, 1983). Women abused by a family member were found to report more chronic CSA (Finkelhor, 1994a; Fleming, 1997; Kinzl et al., 1995; McLean & Gallop, 2003; Trickett et al., 2001), beginning at an earlier age (McLean & Gallop, 2003; Runtz & Schallow, 1997; Trickett et al., 2001), involving greater levels of invasiveness (Bennett, Hughes, & Luke, 2000; Hulme & Agrawal, 2004), older perpetrators (Sperry & Gilbert, 2005), more perpetrators (Long &

Jackson, 1991), a lower level of disclosure (Harvey, Orbuch, Chwalisz, & Garwood, 1991), and less support in response to their disclosure (Hotte & Rafman, 1992), than women who experienced CSA by extrafamilial perpetrators.

*The Impact of the Perpetrator's Age and Gender on Adult Outcomes of Child Sexual Abuse Survivors*

The examination of relationship between the age of the perpetrator involved in the CSA act/s and adult outcomes of CSA survivors received mixed findings (Cyr, Wright, McDuff, & Perron, 2002; Shaw et al., 2000). Some studies found poorer adult outcomes in CSA survivors when there was a greater age discrepancy between the victim and perpetrator (Herman et al., 1986), whereas others found no difference in outcomes of women abused by children, adolescents, or adults (Maker et al., 2001; Shaw et al., 2000; Sperry & Gilbert, 2005). Some studies found CSA perpetrated by a father or stepfather to be associated with poorer adult outcomes than CSA committed by another perpetrator (Beitchman et al., 1992; Briere & Runtz, 1988c; Browne & Finkelhor, 1986; Finkelhor, 1979; Gold, 1986; Herman et al., 1986). However, others found that victims of sibling incest reported relationship outcomes as equally negative as those abused by an adult perpetrator (Cyr et al., 2002; Russell, 1983). There was also little evidence that male perpetrated CSA is associated with worse outcomes than CSA committed by a female (Denov, 2004; Grayston & De Luca, 1999; Rudin et al., 1995), however, this issue has been explored in only a few studies. CSA involving more than one perpetrator was found to be associated with worse outcomes in adulthood, particularly psychological distress, than CSA involving only one perpetrator (Beitchman et al., 1991; Herman et al., 1986; Roesler & McKenzie, 1994; Russell, 1983; Steel, Sanna, Hammond, Whipple, & Cross, 2004). However, others did not find an association between multiple perpetrators and adult outcomes of CSA survivors,

especially in regards to relationship functioning (DiLillo, 2001). Therefore increasing levels of familiarity or relatedness between the victim and perpetrator appear to be associated with worse adult outcomes in CSA survivors, but there is insufficient evidence that the age or gender of the perpetrator influences these outcomes.

*The Impact of Disclosure on Adult Outcomes of Child Sexual Abuse Survivors*

Disclosure that CSA has occurred to someone who is close soon after the abuse is associated with better functioning in adulthood, including lower levels of depression and anxiety (Finkelhor et al., 1990; Harvey et al., 1991; Jonzon & Lindblad, 2005; Testa, Miller, Downs, & Panek, 1992; Wyatt & Newcomb, 1990). Children and adults who disclosed CSA reported lower levels of distress and psychological symptoms than those who did not tell anyone about the abuse (Elliot & Briere, 1994; Finkelhor et al., 1990; Harvey et al., 1991; Testa et al., 1992; Wyatt & Newcomb, 1990). There was some evidence that disclosure of CSA may influence the impact of CSA on sexual outcomes (Arata, 1998). Arata (1998) found that CSA survivors who disclosed their abuse were significantly less likely to have experienced sexual revictimisation compared than those who had not disclosed the abuse.

The cause of the association between disclosure and adult outcomes of CSA survivors remains unclear. Disclosure of CSA experiences might result in the victim receiving assistance and the cessation of the abuse. Harvey et al. (1991) found disclosure of CSA to be related to more effective coping on behalf of the victim, which predicted better adult outcomes. However, family-of-origin dysfunction is associated with a reduced likelihood of disclosure and more negative outcomes in CSA survivors (Jonzon & Lindblad, 2004), and it possible that family dysfunction causes both later problems and a low probability of disclosure. Regardless of the cause of this

association, disclosure of the abuse appears to influence the adult outcomes of CSA survivors.

*The Impact of the Victim's Age on Adult Outcomes of Child Sexual Abuse Survivors*

Findings regarding the relationship between the age of the victim at the onset of CSA and the severity of adult outcomes have been inconclusive (Beitchman et al., 1992). Some studies found women abused in their teenage years had poorer outcomes than those abused in childhood (McLean & Gallop, 2003; Meiselman, 1978), while others found the opposite pattern (Bagley & McDonald, 1984; Browne & Finkelhor, 1986; McLean & Gallop, 2003). Other studies found no relationship between the age of the victim at the onset of CSA and adult outcomes (Carlin & Ward, 1992; Russell, 1983; West et al., 2000). The victim's age at the onset of CSA has also been found to be correlated with other abuse characteristics including the level of penetration, the relationship of perpetrator and victim, and the duration of abuse, which makes it difficult to establish its independent impact on the adult outcomes of CSA survivors (Beitchman et al., 1992).

*The Impact of Physical Force and Psychological Coercion on Adult Outcomes of Child Sexual Abuse Survivors*

Higher levels of physical force or violence used by the perpetrator during the CSA act/s was found to be associated with poorer outcomes in adulthood, particularly in regards to psychological symptoms. However, the use of physical force was not found to be a reliable predictor of sexual and relationship outcomes in CSA survivors (Cyr et al., 2006; Finkelhor, 1979; Fromuth, 1986; Herman et al., 1986; Russell, 1983; West et al., 2000). The use of physical force by the perpetrator is also correlated with other characteristics of CSA. Extrafamilial CSA was found to be associated with higher

levels of physical force by the perpetrator than intrafamilial CSA (Denov, 2004), and as abuse committed by a unrelated perpetrator has been found to be associated with better outcomes than that perpetrated by a related individual, the effect of use of physical force during CSA act/s on adult outcomes is obscured. It was proposed that the perpetrator's use of physical force during the CSA act may allow the victim to externalise the blame associated with the abuse and result in less severe outcomes in adulthood (Davenport, Brown, & Palmer, 1994). Forms of psychological coercion used by the perpetrator, although they have been largely neglected in the research, may have a greater impact on adult functioning of CSA survivors than the use of physical force (Davenport et al., 1994). The use of psychological coercion by CSA perpetrators is associated with more trauma and psychological impairment in adult CSA survivors than CSA involving no psychological coercion (Bagley, 1988; Basta & Peterson, 1990). Therefore, the use of physical force during the CSA act/s does not appear to be a reliable predictor of adult outcomes, while the use of psychological coercion by the perpetrator, warrants further exploration in the association between CSA and adult functioning.

*The Impact of the Frequency and Duration of Abuse on Adult Outcomes of Child Sexual Abuse Survivors*

Although some studies found a greater frequency and longer duration of abuse to predict poorer outcomes in CSA survivors, particularly psychological distress (Bagley & Ramsey, 1985; Beitchman et al., 1991; Bifulco et al., 1991; Binder, McNiel, & Goldstone, 1994; Briere & Runtz, 1988c; Herman et al., 1986; Kinzl et al., 1995; Russell, 1983; Steel et al., 2004), others have not, especially in regards to relationship outcomes (Carlin & Ward, 1992; DiLillo, 2001; Finkelhor, 1979; Friedrich et al., 1988; Sarwer & Durlak, 1996). The duration of abuse is associated with the relationship between the victim and perpetrator: Intrafamilial perpetrators were more likely to

commit CSA over a longer period than extrafamilial perpetrators (Finkelhor, 1994a; Fleming, 1997; Kinzl et al., 1995; McLean & Gallop, 2003; Trickett et al., 2001), and as a result it may be this relationship rather than the duration of the abuse which is associated with poorer outcomes (Beitchman et al., 1992).

*Classifying Child Sexual Abuse*

Researchers have used abuse characteristics identified as having the greatest impact on the association between CSA and adult functioning to create continuous CSA severity indexes. However, as illustrated by this review there has been discrepancy regarding which CSA characteristics are associated with worse outcomes in adulthood. This discrepancy is influenced by the adult outcomes measured and the correlations between abuse characteristics. Therefore, several definitions of CSA severity have emerged (Fassler et al., 2005; Hulme & Agrawal, 2004). A major problem with using a continuous scale of CSA severity is that it is seldom equally distributed across the sample (Haugaard, 2000). For example, Haugaard (2000) proposed that CSA severity is distributed in a bimodal fashion, with a large proportion of women experiencing a low severity and a substantial but smaller proportion experiencing a high severity, which appears consistent with empirical findings. However, the exact nature of the distribution of CSA severity has not been sufficiently described by the empirical research. In addition, the use of a severity scale of CSA was not found to improve the prediction of adult outcomes, especially relationship functioning, beyond the dichotomous measure of the presence or absence of abuse (Draucker, 1995; Fassler et al., 2005; Maker et al., 2001; Merrill et al., 2003). It has been argued that to remedy this problem groups of CSA survivors should be identified and considered separately when examining adult outcomes (Alexander & Schaeffer, 1994; Bennett et al., 2000;

Carlin & Ward, 1992; Follette, Naugle, & Follette, 1997; Haugaard, 2000; Hulme & Agrawal, 2004; Trickett et al., 2001).

Researchers have begun to develop classification systems to separate groups of CSA survivors. Typically, these classification systems have been based solely on the CSA act, particularly whether it has involved penetration or not (Carlin & Ward, 1992; Fergusson et al., 1997; Fleming, 1997; Kallstrom-Fuqua et al., 2004; Russell, 1983), or whether it has involved the use of physical force (Kallstrom-Fuqua et al., 2004; Russell, 1983), or on the basis of the relationship between the victim and perpetrator (Sperry & Gilbert, 2005). The problem with this approach is that it does not take into account all of the key CSA characteristics simultaneously when separating groups of abused women (Fassler et al., 2005). Others have used cluster analysis on outcome variables to separate clusters and have then retrospectively examined the CSA characteristics of these clusters (Carlin & Ward, 1992; Follette et al., 1997). For example Carlin and Ward (1992) and Follette et al. (1997) performed cluster analyses on Minnesota Multiphasic Personality Inventory (MMPI) profiles of women with a history of CSA to identify abuse clusters. However, neither of these studies was able to differentiate the abuse clusters on any aspects of their CSA experiences (Carlin & Ward, 1992; Follette et al., 1997).

Four recent studies used cluster analysis of CSA characteristics to identify distinct clusters of abused women (Alexander & Schaeffer, 1994; Bennett et al., 2000; Hulme & Agrawal, 2004; Trickett et al., 2001). Alexander and Schaeffer (1994) used cluster analysis on five abuse characteristics: degree of coercion used by the perpetrator, victim's age at the onset of the abuse, number of perpetrators involved, the invasiveness of the most severe act, and the duration of the abuse, and five family background factors to identify three abuse clusters. The three abuse clusters were found to differ significantly on the abuse characteristics used as indicators for the cluster analysis but

were not compared on other aspects of the abuse (Alexander & Schaeffer, 1994). The abuse clusters were also found to differ in regards to adult psychological functioning, with women who had experienced the most invasive, coercive, chronic, and early abuse by the most perpetrators having the highest scores on avoidant, schizoid, self-defeating, and borderline personality scores on the MMPI, and the highest levels of dissociation compared with the other abuse clusters.

Trickett et al. (2001) performed cluster analysis with six abuse characteristics: invasiveness of the CSA act, victim's age at the onset of the abuse, the relationship between the victim and perpetrator, level of force used by the perpetrator, the duration of the abuse, and the presence of multiple perpetrators, and found three abuse clusters. Trickett et al. found no significant differences in abuse characteristics between the clusters. However, Trickett et al. found the abuse clusters to differ in outcomes. Those women, who were abused by a biological father, over a long duration, beginning at a young age, had higher levels of depression, aggressiveness, and delinquency than the other clusters (Trickett et al., 2001).

Bennett et al. (2000) used cluster analysis of the relationship of the perpetrator and victim, the invasiveness of the CSA act, the level of physical force used by the perpetrator, and the duration of the abuse, to identify eight abuse clusters. These clusters differed regarding whether the perpetrator was related to the victim and the invasiveness of the CSA act (Bennett et al., 2000). Bennett et al. found some differences in adult outcomes between the abuse clusters: Women who had experienced the most invasive abuse reported a higher level of distress than those who had experienced the least severe CSA acts. Hulme and Agrawal (2004) attempted to replicate Bennett et al.'s findings using the same abuse characteristics. Hulme and Agrawal, using cluster analysis identified a seven cluster solution. Similar to Bennett et al., Hulme and Agrawal found that the abuse clusters differed in regard to whether the

perpetrator was related to the victim and the invasiveness of the CSA act. In addition, similar to Bennett et al., Hulme and Agrawal found that those women who had experienced CSA involving high levels of physical contact, particularly if the perpetrator was related to the victim, had poorer adult psychological functioning than those who had experienced noncontact CSA acts.

These four studies suggest that the relationship between the perpetrator and victim and the level of invasiveness involved in the CSA acts are useful abuse characteristics to separate clusters of CSA survivors. However, there are several limitations of these studies. Three of these four studies used student or clinical samples, and the one that used a community sample surveyed only those who had experienced incest and contact abuse (Trickett et al., 2001). In addition, none of these studies employed a comparison group of women without a history of CSA. By using biased samples it is unclear whether the results of these studies are truly representative of the total CSA female population.

Another limitation of these studies is that they used cluster analysis to identify the abuse clusters. Cluster analysis is a statistical method used to find categories of cases within a data set when the composition of groups is unknown (Kovac, Merette, Dongier, & Palmour, 2002). Cluster analysis has been criticised for being nonscientific and arbitrary, and outcomes of this analysis are strongly influenced by subjective factors such as the way in which variables are measured (Uebersax, 1993; Vermunt & Magidson, 2000). Latent class analysis (LCA) is similar to cluster analysis in that both methods seek to classify individuals into groups, where group membership is unknown (Uebersax, 1993). However, LCA has several advantages over cluster analysis: (a) unlike cluster analysis LCA is a model-based approach and the choice of indicators or criteria for class membership are less arbitrary; (b) LCA has more formal criteria by which to assess model fit and to make decisions about the number of classes to retain

than cluster analysis; and (c) LCA can tolerate variables with mixed measurement levels and scaling has less influence on outcomes compared with cluster analysis (Vermunt & Magidson, 2000).

A further limitation of these studies is that they have identified clusters with very small numbers of participants (as small as 6 participants) which would not provide sufficient power to detect differences between clusters (Hulme & Agrawal, 2004). Another criticism of these studies is that the measures of adult adjustment used focused solely on psychological outcomes; none of these studies assessed adult relationship functioning. Furthermore, most of these studies identified clusters of CSA survivors that were not reliably different across a range of abuse characteristics and adult outcomes (Hulme & Agrawal, 2004), which makes the utility of these clusters questionable.

In summary, a continuous measure of CSA severity does not successfully predict adult outcomes. Therefore, the need to distinguish separate groups of CSA survivors has been identified. Aspects of the CSA experience, particularly the level of physical contact involved, the relationship between the victim and perpetrator, the victim's disclosure of the abuse, and the use of psychological coercion by the perpetrator appear to influence the association between CSA and adult outcomes. However initial attempts to separate groups of CSA survivors have been hampered by methodological constraints. Therefore research using a random community sample, a *nonabused* comparison group, and appropriate statistical analyses such as LCA, is required to examine the existence of distinct classes of CSA survivors and their adult relationship outcomes.

*The Impact of Family-of-Origin Functioning on Adult Outcomes of Child Sexual Abuse Survivors*

Studies have found CSA survivors to have higher rates of family-of-origin dysfunction than nonabused women. Studies found higher rates of parental divorce (Colman & Spatz Widom, 2004; Higgins & McCabe, 1994); aggression (Fergusson et al., 1997; Paveza, 1988; Rumm, Cummings, Krauss, Bell, & Rivara, 2000; Vigil et al., 2005); marital conflict (Bryer et al., 1987; Edwards & Alexander, 1992); parental alcohol and substance abuse (Nelson et al., 2002); parental criminal behaviour; parental histories of child abuse (Black, Heyman, & Smith-Slep, 2001a; Drake & Pandey, 1996; Fergusson et al., 1997; Friedrich et al., 1988; Higgins & McCabe, 1994; Maker et al., 2001; Moeller et al., 1993; Russell, 1983; Silbert & Pines, 1981); parental psychiatric problems; unemployment; family poverty (Colman & Spatz Widom, 2004; Drake & Pandey, 1996; Fergusson et al., 1997; Paveza, 1988); and step and single-parents (Black et al., 2001a; Bryer et al., 1987; Fergusson et al., 1997) in the families of origin of CSA survivors compared with their nonabused peers. In addition, lower levels of parental marital satisfaction (Paveza, 1988), education, supervision, and poor relationships between mothers and daughters (Black et al., 2001a; Fergusson et al., 1997), and less family cohesion and support (Harter et al., 1988; Weissmann-Wind & Silvern, 1994), were found in the families of origin of CSA survivors compared with their nonabused peers.

In addition, there is now considerable evidence that different types of child maltreatment coincide (Black et al., 2001a; Boney-McCoy & Finkelhor, 1995; Dong et al., 2003; Fergusson et al., 1997; Finkelhor et al., 2005; Ney, Fung, & Wickett, 1994; Styron & Janoff-Bulman, 1997). For example, Finkelhor et al. (2005) in a nationally representative sample of 2000 children found 97% of those who had been sexually abuse had also experienced other forms of maltreatment, and were particularly at risk of

experiencing child physical abuse. Ney et al. (1994) found CSA to be associated with a range of other forms of child abuse, particularly physical neglect. Dong et al. (2003) using retrospective data from 10,000 women, found CSA to reliably increase the odds for experiencing emotional and physical abuse, and emotional and physical neglect as a child. Black et al. (2001a) found prior child maltreatment increased the odds of experiencing CSA by 1170%. These findings provide substantial evidence that CSA often occurs within a context of family-of-origin dysfunction including other forms of child maltreatment.

These findings pose the question of whether the outcomes CSA survivors experience are a result of CSA or are caused by family-of-origin dysfunction and other forms of child maltreatment. Some researchers argued that it is family-of-origin dysfunction rather than CSA that is associated with the negative outcomes seen in these women (Bagley & Ramsey, 1985; Bifulco et al., 1991; Mullen et al., 1993; Rind et al., 1998). A lack of affection; high levels of parental control (Bifulco et al., 1991; Fromuth, 1986; Mullen et al., 1996; Peters, 1988), family conflict and violence (Bifulco et al., 1991; Binder et al., 1994; Mullen et al., 1996); parents' poor physical and mental health and drug use; and lack of social and family support (Luster & Small, 1997; Weissmann-Wind & Silvern, 1994), were found to be strong predictors of psychological outcomes in CSA survivors (Mullen et al., 1996). After controlling for these family variables, the strength of the association between CSA and psychological outcomes was considerably reduced and sometimes completely removed (Bagley & Ramsey, 1985; Bifulco et al., 1991; Fleming, Mullen, Sibthorpe, Attewell, & Bammer, 1998; Mullen et al., 1993). It has been argued that without the accompanying family-of-origin dysfunction, CSA is only responsible for a very small proportion of the adult psychological outcomes experienced by CSA survivors (Bifulco et al., 1991).

Similarly parental conflict, violence, and separation; social isolation; the parent-child relationship; parental sex education; mothers' mental health; parent-child attachment; and parental antisocial behaviour and drug use have been found to moderate the relationship between CSA and adult relationship functioning (Colman & Spatz Widom, 2004; Fergusson et al., 1997; Fleming et al., 1999; Kinzl et al., 1995; Liang, et al., 2006; Maker et al., 2001; Meston et al., 1999; Moeller et al., 1993; Mullen et al., 1996; Schaaf & McCanne, 1998). However, in comparison to psychological outcomes, when these family-of-origin variables are controlled for there is still a strong and unique association between CSA and most relationship outcomes (Colman & Spatz Widom, 2004; Fergusson et al., 1997; Fleming et al., 1999; Kinzl et al., 1995; Liang et al., 2006; Mullen et al., 1996; Vigil et al., 2005). Therefore CSA appears to act as a more direct risk factor for relationship rather than psychological outcomes in adulthood (Noll et al., 2003; Thompson et al., 2003).

Others have argued that it is not family-of-origin dysfunction that leads to negative outcomes seen in CSA survivors, but rather the accumulation of child trauma. It was proposed that experiencing more than one form of abuse is associated with worse adult outcomes than experiencing CSA alone (Banyard et al., 2001; Boney-McCoy & Finkelhor, 1995; Luster & Small, 1997; Schloredt & Heiman, 2003). Many of the psychological outcomes experienced by CSA survivors were found to be common amongst those who were physically or emotionally abused as a child (Bryer et al., 1987). Depression, anxiety, eating disorders, alcohol and substance abuse, and suicide ideation and attempts have been found to be significantly predicted by child sexual, physical, and emotional abuse (Bryer et al., 1987; Luster & Small, 1997; Moeller et al., 1993; Surrey et al., 1990). In comparison, the relationship outcomes experienced by CSA survivors were found to be more specific to this form of abuse (Briere & Runtz, 1988c; Davis & Petretic-Jackson, 2000). However, some studies found that both

physical and sexual child abuse were associated with negative adult relationship outcomes (Arata & Lindman, 2002; Colman & Spatz Widom, 2004; McCauley et al., 1997). Others found an additive effect of different forms of child maltreatment on adult relationship outcomes in CSA survivors (Boney-McCoy & Finkelhor, 1995; Davis et al., 2001; Luster & Small, 1997; Mullen et al., 1996). Still others proposed that CSA may actually lead to an increased risk for other forms of child maltreatment and as a result increase the risk of negative adult outcomes (Banyard et al., 2001).

Others proposed a specificity model of trauma, arguing that individual childhood traumas have unique debilitating effects in adulthood (Briere & Runtz, 1990; Maker et al., 2001; Meston et al., 1999). There is some evidence for the specificity model of trauma, for example child emotional abuse was found to be uniquely associated with low self-esteem, child physical abuse with aggression and relationship conflict, and CSA with risky sexual behaviour, sexual difficulties, and revictimisation (Briere & Runtz, 1990; Elliot & Briere, 1995; Meston et al., 1999; Mullen et al., 1996; Van Bruggen et al., 2006).

To establish whether CSA or other family-of-origin characteristics were more successful in predicting adult outcomes, researchers typically considered these variables simultaneously using multiple regression or canonical correlation statistical techniques. However, despite the inclusion of these family-of-origin factors, these studies continued to find a unique association between CSA and adult relationship functioning (Briere & Runtz, 1990; Colman & Spatz Widom, 2004; Fergusson et al., 1997; Fleming et al., 1999; Kinzl et al., 1995; Liang et al., 2006; Maker et al., 2001; Meston et al., 1999; Mullen et al., 1996; Nelson et al., 2002). These results suggest that CSA is uniquely associated with negative relationship outcomes in adulthood.

There are a number of problems with using the aforementioned statistical procedures to determine if CSA or other forms of family-of-origin dysfunction cause

adult outcomes. First, if these variables are highly correlated, then partitioning out one will result in a very small and even meaningless semipartial correlation, as CSA must correlate with all outcomes after the shared variance for all family-of-origin factors has been removed (Briere, 1992). Second, if there is evidence that the CSA caused the family dysfunction or that CSA and family dysfunction interact synergistically, then it is inappropriate to perform these types of analyses (Pedhauzur, 1982). The interaction between these constructs is particularly problematic in cross-sectional research where the participant's perceptions of their family-of-origin functioning and adult adjustment are likely to be influenced by their report of CSA (Briere & Elliott, 1993). To definitively establish whether CSA or other forms of family-of-origin dysfunction are responsible for difficulties in adult intimate relationships, a prospective research design in which women with and without a history of CSA are matched on all other characteristics is needed (Boney-McCoy & Finkelhor, 1996; Briere, 1992). One prospective study matching women with and without a history of CSA on other family characteristics was performed and found that although family-of-origin dysfunction moderated the relationship between CSA and adult outcomes, a unique relationship between this form of abuse and adult functioning remained (Boney-McCoy & Finkelhor, 1996).

There is also some evidence to suggest that family-of-origin dysfunction varies in a consistent way with CSA characteristics. Victims of intrafamilial CSA were found to have higher rates of parental separation or divorce, family conflict, and other forms of child abuse and neglect (Alexander & Schaeffer, 1994; Dong et al., 2003), and less family-of-origin support (Long & Jackson, 1991), than those abused by extrafamilial perpetrators. In addition, CSA survivors who experienced the most invasive sexual acts were found to have the highest level of family-of-origin dysfunction (Bennett et al., 2000; Hulme & Agrawal, 2004). Therefore, it is argued that when using cross-sectional

designs, the most effective way to examine the impact of family-of-origin dysfunction on the association between CSA and adult outcomes, is to examine its relationship with characteristics of the abuse.

In summary, CSA often coincides with family-of-origin dysfunction including other forms of child maltreatment. Family-of-origin dysfunction moderates the association between CSA and adult outcomes. However, in contrast to the association between CSA and psychological outcomes, which appears to be heavily moderated by family-of-origin dysfunction, CSA appears to act as a more direct risk factor for adult relationship difficulties. Cross-sectional studies cannot accurately assess whether abuse or family-of-origin dysfunction are responsible for negative adult outcomes. Abuse characteristics and family-of-origin dysfunction appear to be associated. Therefore, by identifying classes of CSA survivors and characteristics of their families of origin, the influence of family dysfunction on adult outcomes amongst this population can be clarified.

*Conclusions Concerning the Long-Term Effects of Child Sexual Abuse*

In conclusion, CSA is associated with a range of negative outcomes in adulthood, but appears to be most strongly and directly associated with adult relationship functioning. However, CSA does not inevitably lead to negative adult outcomes. Aspects of the CSA experience, particularly the level of physical contact involved, the relationship of the victim and perpetrator, disclosure of the abuse, and the use of psychological coercion by the perpetrator appear to influence the association between CSA and adult outcomes. CSA severity has not been found to be continuously distributed and there is a need to distinguish separate classes of CSA survivors. CSA often coincides with family-of-origin dysfunction, and characteristics of the abuse and the family environment appear to be associated with one another. Therefore classes of

CSA survivors, their differential abuse and family-of-origin characteristics, and adult relationship outcomes need to be examined

# CHAPTER THREE

## Mediators of the Association Between Child Sexual Abuse and Adult Relationship Functioning

The purpose of this chapter is to explain how a distal event such as CSA impacts on adult relationship functioning. This chapter also seeks to explain the heterogeneity in long-term outcomes of CSA survivors by examining variables that mediate the association between CSA and adult relationship functioning. First, a critical analysis of existing theoretical models of the association between CSA and adult relationship functioning is provided. The model of emotional avoidance (Leonard & Follette, 2002; Polusny & Follette, 1995) is outlined and its empirical support evaluated. This chapter culminates with a critical review of factors that protect CSA survivors from experiencing negative relationship outcomes, and integrates this material with that of the model of emotional avoidance to present the model to be tested by this dissertation.

### *Theoretical Models of the Association Between Child Sexual Abuse and Adult Relationship Functioning*

Over the last 20 years several theoretical models have been proposed to explain the relationship between CSA and adult outcomes (Freeman & Morris, 2001). Seven models have been developed to explain adult relationship outcomes in CSA survivors. This chapter provides a critical review of these theoretical models. This review is divided into two sections, considering those models which focus on contextual variables within the abusive environment (Finkelhor & Browne, 1985; Summit, 1983), and developmental approaches (Alexander, 1992; Cole & Putnam, 1992; Spaccarelli, 1994) to explain the association between CSA and adult relationship outcomes.

*Contextual Models of Adult Relationship Functioning of Child Sexual Abuse Survivors*

*Summit's child sexual abuse accommodation syndrome model.* Summit's (1983) CSA accommodation syndrome model proposed that five characteristics of the family context in which CSA occurs produce negative adult relationship outcomes. These characteristics are secrecy; helplessness; entrapment and accommodation; delayed, conflicted, and unconvincing disclosure; and retraction (Summit, 1983). Summit proposed that as a result of the secrecy and helplessness within the family environment of the CSA survivor, little support would be provided to her and she would blame herself for the abuse, and be unable to tell anyone about it. Summit proposed, that as a result of being unable to stop the abuse from occurring, the child would try to adapt to the abusive situation by using pathological coping strategies. However, due to the inevitable breakdown of these coping strategies the child would disclose the abuse (Summit, 1990). Summit proposed that as a result of the negative family environment, the child would be unlikely to be supported in her disclosure, would recant the allegations of abuse, and as a result would be unable to establish intimate and trusting relationships in adulthood.

*Finkelhor and Browne's traumagenic dynamics model.* Finkelhor and Browne (1985) proposed that four factors associated with CSA called traumagenic dynamics result in negative adult relationship outcomes. In particular, Finkelhor and Browne's model sought to explain why CSA survivors engage in risky and compulsive sexual behaviour, develop negative thoughts and feelings about sex and intimate relationships, and experience sexual revictimisation in adulthood. The first factor of this model is called traumatic sexualization, which refers to the process whereby the CSA experience leads to the development of precocious and negative feelings and attitudes about sex, resulting in promiscuous and risky sexual behaviour (Finkelhor & Browne, 1985). The second traumagenic dynamic, betrayal, refers to the failure of trusted adults to stop the

abuse and was proposed to lead the CSA survivor to have poor judgment concerning who to trust in adulthood which could increase the risk of revictimisation. Alternatively, as a result of this betrayal CSA survivors may become suspicious of intimate relationships and avoid them altogether (Finkelhor & Browne, 1985). The third traumagenic dynamic, powerlessness is elicited by the child's ineffective attempts to end the abuse, which Finkelhor and Browne proposed would result in the use of pathological coping strategies. Finkelhor and Browne proposed that this powerlessness could result in CSA survivors lacking assertion in their adult relationships, placing them at risk of sexual revictimisation. The final traumagenic dynamic, stigmatization, refers to the development of the CSA survivor's negative views of herself as a result of the perpetrator's or other adults' negative communications with her concerning the abuse (Finkelhor & Browne, 1985). Finkelhor and Browne proposed that as a result of this stigmatization, the CSA survivor might feel that she is damaged and may act in a sexually permissive manner or avoid intimate relationships.

Summit's (1983) CSA accommodation model and Finkelhor and Browne's (1985) traumagenic dynamics model represent the earliest attempts to explain why women with a history of CSA experience relationship difficulties in adulthood. These models have identified some potentially important variables, such as maladaptive coping strategies, in mediating the association between CSA and adult outcomes. A strength of Summit's and Finkelhor and Browne's models is that they recognise the importance of factors within the CSA survivor's family of origin, such as a lack of family support in moderating the effects of CSA. However, both of these models would benefit from a more comprehensive description of how aspects of the CSA survivor's family of origin moderate the relationship outcomes they experience. Despite its contributions to the field, Summit's model is based solely on his clinical work with CSA survivors (Freeman & Morris, 2001).

Finkelhor and Browne's (1985) model has been empirically examined and has received mixed support. There is evidence that the traumagenic dynamics outlined in the model are common in CSA survivors. Traumatic sexualization is evident in the finding that CSA victims are more sexually precocious as children and adolescents (Beitchman et al., 1991), and as adults engage in greater sexual activity and sexual risk taking behaviours (Fergusson et al., 1997) than their nonabused peers. Further, studies found stigmatization to mediate the association between CSA and psychological outcomes (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996a; Gold, 1986; Kessler & Bieschke, 1999; Wyatt & Newcomb, 1990). However, stigmatization was found to be inconsistently associated with adult relationship functioning (Arata, 2000; Filipas & Ullman, 2006; Kallstrom-Fuqua et al., 2004). Compared to traumatic sexualization and stigmatization, there has been less support for the mediation of adult outcomes of CSA through the traumagenic dynamics of betrayal (Kallstrom-Fuqua et al., 2004) and powerlessness (Coffey et al., 1996a; Draucker, 1995).

Summit's (1983) and Finkelhor and Browne's (1985) models can also be criticised for a lack of specificity regarding the relationship outcomes they seek to explain. For example, Summit does not identify which relationship outcomes the model is intended to explain beyond a general description of deficits in intimacy and trust. Likewise, the objectives of Finkelhor and Browne’s model are obscured due to seeking to explain such a diversity of adult outcomes. Another criticism of Summit’s and Finkelhor and Browne’s models is that, due to their focus on the family context in which the abuse occurs, they are only applicable to women who experience CSA by a family member, and therefore do not apply to cases of extrafamilial CSA (Freeman & Morris, 2001). Furthermore, these models do not explain how the relationship difficulties experienced by CSA survivors are maintained in adulthood, and why not all females with a history of CSA experience these outcomes.

*Developmental Models of Adult Relationship Functioning of Child Sexual Abuse Survivors*

*Cole and Putnam's developmental model.* Cole and Putnam (1992) proposed a developmental model to explain the association between CSA and adult relationship outcomes. Cole and Putnam argued that CSA would disrupt the child's ability to master critical developmental tasks and would lead to the use of maladaptive coping strategies and inhibit the use of effective coping skills. Cole and Putnam proposed that the types of coping strategies used would depend on the age and developmental period at which the abuse occurred. The use of these coping strategies was proposed to be associated with a failure to develop a sense of confidence and trust in adult intimate relationships. Cole and Putnam recognised the importance of the family environment in moderating the effect of CSA on adult relationship outcomes. Cole and Putnam proposed that if the nonoffending parent colluded with the abusive parent CSA survivors would experience more negative outcomes, and that supportive relationships either within or external to the family of origin could moderate the effect of CSA on adult relationship functioning.

*Spaccarelli's developmental model.* Spaccarelli (1994) developed a model of the long-term effects of CSA based on the transactional theory of development which proposed that development occurs as a result of a series of personality-environment interactions that can result in either healthy or pathological outcomes, depending on the type of interactions occurring (Sameroff & Fiese, 1990). Spaccarelli outlined a framework to explain the negative adult outcomes of CSA survivors consisting of two tenets. The first tenet stated that children who experience CSA, are faced with a series of stressors and that the likelihood of experiencing adverse outcomes is in direct proportion to the number of these stressors (Spaccarelli, 1994). The second tenet is that the effects of CSA are mediated by negative cognitive appraisals and the use of problematic coping responses (Spaccarelli, 1994). According to Spaccarelli's model,

victims' cognitive appraisals and coping responses are affected not only by characteristics of the abuse, but also by environmental variables such as the quality of the parent-child relationship, and individual factors such as personality and developmental variables. Spaccarelli acknowledged the moderating impact of family-of-origin variables on the association between CSA and adult outcomes. Spaccarelli proposed that family dysfunction could amplify symptoms in CSA survivors by increasing the stress associated with the abuse or by reducing the victim's ability to develop more effective coping responses. Conversely, Spaccarelli proposed that a supportive family environment could protect CSA survivors from experiencing negative adult outcomes by fostering the use of active coping strategies to deal with the abuse and its sequelae.

*Alexander's application of attachment theory.* Alexander's (1992) conceptualisation of the relationship outcomes of CSA survivors used attachment theory. Attachment theory, developed by Bowbly (1969, 1973, 1977, 1980) proposed that attachments are formed through interactions between the child and caregivers early in life. The type of attachment relationship that is formed depends on the extent to which the caregiver is consistently available and loving in response to the infant's needs (Bowbly, 1977). Through multiple attachment-related experiences the child develops internal cognitive models and expectancies of the self and the attachment figure, which are believed to generalise to expectancies about the individual's and others' roles in adult relationships (Bowbly, 1977).

Bartholomew and Horowitz (1991) refined Bowbly's (1977) concept of representational models, proposing the development of two internal working models. The first is a model of self that comprises an individual's belief about their worthiness of love and support (Bartholomew & Horowitz, 1991). The second is a model of the other, consisting of the individual's beliefs about the general trustworthiness and

availability of important others (Bartholomew & Horowitz, 1991). The theoretical development of these two internal working models resulted in the delineation of four attachment styles: secure, preoccupied, dismissive, and fearful (Bartholomew & Horowitz, 1991). A secure attachment involves a positive view of the self and others. A preoccupied attachment comprises a positive view of others but a negative view of self. A dismissive attachment involves a positive view of self but a negative view of others. A fearful attachment comprises a negative view of others and self (Bartholomew & Horowitz, 1991).

Alexander (1992) used attachment theory to explain why CSA survivors may avoid intimate relationships, engage in sexually risky behaviours, and experience sexual revictimisation. Alexander proposed that different types of insecure attachment may develop in response to CSA and are linked in specific ways to adverse reactions. For example, Alexander proposed that preoccupied CSA survivors are often hypervigilent, depressed, anxious, use alcohol or drugs to regulate intense affect, and are likely to become targets of revictimisation. Dismissive CSA survivors are likely to experience a sense of social isolation and estrangement from others, and use alcohol and drugs to suppress negative affect. A fearful attachment style could result in CSA survivors engaging in a compulsive form of sexuality in which the anxiety associated with close emotional relationships is avoided without necessitating the individual’s complete avoidance of contact with others (Alexander, 1992).

A strength of Alexander's (1992) application of attachment theory is that it explicitly recognised the importance of the family context in moderating the effect of CSA on adult relationship outcomes. Alexander proposed that other forms of child maltreatment, parental psychopathology and attachment history, and inadequate parenting (which have been found to be common in the family backgrounds of CSA

survivors), would increase the likelihood of a child developing an insecure attachment, which without mitigating experiences would be continued in adulthood.

*Greenberg and colleagues' emotion theory.* Another conceptualisation of the relationship outcomes of CSA survivors is Greenberg and his colleagues' emotion theory (Elliot & Greenberg, 2002; Greenberg & Bolger, 2001; Greenberg, Korman, & Paivio, 2002; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliot, 1993; Greenberg & Safran, 1989). Elliot and Greenberg (2002) proposed that CSA would result in the development of maladaptive schemas including the belief that being intimate with others causes harm. Elliot and Greenberg argued that these schemas could be strengthened or attenuated by family-of-origin functioning. CSA survivors would have these schemas activated by intimate relationships, and physiological arousal and negative beliefs and expectations would be evoked. Greenberg and his colleagues proposed that the activation of these maladaptive schemas could result in relationship problems for CSA survivors including the avoidance of intimacy, relationship conflict, and sexual problems (Elliot & Greenberg, 2002; Greenberg & Bolger, 2001; Greenberg et al., 2002; Greenberg & Paivio, 1997; Greenberg et al., 1993).

These developmental models have several strengths regarding their explanation of the association between CSA and adult relationship outcomes. First, these models have identified some important mediating variables of the association between CSA and adult relationship outcomes including attachment, attributions, cognitive schemas, and coping strategies. Second, these models have been based on established theory and have received some empirical support. Consistent with both Spaccarelli's (1994) and Cole and Putnam's (1992) models, CSA survivors made significantly more negative self attributions that were internal, global, and stable and attributed positive outcomes to external events significantly more often than their nonabused counterparts (Gold, 1986; Mynatt & Allgeier, 1990; Wenninger & Ehlers, 1998). In addition, negative self-

attributions were found to mediate the association between CSA and adult psychological outcomes (Gold, 1986; Mynatt & Allgeier, 1990; Wenninger & Ehlers, 1998; Wyatt & Newcomb, 1990). However, negative self-attributions were not found to mediate the association between CSA and adult relationship outcomes (Mandoki & Burkhart, 1989; Mayall & Gold, 1995; Runtz & Briere, 1986). Therefore, Spaccerelli's and Cole and Putnam's models may be more useful in explaining psychological rather than relationship outcomes of CSA survivors.

Alexander's (1992) application of attachment theory to explaining the relationship outcomes of CSA survivors has also received some empirical support: CSA survivors were found to be significantly more likely than their nonabused peers to have an insecure attachment, and in particular a fearful attachment in adulthood (Alexander et al., 1998; Kutil, 2000; Roche et al., 1999; Styron & Janoff-Bulman, 1997; Whiffen et al., 1999). Adult attachment was also found to mediate the association between CSA and several psychological outcomes (Alexander et al., 1998; Roche et al., 1999; Styron & Janoff-Bulman, 1997). In an attempt to explain the impact of attachment as a mediator of the association between CSA and adult relationship outcomes, Alexander et al. (1998) proposed that different subtypes of insecure attachment would be related to relationship functioning differentially. For example Alexander et al. proposed that women with fearful attachment styles might develop a strategy of compulsive sexuality, while women with a preoccupied attachment may be more likely to enter and remain in unhealthy relationships where they may be physically, psychologically, and/or sexually abused. Alexander et al. provided some support for these assertions: she found women with fearful attachments to be less likely, and preoccupied individuals to be more likely, to be in a committed relationship than other individuals. Further empirical examination of attachment as a mediator of the relationship outcomes of CSA survivors is warranted.

Another strength of these developmental models is they recognise the importance of family-of-origin functioning as a moderator of the impact of CSA on adult outcomes. These models have proposed that family-of-origin dysfunction could moderate the impact of CSA on adult relationship outcomes by reducing the opportunity for the development of adaptive coping strategies (Cole & Putnam, 1992; Spaccarelli, 1994), and a secure attachment (Alexander, 1992).

Although these developmental models have identified important mediating variables of the association between CSA and adult relationship outcomes, they have some limitations. First, these models cannot explain relationship functioning in survivors of extrafamilial CSA as they have focused on the importance of contextual factors within the abusive family environment. Second, although these models have explained the development of difficulties resulting from CSA clearly, they do not elucidate how these problems are maintained in adulthood.

*A Synthesis of the Models of the Association Between Child Sexual Abuse and Adult Relationship Functioning*

Several theoretical models have been proposed to explain the association between CSA and adult relationship outcomes. These models have some strong similarities. First, all of these models have proposed that experiencing CSA leads to the generation of negative affect and / or cognitions concerning the self and / or intimate relationships. Second, many of these models have postulated that in order to reduce this negative affect, thoughts, or behavioural outcomes, CSA survivors use maladaptive coping strategies that can have detrimental effects on adult relationships. Third, most of these models have recognised that family-of-origin factors moderate the effect of CSA on adult relationship outcomes.

However, these models also have some differences. First, these models have differed regarding the mechanisms through which they have proposed CSA leads to the development of negative affect and / or cognitions and maladaptive coping strategies, with some focusing on the nature of the abuse or how it is responded to by the victim's family (Finkelhor & Browne, 1985; Summit, 1983) and others attending to the development of cognitive schemata and attachment relationships (Alexander, 1992; Cole & Putnam, 1992; Spaccarelli, 1994). Second, the models have differed in regards to the importance they have placed on family-of-origin dysfunction in moderating the effect of CSA on adult relationship outcomes. Third, the models have differed in the extent to which they have explained how the mediating variables influence adult behaviour of CSA survivors and the types of adult outcomes they seek to explain.

Although, these models have identified some important moderator and mediator variables of the association between CSA and adult relationship outcomes, including family dysfunction, attachment, and the use of maladaptive coping strategies, several criticisms can be made of them. First, many of these models are largely descriptive and have not been empirically evaluated. Second, most of these models do not operationalise variables in a manner which allows them to be easily empirically tested. For example, how would one go about assessing the 'secrecy and helplessness' of the family environment of CSA survivors as outlined by Summit (1983), or the process through which traumatic sexualization (Finkelhor & Browne, 1985) occurs, or the personality-environment interactions as outlined by Spaccarelli's (1994) model? Third, although these models seek to explain adult relationship outcomes in CSA survivors they often do not clearly define what these are. Unlike the general couple literature in which the dependent variable is first clearly articulated (i.e., relationship satisfaction, communication, or physical assault), and theoretical models are then constructed with these in mind, this field seems to focus largely on the independent variable (i.e., the

CSA experience), and in doing so the types of adult relationship difficulties they are seeking to explain are often obscured. Fourth, none of these models have clearly outlined the mechanisms by which the relationship problems caused by contextual dynamics (Finkelhor & Browne, 1985; Summit, 1983), attachment relationships (Alexander, 1992), attributions (Cole & Putnam, 1992; Spaccarelli, 1994), or schemata (Elliot & Greenberg, 2002) are maintained in adulthood. Fifth, many of these models by focusing on the family context in which CSA occurs cannot account for adult difficulties of women abused by an extrafamilial perpetrator. Sixth, none of these models has adequately explained why only some women who experience CSA have poor adult relationship outcomes. In conclusion, it is argued that by focusing primarily on the context in which the abuse occurs these models provide a useful but only partial explanation of the association between CSA and adult relationship outcomes. In order to provide a more comprehensive explanation of this association both the childhood phenomena leading to the establishment of these sequelae and the factors which maintain it in adulthood need to be accounted for.

### *Polusny and Follette's Emotional Avoidance Model*

Polusny and Follette (1995) proposed a behavioural model of the relationship outcomes of CSA survivors based on Hayes and colleagues' (1994) theory of experiential avoidance. Polusny and Follette's model contains two major tenets; first that behaviour is best understood in terms of its function as opposed to its topography; that is, when trying to understand the behaviour of sexual intercourse, we would not look to the form or type of sexual intercourse, rather we would look to the function that sexual intercourse is serving for the individual (e.g., emotional closeness) (Polusny & Follette, 1995). The second tenet is that the function of a particular behaviour is related to both proximal and distal factors (Polusny & Follette, 1995). Distal factors refer to

the individual's learning history including the CSA experience, whereas proximal variables refer to aspects of the current relationship (Polusny & Follette, 1995).

A recent update of this model to incorporate principles of learning theory (Leonard & Follette, 2002) proposed that CSA serves as a distal event, which results in the development of negative associations with sex and intimacy through the process of classical conditioning. Although Leonard and Follette proposed that the negative associations would primarily involve affect, it is also possible, using social learning theory, to extrapolate this to the development of an insecure adult attachment and extreme gender role beliefs. Second, in order to avoid or reduce the aversive affect and cognitions associated with sexual or intimate stimuli, Leonard and Follette proposed that avoidant coping strategies are used, and these strategies are negatively reinforced by a reduction of the aversive affect. However, engaging in these coping strategies is proposed to lead to negative relationship outcomes (Leonard & Follette, 2002).

It is argued that the model of emotional avoidance (Leonard & Follette, 2002; Polusny & Follette, 1995) is the most advantageous theoretical explanation of the association between CSA and adult relationship functioning for three reasons. First, as will be demonstrated in this chapter, the model of emotional avoidance is consistent with empirical research concerning CSA survivors and the development of relationship difficulties. Second, due to its focus on behavioural outcomes, the model of emotional avoidance can be easily empirically evaluated. Third, the model of emotional avoidance improves on prior models by focusing on the current behaviour of CSA survivors to explain how relationship difficulties are maintained in adulthood.

*The Development of Negative Associations with Sex and Intimacy by Child Sexual Abuse Survivors*

A key proposition of the model of emotional avoidance is that through classical conditioning CSA survivors develop negative associations with sex and intimacy. Although not postulated by Leonard and Follette's (2002) and Polusny and Follette's (1995) emotional avoidance model, it is probable that the experience of CSA would result not only in negative affect, but also in the development of negative cognitions concerning sexuality and intimate relationships. Social learning theory proposed that an individual's behaviour is determined by its outcomes (Bandura, 1977; Rotter, 1982). Both Rotter (1982) and Bandura (1977) argued that through direct experience in childhood, an individual learns that certain behaviours will lead to particular outcomes, and as a result expectancies concerning these behaviours are developed and applied to new situations. It is proposed that experiencing CSA could lead to the development of an insecure adult attachment and extreme gender role beliefs.

There is evidence to support the proposition that CSA could lead to the development of an insecure adult attachment. Children who experience CSA were found to be more likely to be insecurely attached to their primary caregivers than those who had not (Carlson, Cicchetti, Barnett, & Braunwald, 1989a; Egeland & Sroufe, 1981; Friedrich, 1990, 1996; Lyons-Ruth, Connell, Zoll, & Stahl, 1987; Styron & Janoff-Bulman, 1997), and continuity of attachment to primary caregivers in childhood to attachment to adult intimate partners has been demonstrated (Ainsworth, Blehar, Waters, & Wall, 1978; Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Main & Goldwyn, 1988; Shaw & Vondra, 1995; Urban, Carlson, Egeland, & Srouge, 1991). Significantly higher rates of insecure attachment were found in CSA survivors' adult relationships compared to those of their nonabused peers (Alexander, 1992; Roche et al., 1999; Swanson & Mallinckrodt, 2001; Whiffen et al., 1999). In particular, CSA was

associated with higher levels of fearful adult attachment, characterised by both a fear of being abandoned by one's partner and of experiencing discomfort with intimacy (Alexander, 1992; Alexander et al., 1998; Kutil, 2000; Roche et al., 1999).

Incorporating attachment theory into the explanation of why CSA survivors experience difficulties in adult intimate relationships also serves as a vehicle through which the moderating impact of family-of-origin factors on adult outcomes can be explicated. Alexander (1992) proposed that an insecure attachment could either precede or be the result of CSA in one's family of origin. However, Alexander argued that the actual relationship context of the abuse, rather than the abuse itself, would determine the nature of the CSA survivor's attachment style. In accordance with Alexander's reasoning, those individuals abused by a family member would be more likely to develop an insecure attachment, while women abused by extrafamilial perpetrators would be expected to have more opportunity to be exposed to positive attachment relationships (e.g., within the family) that may contribute to more secure attachments. There is some evidence to support this proposition: CSA survivors abused by family members were found to have greater attachment avoidance (Swanson & Mallinckrodt, 2001), and anxiety (Whiffen et al., 1999), and to be more likely to have a fearful attachment (Roche et al., 1999), than women abused by extrafamilial perpetrators.

There is also evidence for the proposition that CSA could lead to the development of extreme gender role beliefs. There is considerable evidence that gender role beliefs develop very early in life and are strongly influenced by parental attitudes and behaviour (Arliss, 1991; Santrock, 1994; Witt, 1997). As children of parents who hold extreme gender role beliefs are more likely to experience CSA than those with parents who hold more flexible beliefs (Allen & Pothast, 1994; Finkelhor, 1980), CSA survivors may be more likely than their nonabused peers to develop hyperfeminine beliefs. Hypermasculinity and hyperfemininity are exaggerated or extreme gender roles

(Ray & Gold, 1996). Hypermasculinity is exemplified by beliefs that violence is manly, danger is exciting, and sexually callous attitudes towards women are appropriate (Mosher & Sirkin, 1984). Hypermasculine men report higher levels of acceptance of rape myths, interpersonal violence, and have more hostile attitudes towards women (Breitenbecher, 1999; Murnen & Byrne, 1991). Similarly, hyperfemininity refers to an extreme and exaggerated adherence to the feminine gender role exemplified by an emphasis on the importance of relationships with men, the use of sex to gain or maintain a romantic relationship, and the preference for hypermasculine behaviour in partners (Murnen & Byrne, 1991). Hyperfeminine women are described as being passive and dependent in their intimate relationships and valuing themselves as sexual objects (Weis & Borges, 1973). Hyperfemininity is associated with an increased acceptance by women of rape myths and abusive relationships, higher levels of sexual and verbal aggression for both men and women, and less sexual and relationship satisfaction (Murnen & Byrne, 1991; Ray & Gold, 1996; Xenos & Smith, 2001). Hyperfeminine women are more attracted to, and more likely to form and maintain relationships with, hypermasculine men who were more violent, than nonhyperfeminine women (Maybach & Gold, 1994; McKelvie & Gold, 1994; Murnen & Byrne, 1991).

The relationship between CSA and hyperfemininity has only been investigated in one study. Maybach and Gold (1994), in a study of 126 students, found that of the 14 women who reported a history of CSA, 10 were high in hyperfemininity. However, due to the small number of CSA survivors, the relationship between CSA and hyperfemininity could not be effectively evaluated (Maybach & Gold, 1994). However, other studies have found CSA survivors to exhibit behaviour and opinions consistent with hyperfeminine gender role beliefs. For example, CSA survivors were found to establish relationships with men characterised by more extreme gender roles (Compton & Follette, 1998). In addition, Jehu (1988), using a clinical sample, found 86% of CSA

survivors to endorse the statement that “No man could care for me without a sexual relationship,” and that 30% of CSA survivors reported oversexualising relationships with men, while 50% reported doing so in the past. Due to the very nature of CSA, a female victim is likely to be encouraged to be both passive and dependent in her relationship with the perpetrator and to learn to view herself as a sexual object. As most perpetrators of female CSA are male, it is likely that the victim will associate these characteristics with future intimate relationships with men.

There is also some evidence that an insecure adult attachment and extreme gender roles may be related. McKelvie and Gold (1994) hypothesised that hyperfemininity may be associated with attachment anxiety due to both of these constructs being associated with a negative view of self and a positive view of others, high emotional expressiveness, and dependence on others. This proposition was supported by Riggs (2000) who found hyperfeminine women were more likely to have an anxious attachment to their partner than nonhyperfeminine women. Therefore, CSA survivors through their abuse and family-of-origin experiences may be more likely to develop an insecure adult attachment and hyperfeminine gender role beliefs, and these negative expectancies of intimate relationships appear to be related to one another.

*The Use of Emotionally Avoidant Coping Strategies by Child Sexual Abuse Survivors*

There is also evidence for the proposition of Leonard and Follette's (2002) and Polusny and Follette's (1995) emotional avoidance model that (a) negative associations with sex and intimacy (i.e., insecure attachment, and hyperfeminine gender role beliefs) are associated with an increased use of avoidant coping strategies; (b) that CSA survivors use more avoidant coping strategies than their nonabused peers; and (c) engaging in these avoidant coping strategies is associated with negative relationship outcomes. This review considers two examples of avoidant coping strategies that CSA

survivors may use to reduce negative thoughts and feelings concerning intimate relationships: multiple short-term sexual relationships and a high level of alcohol consumption.

There is evidence that an avoidant attachment is associated with an increased use of avoidant coping strategies. Fraley and Shaver (2000) proposed that the avoidance dimension of attachment regulates attachment-relevant behaviour, particularly during stressful situations, and those high in attachment avoidance would be more inclined to use avoidant coping strategies (Fraley & Shaver, 2000). Consistent with Fraley and Shaver's proposition, individuals with an avoidant attachment were found to have more short-term sexual relationships than those with a more secure attachment (Brennan & Shaver, 1995; Feeney & Noller, 2004; Gentzler & Kerns, 2004; Simpson, 1990).

There is also evidence that CSA survivors have more short-term sexual relationships than their nonabused peers and that engaging in this avoidant coping behaviour is associated with avoidant attachment in these women. Some CSA survivors reported a decreased sexual desire and a tendency to avoid sexual activity and even intimate relationships altogether (Jackson et al., 1990; Jehu, 1988; Kinzl et al., 1995; Sarwer & Durlak, 1996; Stein et al., 1988; Westerlund, 1992). Other CSA survivors reported having a strong desire for sexual contact and a tendency to engage in multiple short-term relationships (Herman & Harvey, 1997; Leonard & Follette, 2002; Noll et al., 2003). Leonard and Follette (2002) proposed that although topographically these behaviours are seemingly opposite, both have the same function of avoiding negative affect associated with sex and intimacy. The negative affect associated with sex and intimacy experienced by CSA survivors appears to be most pronounced in intimate, as opposed to casual, sexual relationships (Davis & Petretic-Jackson, 2000). For example, Westerlund (1992) found that when CSA survivors perceived their relationships as being more intimate they reported feeling more dependent and vulnerable, which they

described as being unpleasant. Therefore, the multiple short-term sexual relationships of CSA survivors may operate to meet their sexual needs without interference from negative affect associated with an avoidant attachment (Alexander, 1992; Jehu, 1988; Westerlund, 1992).

There is also evidence that engaging in multiple short-term sexual relationships is associated with negative relationship outcomes. CSA survivors' involvement in multiple short-term sexual relationships predicts sexual revictimisation (Breitenbecher, 2001; Fergusson & Mullen, 1999; Koss & Dinero, 1989; Krahe, 2000; Messman-Moore & Long, 2003). Two mechanisms have been proposed to account for the relationship between short-term sexual relationships and revictimisation: (a) women who have more sexual partners are more likely to encounter a sexually aggressive male (Koss & Dinero, 1989; Krahe, 2000; Messman-Moore & Long, 2003), and, (b) these women's negative self-perceptions regarding their sexuality may make them more likely to be associated with potential perpetrators of sexual abuse (Breitenbecher, 2001; Fergusson & Mullen, 1999; Koss & Dinero, 1989; Messman-Moore & Long, 2003). However engaging in short-term relationships that lack intimacy predicts sexual and relationship dissatisfaction (Hawton, Catalan, & Fagg, 1992; McCabe, 1999; Rosen & Leiblum, 1995a; Wincze & Carey, 2001; Young, Denny, Young, & Luquis, 2000).

There is also evidence to support the proposition that CSA survivors consume more alcohol than their nonabused peers, and that engaging in this avoidant coping strategy is associated with a fearful attachment and hyperfeminine beliefs. CSA survivors are significantly more likely to abuse alcohol than other women (Briere & Runtz, 1988b; Fleming et al., 1999; Kinzl & Biebl, 1992; Messman-Moore & Long, 2003; Mullen et al., 1996). It was proposed that CSA survivors may use alcohol to alleviate negative feelings associated with sex and intimacy (Messman-Moore & Long, 2003; Westerlund, 1992). Consistent with the proposition that alcohol abuse may be

related to negative views of sex, negative attitudes about sex were found to be more prevalent in women who were heavy drinkers in comparison to those who drink moderately (Klassen & Wilsnack, 1986). Female heavy drinkers were found to have positive expectancies concerning the effects of alcohol on sex (Klassen & Wilsnack, 1986; Leigh, 1990), and to use alcohol to reduce their sexual inhibitions (Norris, 1994).

There is also evidence that a fearful attachment, that is individuals with high levels of both attachment avoidance and anxiety are more likely to engage in this avoidant coping strategy. Individuals with a fearful attachment were found to experience great difficulty with affect regulation in intimate relationships (Alexander, 1992), and to use alcohol to reduce negative affect (Alexander, 1992; Bartholomew & Horowitz, 1991; Brennan & Shaver, 1995; Cooper, Shaver, & Collins, 1998). Hyperfeminine gender role beliefs were also found to be associated with higher levels of alcohol use (Ray & Gold, 1996).

There is also evidence that drinking high levels of alcohol is associated with negative relationship outcomes. Alcohol abuse is associated with a high risk for sexual revictimisation (Breitenbecher, 2001; Koss & Dinero, 1989; Messman-Moore & Long, 2002): It is associated with as many as 80% of sexual assaults (Nurius, 2000). Alcohol use was found to increase the likelihood that males will be sexually aggressive (Grauerholz, 2000; Nurius, 2000), and to impair problem solving and escape behaviours by women (Grauerholz, 2000; Messman-Moore & Long, 2002; Nurius, 2000). In addition, women who drink alcohol are likely to encounter sexually aggressive males in the settings in which alcohol is consumed (Messman-Moore & Long, 2003), and at least some men perceive women who are drinking as more sexually responsive (Messman-Moore & Long, 2003). In contrast to some men's perceptions, heavy drinking is actually associated with a lack of sexual interest, decreased sexual arousal, and inability to achieve orgasm (Norris, 1994; Wilsnack, 1984). Alcoholic women experience high

rates of sexual dysfunction (Covington & Kohen, 1984), and even moderate alcohol use in women has been found to decrease sexual responsiveness (Norris, 1994). Alcohol abuse in women is also associated with relationship distress (Kelly, Halford, & Young, 2002a, 2002b; Olenick & Chalmers, 1991).

In conclusion, the model of emotional avoidance proposed that to alleviate negative affect associated with sex and intimacy arising from their abuse experiences, CSA survivors used avoidant coping strategies, which are associated with relationship problems. CSA survivors experience more negative affect and expectancies concerning sex and intimacy, are more likely to form insecure attachments to their adult partners, and to engage in hyperfeminine gender role behaviour, than their nonabused peers. CSA survivors engage in higher rates of short-term casual sexual relationships and drink alcohol at higher levels than their nonabused peers. CSA survivors appear to engage in these behaviours as a way of dealing with negative associations with sex and intimacy, particularly in response to an insecure attachment and extreme gender role beliefs. However, engaging in these avoidant coping behaviours is associated with negative relationship outcomes. Despite this wealth of evidence supporting the use of the emotional avoidance model to explain the association between CSA and adult relationship functioning, to date it has not been empirically evaluated, and therefore this dissertation sought to examine this model.

### *Resiliency to Negative Relationship Outcomes by Childhood Sexual Abuse Survivors*

Leonard and Follette's (2002) and Polusny and Follette's (1995) emotional avoidance model sought to explain the risk factors associated with negative relationship outcomes of CSA survivors, but did not address protective factors. Research concerning resiliency to the long-term sequelae of CSA is limited. As described in the coping literature, during a stressful event avoidant coping strategies can be beneficial,

especially when an individual has limited resources they can mobilise and the stressor is outside of their control (Lazarus & Folkman, 1984; Roth & Cohen, 1986). However, the use of avoidant coping strategies over time prevents the resolution of the stressful event, and has been found to lead to negative outcomes (Lazarus & Folkman, 1984; Roth & Cohen, 1986). In contrast, approach-oriented coping initially may increase distress as it involves confronting the stressor, but has been found to result in the resolution of the trauma and increased self-efficacy in dealing with such events (Lazarus & Folkman, 1984; Mullen & Suls, 1982). Consistent with this pattern, during childhood avoidance coping in response to CSA was found to be beneficial (Chaffin, Wherry, & Dykman, 1997; Merrill et al., 2001). However, during adulthood the use of approach-oriented coping strategies was associated with better psychological outcomes (Bal, Crombez, Oost, & Debourdeaudhuij, 2003; Binder et al., 1994; Coffey et al., 1996b; Draucker, 1995; Gold, 1986; Himelein & McElrath, 1996; Thompson et al., 2003; Wyatt & Newcomb, 1990).

Research concerning resiliency to the long-term outcomes of CSA, has focused on coping directly with the experience of CSA or with stress in daily life and the psychological outcomes associated with the use of these coping strategies (Brand & Alexander, 2003). The current study aims to extend this work to how CSA survivors cope with negative expectancies concerning intimate relationships, and the effect of these coping strategies on relationship outcomes.

It is argued that a major ‘approach’ coping strategy CSA survivors may use within their adult intimate relationships to cope with negative thoughts and feelings is relationship self-regulation. According to Halford, Sanders, and Behrens (1994) relationship self-regulation involves the ability to modulate thought, affect, and behaviour within an intimate relationship. Halford et al. proposed that relationship self-regulation consists of four key metacompetencies: appraisal, goal setting,

implementation of change, and evaluation of change efforts. Appraisal of relationship functioning involves the individual describing to their partner both helpful and unhelpful behaviours occurring within their relationship, the causes of those behaviours, and their outcomes, in a manner which enhances the relationship (Wilson et al., 2005). The second metacompetency, self-directed goal setting, involves the individual defining specific goals for change in their own behaviour in response to appraising relationship functioning (Wilson et al., 2005). The third metacompetency is implementation, in which the individual takes active steps to achieve the relationship goals identified (Wilson et al., 2005). The last metacompetency involves the individual evaluating the outcomes of their behaviour in achieving the desired relationship changes (Wilson et al., 2005).

Engaging in relationship self-regulation strategies is positively associated with relationship satisfaction (Collins & Feeney, 2000; Cramer, 2004; Wilson et al., 2005). Cramer (2004) proposed that by working together on the relationship and individual concerns that affect it, couples can prevent individual distress and relationship conflict, and increase the emotional intimacy within the relationship. The level of emotional closeness in a relationship was also found to significantly predict individual well-being and relationship satisfaction (Gottman & Levenson, 1986). Therefore, viewing individual concerns as shared couple issues, discussing these together as a couple, and working to improve the relationship are central to creating a satisfying intimate relationship.

Another factor that may protect CSA survivors from experiencing negative relationship outcomes in adulthood is social support. CSA survivors, who received social support from their family during childhood, or as an adult from friends and family, were found to experience more positive psychological outcomes than those who did not (Conte & Schuerman, 1987; Gold, 1986; Spaccarelli, 1994; Testa et al., 1992;

Wyatt & Newcomb, 1990). Although CSA survivors have been found to have difficulty in communicating to their partners their feelings and personal concerns (Bendixen et al., 1994; Briere & Runtz, 1988b), those who seek support, especially from their partners, experience fewer psychological symptoms (Alexander, 1993; Feinauer et al., 1996; Gold, Hughes, & Hohnecker, 1994; Valentine & Feinauer, 1993). Couples who engage in more supportive and caring behaviours have also been found to be more satisfied with their relationship (Collins & Feeney, 2000; Cramer, 2004). Although few studies have examined the role of social support in sexual functioning, one study found support provided both within and external to an intimate relationship to be associated with increased sexual satisfaction (Ojanlatva et al., 2005).

Another factor that may protect CSA survivors from experiencing negative relationship outcomes in adulthood is sexual assertion. Sexual assertion, according to Morokoff et al. (1997) involves the ability to initiate wanted sexual activity and to refuse unwanted sexual activity. Women, particularly CSA survivors, who were more sexually assertive, were found to be more satisfied with their intimate relationship and sex lives (Haavio-Mannila & Kontula, 1997; Morokoff et al., 1997), and less likely to experience adult sexual coercion and assault as an adult (Classen, Field, Koopman, Nevill-Manning, & Spiegel, 2001; Cloitre, Scarvalone, & Difede, 1997), than women who did not engage in sexually assertive behaviour. In summary, it is proposed that approach-oriented coping strategies including relationship self-regulation, seeking social support, and sexual assertion could protect CSA survivors from experiencing negative relationship outcomes in adulthood.

Although approach-oriented coping strategies may protect CSA survivors from experiencing negative relationship outcomes in adulthood, these women may be less likely than others to develop and use these effective coping strategies. Social learning theory proposed that in the process of observing their parents and noting what

behaviours are reinforced and punished children learn patterns of behaviour they tend to repeat in later relationships (Pape Cowan & Cowan, 2005). Researchers have proposed that relationship expectations and interpersonal behaviour are learnt in one's family of origin (O'Leary, 1988; Story, Karney, Lawrence, & Bradbury, 2004; Tallman, Gray, Kullberg, & Henderson, 1999). For example, children of parents who are warm, nurturing, supportive, responsive, set limits on behaviour, and provide age-appropriate autonomy, demonstrate more competence in their relationships with peers and adult intimate partners (Conger, Ge, Elder, Lorenz, & Simons, 1994). Poor parenting practices, including harsh and inconsistent discipline, poor supervision of children, and poor family problem solving, are associated with a failure to acquire the social skills necessary to engage in productive social relationships, and rejection by nondeviant peers (Capaldi, DeGarmo, Patterson, & Forgatch, 2002; Capaldi, Pears, Patterson, & Owen, 2003; Dishion, French, & Patterson, 1995; Patterson, 1997). These poor parenting practices are also associated with problems in the adult intimate relationships of offspring including poor communication, less provision or receipt of social support from one's partner, lower relationship satisfaction, and relationship violence (Andrews, Foster, Capaldi, & Hops, 2000; Kwong, Henderson, & Trinke, 2003; Linder & Collins, 2005; Tallman et al., 1999). In addition, poor parental marital quality, especially marital conflict, is associated with relationship distress, violence, and dissolution in offspring (Andrews et al., 2000; Capaldi & Crosby, 1997; Tallman et al., 1999).

Parents of children who experienced CSA were found to experience more marital conflict, violence, and dissatisfaction; higher levels of divorce; and greater psychopathology, alcohol and substance abuse, and criminal behaviour than the parents of children who did not experience this form of abuse (Black et al., 2001a; Drake & Pandey, 1996; Fergusson et al., 1997; Friedrich et al., 1988; Higgins & McCabe, 1994; Maker et al., 2001; Moeller et al., 1993; Russell, 1983; Silbert & Pines, 1981). These

parental characteristics have been implicated in poor social and communication skills and adult relationship difficulties in offspring (Capaldi et al., 2002; Patterson, 1997). Therefore, because CSA often occurs in a context of family-of-origin dysfunction and this family dysfunction is associated with poor parenting practices, pro-social behaviour may not be modelled to CSA survivors. Due to this lack of parental modelling, CSA survivors may not develop and use approach coping strategies in their intimate relationships, and as a result may experience negative relationship outcomes.

It is also likely that the family environments which lead to a failure of offspring to develop the pro-social skills necessary for a satisfying relationship are also those that produce an insecure attachment. Many types of childhood maltreatment are associated with an insecure attachment to primary caregivers (Carlson, Cicchetti, Barnett, & Braunwald, 1989b; Stovall-McClough & Cloitre, 2006). Maternal depression, a dysfunctional parental marital relationship and lower relationship satisfaction, high parenting stress, and poor mother-child relationships are also associated with higher rates of insecure attachment in children (Davies & Cummings, 1994; Egeland & Farber, 1984; Moss, Bureau, Cyr, Mongeau, & St-Laurent, 2004; Moss, Rousseau, Parent, St-Laurent, & Saintonge, 1998). The family-of-origin characteristics associated with the development of insecure attachment in children are common in CSA survivors' families of origin (Black et al., 2001a; Drake & Pandey, 1996; Fergusson et al., 1997; Friedrich et al., 1988; Higgins & McCabe, 1994; Maker et al., 2001; Moeller et al., 1993; Russell, 1983; Silbert & Pines, 1981). Furthermore, insecure attachment in children is associated with negative and aggressive peer relationships and a lack of effective social skills (Cassidy, Kirsh, Scolton, & Parke, 1996; Lyons-Ruth, Alpern, & Repacholi, 1993). There is also evidence that without mitigating experiences those with an insecure attachment in childhood will continue this attachment in adult relationships

(Ainsworth et al., 1978; Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Main & Goldwyn, 1988; Shaw & Vondra, 1995; Urban et al., 1991).

There is also evidence to link insecure adult attachment to a lack of approach-oriented coping (Fraley & Shaver, 2000). Individuals with an avoidant attachment were found to give and seek less social support, particularly in response to stress, and to derive less positive feelings from it, than those with a secure attachment (Campbell, Simpson, Boldry, & Kashy, 2005; Collins & Feeney, 2000; Fraley & Shaver, 2000; Simpson, 1990). In addition, individuals with high levels of attachment anxiety were found to make more negative attributions about their partner's behaviour, to trust their partner less, and to be less satisfied with the social support they receive than securely attached women (Brennan & Shaver, 1995; Collins & Read, 1990; Hazan & Shaver, 1987; Simpson, 1990). Therefore, the lack of approach-oriented coping by CSA survivors with high levels of attachment avoidance may be due to not receiving positive benefits from seeking out help or support from interpersonal relationships. Conversely, women with high levels of attachment anxiety and hyperfemininity may not engage in approach oriented coping due to their fear of abandonment and expectation of rejection that leads them not to trust others to provide needed assistance (Fraley & Shaver, 2000; Murnen & Byrne, 1991; Ray & Gold, 1996). In conclusion, due to the context of family dysfunction in which CSA often occurs, survivors may fail to develop approach coping strategies in childhood as a result of either poor parental modelling of these behaviours or through the development of an insecure attachment, and there is evidence that this behaviour may continue into adulthood and lead to negative relationship outcomes.

### *Conclusions and Overview of the Research Program*

CSA is common in females and associated with a range of negative relationship outcomes in adulthood. However, CSA does not inevitably lead to these negative

outcomes. Aspects of the CSA experience, particularly the level of physical contact involved, the relationship of the victim and perpetrator, disclosure of the abuse, and the use of psychological coercion by the perpetrator, influence the effect of CSA on adult relationship outcomes. CSA often coincides with family-of-origin dysfunction, and there is evidence that characteristics of the abuse and the family environment are associated. However, researchers have been unable to reliably predict which CSA survivors will experience, on the basis of the nature of the abuse they endured or other family-of-origin factors, deficits in adult relationship functioning. Therefore, the first aim of this thesis was to better describe the diversity of CSA experiences and family-of-origin factors that account for the variability in adult relationship outcomes of CSA survivors.

The second aim of this thesis was to test a model seeking to explain the variables that mediate the association between CSA and adult relationship outcomes, which incorporates the model of emotional avoidance. The model of emotional avoidance proposed that CSA leads to the development of negative associations with sex and intimacy, and to cope with this aversive stimuli women use avoidant coping strategies which are associated with poor relationship functioning (Leonard & Follette, 2002; Polusny & Follette, 1995). In the current study, the negative associations CSA survivors have with sex and intimacy are represented by attachment avoidance and anxiety and hyperfeminine gender role beliefs, while examples of the avoidant coping strategies CSA survivors may use include engaging in multiple short-term sexual relationships and high levels of alcohol consumption.

Although the model of emotional avoidance explains factors which put CSA survivors at greater risk of experiencing relationship difficulties, it does not address protective factors. Approach-oriented coping strategies, including engaging in relationship self-regulation, seeking social support, and being sexually assertive, may

protect CSA survivors from experiencing negative relationship outcomes. As shown in Figure 1, these protective factors were integrated with the risk factors of the model of emotional avoidance to form the dual pathway model to be evaluated by this dissertation.

The findings of the dissertation are divided across two chapters. Chapter 4 addresses the first aim of the current study, to examine classes of CSA survivors and their association with relationship outcomes. Chapter 5 addresses the second aim of the current study, to test the proposed dual pathway model of the association between CSA and adult outcomes.

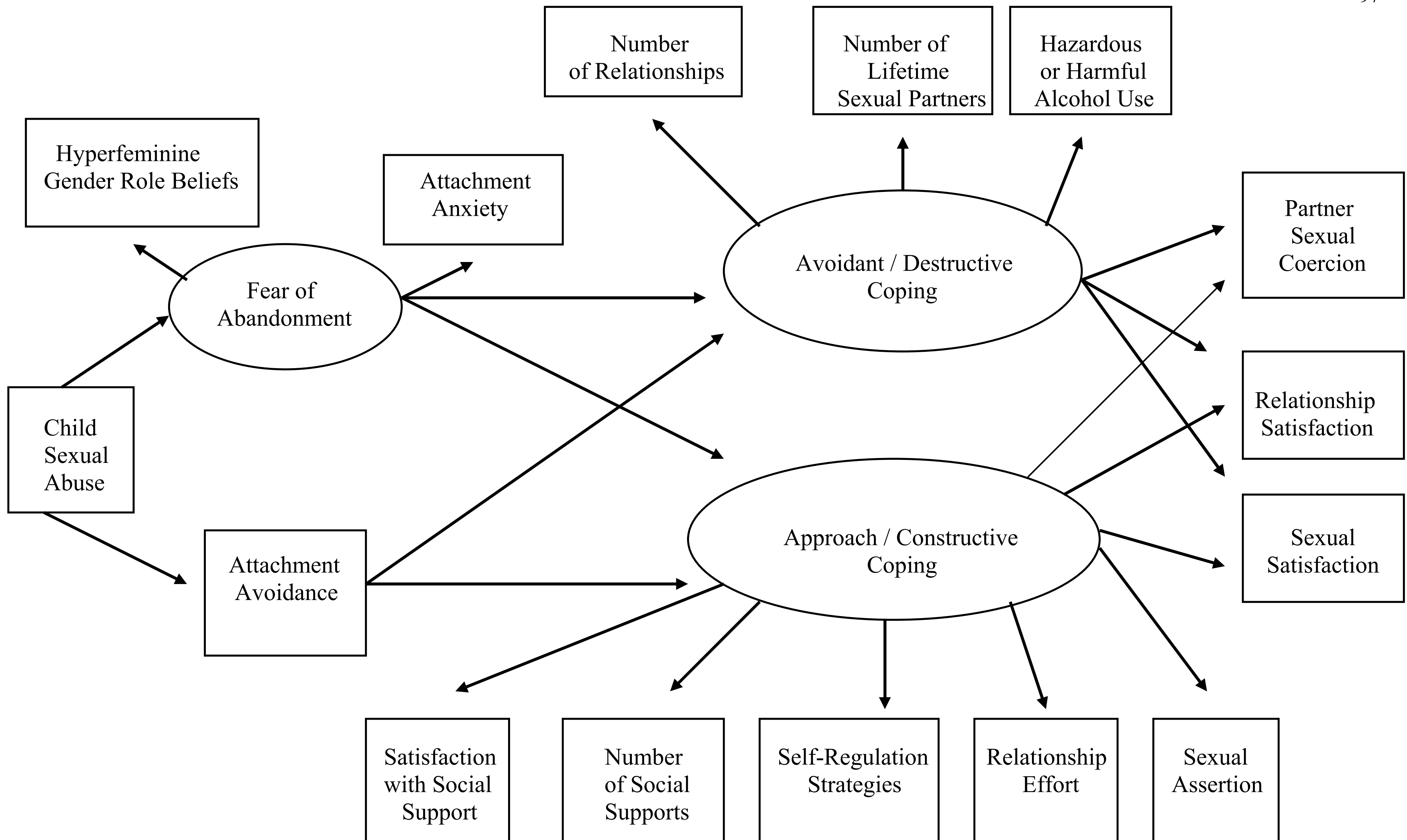


*Figure 1.* The proposed dual pathway model of the association between CSA and adult relationship outcomes.[2]

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[2] This is a heuristic model in which the boxes represent observed or manifest variables and the circles represent latent variables.

# CHAPTER FOUR

## Study Part 1: Classes of Child Sexual Abuse and Couple Relationship Outcomes

This chapter reports on the first part of a study assessing whether CSA of girls can be classified into meaningful classes, and whether these classes are associated with negative couple relationship outcomes for women in adulthood. As noted previously in this thesis, there have been prior attempts to classify CSA. Most of these attempts rated CSA severity on a single continuous scale, but severity by itself is not reliably associated with adult couple relationship outcomes (Draucker, 1995; Fassler et al., 2005; Maker et al., 2001; Merrill et al., 2003). In fact CSA severity is often found to be bimodally distributed (Haugaard, 2000), suggesting the presence of two or more classes of abuse rather than a continuum. Some recent approaches to classifying CSA have used cluster analysis using multiple aspects of abuse to define clusters, but again there was not a reliable association between identified clusters of CSA and couple relationship outcomes (Alexander & Schaeffer, 1994; Bennett et al., 2000; Hulme & Agrawal, 2004; Trickett et al., 2001).

In the current study Latent Class Analysis (LCA) was used, a technique developed to classify individuals into classes on the basis of multiple indicators, when the classes are unknown before the analysis (Uebersax, 1993). LCA has several advantages over cluster analysis including that the criteria for class membership are defined in terms of reducing deviance on the indicator variable, and that the analysis gives a reliable assessment of the accuracy of classification into classes (Uebersax, 1993; Vermunt & Magidson, 2000). Prior research has identified that each of the CSA characteristics of the level of physical contact with the victim by the perpetrator, the level of psychological coercion used by the perpetrator on the victim during the abuse, a close relationship of the victim and perpetrator, and a failure to disclose the abuse is associated with CSA survivors having poorer adult relationship outcomes (Alexander &

Schaeffer, 1994; Bennett et al., 2000; Hulme & Agrawal, 2004; Trickett et al., 2001). Therefore, in the current study these five variables were used as the indicators in LCA to define the classes of CSA.

Prior research (as outlined in chapter 2) has established that CSA survivors are significantly more likely than their nonabused peers to: (a) begin having consensual intercourse and give birth to their first child as a younger age; (b) have more lifetime sexual partners and short-term relationships; (c) separate and divorce; (d) experience partner-perpetrated sexual coercion and physical assault; (e) potentially perpetrate acts of sexual coercion and physical assault on their intimate partners; and, (f) be less satisfied with their intimate relationships and sex lives. Classes of CSA survivors may also experience different relationship outcomes. Higher levels of physical contact and psychological coercion, a more closely related perpetrator and lower levels of disclosure, are aspects of CSA that are associated with higher rates of negative relationship outcomes (Arata, 1998; Bagley, 1988; Basta & Peterson, 1990; Beitchman et al., 1991; Bifulco et al., 1991; Browne & Finkelhor, 1986; Cyr et al., 2006; Feinauer et al., 1996; Fergusson et al., 1997; Fleming et al., 1999; Herman et al., 1986; Jonzon & Lindblad, 2005; McLean & Gallop, 2003; Najman et al., 2005; Noll et al., 2003; Russell, 1983; Sarwer & Durlak, 1996; Saunders et al., 1992). Therefore, the current study sought to determine whether particular classes of CSA survivors differed on these relationship outcomes. Being able to determine which CSA survivors are most likely to experience negative relationship outcomes in adulthood is important. Relationship dysfunction places an enormous economic burden on our society (Halford, Kelly, & Markham, 1997; Standing Committee on Legal and Constitutional Affairs: House of Representatives, 1998). Therefore, being able to determine which CSA survivors are most at risk of relationship dysfunction would markedly improve specificity in targeting

treatment interventions and could have substantial public health and economic implications.

CSA survivors experience higher levels of family-of-origin dysfunction and child maltreatment than their nonabused peers. In particular, compared with their nonabused peers, CSA survivors' families of origin have elevated rates of parental divorce, marital conflict, parental marital dissatisfaction, and lower levels of family support (Bryer et al., 1987; Colman & Spatz Widom, 2004; Edwards & Alexander, 1992; Harter et al., 1988; Higgins & McCabe, 1994; Paveza, 1988; Weissmann-Wind & Silvern, 1994). Other forms of child maltreatment particularly child physical abuse and physical neglect are also experienced more frequently by CSA survivors compared with their nonabused peers (Black et al., 2001a; Dong et al., 2003; Finklehor et al., 2005; Ney et al., 1994). There is also evidence that family-of-origin dysfunction varies in a reliable way with CSA characteristics. Victims of intrafamilial CSA and those who experienced higher levels of physical contact were found to have higher rates of family-of-origin dysfunction than victims of extrafamilial CSA and those who experienced lower levels of physical contact (Alexander & Schaeffer, 1994; Bennett et al., 2000; Dong et al., 2003; Hulme & Agrawal, 2004; Long & Jackson, 1991). Therefore, the current study sought to determine whether classes of CSA survivors could be distinguished from one another on aspects of their family-of-origin functioning including parental divorce, marital conflict, parental marital dissatisfaction, family support, and other forms of child abuse. Clarifying the relationship between CSA characteristics and family-of-origin dysfunction is important; it would improve the ability to identify those most at risk of negative relationship outcomes and to target treatment inventions.

In summary, three key hypotheses are tested in the current study. The first prediction is that girls' experience of CSA can be meaningfully separated into distinct

classes on the basis of the level of physical contact involved in the abuse, the closeness of the relationship of the victim and perpetrator, whether the occurrence of abuse was disclosed, and the use of psychological coercion by the perpetrator (Hypothesis 1). Second, the current study tested the prediction that identifiable classes of CSA are associated with different couple relationship outcomes in adulthood (Hypothesis 2). Finally, it was predicted that there would be different levels of reported family-of-origin dysfunction in different classes of CSA survivors (Hypothesis 3).

## *Method*

### *Participants*

Five thousand women aged 18 to 41 years were randomly selected from the Australian electoral roll. The Australian Electoral Commission (AEC) provided name, address, gender, and age-range information for this approved medical research study in conformity with item 2 of subsection 90B(4) of the Commonwealth Electoral Act 1918 and sub regulation 10(1) of the Electoral and Referendum Regulations 1940 (Attorney-General's Department, 2003). Stratified random sampling from the electoral roll was performed whereby the number of names selected from each state and territory was consistent with the percentage of women living in these areas of the total female population aged 18 to 41 years. This recruitment strategy was chosen to maximise the representativeness of the sample of the broader female population. Nine of the elector extracts were identified to be of male gender. The remaining 4,991 women were sent a postal questionnaire investigating the relationship between childhood experiences and adult relationship functioning. Approximately 423 questionnaires were returned due to the individual moving residence. Of the remaining questionnaires, a total of 1,335 (29.23%) valid responses were received.

The mean age of the sample was 29.83 years (*SD* = 6.67). Most participants were employed; 42.4% on a full-time basis and 31.9% in part-time or casual work. Approximately 12.8% of participants were students. The mean income of the sample was $29, 668 (*SD* = $21,378) with a range of $0 to $82,000. The participants were well educated; more than half of the sample (63.3%) had received additional educational qualifications since completing secondary education. Most participants were born in Australia (87.8%) and half of the sample (46.5%) had an Australian ancestry. The remainder of the sample had a British (41.1%), European (16.1%), or Chinese (2.9%) background. Fifteen women (1.1%) were indigenous Australians, while 5 women (0.4%) were Torres Strait Islanders. Most participants (78.9%) were religious, predominantly Catholic (29.7%) or Anglican (22.2%).

The participants were generally in good health; 88.4% of the sample reported not currently suffering from a disease or other health condition listed. Despite their good health, participants reported a high rate of medication and health service usage. Two thirds of the sample (63.1%) reported taking medication in the last four weeks, most commonly the contraceptive pill (36.6%), painkillers (34.8%), and antidepressants (8.4%). A third (34%) of the sample had consulted a health worker during the last four weeks, and almost all participants (95.2%) described doing so over the last 12 months. Approximately 20.2% of the sample reported spending at least 1 day in hospital in the last year.

Three quarters of the sample (75.9%) were currently in an intimate relationship; 39.5% were married, 21.4% were in cohabiting relationships, and 14.9% were dating. Few women were currently separated (1.9%) or divorced (1.6%). Most participants (95.5%) were heterosexual. Approximately half (45.9%) of the sample had children; most of these women had three or fewer children (93%), less than five years of age (43.3%). Sixty-two participants (4.6%) were currently pregnant.

*Materials*

Seventeen self-report questionnaires were administered to participants. These questionnaires assessed demographic characteristics, CSA, adult sexual and relationship functioning (relationship satisfaction, sexual satisfaction, and self and partner sexual coercion and physical assault), proposed mediator variables (hyperfemininity, adult attachment, avoidant / destructive coping, and approach / constructive coping), family-of-origin functioning, and child abuse and neglect.

*Demographic characteristics.* The first questionnaire was used to collect demographic information concerning employment, income, education, religion, place of birth, ancestry, relationship status, information concerning offspring and sexual orientation, physical and mental health, and medication and health service usage. The general health (GHS) and mental health scales (MHS) from the Short-Form Health Survey (SF36) (Ware & Sherbourne, 1992) were included in the demographic questionnaire (see Appendix A). The GHS consists of a single-item rating of health, which asks participants to rate their health from excellent to poor, and four items from the Health Perceptions Questionnaire which are rated on a 5-point Likert scale from *definitely true* to *definitely false* (item e.g. “I seem to get sick a little easier than other people”) (Ware, 1993). The MHS consists of five items, which assess four major mental health dimensions (anxiety, depression, loss of behavioural / emotional control, and psychological well-being), on a 6-point Likert scale ranging from *all of the time* to *none of the time* (item e.g. “Have you felt downhearted and blue?”) (Ware & Sherbourne, 1992). Higher scores on the GHS and MHS indicate better health perceptions and mental health respectively (Ware & Sherbourne, 1992). Scott, Tobias, Sarfati, and Haslettt (1999) and Peek, Ray, Patel, Stoebner-May, and Ottenbacher (2004) reported high internal consistency for both the GHS ($\alpha$ = .82) and MHS ($\alpha$ = .80 and .82). The GHS is strongly correlated with other health measures, such as the Health

Perceptions Questionnaire, and is a good predictor of health service use, medical care expenditures, and a range of health outcomes (Ware & Sherbourne, 1992). The GHS and MHS reliably differentiate people with physical and mental illness from healthy populations (Adler, Bungay, Cynn, & Kosinski, 2000).

*Child sexual abuse.* CSA was assessed using the 9-item Early Sexual Experiences Checklist (ESEC) (Miller, Johnson, & Johnson, 1991) (see Appendix B). The ESEC provides a list of 10 unwanted sexual behaviours and asks participants to indicate those they experienced prior to 16 years of age. For the purposes of the current study, CSA was defined as any unwanted sexual behaviours with another person listed on the ESEC, occurring at 16 years of age or younger. The ESEC also asks questions regarding the age of onset of the abuse, age of perpetrator, relationship to perpetrator, frequency and duration of abuse, how upsetting the experience was when it occurred and currently (7-point Likert scale ranging from *not at all* to *extremely*), and types of psychological or physical force used by the perpetrator (Miller et al., 1991). Miller et al. (1991) found a 1-month test-retest reliability of $r = .92$ for the types of unwanted sexual behaviours endorsed on the ESEC. The ESEC has been found to capture CSA experiences not mentioned when brief general questions are used (Miller et al., 1991). The ESEC, however, does not include a full range of noncontact CSA acts, therefore four items were added to the initial checklist: “Another person verbally invited or requested to do something sexual with you”, “Other people engaged in sexual activities while you watched at their insistence”, “Someone touched or fondled your breasts, buttocks, or thighs”, and “Someone kissed or hugged you in a sexual way.” These items were taken from Finkelhor's (1979) Survey of Childhood Experiences. Questions were also added to the ESEC to measure the involvement of multiple perpetrators; disclosure of the abuse, and response to it; and the type and utility of any professional help sought.

*Adult sexual and relationship functioning.* Adult sexual and relationship functioning was assessed using the Abbreviated Dyadic Adjustment Scale (ADAS) (Sharpley & Rogers, 1984), the Female Sexual Function Index (FSFI) (Rosen et al., 2000), and the Revised Conflict Tactics Scale (CTS2) (Straus et al., 1996). The ADAS has 7 items (Sharpley & Rogers, 1984) (see Appendix C). Items 1 to 3 are measured on a 6-point Likert scale from *always agree* to *always disagree*. Items 4 to 6 are measured on a 6-point Likert scale from *never* to *more often*. Item 7 is measured on a 6-point Likert scale from *extremely unhappy* to *perfect* (Sharpley & Rogers, 1984). The ADAS provides one overall score ranging from 0 to 36, with higher scores indicating greater relationship satisfaction. The ADAS has adequate internal consistency ranging from $\alpha = .76$ to .82 (Hunsley, Best, Lefebvre, & Vito, 2001; Hunsley, Pinsent, Lefebvre, James-Tanner, & Vito, 1995; Sharpley & Cross, 1982). The ADAS significantly differentiates between married, separated, and divorced participants (Sharpley & Rogers, 1984) and those seeking marital therapy, from community samples (Hunsley et al., 2001). The ADAS also positively correlates with other measures of relationship adjustment, such as the Kansas Marital Satisfaction Scale (Hunsley et al., 2001; Hunsley et al., 1995).

The 19-item FSFI was used to assess sexual functioning (Rosen et al., 2000) (see Appendix D). The FSFI consists of six domains: desire, arousal, lubrication, orgasm, pain, and sexual satisfaction (Rosen et al., 2000). The FSFI provides participants with a definition of sexual activity, intercourse, and sexual stimulation and asks them to indicate their response to questions in terms of the last 4 weeks only (Rosen et al., 2000). Most items use a 6-point Likert scale, except for items 1, 2 and 4, which use a 5-point Likert scale. Six domain scores and an overall sexual function index score can be computed with higher scores indicating better sexual functioning (Rosen et al., 2000). Test-retest reliability coefficients are high for each of the domains ($r = 0.79$ to 0.86) and for the overall sexual function index ($r = .88$). A high degree of internal consistency

also exists for each of the domains ($\alpha$ = .89 to .96) and for the overall sexual function index ($\alpha$ = .97) (Rosen et al., 2000). The FSFI significantly differentiates between clinical and nonclinical populations on each of the six domains and the overall sexual function index, and is significantly positively correlated with marital satisfaction (Rosen et al., 2000).

Adult sexual coercion and physical assault were assessed using a short version of the CTS2 (Straus et al., 1996) (see Appendix E). The CTS2 consists of five subscales: physical assault, psychological aggression, negotiation, injury, and sexual coercion, and collects data on the behaviour of both partners. The negotiation subscale assesses the use of discussion to resolve disagreements (item e.g. “I explained my side of a disagreement to my partner”). The psychological aggression subscale measures the use of verbal and nonverbal threats (item e.g. “I insulted or swore at my partner”). The physical assault subscale measures the use of physical violence (item e.g. “I pushed or shoved my partner”). The injury subscale assesses physical injury caused by a partner (item e.g. “I went to a doctor because of a fight with my partner”). The sexual coercion subscale measures the use of psychological and physical force to compel a partner to engage in unwanted sexual activity (item e.g. “I used force [like hitting, holding down, or using a weapon] to make my partner have sex”). The CTS2 uses an 8-point scale ranging from *this has never happened* to *more than 20 times in the past year*; there is also the response choice *not in the past year but it did happen before*. For the current study a total of 12 of the 39 items were selected: two items each from the negotiation, psychological aggression, and injury subscales, and three items each from the physical assault and sexual coercion subscales. For the negotiation and psychological aggression subscales, those items which highest levels of internal consistency were chosen. For the physical assault, sexual coercion and injury subscales a balance between minor and severe acts was sought, and internal consistency considered. Indices of prevalence and

chronicity for the CTS2 subscales are typically calculated for the physical assault, injury, and sexual coercion subscales (Straus et al., 1996). The CTS2 has high internal consistency ranging from $\alpha = .79$ for the psychological aggression subscale to $\alpha = .95$ for the injury subscale (Lafontaine & Lussier, 2005; Straus et al., 1996). CTS2 subscale scores correlate with each other in a theoretically meaningful manner, for example the subscales of psychological aggression and physical assault are strongly positively correlated, while the subscale of negotiation is uncorrelated with the subscales of physical assault, sexual coercion, and injury (Straus et al., 1996). Studies have confirmed the five-factor structure of the CTS2 (Connelly, Newton, & Aarons, 2005), and the physical assault, psychological aggression, sexual coercion, and injury subscales have been found to be positively and significantly correlated with other measures of partner abuse (Jones, Ji, Beck, & Beck, 2002).

*Proposed mediator variables.* The latent variable fear of abandonment comprised of hyperfeminine gender role beliefs assessed by the Hyperfemininity Scale (HF) (Murnen & Byrne, 1991) and attachment anxiety as measured by the Experiences in Close Relationships Inventory (ECR) (Brennan, Clark, & Shaver, 1998). Attachment avoidance was assessed using the Experiences in Close Relationships Inventory (ECR) (Brennan, Clark, & Shaver, 1998). The latent variable of avoidant / destructive coping consisted of the number of relationships and lifetime sexual partners as assessed by the Relationship and Sexual History Questionnaire (RSHQ) and hazardous or harmful alcohol use measured by the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993). The latent variable of approach / constructive coping comprised of satisfaction with social support and number of social supports as assessed by the Social Support Questionnaire (SSQ-6) (Sarason, Levine, Bashman, & Sarason, 1983), self-regulation strategies and relationship effort measured by the short version of the, the self version of the Behavioral Self-Regulation for Effective Relationships Scale

(BSRERS-Self) (Wilson et al., 2005), and sexual assertion assessed using the initiation and refusal subscales of the Sexual Assertiveness Scale (SAS) (Morokoff et al., 1997).

Hyperfeminine gender role beliefs were assessed using the 26-item HF scale (Murnen & Byrne, 1991) (see Appendix F). The HF provides respondents with a pair of statements and asks them to choose one statement that is more characteristic of them (item e.g. "(a) I never use my sexuality to manipulate men, (b) I sometimes act sexy to get what I want from a man"), with higher scores indicating greater levels of Hyperfemininity (Murnen & Byrne, 1991). The HS has adequate internal consistency ($\alpha$ = .76 to .90) and test-retest reliability ($r$ = .89) for a 2-week period (Murnen & Byrne, 1991). HS scores are positively associated with a greater endorsement of traditional gender roles and acceptance of women's sexual subordination; more self-blame when women are victims of sexual coercion; and greater endorsement of rape myths and attraction to hypermasculine men (Maybach & Gold, 1994; McKelvie & Gold, 1994; Murnen & Byrne, 1991).

Adult attachment was assessed using the 36-item ECR (Brennan et al., 1998) (see Appendix G). The ECR consists of two subscales: avoidance (item e.g. "I get uncomfortable when a romantic partner wants to be very close") and anxiety (item e.g. "I worry that romantic partners won't care about me as much as I care about them") (Brennan et al., 1998). Participants are asked to rate the extent to which they agree or disagree with each item on a 7-point Likert scale ranging from *strongly disagree* to *strongly agree*. Brennan et al. (1998) reported high internal consistency for both avoidance ($\alpha$ =. 94) and anxiety ($\alpha$ =. 91) subscales. Lafontaine and Lussier (2005) reported similar internal consistency coefficients for the ECR ($\alpha$ = .88 anxiety, $\alpha$ = .86 avoidance). ECR scores correlate significantly with both Collins and Read's (1990) and Griffin and Bartholomew's (1994) measures of adult attachment. The avoidance subscale correlates positively with measures of avoidance and discomfort with

closeness, whilst the anxiety scale correlates positively with scales assessing anxiety and preoccupation with attachment, jealousy, and fear of rejection (Brennan et al., 1998). The avoidance and anxiety subscales of the ECR are almost uncorrelated, as would be anticipated (Brennan et al., 1998).

Participants' sexual history was assessed using the RSHQ, which comprised of two questions concerning the number of lifetime sexual partners and the age of onset of first consensual sexual intercourse based on similar questions by Fergusson et al. (1997) and Wyatt et al. (1992) (see Appendix H). The RSHQ also assessed whether participants have ever been in (a) a committed intimate relationship; (b) married; (c) separated; and, (d) divorced, and if so how many times they have experienced each of these.

Hazardous and harmful alcohol use was assessed using the 10-item AUDIT (Saunders et al., 1993) (see Appendix I). The AUDIT measures three domains: alcohol consumption (items one to three, e.g. "How often do you have a drink containing alcohol?"), drinking behaviour related to dependence (items four to six, e.g. "How often during the last year have you found that you were not able to stop drinking once you had started?), and alcohol-related problems (items seven to ten, e.g. "Have you or someone else been injured as a result of your drinking?"). A score of 8 is associated with harmful or hazardous drinking, while a score of 13 indicates alcohol dependence. Allen, Litten, Fertig, and Babor (1997) reported high internal consistency for the AUDIT ($\alpha$ =. 80 to .94), and Daeppen, Yersin, Landry, Pecoud, and Decrey (2000) provided evidence of the AUDIT's temporal stability, reporting a test-retest reliability coefficient of $r$ = .88 over a 6-week period. The AUDIT has been found to predict alcohol-related physical disorders and social problems more successfully than standard biochemical markers (Classen & Aasland, 1993; Conigrave, Hall, & Saunders, 1995). The AUDIT correlates strongly with other self-report measures of alcohol use such as

the Michigan Alcoholism Screening Test and the CAGE (Allen et al., 1997), yet appears to be more sensitive to nondependent problem drinking than these measures (Barry & Fleming, 1993; MacKenzie, Langa, & Brown, 1996).

Social support was assessed using the 6-item short version of the SSQ-6 (Sarason et al., 1983) (see Appendix J). The SSQ-6 assesses the number of support persons (from 0 to 9 people) and the satisfaction with this support on a 6-point Likert scale (ranging from *very dissatisfied* to *very satisfied*, with higher scores indicating greater satisfaction) in response to a variety of situations (item e.g. “Whom can you really count on to distract you from your worries when you feel under stress?”) (Sarason et al., 1983). The SSQ-6 has high internal consistency ($\alpha$ = .97 total number of supports, $\alpha$ = .94 total satisfaction) (Sarason et al., 1983). Factor analysis supports the validity of the two dimensions of support as measured by the SSQ-6, which are only moderately correlated (Caplan, 1974; Weiss, 1974), as would be expected. SSQ-6 scores are negatively related to depression, anxiety, hostility, and neuroticism, and positively associated with extraversion (Sarason et al., 1983; Sarason, Sarason, Shearin, & Pierce, 1987).

Relationship self-regulation was measured using the 16-item BSRERS-Self (Wilson et al., 2005) (see Appendix K). The BSRERS-Self assesses how much individuals work at improving their intimate relationship on a 5-point scale ranging from *not true at all* to *very true*. The BSRERS-Self is comprised of two subscales: self-regulation strategies (item e.g. “I try to apply ideas about effective relationships to improving our relationship”) and relationship effort (item e.g. “Even when I know what I could do differently to improve things in our relationship, I can’t seem to change my behaviour”) (Wilson et al., 2005). The BSRERS-Self has high levels of internal consistency ($\alpha$ = .86 relationship strategies, $\alpha$= .83 relationship effort, $\alpha$ = .88 total score) (Wilson et al., 2005). There is strong evidence of test-retest reliability for

women *r* = .67 and men *r* = .66 across the first year of marriage (Wilson et al., 2005). The BSRERS-Self accounts for substantial variance in relationship satisfaction and is independent of negative mood or depression (Wilson et al., 2005). As anticipated the BSRERS-Self has modest correlations with general self-regulation, no association with intelligence, and low correlations with dimensions of personality (Wilson et al., 2005).

Sexual assertion, that is the ability to initiate wanted sexual behaviour (item e.g. "I begin sex with my partner if I want to"), and to refuse unwanted sexual experiences (item e.g. "I refuse to have sex if I don't want to, even if my partner insists") was measured using the 6-item initiation and refusal subscales of the SAS (Morokoff et al., 1997) (see Appendix L). Participants were asked to respond to these questions based on their current or last sexual relationship. The response format is a 5-point Likert scale ranging from *never, 0% of the time* to *always 100% of the time* (Morokoff et al., 1997). Subscale scores range from 6 to 30, with higher scores indicating greater sexual assertiveness. Morokoff et al. (1997) reported adequate internal consistency ($\alpha$ = .74 refusal, $\alpha$ = .82 initiation), and test-retest reliability (*r* = .59 to .65) for the SAS. The initiation subscale is positively associated with the frequency of sexual experience and the positivity of sexual attitudes (Morokoff et al., 1997). The refusal subscale is negatively correlated with sexual victimisation and anticipation of a negative partner reaction to sexually assertive behaviour, and is positively associated with self-efficacy (Morokoff et al., 1997).

*Family-of-origin functioning*. Family of origin functioning was assessed using the cohesion, expressiveness, and conflict subscales of the Family Environment Scale (FES) (Moos & Moos, 1994), three questions assessing parental separation and divorce, and the Parental Conflict Tactics Scale (PCTS) (Halford et al., 1999). The subscales of cohesion, expressiveness, and conflict of the FES consist of nine forced-choice (*true / false*) items each, with higher scores indicating a stronger presence of each family

dimension (see Appendix M). The cohesion subscale measures the extent of commitment and support within the family (item e.g. "Family members really helped and supported one another"). The expressiveness subscale assesses the amount of emotional expression between family members (item e.g. "It was hard to 'blow off steam' at home without upsetting somebody"). The conflict subscale measures the amount of anger and conflict within the family (item e.g. "Family members sometimes got so angry they threw things") (Moos & Moos, 1994). A family relationships index can be computed from the FES by summing the cohesion, expressiveness and reversed conflict subscales (Moos & Moos, 1994). Participants were instructed to respond to the questions with regard to their family of origin during childhood. Internal consistency for the subscales of cohesion ($\alpha = .78$), expressiveness ($\alpha = .69$), and conflict ($\alpha = .75$) are all within an acceptable range (Bischof, Stith, & Whitney, 1995; Moos & Moos, 1994). Test-retest reliability for 2-months suggests the FES it is a stable test (cohesion $r = .86$, expressiveness $r = .73$, conflict $r = .85$) (Moos & Moos, 1994), with similar reliability coefficients being reported in other studies (McCray, King, & Bailly, 2005; Sandhu & Tung, 2004). FES subscales reliably differentiate distressed and nondistressed families (Bischof et al., 1995; Moos & Moos, 1994), and are highly correlated with similar measures of family functioning including the Family Assessment Device, the Structural Family Interaction Scale, and the Family Adaptability and Cohesion Evaluation Scales (Moos & Moos, 1994). The cohesion subscale is positively correlated with measures of social support and marital adjustment, while the conflict subscale is negatively correlated with these constructs (Abbot & Brody, 1985; Moos & Moos, 1994; Waring, McElrath, Lefcoe, & Weisz, 1981).

Three questions assessing the occurrence of permanent parental separation or divorce (4-point scale ranging from *never* to *more than twice*), age of individual at the time of this separation (4-point scale ranging from *0-5 years* to *18 and older*), and who

the individual lived with after the separation (4-point scale *mother*, *father*, *joint* or *other*) were included in the questionnaire package (see Appendix N). These questions were taken from Griffith University's Newlywed Project (Halford et al., 1999).

A short 10-item version of the PCTS developed by Halford et al. (1999) was used in the current study (see Appendix O). This measure is based on the Conflict Tactics Scale (CTS) (Straus, 1990), and asks the participant if, and how often, they witnessed their parents engaging in particular conflict behaviours using a 4-point Likert scale ranging from *never* to *more than twice* (item e.g. "Did you ever see your Mother push, hit or slap your Father?"). Halford et al. (1999) adapted this measure by changing the wording from *partner* to *mother* and *father* and selecting the most strongly endorsed items from each of the three subscales: violence, verbal aggression and reasoning. The last item of this measure was taken from the Dyadic Adjustment Scale (Spanier, 1976) and assesses parental marital adjustment using a 7-point Likert scale ranging from *very happy* to *very unhappy*.

*Child abuse and neglect.* The emotional abuse, physical abuse, emotional neglect, and physical neglect subscales of the screening version of the Childhood Trauma Questionnaire (CTQ-SF) (Bernstein et al., 2003) were used to assess child abuse and neglect. The 5-item subscales of the CTQ-SF are rated on a 5-point Likert scale ranging from *never true* to *very often true*, with higher scores indicating greater levels of abuse or neglect (Bernstein et al., 2003) (see Appendix P). The emotional abuse subscale measures verbal assaults or any demeaning behaviour directed toward a child by a caretaker (item e.g. "When I was growing up, my family said hurtful or insulting things to me"). The physical abuse subscale assesses bodily assaults on a child by a family member that posed a risk of, or resulted in, injury (item e.g. "When I was growing up, people in my family hit me so hard that it left me with bruises or marks"). The emotional neglect subscale captures the inadequacy of caretakers to meet children's

basic psychological needs (item e.g. "When I was growing up, I felt that I was loved"). The physical neglect subscale measures the failure of caretakers to fulfil a child's basic physical needs (item e.g. "When I was growing up, my parents were too drunk or high to take care of my family") (Bernstein et al., 2003). Bernstein et al. (2003) reported acceptable internal consistency for the subscales of the CTQ-SF: emotional abuse ($\alpha$ = .84 to .89), physical abuse ($\alpha$ = .81 to .86), emotional neglect ($\alpha$ = .85 to .91) and physical neglect ($\alpha$ = .61 to .78). Rosenbaum and Leisring (2003) reported internal consistency coefficients for the CTQ-SF subscales ranging from $\alpha$ = .79 to .94. The factor structure of the CTQ-SF has been replicated across clinical, adolescent, and normative adult samples (Bernstein et al., 2003), it has been found to reliably distinguish clinical from nonclinical groups (Bernstein et al., 2003; Rosenbaum & Leisring, 2003), and to significantly predict observational ratings made by therapists of corresponding forms of child abuse and neglect (Bernstein et al., 2003).

*Procedure*

Participants were sent an information sheet outlining the nature of the current study and their participation, and the questionnaire package. Potential participants were informed that the aim of the current study was to examine the relationship between their experiences in their family of origin and their current relationship and sexual functioning. Women wanting to participate in the current study were asked to complete the questionnaire package and return it to the university in a reply-paid envelope provided. Single women were instructed to complete twelve questionnaires of the package, excluding those which assess aspects of relationship functioning, taking approximately 90 minutes; women who were currently in a sexual relationship with a male partner, and had been so for a minimum of six months duration, were asked to complete the entire package, taking approximately 120 minutes. Questionnaire

packages were returned in a de-identified manner and follow-up letters were sent to all women to prompt those considering participating. Women were not paid for their participation. Participants were made aware that some of the questions concerned sensitive matters such as sexual behaviours, conflict, and violence, and were reminded of the voluntary nature of their participation and their right to withdraw from the study. A list of counselling services and their contact details was provided with the information sheet sent to participants as well as on a website with further information concerning the current study.

## *Results*

### *Overview of Statistical Analyses*

First, data were inspected for missing values and violation of the assumptions of multivariate analysis. The demographic characteristics of the sample were then compared to the Australian Bureau of Statistics (2001) census data to determine how representative the participants were of the female population. The prevalence and nature of CSA as reported by the participants was then examined. A LCA was then performed to examine the existence of abuse classes within the sample, and the composition of these classes. The impact of abuse class membership on relationship and sexual functioning was then explored using analyses of variance (ANOVAs) and chi-square analyses. The association between abuse class membership and family-of-origin factors was then examined.

### *Missing Values Analysis*

Prior to analysis, data were inspected for missing values. Missing values analysis revealed that most items had less than 5% of data missing. The satisfaction questions on the SSQ-6 had 5.8% to 7.2% of data missing; item 16 on the HS had

19.5% missing data points. All data were missing completely at random as assessed by Little's MCAR test, and in accordance with current recommendations (Abraham & Russell, 2004; Schafer & Graham, 2002), expectation maximisation substitution was used to replace all missing values. Sixty participants did not indicate whether they had experienced CSA and, as a result, the data from these women were excluded from analyses. In the current study, CSA was defined as unwanted sexual behaviours with another person, occurring at or prior to 16 years of age. Using this definition of CSA, data from three participants reporting unwanted sexual behaviours occurring after 16 years of age were excluded from the analyses.

*Checking the Assumptions of Multivariate Analysis*

After the abuse classes were formed, the assumptions of multivariate analysis were evaluated at the group level (i.e., abuse classes) for variables to be used in parametric analyses. As LCA and mixture modelling do not assume linearity, normal distribution of data, or homogeneity of variance (Uebersax, 1993), these assumptions were evaluated only for variables to be used in ANOVAs. Transformations were used to reduce skewness, kurtosis, and the number of outliers, and to improve homogeneity of variance across groups. ANOVAs were performed with and without the transformed scores. There was no difference in the significance level of the $F$ statistic for any of these comparisons, and as a result the untransformed version of these variables was retained for analyses. One participant was 62 years of age and therefore not representative of the target population of women aged 18 to 41 years; this participant's data were excluded from the analyses. The remaining participants' data appeared to be representative of target population, and as a result were not altered.

In situations of unequal group size and variance across groups, Type I error is increased (Tabachnick & Fidell, 2001). To control for Type I error, in accordance with

Field's (2000) recommendations, planned comparison procedures accounting for unequal group size and variance were used. The risk of making a Type I error also increases dramatically with the number of ANOVAs performed (Huberty & Morris, 1989; Smith, Levine, Lachlan, & Fediuk, 2002). In the current study only a small number of ANOVAs were performed with a sufficient sample size, using variables with low correlations (which are provided for inspection) to further reduce the likelihood of committing a Type I error. Using a $p < .001$ criterion for Mahalanobis distance no multivariate outliers were found and residuals were distributed normally. This data screening resulted in 1,271 cases that were suitable for analysis.

*The Representativeness of the Sample*

The demographic characteristics of the sample were then compared to Australian Bureau of Statistics (2001) census data to determine how representative participants were of the female population aged 18 to 41 years. As shown in Table 3, the current sample overrepresented more highly educated women; nearly twice the number of women in the current sample had completed secondary education and gained additional qualifications than in the general population. As shown in Table 3, the current sample underrepresented separated and divorced women; twice as many women in the general population were separated than in the current sample and three times as many women were divorced. Otherwise the sample was representative of women in the general population aged 18 to 41 years.

Table 3

*A Comparison of Demographic Characteristics as Percentages (%) of the Sample (N =1271) with the General Population*

| Demographic Characteristics | Current Sample (18-41 years) % | ABS Statistics (20-39 years) % |
|---|---|---|
| Median weekly earnings | $450.00 | $300.00 - $399.00[b] |
| Employed | 74.00 | 69.00 |
| Employed full-time | 42.00 | 35.00 |
| Employed part-time | 32.00 | 27.40 |
| Unemployed | 26.00 | 27.70 |
| Completed secondary education | 92.10 | 56.90 |
| Additional nonschool qualification | 63.40 | 34.30[b] |
| Married | 40.00 | 42.70 |
| Cohabiting | 21.40 | 12.40 |
| Separated | 1.90 | 3.90 |
| Divorced | 1.70 | 5.10 |
| Widowed | 0.50 | 0.40 |
| Fertility rate (parity) | 0.95 | 1.76[b] |
| Born in Australia | 87.90 | 72.00[b] |
| Indigenous Australian | 1.30 | 2.40 |
| Religious | 78.80 | 86.10[b] |
| Self-reported good health | 87.60 | 88.60[b] |
| Used medication for mental health [a] | 10.40 | 9.70[b] |
| Health consultation [a] | 34.20 | 43.20[b] |

*Note*. [a] Refers to last 4 weeks. [b] Represents total female population aged 18 years and over.

*The Prevalence and Nature of Child Sexual Abuse*

A total of 569 participants (45% of the sample) reported at least one unwanted sexual incident prior to 16 years of age on the ESEC (Miller et al., 1991). On average each of these women experienced 3 to 4 CSA acts ($M$ = 3.6, $SD$ = 2.9), with a range of 1 to 14 acts. Figure 2 shows the most common types of CSA contact acts. It is evident from viewing Figure 2 that the most common contact CSA acts involved the perpetrator touching the victim in a sexually inappropriate manner, or the victim being coerced into touching the perpetrator; vaginal, oral, and anal sex were less common.

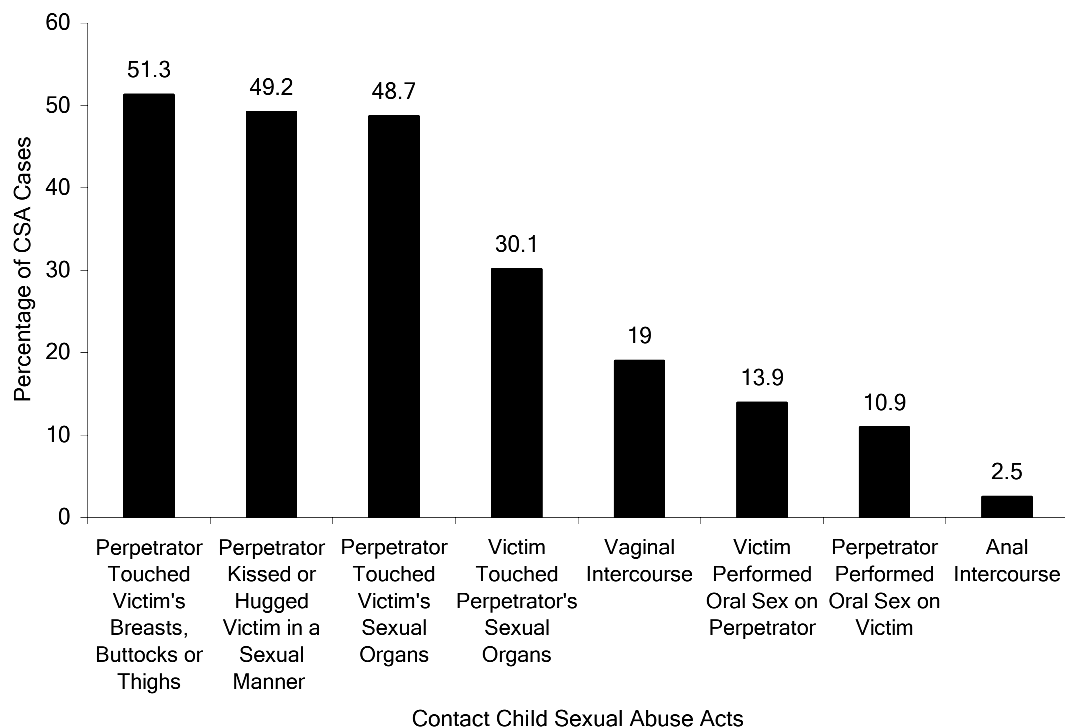


*Figure 2.* The prevalence of contact CSA acts ($n$ = 569).

Figure 3 shows the most common noncontact CSA acts reported by participants with a history of CSA. It is evident from viewing Figure 3 that the perpetrator exposing their genitals, coercing the victim to expose her genitals, and making unwanted sexual requests were common experiences of women with a history of CSA.

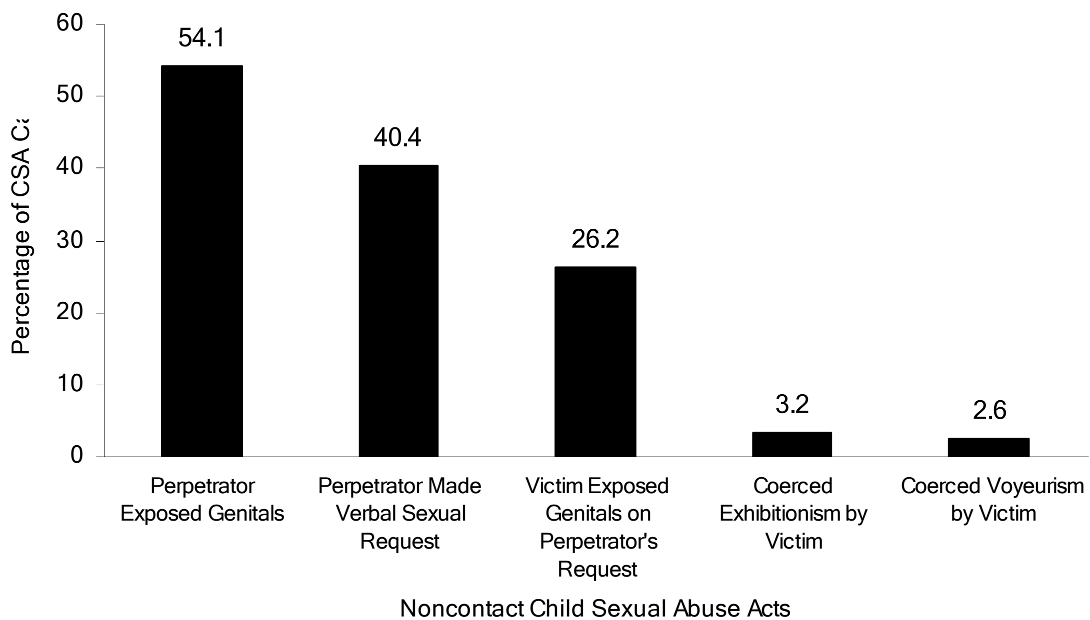


*Figure 3.* The prevalence of noncontact CSA acts (*n* = 569).

Most (65%) women's experience of CSA involved physical contact with the perpetrator, but not intercourse. One fifth (20%) of CSA survivors experienced vaginal or anal intercourse with the perpetrator. Only 15% of CSA survivors experienced noncontact CSA acts only.

In nearly three quarters (73%) of CSA cases, women reported that the perpetrator used pressure or force during the act. Over three quarters (77%) of these women reported that methods of psychological coercion were used during the CSA act; 5% reported that the perpetrator used threats of violence; in 18% of these cases actual physical force was used. Figure 4 shows the most common forms of psychological coercion used by CSA perpetrators. From viewing Figure 4 it is evident that the most common forms of psychological coercion used by CSA perpetrators involved verbally persuading the victim or intimidating the victim by the perpetrator's physical size or strength.

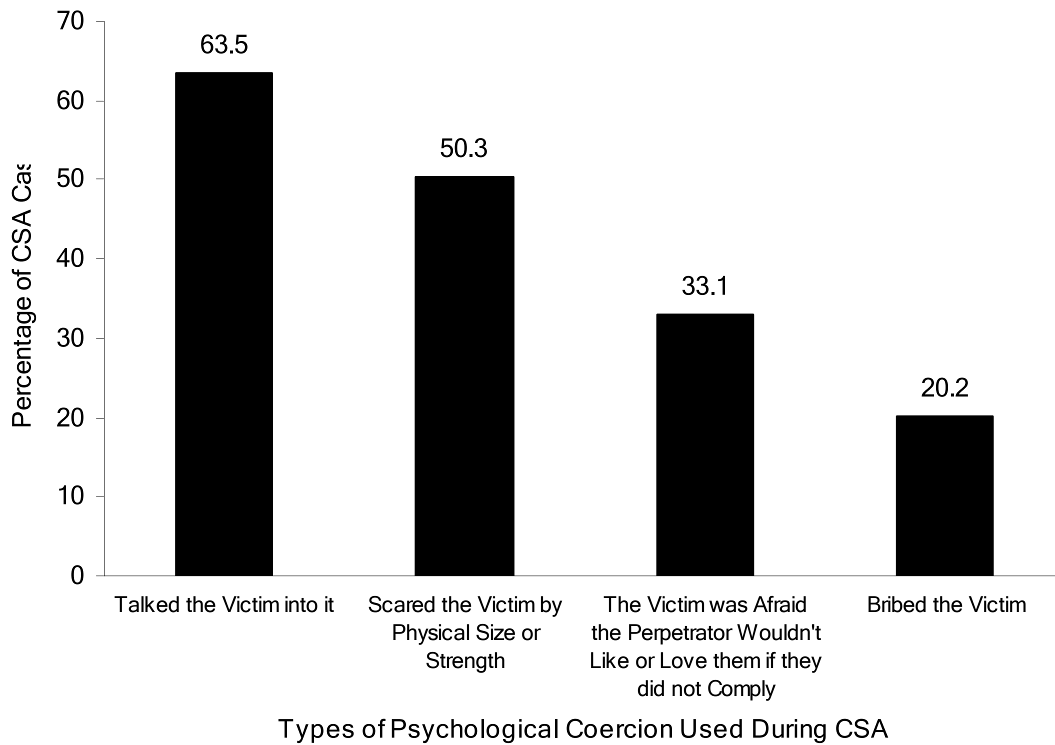


*Figure 4.* Types of psychological coercion used during CSA acts ($n$ = 356).

Figure 5 shows the most common types of physical violence used by CSA perpetrators. From viewing Figure 5 it is evident that the most common form of physical violence used by CSA perpetrators involved pushing, hitting, or physically restraining the victim; the use of weapons and violence causing actual physical injury were less common.

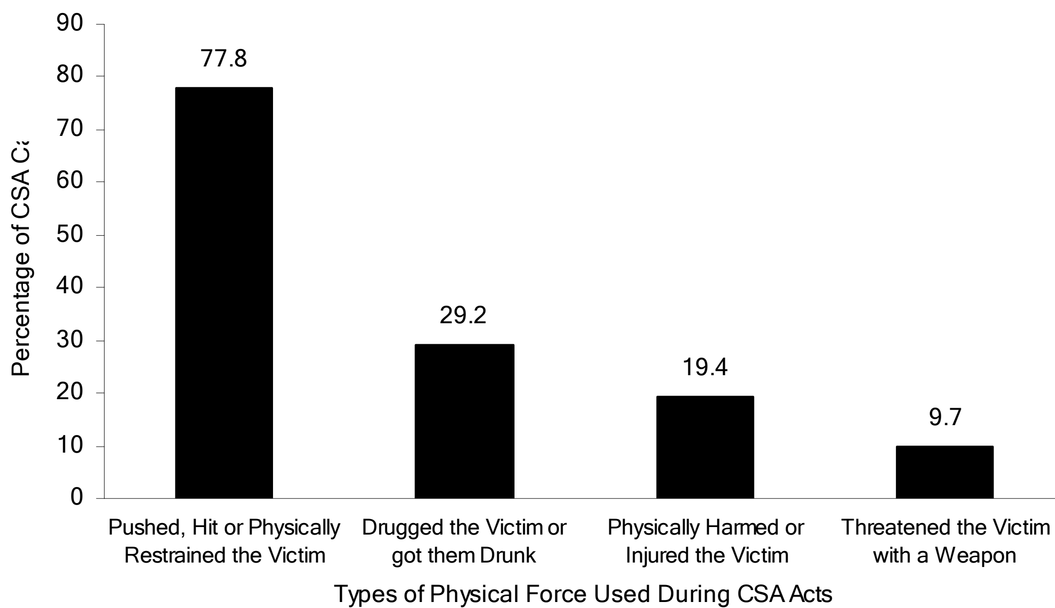


*Figure 5.* Types of physical force used during CSA acts (*n* = 72).

*Victim characteristics.* The average age of the victim when the first incident of CSA occurred was 11.0 years (*SD* = 3.6 years), with a range of 3 to 16 years. On average, each CSA case involved two incidents, and occurred over a period of 1 month or less, although more than a third (36%) of women reported the abuse took place over a period of several months to a year or more. At the time the CSA occurred half (46%) of the women reported that it was extremely distressing, and an additional third (38%) stated it was moderately upsetting. Currently, half (49%) of the CSA survivors reported that the abuse did not bother them at all, and a third (34%) described it as moderately distressing.

*Perpetrator characteristics.* There was great variability in the age of CSA perpetrators. The average age of CSA perpetrators at the time the abuse occurred was 28.4 years (*SD* = 15.6 years) with a range of 4 to 70 years of age. The average age difference between the perpetrator and victim at the time the abuse occurred was 17.5 years (*SD* = 15.4 years). The majority of perpetrators (67%) were adults over 18 years of age. One quarter of perpetrators (25%) were teenagers or young adults between 13

and 17 years of age. A small proportion of perpetrators (8%) were children under 13 years of age. Most women (86%) reported only one perpetrator involved in the CSA act/s (*M* = 1.2, *SD* = 0.7). The majority (89%) of victims knew their perpetrator; half of the perpetrators (55%) were friends and a third (34%) were relatives. Strangers were perpetrators in only 18% of incidents. Figure 6 shows the most common incest perpetrators. As is evident from viewing Figure 6, brothers, fathers, male cousins, and uncles were all frequently reported as perpetrators of incest. Intrafamilial perpetrators were considerably more likely to be male (91%) than female (9%).

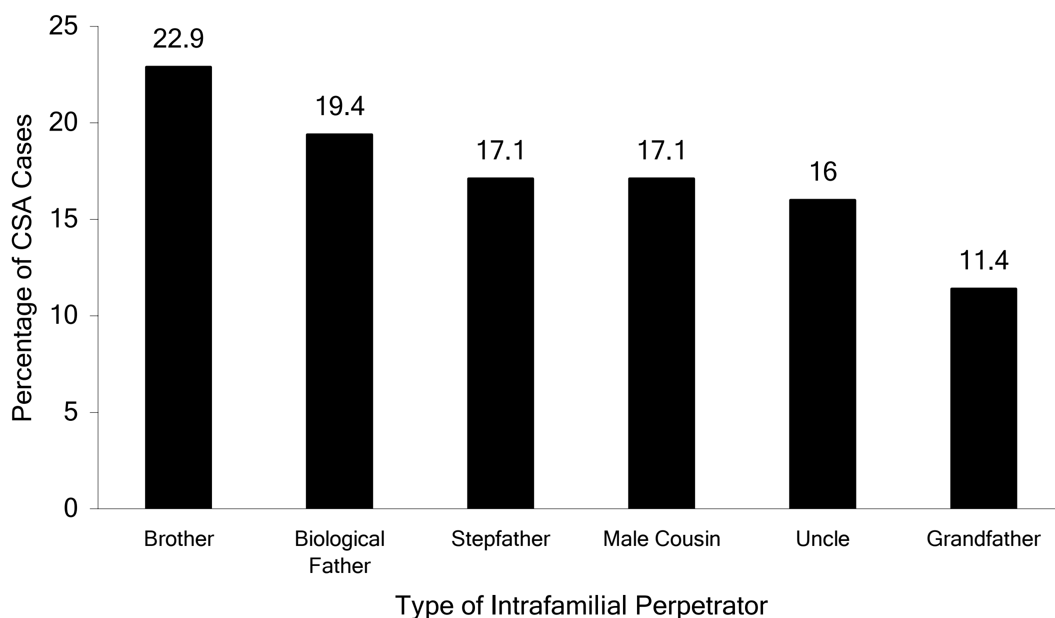


*Figure 6.* Types of intrafamilial perpetrators involved in CSA acts (*n* = 179).

*Disclosure and help seeking.* Half (54%) of the women who experienced CSA disclosed the incident, predominantly to their mother (49%), a friend (44%), or to a brother or sister (18%). Only 20 women (7% of women who experienced CSA) reported the abuse to police or other authorities. Of those women who told their mother about the abuse, half (54%) found her to be very supportive, and half (46%), reported that their mother was not at all or only mildly supportive. In total 87 participants (16% of women who experienced CSA) reported having sought professional help regarding

their abuse experiences. Most of these women sought help from a counsellor (74%), psychologist (40%), or psychiatrist (28%). Of the women who sought professional help regarding CSA, most (80%) reported it to be useful.

*A summary of the prevalence and nature of child sexual abuse.* In summary, CSA was found to be common; half of the sample reported experiencing at least one unwanted sexual incident prior to 16 years of age. Most women's CSA experiences occurred during their prepubescent years, and involved direct physical contact with a male perpetrator who was known to them. Most cases of CSA were isolated incidents, however more than a third of victims reported the abuse continued over a period of months or years. Half of the CSA survivors told someone about their abuse experiences, however only a very small proportion of these women disclosed the abuse to the police. Most CSA survivors were considerably distressed by their abuse experiences at the time they occurred. Currently about half of these women reported being substantially affected by their CSA experiences. Only a small proportion of CSA survivors had received professional help for their abuse experiences.

### *Latent Class Analysis of Child Sexual Abuse Characteristics*

LCA is a statistical method used to find classes of related cases within a data set when the size, number, and composition of classes are unknown (Kovac et al., 2002; Lubke & Muthen, 2005; Muthen & Muthen, 2000; Schrepp, 2005). In LCA, classes are considered to be *latent* because they are not directly observable, but rather are identified through combinations of observed indicator variables (Lubke & Muthen, 2005; Schrepp, 2005). LCA estimates model parameters from indicator variables using the maximum likelihood criterion (Lanza, Collins, Schafer, & Flaherty, 2005). LCA estimates three types of parameters: (a) the size and prevalence of each latent class, (b) posterior probabilities which give the probability for an individual to belong to each of the

classes, and (c) conditional probabilities for individuals in a particular class to endorse a specific item. After model estimation, cases are assigned to the class for which they have the highest posterior probability (Kovac et al., 2002; Lanza et al., 2005; Uebersax, 1993).

Model fit in LCA is assessed using either goodness-of-fit or parsimony indices. The most common goodness-of-fit index used in LCA is the likelihood ratio chi-square statistic. A likelihood ratio chi-square value below a critical value of $p < .10$ is typically used as evidence of model fit (Muthen & Muthen, 2000; Schrepp, 2005; Uebersax, 1993). However, with large sample sizes, significance tests are sensitive to small deviations from the null hypothesis, and as a result most models are rejected (Kuha, 2004; Vermunt & Magidson, 2000).

In situations where traditional significance tests of model fit are not appropriate, the fit of alternative models are compared using parsimony indices. These statistics offer a trade-off between the fit of the model to the data according to the likelihood-ratio statistic and the number of parameters in the model. Common parsimony indices include the Akaike Information Criterion (AIC), the Bayesian Information Criterion (BIC), and the Sample-Size Adjusted BIC. The model with the lowest BIC, AIC, or Sample-Size Adjusted BIC is considered to best represent the data (Schrepp, 2005; Uebersax, 1993; Vermunt & Magidson, 2000).

To determine the number of classes that should compose the model, one runs LCA models with up to the maximum plausible number of classes, and then statistically compares the fit of each one to the data using parsimony indices, with the one with the lowest values being selected. Parameter estimates can also be examined in determining how many classes to keep; for example one might reject models as having too many classes if some classes have a very small prevalence of cases (Schrepp, 2005; Uebersax, 1993; Vermunt & Magidson, 2000).

A LCA was performed to establish the existence of different classes of CSA using abuse characteristics assessed by the ESEC (Miller et al., 1991). Exploratory latent class models were fitted to three ordinal indicators of CSA, namely: severity of the CSA act (1 = noncontact CSA act, 2 = contact CSA act not involving intercourse, 3 = CSA act involving vaginal or anal penetration), relatedness of victim and perpetrator (1 = stranger perpetrator, 2 = friend perpetrator, 3 = extended family member perpetrator, 4 = immediate family member perpetrator), and psychological coercion (ranging from 1 to 4, with each number representing an additional form of psychological coercion being used by the perpetrator during the CSA act), and one categorical indicator of CSA, disclosure (0 = did not disclose CSA, 1 = disclosed CSA), using Mplus software. As some women reported being abused by more than one perpetrator, the relatedness variable was computed on the most closely related perpetrator to the victim. Using an exploratory approach, all model parameters were estimated without a priori restrictions.

The relative fit of one-, two-, three-, and four-class models were compared. As shown in Figure 6, AIC, BIC, and Sample-Size Adjusted BIC parsimony indices improved dramatically from a one- to a two-class model, and from a two- to a three-class model. A three-class model was the most parsimonious; with four or more classes parsimony values began to increase and models became increasingly unstable.

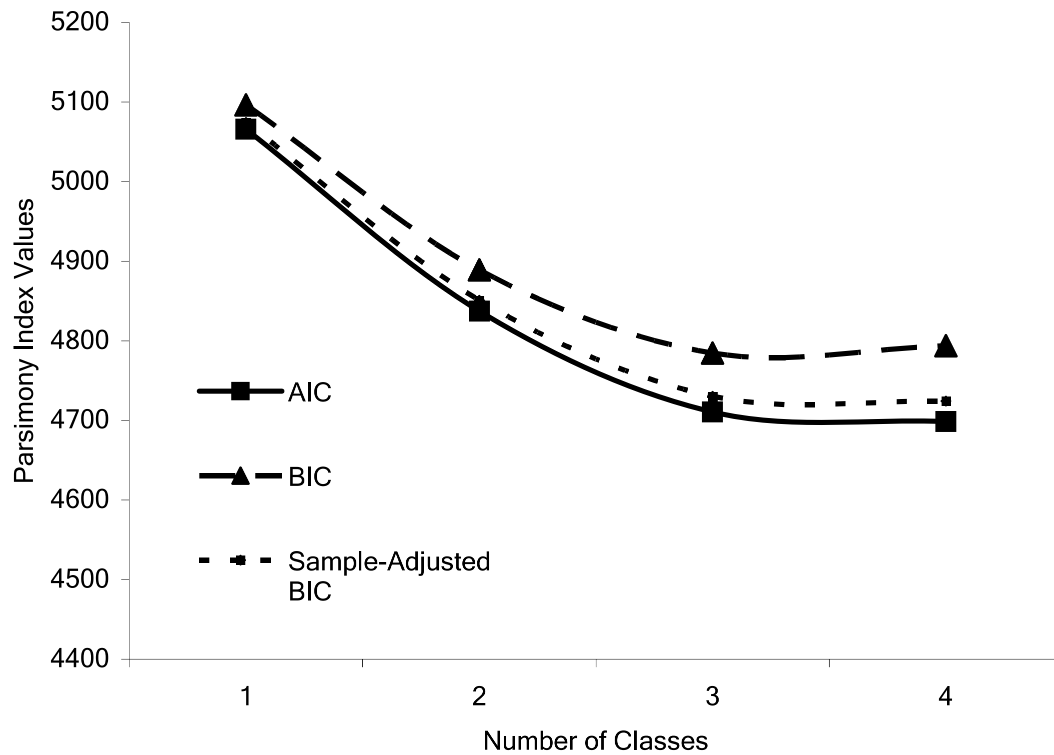


*Figure 7.* Indices of model fit for LCA of CSA variables (*n* = 569).

Average latent class probabilities for most likely latent class membership are shown in Table 4. From these average latent class probabilities three distinct classes of CSA survivors are evident. As shown in Table 4, the friend abuse class is the largest composing 55% of CSA survivors. The family abuse class contains 31% of CSA survivors. The stranger abuse class is the smallest consisting of 14% CSA survivors.

Table 4

*Average Latent Class Probabilities for Most Likely Latent Class Membership*

| Class | Friend Abuse Class (*n* = 310) | Family Abuse Class (*n* = 179) | Stranger Abuse Class (*n* = 80) |
|---|---|---|---|
| Friend abuse class | 0.999 | 0.000 | 0.001 |
| Family abuse class | 0.016 | 0.984 | 0.000 |
| Stranger abuse class | 0.008 | 0.000 | 0.992 |

Table 5 shows the descriptive data concerning the indicator variables for each class. It is evident from viewing Table 5 that women in the family abuse class reported the greatest severity of CSA act and the highest level of psychological coercion used by the perpetrator, and were the least likely to disclose the abuse. Women in the stranger abuse class reported the lowest severity of CSA act and the lowest level of psychological coercion, and were the most likely to tell someone about the abuse. The friend abuse class had a moderate level of CSA severity, psychological coercion, and disclosure. Of the women in the family abuse class 20 (11%) were abused by a friend, and 8 (5%) were abused by a stranger as well as by a family member. Nine (3%) of the women in the friend abuse class were abused by a stranger as well as by a friend. All of the women in the stranger abuse class were abused only by strangers.

Table 5

*Descriptive Data Concerning the Indicator Variables for Each Latent Class*

| | Participant Groups | | | | | |
|---|---|---|---|---|---|---|
| | Friend Abuse Class ($n$ = 310) | | Family Abuse Class ($n$ = 179) | | Stranger Abuse Class ($n$ = 80) | |
| Variables | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Psychological Coercion [a] | 0.99 | (1.05) | 1.28 | (1.15) | 0.73 | (0.86) |
| Severity of CSA Act [b] | 18.4% intercourse<br>67.4% contact<br>14.2% noncontact | | 22.3% intercourse<br>70.4% contact<br>7.3% noncontact | | 17.5% intercourse<br>41.3% contact<br>41.3% noncontact | |
| Relatedness [c] | 100% friend<br>3.3% stranger | | 100% family<br>11.2% friend<br>4.5% stranger | | 100% stranger | |
| Disclosure [d] | 47.7% | | 40.2% | | 73.8% | |

*Note.* [a] Psychological coercion is measured on a scale from 1 to 4 with each number representing an additional form of psychological coercion being used by the perpetrator during the CSA act. The types of psychological coercion included are: “tried to talk the victim into it”, “scared the victim because of their [the perpetrator’s] physical size or strength”, “bribed the victim”, and “the victim was afraid that they [the perpetrator] wouldn’t like or love them if they did not comply”. [b] Severity of CSA act is measured on a scale of 1 = non-contact CSA act, 2 = contact CSA act not involving intercourse, 3 = CSA act involving anal or vaginal penetration. [c] Relatedness of victim and perpetrator is measured on a scale of 1 = stranger perpetrator, 2 = friend perpetrator, 3 = extended family member perpetrator, 4 = immediate family member perpetrator. Relatedness does not add up to 100% due to women abused by multiple perpetrators. Where a woman was abused by more than one perpetrator relatedness was scored as the most closely related perpetrator. [d] Disclosure of CSA act is measured on a scale of 0 = did not disclose CSA, 1 = disclosed CSA.

*Comparing Abuse Classes*

*Differences in CSA characteristics between abuse classes.* A series of chi-square analyses and ANOVAs with multiple group comparisons were used to examine differences in the nature of CSA across abuse classes as assessed by the ESEC (Miller et al., 1991). Effect size was calculated using phi (ϕ) for dichotomous variables (small = 0.1, medium = 0.3, and large = 0.5), *r* for continuous variables (small = .1, medium = .3, and large = .5), and *d* for pairwise comparisons (small = 0.2, medium = 0.5, and large = 0.8) (Cohen, 1992). Table 6 shows that the correlations between CSA characteristics are generally low, reducing the likelihood of a Type I error occurring. Due to the high correlation between the frequency and duration of abuse, the frequency of the CSA act was not used in the ANOVAs.

Table 6

*Correlations Between CSA Characteristics*

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 1. Frequency [a] | -- | .91** | .11* | -.15** | .11** | .03 | .24** | -.19** |
| 2. Duration [b] | | -- | .14** | -.15** | .13** | .05 | .29** | -.20** |
| 3. No of perpetrators | | | -- | -.14** | .04 | .07 | .12** | -.09 |
| 4. Victim's Age | | | | -- | -.03 | .01 | -.25** | .05 |
| 5. Perpetrator's Age | | | | | -- | .25** | .18** | -.04 |
| 6. Distress at time [c] | | | | | | -- | .23** | -.09 |
| 7. Current Distress [d] | | | | | | | -- | -.23** |
| 8. Mother's Support [e] | | | | | | | | -- |

*Note.* [a] Frequency of CSA was assessed using the following scale 1 = just once, 2 = twice, 3 = 3 or 4 times, 4 = 5 times or more. [b] Duration of CSA was assessed using the following scale 1 = just once, 2 = a month or less, 3 = several months, 4 = a year or more. [cde] The participants were asked the following questions: [c] "How much did the experience [CSA] bother you at the time?" and [d] "How much does the experience [CSA] bother you now?" on a 7-point Likert scale ranging from *not at all* to *extremely* and [e] "If you told your mother how supportive was she?" very = 3, mildly = 2, a little = 1, not at all = 0.
* $p < .05$. ** $p < .01$.

As shown in Table 7, the abuse classes differed significantly on many aspects of their CSA experiences. First, all three abuse classes significantly differed from one another concerning the duration of the abuse. The family abuse class reported a significantly longer duration of abuse than either the stranger (*d* = 1.18) or the friend (*d* = .54) abuse classes. The friend abuse class also reported a significantly longer duration of abuse (*d* = .63) than the stranger abuse class. Women in the family abuse class were significantly younger at the time the abuse occurred than women in the stranger (*d* = .81) and friend (*d* = .70) abuse classes. There was no significant difference in the age of women at the time the abuse occurred between the stranger and friend abuse classes.

Women in the family abuse class reported significantly more perpetrators involved in the abuse (*d* = .25) than women in the friend abuse class. There was no significant difference in the number of CSA perpetrators between the family and stranger abuse class, or between the stranger and friend abuse class. Perpetrators in the friend abuse class were significantly younger than those in the family (*d* = .40) and stranger (*d* = .29) abuse classes. There was no significant difference in perpetrators' age between the family and stranger abuse classes.

Although there was no significant difference between the abuse classes in the amount of distress they experienced at the time the CSA occurred, there was a significant difference in the amount of distress the women reported currently concerning the abuse. Women in the family abuse class reported significantly more current distress concerning the abuse than women in the stranger (*d* = .91) and friend (*d* = .66) abuse classes. There was no significant difference in the amount of current distress concerning CSA reported by women in the stranger or friend abuse classes.

All of the abuse classes significantly differed concerning the amount of support they received if they told their mother abuse the abuse. Women in the family abuse class who told their mother about the abuse reported receiving significantly less support

from her than those in the stranger (*d* = .88) and friend (*d* = .42) abuse classes. Women in the friend abuse class also reported receiving significantly less support from their mother in response to disclosing the abuse compared with those in the stranger abuse class (*d* = .46).

There was a significant difference between abuse classes in whether women had sought professional help regarding their abuse experiences [$\chi^2$ (2, $N$ = 569) = 16.94, $p$ < .000, $\phi$ = .18]. A small proportion of women in the friend abuse class (12%) and the stranger abuse class (9%) reported seeking professional help concerning the abuse in comparison to a quarter of women in the family abuse class (25%). There was no significant difference between abuse classes in the whether women who had sought professional help regarding the abuse found this help useful [$\chi^2$ (2, $N$ = 569) = 3.80, $p$ > .05, $\phi$ = .20].

There was a significant difference between abuse classes in whether physical force was used by perpetrators during CSA acts [$\chi^2$ (2, $N$ = 569) = 6.65, $p$ < .05, $\phi$ = .11], with the highest prevalence of physical force reported by women in the stranger abuse class (16%), then the friend abuse class (11%), and the family abuse class (6%) reporting the lowest prevalence of physical force.

Table 7

*Analysis of Variance of CSA Characteristics by Abuse Class Membership*

| | Participant Groups | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Friend Abuse Class | | | Family Abuse Class | | | Stranger Abuse Class | | | | | |
| Source | *N* | *M* | *SD* | *N* | *M* | SD | *N* | *M* | SD | *df* | *F* | *r* |
| Duration [a] | 310 | 1.99 | (1.06) | 179 | 2.64 | (1.30) | 80 | 1.24 | (0.70) | 2, 568 | 47.04** | .28 |
| Number of perpetrators | 310 | $1.15_a$ | (0.59) | 179 | $1.35_b$ | (0.81) | 80 | $1.15_{ab}$ | (0.55) | 2, 568 | 5.73* | .10 |
| Victim's age | 310 | $11.69_a$ | (3.22) | 179 | 9.28 | (3.39) | 80 | $12.07_a$ | (3.00) | 2, 568 | 36.52* | .25 |
| Perpetrator's age | 310 | 25.90 | (14.07) | 179 | $31.82_a$ | (16.42) | 80 | $30.16_a$ | (12.59) | 2, 568 | 9.97* | .13 |
| Distress at time [b] | 310 | $4.76_a$ | (1.96) | 179 | $5.08_a$ | (1.91) | 80 | $4.81_a$ | (1.93) | 2, 568 | 1.60 | .05 |
| Current distress [c] | 310 | $2.84_a$ | (1.84) | 179 | 4.18 | (2.11) | 80 | $2.31_a$ | (1.77) | 2, 568 | 37.26* | .25 |
| Mother's support [d] | 240 | 2.06 | (0.71) | 157 | 1.72 | (0.91) | 50 | 2.44 | (0.70) | 2, 446 | 18.37* | .18 |

*Note*. Means having the same subscript ($_{a,\,b}$) are not significantly different at $p < .05$ using planned comparison procedures.

[a] Duration of CSA was assessed using the following scale 1 = just once, 2 = a month or less, 3 = several months, 4 = a year or more [bcd] The participants were asked the following questions: [b] "How much did the experience [CSA] bother you at the time?" and [c] "How much does the experience [CSA] bother you now?" on a 7-point Likert scale ranging from *not at all* to *extremely* and [d] "If you told your mother how supportive was she?" very = 3, mildly = 2, a little = 1, not at all = 0.

* $p < .01$. ** $p < .000$.

*Differences in sexual and relationship functioning between abuse classes.* A series of chi-square analyses and ANOVAs was used to examine the association of abuse class membership with current sexual and relationship functioning. Table 8 shows that relationship satisfaction as assessed by the ADAS (Sharpley & Rogers, 1984), and sexual satisfaction, and sexual functioning measured using the FSFI (Rosen et al., 2000) are significantly and positively correlated with one another, as are number of lifetime sexual partners and relationships as measured by the RSHQ. Due to the high correlations between sexual functioning and sexual satisfaction as shown in Table 8, sexual functioning was excluded from the ANOVAs to reduce the likelihood of committing a Type I error.

Table 8

*Correlations Between Relationship and Sexual Variables*

| Variables | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1. Relationship satisfaction | -- | .35** | .45** | -.08* | -.01 | .00 |
| 2. Sexual functioning | | -- | .86** | .02 | .03 | .06 |
| 3. Sexual satisfaction | | | -- | -.05 | .02 | .06 |
| 4. Number of lifetime sexual partners | | | | -- | .47** | .03 |
| 5. Number of relationships | | | | | -- | .02 |

*Note.* * $p > .05$. ** $p > .01$.

To examine the association between abuse class membership and whether women had ever been married, separated or divorced, whether they had consensual sexual intercourse prior to 16 years and their first child prior to 19 years, and the prevalence of physical assault and sexual coercion by women or their partners in the last 12 months, two types of comparisons were performed. First a chi-square analysis was performed comparing women with and without a history of CSA. A second chi-square

analysis was then performed comparing women in the friend, family, and stranger abuse classes.

Table 9 shows that CSA survivors were significantly more likely to have separated or divorced, to have had consensual sexual intercourse prior to 16 years of age and their first child prior to 19 years of age, and to have received and perpetrated physical assault and sexual coercion toward their intimate partners than their nonabused peers. There was no significant difference between CSA survivors and their nonabused peers regarding whether they had ever been married as assessed by the RSHQ. Although CSA survivors reported a higher occurrence of all types of self- and partner-perpetrated physical assault as assessed by the CTS2 (Straus et al., 1996) than their nonabused peers, the largest differences between women with and without a history of CSA were found in regards to minor acts such as pushing and shoving. Similarly, although CSA survivors reported a higher occurrence of all types of partner-perpetrated sexual coercion and some forms committed by themselves on their partners as assessed by the CTS2 (Straus et al., 1996) than their nonabused peers, the largest differences between women with and without a history of CSA were in regard to minor acts such as insisting on sex when one partner did not want to but not using physical force.

Second, it is evident from viewing Table 9 that there was a significant difference in whether women had ever been separated or divorced as assessed by the RSHQ between the abuse classes. Women in the family abuse class were significantly more likely to have separated or divorced than women in the friend and stranger abuse classes. There were no significant differences between the abuse classes in whether the women had consensual sexual intercourse prior to 16 years of age, their first child prior to 19 years, or had ever been married, or in the rates of self- or partner-perpetrated physical assault or sexual coercion.

Table 9

*Chi-Square Analysis of Relationship and Sexual Functioning by Abuse Group Membership*

| | Participant Group | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Characteristic | Friend Abuse Class ($n$ = 310) | | Family Abuse Class ($n$ = 179) | | Stranger Abuse Class ($n$ = 80) | | Nonabused Class ($n$ = 702) | | $\chi^2 1$ | $\phi 1$ | $\chi^2 2$ | $\phi 2$ |
| | $N$ | % | $N$ | % | $N$ | % | $n$ | % | | | | |
| Intercourse < 16yrs | 141 | 45.48 | 92 | 51.40 | 45 | 56.25 | 264 | 37.61 | 16.26*** | .11 | 3.62 | .08 |
| Age at first birth < 19yrs | 10 | 3.23 | 4 | 2.23 | 4 | 5.00 | 8 | 1.14 | 6.47** | .07 | 1.32 | .05 |
| Ever married | 157 | 50.65 | 95 | 53.07 | 39 | 48.75 | 329 | 46.87 | 2.30 | .04 | 0.48 | .03 |
| Ever separated / divorced [a] | 45 | 28.66 | 43 | 45.26 | 12 | 30.77 | 67 | 20.36 | 15.41*** | .16 | 7.37* | .16 |
| Physical assault (self)[b] | 73 | 33.95 | 40 | 30.77 | 24 | 40.00 | 126 | 24.90 | 8.73** | .10 | 1.57 | .06 |
| Physical assault (partner) [b] | 54 | 25.12 | 28 | 21.54 | 17 | 28.33 | 82 | 16.21 | 9.59** | .10 | 1.14 | .05 |
| Sexual coercion (self) [b] | 31 | 14.42 | 14 | 10.77 | 4 | 6.67 | 33 | 6.52 | 8.49** | .10 | 3.21 | .09 |
| Sexual coercion (partner) [b] | 54 | 25.12 | 30 | 23.08 | 12 | 20.00 | 74 | 14.62 | 12.15*** | .12 | 0.74 | .04 |

*Note.* [a] This measure was completed only by women who had ever been married and refers to the percentage of women who had ever been separated from a husband or divorced.

[b] These measures were completed only by women who were currently in an intimate relationship, and refer to the percentage of women who perpetrated or received physical assault or sexual coercion in the last 12 months in their current relationship.

* $p < .05$. ** $p < .01$ *** $p < .000$.

To examine the association of abuse class membership with relationship and sexual satisfaction, and number of relationships and lifetime sexual partners, ANOVAs were performed with three planned orthogonal comparisons. First women with a history of CSA were compared to women without a history of CSA. Second women in the family abuse class were compared to the remaining CSA survivors. Third women in the friend and stranger abuse classes were compared to one another. There were many differences in the couple relationship functioning of CSA survivors compared with their nonabused peers on continuous measures, however, these differences were all of a small effect size. CSA survivors had significantly more relationships ($d$ = .24) and lifetime sexual partners ($d$ = .39), than their nonabused peers. Women with a history of CSA were also significantly less satisfied with their intimate relationships ($d$ = .19) and sex lives ($d$ = .24), than women without a history of CSA. Compared to other women who had experienced CSA, women in the family abuse class reported significantly less relationship satisfaction ($d$ = .23). There were no significant differences between women in the family abuse class and the other CSA survivors regarding the number of relationships or lifetime sexual partners or sexual satisfaction. Women in the friend and stranger abuse classes did not significantly differ on any of these relationship outcomes.

Although all classes of CSA were associated with poorer mean relationship functioning than the nonabused class, many CSA survivors were functioning well in their intimate relationships. In the current study, 129 (31.9%) of CSA survivors who were currently in an intimate relationship did not report having ever separated or divorced, physical assault or sexual coercion occurring in their intimate relationship in the last year, relationship dissatisfaction as assessed by a cut-off score below 21.3 on the ADAS (Hunsley et al., 2001), or sexual dissatisfaction as assessed by a cut-off score below 3.13 on the sexual satisfaction domain of the FSFI (Rosen et al., 2000).

Table 10

*Analysis of Variance of Relationship and Sexual Functioning by Abuse Group Membership*

| Characteristic | Participant Groups | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Friend Abuse Class | | | Family Abuse Class | | | Stranger Abuse Class | | | Nonabused class | | | | | |
| | *N* | *M* | *SD* | *N* | *M* | *SD* | *N* | *M* | *SD* | *n* | *M* | *SD* | *df* | *F* | *r* |
| Number of relationships [a] | 310 | $2.39_a$ | (1.64) | 179 | $2.67_a$ | (1.67) | 80 | $2.40_a$ | (1.28) | 702 | 2.10 | (1.52) | 3, 1267 | 3.24* | .05 |
| Number of lifetime sexual partners [a] | 310 | $7.67_a$ | (6.63) | 179 | $8.58_a$ | (6.56) | 80 | $8.95_a$ | (6.06) | 702 | 5.75 | (5.60) | 3, 1267 | 13.37* | .10 |
| Relationship satisfaction [b] | 215 | $24.35_a$ | (5.17) | 130 | 22.87 | (5.47) | 60 | $23.76_a$ | (5.66) | 506 | 24.78 | (5.12) | 3, 910 | 4.89* | .07 |
| Sexual satisfaction [b] | 215 | $4.50_a$ | (1.58) | 130 | $4.38_a$ | (1.64) | 60 | $4.59_a$ | (1.50) | 506 | 4.83 | (1.43) | 3, 910 | 4.53* | .07 |

*Note.* Means having the same subscript ($_{a,}$) are not significantly different at $p < .05$ using a planned comparison procedure. [a] An age-adjusted index of number of sexual partners and relationships was used because age was found to significantly correlate with number of sexual partners ($r = .23$, $p < .01$) and the number of relationships ($r = .34$, $p < .01$). These age-adjusted indexes were calculated by dividing the sample into eight three-year age brackets, subtracting each individual's number of lifetime sexual partners and relationships from the mean for their age bracket, and dividing this number by the standard deviation for the corresponding age bracket. However to facilitate interpretation, the actual mean number of relationships and sexual partners are shown. [b] Relationship and sexual satisfaction were assessed for only those women who are currently in an intimate relationship.

* $p < .01$.

*Differences in family-of-origin functioning between abuse classes.* The association between CSA and family-of-origin functioning was explored using a series of ANOVAs with multiple group comparisons and chi-square analyses. Table 11 shows the correlations between the family-of-origin characteristics. Due to the high correlations between child physical and emotional abuse, between child physical and emotional neglect (as assessed by the CTQ-SF, Bernstein, et al., 2003), and between the family relationships index (as assessed by the FES, Moos & Moos, 1994) and emotional abuse and neglect, emotional abuse and neglect were excluded from ANOVAs to reduce the likelihood of committing a Type I error.

Table 11

*Correlations Between Family-of-Origin Characteristics*

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 1. Family relationships index [a] | -- | .56 | -.39 | -.70 | -.53 | -.83 | -.51 | -.26 |
| 2. Parental marital adjustment | | -- | -.44 | -.50 | -.41 | .55 | -.43 | -.58 |
| 3. Interparental aggression [b] | | | -- | .37 | .42 | .31 | .35 | .19 |
| 4. Child emotional abuse | | | | -- | .68 | .72 | .55 | .22 |
| 5. Child physical abuse | | | | | -- | .55 | .49 | .21 |
| 6. Child emotional neglect | | | | | | -- | .66 | .27 |
| 7. Child physical neglect | | | | | | | -- | .28 |
| 8. Permanent parental separation / divorce | | | | | | | | -- |

*Note.* All correlations significant at the $p < .01$ level. [a] The family relationships index is a measure of family-of-origin support and is a composite of the cohesion, expressiveness and reversed conflict subscales of the FES. [b] Interparental aggression is a composite measure of reports of both parents verbal aggression and violence toward one another.

To examine the association of abuse class membership with family-of-origin functioning ANOVAs were performed with three planned orthogonal comparisons. First women with a history of CSA were compared to women without a history of CSA. Second women in the family abuse class were compared to the remaining CSA survivors. Third women in the friend and stranger abuse classes were compared to one another.

CSA survivors experienced significantly more child physical abuse ($d$ = .51) and neglect ($d$ = .41) than their nonabused peers. CSA survivors also reported significantly less family-of-origin support as assessed by the family relationships index ($d$ = .50), and parental marital adjustment ($d$ = .34), and reported significantly higher levels of interparental aggression ($d$ = .27), than their nonabused peers.

Compared to other women who had experienced CSA, women in the family abuse class reported significantly higher levels of child physical abuse ($d$ = .51) and neglect ($d$ = .53), and significantly lower levels of parental marital adjustment ($d$ = .36) and family-of-origin support ($d$ = .47). There was no significant difference between women in the family abuse class and other CSA survivors in the level of interparental aggression. There were no significant differences between the friend and stranger abuse classes on any aspect of family-of-origin functioning assessed.

The prevalence of permanent parental separation / divorce also differed across abuse classes. Parents of CSA survivors (31%) were significantly more likely to have permanently separated or divorced than those of their nonabused counterparts (25%) [$\chi^2$ (1, $N$ = 1264) = 29.35, p < .000, $\phi$ = .15]. Parents of women in the family abuse class were significantly more likely to have permanently separated or divorced (50%), than those of women in the stranger (38%) and friend (33%) abuse classes [$\chi^2$ (2, $N$ = 565) = 14.28, p < .01, $\phi$ = .16].

Table 12

*Analysis of Variance of Family-of-Origin Functioning by Abuse Class Membership*

| | Participant Group | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Family Background Variable | Friend Abuse Class ($n$ = 310) | | Family Abuse Class ($n$ = 179) | | Stranger Abuse Class ($n$ = 80) | | Nonabused Class ($n$ = 702) | | $F$ | $r$ |
| | $M$ | $SD$ | $M$ | $SD$ | $M$ | $SD$ | $M$ | $SD$ | | |
| Parent marital adjustment | $3.80_a$ | (1.92) | 3.02 | (2.05) | $3.65_a$ | (2.01) | 4.19 | (1.85) | 19.01* | .12 |
| Family relationships index [a] | $15.06_a$ | (6.49) | 11.97 | (7.12) | $15.10_a$ | (6.23) | 17.36 | (6.04) | 37.78* | .17 |
| Interparental aggression [b] | $5.96_a$ | (5.38) | $6.91_a$ | (5.57) | $6.57_a$ | (5.04) | 4.97 | (4.61) | 9.46* | .09 |
| Child physical abuse | $7.56_a$ | (3.61) | 9.04 | (4.50) | $7.16_a$ | (2.85) | 6.30 | (2.46) | 40.05* | .18 |
| Child physical neglect | $6.54_a$ | (2.69) | 7.57 | (3.29) | $6.10_a$ | (1.95) | 5.84 | (1.75) | 29.25* | .15 |

Note. $df$ = 3, 1267 for all variables. Means having the same subscript ($_{a,}$) are not significantly different at $p < .05$ using a multiple comparison procedure. [a] The family relationships index measures family-of-origin support and is a composite of the cohesion, expressiveness, and reversed conflict subscales of the FES. [b] Interparental aggression is a composite measure of reports of both parents' verbal aggression and violence toward one another.

* p < .000.

*A summary of the differences between abuse classes.* In summary, CSA survivors reported poorer current relationship functioning and greater levels of family-of-origin dysfunction than their nonabused peers. CSA survivors were more likely to have had consensual sexual intercourse prior to 16 years of age and their first child prior to 19 years of age; to have had more relationships and lifetime sexual partners; to have experienced separation and divorce, and self- and partner-perpetrated sexual coercion and physical assault; and to have lower levels of relationship and sexual satisfaction than their nonabused peers. CSA survivors also experienced higher levels of child physical abuse, child physical neglect, and interparental aggression, and lower levels of parental marital adjustment and family-of-origin support than their nonabused peers.

In contrast to women in the friend and stranger abuse classes, women in the family abuse class experienced more severe CSA. Women in the family abuse class experienced more invasive CSA acts, involving greater levels of psychological coercion, and more perpetrators, at a younger age, and for a longer duration than other CSA survivors. Women in the family abuse class were also less likely to tell someone about the abuse, and received less support in response to this disclosure compared to other CSA survivors. Furthermore, women in the family abuse class reported the highest level of current distress regarding their CSA experiences, and were more likely to seek professional help than other CSA survivors. Women abused by a family member also reported poorer current relationship functioning than other CSA survivors; they reported higher rates of separation and divorce and less relationship satisfaction. Women abused by a family member also experienced greater family-of-origin dysfunction than women in the other abuse classes; they reported higher levels of child physical abuse and neglect, and permanent parental separation and divorce, and lower levels of parental marital adjustment and family-of-origin support.

There were fewer differences between women in the friend abuse class and women in the stranger abuse class in the nature of CSA, than between women in the family abuse class and other CSA survivors. Women in the friend abuse class experienced more invasive CSA acts, involving greater levels of psychological coercion, for a longer duration, than women in the stranger abuse class. Women in the friend abuse class were also less likely to tell someone about the abuse, and received less support in response to this disclosure, compared to women in the stranger abuse class. There were no significant differences in current relationship functioning or family-of-origin dysfunction between women in the friend and stranger abuse classes.

## *Discussion*

The aim of the first section of the current study was to describe the diversity of CSA experiences and family background variables that account for the variability in adult relationship outcomes of CSA survivors. Hypothesis 1 was supported: Women's experience of CSA was meaningfully separated into distinct classes using characteristics of the abuse including the level of physical contact involved, the relationship of the victim and perpetrator, disclosure of the abuse, and the use of psychological coercion by the perpetrator. The prediction that different classes of CSA survivors would have different couple relationship outcomes in adulthood (Hypothesis 2) was also supported by the results of the current study. Finally, Hypothesis 3 that different classes of CSA survivors would experience different levels of family-of-origin dysfunction was supported by the results of the current study.

### *The Composition of Child Sexual Abuse Classes*

The CSA classes found in the current study differed markedly on many aspects of their CSA experiences. Women in the family abuse class experienced earlier, more

severe, chronic, and coercive CSA, by more perpetrators, were least likely to disclose the abuse, and received a lower level of support in response to their disclosure, than women in the friend or stranger abuse classes. Furthermore, compared to other CSA survivors, women abused by a family member reported more distress about their CSA experiences, and were more likely to have sought professional help in regards to these experiences as adults.

Consistent with the current findings, previous research also found that CSA perpetrated by family members was typically more chronic and severe than CSA perpetrated by other people, and was associated with greater victim distress (Bennett et al., 2000; Finkelhor, 1994a; Fleming, 1997; Harvey et al., 2001; Hotte & Rafman, 1992; Hulme & Agrawal, 2004; Kinzl et al., 1995; Long & Jackson, 1991; McLean & Gallop, 2003; Runtz & Schallow, 1997; Trickett et al., 2001). The current findings extend that work showing there is a meaningful class of family CSA perpetration with a range of distinctive characteristics of the abuse.

There were fewer differences in the nature of CSA between women in the friend abuse class and those in the stranger abuse class compared to women in the family abuse class with other CSA survivors. Nonetheless, there were some important differences in the nature of CSA between women in the friend and stranger abuse classes. First, women in the friend abuse class experienced more invasive CSA acts than those in the stranger abuse class, that is, they reported higher rates of abuse involving physical contact with the perpetrator. Second, women in the friend abuse class experienced CSA over a longer duration than those in the stranger abuse class. Third, women in the friend abuse class were less likely to tell someone about their abuse experiences and received less support in response to their disclosure than those in the stranger abuse class. This is the first study to compare the nature of CSA between

women abused by a friend with those abused by a stranger and its findings suggest that these groups differ in important ways.

The results of the current study extend prior research regarding the classification of CSA. Prior research has represented variations in CSA as a single continuum of severity (Haugaard, 2000), or as classes of CSA defined by a single aspect of the abuse, (e.g., whether the CSA involved intercourse or not) (Carlin & Ward, 1992; Fergusson et al., 1997; Fleming, 1997; Kallstrom-Fuqua et al., 2004; Russell, 1983). The current study better classifies CSA by using five different aspects of the abuse simultaneously to define classes of abuse. The results of the current study show CSA perpetrated by a family member, friend, or stranger represent distinct phenomena.

*Differences in Adult Relationship Outcomes of Child Sexual Abuse Classes*

The classes of CSA survivors identified in the current study also differed in their current relationship functioning. Women in the family abuse class experienced lower levels of relationship satisfaction than other CSA survivors. While the association of abuse class with relationship satisfaction was only small, given the high prevalence of CSA even a small effect size has substantial public health significance. This is underscored by the finding that women in the family abuse class had almost double the rate of separation and divorce than other CSA survivors. Low relationship satisfaction is associated with risk for separation, and even a small difference in relationship satisfaction at a particular point in time seems to be related to a much higher rate of separations over long periods of time. The current findings replicate prior research that women abused by a family member experience higher rates of relationship difficulties than women abused by other perpetrators (Herman & Hirschman, 1981; McLean & Gallop, 2003; Meiselman, 1978; Noll et al., 2003).

In the current study CSA survivors in the friend and stranger abuse classes did not differ from each other in their current relationship functioning. However, all classes of CSA were associated with poorer mean relationship functioning than the nonabused class. Overall the results of the current study and prior research demonstrate that CSA survivors are at a considerably higher risk of experiencing relationship problems in adulthood than their nonabused peers. As one CSA survivor in the current study described: "My childhood experience constantly effects (*sic*) my relationship with my husband… I have intimacy problems." Another participant in the current study reported: "Being sexually abused as a child, does affect relationships…"

Consistent with prior research (Anderson et al., 1993; Bifulco et al., 1991; Brown et al., 2004; Cherlin et al., 2004; Colman & Spatz Widom, 2004; DiLillo et al., 2001; Fleming et al., 1999; Herman-Giddens et al., 1998; Messman-Moore & Long, 2000; Mullen et al., 1996; Noll et al., 2003; Russell, 1983; Schloredt & Heiman, 2003; Testa et al., 2005; Vigil et al., 2005; Zierler et al., 1991), in the current study CSA survivors began consensual sexual intercourse and had children at an earlier age, had more difficulty maintaining intimate relationships, had more short-term casual sexual partners, and were considerably more likely to have been a victim of partner-perpetrated physical assault and sexual coercion than their nonabused peers. The current study extends prior research by documenting that CSA survivors perpetrate sexual coercion and physical assault on their partners at a significantly higher rate than their nonabused peers. It is therefore not surprising, given the instability and violent nature of their relationships, that CSA survivors are more dissatisfied with their relationships and sex lives than their nonabused peers (Colman & Spatz Widom, 2004; Davis et al., 2001; DiLillo & Long, 1999; Feinauer et al., 1996; Fleming et al., 1999; Gold, 1986; Hunter, 1991; Jackson et al., 1990; Jehu, 1988; Liang et al., 2006; Schloredt & Heiman, 2003; Testa et al., 2005; Van Bruggen et al., 2006; Westerlund, 1992).

Despite the high rate of adult relationship difficulties experienced by CSA survivors, the results of the current study and previous research demonstrate that CSA does not inevitably lead to adult relationship difficulties. One resilient CSA survivor in the current study described her relationship: "My husband and I have been married for twenty years and have certainly had our ups and downs… We talk a lot and compromise… I have accepted what happened as a child and like who I am today." Although the proportion of women who are functioning well in their intimate relationships varies depending on the outcome measured, in the current study, approximately one third of CSA survivors did not report any deleterious relationship outcomes, which is consistent with the findings of prior research (Colman & Spatz Widom, 2004; Davis & Petretic-Jackson, 2000; Liem et al., 1997). Although there is substantial evidence that CSA acts as a risk factor for poor relationship functioning in adulthood, it is clear that not all abused women will experience such problems. The current study has identified that the nature of the CSA experience, most notably the relationship between the victim and perpetrator, can be used as marker to identify those CSA survivors who are most at risk of experiencing negative relationship outcomes in adulthood.

The ability to determine which CSA survivors are most likely to experience negative adult relationship outcomes is important and has substantial public health implications. Being in a mutually satisfying marriage is associated with lower rates of mental and physical health problems (Halford et al., 1997), greater life expectancy (Burman & Margolin, 1992), fewer financial difficulties, and less work absenteeism (Forthofer, Markman, Cox, Stanley, & Kessler, 1996). The relationship difficulties experienced by CSA survivors substantially and negatively impact on their mental and physical health (Banyard et al., 2001; Cloitre et al., 1997; Whiffen et al., 1999; Wyatt et al., 1992), and these types of relationship difficulties also have a negative impact on

children (Amato, 2001; Grych, Fincham, Jouriles, & McDonald, 2000). Relationship difficulties also have a substantial economic impact on the community (Standing Committee on Legal and Constitutional Affairs: House of Representatives, 1998).

A good example of the economic impact CSA can have on the community is through its association with marital separation. In 2005 there were 52, 399 divorces (Australian Bureau of Statistics, 2005), which cost the Australian community three (Standing Committee on Legal and Constitutional Affairs: House of Representatives, 1998), to six billion dollars (AMP.NATSEM, 2005). If we assume that the prevalence of CSA and the separation rates of women with and without a history of CSA found in the current study are representative of the general population, we can calculate the additional number and cost of divorces annually that are associated with CSA. In the current study 45% of women experienced CSA and the relative risk of woman with a history of CSA to women without a history of CSA to separate from a husband was 1.7. Therefore, each year approximately 3278 additional divorces or about 6% of all divorces are associated with CSA. These additional divorces cost Australia approximately 270 million dollars per year. This figure suggests that CSA has a substantial economic impact on the community. As alarming as this figure is, it underrepresents the cost of CSA, as it does not take into account the costs associated with relationship violence.

However, the current study used a self-selecting sample and given the low response rate, the prevalence of CSA and of relationship difficulties may not been representative of those found in the general population. It is possible that individuals with a history of CSA may have been more likely to participate in the current study than those without a history of CSA, inflating the rate of CSA. However, given that the current sample did not differ from the Australian population, except in regards to underestimating people with low education and those who were separated or divorced, it

seems more likely that if anything, the sample underrepresented CSA and relationship difficulties. Low education and socio-economic status are associated with increased rates of CSA and relationship difficulties (Anderson et al., 1993; Messman-Moore & Long, 2000; Orbuch, Veroff, Hassan, & Horrocks, 2002). The consistency between the CSA prevalence rate obtained in the current study with those of prior community studies (Russell, 1984; Saunders et al., 1992; Wyatt et al., 1992) provides further evidence to support the extrapolation of the current findings to the general population.

Given that CSA survivors are at high risk of experiencing relationship difficulties, and considering the impact these difficulties can have on their mental and physical health, and the resulting financial burden placed on society, it is clear that relationship education programs that explicitly target this population are required. By determining which CSA survivors are most likely to experience difficulties in adult relationship functioning, that is women who have experienced incest, treatment interventions aimed at preventing or ameliorating these difficulties can be targeted with much greater specificity.

*Differences in Family-of-Origin Dysfunction of Child Sexual Abuse Classes*

The abuse classes identified in the current study also differed in their level of family-of-origin dysfunction. Women in the family abuse class who experienced the most severe CSA and the worst relationship outcomes in adulthood also experienced substantially higher rates of family-of-origin dysfunction than women in the other abuse classes. Women in the family abuse class reported significantly higher rates of child physical abuse, child physical neglect, and parental divorce, and lower rates of parental martial adjustment and family-of-origin support than other CSA survivors, which is consistent with the findings of prior research (Alexander & Schaeffer, 1994; Hulme &

Agrawal, 2004). There were no differences in the level of family-of-origin dysfunction between women in the friend and stranger abuse classes.

Although there were no differences in the level of family-of-origin dysfunction between women in the friend and stranger abuse classes, all classes of CSA were associated with higher rates of family-of-origin dysfunction than the nonabused class. The findings that all classes of CSA were associated with significantly higher levels of interparental aggression, parental separation and divorce, child physical abuse and neglect, and lower levels of family-of-origin support and parental marital adjustment than the nonabused class, are consistent with those of prior research (Black et al., 2001a; Boney-McCoy & Finkelhor, 1995; Colman & Spatz Widom, 2004; Dong et al., 2003; Drake & Pandey, 1996; Edwards & Alexander, 1992; Fergusson et al., 1997; Finkelhor et al., 2005; Higgins & McCabe, 1994; Nelson et al., 2002; Ney et al., 1994; Paveza, 1988; Styron & Janoff-Bulman, 1997). One CSA survivor in the current study described her family of origin: "I came from a very violent background. He [her father] used to knock my mother around all the time until he killed himself when I was in grade 3."

The results of the current study and prior research highlight that CSA does not occur in isolation and that there is a strong association between classes of CSA and family-of-origin dysfunction. Given that women in family abuse class, who experienced the most severe CSA, and worst adult relationship outcomes, also experienced the highest rate of family-of-origin dysfunction and child maltreatment, it may be that the family environment rather than CSA that is responsible for these outcomes. Prior research has found family environment factors to moderate the relationship between CSA and adult relationship outcomes (Colman & Spatz Widom, 2004; Fergusson et al., 1997; Fleming et al., 1999; Kinzl et al., 1995; Liang et al., 2006; Mullen et al., 1996; Vigil et al., 2005). In addition, other forms of child maltreatment

were associated with negative relationship outcomes (Arata & Lindman, 2002; Colman & Spatz Widom, 2004; McCauley et al., 1997), and there is evidence of an additive effect of different forms of child abuse on these outcomes (Banyard et al., 2001; Boney-McCoy & Finkelhor, 1995; Luster & Small, 1997; Schloredt & Heiman, 2003). However, when these family environment factors including other forms of child maltreatment were controlled for a unique association between CSA and relationship outcomes continued to exist (Colman & Spatz Widom, 2004; Fergusson et al., 1997; Fleming et al., 1999; Kinzl et al., 1995; Liang et al., 2006; Mullen et al., 1996; Vigil et al., 2005). These findings suggest that both the CSA experience and family-of-origin functioning influence the relationship outcomes these women experience and probably do so in a synergistic manner.

Some of these aspects of family-of-origin dysfunction may serve to increase the likelihood of CSA occurring in the first place. In the current study a large proportion of the survivors of incestuous abuse reported that their abuse was perpetrated by fathers. Incest survivors in the current study also reported a higher rate of parental marital maladjustment and divorce in their families of origin compared with other CSA survivors and their nonabused counterparts. It is possible that fathers may engage in sexually abusive relationships with their daughters as a result of their dissatisfaction with their relationships with their wives (Paveza, 1988). Therefore, parental relationship maladjustment may increase the likelihood of CSA occurring.

Other aspects of family dysfunction may prevent CSA from being disclosed or effectively responded to, and lead to a longer duration of abuse and worse adult outcomes. CSA survivors' families of origin compared to those of their nonabused peers were found to have higher rates of father-perpetrated domestic violence (Bryer et al., 1987; Edwards & Alexander, 1992; Fergusson et al., 1997; Paveza, 1988; Rumm et al., 2000; Vigil et al., 2005), and this appears to be particularly prevalent in incestuous

families (Paveza, 1988). Women in the current study, who had experienced incestuous abuse, described higher levels of interparental aggression in their families of origin than their nonabused peers, and there was a nonsignificant pattern of higher levels of family-of-origin violence in the family abuse class compared with other CSA survivors. If a mother is experiencing domestic violence by her husband she may be unlikely intervene to stop him from sexually abusing their daughter (Paveza, 1988), and therefore the abuse may continue over a longer duration, and be associated with worse adult outcomes (Finkelhor, 1994a; Fleming, 1997; Kinzl et al., 1995; McLean & Gallop, 2003; Trickett et al., 2001).

The relationship between the victim and her mother may also be critical for determining adult relationship outcomes of CSA survivors, and in particular how they cope with the abuse. The current study found survivors of incest were less likely to disclose the abuse and received less support from their mother if they told her about the abuse than other CSA survivors. Prior research has found mothers of incest victims to be perceived by their daughters as being less loving (Hotte & Rafman, 1992) and less available (Madonna, Van Scoyk, & Jones, 1991), and to have poorer relationships with their daughters than the mothers of nonabused women (Hotte & Rafman, 1992; Paveza, 1988). CSA survivors who disclosed the abuse, particularly to their mothers, report lower levels of distress than those who did not tell anyone about the abuse (Elliot & Briere, 1994; Finkelhor et al., 1990; Harvey et al., 1991; Testa et al., 1992; Wyatt & Newcomb, 1990). Therefore, a lack of support provided by mothers of incestuously abused girls may undermine their ability to cope with the abuse and lead to poorer adult outcomes.

Other aspects of family-of-origin dysfunction may also affect the nature of the CSA experienced and how a victim copes with it. Survivors of incest in the current study were more likely than other CSA survivors to have experienced abuse by more

than one perpetrator. It may be that characteristics of incestuous families promote sexualised relationships. Madonna et al. (1991) found that compared to nonabusive families, incestuous families had more indistinct physical and emotional boundaries between individuals. The current study also found incestuous families to be less supportive than those of other CSA survivors. Madonna et al. (1991) found individuals within incestuous families compared to nonabusive families, had greater difficulty with problem solving; a more intrusive communication style, for example telling each other how to think, feel, and behave; rarely expressed their feelings; and responded to other family members' feelings with a lack of empathy. The lack of support in incestuous families may lead the victim to believe that her report of her abuse experiences will not be validated by the family, reducing the likelihood of her disclosure and her ability to cope with the abuse.

Although women abused by a family member reported higher levels of family-of-origin dysfunction than other CSA survivors in the current study, women abused by an extrafamilial perpetrator reported higher levels of family-of-origin dysfunction than nonabused women. The families of origin of CSA survivors have been found to provide less supervision to their children than families of nonabused women (Black et al., 2001a; Fergusson et al., 1997). Therefore, it may be that due to high levels of marital dissatisfaction, couple violence, and separation, that parents are preoccupied with their own relationship and unable to provide appropriate supervision of their children, making them vulnerable to abuse by extrafamilial perpetrators. The families of origin of extrafamilial survivors of CSA have not been previously compared to those of incestuous families and further study of these family dynamics is required.

*Limitations of the First Section of the Current Study*

Although several differences were found between abuse classes concerning the nature of CSA, adult relationship outcomes, and family-of-origin dysfunction, the current study may understate class differences. Despite the large sample size in the current study, there were only 80 women in the stranger abuse class and only 60 of these women were currently in an intimate relationship. On dichotomous outcomes this gave adequate power of $\beta = 0.8$ at $p < .05$ to detect medium but not small effect size differences (Cohen, 1992) from other abuse classes. Future research with a larger sample might detect additional relationship outcomes associated with these abuse classes. Given the high prevalence of CSA reported (45% of the current sample) even small differences in rates of relationship problems associated with different abuse classes could have substantial public health implications.

*Conclusions of the First Section of the Current Study*

The results of the first section of the current study demonstrate that CSA is not a homogeneous phenomenon. Rather, CSA perpetrated by a family member, friend, or stranger represent qualitatively different phenomenon both in terms of the nature of the abuse typically experienced, the extent of family-of-origin dysfunction, and the extent of difficulties in adult relationship functioning experienced by its victims. Abuse committed by a family member is typically more chronic and severe than other classes of CSA, and is associated with the most severe deficits in relationship functioning in adulthood. However, each class of CSA is associated with more difficulties in adult intimate relationships than women who have not experienced CSA.

# CHAPTER FIVE

## Study Part 2: Mediators of the Association Between Child Sexual Abuse and Adult Relationship Functioning

This chapter reports on the second section of the current study, assessing the variables that mediate the association between CSA and adult relationship outcomes. The aim of the second section of the current study is to test the dual pathway model of the association between CSA and adult relationship functioning. The dual pathway model extends Leonard and Follette's (2002) and Polusny and Follette's (1995) model of emotional avoidance. The model of emotional avoidance proposed that to alleviate negative affect and thoughts associated with intimate relationships arising from their abuse experiences, CSA survivors used avoidant coping strategies, which led to relationship problems (Leonard & Follette, 2002; Polusny & Follette, 1995). The model of emotional avoidance is used as the foundation of the dual pathway model to be tested by this dissertation because (as outlined in chapter 3) it is consistent with empirical research concerning CSA survivors and the development of relationship difficulties, and it can be easily empirically evaluated and used to explain how relationship difficulties in CSA survivors are maintained in adulthood. The emotional avoidance model is conceptually extended by the current study by addressing factors that protect CSA survivors from experiencing negative relationship outcomes. It is proposed that if approach-oriented or constructive coping strategies are used to reduce negative thoughts and feelings concerning intimate relationships this would lead to more positive relationship outcomes in CSA survivors. Therefore, the second section of the current study tested the prediction that the dual pathway model, as shown in Figure 8, can account for the association between CSA and adult relationship outcomes (Hypothesis 1).

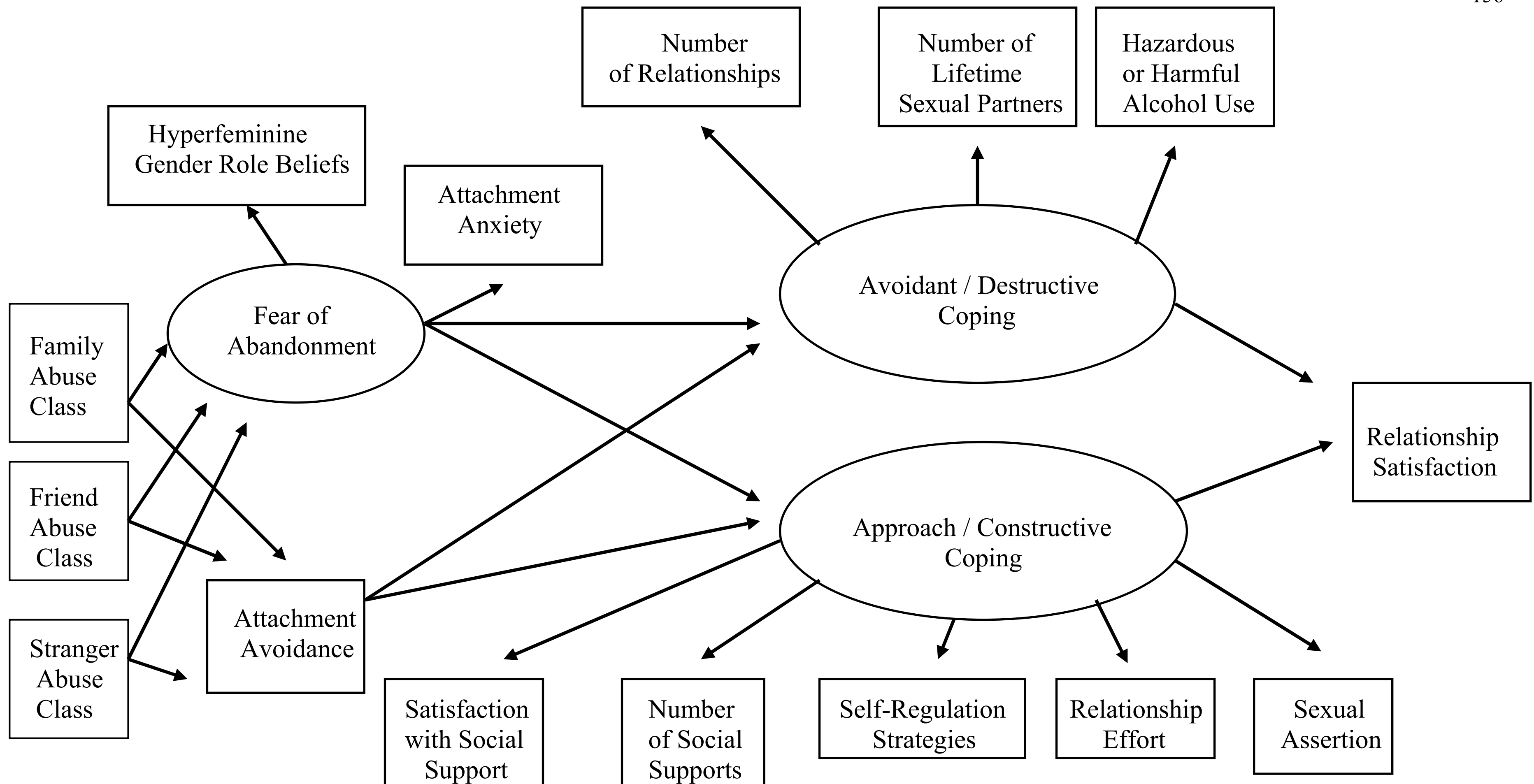


*Figure 8*. The proposed dual pathway model of the association between CSA and adult relationship outcomes

[3] This model represents the structural and measurement components of the mixture model to be tested in this dissertation. Mixture modelling allows the modelling of a mix of categorical and continuous variables. The boxes represent the manifest variables and the circles represent latent variables. Note exactly the same model was used to predict three manifest dependent variables: relationship satisfaction, sexual satisfaction and partner sexual coercion.

As shown in Figure 8, adult attachment and hyperfeminine gender role beliefs are used to represent the negative thoughts and feelings concerning intimate relationships CSA survivors may develop as a result of their abuse experiences because (a) CSA appears to be associated with an increased likelihood of developing an insecure attachment to one's partner, in particular attachment anxiety and avoidance, and hyperfeminine gender role beliefs (Alexander, 1992; Allen & Pothast, 1994; Finkelhor, 1980; Jehu, 1988; Roche et al., 1999; Swanson & Mallinckrodt, 2001; Whiffen et al., 1999); and, (b) attachment avoidance and anxiety, and hyperfeminine gender role beliefs were found to be associated with engaging in higher rates of destructive coping behaviours and lower rates of constructive coping behaviours (Brennan & Shaver, 1995; Feeney & Noller, 2004; Gentzler & Kerns, 2004; Ray & Gold, 1996; Simpson, 1990).

As shown in Figure 8, harmful or hazardous alcohol use, and number of lifetime sexual partners and relationships are used as three examples of destructive or avoidant coping strategies CSA survivors may use to alleviate negative thoughts and feelings concerning intimate relationships. Harmful or hazardous alcohol use, and number of lifetime sexual partners and relationships were selected to represent destructive or avoidant coping strategies CSA survivors may use because (a) CSA has been found to be associated with higher levels of these behaviours (Briere & Runtz, 1988b; Fleming et al., 1999; Herman & Harvey, 1997; Kinzl & Biebl, 1992; Leonard & Follette, 2002; Messman-Moore & Long, 2002b; Mullen et al., 1996; Noll et al., 2003); and (b) engaging in high levels of these behaviours is associated with high levels of sexual coercion (Brietenbecher, 2001; Classen et al., 2001; Messman-Moore & Long, 2002a; Nurius, 2000), and sexual and relationship dissatisfaction (Haavio-Mannila & Kontula, 1997; Kelly et al., 2002a; McCabe, 1999; Olenick & Chalmers, 1991; Rosen & Leiblum, 1995a).

As shown in Figure 8, relationship effort, self-regulation strategies, number of social supports, satisfaction with social support, and sexual assertion are used to represent constructive or approach oriented coping CSA survivors may use to alleviate negative thoughts and feelings concerning intimate relationships, because (a) constructive coping was found to be associated with better adjustment and psychological outcomes in CSA survivors (Bal et al., 2003; Binder et al., 1994; Coffey et al., 1996b; Draucker, 1995; Gold, 1986; Himelein & McElrath, 1996; Thompson et al., 2003; Wyatt & Newcomb, 1990); and (b) engaging in higher levels of the aforementioned constructive coping behaviours is associated with higher levels of relationship satisfaction (Collins & Feeney, 2000; Cramer, 2004; Wilson et al., 2005) and sexual satisfaction (Haavio-Mannila & Kontula, 1997; Morokoff et al., 1997; Ojanlatva et al., 2005), and lower levels of sexual coercion (Classen et al., 2001; Cloitre et al., 1997).

As shown in Figure 8, relationship satisfaction, sexual satisfaction, and partner sexual coercion are used as the dependent variables in the dual pathway model because (a) as demonstrated by the findings of the current study in chapter 4 and in the review of the literature in chapter 2, these relationship outcomes are associated with CSA; and (b) the destructive and constructive coping strategies in the dual pathway model have been found to be most strongly associated with these aspects of adult relationship functioning (Brietenbecher, 2001; Classen et al., 2001; Cloitre et al., 1997; Collins & Feeney, 2000; Cramer, 2004; Haavio-Mannila & Kontula, 1997; Kelly et al., 2002a; McCabe, 1999; Messman-Moore & Long, 2002a; Morokoff et al., 1997; Nurius, 2000; Ojanlatva et al., 2005; Olenick & Chalmers, 1991; Rosen & Leiblum, 1995a; Wilson et al., 2005).

As shown in Figure 8, membership of the three abuse classes (friend, family, and stranger abuse classes) identified in chapter 4 is used as the independent variable in the model. Abuse class membership is used as the independent variable in the model as

opposed to the presence or absence of CSA as it was found to more reliably predict relationship outcomes as discussed in chapter 4.

Belonging to the family abuse class is anticipated to be more strongly associated with attachment anxiety and avoidance, and hyperfeminine gender role beliefs than belonging to the friend or stranger abuse classes. Women abused by extrafamilial perpetrators would have more opportunity to be exposed to other positive attachment and gender-role relationships (e.g., within the family) that may contribute to more secure attachments and flexible gender role beliefs. This proposal is consistent with the findings of prior research that women abused by family members have greater attachment avoidance and anxiety than women abused by extrafamilial perpetrators (Roche et al., 1999; Swanson & Mallinckrodt, 2001; Whiffen et al., 1999).

Women in the family abuse class are also anticipated to be more inclined than women in the other abuse classes to engage in more destructive and less constructive coping behaviour for two reasons. First, due to the high level of family-of-origin dysfunction present in this group, these women may be less likely to be exposed to constructive parenting and models of intimate relationships than other CSA survivors, which are associated with better relationship skills in adulthood (Conger et al., 1994). Second, due to the family-of-origin dysfunction present in the family abuse class, these women may be more likely to be exposed to more poor parenting and more negative models of intimate relationships than other CSA survivors, which are associated with the failure to develop the social skills required for happy intimate relationships (Capaldi et al., 2002; Capaldi et al., 2003; Dishion et al., 1995; Patterson, 1997). In addition, if women abused by a family member are more likely to develop an insecure attachment in childhood, this attachment may preclude them from developing effective social skills and adaptive behaviours in intimate relationships. An insecure attachment in childhood

is associated with an insecure attachment in adulthood and with a lack of constructive coping in intimate relationships (Campbell et al., 2005; Fraley & Shaver, 2000).

Identifying the variables which mediate the association between CSA and adult relationship outcomes is important as it would provide much greater specificity in developing treatment interventions to prevent or ameliorate negative relationship outcomes. In addition, if these pathways are distinct for different classes of CSA survivors this would also provide greater specificity in targeting such treatment interventions.

## *Method*

This research was part of the original study outlined in chapter 4. The participants comprised of 1,335 women aged 18 to 41 years ($M$ = 29.83, $SD$ = 6.67) who were randomly selected from the Australian electoral roll. The participants were largely representative of the general population except they were more highly educated and less likely to be separated or divorced. Women were sent an information sheet and the questionnaire package (as outlined in chapter 4) and those wanting to participate were asked to complete the questionnaire package and return it to the university.

## *Results*

### *Overview of Statistical Analyses*

Mplus software (Muthen & Muthen, 2005) was used to test the proposed model accounting for the relationship between abuse group membership and relationship functioning, as shown in Figure 8. First, the measurement model was tested using confirmatory factor analysis (CFA) and a composite was created for the latent variable with less than three indicators. The structural model was then tested using mixture modelling, which allows modelling of a mix of categorical and continuous variables.

Mixture modelling is robust to moderate violations of normality and does not assume linearity of data or homogeneity of variance (Uebersax, 1993). Only participants who were currently in an intimate relationship with a male partner for a minimum of 6 months duration were included within the analyses.

Membership of the three abuse classes (friend, family, and stranger abuse classes) identified in chapter 4 was used as the independent variable in the model and was compared to membership of the nonabused class, which was used as the reference class. As shown in Figure 8, the model comprised of four mediating variables: fear of abandonment, attachment avoidance, destructive coping, and constructive coping. Fear of abandonment represented a composite variable of hyperfeminine gender role beliefs as assessed by the HF (Murnen & Byrne, 1991) and anxious attachment measured using the ECR (Brennan et al., 1998). Avoidant attachment as assessed by the ECR (Brennan et al., 1998) was an observed indicator. Destructive coping was a latent variable that consisted of the number of relationships and lifetime sexual partners, as assessed by the RSHQ, and hazardous or harmful alcohol use, measured using the AUDIT (Saunders et al., 1993). Constructive coping was a latent variable comprised of satisfaction with social support and number of social supports, as assessed by the SSQ-6 (Sarason et al., 1983), self-regulation strategies and relationship effort, measured using the BSRERS-Self (Wilson et al., 2005), and sexual assertion (including both the ability to initiate wanted sexual experiences and refuse unwanted ones), as assessed by the SAS (Morokoff et al., 1997). The three relationship outcomes tested were relationship satisfaction as assessed by the ADAS (Sharpley & Rogers, 1984), sexual satisfaction, as measured by the FSFI (Rosen et al., 2000), and partner sexual coercion, as assessed by the CTS2 (Straus et al., 1996), which were evaluated in separate models.

To evaluate model fit the chi-square ($\chi^2$), comparative fit index (CFI) (Bentler, 1990), root mean square error of approximation (RMSEA) (Steiger, 1998), standardised

root mean residual (SRMR), and the WRMR (Muthen & Muthen, 2005) were used. Chi-square is very sensitive to sample size, and models using large samples are almost always rejected. Therefore, rather than using the significance level of $\chi^2$ as an index of model fit, the ratio of $\chi^2$ to degrees of freedom was used. There seems to be a consensus that a $\chi^2$ value that is equal to or less than three times the number of degrees of freedom in the model represents acceptable fit, and equal or less than two times represents good fit (Bollen, 1989; Hair, 1992). A CFI value of .90 or above indicates acceptable fit and a value of or above .95 indicates good fit (Bentler, 1990). For both the RMSEA and SRMR a value of less than .08 indicates acceptable fit and a value of less than .06 indicates good fit (Hu & Bentler, 1999). A WRMR less than 0.90 indicates good fit for models with categorical outcomes (Muthen & Muthen, 2005).

In order to establish whether the measurement and structural models were class-invariant or equivalent across abuse classes, the model fit for the whole sample (i.e. single-class model), in which factor loadings and factor variances / covariances and structural paths were constrained to be equal across classes, was compared to a multiple-class model in which these parameters were allowed to vary across abuse classes. Given that the constrained model is nested within the multiple-class model, the difference in $\chi^2$ between the single-class and multiple-class models is distributed as $\chi^2$, with degrees of freedom equal to the difference in degrees of freedom between the two models (Byrne, 1998). A difference in $\chi^2$ between the single-class and multiple-class models that is not statistically significant suggests that the factor structure and structural paths are equivalent across classes and that a single-class model best represents the data (Byrne, 1998).

After the measurement model was established, the structural model was fitted. For models with continuous outcome variables (i.e., relationship and sexual satisfaction), linear multiple regression coefficients representing the structural

relationships were produced using a maximum likelihood estimator. For the model predicting partner sexual coercion (categorical outcome variable), logistic regression coefficients representing the structural relationships were produced using the weighted least square estimator (Muthen & Muthen, 2005).

*Constructing Composites*

Bagozzi and Edwards (1998) identified several different levels of aggregation of variables to be used in SEM measurement models, including (a) using individual item responses as separate indicators, (b) using subsets of items (item-parcels) as separate indicators, (c) using total scale scores as separate indicators, or (d) creating composites of scale scores. Bagozzi and Edwards (1998) argued that in situations where the construct of interest is broadly defined, the higher levels of aggregation: using total scale scores as separate indicators or creating composites of scale scores, are most appropriate. Indeed, it has been argued that using composite indicators is advantageous because they: (a) reduce the likelihood of spurious correlations; (b) reduce measurement and sampling error; (c) result in greater normality, validity, continuity, and reliability; and (d) are more likely to result in stable models (Bagozzi & Edwards, 1998; MacCallum & Austin, 2000; MacCallum, Zhang, Preacher, & Rucker, 2002). Therefore, in accordance with Bagozzi and Edward's (1998) recommendations, total scale scores were used as separate indicators of latent variables.

According to the current recommendations (Byrne, 1998; Hair, 1992) latent variables need to be comprised of at least three manifest variables. According to Bollen (1989), latent constructs with less than three indicators make model identification problematic, are associated with an increased likelihood of incorrect solutions, and require analyses external to SEM to remove error from latent constructs. As a result of this, an observed score composite, rather than a latent variable, was created for fear of

abandonment, which had less than three indicators. The fear of abandonment construct was created by converting the total scores of attachment anxiety and hyperfeminine gender role beliefs to a *z* score and adding them together and dividing by two to provide a standardised score. The fear of abandonment composite consisted of 44 items and had good internal consistency ($\alpha = .84$). As shown in Table 13, hyperfemininity, attachment anxiety, and attachment avoidance were positively correlated, though the magnitude of correlations was low to very low.

Table 13

*Correlations Between Hyperfemininity, Attachment Anxiety and Attachment Avoidance*

| Variables | 1 | 2 | 3 |
|---|---|---|---|
| 1. Hyperfemininity | -- | .34* | .13* |
| 2. Attachment Anxiety | | -- | .35* |
| 3. Attachment Avoidance | | | -- |

*Note*. * $p > .01$.

*Testing the Measurement Model*

Two latent variables comprised the measurement model: constructive coping, which consisted of satisfaction with social support, number of social supports, self-regulation strategies, relationship effort, and sexual assertion (including both the ability to initiate wanted sexual experiences and refuse unwanted ones); and destructive coping, which comprised hazardous or harmful alcohol use, age-adjusted number of lifetime sexual partners, and age-adjusted number of intimate relationships. An age-adjusted index of number of lifetime sexual partners and relationships was used because age significantly correlated with number of lifetime sexual partners ($r = .23$, $p < .01$), and the number of relationships ($r = .34$, $p < .01$). These age-adjusted indexes were

calculated by dividing the sample into eight three-year age brackets, subtracting each individual's number of lifetime sexual partners and relationships from the mean for their age bracket, and dividing this number by the standard deviation for the corresponding age bracket. The measurement model was tested using CFA. Loadings between indicators and the latent factors were freely estimated. The factor loading for the first item of each latent variable was set to 1.0. The measurement model provided good fit to the data $\chi^2$ (19, $N$ = 911) = 82.99, $p < .000$; CFI = 0.94; RMSEA = .06; SRMR = .05. The factor loadings for the measurement model are presented in Table 14. As Table 14 shows, parameter tests for all factor loadings were significant at $p < .01$.

Table 14

*Parameters of Confirmatory Factor Analysis of Constructive and Destructive Coping*

| Measure | Unstandardised loadings | Standard error | Standardised loading [a] | $R^2$ |
|---|---|---|---|---|
| Constructive Coping | | | | |
| Satisfaction with social support | 1.00[b] | 0.00 | 0.49 | 23.50 |
| Number of social supports | 2.44 | 0.25 | 0.49 | 23.50 |
| Self-regulation strategies | 1.51 | 0.14 | 0.58 | 34.20 |
| Relationship effort | 1.24 | 0.11 | 0.71 | 50.80 |
| Sexual assertion | 1.65 | 0.16 | 0.54 | 29.10 |
| Destructive Coping | | | | |
| Hazardous or harmful alcohol use | 1.00[b] | 0.00 | 0.37 | 13.40 |
| Age-adjusted number of lifetime sexual partners | 0.52 | 0.09 | 0.92 | 84.40 |
| Age-adjusted number of Relationships | 0.25 | 0.03 | 0.47 | 22.00 |

*Note.* [a] All significant at $p < .01$. [b] Parameter was fixed to 1.00 during estimation.

To establish whether the measurement model was class-invariant the model fit for the whole sample (i.e. single-class model), in which factor loadings and factor variances / covariances were constrained to be equal across abuse classes, was compared to a multiple-class model in which they were allowed to vary. The multiple-class model was not a better fit to the data than the single-class model $\Delta\chi^2$ (62, $N$ = 911) = 74, $p > .05$, and the single-class measurement model was retained.

*Testing The Structural Model*

*Predicting relationship satisfaction.* First a structural model was tested to predict relationship satisfaction. The independence model that tests the hypothesis that variables are uncorrelated with one another was easily rejected $\chi^2$ (88, *N* = 911) = 2268.49, $p < .000$. The hypothesised model provided acceptable fit to the data $\chi^2$ (66, *N* = 911) = 225.58, $p < .000$; CFI = .93; RMSEA = .05; SRMR = .05, accounting for 48% of the variance in relationship satisfaction. The hypothesised model provided better fit to the data than the independence model $\Delta\chi^2$ (22, *N* = 911) = 2042.91, $p < .001$.

There were significant but small pathway coefficients from the family and friend abuse classes to fear of abandonment and attachment avoidance. In contrast to women who were not abused, belonging to either the family or friend abuse class was associated with higher fear of abandonment and attachment avoidance. The pathways from the stranger abuse class to fear of abandonment and attachment avoidance did not differ from the nonabused class. There were significant pathways from fear of abandonment and attachment avoidance to constructive and destructive coping. Women with high fear of abandonment or attachment avoidance engaged in less constructive coping and more destructive coping. Constructive and destructive coping predicted relationship satisfaction. Women who engaged in high constructive coping and low destructive coping reported high relationship satisfaction[4].

Comparing the direct effects of belonging to the family abuse class on constructive coping ($b = -3.64$, $SE = .75$, $p < .01$, $\beta = -.21$), with the effect of belonging to the family abuse class on constructive coping when fear of abandonment and

[4] The mediation pathways as shown in Figure 9, were verified using Baron and Kenny's (1986) approach in which mediation is demonstrated when a significant relationship between two variables becomes nonsignificant when a third variable, which is also correlated with the first two variables, is partialled from this association. Partial mediation is demonstrated when the correlation between two variables is reduced due to the addition of the third variable but does not become nonsignificant (Baron & Kenny, 1986). The mediation pathways shown in Figure 9, were also verified using tests of indirect effects which indicate that the effect of the IV on the DV via the mediating variables is significantly different from zero (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002; Shrout & Bolger, 2002).

attachment avoidance were included in the model ($b = -1.40$, $SE = .56$, $p < .05$, $\beta = -.08$), confirmed the presence of partial mediation only, as belonging to the family abuse class still significantly predicted constructive coping despite the mediators being included in the model. Similarly, comparing the direct effects of belonging to the family abuse class on destructive coping ($b = 0.74$, $SE = .22$, $p < .01$, $\beta = .15$), the friend abuse class on destructive coping ($b = 0.49$, $SE = .17$, $p < .01$, $\beta = .12$), and the stranger abuse class on destructive coping ($b = 0.86$, $SE = .29$, $p < .01$, $\beta = .12$), with the effect of belonging to these abuse classes on destructive coping when fear of abandonment and attachment avoidance were included in the model (family $b = 0.66$, $SE = .22$, $p < .01$, $\beta = .12$), (friend $b = .47$, $SE = .18$, $p < .01$, $\beta = .11$), (stranger $b = .94$, $SE = .31$, $p < .01$, $\beta = .12$), confirmed the presence of partial mediation only, as belonging to these abuse classes was still significantly associated with destructive coping, despite the mediators being included in the model. Therefore the model was modified adding direct paths from belonging to the family abuse class to constructive coping, and from belonging to the family, friend, and stranger abuse classes to destructive coping. The modified model provided acceptable fit to the data $\chi^2$ (62, $N = 911$) = 196.71, $p < .000$; CFI = .94; RMSEA = .05; SRMR = .04, accounting for 48% of the variance in relationship satisfaction. The addition of extra pathways in the modified model provided better fit to the data $\Delta\chi^2$ (4, $N = 911$) = 28.87, $p < .001$. The modified model is shown in Figure 9.

A multiple-class model predicting relationship satisfaction from fear of abandonment, attachment avoidance, and constructive and destructive coping, was compared to a single-class version of this model to determine whether the pathways significantly differed across abuse classes. The multiple-class model provided acceptable fit to the data $\chi^2$ (178, $N = 911$) = 322.10, $p < .000$; CFI = .93; RMSEA = .06; SRMR = .07. The single-class model also provided acceptable fit to the data $\chi^2$ (40,

$N$ = 911) = 190.25, $p < .000$; CFI = .93; RMSEA = .06; SRMR = .06. The multiple-class model was not a better fit to the data than the single class model $\Delta\chi^2$ (138, $N$ = 911) = 131.85 $p > .05$, and the single-class model was retained.

In summary, fear of abandonment and attachment avoidance were higher in the family and friend abuse classes compared to the nonabused class, and this elevation was associated with less constructive coping and more destructive coping. However, the pathway coefficients from these abuse classes to fear of abandonment and attachment avoidance were small in size. In addition, the low constructive coping and high destructive coping seen in the family and friend abuse classes was associated with lower relationship satisfaction. However, the stranger and nonabused classes did not differ in the strength of their association with fear of abandonment or attachment avoidance. In addition, the stranger, friend, and nonabused class did not differ in the strength of their association with relationship satisfaction.

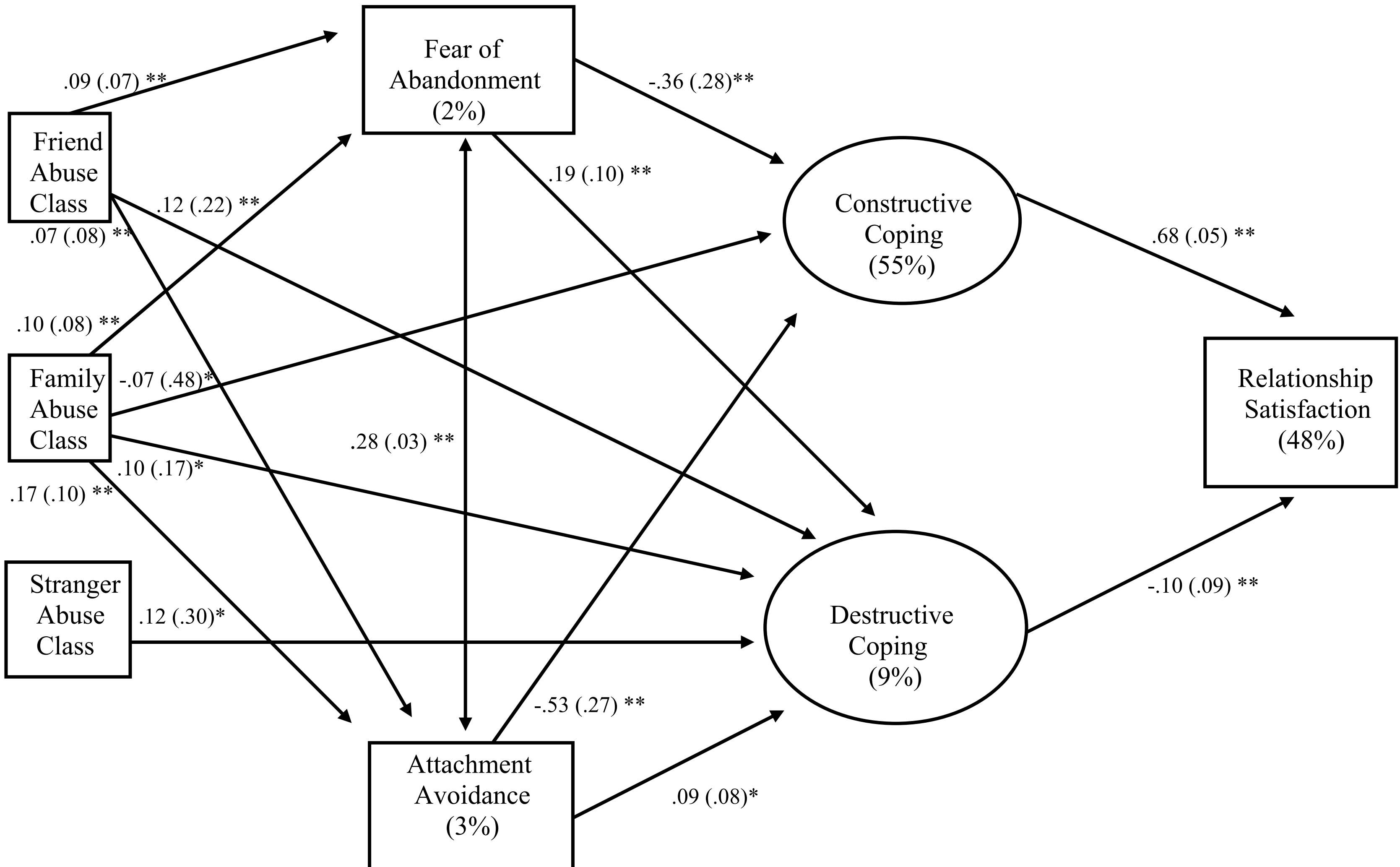


*Figure 9.* A model predicting relationship satisfaction from abuse class membership, fear of abandonment, attachment avoidance, and constructive and destructive coping ($n$ = 911). Numbers represent standardised regression coefficients, standard errors, and proportion of variance accounted for ($R^2$).
* $p < .05$. ** p < .01.

*Predicting sexual satisfaction.* A structural model was tested to predict sexual satisfaction. The independence model was easily rejected $\chi^2$ (88, $N$ = 911) = 2045.95, $p < .000$. The hypothesised model provided acceptable fit to the data $\chi^2$ (66, $N$ = 911) = 230.72, $p < .000$; CFI = .92; RMSEA = .05; SRMR = .05, accounting for 26% of the variance in sexual satisfaction. The hypothesised model provided better fit to the data than the independence model $\Delta\chi^2$ (22, $N$ = 911) = 1815.23, $p < .001$.

There were significant but small pathway coefficients from the family and friend abuse classes to fear of abandonment and attachment avoidance. In contrast to women who were not abused, belonging to either the family or friend abuse class was associated with higher fear of abandonment and attachment avoidance. The pathways from the stranger abuse class to fear of abandonment and attachment avoidance did not differ from the nonabused class. There were also significant pathways from fear of abandonment and attachment avoidance to constructive and destructive coping. Women with high fear of abandonment or attachment avoidance engaged in less constructive coping and more destructive coping. Constructive coping predicted sexual satisfaction. Women who engaged in high constructive coping reported high sexual satisfaction. However, destructive coping did not predict sexual satisfaction[5]. The model was modified to exclude destructive coping, and this modified model provided acceptable fit to the data $\chi^2$ (37, $N$ = 911) = 123.44, $p < .000$; CFI = .94; RMSEA = .05; SRMR = .04, accounting for 27% of the variance in sexual satisfaction. The modified model provided better fit to the data than the original model $\Delta\chi^2$ (29, $N$ = 911) = 107.28, $p < .001$.

Comparing the direct effects of fear of abandonment on sexual satisfaction ($b$ = -0.18, $SE$ = .06, $p < .01$, $\beta$ = -.10), with the effect of fear of abandonment on sexual satisfaction when constructive coping was included in the model ($b$ = .22, $SE$ = .08, $p$

[5] The mediation pathways as shown in Figure 10, were verified using Baron and Kenny's (1986) approach and tests of indirect effects (MacKinnon et al., 2002; Shrout & Bolger, 2002).

$<.01$, $\beta = .12$), did not provide support for mediation, as fear of abandonment continued to have a significant relationship with sexual satisfaction after the mediator was included in the model, and surprisingly this relationship was in a positive direction. As a result of this finding and the previously identified direct relationship between belonging to the family abuse class and constructive coping, the model was modified adding direct paths from belonging to the family abuse class to constructive coping, and from fear of abandonment to sexual satisfaction. The modified model provided good fit to the data $\chi^2$ (35, $N$ = 911) = 104.57, $p < .000$; CFI = .95; RMSEA = .05; SRMR = .03, accounting for 30% of the variance in sexual satisfaction. The addition of extra pathways in the modified model provided better fit to the data $\Delta\chi^2$ (2, $N$ = 911) = 18.87, $p < .001$. The modified model is shown in Figure 10.

A multiple-class model predicting sexual satisfaction from fear of abandonment, attachment avoidance, and constructive coping, was compared to a single-class version of this model to determine whether the pathways significantly differed across abuse classes. The multiple-class model provided acceptable fit to the data $\chi^2$ (84, $N$ = 911) = 154.41, $p < .000$; CFI = .95; RMSEA = .06; SRMR = .05. The single-class model also provided acceptable fit to the data $\chi^2$ (18, $N$ = 911) = 77.72, $p < .000$; CFI = .96; RMSEA = .06; SRMR = .03. The multiple-class model was not a better fit to the data than the single-class model $\Delta\chi^2$ (66, $N$ = 911) = 76.69, $p > .05$, and the single-class model was retained.

In summary, fear of abandonment and attachment avoidance were higher in the family and friend abuse classes compared to the nonabused class, and this elevation was associated with less constructive coping. However, the pathway coefficients from these abuse classes to fear of abandonment and attachment avoidance were small in size. In addition, the low constructive coping seen in the family and friend abuse classes was associated with low sexual satisfaction. However, the stranger and nonabused classes

did not differ in the strength of their association with fear of abandonment, attachment avoidance, or sexual satisfaction.

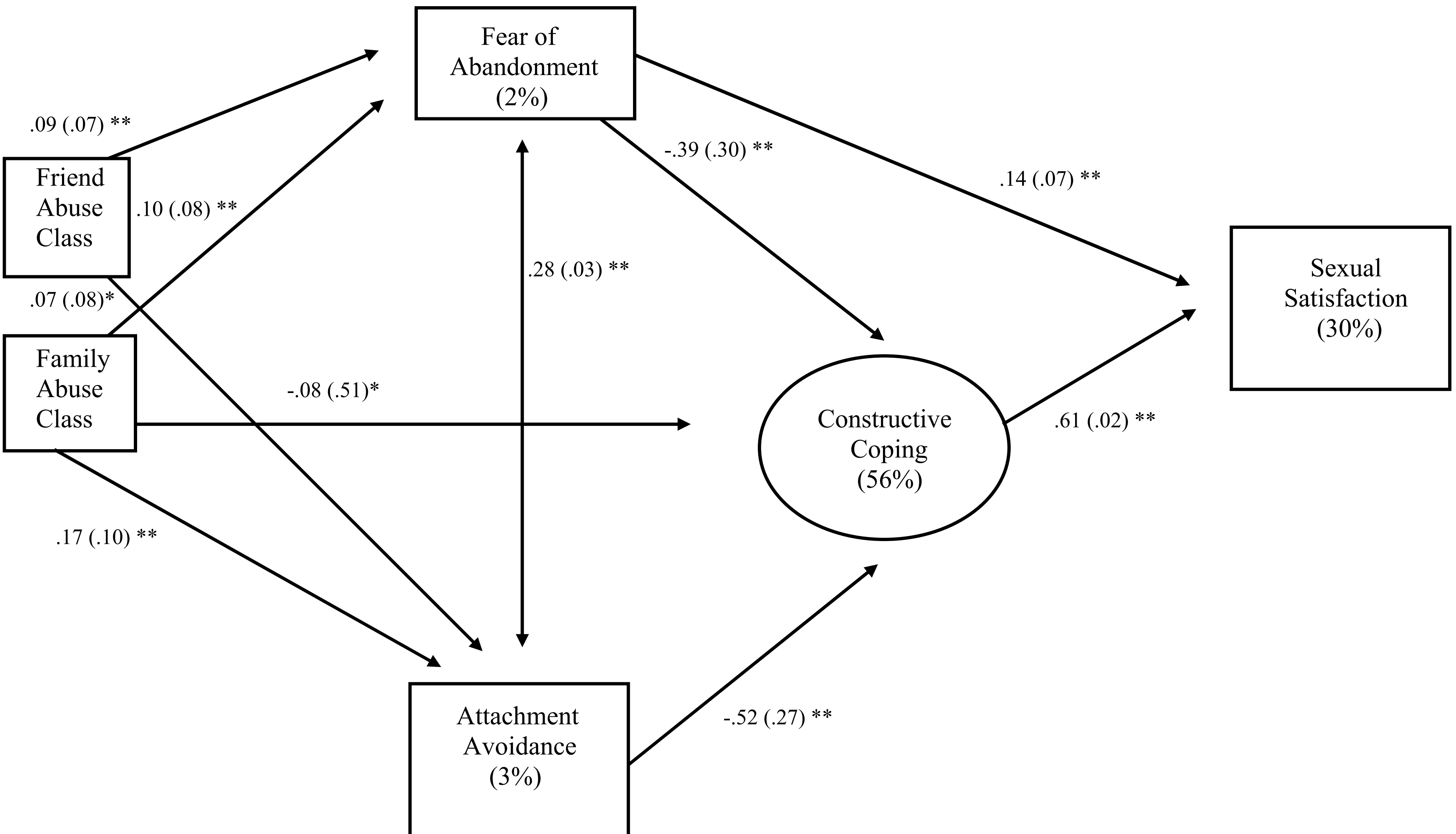


*Figure 10.* A model predicting sexual satisfaction from abuse class membership, fear of abandonment, attachment avoidance, and constructive coping ($n$ = 911). Numbers represent standardised regression coefficients, standard errors, and proportion of variance accounted for ($R^2$). The stranger abuse class is not represented in this figure as it did not have any significant paths to the mediators or the dependent variable.

* $p$ < .05. ** p < .01.

*Predicting partner sexual coercion.* A structural model was tested to predict partner sexual coercion. The independence model was easily rejected $\chi^2$ (36, *N* = 911) =1210.56, $p < .000$. The hypothesised model did not fit the data well, $\chi^2$ (43, *N* = 911) = 209.31, $p < .000$; CFI = .86; RMSEA = .07; WRMR = 1.52, accounting for 13% of the variance in partner sexual coercion. However the hypothesised model fitted the data better than the independence model $\Delta\chi^2$ (7, $N = 911$) = 1001.25, $p < .001$.

There were significant but small pathway coefficients from the family and friend abuse classes to fear of abandonment and attachment avoidance. In contrast to women who were not abused, belonging to either the family or friend abuse class was associated with higher fear of abandonment and attachment avoidance. The pathways from the stranger abuse class to fear of abandonment and attachment avoidance did not differ from the nonabused class. There were significant pathways from fear of abandonment and attachment avoidance to constructive and destructive coping. Women with high fear of abandonment or attachment avoidance reported engaging in less constructive coping and more destructive coping. Constructive coping predicted partner sexual coercion. Women who engaged in high constructive coping reported low partner sexual coercion. However, destructive coping did not predict partner sexual coercion.[6] The model was modified to exclude destructive coping and this modified model provided acceptable fit to the data $\chi^2$ (29, $N = 911$) = 97.49, $p < .000$; CFI = .93; RMSEA = .05; WRMR = .04, accounting for 13% of the variance in partner sexual coercion. The modified model provided better fit to the data than the original model $\Delta\chi^2$ (14, $N = 911$) = 111.82, $p < .001$.

Comparing the direct effects of belonging to the family abuse class on partner sexual coercion ($b = 0.32$, $SE = .14$, $p < .05$, $\beta = .11$), with the effect of belonging to the

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[6] The mediation pathways as shown in Figure 11 were verified using Baron and Kenny's (1986) approach and tests of indirect effects (MacKinnon et al., 2002; Shrout & Bolger, 2002).

family abuse class on partner sexual coercion when constructive coping was included in the model ($b = .32$, $SE = .14$, $p < .05$, $\beta = .11$), did not provide support for mediation, as belonging to the family abuse class still significantly predicted partner sexual coercion despite the mediator's presence. Likewise, comparing the direct effects of belonging to the friend abuse class on partner sexual coercion ($b = 0.38$, $SE = .12$, $p < .01$, $\beta = .16$), with the effect of belonging to the friend abuse class on partner sexual coercion when constructive coping was included in the model ($b = .38$, $SE = .12$, $p < .01$, $\beta = .16$), also did not provide support for mediation, as belonging to the friend abuse class continued to significantly predict partner sexual coercion when the mediator was included in the model. Comparing the direct effects of fear of abandonment on partner sexual coercion ($b = 0.24$, $SE = .06$, $p < .01$, $\beta = .18$), with the effect of fear of abandonment on partner sexual coercion when constructive coping was included in the model ($b = .24$, $SE = .06$, $p < .01$, $\beta = .18$), did not provide support for mediation, as fear of abandonment continued to have a significant association with partner sexual coercion after the mediator was included in the model. Similarly, comparing the direct effect of attachment avoidance on partner sexual coercion ($b = 0.15$, $SE = .05$, $p < .01$, $\beta = .14$), with the effect of attachment avoidance on partner sexual coercion when constructive coping was included in the model ($b = 0.15$, $SE = .05$, $p < .01$, $\beta = .14$), did not provide support for mediation, as attachment avoidance continued to have a significant association with partner sexual coercion after the mediator was included in the model.

In light of these findings and the previously identified direct relationship from the family abuse class to constructive coping, the model was evaluated adding direct paths from belonging to the family and friend abuse class, fear of abandonment, and attachment avoidance to partner sexual coercion, and from being in the family abuse class to constructive coping. When these direct relationships were included in the model, only the pathway from the friend abuse class to partner sexual coercion

remained significant. Therefore the model was modified including a direct path from being the friend abuse class to partner sexual coercion, and from being in the family abuse class to constructive coping. The modified model provided acceptable fit to the data $\chi^2$ (28, $N$ = 911) = 80.08, $p < .000$; CFI = .94; RMSEA = .05; WRMR = 0.99, accounting for 15% of the variance in partner sexual coercion. The addition of extra pathways in the modified model provided better fit to the data $\Delta\chi^2$ (1, $N$ = 911) = 17.41, $p < .001$. The modified model is shown in Figure 11. Figure 11 shows that belonging to the friend abuse class, relative to the nonabused class, increased the odds of experiencing partner sexual coercion by 15%. It is also evident from viewing Figure 11, that for a one unit increase in constructive coping a woman was 0.70 times as likely or 30% less likely to experience sexual coercion by her partner.

A multiple-class model predicting partner sexual coercion from fear of abandonment, attachment avoidance, and constructive coping, was compared to a single-class version of this model to determine whether the pathways significantly differed across abuse classes. The multiple-class model provided acceptable fit to the data $\chi^2$ (54, $N$ = 911) = 96.77, $p < .000$; CFI = .93; RMSEA = .06; WRMR = 1.58. The single-class model also provided acceptable fit to the data $\chi^2$ (16, $N$ = 911) = 79.36, $p <$ .000; CFI = .91; RMSEA = .07; WRMR = 1.08. The multiple-class model was not a better fit to the data than the single-class model $\Delta\chi^2$ (38, $N$ = 911) = 17.41, $p > .05$, and the single-class model was retained.

In summary, fear of abandonment and attachment avoidance were higher in the family and friend abuse classes compared to the nonabused class, and this elevation was significantly associated less constructive coping. However, the pathway coefficients from these abuse classes to fear of abandonment and attachment avoidance were small in size. In addition, the low constructive coping seen in the family and friend abuse classes was associated with high partner sexual coercion. However, the stranger and

nonabused classes did not differ in the strength of their association with fear of abandonment, attachment avoidance, or partner sexual coercion.

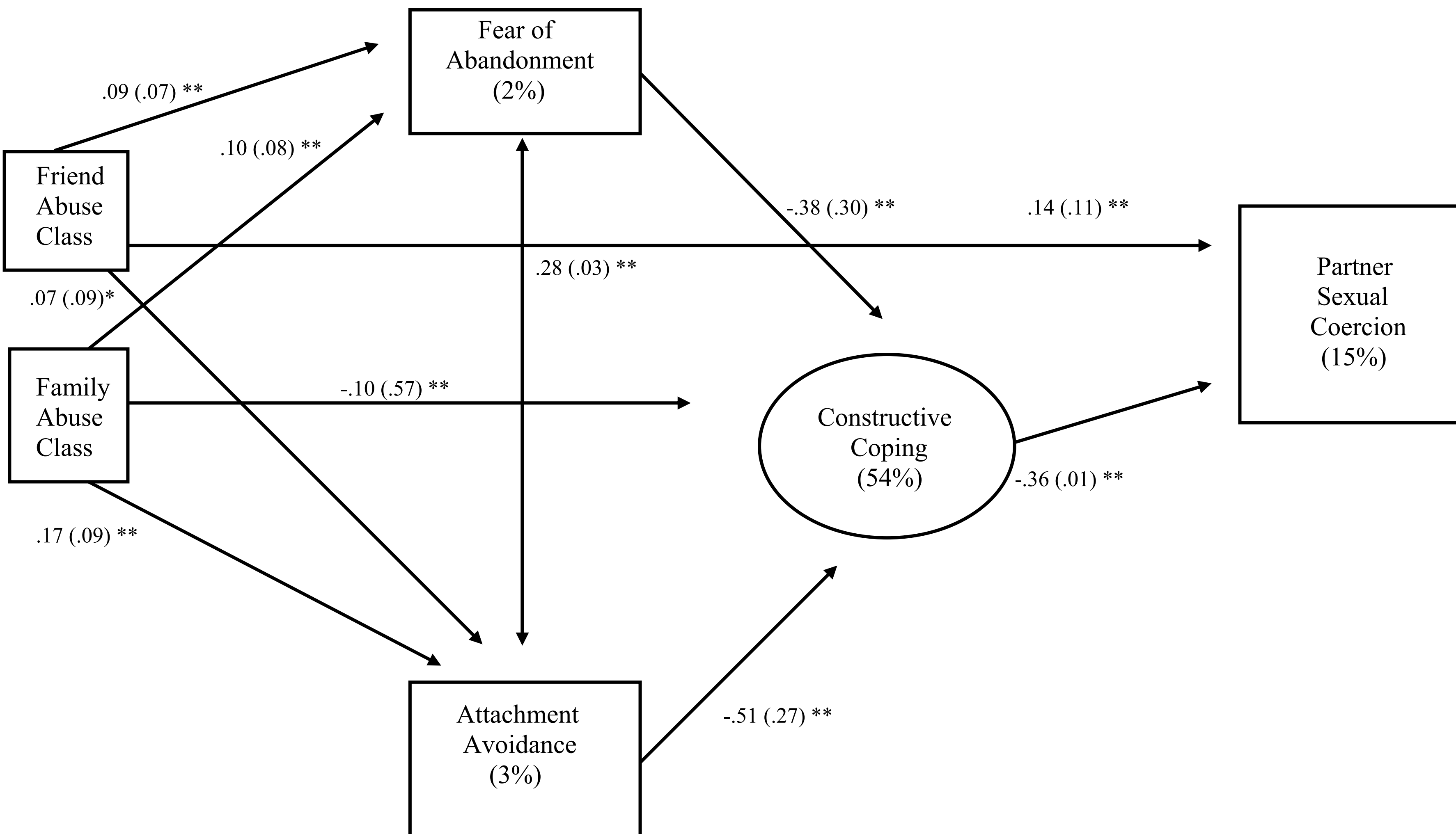



*Figure 11*. A model predicting the presence of partner sexual coercion from abuse class membership, fear of abandonment, attachment avoidance, and constructive coping ($n$ = 911). Numbers represent standardised regression coefficients, standard errors, and proportion of variance accounted for ($R^2$). The stranger abuse class is not represented in this figure as it did not have any significant paths to the mediators or the dependent variable.

* $p < .05$. ** $p < .01$

*Integrative Summary*

The initial model tested in the current study received mixed support. The fit of the model to the data in explaining relationship outcomes in CSA survivors varied depending on the class of CSA, and the type of relationship outcome and mediator assessed. First, the model better explained the relationship outcomes of women in the family and friend abuse classes than those of women in the stranger abuse class. Family abuse class membership predicted each of the relationship outcomes[7] and was associated with high fear of abandonment, attachment avoidance, and destructive coping and low constructive coping. In contrast, the stranger abuse class did not differ from the nonabused class in its strength of association with any of the outcomes measured[7] or the mediators (except destructive coping). Therefore, the model cannot be used to explain relationship functioning for these women. The model explained the association between CSA and some (sexual satisfaction and partner sexual coercion), but not all relationship outcomes (relationship satisfaction) for women in the friend abuse class[7] and membership of this class was associated with high fear of abandonment, attachment avoidance, and destructive coping and low constructive coping. However, it should be noted that the pathway coefficients from the family and friend abuse classes to fear of abandonment and attachment avoidance, although significant, were small in size.

Second, the effectiveness of the model differed depending on the relationship outcome assessed. The model accounted for more variance in relationship and sexual satisfaction than partner sexual coercion in CSA survivors. Third, the ability of the model to predict relationship outcomes in CSA survivors, varied depending on the

[7] The direct pathways for each of the three abuse classes (family, friend, and stranger) using the nonabused group as a reference class, to each of the relationship outcomes was evaluated during tests of mediation, which are not represented here. Belonging to the family abuse class significantly predicted relationship and sexual dissatisfaction and partner sexual coercion; membership of the friend abuse class significantly predicted sexual dissatisfaction and partner sexual coercion but not relationship satisfaction; and membership of the stranger abuse class did not significantly predict any of the relationship outcomes.

mediators used. Constructive coping was a better mediator of the association between class of CSA and relationship outcomes than destructive coping.

*Discussion*

The aim of the second section of the current study was to test the dual pathway model of the association between CSA and adult relationship functioning. Consistent with the dual pathway model, CSA perpetrated by a family member or friend was associated with negative associations with sex and intimacy. As proposed by the dual pathway model, the current study found these negative associations with sex and intimacy, were associated with more destructive coping in CSA survivors abused by friends or family members. Also consistent with the dual pathway model, the current study found engaging in more destructive coping strategies was associated with less relationship satisfaction in CSA survivors. However, engaging in more destructive coping was not associated with less sexual satisfaction or more partner sexual coercion.

The current study expands on prior research by being the first to examine factors that might protect CSA survivors from experiencing relationship difficulties in adulthood. The current study extends Leonard and Follette's (2002) and Polusny and Follette's (1995) emotional avoidance model by finding that rather than the use of destructive coping strategies, a lack of engaging in constructive coping strategies was more predictive of adult relationship functioning in CSA survivors. Consistent with the dual pathway model the current study found more positive associations with sex and intimacy were associated with more constructive coping, and more constructive coping was associated with better relationship outcomes in CSA survivors abused by a family member or friend. The findings of the current study are important as they provide greater specificity in targeting and developing treatment interventions to prevent or ameliorate relationship difficulties.

*Negative Associations with Sex and Intimacy as Mediators of Relationship Outcomes of Child Sexual Abuse Survivors*

The current study found CSA perpetrated by a family member or friend was associated with negative thoughts and feelings concerning intimate relationships. The finding that CSA predicts attachment avoidance and anxiety in adulthood is consistent with prior research (Alexander, 1992; Roche et al., 1999; Swanson & Mallinckrodt, 2001; Whiffen et al., 1999). This finding is also consistent with the statements made by CSA survivors in the current study, for example: “Due to my abuse… I have abandonment issues.” Another CSA survivor in the current study reported: “I can’t seem to make long term commitments to relationships.”

The current study found that CSA perpetrated by a family member or friend was also associated with hyperfeminine gender role beliefs. Only one study has examined the association between CSA and hyperfemininity directly, and due to a small sample the relationship between these variables could not be adequately evaluated (Maybach & Gold, 1994). However, prior research found that CSA survivors compared to their nonabused peers were more likely to form relationships with men characterised by more extreme gender role beliefs (Compton & Follette, 1998), and to describe opinions and engage in behaviours consistent with hyperfeminine gender role beliefs (Jehu, 1988; Weis & Borges, 1973).

Although CSA committed by a family member or friend, significantly predicted fear of abandonment, attachment avoidance, and hyperfeminine gender role beliefs, an individual’s abuse history accounted for only a small proportion of variance in these variables. Therefore, it is clear that other family-of-origin experiences influence CSA survivors’ adult attachment and gender role beliefs. Other forms of child maltreatment and family-of-origin dysfunction including a dysfunctional parental marital relationships and lower relationship satisfaction, high parenting stress, and poor mother-

child relationships, were found to be associated with an insecure adult attachment and hyperfeminine gender role beliefs (Carlson et al., 1989a; Davies & Cummings, 1994; Egeland & Farber, 1984; Moss, Cyr, & Dubois-Comtois, 2004; Moss et al., 1998; Stovall-McClough & Cloitre, 2006), and these forms of child maltreatment and family-of-origin dysfunction were found in the current study and prior research to occur at elevated rates in CSA survivors, particularly those abused by family members, compared with their nonabused peers (Black et al., 2001a; Colman & Spatz Widom, 2004; Drake & Pandey, 1996; Edwards & Alexander, 1992; Fergusson et al., 1997; Nelson et al., 2002; Paveza, 1988).

Family-of-origin dysfunction and CSA may operate in a synergistic manner in their association with adult relationship outcomes (Briere, 1992), and it is proposed that they are also likely to do so in regards to adult attachment and hyperfeminine gender role beliefs. For example, some aspects of functioning in the families of origin of CSA survivors, such as the relationship between the victim and her mother and the level of support provided to the victim by her family, may be critical in influencing their attachment and gender role beliefs (Elliot & Briere, 1994; Finkelhor et al., 1990; Harvey et al., 1991; Madonna et al., 1991; Testa et al., 1992; Wyatt & Newcomb, 1990). As well as being influenced by family-of-origin factors, attachment and gender role beliefs are also influenced by adult experiences. Adult attachment is influenced by peer and intimate relationships during childhood, adolescence, and adulthood (Linder & Collins, 2005). Therefore, the development of an insecure adult attachment and hyperfeminine gender role beliefs in CSA survivors abused by a family member or friend may be the product of both their abuse experiences and concomitant family-of-origin dysfunction and later adult experiences.

*Constructive Coping as a Mediator of Relationship Outcomes of Child Sexual Abuse Survivors*

The current study found a lack of engaging in constructive coping strategies, rather than the use of destructive coping, predicted negative adult relationship outcomes in CSA survivors abused by a family member or friend. Women with a more secure attachment to their intimate partner and less extreme gender role beliefs have higher social support and sexual assertion, than women with an insecure attachment or hyperfeminine gender role beliefs, which is consistent with prior research (Bartholomew & Horowitz, 1991; Brennan & Shaver, 1995; Collins & Feeney, 2000; Hazan & Shaver, 1987; Murnen & Byrne, 1991; Ray & Gold, 1996; Simpson, 1990). Individuals with a secure attachment to their partner (Brennan & Shaver, 1995; Collins & Feeney, 2000; Hazan & Shaver, 1987; Simpson, 1990) and less extreme gender role beliefs (Murnen & Byrne, 1991; Ray & Gold, 1996) appear to derive more positive benefits from social support, especially the support they receive from their partners; have more positive expectations concerning their partner's behaviour; and trust their partner more, than women with an anxious or avoidant attachment or hyperfeminine gender role beliefs.

Prior research also supports the finding that constructive coping strategies are associated with better relationship outcomes, including higher levels of relationship and sexual satisfaction (Collins & Feeney, 2000; Cramer, 2004; Haavio-Mannila & Kontula, 1997; Morokoff et al., 1997; Ojanlatva et al., 2005; Wilson et al., 2005), and lower levels of partner sexual coercion (Classen et al., 2001; Holtzworth-Munroe, Stuart, & Hutchinson, 1997; Morokoff et al., 1997; Nurius, 2000). CSA survivors in particular may benefit from using these constructive coping strategies in their intimate relationships. CSA survivors who seek support, especially from their intimate partners, experienced fewer psychological symptoms than CSA survivors who do not seek

support (Alexander, 1993; Feinauer et al., 1996; Valentine & Feinauer, 1993). CSA survivors who tell their partners about their abuse experiences and receive a positive response from them reported fewer psychological symptoms than those who received a negative response from their partners or those who did not disclose the abuse to their partners (Himelein & McElrath, 1996; Jonzon & Lindblad, 2005). Therefore, it appears that viewing individual concerns as shared couple issues, and working to improve the relationship are central to creating a satisfying intimate relationship, and may alleviate psychological distress in some CSA survivors. This assertion is consistent with qualitative findings of the current study. For example one CSA survivor in the current study reported: "Being sexually abused as a child, does affect relationships… I am lucky I have a very understanding husband." Another CSA survivor in the current study reported: "… I have discovered how crucial it is to have a supportive partner… and an external support network."

The current study found that although constructive coping strategies are associated with more positive relationship outcomes in adulthood, the experience of CSA especially that committed by a family member or friend, reduced the likelihood that they will use these strategies. The lack of constructive coping by CSA survivors was evident in CSA survivors' statements in the current study, for example: "I have to seek help to learn to 'trust' other people…" Another participant stated: "No matter how much I try to work this out I still have problems with trust in relationships…" Many of the constructive coping strategies associated with better relationship outcomes are learned in one's family of origin (O'Leary, 1988; Story et al., 2004; Tallman et al., 1999). In addition, the failure to acquire these constructive coping strategies was found to be associated with poor parenting practices and a failure of parents to model these pro-social coping behaviours in their relationship (Andrews et al., 2000; Capaldi et al., 2002; Capaldi et al., 2003; Dishion et al., 1995; Patterson, 1997; Tallman et al., 1999).

Therefore, because CSA, particularly that committed by an intrafamilial perpetrator, often occurs in a context of parental maladjustment and poor parenting practices, pro-social behaviour may not modelled to CSA survivors, which would explain why they do not develop these constructive coping strategies. In addition, a lack of constructive coping as demonstrated in the current study is also influenced by adult attachment and gender role beliefs. The family characteristics which are common in CSA survivors' families of origin and associated with less constructive coping were also found to be associated with the development of an insecure attachment (Carlson et al., 1989b; Egeland & Sroufe, 1981).

*Destructive Coping as a Mediator of Relationship Outcomes of Child Sexual Abuse Survivors*

The current study found negative associations with sex and intimacy to be associated with the use of higher levels of destructive coping strategies including engaging in multiple short-term sexual relationships and alcohol use. The finding that women with an avoidant attachment to their partner engage in more short-term sexual relationships than securely attached women is consistent with prior research (Brennan & Shaver, 1995; Feeney & Noller, 2004; Simpson, 1990). It may be through casual short-term relationships that CSA survivors with an avoidant attachment can meet their sexual needs without experiencing discomfort associated with more emotionally intimate relationships (Alexander, 1992). This conclusion is consistent with the statements made by CSA survivors in the current study, for example: "I prefer to keep sex on a purely physical, rather than intimate level." Another CSA survivor states: "Due to the events I struggled with any relationship I had. My boyfriends lasted less than 2 weeks and I haven't had one since I was 15."

There is also some evidence to support the association of high attachment anxiety and hyperfemininity in CSA survivors abused by a family member or friend with the use of destructive coping strategies including alcohol use, and having multiple short-term sexual relationships. It has been proposed that women with an anxious attachment and hyperfeminine gender role beliefs, due to their fear of abandonment and their belief of the importance of intimate relationships, are hypervigilant in monitoring their partner's behaviour, and any sign of rejection from their partner is perceived by them as a threat to the relationship and to their sense of self (Alexander, 1992; Ray & Gold, 1996). Due to their high levels of negative affect and poor affect regulation skills, women with high levels of attachment anxiety and hyperfemininity have been found to engage in more relationship-damaging behaviours including higher alcohol use, and to experience higher rates of relationship breakdown than women with low attachment anxiety and hyperfemininity (Brennan & Shaver, 1995; Campbell et al., 2005; Collins & Feeney, 2000; Feeney & Noller, 2004; Hazan & Shaver, 1987; Ray & Gold, 1996; Simpson, 1990). As a result of their difficulty in maintaining long-term relationships coupled with the belief of the importance of intimate relationships, anxiously attached individuals and those with hyperfeminine gender role beliefs may engage in multiple short-term sexual relationships in an attempt to find an enduring relationship. Testa et al. (2005) hypothesised that relationship difficulties and sexual risk taking in CSA survivors are likely to be linked; women who have difficulty maintaining relationships are likely to have many short-term relationships, and Heiman and Heard-Davison (2004) stated "More sexual partnerships may say more about a woman's relationship choices than about her sexual choices." (p. 40).

Although attachment avoidance and anxiety and hyperfeminine gender role beliefs significantly predicted the use of destructive coping strategies in the current study, they only accounted for 9% of variance in this construct. In addition, simply

being a CSA survivor was found to have a significant and direct relationship with the use of destructive coping strategies. Therefore, it is clear that there are other factors not accounted for in the current study, that explain why CSA survivors are more likely to have multiple short-term casual sexual relationships and to use alcohol at hazardous or harmful levels. CSA survivors have been found to be more likely to run away from home, and to become involved in deviant peer groups at an early age than nonabused women (Testa et al., 2005). Therefore, association with deviant adolescent peer groups may mediate the relationship between experiencing CSA and drinking more alcohol and engaging in more short-term sexual relationships.

There is some evidence that the use of destructive coping strategies including engaging in multiple short-term sexual relationships and alcohol use is associated with negative relationship outcomes in CSA survivors. In the current study, the use of destructive coping strategies was associated with relationship dissatisfaction, but not sexual dissatisfaction or partner sexual coercion. Previous studies have found that alcohol abuse in women or their partners is associated with lower levels of relationship satisfaction (Halford, 2002; Kelly et al., 2002a; Olenick & Chalmers, 1991). Second, Testa et al. (2005) proposed that young sexually active CSA survivors may be more likely than nonabused women to form relationships with males within deviant peer groups who are also more likely to abuse substances and be violent. Relationship violence is strongly associated with lower levels of relationship satisfaction (Holtzworth-Munroe et al., 1997), and there is a strong and bidirectional relationship between alcohol abuse and relationship conflict and violence (Murphy, O'Farrell, Fals-Stewart, & Feehan, 2001).

In the current study the use of destructive coping strategies by CSA survivors did not significantly predict sexual satisfaction. The finding that engaging in multiple short-term casual sexual relationships is not associated with sexual satisfaction is

surprising as a lack of intimacy in a relationship is a strong predictor of sexual dissatisfaction (Hawton et al., 1992; McCabe, 1999; Rosen & Leiblum, 1995a; Wincze & Carey, 2001; Young et al., 2000). However, it has been speculated that CSA survivors may engage in multiple short-term sexual relationships as a way of meeting their sexual needs without interference from negative affect associated with intimacy (Jehu, 1988; Westerlund, 1992). Therefore, the lack of association between having many short-term sexual relationships and sexual satisfaction may be the result of the opposing influences of meeting one's sexual needs through casual relationships without negative affect occurring, yet lacking emotional intimacy with sexual partners.

Similarly the finding that higher levels of alcohol consumption is not associated with sexual satisfaction is surprising, as heavy drinking has been found to be associated with a lack of sexual interest, decreased sexual arousal, and inability to achieve orgasm (Covington & Kohen, 1984; Norris, 1994; Wilsnack, 1984). However, females who abuse alcohol have been found to have positive expectancies concerning the effect of alcohol on their sexual behaviour (Kelly, Halford, & Young, 2002b; Klassen & Wilsnack, 1986; Leigh, 1990), and to use alcohol to reduce their sexual inhibitions (Norris, 1994). Sexual satisfaction, as assessed by the FSFI (Rosen et al., 2000) in the current study contains both physical and psychological components. Therefore, although the alcohol may be impairing these women's physiological sexual function, the reduction in negative affect caused by the alcohol may lead CSA survivors to feel more emotionally satisfied with their sexual activity.

*Predicting Partner Sexual Coercion of Child Sexual Abuse Survivors*

In the current study the use of destructive coping strategies by CSA survivors was not associated with experiencing higher levels of partner sexual coercion. This finding is intriguing as engaging in multiple short-term sexual relationships and

drinking high levels of alcohol were found to be strongly associated with experiencing sexual assault, particularly amongst CSA survivors (Breitenbecher, 2001; Filipas & Ullman, 2006; Grauerholz, 2000; Himelein & McElrath, 1996; Koss & Dinero, 1989; Messman-Moore & Long, 2002). According to the exposure hypothesis, the more sexual partners a woman has, the more likely she is to encounter a sexually aggressive partner, especially in settings where alcohol is consumed (Messman-Moore & Long, 2002; Muehlenhard et al., 1998). Alcohol use increases the likelihood that males will be sexually aggressive (Grauerholz, 2000; Nurius, 2000), and impairs problem solving and escape behaviours by women (Grauerholz, 2000; Messman-Moore & Long, 2002; Nurius, 2000). A partial explanation for the lack of a significant relationship between use of destructive coping strategies and partner sexual coercion may be that sexual coercion in the current study was assessed only in the current intimate relationship. If the lifetime prevalence of sexually coercive behaviours by males had been measured a different picture may have emerged. It has been proposed that sexual coercion by intimate partners may involve different risk factors than revictimisation by other perpetrators (Messman-Moore & Long, 2003).

Although a lack of constructive coping strategies significantly predicted the occurrence of partner sexual coercion, it accounted for only 15% of variance in this outcome. This finding suggests that there are other factors not assessed in the current study that increase a CSA survivor's risk of experiencing sexual coercion by her partner. Prior research has found that female communication and behaviour during conflict is not a good predictor of male aggression (Jacobson et al., 2000). However, to date there has been little examination of the influence of the female partner's behaviour on the occurrence of partner sexual coercion (Black, Heyman, & Smith-Slep, 2001b). However, it is possible that like males' aggression, their sexual coercion may have little association with characteristics of their female partner.

One factor which may be useful in explaining the higher rate of sexual coercion experienced by CSA survivors is characteristics of their male partners. In the current study several CSA survivors described negative characteristics of their male partners. For example, one CSA survivor in the current study stated: “I was not ready for marriage at 17. I had too much work on myself to do (*sic*) before I was fit to choose a life partner. He’s very negative, jealous and oppressive. He ran away with them [her children] when we separated and it was the worst experience of my whole life.” Goodyear, Newcomb, and Locke (2002) found a strong positive relationship between CSA and choosing an intimate partner who women viewed both negatively and as a source of physical harm to themselves. In a clinical sample, Jehu (1988) found 58% of CSA survivors endorsed the statement “Only bad, worthless guys would be interested in me.”

Supporting evidence for the importance of partner selection in predicting partner sexual coercion in CSA survivors comes from the study of hyperfemininity. Women with hyperfeminine gender role beliefs were found to be more attracted to hypermasculine men than nonhyperfeminine women, and hypermasculine males have been found to be more violent and sexually coercive in their relationships than nonhypermasculine males (Murnen, Wright, & Kaluzny, 2002). CSA survivors abused by a family member or friend in the current study more strongly endorsed hyperfeminine gender role beliefs than their nonabused peers. Therefore, it may be through their attraction to hypermasculine males, CSA survivors are at a greater risk for experiencing sexual coercion. Similar evidence for the importance of partner selection in the occurrence of relationship sexual coercion and violence comes from the attachment literature. Women with an insecure attachment were found to be more attracted to insecurely attached males (Klohnen & Luo, 2003), who were more violent and sexually coercive in their intimate relationships than securely attached males

(Babcock, Jacobson, Gottman, & Yerington, 2000; Dutton, Saunders, Starzomski, & Bartholomew, 1994; Feeney & Noller, 2004; Holtzworth-Munroe et al., 1997; Lafontaine & Lussier, 2005). CSA survivors abused by a family member or friend in the current study were more likely to have an insecure adult attachment than their nonabused peers. Therefore, as a result of being more attracted to (Klohnen & Luo, 2003; Murnen et al., 2002) or familiar with (Chewning-Korpach, 1996) insecurely attached and / or hypermasculine males, or simply as a failure to screen out violent partners, CSA survivors may be at higher risk of partner sexual coercion than their nonabused peers.

*Differential Pathways to Relationship Outcomes for Classes of Child Sexual Abuse Survivors*

The results of the current study also suggest that belonging to each of the abuse classes, compared to the nonabused class, is associated differentially with the mediators and adult relationship outcomes. Compared to the nonabused class, women in the family and friend abuse classes experienced higher levels of fear of abandonment and attachment avoidance. In contrast the level of fear of abandonment and attachment avoidance experienced by women in the stranger abuse class did not differ from nonabused women. All CSA survivors reported engaging in more destructive coping than women who had not been abused, however, only those abused by family members reported lower levels of constructive coping than women in the nonabused class. It should be noted however, that the pathway coefficients from the abuse classes to each of the mediating variables although significant, were small in size. Furthermore, only membership of the family and friend abuse classes predicted poorer relationship functioning than the nonabused class. Family abuse class membership predicted lower levels of relationship and sexual satisfaction and higher partner sexual coercion than the

nonabused class. Friend abuse class membership also predicted lower sexual satisfaction and higher partner sexual coercion than the nonabused class, but did not predict lower levels of relationship satisfaction. In contrast membership of the stranger abuse class compared with the nonabused class did not predict any of the relationship outcomes evaluated.

In the current study, women in the family abuse class who experienced the poorest adult relationship outcomes also reported the highest levels of family-of-origin dysfunction and the most severe CSA experiences, which is consistent with prior research (Alexander & Schaeffer, 1994; Dong et al., 2003; Hulme & Agrawal, 2004; Long & Jackson, 1991). The betrayal of trust involved in the perpetration of incestuous abuse and the lack of support provided by one's family in responding to the abuse, may provide little opportunity for the victim to have positive relationship experiences in childhood. As a result of the lack of positive relationship experiences, women abused by a family member may develop negative generalised expectancies of intimate relationships, including an insecure attachment. The types of family dysfunction which characterise incestuous families were found to be associated with the development of an insecure attachment in childhood (Carlson et al., 1989b; Davies & Cummings, 1994; Egeland & Faber, 1984; Moss et al., 1994; Moss et al., 1998; Stovall-McClough & Cloitre, 2006). The types of dysfunction that were found in the families of origin of incest survivors were also associated with the failure to develop effective relationship skills in childhood (Capaldi et al., 2002; Patterson, 1997), and poorer relationship outcomes in adulthood (Andrews et al., 2000; Kwong et al., 2003; Linder & Collins, 2005; Tallman et al., 1999). In addition, having an insecure attachment in childhood is associated with the failure to develop good relationship skills (Cassidy et al., 1996; Lyons-Ruth et al., 1993). Therefore, due to both the abuse experience and concomitant family-of-origin dysfunction, incest survivors may fail to develop effective relationship

skills and a secure attachment in childhood, which is associated with negative relationship outcomes in adulthood.

In the current study, belonging to the friend abuse class was significantly associated with an insecure adult attachment and hyperfeminine gender role beliefs, whereas belonging to the stranger abuse class was not. However, the pathway coefficients from the friend abuse class to adult attachment and hyperfeminine gender role beliefs were small in size. Membership of the friend abuse class also predicted sexual dissatisfaction and partner sexual coercion, whereas membership of the stranger abuse class did not predict any of the relationship outcomes assessed. Women in the friend and stranger abuse classes have higher rates of family-of-origin dysfunction compared to women who had not experienced CSA. However, the extent of family-of-origin dysfunction did not differ between women in the friend and stranger abuse classes. There were some differences in the nature of CSA experienced by women in the friend and stranger abuse classes. Women in the friend abuse class compared to those in the stranger abuse class experienced more invasive and chronic CSA, and were less likely to disclose the abuse and received less support in response to this disclosure. These findings suggest that experiencing chronic abuse by a known individual may be associated with the development of generalised negative perceptions of intimate relationships, particularly if combined with a family who the victim feels unable to disclose the abuse to. In contrast, experiencing CSA as an isolated event by an unknown individual may lead the victim to view the incident as traumatic but not representative of all intimate relationships, and result in them not developing an insecure attachment and hyperfeminine gender role beliefs.

There may also be differences in the families of origin of women in the friend and stranger abuse classes that account for the development of an insecure attachment and hyperfeminine gender role beliefs, on factors that were not assessed in the current study.

For example, the current study assessed the amount of support in CSA survivors' families of origin, but the amount of support provided by the mother may be more critical in influencing attachment and gender role beliefs in CSA survivors. The finding that women abused by a friend compared to those abused by a stranger received less support from their mother if they told her about the abuse supports this assertion. Prior research has found poor mother-child relationships to be a strong predictor of insecure attachment in children (Davies & Cummings, 1994; Egeland & Farber, 1984; Moss et al., 2004; Moss et al., 1998). In addition, mothers' mental health, in particular, maternal depression is also associated with the development of an insecure attachment in childhood (Davies & Cummings, 1994; Egeland & Farber, 1984; Moss et al., 2004; Moss et al., 1998). Prior research has also found the families of origin of CSA survivors to provide less supervision to their children than families of nonabused women (Black et al., 2001a; Fergusson et al., 1997). Therefore, it may be that a poor mother-daughter relationship and characteristics of the mother's mental health, prevent her providing appropriate supervision to her children, making them vulnerable to abuse by extrafamilial perpetrators, and these characteristics may also influence the type of relationship behaviours she models and encourages in her children. In contrast, being abused by a stranger if coupled with a functional family of origin who can respond effectively to the abuse and provide the victim with more positive models of relationships may not prevent the victim from developing a secure attachment, flexible gender role beliefs and good relationship skills.

*Conclusions Concerning the Association Between Child Sexual Abuse and Adult Relationship Functioning*

The current study expands on prior research by identifying several variables operating in women's current intimate relationships that mediate the association

between CSA and adult relationship functioning. There was partial support for emotional avoidance mediating the development of relationship difficulties of CSA survivors: CSA survivors used avoidant coping and use of these coping strategies predicted relationship maladjustment. However, the use of constructive strategies predicted more variance in adult relationship functioning in CSA survivors than the use of avoidant strategies. Resilient CSA survivors, who have a secure attachment to their partners, put more effort into working on their relationships, seek more support, behave in a more sexually assertive manner, and more often report having a satisfying intimate relationship.

The family-of-origin dysfunction often associated with CSA, particularly in the family class of CSA, might be the reason why women who experienced family CSA are less likely to use adaptive relationship coping skills. It seems likely that the dysfunctional family-of-origin would not provide adequate role models of such adaptive skills, and therefore these women would be likely to have deficits in these skills. Furthermore, due to their attachment anxiety and hyperfemininity or simply the deviant partners that are available at the early age they begin having consensual sexual activity, CSA survivors may be more likely than their nonabused peers to partner with insecurely attached and hypermasculine males, who are more violent and drink more alcohol, resulting in negative relationship outcomes.

The current study also expands on prior research by being the first to highlight the possibility of different mechanisms mediating the development of negative relationship outcomes for distinct classes of CSA survivors. The results of the current study suggest that women abused by a family member are the most likely of all CSA survivors to experience relationship difficulties in adulthood, and deficits in positive relationship skills may be an important mediator of these difficulties for women in this class.

# CHAPTER SIX

## General Discussion

The current study demonstrates that CSA is a common experience of girls. Three distinct classes of CSA survivors were identified in the current study, the friend, family and stranger abuse classes. Abuse committed by a family member is the most deleterious form of CSA; it is the most severe in nature, and associated with the highest levels of family-of-origin dysfunction and negative adult relationship outcomes of all classes of abuse. However, all classes of CSA survivors experience a higher rate of difficulties in adult intimate relationships than their nonabused peers. CSA committed by a family member or friend is associated with a greater likelihood of developing an insecure adult attachment and hyperfeminine gender role beliefs, and deficits in constructive coping strategies mediate the association of CSA to poor adult relationship outcomes. The findings of the current study are important as they provide greater specificity in both developing treatment interventions to prevent or ameliorate the negative relationship outcomes, and in identifying those CSA survivors most likely to experience these outcomes.

### *Implications for Treatment Interventions for Child Sexual Abuse Survivors*

As CSA occurs in nearly half of the female population, and up to two thirds of CSA survivors (up to one third of the total female population) experience difficulties in their relationships in adulthood, CSA should be considered a major public health concern. The relationship difficulties associated with CSA predict higher rates of mental and physical health problems (Halford et al., 1997), a shorter life expectancy (Burman & Margolin, 1992), financial problems and work absenteeism (Forthofer et al., 1996), and problems in offspring (Amato, 2001; Grych et al., 2000). CSA also places a huge economic burden on society (Standing Committee on Legal and Constitutional

Affairs: House of Representatives, 1998). A national report commissioned by the Kids First Foundation in 2001 estimated that child abuse and neglect cost Australian taxpayers almost $5 billon each year (Keatsdale Pty Ltd, 2003). The current study estimated that CSA maybe associated with as many as 3278 additional divorces annually, which would cost Australia approximately 270 million dollars.

Engaging in methods of primary prevention, that is, stopping CSA from occurring would be ideal. Unfortunately attempts to reduce the prevalence of CSA have not been highly successful (Purvis & Joyce, 2005). As Roche et al. (1999) stated, if we assume the relationship between CSA and adult outcomes is direct "… we might be unnecessarily pessimistic about the prognosis for survivors of abuse because nothing can be done to change the fact that CSA had occurred." (p. 185). However, there is evidence that the association between CSA and adult relationship functioning is not direct, and that mediating variables are amenable to change (Arata, 2002). Results the current study and prior research have identified several mediators that could be targets for both secondary and tertiary prevention aimed at reducing the risk of CSA survivors experiencing negative relationship outcomes.

Secondary prevention efforts for CSA survivors could focus on preventing relationship problems from occurring by intervening during adolescence, and prior to women entering a committed adult relationship, or soon after women enter a relationship but prior to the development of relationship problems. The results of the current study provide specific markers for identifying those CSA survivors most likely to develop negative relationship outcomes in adulthood, most notably the presence of an intrafamilial perpetrator and other forms of family-of-origin dysfunction. Consideration of these markers could result in treatment interventions being targeted with much greater specificity.

Existing education programs aimed at preventing relationship distress would be beneficial to CSA survivors. These programs typically focus on teaching skills in the areas of communication, conflict management, problem solving, and sexual intimacy, and assist the couple to evaluate relationship standards and expectations (Halford, Wilson, Moore, Dyer, & Farrugia, 2006; Markham, Stanley, & Blumberg, 1994). Some of these relationship education programs also attend to family-of-origin influences on relationship expectations and behaviour (Halford et al., 2006). These programs would benefit CSA survivors by increasing their use of constructive coping strategies such as self-regulation and engaging in supportive and positive behaviours in their relationships, which has been found in normative samples (Halford et al., 2006). In addition, CSA survivors may also benefit from interventions focused on increasing assertiveness, identifying high risk situations for violence and sexual coercion, and in developing skills for making decisions about relationships and sexual partners (Messman-Moore & Long, 2003; Van Bruggen et al., 2006). Based on the findings of the current study, it would also be useful to assist CSA survivors to identify behaviours they engage in to avoid negative affect, particularly those which arise in intimate relationships, as these are associated with relationship maladjustment. Acceptance-based therapies such as Acceptance and Commitment Therapy (Hayes et al., 1999) could be useful in encouraging CSA survivors to reduce their use of avoidant coping strategies.

Once a CSA survivor is involved in an intimate relationship and the couple are experiencing relationship difficulties, methods of tertiary prevention are required. Current treatment approaches for CSA survivors have been criticised for ignoring relationship issues (Alexander et al., 1998; Bacon & Lein, 1996; Feinauer et al., 1996; Reid, Wampler, & Taylor, 1996; Valentine & Feinauer, 1993). The use of individual psychotherapy with CSA survivors has also been found to increase relationship dissatisfaction (Jehu, 1988; Nelson & Wampler, 2000; Pistorello & Follette, 1998) and

male partners often report feeling alienated from the therapeutic process (Bacon & Lein, 1996; Reid, Matthews, & Liss, 1995).

Couple therapy could provide the opportunity for CSA survivors to rework expectations about themselves, their partner, and their relationships more generally, and gain mastery over the effects of the trauma (Alexander, 1992; Johnson & Williams-Keeler, 1998; Roche et al., 1999). Greenberg and Johnson's (1986) Emotion Focused Couple Therapy (EFT) is based on attachment theory and has been used with trauma victims. EFT is claimed to change attachment and address vulnerabilities based on developmental experiences and was found to reduce couple distress (Johnson & Greenberg, 1995).

In summary, due to the high prevalence of CSA and of relationship difficulties in this population, CSA should be viewed as a major pubic health concern that could be targeted using relationship education programs focused on preventing these difficulties and couple therapy to ameliorate their effects. The results of the current study also suggest that women abused by a family member, who have the highest rate of relationship difficulties, would have the most to gain from these interventions.

### *Limitations of the Current Study*

There are several limitations of the current study. First although the use of a large random community sample was a considerable improvement on the use of convenience samples by prior studies in providing the power to detect the effects of CSA (Beitchman et al., 1992), the sample was not truly representative of the Australian population, underrepresenting women with low education. Low education and social disadvantage are associated with a decreased likelihood of getting married (Lorenz, Simons, & Chao, 1996), high rates of relationship distress, marital separation (Orbuch et al., 2002), and domestic violence (Schumacher, Feldbau-Kohn, Smith-Slep, & Heyman, 2001). Social

disadvantage and socioeconomic status are also associated with CSA (Anderson et al., 1993; Messman-Moore & Long, 2000; Mullen et al., 1996; Russell, 1983, 1984). Although education level does not appear to be directly associated with CSA (Anderson et al., 1993; Moeller et al., 1993; Russell, 1983, 1984), poor academic performance is (Manion et al., 1996; Paradise et al., 1994), and those CSA survivors with higher levels of education are more likely to have experienced milder forms of abuse (Arata, 1998; Filipas & Ullman, 2006; Van Bruggen et al., 2006). Therefore, the rate of CSA and relationship problems reported in the current study may have been moderated by a sampling bias. If the current study underrepresented women who had experienced CSA and those with the highest risk of relationship problems, then the association of CSA with poor relationship outcomes may have been understated.

Another limitation of the current study that may have contributed to underestimating negative relationship outcomes in participants was the use of a shortened version of the CTS2 and the manner in which these items were selected. In the current study items with the highest internal reliabilities were selected and a balance was sought between minor and severe items. The approach used in the current study to create a shortened version of the CTS2 is similar to that adopted by Straus and Douglas (2004). Another option of shortening the CTS2 would have been to select items most frequently endorsed. Either method of abbreviating the CTS2 is likely to underestimate the prevalence of aggression and sexual coercion, as each additional conflict tactic in the CTS2 provides greater opportunity for people to meet the criteria for engaging in physical assault or sexual coercion (Straus & Douglas, 2004). Indeed, Straus and Douglas (2004) found the full CTS2 resulted prevalence rates 20% to 50% greater than those obtained when using a shortened version. In hindsight however, selecting items most frequently endorsed may have been a preferable method to create a shortened version of the CTS2.

Another limitation of the current study is the use of a cross-sectional design. The use of a cross-sectional design has several consequences for the interpretation of the findings of the current study. First, despite the robust association between CSA and adult relationship functioning, it cannot be concluded that it is the abuse causes these outcomes. In the current study, women with and without a history of CSA were not equivalent on other factors. Women with a history of CSA, especially those in the family abuse class, reported much higher rates of family-of-origin dysfunction than did women abused by other perpetrators and those with no history of abuse. It is possible that family-of-origin dysfunction, rather than CSA is responsible for the negative adult relationship outcomes these women experience. In particular, it could be as a result of either a deficit in positive parenting or the presence of negative parenting that leads to a failure to acquire adaptive relationship expectancies and skills and that the lack of these skills is responsible for difficulties in adult relationship functioning. To definitively determine whether CSA or family-of-origin variables are the cause of adult outcomes, prospective research designs are required (Briere, 1992; Pedhauzur, 1982).

Another problem with using a cross-sectional design is it becomes difficult to disentangle the consequences of child versus adult abuse. There are similarities in the sequelae of both child and adult sexual assault, and it is difficult to establish whether these problems developed pre-CSA, post-CSA, pre-adult abuse, or post-adult abuse (Fergusson et al., 1997; Maker et al., 2001; Messman-Moore & Long, 2000). In addition, by using a cross-sectional design the temporal sequence between CSA, mediating variables, and relationship outcomes illustrated by the findings of the current study cannot be assumed to be correct. The associations between the mediators and outcomes are likely to be much more complex than shown. For example, it is possible that the mediators have a reciprocal association with relationship functioning, for example relationship satisfaction may also lead to an increased use of constructive

coping strategies and a more secure attachment.

Another limitation of the current study is its reliance on retrospective self-report, especially of CSA. The reliability and validity of reports of CSA has been an ongoing controversy for over 100 years. However, it has been demonstrated that retrospective reports of childhood experiences have quite high reliability, provided that they are of behaviourally specific actions and relate to stressful events, and the mode of questioning does not introduce biases through repeated questioning, suggestion, or the presentation of misleading information (Ghetti et al., 2002; Goodman et al., 2002; Goodman et al., 1996). In the current study I sought to meet these criteria, but it is still possible that there were reporting biases. Reporting biases in this area are usually found in the false negative rather than the false positive direction (Burgess, Hartman, & Baker, 1995; Femina et al., 1990; Widom & Morris, 1997; Widom & Shepard, 1996; Williams, 1994a). Therefore, some individuals who did not disclose their abuse history in the current study may have been included in the nonabused comparison group, obscuring between-group differences. However, by making participation anonymous and providing no direct consequences for recalling abuse, the current study reduced the likelihood of deliberate falsification. Some researchers have argued that when conducting retrospective research the sample should be restricted to those CSA cases that have been validated by child protection or police records (Briere, 1992). However, as most CSA victims do not disclose their abuse to official authorities this sampling method would result in findings not representative of the total CSA population.

Another limitation of the current study is a lack of independence in assessment of the independent and dependent variables, which can produce a response bias (Kerlinger & Lee, 2000). Concurrent assessment of child and adult experiences may allow an individual’s perception of their CSA experiences to be influenced by their current perception of their relationship functioning (Briere, 1992). In addition, the measures

selected to assess Leonard and Follette's (2002) and Polusny and Follette's (1995) model of emotional avoidance did not directly assess the *function* of the mediating variables. That is, the current study did not assess whether the negative associations with sex and intimacy had been developed through the process of classical conditioning, or if the avoidant behaviours the women demonstrated were actually being used to cope with aversive affect, or if engaging in these strategies was negatively reinforced.

A final limitation of the current study is that the assessment of relationship outcomes was based solely on women's self-reports. Typically CSA research focuses on the characteristics of the victim (Messman-Moore et al., 2000). However, relationship functioning in CSA survivors could be influenced by many factors. When assessing relationship functioning future studies should attempt to collect data from the male partners of CSA survivors and use observational as well as self-report measures.

### *Suggestions for Future Research*

Based on the findings of the current study and prior research several recommendations can be made regarding future research in this area. First, it is critical that this field attains a consensus regarding the definition of CSA; until this occurs studies will continue to report discrepant findings concerning the prevalence of CSA and its impact on adult functioning (Haugaard, 2000). It is suggested that due to the heterogeneity of CSA, behaviourally specific questions and broad and inclusive definitions should be used to capture the full spectrum of abuse experiences and adult outcomes, and to ensure that differences between women with and without a history of CSA are not obscured by contaminating the nonabused class with CSA survivors (Anderson et al., 1993; Briere, 1992). Second, it is imperative that when conducting research to estimate the impact of CSA on adult relationship functioning, studies use random community samples which are representative of the general population and

large enough to have sufficient power to detect the effects of this form of abuse (Baker, 2002; Briere & Runtz, 1988b).

There is now evidence to suggest that the heterogeneity of CSA is not appropriately conceptualised using a continuous measure of severity (Fassler et al., 2005; Maker et al., 2001; Merrill et al., 2003). CSA does not appear to be a unitary construct, and in order to identify the trajectories of CSA survivors, and to be able to target treatment interventions with greater specificity, typological approaches are more useful. To appropriately model the heterogeneity of CSA large sample sizes and latent modelling statistical approaches such as LCA are required. The current study has demonstrated that CSA survivors can be separated into three meaningfully different classes based on their abuse characteristics; future research is required to substantiate the composition and outcomes of these classes of abuse.

The current study has also shown that there are clear differences between CSA survivors and nonabused women and also between different classes of abused women in family-of-origin functioning. Future research needs to move beyond focusing on CSA in isolation to broader conceptualisations of child maltreatment and family-of-origin dysfunction when considering adult relationship functioning of CSA survivors (Black et al., 2001a; Davis et al., 2001; Finkelhor et al., 2005; Schloredt & Heiman, 2003).

An extensive array of relationship difficulties of adult CSA survivors have now been catalogued; the current study has added to this by drawing the literature's attention to the perpetration of sexual and physical assault by these women on their partners, and this association requires further study. Sexual and physical aggression by women generally (Holtzworth-Munroe, 2005), and in particular CSA survivors (Messman-Moore & Long, 2003; Muehlenhard et al., 1998), is a controversial topic and some have argued that this line of research could be used to "blame the victim" for her relationship difficulties. However as stated by Messman-Moore and Long (2003) if we shy away

from this area of research we will "…impede progress in the development of effective risk reduction programming and treatment for survivors." (p. 564). The CSA survivors' reactions to questions concerning their adult relationships in the current study suggest that they view this research to be beneficial. For example one CSA survivor in the current study stated: "Thank you for giving me the opportunity to help others that might have been in the same situation." Another CSA survivor in the current study reported: "This survey has come at a very pertinent time for me. I am working out some relationship behaviours I have had for a long time and it has helped me greatly to clarify some issues."

In addition, there is evidence that the nature of the relationship difficulties experienced, and the type of coping behaviours used by CSA survivors may change over time (Banyard et al., 2001). Future research needs to use prospective studies in which women are assessed prior to CSA and where both abused and nonabused participants are continuously studied as they progress throughout the lifespan, to gain a clearer understanding of the trajectory of relationship development in CSA survivors.

The current study extends prior research by empirically testing a theory explaining the association between CSA and adult relationship functioning. As Kendall-Tackett, Williams, & Finkelhor (1993) stated, there is "… a glaring inadequacy in the literature: a nearly universal absence of theoretical underpinnings in the studies being conducted on this subject to date." (p. 181), a situation which has improved but still exists to date. Treatment interventions for CSA survivors have also been criticised for not being based on theory (Price, Hilsenroth, Petretic-Jackson, & Bonge, 2001). Therefore future research examining the association between CSA and adult functioning, focusing on the development of treatment interventions for CSA survivors, needs to use a theoretical formulation as its foundation.

On the basis of the findings of the current study a new model explaining the association between CSA and adult relationship functioning is proposed. This model proposes that CSA often occurs within a dysfunctional family environment including other forms of child maltreatment, which together are likely to produce an insecure attachment in children. Due to the concomitance of parental psychopathology, relationship maladjustment and conflict with CSA, CSA survivors are likely to develop unhelpful templates of adult intimate relationships (one characteristic of which might be an adherence to extreme gender roles). Due to a lack of parental modelling of adaptive relationship skills or more directly through poor parenting practices, the child may fail to develop pro-social coping skills. As a result of having an insecure attachment and a lack of pro-social coping skills, during adolescence CSA survivors may be more likely than their nonabused counterparts to associate with deviant peers and through a process of assortative mating may select a partner with similar difficulties. Due to their lack of adaptive coping skills these couples may fail to deal with sources of stress in their relationship, may abuse alcohol or other substances and experience more violence and lower relationship and sexual satisfaction, and consequently may experience higher rates of relationship dissolution. In addition, CSA survivors may have many short-term sexual relationships in an attempt to find a more fulfilling and long-term intimate relationship. The proposed model would be most effectively tested through a prospective study of CSA survivors during childhood, adolescence, and early adulthood as they enter their first intimate relationships.

An area which has been neglected in the research examining the relationship outcomes of CSA survivors is their male partners. Future research would benefit by exploring the characteristics of male partners of CSA survivors, such as their family-of-origin functioning, attachment style, gender role beliefs, and behaviour in their intimate relationships (Grauerholz, 2000). In addition, it would be beneficial to examine the

trajectories and dynamics of CSA survivors' adult intimate relationships, in more depth through the use of observational measures.

Furthermore the relationship functioning of male survivors of CSA also requires empirical attention. Male victims of CSA also experience difficulties in their adult intimate relationships, including confusion regarding gender identity and sexual preference, sexual dysfunction, and an increased risk for committing sexual and physical violence (Beitchman et al., 1992; Cahill et al., 1991). It would be interesting to examine whether the experience of CSA in males is as heterogeneous as it is in females and whether the classes of CSA survivors identified in this dissertation apply to males. Boys were found to be less likely to be abused by a family member than girls, most commonly experiencing CSA committed by strangers (Baker & Duncan, 1985; Finkelhor, 1984; Finkelhor et al., 1990; Kercher & McShane, 1984; Pierce & Pierce, 1985; Siegel et al., 1987). Males' experiences of CSA compared to those of females were found to be shorter in duration and to involve fewer invasive acts (Baker & Duncan, 1985; Finkelhor, 1984; Finkelhor et al., 1990; Kercher & McShane, 1984; Pierce & Pierce, 1985; Siegel et al., 1987). Therefore, the current study's findings that those abused by a stranger reported the least difficulties in adult relationship functioning, if equally applicable to males, may explain why they appear to experience fewer negative outcomes than women. Supporting evidence for this assertion comes from the findings that the magnitude of the effect of CSA on adult outcomes was found to be weaker for males than females and less proximal to the abuse (Kinzl et al., 1996; Rind et al., 1998).

The research concerning the effects of CSA on women's adult relationships and the variables that mediate this association has reached a point where it can be used to develop more specific treatment interventions aimed directly at preventing or ameliorating the negative relationship outcomes these women experience. To date

many of the interventions used to treat CSA survivors have ignored the relationship difficulties they experience and have not been based on a theory concerning the association between CSA and adult relationship outcomes (Alexander et al., 1998; Bacon & Lein, 1996; Feinauer et al., 1996; Reid et al., 1996; Valentine & Feinauer, 1993). Existing relationship education programs and couple therapies would be useful for CSA survivors and could be easily adapted to meet their needs. The effectiveness of these interventions in treating the relationship difficulties of CSA survivors needs to be evaluated.

### *Conclusions*

The results of the current and previous research demonstrate that CSA is a major public health concern; CSA is common in girls and associated with a wide range of negative adult relationship outcomes. However, CSA does not inevitably lead to these negative outcomes. One factor that predicts the relationship outcomes of CSA survivors is the nature of the abuse they experienced. The results of the current study suggest it is useful to categorise the childhood experiences of CSA into discrete classes, which are associated with somewhat different sequelae. Women abused by a family member experience the most severe abuse, the highest rate of family-of-origin dysfunction, and the worst adult relationship outcomes of all CSA survivors.

The long-term association of CSA with difficulties in intimate relationships is mediated by a range of factors. CSA survivors abused by a family member or friend are more likely than their nonabused peers to develop an insecure adult attachment and hyperfeminine gender role beliefs, and to engage in less constructive and more destructive coping in their relationships. The results of the current study suggest that the use of constructive coping strategies, rather than destructive strategies is more predictive of adult relationship functioning of CSA survivors. CSA survivors'

willingness to actively cope with relationship difficulties allows them to have positive relationship experiences. The CSA survivors in the current study described this healing journey eloquently.

> I've had an extremely challenging and painful life so much of the time up to my current partner (*sic*). I've read, been to counselling… I got to the point where I was becoming so much more aware of myself… I have such a genuinely happy, fulfilling and supportive relationship now, and I've discovered how crucial it is to have a supportive partner, but also an external support network.
>
> At the moment in my life I am content at the fact that I feel like "I survived" my childhood. I've turned all the negativity that happened to me into a positive learning experience, that without, I wouldn't be who I 'am today.

In summary, CSA in girls has an important influence on adult couple relationships, but there is enormous variability in how female CSA survivors adapt and develop their couple relationships. Girls abused by a family member have the most chronic and severe abuse, often experience concomitant family-of-origin dysfunction, and have a greater vulnerability to developing relationship difficulties as an adult than other CSA survivors. Yet even among the victims of the worst family abuse, some CSA survivors develop adaptive relationship behaviours, and attain happy and fulfilling intimate relationships in adulthood. As we come to better understand how many survivors of CSA transcend such extreme adversity, this can guide us in how better to assist others who struggle with the legacy of being sexually abused in childhood.

References

Abbot, D. A., & Brody, G. H. (1985). The relation of child age, gender and number of children to the marital adjustment of wives. *Journal of Marriage and the Family, 47*, 77-84.

Abraham, W. T., & Russell, D. W. (2004). Missing data: A review of current methods and applications in epidemiological research. *Current Opinion Psychiatry, 17*, 315-321.

Adler, D. A., Bungay, K. M., Cynn, D. J., & Kosinski, M. (2000). Patient-based health status assessments in an outpatient psychiatry setting. *Psychiatric Services, 51*(3), 341-348.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment.* Hillsdale, NJ: Erlbaum.

Albach, F., & Everaerd, W. (1992). Posttraumatic stress symptoms in victims of childhood incest. *Journal of Psychotherapy and Psychosomatics, 57*, 143-151.

Alessi, H. D., & Ballard, M. B. (2001). Memory development in children: Implications for children as witnesses in situations of possible abuse. *Journal of Counseling and Development, 79*(4), 398-404.

Alexander, P. C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology, 60*(2), 185-195.

Alexander, P. C. (1993). The differential effects of abuse characteristics and attachment in the prediction of long-term effects of sexual abuse. *Journal of Interpersonal Violence, 8*(3), 346-362.

Alexander, P. C., Anderson, C. L., Brand, B., Schaeffer, C. M., Grelling, B. Z., & Kretz, L. (1998). Adult attachment and long-term effects in survivors of incest. *Child Abuse and Neglect, 22*(1), 45-61.

Alexander, P. C., & Schaeffer, C. M. (1994). A typology of incestuous families based on cluster analysis. *Journal of Family Psychology, 8*(4), 458-470.

Allen, C. M., & Pothast, H. L. (1994). Distinguishing characteristics of male and female child sex abusers. *Journal of Offender Rehabilitation, 21*, 73-88.

Allen, J. P., Litten, R. Z., Fertig, J. B., & Babor, T. F. (1997). A review of research on the Alcohol Use Disorders Identification Test (AUDIT). *Alcoholism: Clinical and Experimental Research, 21*(4), 613-619.

Alvarez, J., Kimerling, R., Pavao, J., & Baumrind, N. (2005). *Epidemiology and consequences of women's revictimisation.* Paper presented at the 39th Annual Association for Behavioral and Cognitive Therapies Convention, Washington, DC.

Amato, P. R. (2001). Children of divorce in the 1990s: An update of the Amato and Keith (1991) meta-analysis. *Journal of Family Psychology, 15*(3), 355-370.

American Psychiatric Association. (1993). *Statement on memories of sexual abuse.* Washington, DC: Author.

American Psychological Association. (1992). *Ethical principles of psychologists and code of conduct.* Washington DC: Author.

American Psychological Association Working Group on Investigation of Memories of Childhood Abuse. (1994). *Interim report of the Working Group on Investigation of Memories of Childhood Abuse.* Washington DC: Author.

AMP.NATSEM. (2005). Financial impact of divorce in Australia: Love can hurt, divorce will cost. *AMP.NATSEM Income and Wealth Report, 10*, 1-16.

Anderson, J. C., Martin, J. L., Mullen, P. E., Romans, S. E., & Herbison, G. P. (1993). Prevalence of childhood sexual abuse in a community sample of women. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(5), 911-920.

Andrews, B., Valentine, R., & Valentine, J. D. (1995). Depression and eating disorders following abuse in childhood in two generations of women. *British Journal of Clinical Psychology, 34*, 37-52.

Andrews, G., Gould, B., & Corry, J. (2002). Child sexual abuse revisited. *Medical Journal of Australia, 176*, 458-459.

Andrews, J. A., Foster, S. L., Capaldi, D., & Hops, H. (2000). Adolescent and family predictors of physical aggression, communication, and satisfaction in young adult couples: A prospective analysis. *Journal of Consulting and Clinical Psychology, 68*(2), 195-208.

Araji, S. K. (1997). *Sexually aggressive children: Coming to understand them.* Thousand Oaks, CA: Sage.

Arata, C. M. (1998). To tell or not to tell: Current functioning of child sexual abuse survivors who disclosed their victimization. *Child Maltreatment, 3*(1), 63-71.

Arata, C. M. (2000). From child victim to adult victim: A model for predicting sexual revictimisation. *Child Maltreatment, 5*(1), 28-38.

Arata, C. M. (2002). Child sexual abuse and sexual revictimisation. *Clinical Psychology: Science and Practice., 9*, 135-164.

Arata, C. M., & Lindman, L. (2002). Marriage, child abuse, and sexual revictimisation. *Journal of Interpersonal Violence, 17*(9), 953-971.

Arliss, L. P. (1991). *Gender communication*. Englewood Cliffs, NJ: Prentice-Hall.

Arriola, K. R. J., Louden, T., Doldren, M. A., & Fortenberry, R. M. (2005). A meta-analysis of the relationship of child sexual abuse to HIV risk behavior among women. *Child Abuse and Neglect, 29*, 725-746.

Attorney-General's Department. (2003). *Electoral and referendum regulations 1940: Commonwealth electoral act 1918 and the referendum (machinery provisions) act 1984*. Canberra: Attorney-General's Department.

Australian Bureau of Statistics. (2001). *Census of population and housing*. Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. (2003). *4510.0 Recorded Crime, Australia.* Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. (2005). *3307.0.55.001 - Divorces, Australia, 2005.* Canberra: Australian Bureau of Statistics.

Australian Institute of Health and Welfare. (2006). *Child protection Australia: 2004-5*. Canberra.

Australian Psychological Society. (1994). *Guidelines relating to the reporting of recovered memories.* Carlton, Victoria: Author.

Babcock, J. C., Jacobson, N. S., Gottman, J. M., & Yerington, T. P. (2000). Attachment, emotional regulation, and the function of marital violence: Differences between secure, preoccupied, and dismissing violent and nonviolent husbands. *Journal of Family Violence, 15*(4), 391-409.

Bacon, B., & Lein, L. (1996). Living with a female sexual abuse survivor: Male partners' perspectives. *Journal of Child Sexual Abuse, 5*(2), 1-16.

Bagley, C. (1988). Depression, self-esteem and suicidal behavior as sequels of sexual abuse in childhood: Research and therapy. In M. Rothey & G. Cameron (Eds.), *Child maltreatment: Expanded conceptions of helping* (pp. 164-185). Waterloo, Ontario: Wilford Launder University Press.

Bagley, C., & McDonald, M. (1984). Adult mental health sequels of child sexual abuse, physical abuse and neglect in maternally separated children. *Canadian Journal of Community Mental Health, 3*, 15-26.

Bagley, C., & Ramsey, R. (1985). Sexual abuse in childhood: Psychosocial outcomes and implications for social work practice. *Journal of Social Work and Human Sexuality, 4*, 33-48.

Bagozzi, R. P., & Edwards, J. R. (1998). A general approach for representing constructs in organizational research. *Organizational Research Methods, 1*, 45-87.

Baker, A. W., & Duncan, S. P. (1985). Child sexual abuse: A study of prevalence in Great Britain. *Child Abuse and Neglect, 9*, 457-467.

Baker, C. D. (2002). *Female survivors of sexual abuse: An integrated guide to treatment.* New York: Brunner Routledge.

Bal, S., Crombez, G., Oost, P. V., & Debourdeaudhuij, I. (2003). The role of social support in well-being and coping with self-reported stressful events in adolescents. *Child Abuse and Neglect, 27*, 1377-1395.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall.

Banyard, V. L., Arnold, S., & Smith, J. (2000). Childhood sexual abuse and dating experiences of undergraduate women. *Child Maltreatment, 5*(1), 39-48.

Banyard, V. L., Williams, L. M., & Siegal, J. A. (2001). The long-term mental health consequences of child sexual abuse: An exploratory study of the impact of multiple traumas in a sample of women. *Journal of Traumatic Stress, 14*(4), 697-715.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182.

Barry, K. L., & Fleming, M. F. (1993). The Alcohol Use Disorders Identification Test (AUDIT) and the SMAST-13: Predictive validity in a rural primary care sample. *Alcohol and Alcoholism, 28*(1), 33-42.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226-244.

Baskin, D. R., & Sommers, I. B. (1998). *Casualties of community disorder: Women's careers in violence crime*. Boulder, CO: Westview.

Bass, E., & Davis, L. (1994). *The courage to heal* (3rd ed.). New York: Harper & Row.

Basta, S. M., & Peterson, R. F. (1990). Perpetrator status and the personality characteristics of molested children. *Child Abuse and Neglect, 14*, 555-566.

Beck, A.T., Rial, W. Y., Rickets, K. (1974). Short form of Depression Inventory: Cross-validation. *Psychological Reports 34 (3),* 1184-1186.

Beitchman, J. H., Zucker, K. J., Hood, J. E., Da Costa, G. A., & Akman, D. (1991). A review of the short-term effects of child abuse. *Child Abuse and Neglect, 15*, 537-556.

Beitchman, J. H., Zucker, K. J., Hood, J. E., Da Costa, G., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect, 16*, 101-118.

Bendixen, M., Muus, K. M., & Schei, B. (1994). The impact of child sexual abuse: A study of a random sample of Norwegian students. *Child Abuse and Neglect, 18*(10), 837-847.

Bennett, S. E., Hughes, H. M., & Luke, D. A. (2000). Heterogeneity in patterns of child sexual abuse, family functioning, and long-term adjustment. *Journal of Interpersonal Violence, 15*(2), 134-157.

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin, 107*, 238-246.

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., et al. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse and Neglect, 27*, 169-190.

Bifulco, A., Brown, G. W., & Adler, Z. (1991). Early sexual abuse and clinical depression in adult life. *British Journal of Psychiatry, 159*, 115-122.

Binder, R. L., McNiel, D. E., & Goldstone, R. L. (1994). Patters of recall of childhood sexual abuse as described by adult survivors. *Bulletin of the American Academy of Law, 22*(3), 358-366.

Bischof, G. P., Stith, S. M., & Whitney, M. L. (1995). Family environments of adolescent sex offenders and other juvenile delinquents. *Adolescence, 30*(117), 157-170.

Black, D. A., Heyman, R. E., & Smith-Slep, A. M. (2001a). Risk factors for child sexual abuse. *Aggression and Violent Behavior, 6*, 203-229.

Black, D. A., Heyman, R. E., & Smith-Slep, A. M. (2001b). Risk factors for male-to-female partner sexual abuse. *Aggression and Violent Behavior, 6*, 269-280.

Bollen, K. A. (1989). *Structural equations with latent variables*. New York: John Wiley & Sons.

Boney-McCoy, S., & Finkelhor, D. (1995). Prior victimization: A risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth. *Child Abuse and Neglect, 19*, 1401-1421.

Boney-McCoy, S., & Finkelhor, D. (1996). Is youth victimization related to trauma symptoms and depression after controlling for prior symptoms and family relationships? A longitudinal, prospective study. *Journal of Consulting and Clinical Psychology, 64*(6), 1406-1416.

Bowlby, J. (1969). *Attachment and loss: Vol 1. Attachment.* New York: Basic Books.

Bowbly, J. (1973). *Attachment and loss: Vol 2. Separation: Anxiety and anger.* New York: Basic Books.

Bowbly, J. (1977). The making and breaking of affectional bonds. *British Journal of Psychiatry, 130*, 201-210.

Bowlby, J. (1980). *Attachment and loss: Vol 3. Loss.* New York: Basic Books.

Bradley, R., Jenei, J., & Westen, D. (2005). Etiology of borderline personality disorder: Disentangling the contributions of intercorrelated antecedents. *The Journal of Nervous and Mental Disease, 193*(1), 24-31.

Brand, B., & Alexander, P. C. (2003). Coping with incest: The relationship between recollections of childhood coping and adult functioning in female survivors of incest. *Journal of Traumatic Stress, 16*(3), 285-293.

Breitenbecher, K. H. (1999). The association between the perception of threat in a dating situation and sexual victimization. *Violence and Victims, 14*(2), 135-146.

Breitenbecher, K. H. (2001). Sexual revictimisation among women: A review of the literature focusing on empirical investigations. *Aggression and Violent Behavior, 6*, 415-432.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York: Guilford.

Brennan, K. A., & Shaver, P. R. (1995). Dimensions of adult attachment, affect regulation, and romantic relationship functioning. *Personality and Social Psychology Bulletin, 21*, 267-283.

Briere, J. (1992). Methodological issues in the study of sexual abuse effects. *Journal of Consulting and Clinical Psychology, 60*(2), 196-203.

Briere, J., & Elliott, D. M. (1993). Sexual abuse, family environment, and psychological symptoms: On the validity of statistical control. *Journal of Consulting and Clinical Psychology, 61*(2), 284-288.

Briere, J., & Runtz, M. (1988a). Multivariate correlates of childhood psychological and physical maltreatment among university women. *Child Abuse and Neglect, 12*, 331-341.

Briere, J., & Runtz, M. (1988b). Post sexual abuse trauma: Data and implications for clinical practice. *Journal of Interpersonal Violence, 2*(4), 367-379.

Briere, J., & Runtz, M. (1988c). Symptomatology associated with childhood sexual victimization in a nonclinical adult sample. *Child Abuse and Neglect, 12*, 51-59.

Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect, 14*, 357-364.

Briggs, L., & Joyce, P. R. (1997). What determines post-traumatic stress disorder symptomatology for survivors of childhood sexual abuse. *Child Abuse and Neglect, 21*(6), 575-582.

British Psychological Society. (1995). *Report of the Working Party of the British Psychological Society on recovered memories.* East Leicester, UK: Author.

Brown, J., Cohen, P., Chen, H., Smailes, E., & Johnson, J. G. (2004). Sexual trajectories of abused and neglected youths. *Developmental and Behavioral Paediatrics, 25*(2), 77-82.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*, 66-77.

Bryer, J. B., Nelson, B. A., Miller, J. B., & Krol, P. A. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry, 144*(11), 1426-1430.

Burgess, A. W., Hartman, C. R., & Baker, T. (1995). Memory presentations of child sexual abuse. *Journal of Psychosocial Nursing, 33*, 9-16.

Burman, B., & Margolin, G. (1992). Analysis of the association between marital relationships and health problems: an interactional perspective. *Psychological Bulletin, 112*, 29-63.

Byrne, B. M. (1998). *Structural equation modeling with LISREL, PRELIS, and SIMPLIS: Basic concepts, applications, and programming*. Mahwah, New Jersey: Lawrence Erlbaum.

Cahill, C., Llewelyn, S. P., & Pearson, C. (1991). Long-term effects of sexual abuse which occurred in childhood: A review. *British Journal of Clinical Psychology, 30*, 117-130.

Cameron, C. (1994). *Recovery from childhood sexual trauma: A longitudinal report.* Paper presented at the 23rd International Congress of Applied Psychology, Madrid, Spain.

Campbell, L., Simpson, J. A., Boldry, J., & Kashy, D. A. (2005). Perceptions of conflict and support in romantic relationships: The role of attachment anxiety. *Journal of Personality and Social Psychology, 88*(3), 510-531.

Canadian Psychiatric Association, E. C. (1996). Adult recovered memories of childhood sexual abuse. *The Canadian Journal of Psychiatry, 41*, 305-306.

Cantwell, H. B. (1995). Sexually aggressive children and societal response. In M. Hunter (Ed.), *Child survivors and perpetrators of sexual abuse: Treatment innovations* (pp. 79-107). Thousand Oaks, CA: Sage.

Capaldi, D., DeGarmo, D., Patterson, G. R., & Forgatch, M. (2002). Contextual risk across the early life span and association with antisocial behaviour. In *Antisocial behaviour in children and adolescents: A developmental analysis and model for intervention* (pp. 123-145). Washington, DC: American Psychological Association.

Capaldi, D. M., & Crosby, L. (1997). Observed and reported psychological and physical aggression in young, at-risk couples. *Social Development, 6*(2), 184-206.

Capaldi, D. M., Pears, K. C., Patterson, G. R., & Owen, L. D. (2003). Continuity of parenting practices across generations in an at-risk sample: A prospective comparison of direct and mediated associations. *Journal of Abnormal Child Psychology, 31*(2), 127-139.

Caplan, G. (1974). *Support systems and community mental health*. New York: Behavioral Publications.

Carlin, A. S., & Ward, N. G. (1992). Subtypes of psychiatric inpatient women who have been sexually abused. *The Journal of Nervous and Mental Disease, 180*(6), 392-397.

Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989a). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology, 25*, 525-531.

Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. G. (1989b). Finding order in disorganization: Lessons from research on maltreated infants' attachment to their caregivers. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 494-528). New York: Cambridge University Press.

Cassidy, J., Kirsh, S. J., Scolton, K. L., & Parke, R. D. (1996). Attachment and representations of peer relationships. *Developmental Psychology, 32*, 892-904.

Ceci, S. J., & Bruck, M. (1993). The suggestibility of the child witness: A historical review and synthesis. *Psychological Bulletin, 113*, 403-439.

Ceci, S. J., Huffman, M. L. C., Smith, E., & Loftus, E. F. (1994). Repeatedly thinking about a non-event: Source misattribution among preschoolers. *Consciousness and Cognition, 3*, 388-407.

Ceci, S. J., Loftus, E. F., Leitchtman, M. D., & Bruck, M. (1994). The possible role of source misattributions in the creation of false beliefs among preschoolers. *International Journal of Clinical and Experimental Hypnosis, 42*, 304-320.

Chaffin, M., Wherry, J. N., & Dykman, R. (1997). School age children's coping with sexual abuse: Abuse stresses and symptoms associated with four coping strategies. *Child Abuse and Neglect, 21*, 227-240.

Chang, C. Y., & Myers, J. E. (1997). Understanding and counseling Korean Americans: Implications for training. *Counselor Education and Supervision, 37*, 35-49.

Cherlin, A. J., Burton, L. M., Hurt, T. R., & Purvin, D. M. (2004). The influence of physical and sexual abuse on marriage and cohabitation. *American Sociological Review, 69*, 768-789.

Chewning-Korpach, M. (1996). Sexual revictimisation: A cautionary note. In M. F. Schwartz & L. Cohn (Eds.), *Sexual abuse and eating disorders* (pp. 179-190). Philadelphia, PA: Brunner/Mazel.

Chu, J. A., & Dill, D. L. (1990). Dissociative symptoms in relation to childhood physical and sexual abuse. *American Journal of Psychiatry, 147*, 887-892.

Classen, B., & Aasland, O. G. (1993). The Alcohol Use Disorders Identification Test (AUDIT) in a routine health examination of long-term unemployed. *Addiction, 88*(3), 363-368.

Classen, C., Field, N. P., Koopman, C., Nevill-Manning, K., & Spiegel, D. (2001). Interpersonal problems and their relationship to sexual revictimisation among women sexually abused in childhood. *Journal of Interpersonal Violence, 16*(6), 495-509.

Cloitre, M., Scarvalone, P., & Difede, J. (1997). Posttraumatic stress disorder, self- and interpersonal dysfunction among sexually retraumatized women. *Journal of Traumatic Stress, 10*(3), 437-452.

Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R. T. (1996a). Mediators of the long-term impact of child sexual abuse: Perceived stigma, betrayal, powerlessness, and self-blame. *Child Abuse and Neglect, 20*(5), 447-455.

Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R. T. (1996b). The relation between methods of coping during adulthood with a history of childhood sexual abuse and current psychological adjustment. *Journal of Consulting and Clinical Psychology, 64*(5), 1090-1093.

Cohen, J. (1992). Quantitative methods in psychology: A power primer. *Psychological Bulletin, 112*(1), 115-159.

Cole, P. M., & Putnam, F. W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology, 60*(2), 174-184.

Collins, N. L., & Feeney, B. C. (2000). A safe haven: An attachment theory perspective on support seeking and caregiving in intimate relationships. *Journal of Personality and Social Psychology, 78*, 1053-1073.

Collins, N. L., & Read, S. J. (1990). Adult attachment, working models, and relationship quality in dating couples. *Journal of Personality and Social Psychology, 58*, 644-663.

Colman, R. A., & Spatz Widom, C. (2004). Childhood abuse and neglect and adult intimate relationships: a prospective study. *Child Abuse and Neglect, 28*, 1133-1151.

Compton, J. S., & Follette, V. M. (1998). Couples surviving trauma: Issues and interventions. In V. M. Follette, J. I. Ruzek & F. R. Abueg (Eds.), *Cognitive-behavioral therapies for trauma* (pp. 321-352). New York: The Guilford Press.

Conger, R. D., Ge, X., Elder, G. H., Lorenz, F. O., & Simons, R. L. (1994). Economic stress, coercive family process, and developmental problems of adolescents. *Child Development, 65*, 541-561.

Conigrave, K. M., Hall, W. D., & Saunders, J. B. (1995). The AUDIT questionnaire: Choosing a cut-off score. *Addiction, 90*, 1349-1356.

Connelly, C. D., Newton, R. R., & Aarons, G. A. (2005). A psychometric examination of English and Spanish versions of the Revised Conflict Tactics Scale. *Journal of Interpersonal Violence, 20*(12), 1560-1579.

Constantine, L. L. (1981). The effects of early sexual experience: A review and synthesis of research. In L. L. Constantine & F. M. Martinson (Eds.), *Children and sex* (pp. 379-394). Boston: Little, Brown and Company.

Conte, J. R., & Schuerman, J. R. (1987). Factors associated with an increased impact of child sexual abuse. *Child Abuse and Neglect, 11*, 201-211.

Conte, J. R., & Schuerman, J. R. (1988). The effects of sexual abuse on children: A multidimensional view. *Journal of Interpersonal Violence, 2*(4), 380-390.

Cooper, M. L., Shaver, P. R., & Collins, N. L. (1998). Attachment styles, emotion regulation, and adjustment in adolescence. *Journal of Personality and Social Psychology, 74*, 1380-1397.

Cosentino, C. E., Meyer-Bahlburg, H. L. F., Albert, J. L., & Gaines, R. (1993). Cross-gender behavior and gender conflict in sexually abused girls. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*, 940-947.

Courtois, C. A. (1999). *Recollections of sexual abuse: Treatment principles and guidelines.* New York: W. W. Norton.

Covington, S. S., & Kohen, H. (1984). Women, alcohol and sexuality. In B. Stimmel (Ed.), *Cultural and sociological aspects of alcoholism and substance abuse* (pp. 41-56). New York: Haworth Press.

Cramer, D. (2004). Satisfaction with a romantic relationship, depression, support and conflict. *Psychology and Psychotherapy: Theory, Research and Practice, 77*, 449-461.

Cyr, M., McDuff, P., & Wright, J. (2006). Prevalence and predictors of dating violence among adolescent female victims of child sexual abuse. *Journal of Interpersonal Violence, 21*(8), 1000-1017.

Cyr, M., Wright, J., McDuff, P., & Perron, A. (2002). Intrafamilial sexual abuse: brother-sister incest does not differ from father-daughter and stepfather-stepdaughter incest. *Child Abuse and Neglect, 26*, 957-973.

Daeppen, J. B., Yersin, B., Landry, U., Pecoud, A., & Decrey, H. (2000). Reliability and validity of the Alcohol Use Disorders Identification Test (AUDIT) imbedded within a general health risk screening questionnaire: Results of a survey if 332 primary care patients. *Alcoholism: Clinical and Experimental Research, 24*(5), 659-665.

Davenport, C., Brown, K., & Palmer, R. (1994). Opinions on the traumatizing effects of child sexual abuse: Evidence for consensus. *Child Abuse and Neglect, 18*(9), 725-738.

Davies, P., & Cummings, E. (1994). Marital conflict and child adjustment: An emotional security hypothesis. *Psychological Bulletin, 116*, 387-411.

Davis, J. L., & Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior, 5*(3), 291-328.

Davis, J. L., Petretic-Jackson, P. A., & Ting, L. (2001). Intimacy dysfunction and trauma symptomatology: Long-term correlates of different types of child abuse. *Journal of Traumatic Stress, 14*(1), 63-79.

Denov, M. S. (2004). The long-term effects of child sexual abuse by female perpetrators: A qualitative study of male and female victims. *Journal of Interpersonal Violence, 19*(10), 1137-1156.

DiLillo, D. (2001). Interpersonal functioning among women reporting a history of childhood sexual abuse: Empirical findings and methodological issues. *Clinical Psychology Review, 21*(4), 553-576.

DiLillo, D., DeGue, S., Kras, A., Di Loreto-Colgan, A. R., & Nash, C. (2006). Participant responses to retrospective surveys of child maltreatment: Does mode of assessment matter? *Violence and Victims, 21*(4), 410-424.

DiLillo, D., Giuffre, D., Tremblay, G. C., & Peterson, L. (2001). A closer look at the nature of intimate partner violence reported by women with a history of child sexual abuse. *Journal of Interpersonal Violence, 16*(2), 116-132.

DiLillo, D., & Long, P. J. (1999). Perceptions of couple functioning among female survivors of child sexual abuse. *Journal of Child Sexual Abuse, 7*, 59-76.

Dion, K. K., & Dion, K. L. (1993). Individualistic and collectivistic perspectives on gender and cultural context of love and intimacy. *Journal of Social Issues, 49*(3), 53-69.

Dishion, T. J., French, D. C., & Patterson, G. R. (1995). The development and ecology of antisocial behavior. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychology: Vol. 2. Risk, disorder, and adaptation* (pp. 421-471). New York: Wiley.

Dong, M., Anda, R. F., Dube, S. R., Giles, W. H., & Felitti, V. J. (2003). The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood. *Child Abuse and Neglect, 27*, 625-639.

Drake, B., & Pandey, S. (1996). Understanding the relationship between neighbourhood poverty and specific types of child maltreatment. *Child Abuse and Neglect, 20*, 1003-1018.

Draucker, C. B. (1995). A coping model for adult survivors of childhood sexual abuse. *Journal of Interpersonal Violence, 10*(2), 159-175.

Dubowitz, H., Black, M., Harrington, D., & Verschoore, A. (1993). A follow-up study of behavior problems associated with child sexual abuse. *Child Abuse and Neglect, 17*, 743-754.

Dunne, M. P., Purdie, D. M., Cook, M. D., Boyle, F. M., & Najman, J. M. (2003). Is child sexual abuse declining? Evidence from a population-based survey of men and women in Australia. *Child Abuse and Neglect, 27*, 141-152.

Dutton, D. G., & Nichols, T. L. (2005). The gender paradigm in domestic violence research and theory: Part 1-The conflict theory and data. *Aggression and Violent Behavior, 10*, 680-714.

Dutton, D. G., Saunders, K., Starzomski, A., & Bartholomew, K. (1994). Intimacy-anger and insecure attachment as precursors of abuse in intimate relationships. *Journal of Applied Social Psychology, 24*(15), 1367-1386.

Earls, C. M., & David, H. (1990). Early family and sexual experiences of male and female prostitutes. *Canada's Mental Health, 38*(4), 7-11.

Edwards, J. J., & Alexander, P. C. (1992). The contribution of family background to the long-term adjustment of women sexually abused as children. *Journal of Interpersonal Violence, 7*(3), 306-320.

Egeland, B., & Farber, E. (1984). Infant-mother attachment: Factors related to its development and changes over time. *Child Development, 55*, 753-771.

Egeland, B., & Sroufe, L. A. (1981). Attachment and early maltreatment. *Child Development, 52*, 44-52.

Elliot, D. M., & Briere, J. (1994). Forensic sexual abuse evaluations of older children: Disclosures and symptomatology. *Behavioral Science and Law, 12*, 261-277.

Elliott, D. M., & Briere, J. (1995). Posttraumatic stress associated with delayed recall of sexual abuse: A general population study. *Journal of Traumatic Stress, 8*, 629-648.

Elliot, R., & Greenberg, L. S. (2002). Process-experiential psychotherapy. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 279-306). Washington, DC: American Psychological Association.

Everill, J., & Waller, G. (1995). Disclosure of sexual abuse and psychological adjustment in female undergraduates. *Child Abuse and Neglect, 19*(1), 93-100.

Fassler, I. R., Amodeo, M., Griffin, M. L., Clay, C. M., & Ellis, M. A. (2005). Predicting long-term outcomes for women sexually abused in childhood: Contribution of abuse severity versus family environment. *Child Abuse and Neglect, 29*, 269-284.

Feeney, J. A., & Noller, P. (2004). Attachment and sexuality in close relationships. In J. H. Harvey, A. Wenzel & S. Sprecher (Eds.), *Handbook of sexuality in close relationships* (pp. 355-377). Mahwah, NJ: Erlbaum.

Feinauer, L. L., Callahan, E. H., & Hilton, H. G. (1996). Positive intimate relationships decrease depression in sexually abused women. *The American Journal of Family Therapy, 24*(2), 99-106.

Feiring, C., Taska, L. S., & Lewis, M. (1998). Social support and children's and adolescents' adaptation to sexual abuse. *Journal of Interpersonal Violence, 13*(2), 240-260.

Feldman-Summers, S., & Pope, K. S. (1994). The experience of "forgetting" childhood abuse: A national survey of psychologists. *Journal of Consulting and Clinical Psychology, 62*, 636-639.

Femina, D. D., Yeager, C. A., & Lewis, D. O. (1990). Child abuse: Adolescent records vs. adult recall. *Child Abuse and Neglect, 14*, 227-231.

Ferenczi, S. (1988). *The clinical diary of Sandor Ferenczi*. Cambridge, MA: Harvard University Press.

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviours and sexual revictimisation. *Child Abuse and Neglect, 21*(8), 789-803.

Fergusson, D. M., & Mullen, P. E. (1999). *Childhood sexual abuse: An evidence based perspective.* California: Sage.

Field, A. (2000). *Discovering statistics: using SPSS for windows*. London: Sage.

Filipas, H. H., & Ullman, S. E. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimisation. *Journal of Interpersonal Violence, 21*(5), 652-672.

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

Finkelhor, D. (1980). Risk factors in the sexual victimization of children. *Child Abuse and Neglect, 4*, 265-273.

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

Finkelhor, D. (1990). New ideas for child sexual abuse prevention. In K. R. Oates (Ed.), *Understanding and managing child sexual abuse* (pp. 385-396). Sydney: Harcourt Brace Jovanovich.

Finkelhor, D. (1994a). Current information on the scope and nature of child sexual abuse. *Sexual Abuse of Children, 4*(2), 31-53.

Finkelhor, D. (1994b). The international epidemiology of child sexual abuse. *Child Abuse and Neglect, 18*(5), 409-417.

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

Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse and Neglect, 14*, 19-28.

Finkelhor, D., Moore, D., Hamby, S. L., & Straus, M. A. (1997). Sexually abused children in a national survey of parents: Methodological issues. *Child Abuse and Neglect, 21*, 1-9.

Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment, 10*(1), 5-25.

Flavell, J. H., Flavell, E., & Green, F. L. (1987). Young children's knowledge about the apparent-real and pretend-real distinctions. *Developmental Psychology, 23*, 816-822.

Fleming, J., Mullen, P. E., Sibthorpe, B., Attewell, R., & Bammer, G. (1998). The relationship between childhood sexual abuse and alcohol abuse in women - a case-control study. *Addiction, 93*(12), 1787-1798.

Fleming, J., Mullen, P. E., Sibthorpe, B., & Bammer, G. (1999). The long-term impact of childhood sexual abuse in Australian women. *Child Abuse and Neglect, 23*(2), 145-159.

Fleming, J. M. (1997). Prevalence of childhood sexual abuse in a community sample of Australian women. *The Medical Journal of Australia, 166*, 65-68.

Follette, W. C., Naugle, A. E., & Follette, V. M. (1997). MMPI-2 profiles of adult women with child sexual abuse histories: Cluster-analytic findings. *Journal of Consulting and Clinical Psychology, 65*(5), 858-866.

Forthofer, M. S., Markman, H. J., Cox, M., Stanley, S., & Kessler, R. C. (1996). Associations between marital distress and work loss in a national sample. *Journal of Marriage and the Family, 58*(3), 597-605.

Fraley, R. C., & Shaver, P. R. (2000). Adult romantic attachment: Theoretical developments, emerging controversies, and unanswered questions. *Review of General Psychology, 4*, 132-154.

Freeman, K. A., & Morris, T. L. (2001). A review of conceptual models explaining the effects of child sexual abuse. *Aggression and Violent Behavior, 6*, 357-373.

Freud, S. (1953). Three essays on the theory of sexuality. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud: Vol. 7.* (pp. 135-243). London: Hogarth Press.

Fricker, A. E., Smith, D. W., Davis, J. L., & Hanson, R. F. (2003). Effects of context and question type on endorsement of childhood sexual abuse. *Journal of Traumatic Stress, 16*(3), 265-268.

Friedrich, W. N. (1990). *Psychotherapy of sexually abused children and their families*. New York: W. W. Norton.

Friedrich, W. N. (1996). An integrated model of psychotherapy for abused children. In J. Briere, L. Berliner, J. A. Bulkley, C. Jenny & T. Reid (Eds.), *The APSAC handbook on child maltreatment*. Thousand Oaks, CA: Sage.

Friedrich, W. N. (2000). Children and adolescents who are sexually abusive of others. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(7), 809-821.

Friedrich, W. N., Beilke, R. L., & Urquiza, A. J. (1988). Children from sexually abusive families: A behavioral comparison. *Journal of Interpersonal Violence, 2*(4), 391-402.

Fromuth, M. E. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. *Child Abuse and Neglect, 10*, 5-15.

Gay & Lesbian Rights Lobby. (2001). *The age of consent and gay men in New South Wales: Section three - homosexual age of consent in Australia*. Retrieved from http://www.glrl.org.au/publications/major_reports/age_of_consent

Gelles, R. J., & Conte, J. R. (1990). Domestic violence and sexual abuse of children: A review of research in the eighties. *Journal of Marriage and the Family, 52*, 1045-1058.

Gentzler, A. L., & Kerns, K. A. (2004). Associations between insecure attachment and sexual experiences. *Personal Relationships, 11*, 249-265.

Ghetti, S., Goodman, G. S., Eisen, M. L., Qin, J., & Davis, S. L. (2002). Consistency in children's reports of sexual and physical abuse. *Child Abuse and Neglect, 26*, 977-995.

Gil, E., & Johnson, T. C. (1993). *Sexualized children: Assessment and treatment of sexualized children and children who molest*. Rockville, MD: Launch Press.

Gold, E. R. (1986). Long-term effects of sexual victimization in childhood: An attributional approach. *Journal of Consulting and Clinical Psychology, 54*(4), 471-475.

Gold, S. N., Hughes, D., & Hohnecker, L. (1994). Degrees of repression of sexual abuse memories. *American Psychologist, 49*, 440-441.

Gold, S. R., Sinclair, B. B., & Balge, K. A. (1999). Risk of sexual revictimisation: A theoretical model. *Aggression and Violent Behavior, 4*(4), 457-470.

Goldman, D. G., & Padayachi, U. K. (1997). The prevalence and nature of child sexual abuse in Queensland, Australia. *Child Abuse and Neglect, 21*(5), 489-498.

Gomes-Schwartz, B., Horowitz, J. M., & Cardarelli, A. P. (1990). *Child sexual abuse: The initial effects*. Newbury Park, CA: Sage.

Goodman, G. S., Batterman-Faunce, J. M., Schaaf, J. M., & Kenney, R. (2002). Nearly 4 years after the event: Children's eyewitness memory and adults' perceptions of children's accuracy. *Child Abuse and Neglect, 26*, 849-884.

Goodman, G. S., Quas, J. A., Batterman-Fauce, J. M., Riddlesberger, M., & Kuhn, J. (1994). Predictors of accurate and inaccurate memories of traumatic events experienced in childhood. *Consciousness and Cognition, 3*, 269-294.

Goodman, G. S., Quas, J. A., Batterman-Faunce, J. M., Riddlesberger, M. M., & Kuhn, J. (1996). Predictors of accurate and inaccurate memories of traumatic events experienced in childhood. In K. Pezdek & W. P. Banks (Eds.), *The recovered memory/false memory debate* (pp. 3-18). New York: Academic Press.

Goodman, G. S., Rudy, L., Bottoms, B., & Aman, C. (1990). Children's concerns and memory: Issues of ecological validity in the study of children's eyewitness testimony. In R. Fivush & J. A. Hudson (Eds.), *Knowing and remembering in young children* (pp. 249-284). Cambridge, England: Cambridge University Press.

Goodyear, R. K., Newcomb, M. D., & Locke, T. F. (2002). Pregnant Latina teenagers: Psychosocial and developmental determinants of how they select and perceive the men who father their children. *Journal of Counseling Psychology, 49*(2), 187-201.

Gorcey, M., Santiago, J. M., & McCal-Perez, F. (1986). Psychological consequences for women sexually abused in childhood. *Social Psychiatry, 21*, 129-133.

Gorey, K. M., & Leslie, D. R. (1997). The prevalence of child sexual abuse: Integrative review adjustment for potential response and measurement biases. *Child Abuse and Neglect, 21*(4), 391-398.

Gottman, J. M., & Levenson, R. W. (1986). Assessing the role of emotion in marriage. *Behavioral Assessment, 8*, 31-48.

Grauerholz, L. (2000). An ecological approach to understanding sexual revictimisation: Linking personal, interpersonal, and sociocultural factors and processes. *Child Maltreatment, 5*(1), 5-17.

Grayston, A. D., & De Luca, R. V. (1999). Female perpetrators of child sexual abuse: A review of the clinical and empirical literature. *Aggression and Violent Behavior, 4*(1), 93-106.

Greenberg, L. S., & Bolger, L. (2001). An emotion focus approach to the over-regulation of emotion and emotional pain. *In-Session, 57*, 192-212.

Greenberg, L. S., & Johnson, S. M. (1986). Emotionally focused couple therapy: An affective systematic approach. In N. S. Jacobson & A. S. Gurman (Eds.), *Handbook of clinical and marital therapy* (pp. 253-276). New York: Guilford.

Greenberg, L. S., Korman, L. M., & Paivio, S. C. (2002). Emotion in humanistic psychotherapy. In D. J. Cain & K. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 499-530). Washington, DC: American Psychological Association.

Greenberg, L. S., & Paivio, S. C. (1997). *Working with emotions in psychotherapy*. New York: Guilford.

Greenberg, L. S., Rice, L. N., & Elliot, R. (1993). *Facilitating emotional change: The moment-by-moment process.* New York: Guilford.

Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. *American Psychologist, 44*, 19-29.

Greenwald, E., Lettenberg, H., Cado, S., & Tarran, M. J. (1990). Childhood sexual abuse: Long-term effects on psychological and sexual functioning in a nonclinical and nonstudent sample of adult women. *Child Abuse and Neglect, 14*, 503-513.

Griffin, D., & Bartholomew, K. (1994). Model of the self and other: Fundamental dimensions and underling measures of adult attachment. *Journal of Personality and Social Psychology, 67*, 430-445.

Grych, J. H., Fincham, F. D., Jouriles, E. N., & McDonald, R. (2000). Interparental conflict and child adjustment: Testing the mediational role of appraisals in the cognitive-contextual framework. *Child Development, 71*(6), 1648-1661.

Haavio-Mannila, E., & Kontula, O. (1997). Correlates of increased sexual satisfaction. *Archives of Sexual Behavior, 26*(4), 399-420.

Hair, J. F. (1992). *Multivariate data analysis with readings*. New York: Macmillan.

Halford, K., Lizzio, A., Eadie, K., & Wilson, K. (1999). *Newlywed Project 1999 - Follow-up 4.* Griffith University, Brisbane.

Halford, K. W. (2002). Brief couple therapy: Helping partners help themselves. In K. W. Halford (Ed.), *Couple Therapy*. Brisbane: Griffith University.

Halford, K. W., Kelly, A., & Markham, H. J. (1997). The concept of a healthy marriage. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couple intervention* (pp. 3-9). Brisbane: John Wiley & Sons.

Halford, K. W., Sanders, M. R., & Behrens, B. C. (1994). Self-regulation in behavioral couples therapy. *Behavior Therapy, 25*, 431-452.

Halford, K. W., Wilson, K., Moore, E., Dyer, C., & Farrugia, C. (2006). *Couple CARE: Couple commitment and relationship enhancement. Relationship educator's manual*. Brisbane: Australian Academic Press.

Harter, S., Alexander, P. C., & Neimeyer, R. A. (1988). Long-term effects of incestuous child abuse in college women: Social adjustment, social cognition, and family characteristics. *Journal of Consulting and Clinical Psychology, 56*(1), 5-8.

Harvey, J. H., Orbuch, T. L., Chwalisz, K. D., & Garwood, G. (1991). Coping with sexual assault: The roles of account-making and confiding. *Journal of Traumatic Stress, 4*(4), 515-531.

Haugaard, J. J. (2000). The challenge of defining child sexual abuse. *American Psychologist, 55*(9), 1036-1039.

Haverkamp, B., & Daniluk, J. C. (1993). Child sexual abuse: Ethical issues for the family therapist. *Family Relations, 42*(2), 134-139.

Hawton, K., Catalan, J., & Fagg, J. (1992). Sex therapy for erectile dysfunction: Characteristics of couples, treatment outcome, and prognostic factors. *Archives of Sexual Behavior, 21*(2), 161-175.

Hayes, S. C. (1994). Content, context, and the types of psychological acceptance. In S. C. Hayes, N. S. Jacobson, V. M. Follette, & M. J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy* (pp. 13-32). Reno, NV: Context Press.

Hayes, S. C., Bissett, R. T., Korn, Z., Zettle, R. D., Rosenfarb, I. S., Cooper, L. D., et al. (1999). The impact of acceptance versus control rationales on pain tolerance. *The Psychological Record, 49*, 33-47.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52*, 511-524.

Heiman, J. R., & Heard-Davison, A. R. (2004). Child sexual abuse and adult sexual relationships: Review and perspective. In L. J. Koenig, L. S. Doll, A. O'Leary & P. Willo (Eds.), *Child sexual abuse to adult sexual risk: Trauma, revictimisation, and intervention* (pp. 13-47). Washington, DC: American Psychological Association.

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

Herman, J., Russell, D., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. *American Journal of Psychiatry, 143*(10), 1293-1296.

Herman, J. L., & Harvey, M. R. (1997). Adult memories of childhood trauma: A naturalistic clinical study. *Journal of Traumatic Stress, 10*(4), 557-571.

Herman, J. L., Perry, J. C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *The American Journal of Psychiatry, 146*(4), 490495.

Herman, J. L., & Schatzow, E. (1987). Recovery and verification of memories of childhood sexual trauma. *Psychoanalytic Psychology, 4*, 1-14.

Herman-Giddens, M. E., Kotch, J. B., Browne, D. C., Ruina, M. B. A., Winsor, J. R., Jung, J., et al. (1998). Childbearing patterns in a cohort of women sexually abused as children. *Journal of Interpersonal Violence, 13*, 504-514.

Higgins, D. J., & McCabe, M. P. (1994). The relationship of child sexual abuse and family violence to adult adjustment: Toward an integrated risk-sequelae model. *The Journal of Sex Research, 31*(4), 255-268.

Hill, J., Picklers, A., Burnside, E., Byatt, M., Rollinson, L., Davis, R., et al. (2001). Child sexual abuse, poor parental care and adult depression: Evidence for different mechanisms. *British Journal of Psychiatry, 179*, 104-109.

Himelein, M. J., & McElrath, J. V. (1996). Resilient child sexual abuse survivors: Cognitive coping and illusion. *Child Abuse and Neglect, 20*(8), 747-758.

Holtzworth-Munroe, A. (2005). Female perpetration of physical aggression against an intimate partner: A controversial new topic of study. *Violence and Victims, 20*(2), 251-259.

Holtzworth-Munroe, A., Stuart, G. L., & Hutchinson, G. (1997). Violence versus nonviolent husbands: Differences in attachment patterns, dependency, and jealousy. *Journal of Family Psychology, 11*(3), 314-331.

Horton, C. B. (1996). Children who molest other children: The school psychologist's response to the sexually aggressive child. *School Psychology Review, 25*(4), 540-557.

Hotte, J. P., & Rafman, S. (1992). The specific effects of incest on prepubertal girls from dysfunctional families. *Child Abuse and Neglect, 16*, 273-283.

Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling, 6*, 1-55.

Huberty, C. J., & Morris, J. D. (1989). Multivariate analysis versus multiple univariate analyses. *Psychological Bulletin, 105*(2), 302-308.

Hulme, P. A., & Agrawal, S. (2004). Patterns of childhood sexual abuse characteristics and their relationships to other childhood abuse and adult health. *Journal of Interpersonal Violence, 19*(4), 389-405.

Hunsley, J., Best, M., Lefebvre, M., & Vito, D. (2001). The seven-item short form of the Dyadic Adjustment Scale: Further evidence for construct validity. *The American Journal of Family Therapy, 29*, 325-335.

Hunsley, J., Pinsent, C., Lefebvre, M., James-Tanner, S., & Vito, D. (1995). Assessment of couples, marriages, and families: Construct validity of the short forms of the dyadic adjustment scale. *Family Relations, 44*, 231-237.

Hunter, J. A. (1991). A comparison of the psychosocial maladjustment of adult males and females sexually molested as children. *Journal of Interpersonal Violence, 6*(2), 205-217.

Jackson, J. L., Calhoun, K. S., Amick, A. A., Maddever, H. M., & Habif, V. L. (1990). Young adult women who report childhood intrafamilial sexual abuse: Subsequent adjustment. *Archives of Sexual Behavior, 19*, 211-221.

Jacobson, N. S., Gottman, J. M., Waltz, J., Rushe, R., Babcock, J., & Holtzworth-Munroe, A. (2000). Affect, verbal content, and psychophysiology in the arguments of couples with a violent husband. *Prevention and Treatment, 3*(19), 1-15.

Janet, P. (1925). *Psychological healing:* Vol. 1-2. New York: Macmillan.

Jehu, D. (1988). *Beyond sexual abuse: Therapy with women who were childhood victims.* New York: John Wiley.

Johnson, S. M., & Greenberg, L. S. (1995). The emotionally focused approach to problems in adult attachment. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 121-141). New York: Guilford.

Johnson, S. M., & Williams-Keeler, L. (1998). Creating healing relationships for couples dealing with trauma: The use of emotionally focused marital therapy. *Journal of Marital and Family Therapy, 24*(1), 25-40.

Jones, N. T., Ji, P., Beck, M., & Beck, N. (2002). The reliability and validity of the Revised Conflict Tactics Scale (CTS2) in a female incarcerated population. *Journal of Family Issues, 23*(3), 441-457.

Jonzon, E., & Lindblad, F. (2004). Disclosure, reactions, and social support: Findings from a sample of adult victims of child sexual abuse. *Child Maltreatment, 9*(2), 190-200.

Jonzon, E., & Lindblad, F. (2005). Adult female victims of child sexual abuse: Multitype maltreatment and disclosure characteristics related to subjective health. *Journal of Interpersonal Violence, 20*(6), 651-666.

Jumper, S. A. (1995). A meta-analysis of the relationship of child sexual abuse to adult psychological adjustment. *Child Abuse and Neglect, 19*(6), 715-728.

Kallstrom-Fuqua, A. C., Weston, R., & Marshall, L. L. (2004). Childhood and adolescent sexual abuse of community women: Mediated effects on psychological distress and social relationships. *Journal of Consulting and Clinical Psychology, 72*(6), 980-992.

Kaplan, R., & Manicavasagar, V. (2001). Is there a false memory syndrome? A review of three cases. *Comprehensive Psychiatry, 42*(4), 342-348.

Katerndahl, D., & Burge, S. (2005). Predictors of development of adult psychopathology in female victims of childhood sexual abuse. *The Journal of Nervous and Mental Disease, 193*(4), 258-264.

Keatsdale Pty. Ltd. (2003). *Report into the cost of child abuse and neglect in Australia.* Queensland: Author.

Kelly, A. B., Halford, K. W., & Young, R. M. (2002a). Couple communication and female problem drinking: A behavioral observation study. *Psychology of Addictive Behaviors, 16*(3), 269-271.

Kelly, A. B., Halford, K. W., & Young, R. M. (2002b). Expectations of the effects of drinking on couple relationship functioning: An assessment of women in distressed relationships who consume alcohol at harmful levels. *Addictive Behaviors, 27*, 451-464.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*, 164-180.

Kercher, G. A., & McShane, M. (1984). The prevalence of child sexual abuse victimization in an adult sample of Texas residents. *Child Abuse and Neglect, 8*, 495-501.

Kerlinger, F. N., & Lee, H. B. (2000). *Foundations of behavioral research* (4th ed.). Philadelphia: Harcourt.

Kessler, B. L., & Bieschke, K. J. (1999). A retrospective analysis of shame, dissociation, and adult victimization in survivors of childhood sexual abuse. *Journal of Counseling Psychology, 46*(3), 335-341.

Kilpatrick, A. (1987). Childhood sexual experiences: Problems and issues in studying long-range effects. *The Journal of Sex Research, 23*, 173-196.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behaviour in the human female.* Philadelphia: W.B. Saunders.

Kinzl, J., & Biebl, W. (1992). Long-term effects of incest: Life events triggering mental disorders in female patients with sexual abuse in childhood. *Child Abuse and Neglect, 16*, 567-573.

Kinzl, J. F., Mangweth, B., Traweger, C., & Biebl, W. (1996). Sexual dysfunction in males: Significance of adverse childhood experiences. *Child Abuse and Neglect, 20*(8), 759-766.

Kinzl, J. F., Traweger, C., & Biebl, W. (1995). Sexual dysfunctions: Relationship to childhood sexual abuse and early family experiences in a nonclinical sample. *Child Abuse and Neglect, 19*(7), 785-792.

Kisiel, C. L., & Lyons, J. S. (2001). Dissociation as a mediator of psychopathology among sexually abused children and adolescents. *American Journal of Psychiatry, 158*, 1034-1039.

Klassen, A. D., & Wilsnack, S. C. (1986). Sexual experience and drinking among women in a U.S. national survey. *Archives of Sexual Behavior, 15*(5), 363-392.

Klohnen, E. C., & Luo, S. (2003). Interpersonal attraction and personality: What is attractive-self similarity, ideal similarity, complementarity, or attachment security? *Journal of Personality and Social Psychology, 85*(4), 709-722.

Koss, M. P., & Dinero, T. E. (1989). Discriminant analysis of risk factors for sexual victimization among a national sample of college women. *Journal of Consulting and Clinical Psychology, 57*, 242-250.

Kovac, I., Merette, C., Dongier, M., & Palmour, R. M. (2002). Evidence in an international sample of alcohol-dependent subjects of subgroups with specific symptom patterns of antisocial personality disorder. *Alcoholism: Clinical and Experimental Research, 26*(7), 1088-1096.

Krahe, B. (2000). Childhood sexual abuse and revictimisation in adolescence and adulthood. In J. H. Harvey & B. G. Pauwels (Eds.), *Post-traumatic stress theory: Research and application* (pp. 49-66). Philadelphia: Brunner/Mazel.

Krahe, B., Scheinberger-Olwig, R., Waizenhofer, E., & Kolpin, S. (1999). Childhood sexual abuse and revictimisation in adolescence. *Child Abuse and Neglect, 23*(4), 383-394.

Kuha, J. (2004). AIC and BIC: Comparisons of assumptions and performance. *Sociological Methods and Research, 33*(2), 188-229.

Kutil, R. M. (2000). *Attachment theory and childhood sexual abuse.* University of Wisconsin-Madison, Wisconsin-Madison.

Kwong, M., Henderson, A. J. Z., & Trinke, S. J. (2003). The intergenerational transmission of relationship violence. *Journal of Family Psychology, 17*(3), 288-301.

Kwong, M. J., Bartholomew, K., & Dutton, D. G. (1999). Gender differences in patterns of relationship violence in Alberta. *Canadian Journal of Behavioural Science, 31*(3), 150-160.

Lafontaine, M. F., & Lussier, Y. (2005). Does anger toward the partner mediate and moderate the link between romantic attachment and intimate violence. *Journal of Family Violence, 20*(6), 349-361.

Lamb, S., & Edgar-Smith, S. (1994). Aspects of disclosure: Mediators of outcome of child sexual abuse. *Journal of Interpersonal Violence, 9*(3), 307-326.

Lang, A. J., Stein, M. B., Kennedy, C. M., & Foy, D. W. (2004). Adult psychopathology and intimate partner violence among survivors of childhood maltreatment. *Journal of Interpersonal Violence, 19*(10), 1102-1118.

Lanktree, C., Briere, J., & Zaidi, L. (1991). Incidence and impact of sexual abuse in a child outpatient sample: The role of direct inquiry. *Child Abuse and Neglect, 15*, 447-453.

Lanza, S. T., Collins, L. M., Schafer, J. L., & Flaherty, B. P. (2005). Using data augmentation to obtain standard errors and conduct hypothesis tests in latent class and latent transition analysis. *Psychological Methods, 10*(1), 84-100.

Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. *Journal of the American Medical Association, 281*(537-544).

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Leigh, B. C. (1990). The relationship of sex-related alcohol expectancies to alcohol consumption and sexual behavior. *British Journal of Addiction, 85*(7), 919-928.

Leonard, L. M., & Follette, V. M. (2002). Sexual functioning in women reporting a history of child sexual abuse: Review of the empirical literature and clinical implications. *Annual Review of Sex Research, 13*, 346-388.

Leventhal, J. M. (1990). Epidemiology of child sexual abuse. In K. R. Oates (Ed.), *Understanding and managing child sexual abuse* (pp. 18-41). Sydney: Harcourt Brace Jovanovich.

Liang, B., Williams, L. M., & Siegel, J. A. (2006). Relational outcomes of childhood sexual trauma in female survivors. *Journal of Interpersonal Violence, 21*(1), 42-57.

Liem, J. H., James, J. B., O'Toole, J. G., & Boudewyn, A. C. (1997). Assessing resilience in adults with histories of childhood sexual abuse. *American Journal of Orthopsychiatry, 67*(4), 594-606.

Linder, J. R., & Collins, W. A. (2005). Parent and peer predictors of physical aggression and conflict management in romantic relationships in early adulthood. *Journal of Family Psychology, 19*(2), 252-262.

Lipman, E., MacMillan, H. L., & Boyle, M. H. (2001). Childhood abuse and psychiatric disorders among single and married mothers. *American Journal of Psychiatry, 158*, 73-77.

Long, P. J., & Jackson, J. L. (1991). Children sexually abused by multiple perpetrators: Familial risk factors and abuse characteristics. *Journal of Interpersonal Violence, 6*(2), 147-159.

Lorenz, F. O., Simons, R. L., & Chao, W. (1996). Family structure and mother's depression. In R. L. Simons (Ed.), *Understanding differences between divorced and intact families: Stress, interaction, and child outcome* (pp. 62-82). Thousand Oaks, CA: Sage.

Lubke, G. H., & Muthen, B. (2005). Investigating population heterogeneity with factor mixture models. *Psychological Methods, 10*(1), 21-39.

Luster, T., & Small, S. A. (1997). Sexual abuse history and problems in adolescence: Exploring the effects of moderating variables. *Journal of Marriage and the Family, 59*, 131-142.

Lyons-Ruth, K., Alpern, L., & Repacholi, B. (1993). Disorganized infant attachment classification and maternal psychological problems as predictors of hostile-aggressive behavior in the preschool classroom. *Child Development, 64*(572-585).

Lyons-Ruth, K., Connell, D. B., Zoll, D., & Stahl, J. (1987). Infants at social risk: Relations among infant maltreatment, maternal behavior, and infant attachment behavior. *Developmental Psychology, 23*, 223-232.

MacCallum, R. C., & Austin, J. T. (2000). Applications of structural equation modeling in psychological research. *Annual Review of Psychology, 51*, 201-226.

MacCallum, R. C., Zhang, S., Preacher, K. J., & Rucker, D. D. (2002). On the practice of dichotomization of quantitative variables. *Psychological Methods, 7*(1), 19-40.

MacKenzie, D. M., Langa, A., & Brown, T. M. (1996). Identifying hazardous or harmful alcohol use in medical admissions: A comparison of AUDIT, CAGE and brief MAST. *Alcohol and Alcoholism, 31*(6), 591-599.

MacKinnon, D. P., Lockwood, C. M., Hoffman, J. M., West, S. G., & Sheets, V. (2002). A comparison of methods to test mediation and other intervening variable effects. *Psychological Methods, 7*(1), 83-104.

Madonna, P. G., Van Scoyk, S., & Jones, D. P. H. (1991). Family interactions within incest and nonincest families. *The American Journal of Psychiatry, 148*(1), 46-49.

Madu, S. N., & Peltzer, K. (2001). Prevalence and patterns of child sexual abuse and victim-perpetrator relationship among secondary school students in Northern Province (South Africa). *Archives of Sexual Behavior, 30*(3), 311-321.

Main, M., & Goldwyn, R. (1988). Categories of response union with the parent at age 6: Predictable from infant classifications and stable over a one-month period. *Developmental Psychology, 24*(415-426).

Maker, A. H., Kemmelmeier, M., & Peterson, C. (2001). Child sexual abuse, peer sexual abuse, and sexual assault in adulthood: A multi-risk model of revictimisation. *Journal of Traumatic Stress, 14*(2), 351-368.

Mandoki, C. A., & Burkhart, B. R. (1989). Sexual victimization: Is there a vicious cycle? *Violence and Victims, 4*, 179-189.

Manion, I. G., McIntyre, J., Firestone, P., Ligezinka, M., Ensom, R., & Wells, G. (1996). Secondary traumatization in parents following the disclosure of extrafamilial child sexual abuse: Initial effects. *Child Abuse and Neglect, 20*, 1095-1109.

Markham, H. J., Stanley, S., & Blumberg, S. L. (1994). *Fighting for your marriage: Positive steps for preventing divorce and preserving a listing love*. San Francisco, CA: Josey-Bass.

Martin, J., Anderson, J., Romans, S., Mullen, P., & O'Shea, M. (1993). Asking about child sexual abuse: Methodological implications of a two stage survey. *Child Abuse and Neglect, 17*, 383-392.

Mayall, A., & Gold, S. R. (1995). Definitional issues and mediating variables in the sexual revictimisation of women sexually abused as children. *Journal of Interpersonal Violence, 10*, 26-42.

Maybach, K. L., & Gold, S. R. (1994). Hyperfemininity and attraction to macho and non-macho men. *The Journal of Sex Research, 31*(2), 91-96.

McCabe, M. P. (1999). The interrelationship between intimacy, relationship functioning, and sexuality among men and women in committed relationships. *The Canadian Journal of Human Sexuality, 8*(1), 31-38.

McCauley, J., Kern, D. E., Kolodner, K., Dill, L., Schroeder, A. F., DeChant, H. K., et al. (1997). Clinical characteristics of women with a history of childhood abuse. *Journal of the American Medical Association, 277*, 1362-1368.

McConkey, K. M. (1997). Memory, repression, and abuse: Recovered memory and confident reporting of the personal past. In L. J. Dickson, M. B. Riba & J. M. Oldham (Eds.), *Section II of American Psychiatric Press review of psychiatry: Vol. 16. Repressed memories* (pp. 55-78). Washington, DC: American Psychiatric Press.

McCray, J. A., King, A. R., & Bailly, M. D. (2005). General versus gender-specific attributes of the psychology major. *The Journal of General Psychology, 132*(2), 139-150.

McKelvie, M., & Gold, S. R. (1994). Hyperfemininity: Further definition of the construct. *The Journal of Sex Research, 31*(3), 219-226.

McLean, L. M., & Gallop, R. (2003). Implications of childhood sexual abuse for adult borderline personality disorder and complex posttraumatic stress disorder. *American Journal of Psychiatry, 160*(2), 369-370.

Meiselman, K. C. (1978). *Incest: A psychological study of causes and effects with treatment recommendations.* San Francisco: Josey-Bass.

Merrill, L. L., Guimond, J. M., Thomsen, C. J., & Milner, J. S. (2003). Child sexual abuse and number of sexual partners in young women: The role of abuse severity, coping style, and sexual functioning. *Journal of Consulting and Clinical Psychology, 71*(6), 987-996.

Merrill, L. L., Thomsen, C. J., Crouch, J. L., May, P., Gold, S. R., & Milner, J. S. (2005). Predicting adult risk of child physical abuse from childhood exposure to violence: Can interpersonal schemata explain the association? *Journal of Social and Clinical Psychology, 24*(7), 981-1002.

Merrill, L. L., Thomsen, C. J., Sinclair, B. B., Gold, S. R., & Milner, J. S. (2001). Predicting the impact of child sexual abuse on women: The role of abuse severity, parental support, and coping strategies. *Journal of Consulting and Clinical Psychology, 69*(6), 992-1006.

Messman-Moore, T. L., & Long, P. J. (2000). Child sexual abuse and revictimisation in the form of adult sexual abuse, adult physical abuse, and adult psychological maltreatment. *Journal of Interpersonal Violence, 15*(5), 489-502.

Messman-Moore, T. L., & Long, P. J. (2002). Alcohol and substance use disorders as predictors of child to adult sexual revictimisation in a sample of community women. *Violence and Victims, 17*(3), 319-340.

Messman-Moore, T. L., & Long, P. J. (2003). The role of childhood sexual abuse sequelae in the sexual revictimisation of women: An empirical review and theoretical reformulation. *Clinical Psychology Review, 23*(4), 537-571.

Messman-Moore, T. L., Long, P. J., & Siegfried, N. J. (2000). The revictimisation of child sexual abuse survivors: An examination of the adjustment of college women with child sexual abuse, adult sexual abuse, and adult physical abuse. *Child Maltreatment, 5*, 18-27.

Meston, C. M., Heiman, J. R., & Trapnell, P. D. (1999). The relation between early abuse and adult sexuality. *The Journal of Sex Research, 36*(4), 385-395.

Miller, R. S., Johnson, J. A., & Johnson, J. K. (1991). Assessing the prevalence of unwanted childhood sexual experiences. *Journal of Psychology and Human Sexuality, 4*(3), 43-54.

Millon, T. (1994). *Manual for the Millon Clinical Multi-axial Inventory-III (MCMI-III)* (3rd ed.). Minneapolis, MN: National Computer Systems.

Moeller, T. P., Bachmann, G. A., & Moeller, J. R. (1993). The combined effects of physical, sexual, and emotional abuse during childhood: Long-term health consequences for women. *Child Abuse and Neglect, 17*, 623-640.

Moos, R., & Moos, B. (1994). *Family Environment Scale manual* (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.

Morokoff, P. J., Quina, K., Harlow, L. L., Whitmire, L., Grimley, D. M., Gibson, P. R., et al. (1997). Sexual Assertiveness Scale (SAS) for women: Development and validation. *Journal of Personality and Social Psychology, 73*(4), 790-804.

Mosher, D. L., & Sirkin, M. (1984). Measuring in a macho personality constellation. *Journal of Research in Personality, 18*, 150-164.

Moss, E., Bureau, J., Cyr, C., Mongeau, C., & St-Laurent, D. (2004). Correlates of attachment at age 3: Construct validity of the preschool attachment classification system. *Developmental Psychology, 40*(3), 323-334.

Moss, E., Cyr, C., & Dubois-Comtois, K. (2004). Attachment at early school age and developmental risk: Examining family contexts and behavior problems of controlling-caregiving, controlling-punitive, and behaviorally disorganized children. *Developmental Psychology, 40*(4), 519-532.

Moss, E., Rousseau, D., Parent, S., St-Laurent, D., & Saintonge, J. (1998). Correlates of attachment at school age: Maternal reported stress, mother-child interaction, and behavior problems. *Child Development, 69*(1390-1405).

Muehlenhard, C. L., Highby, B. J., Lee, R. S., Bryan, T. S., & Dodrill, W. A. (1998). The sexual revictimisation of women and men sexually abused as children: A review of the literature. *Annual Review of Sex Research, 9*, 177-223.

Mullen, B., & Suls, J. (1982). The effectiveness of attention and rejection as coping styles. *Journal of Psychosomatic Research, 26*, 43-49.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry, 163*, 721-732.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse and Neglect, 20*(1), 7-21.

Murnen, S. K., Wright, C., & Kaluzny, G. (2002). If "Boys will be boys", then girls will be victims? A meta-analytic review of research that relates masculine ideology to sexual aggression. *Sex Roles, 46*(11/12), 359-375.

Murnen, S. K. G., & Byrne, D. (1991). Hyperfemininity: Measurement and initial validation of the construct. *The Journal of Sex Research, 28*, 479-489.

Murphy, C. M., O'Farrell, T. J., Fals-Stewart, W., & Feehan, M. (2001). Correlates of intimate partner violence among male alcoholic patients. *Journal of Consulting and Clinical Psychology, 69*(3), 528-540.

Muthen, B., & Muthen, L. K. (2000). Integrating person-centered and variable-centered analyses: Growth mixture modeling with latent trajectory classes. *Alcoholism: Clinical and Experimental Research, 24*(6), 882-891.

Muthen, L. K., & Muthen, B. O. (2005). *Mplus: Statistical analysis with latent variables. User's guide.* Los Angeles, CA: Muthen & Muthen.

Mynatt, C. R., & Allgeier, E. R. (1990). Risk factors, self-attributions, and adjustment problems among victims of sexual coercion. *Journal of Applied Social Psychology, 20*(2), 130-153.

Najman, J. M., Dunne, M. P., Purdie, D. M., Boyle, F. M., & Coxeter, P. D. (2005). Sexual abuse in childhood and sexual dysfunction in adulthood: An Australian population-based study. *Archives of Sexual Behavior, 34*(5), 517-526.

Nash, C., & West, D. J. (1985). Sexual molestation of young girls: A retrospective survey. In D. J. West (Ed.), *Sexual victimization: Two recent researchers into sex problems and their social effects* (pp. 1-174). London. UK: Gower Medical Publishing.

Nash, M. R., Neimeyer, R. A., Hulsey, T. L., & Lambert, W. (1998). Psychopathology associated with sexual abuse: The importance of complementary designs and common ground. *Journal of Consulting and Clinical Psychology, 66*(3), 568-571.

National Association for Prevention of Child Abuse and Neglect. (2003). *What is Child Abuse?* Canberra: Author.

National Association of Social Workers. (1996). *Evaluation and treatment of adults with the possibility of recovered memories of childhood sexual abuse.* Washington, DC: Author.

Nelson, B. S., & Wampler, K. S. (2000). Systemic effects of trauma in clinic couples: An exploratory study of secondary trauma resulting from childhood abuse. *Journal of Marital and Family Therapy, 26*(2), 171-184.

Nelson, E. C., Heath, A. C., Madden, P. A. F., Cooper, M. L., Dinwiddle, S. H., Bucholz, K. K., et al. (2002). Association between self-reported childhood sexual abuse and adverse psychosocial outcomes: Results from a twin study. *Archives of General Psychiatry, 59*, 139-145.

Neumann, D. A., Houskamp, B. M., Pollock, V. E., & Briere, J. (1996). The long-term sequelae of childhood sexual abuse in women: A meta-analytic review. *Child Maltreatment, 1*(1), 6-21.

Ney, P. G., Fung, T., & Wickett, A. R. (1994). The worst combinations of child abuse and neglect. *Child Abuse and Neglect, 18*(9), 705-714.

Noll, J. G., Trickett, P. K., & Putnam, F. W. (2003). A prospective investigation of the impact of childhood sexual abuse on the development of sexuality. *Journal of Consulting and Clinical Psychology, 71*(3), 575-586.

Norris, J. (1994). Alcohol and female sexuality: A look at expectancies and risks. *Alcohol Research and Health, 18*(3), 197-201.

Nurius, P. S. (2000). Risk perception for acquaintance sexual aggression: A social-cognitive perspective. *Aggression and Violent Behavior, 5*(1), 63-78.

Ojanlatva, A., Rautava, P., Helenius, H., Korkeila, K., Sundell, J., Kivimaki, M., et al. (2005). Associations of social support and sex life - The HeSSup Study. *Patient Education and Counseling, 58*(1), 71-81.

O'Leary, D. (1988). Physical aggression between spouses: A social learning theory perspective. In V. B. Van Hasselt & R. L. Morrison (Eds.), *Handbook of family violence* (pp. 31-55). New York: Plenum.

Olenick, N. L., & Chalmers, D. K. (1991). Gender-specific drinking styles in alcoholics and nonalcoholics. *Journal of Studies on Alcohol, 52*, 324-330.

Ondersma, S. J., Chaffin, M., Berliner, L., Cordon, I., Goodman, G. S., & Barnett, D. (2001). Sex with children is abuse: Comment on Rind, Tromovitch, and Bauserman (1998). *Psychological Bulletin, 127*(6), 707-714.

Orbuch, T. L., Veroff, J., Hassan, H., & Horrocks, J. (2002). Who will divorce: A 14-year longitudinal study of Black couples and White couples. *Journal of Social and Personal Relationships, 19*(2), 179-202.

Ornstein, P. A., Ceci, S. J., & Loftus, E. F. (1998). Adult recollections of childhood abuse: Cognitive and developmental perspectives. *Psychology, Public Policy, and Law, 4*(4), 1025-1051.

Oxford University Press. (1990). *The Concise Oxford Dictionary of Current English*. New York: Author.

Paolucci, E. O., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology, 135*(1), 17-36.

Pape Cowan, C., & Cowan, P. A. (2005). Two central roles for couple relationships: breaking negative intergenerational patterns and enhancing children's adaptation. *Sexual and Relationship Therapy, 20*(3), 275-288.

Paradise, J. E., Rose, L., Sleeper, L. A., & Nathanson, M. (1994). Behavior, family function, school performance, and predictors of persistent disturbance in sexually abused children. *Pediatrics, 93*, 452-459.

Patterson, G. R. (1997). Performance models for parenting: A social interactional perspective. In J. Grusec & L. Kuczynski (Eds.), *Parenting and the socialization of values: A handbook of contemporary theory* (pp. 193-235). New York: Wiley.

Paveza, G. J. (1988). Risk factors in father-daughter sexual abuse. A case-control study. *Journal of Interpersonal Violence, 3*, 290-306.

Pedhauzur, E. J. (1982). *Multiple regression in behavioral research* (2nd ed.). New York: Holt, Rinehart & Winston.

Peek, M. K., Ray, L., Patel, K., Stoebner-May, D., & Ottenbacher, K. J. (2004). Reliability and validity of the SF-36 among older Mexican Americans. *The Gerontologist, 44*(3), 418-425.

Peters, S. D. (1988). Child sexual abuse and later psychological problems. In G. E. Wyatt & G. J. Powell (Eds.), *Lasting effects of child abuse* (pp. 101-117). California: Sage.

Pierce, R., & Pierce, L. H. (1985). The sexually abused child: A comparison of male and female victims. *Child Abuse and Neglect, 9*, 191-199.

Pistorello, J., & Follette, V. M. (1998). Childhood sexual abuse and couples' relationships: Female survivors' reports in therapy groups. *Journal of Marital and Family Therapy, 24*(4), 473-485.

Polusny, M. A., & Follette, V. M. (1995). Long-term correlates of childhood sexual abuse: Theory and review of the empirical literature. *Applied and Preventive Psychology, 4*, 143-166.

Posner, R. A., & Silbaugh, K. B. (1996). *A guide to America's sex laws*. Chicago: University of Chicago Press.

Pribor, E. F., & Dinwiddle, S. H. (1992). Psychiatric correlates of incest in childhood. *American Journal of Psychiatry, 149*, 52-56.

Price, J. L., Hilsenroth, M. J., Petretic-Jackson, P. A., & Bonge, D. (2001). A review of individual psychotherapy outcomes for adult survivors of childhood sexual abuse. *Clinical Psychology Review, 21*(7), 1095-1121.

Purvis, M., & Joyce, A. (2005). Child sexual abuse is a global public health problem: Where is Australia? *Psychiatry, Psychology and Law, 12*(2), 334-344.

Ray, A. L., & Gold, S. R. (1996). Gender roles, aggression and alcohol use in dating relationships. *The Journal of Sex Research, 33*(1), 47-55.

Reid, K., Matthews, G., & Liss, P. S. (1995). My partner is hurting: Group work with male partners of adult survivors of sexual abuse. *Support Groups: Research and Practice, 28*, 448-456.

Reid, K. S., Wampler, R. S., & Taylor, D. K. (1996). The "alienated" partner: Responses to traditional therapies for adult sex abuse survivors. *Journal of Marital and Family Therapy, 22*(4), 443-453.

Riggs, D. N. (2000). *Hyperfemininity and romantic attachment style.* Unpublished doctoral dissertation, Auburn University, Alabama.

Rind, B., Tromovitch, P., & Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin, 124*(1), 22-53.

Roche, D. N., Runtz, M. G., & Hunter, M. A. (1999). Adult attachment: A mediator between child sexual abuse and later psychological adjustment. *Journal of Interpersonal Violence, 14*(2), 184-207.

Roesler, T. A., & McKenzie, N. (1994). Effects of childhood trauma on psychological functioning in adults sexually abused as children. *The Journal of Nervous and Mental Disease, 182*(3), 145-150.

Roodman, A. A., & Clum, G. A. (2001). Revictimisation rates and method variance: A meta-analysis. *Clinical Psychology Review, 21*(2), 183-204.

Rosen, R. C., Brown, C., Heiman, J. R., Leiblum, S. R., Meston, C. M., Shabsigh, R., et al. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex and Marital Therapy, 26*, 191-208.

Rosen, R. C., & Leiblum, S. R. (1995a). The changing focus of sex therapy. In R. C. Rosen & S. R. Leiblum (Eds.), *Case studies in sex therapy* (pp. 3-17). New York: The Guilford Press.

Rosen, R. C., & Leiblum, S. R. (1995b). Treatment of sexual disorders in the 1990s: An integrated approach. *Journal of Consulting and Clinical Psychology, 63*(6), 877-890.

Rosenbaum, A., & Leisring, P. A. (2003). Beyond power and control: Towards an understanding of partner abusive men. *Journal of Comparative Family Studies, 34*(1), 7-18.

Rosenberg. M. (1965). *Society and the adolescent self-image.* New Jersey: Princeton University Press.

Roth, S., & Cohen, L. J. (1986). Approach, avoidance, and coping with stress. *American Psychologist, 41*(7), 813-819.

Rotter, J. B. (1982). *The development and applications of social learning theory: Selected papers.* New York: Praeger.

Rowan, A. B., Foy, D. W., Rodriguez, N., & Ryan, S. (1994). Posttraumatic stress disorder in a clinical sample of adults sexually abused as children. *Child Abuse and Neglect, 18*, 51-61.

Roy, C. A., & Perry, J. C. (2004). Instruments for the assessment of childhood trauma in adults. *The Journal of Nervous and Mental Disease, 192*(5), 343-351.

Rudin, M. M., Zalewski, C., & Bodmer-Turner, J. (1995). Characteristics of child sexual abuse victims according to perpetrator gender. *Child Abuse and Neglect, 19*(8), 963-973.

Rumm, P. D., Cummings, P., Krauss, M. R., Bell, M. A., & Rivara, F. P. (2000). Identified spouse abuse as a risk factor for child abuse. *Child Abuse and Neglect, 24*(11), 1375-1381.

Rumstein-McKean, O., & Hunsley, J. (2001). Interpersonal and family functioning of female survivors of childhood sexual abuse. *Clinical Psychology Review, 21*(3), 471-490.

Runtz, M., & Briere, J. (1986). Adolescent "acting-out" and childhood history of sexual abuse. *Journal of Interpersonal Violence, 1*(3), 326-333.

Runtz, M. G., & Schallow, J. R. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse and Neglect, 21*(2), 211-226.

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

Russell, D. E. H. (1984). The prevalence and seriousness of incestuous abuse: Stepfathers vs. biological fathers. *Child Abuse and Neglect, 8*, 15-22.

Russell, D. E. H. (1999). *The secret trauma: Incest in the lives of girls and women.* New York: Basic Books.

Sameroff, A. J., & Fiese, B. H. (1990). Transactional regulations and early intervention. In S. J. Meisels & K. J. P. Shonkoff (Eds.), *Handbook of early childhood intervention* (pp. 119-149). Cambridge, England: Cambridge University Press.

Sandberg, D. A., Matorin, A. I., & Lynn, S. J. (1999). Dissociation, posttraumatic symptomatology, and sexual revictimisation: A prospective examination of mediator and moderator effects. *Journal of Traumatic Stress, 12*, 127-138.

Sandhu, D., & Tung, S. (2004). Contributions of family environment and identity formation towards adolescents' alienation. *Pakistan Journal of Psychological Research, 19*(1/2), 1-14.

Santrock, J. (1994). *Child development* (6th ed.). Madison: Brown & Benchmark.

Sapp, A., & Carter, D. (1978). *Child abuse in Texas*. Huntsville, TX: Sam Houston State University.

Sarason, I. G., Levine, H. M., Bashman, R. B., & Sarason, B. R. (1983). Assessing social support: The Social Support Questionnaire. *Journal of Personality and Social Psychology, 44*(1), 127-139.

Sarason, I. G., Sarason, B. R., Shearin, E. N., & Pierce, G. R. (1987). A brief measure of social support: practical and theoretical implications. *Journal of Social and Personal Relationships, 4*, 497-510.

Sarwer, D. B., & Durlak, J. A. (1996). Childhood sexual abuse as a predictor of adult female sexual dysfunction: A study of couples seeking sex therapy. *Child Abuse and Neglect, 20*(10), 963-972.

Saunders, B. E., Villeponteaux, L. A., Lipovsky, J. A., Kilpatrick, D. G., & Veronen, L. J. (1992). Child sexual assault as a risk factor for mental disorders among women: A community survey. *Journal of Interpersonal Violence, 7*(2), 189-204.

Saunders, J. B., Aasland, O. G., Babor, T. F., De La Fuente, J., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction, 88*, 792-804.

Schaaf, K. K., & McCanne, T. R. (1998). Relationship of childhood sexual, physical, and combined sexual and physical abuse to adult victimization and posttraumatic stress disorder. *Child Abuse and Neglect, 22*(11), 1119-1133.

Schafer, J. L., & Graham, J. W. (2002). Missing data: Our view of the state of the art. *Psychological Methods, 7*(2), 147-177.

Schloredt, K. A., & Heiman, J. R. (2003). Perceptions of sexuality as related to sexual functioning and sexual risk in women with different types of childhood abuse histories. *Journal of Traumatic Stress, 16*(3), 275-284.

Schrepp, M. (2005). About the connection between knowledge structures and latent class models. *Methodology, 1*(3), 92-102.

Schumacher, J. A., Feldbau-Kohn, S., Smith-Slep, A. M., & Heyman, R. E. (2001). Risk factors for male-to-female partner physical abuse. *Aggression and Violent Behavior, 6*, 281-352.

Scott, K. D. (1992). Childhood sexual abuse: Impact on a community's mental health status. *Child Abuse and Neglect, 16*, 285-295.

Scott, K. M., Tobias, M. I., Sarfati, D., & Haslettt, S. (1999). SF-36 health survey reliability, validity and norms for New Zealand. *Australian and New Zealand Journal of Public Health, 23*, 401-406.

Sedlak, A. J. (1997). Risk factors for the occurrence of child abuse and neglect. *Journal of Aggression, Maltreatment and Trauma, 1*(1), 149-187.

Senn, T. E., Carey, M. P., Vanable, P. A., Coury-Doniger, P., & Urban, M. A. (2006). Child sexual abuse and sexual risk behavior among men and women attending a sexually transmitted disease clinic. *Journal of Consulting and Clinical Psychology, 74*(4), 720-731.

Sharpley, C. F., & Cross, D. G. (1982). A psychometric evaluation of the Spanier Dyadic Adjustment Scale. *Journal of Marriage and the Family, 44*, 739-741.

Sharpley, C. F., & Rogers, H. J. (1984). Preliminary validation of the Abbreviated Spanier Dyadic Adjustment Scale: Some psychometric data regarding a screening test of marital adjustment. *Educational and Psychological Measurement, 44*(1045-1049).

Shaw, D. S., & Vondra, J. I. (1995). Infant attachment security and maternal predictors of early behavior problems: A longitudinal study of low-income families. *Journal of Abnormal Child Psychology, 23*, 335-357.

Shaw, J. A., Lewis, J. E., Loeb, A., Rosado, J., & Rodriguez, R. A. (2000). Child on child sexual abuse: Psychological perspectives. *Child Abuse and Neglect, 24*(12), 1591-1600.

Shrout, P. E., & Bolger, N. (2002). Mediation in experimental and nonexperimental studies: New procedures and recommendations. *Psychological Methods, 7*(4), 422-445.

Siegel, J. A., & Williams, L. M. (2003). The relationship between child sexual abuse and female delinquency and crime: A prospective study. *Journal of Research in Crime and Delinquency, 40*(1), 71-94.

Siegel, J. M., Sorenson, S. B., Golding, J. M., Burnham, M. A., & Stein, J. A. (1987). The prevalence of childhood sexual assault: The Los Angeles epidemiologic catchment area project. *American Journal of Epidemiology, 126*(6), 1141-1153.

Silbert, M. H., & Pines, A. M. (1981). Sexual child abuse as an antecedent to prostitution. *Child Abuse and Neglect, 5*, 407-411.

Simpson, J. A. (1990). Influence of attachment styles on romantic relationships. *Journal of Personality and Social Psychology, 59*(5), 971-980.

Smith, D. W., Davis, J. L., & Fricker-Elhai, A. E. (2004). How does trauma beget trauma? Cognitions about risk in women with abuse histories. *Child Maltreatment, 9*(3), 292-303.

Smith, R. A., Levine, T. R., Lachlan, K. A., & Fediuk, T. A. (2002). The high cost of complexity in experimental design and data analysis: Type I and type II error rates in multiway ANOVA. *Human Communication Research, 28*(4), 515-530.

Snyder, H., & Sickmund, M. (1999). *Juvenile Offenders and Victims: 1999 National Report.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Spaccarelli, S. (1994). Stress, appraisal, and coping in child sexual abuse: A theoretical and empirical review. *Psychological Bulletin, 116*(2), 340-362.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, 15-28.

Spataro, J., Mullen, P. E., Burgess, P. M., Wells, D. L., & Moss, S. A. (2004). Impact of child sexual abuse on mental health: Prospective study in males and females. *British Journal of Psychiatry, 184*, 416-421.

Sperry, D. M., & Gilbert, B. O. (2005). Child peer sexual abuse: Preliminary data on outcomes and disclosure experiences. *Child Abuse and Neglect, 29*, 889-904.

Stander, V. A., Olson, C. B., & Merrill, L. L. (2002). Self-definition as a survivor of childhood sexual abuse among navy recruits. *Journal of Consulting and Clinical Psychology, 70*(2), 369-377.

Standing Committee on Legal and Constitutional Affairs: House of Representatives (1998). *To have and to hold: Strategies to strengthen marriage and relationships* (ISBN 0 644 52772 2). Canberra: Commonwealth of Australia.

Steel, J., Sanna, L., Hammond, B., Whipple, J., & Cross, H. (2004). Psychological sequelae of childhood sexual abuse: abuse-related characteristics, coping strategies, and attributional style. *Child Abuse and Neglect, 28*, 785-801.

Steiger, J. H. (1998). A note on multiple sample extensions of the RMSEA fit index. *Structural Equation Modeling, 5*, 411-419.

Stein, J. A., Golding, J. M., Siegel, J. M., Burnam, M. A., & Sorenson, S. B. (1988). *Long-term psychological sequelae of child sexual abuse: The Los Angeles Epidemiologic Catchment Area Study.* California: Sage.

Stevenson, M. R., & Gajarsky, W. M. (1991). Unwanted childhood sexual experiences relate to later revictimisation and female perpetration. *Journal of Psychology and Human Sexuality, 4*, 57-70.

Story, L. B., Karney, B. R., Lawrence, E., & Bradbury, T. N. (2004). Interpersonal mediators in the intergenerational transmission of marital dysfunction. *Journal of Family Psychology, 18*(3), 519-529.

Stovall-McClough, K. C., & Cloitre, M. (2006). Unresolved attachment, PTSD, and dissociation in women with childhood abuse histories. *Journal of Consulting and Clinical Psychology, 74*(2), 219-228.

Straus, M. A. (1990). Measuring intrafamily conflict and violence: The Conflict Tactics (CT) Scales. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families.* (pp. 29-47). New Brunswick: Transaction Publishers.

Straus, M. A., & Douglas, E. M. (2004). A short form of the Revised Conflict Tactics Scales, and typologies for severity and mutuality. *Violence and Victims, 19*(5), 507-520.

Straus, M. A., & Gelles, R. J. (1986). Society change and change in family violence from 1975 to 1985 as revealed by two national surveys. *Journal of Marriage and Family, 48*, 465-479.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*(3), 283-316.

Styron, T., & Janoff-Bulman, R. (1997). Childhood attachment and abuse: Long-term effects on adult attachment, depression, and conflict resolution. *Child Abuse and Neglect, 21*(10), 1015-1023.

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

Summit, R. C. (1990). The specific vulnerability of children. In K. R. Oates (Ed.), *Understanding and managing child sexual abuse* (pp. 59-74). Sydney: Harcourt Brace Jovanovich.

Surrey, J., Swett, C., Michaels, A., & Levin, S. (1990). Reported history of physical and sexual abuse and severity of symptomatology in women psychiatric outpatients. *American Journal of Orthopsychiatry, 60*(3), 412-417.

Swanson, B., & Mallinckrodt, B. (2001). Family environment, love withdrawal, childhood sexual abuse, and adult attachment. *Psychotherapy Research, 11*(4), 455-472.

Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics*. Boston: Allyn and Bacon.

Tallman, I., Gray, L. N., Kullberg, V., & Henderson, D. (1999). The intergenerational transmission of marital conflict: Testing a process model. *Social Psychology Quarterly, 62*(3), 219-239.

Tardif, M., Auclair, N., Jacob, M., & Carpentier, J. (2005). Sexual abuse perpetrated by adult and juvenile females: an ultimate attempt to resolve a conflict associated with maternal identity. *Child Abuse and Neglect, 29*, 153-167.

Testa, M., Miller, B. A., Downs, W. R., & Panek, D. (1992). The moderating impact of social support following childhood sexual abuse. *Violence and Victims, 7*, 173-186.

Testa, M., VanZile-Tamsen, C., & Livingston, J. A. (2005). Childhood sexual abuse, relationship satisfaction, and sexual risk taking in a community sample of women. *Journal of Consulting and Clinical Psychology, 73*(6), 1116-1124.

Thompson, K. M., Crosby, R. D., Wonderlich, S. A., Mitchell, J. E., Redlin, J., Demuth, G., et al. (2003). Psychopathology and sexual trauma in childhood and adulthood. *Journal of Traumatic Stress, 16*(1), 35-38.

Timnick, L. (1985, August 25). 22% in survey were child abuse victims. *Los Angeles Times,* p. 1.

Trickett, P. K., Noll, J. G., Reiffman, A., & Putnam, F. W. (2001). Variants of intrafamilial sexual abuse experience: Implications for short- and long-term development. *Development and Psychopathology, 13*, 1001-1019.

Uebersax, J. S. (1993). Statistical modeling of expert ratings on medical treatment appropriateness. *Journal of the American Statistical Association, 88*, 421-427.

Urban, J., Carlson, E., Egeland, B., & Srouge, L. A. (1991). Patterns of individual adaptation across childhood. *Development and Psychopathology, 3,* 445-460.

Urquiza, A. J., & Goodlin-Jones, B. L. (1994). Child sexual abuse and adult revictimisation in women of color. *Violence and Victims, 9*, 223-232.

US Department of Health and Human Services, Youth, and Families. (2006). *Child Maltreatment 2004*. Washington, DC.

Valentine, L., & Feinauer, L. L. (1993). Resilience factors associated with female survivors of childhood sexual abuse. *American Journal of Family Therapy, 21*, 216-221.

Van Bruggen, L. K., Runtz, M. G., & Kadlec, H. (2006). Sexual revictimisation: The role of sexual self-esteem and dysfunctional sexual behaviours. *Child Maltreatment, 11*(2), 131-145.

Vermunt, J. K., & Magidson, J. (2000). Latent class cluster analysis. In J. A. Hagenaars & A. L. McCutcheon (Eds.), *Applied latent class analysis* (pp. 89-106). Cambridge, MA: Cambridge University Press.

Vigil, J. M., Geary, D. C., & Byrd-Craven, J. (2005). A life history assessment of early childhood sexual abuse in women. *Developmental Psychology, 41*(3), 553-561.

Vize, C. M., & Cooper, P. J. (1995). Sexual abuse in patients with eating disorders, patients with depression and normal controls: A comparative study. *British Journal of Psychiatry, 167*, 80-85.

Ware, J. E. (1993). *SF-36 Health Survey: Manual and interpretation guide.* Boston: The Health Institute, New England Medical Center.

Ware, J. E., & Sherbourne, C. D. (1992). The MOS 36-Item Short-Form Health Survey (SF-36). *Medical Care, 30*(6), 473-483.

Waring, E., McElrath, D., Lefcoe, D., & Weisz, G. (1981). Dimensions of intimacy in marriage. *Psychiatry, 44*, 169-175.

Weis, K., & Borges, S. S. (1973). Victimology and rape: The case of the legitimate victim. *Issues in Criminology, 8*, 71-115.

Weiss, R. S. (1974). The provisions of social relations. In Z. Rubin (Ed.), *Doing unto others* (pp. 98-111). Englewood Cliffs, NJ: Prentice-Hall.

Weissmann-Wind, T., & Silvern, L. (1994). Parenting and family stress as mediators of the long-term effects of child abuse. *Child Abuse and Neglect, 18*(5), 439-453.

Wenninger, K., & Ehlers, A. (1998). Dysfunctional cognitions and adult psychological functioning in child abuse survivors. *Journal of Traumatic Stress, 11*(2), 281-300.

Wenninger, K., & Heiman, J. R. (1998). Relating body image of psychological and sexual functioning in child sexual abuse survivors. *Journal of Traumatic Stress, 11*(3), 543-562.

West, C. M., Williams, L. M., & Siegel, J. A. (2000). Adult sexual revictimisation among black women sexually abused in childhood: A prospective examination of serious consequences of abuse. *Child Maltreatment, 5*(1), 49-57.

Westerlund, E. (1992). *Women's sexuality after childhood incest.* New York: Norton.

Whiffen, V. E., Judd, M. E., & Aube, J. A. (1999). Intimate relationships moderate the association between childhood sexual abuse and depression. *Journal of Interpersonal Violence, 14*(9), 940-954.

Widom, C. S., & Kuhns, J. B. (1996). Childhood victimization and subsequent risk for promiscuity, prostitution, and teenage pregnancy: A prospective study. *American Journal of Public Health, 86*, 1607-1612.

Widom, C. S., & Morris, S. (1997). Accuracy of adult recollections of childhood victimization. Part II. Childhood sexual abuse. *Psychological Assessment, 9*, 34-46.

Widom, C. S., & Shepard, R. L. (1996). Accuracy of adult recollections of childhood victimization. Part I. Childhood physical abuse. *Psychological Assessment, 8*(4), 412-421.

Williams, L. M. (1994a). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology, 62*, 1167-1176.

Williams, L. M. (1994b). What does it mean to forget child sexual abuse? A reply to Loftus, Garry, and Feldman (1994). *Journal of Consulting and Clinical Psychology, 62*, 1182-1186.

Wilsnack, S. C. (1984). Drinking, sexuality, and sexual dysfunction in women. In S. C. Wilsnack & L. J. Beckman (Eds.), *Alcohol problems in women: Antecedents, Consequences and Interventions* (pp. 189-227). New York: Guilford.

Wilson, A. E., Calhoun, K. S., & Bernat, J. A. (1999). Risk recognition and trauma-related symptoms among sexually revictimized women. *Journal of Consulting and Clinical Psychology, 67*(5), 705-710.

Wilson, K. L., Charker, J., Lizzio, A., Kimlin, S., Iselin, G., & Halford, K. W. (2005). How much do couples work at their relationship? Development of the Behavioral Self-Regulation for Effective Relationships Scale. *Journal of Family Psychology, 19*(3), 385-393.

Wincze, J. P., & Carey, M. P. (2001). *Sexual dysfunction: A guide for assessment and treatment*. New York: The Guilford Press.

Witt, S. D. (1997). Parental influence on children's socialization to gender roles. *Adolescence, 32*(126), 253-259.

Wyatt, G. E. (1985). The sexual abuse of Afro-American and White-American women in childhood. *Child Abuse and Neglect, 9*, 507-519.

Wyatt, G. E., Guthrie, D., & Notgrass, C. M. (1992). Differential effects of women's child sexual abuse and subsequent sexual revictimisation. *Journal of Consulting and Clinical Psychology, 60*(2), 167-173.

Wyatt, G. E., & Newcomb, M. D. (1990). Internal and external mediators of women's sexual abuse in childhood. *Journal of Consulting and Clinical Psychology, 58*(6), 758-767.

Wyatt, G. E., & Peters, S. D. (1986a). Issues in the definition of child sexual abuse in prevalence research. *Child Abuse and Neglect, 10*, 231-240.

Wyatt, G. E., & Peters, S. D. (1986b). Methodological considerations in research on the prevalence of child sexual abuse. *Child Abuse and Neglect, 10*, 241-251.

Xenos, S., & Smith, D. (2001). Perceptions of rape and sexual assault among Australian adolescents and young adults. *Journal of Interpersonal Violence, 16*(11), 1103-1119.

Young, M., Denny, G., Young, T., & Luquis, R. (2000). Sexual satisfaction among married women. *American Journal of Health Studies, 16*(2), 73-84.

Zierler, S., Feingold, L., Laufer, D., Velentgas, P., Kantrowitz-Gordon, L., & Mayer, K. (1991). Adult survivors of childhood sexual abuse and subsequent risk of HIV infection. *American Journal of Public Health, 81*, 572-575.

Appendix A

*Demographic Questionnaire*

**Please place a cross (X) through the circle that best represents your response.**

Age: ______________ years Occupation: ___________________________

**Please indicate your Current Employment Status**:

| | | | | | |
|---|---|---|---|---|---|
| Unemployed | O | Employed Casually | O | Employed Full-Time | O |
| Homemaker | O | Employed Part-Time | O | Retired | O |
| Full-Time Student | O | | | | |

**If you are working full or part-time, how many days in the past 4 weeks did you not attend work?**

| | | | | | |
|---|---|---|---|---|---|
| Not Applicable | O | 1 day | O | 3 to 7 days | O |
| Never | O | 2 days | O | More Than 7 days | O |

**If you are working full or part-time, how many days in the past 4 weeks did you attend work but feel you could not work to your full capacity?**

| | | | | | |
|---|---|---|---|---|---|
| Not Applicable | O | 1 day | O | 3 to 7 days | O |
| Never | O | 2 days | O | More Than 7 days | O |

**Please indicate your <u>Gross (Pre-Tax) Personal Income</u> (including pensions and allowances) that you receive each week from all sources:**

| | | | |
|---|---|---|---|
| Negative Income | O | $300 - $399 per week<br>($15,600 - $20,799 per year) | O |
| Nil Income | O | $400 - $499 per week<br>($20,800 - $25,999 per year) | O |
| $1 - $39 per week<br>($1 - $2,079 per year) | O | $500 - $599 per week<br>($26,000 - $31,199 per year) | O |
| $40 - $79 per week<br>($2,080 - $4,159 per year) | O | $600 - $699 per week<br>($31,200 - $36,399 per year) | O |
| $80 - $119 per week<br>($4,160 - $6,239 per year) | O | $700 - $799 per week<br>($36,400 - $41,599 per year) | O |
| $120 - $159 per week<br>($6,240 - $8,319 per year) | O | $800 - $999 per week<br>($41,600 - $51,999 per year) | O |
| $160 - $199 per week<br>($8,320 - $10,399 per year) | O | $1,000 - $1,499 per week<br>($52,000 - $77,999 per year) | O |
| $200 - $299 per week<br>($10,400 - $15,599 per year) | O | $1,500 or more per week<br>($78,000 or more per year) | O |

**Please indicate the <u>Highest Level of Education</u> you have attained:**

Primary School O TAFE Course / Diploma O

Secondary Education - Junior (14 – 15yrs) O University Degree O

Secondary Education - Senior (16 – 17yrs) O

**Please indicate your <u>religion:</u>**

Catholic O Anglican (Church of England) O Baptist O

Presbyterian O Uniting Church O Islam O

Lutheran O Greek Orthodox O Buddhism O

Other O (please specify) ______________________________

**Please indicate the <u>country in which you were born</u>:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Australia | O | England | O | Scotland | O | Viet Nam | O |
| New Zealand | O | Italy | O | Greece | O | Germany | O |
| Philippines | O | Netherlands | O | Other | O | ____________________ (please specify) | |

**Are you of <u>Aboriginal or Torres Strait Islander origin</u>?**

No O Yes, Aboriginal O Yes, Torres Strait Islander O

**What is your <u>ancestry?</u>**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Australian | O | English | O | Irish | O | Italian | O |
| German | O | Greek | O | Chinese | O | Other (please specify) | O ______________ |

**Please indicate your <u>Current Relationship Status</u>:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Single | O | Living With a Partner | O | Separated | O | Widowed | O |
| In a Dating Relationship | O | Married | O | Divorced | O | | |

**Please indicate your <u>Sexual Orientation</u>:**

Heterosexual O Homosexual O Bisexual O

**Are you <u>currently pregnant</u>?**

No O Yes O

**Do you have any <u>children</u>?**

No O Yes O

**If you have children, please <u>indicate the number of children</u>.**

| 1 | 2 | 3 | 4 | 5 | 6 | More Than 6 |
|---|---|---|---|---|---|---|
| O | O | O | O | O | O | O |

**<u>How old is your OLDEST child?</u>**

| 0-2 years | 3-5 years | 6-10 years | 11-17 years | 18 years or older |
|---|---|---|---|---|
| O | O | O | O | O |

**Do you <u>currently</u> suffer from any of the following <u>diseases or conditions</u>?**

| | | | | | |
|---|---|---|---|---|---|
| Cardiovascular Disease | O | Genital Infection | O | Gynaecological Cancer | O |
| Other Heart Condition | O | Urinary Tract Disease | O | Colon / Rectum / Bowel Cancer | O |
| Multiple Sclerosis | O | Prolapsed Ovaries | O | Stroke (or the after effects of stroke) | O |
| Spinal Cord Injury | O | Endometriosis | O | Sexually Transmitted Disease | O |
| Diabetes | O | Renal Disease | O | Pelvic Inflammatory Disease | O |
| HIV / AIDS | O | Chronic Pain | O | None of the above | O |
| Epilepsy | O | Breast Cancer | O | | |

**Have you taken any of the <u>following medications</u> in the last <u>four</u> weeks?**

| | | | | | |
|---|---|---|---|---|---|
| Sleeping tablets or capsules | O | Painkillers | O | Antidepressants | O |
| Medication for anxiety or nerves | O | Tranquillizers | O | Mood Stabilizers | O |
| Neuroleptics or Antipsychotics | O | Contraceptive Pill | O | Antihypertensive Medication | O |
| Hormone Replacement Therapy | O | None of the above | O | | |

**Are you currently receiving any of the <u>following treatments</u>?**

| | | | | | |
|---|---|---|---|---|---|
| Radiation Treatment | O | Chemotherapy | O | None of these | O |

**Which of these have you consulted in the last <u>4 weeks</u> about <u>your own health</u>?**

| | | | | | |
|---|---|---|---|---|---|
| Aboriginal Health Worker | O | Hypnotherapist | O | Psychiatrist | O |
| General Practitioner | O | Psychologist | O | None of the above | O |
| Occupational Therapist | O | Alcohol and Drug Worker | O | | |
| Accredited Counsellor | O | Nurse | O | | |

**<u>How often</u> (approximately) <u>in the last year have you consulted a doctor</u> (GP or specialist)?**

| Never | O | Once or Twice | O | 3 to 5 Times | O | 5 to 10 Times | O | More Than 10 Times | O |
|---|---|---|---|---|---|---|---|---|---|

**<u>How many days</u>, if any have you had in hospital in the last year?**

None O 1 or 2 O 3 to 7 O 8 to 30 O More Than 30 O

**In general, would you say your health is: Please place a cross (X) through the circle that best represents your response.**

Poor O Fair O Good O Very Good O Excellent O

**How <u>TRUE or FALSE</u> is <u>each</u> of the following statements for you?**

| | Definitely True | Mostly True | Don't Know | Mostly False | Definitely False |
|---|---|---|---|---|---|
| (a) I seem to get sick a little easier than other people. | O | O | O | O | O |
| (b) I am as healthy as anybody I know. | O | O | O | O | O |
| (c) I expect my health to get worse. | O | O | O | O | O |
| (d) My health is excellent. | O | O | O | O | O |

**These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling.**

| | All of the time | Most of the time | A good bit of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|---|---|
| (a) Have you been a very nervous person? | O | O | O | O | O | O |
| (b) Have you felt so down in the dumps That nothing could cheer you up? | O | O | O | O | O | O |
| (c) Have you felt calm and peaceful? | O | O | O | O | O | O |
| (d) Have you felt downhearted and blue? | O | O | O | O | O | O |
| (e) Have you been a happy person? | O | O | O | O | O | O |

Appendix B

*The Early Sexual Experiences Checklist*

**When you were under the age of sixteen (16), did any of these incidents ever happen to you when you did not want them to? Please place a cross (X) through those circles that apply.**

Another person showed his or her sex organs to you. O

You showed your sex organs to another person at his or her request. O

Someone touched or fondled your sexual organs. O

You touched or fondled another person's sex organs at his or her request. O

Another person had sexual intercourse with you. O

Another person performed oral sex on you. O

You performed oral sex on another person. O

Someone told you to engage in sexual activity so that he or she could watch. O

You engaged in anal sex with another person. O

Another person verbally requested to do something sexual with you. O

Other people engaged in sexual activities while you watched at their insistence. O

Someone touched or fondled your breasts, buttocks, or thighs. O

Someone kissed or hugged you in a sexual way. O

Other (please specify): ________________________________________ O

None of these events ever occurred. O

If any of these incidents ever happened to you, **please tick (√) the one behaviour that bothered you most**. Then **please answer the following questions by thinking about the one behaviour that bothered you most.** If none of these incidents occurred please go to the Hyperfemininity Scale.

1. **How old were you when it happened? ___________ years.**

2. **Approximately how old was the other person/s involved? ______________ years.**

**3. How <u>many people</u> were involved? ______________**

**4. <u>Who</u> was / *were* the other person / *people* involved?**

| Relative | O | Friend or acquaintance | O | Stranger | O |
|---|---|---|---|---|---|

**5. If any of the people involved were relatives, <u>how were they related to you</u>? (Cross "X" all that apply)**

| Father | O | Stepmother | O | Male Cousin | O | Aunt | O |
|---|---|---|---|---|---|---|---|
| Stepfather | O | Brother | O | Female Cousin | O | Grandfather | O |
| Mother | O | Sister | O | Uncle | O | Grandmother | O |

**6. <u>How many times</u> did this behaviour occur?**

| Just Once | O | Twice | O | 3 or 4 Times | O | 5 Times or More | O |
|---|---|---|---|---|---|---|---|

**7. Over <u>how long a period</u> did this behaviour occur?**

| Just Once | O | A Month or Less | O | Several Months | O | A Year or More | O |
|---|---|---|---|---|---|---|---|

**8. How much did the experience <u>bother you at the time</u>?**

| O | O | O | O | O | O | O |
|---|---|---|---|---|---|---|
| Not at All | | | Moderately | | | Extremely |

**9. How much does the experience <u>bother you now</u>?**

| O | O | O | O | O | O | O |
|---|---|---|---|---|---|---|
| Not at All | | | Moderately | | | Extremely |

**10. What kind of <u>psychological pressure or physical force</u> did the person use, if any? (Cross "X" all that apply)**

| | |
|---|---|
| They tried to talk you into it. | O |
| They scared you because they were bigger or stronger. | O |
| They said they would hurt you. | O |
| They bribed you. | O |
| They pushed, hit, or physically restrained you. | O |
| You were afraid they wouldn't like or love you. | O |
| They physically harmed or injured you. | O |
| They threatened you with a weapon. | O |
| They drugged you or got you drunk. | O |
| Other (please specify): ____________________________ | O |
| None of these occurred. | O |

**11. Who did you <u>tell</u> about this experience at the time?**

| | | | | | |
|---|---|---|---|---|---|
| Mother | O | Other Adult | O | Friend | O |
| Father | O | Brother / Sister | O | Police / Authorities | O |
| Other | O | (please specify): ______________________________ | | | |

**12. If you told your <u>mother</u> how <u>supportive</u> was she?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Very | O | Mildly | O | A Little | O | Not At All | O |

**13. Have you ever sought any professional help in regards to it such incidents?**

| | | | |
|---|---|---|---|
| **Yes** | O | **No** | O |

**14. If you have answered "YES" to Item 13, tick any of the following professionals you sought help from regarding this / these incident/ s**

| O | O | O | O | O | |
|---|---|---|---|---|---|
| General Practitioner | Counsellor | Psychologist | Psychiatrist | Other (please specify): | ________________ |

15. **Did you find this help useful?**

**Yes** O **No** O

# Appendix C

*The Abbreviated Dyadic Adjustment Scale*

Most persons have disagreement in their relationships. **Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list by placing a cross (X) through the circle, which best represents your response**.

**1. <u>Philosophy of life.</u>**

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Always Agree | Almost Always Agree | Occasionally Disagree | Frequently Disagree | Almost Always Disagree | Always Disagree |

**2. <u>Aims, goals, and things believed important.</u>**

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Always Agree | Almost Always Agree | Occasionally Disagree | Frequently Disagree | Almost Always Disagree | Always Disagree |

**3. <u>Amount of time spent together.</u>**

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Always Agree | Almost Always Agree | Occasionally Disagree | Frequently Disagree | Almost Always Disagree | Always Disagree |

**How often would you say that the following events occur between you and your mate?**

**4. <u>Have a stimulating exchange of ideas.</u>**

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Never | Less Than Once A Month | Once Or Twice A Month | Once Or Twice A Week | Once A Day | More Often |

**5. Calmly discuss something.**

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Never | Less Than Once A Month | Once Or Twice A Month | Once Or Twice A Week | Once A Day | More Often |

**6. Work together on a project.**

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Never | Less Than Once A Month | Once Or Twice A Month | Once Or Twice A Week | Once A Day | More Often |

The circles below represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. **Place a cross through the circle, which best describes the degree of happiness, all things considered, of your relationship**.

| O | O | O | O | O | O | O |
|---|---|---|---|---|---|---|
| Extremely Unhappy | Fairly Unhappy | A Little Unhappy | Happy | Very Happy | Extremely Happy | Perfect |

# Appendix D

*The Female Sexual Function Index*

These questions ask about your sexual feelings and responses during the <u>past 4 weeks</u>. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

<u>**Sexual Activity**</u> can include caressing, foreplay, masturbation and vaginal intercourse.
<u>**Sexual Intercourse**</u> is defined as penile penetration (entry) of the vagina.
<u>**Sexual Stimulation**</u> includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

**Please place a cross (X) through the circle which best describes your response, Cross only one circle per question.**

<u>**Sexual desire**</u> or <u>**interest**</u> is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. <u>Over the past 4 weeks, **how often** did you feel sexual desire or interest?</u>

| O | O | O | O | O |
|---|---|---|---|---|
| Almost Always Or Always | Most Times (More Than Half The Time) | Sometimes (About Half The Time) | A Few Times (Less Than Half The Time) | Almost Never Or Never |

2. <u>Over the past 4 weeks, how would you rate your **level (degree)** of sexual desire or interest?</u>

| O | O | O | O | O |
|---|---|---|---|---|
| Very High | High | Moderate | Low | Very Low Or None At All |

<u>**Sexual arousal**</u> is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. <u>Over the past 4 weeks, **how often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?</u>

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Almost Always or Always | Most Times (More Than Half The Time) | Sometimes (About Half The Time) | A Few Times (Less Than Half The Time) | Almost Never Or Never |

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Very High | High | Moderate | Low | Very Low Or None At All |

5. Over the past 4 weeks, **how confident** were you about becoming sexually aroused during sexual activity or intercourse?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Very High Confidence | High Confidence | Moderate Confidence | Low Confidence | Very Low Or No Confidence |

6. Over the past 4 weeks, **how often** have your been satisfied with your arousal (excitement) during sexual activity or intercourse?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Almost Always or Always | Most Times (More Than Half The Time) | Sometimes (About Half The Time) | A Few Times (Less Than Half The Time) | Almost Never Or Never |

7. Over the past 4 weeks, **how often** did you **become** lubricated ("wet") during sexual activity or intercourse?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Almost Always or Always | Most Times (More Than Half The Time) | Sometimes (About Half The Time) | A Few Times (Less Than Half The Time) | Almost Never Or Never |

8. Over the past 4 weeks, **how difficult** was it **to become** lubricated ("wet") during sexual activity or intercourse?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Extremely Difficult Or Impossible | Very Difficult | Difficult | Slightly Difficult | Not Difficult |

9. Over the past 4 weeks, **how often** did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Almost Always or Always | Most Times (More Than Half The Time) | Sometimes (About Half The Time) | A Few Times (Less Than Half The Time) | Almost Never Or Never |

10. Over the past 4 weeks, **how difficult** was it **to maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Extremely Difficult Or Impossible | Very Difficult | Difficult | Slightly Difficult | Not Difficult |

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, **how often** did you reach orgasm (climax)?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Almost Always or Always | Most Times (More Than Half The Time) | Sometimes (About Half The Time) | A Few Times (Less Than Half The Time) | Almost Never Or Never |

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, **how difficult** was it for you to reach orgasm (climax)?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Extremely Difficult Or Impossible | Very Difficult | Difficult | Slightly Difficult | Not Difficult |

13. Over the past 4 weeks, **how satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Very Satisfied | Moderately Satisfied | About Equally Satisfied and Dissatisfied | Moderately Dissatisfied | Very Dissatisfied |

14. Over the past 4 weeks, **how satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| No Sexual Activity | Very Satisfied | Moderately Satisfied | About Equally Satisfied and Dissatisfied | Moderately Dissatisfied | Very Dissatisfied |

15. Over the past 4 weeks, **how satisfied** have you been with your sexual relationship with your partner?

| O | O | O | O | O |
|---|---|---|---|---|
| Very Satisfied | Moderately Satisfied | About Equally Satisfied and Dissatisfied | Moderately Dissatisfied | Very Dissatisfied |

16. Over the past 4 weeks, **how satisfied** have you been with your overall sexual life?

| O | O | O | O | O |
|---|---|---|---|---|
| Very Satisfied | Moderately Satisfied | About Equally Satisfied and Dissatisfied | Moderately Dissatisfied | Very Dissatisfied |

17. Over the past 4 weeks, **how often** did you experience discomfort or pain **during vaginal penetration**?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Did Not Attempt Intercourse | Almost Always Or Always | Most Times (More Than Half The Time) | Sometimes (About Half The Time) | A Few Times (Less Than Half The Time) | Almost Never Or Never |

18. Over the past 4 weeks, **how often** did you experience discomfort or pain **following vaginal penetration**?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Did Not Attempt Intercourse | Almost Always Or Always | Most Times (More Than Half The Time) | Sometimes (About Half The Time) | A Few Times (Less Than Half The Time) | Almost Never Or Never |

19. Over the past 4 weeks, how would you rate your **level (degree)** of discomfort or pain during or following vaginal penetration?

| O | O | O | O | O | O |
|---|---|---|---|---|---|
| Did Not Attempt Intercourse | Very High | High | Moderate | Low | Very Low Or None At All |

Appendix E

*The Revised Conflict Tactics Scale – Short Form*

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. **Please place a cross (X) through the appropriate circle** to indicate how many times you did each of these things in the past year, and how many times your partner did them in the past year. If you or your partner did not do one of these things in the past year, but it happened before that, place a cross (X) through the circle indicating this.

| | | | | | |
|---|---|---|---|---|---|
| **1** | **=** | **Once in the past year** | **5** | **=** | **11-20 times in the past year** |
| **2** | **=** | **Twice in the past year** | **6** | **=** | **More than 20 Times in the past year** |
| **3** | **=** | **3-5 times in the past year** | **7** | **=** | **Not in the past year, but it did happen before** |
| **4** | **=** | **6-10 times in the past year** | **0** | **=** | **This has never happened before** |

| | | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **0** |
|---|---|---|---|---|---|---|---|---|---|
| 1 | I explained my side of a disagreement to my partner. | O | O | O | O | O | O | O | O |
| 2 | My partner explained his side of a disagreement to me. | O | O | O | O | O | O | O | O |
| 3 | I insulted or swore at my partner. | O | O | O | O | O | O | O | O |
| 4 | My partner did this to me. | O | O | O | O | O | O | O | O |
| 5 | I had a sprain, bruise or small cut because of a fight with my partner. | O | O | O | O | O | O | O | O |
| 6 | My partner had a sprain, bruise, or small cut because of a fight with me. | O | O | O | O | O | O | O | O |
| 7 | I pushed or shoved my partner. | O | O | O | O | O | O | O | O |
| 8 | My partner did this to me. | O | O | O | O | O | O | O | O |
| 9 | I punched or hit my partner with something that could hurt. | O | O | O | O | O | O | O | O |
| 10 | My partner did this to me. | O | O | O | O | O | O | O | O |
| 11 | I went to a doctor because of a fight with my partner. | O | O | O | O | O | O | O | O |
| 12 | My partner went to a doctor because of a fight with me. | O | O | O | O | O | O | O | O |

| | | | | |
|---|---|---|---|---|
| **1** | **=** | **Once in the past year** | **5 = 11-20 times in the past year** | |
| **2** | **=** | **Twice in the past year** | **6 = More than 20 Times in the past year** | |
| **3** | **=** | **3-5 times in the past year** | **7 = Not in the past year, but it did happen before** | |
| **4** | **=** | **6-10 times in the past year** | **0 = This has never happened before** | |

| | | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **0** |
|---|---|---|---|---|---|---|---|---|---|
| 13 | I shouted or yelled at my partner. | O | O | O | O | O | O | O | O |
| 14 | My partner did this to me. | O | O | O | O | O | O | O | O |
| 15 | I used force (like hitting, holding down, or using a weapon) to make my partner have sex. | O | O | O | O | O | O | O | O |
| 16 | My partner did this to me. | O | O | O | O | O | O | O | O |
| 17 | I insisted on sex when my partner did not want to (but did not use physical force). | O | O | O | O | O | O | O | O |
| 18 | My partner did this to me. | O | O | O | O | O | O | O | O |
| 19 | I slapped my partner. | O | O | O | O | O | O | O | O |
| 20 | My partner did this to me. | O | O | O | O | O | O | O | O |
| 21 | I suggested a compromise to a disagreement. | O | O | O | O | O | O | O | O |
| 22 | My partner did this to me. | O | O | O | O | O | O | O | O |
| 23 | I used threats to make my partner have sex. | O | O | O | O | O | O | O | O |
| 24 | My partner did this to me. | O | O | O | O | O | O | O | O |

Appendix F

*The Hyperfemininity Scale*

**For each question, please choose the response (A or B) that is more characteristic of you by placing a cross (X) through the appropriate circle.**

| | | | A | B |
|---|---|---|---|---|
| 1 | (a) | These days men and women should each pay for their own expenses on a date. | O | O |
| | (b) | Men should always be ready to accept the financial responsibility for a date. | | |
| 2 | (a) | I would rather be a famous scientist than a famous fashion model. | | |
| | (b) | I would rather be a famous fashion model than a famous scientist. | O | O |
| 3 | (a) | I like a man who has some sexual experience. | | |
| | (b) | Sexual experience is not a relevant factor in my choice of a male partner. | O | O |
| 4 | (a) | Women should never break up a friendship due to interest in the same man. | O | O |
| | (b) | Sometimes women have to compete with one another for men. | | |
| 5 | (a) | I like to play hard-to-get. | | |
| | (b) | I don’t like to play games in a relationship. | O | O |
| 6 | (a) | I would agree to have sex with a man if I thought I could get him to do what I want. | O | O |
| | (b) | I never use sex as a way to manipulate a man. | | |
| 7 | (a) | I try to state my sexual needs clearly and concisely. | | |
| | (b) | I sometimes say “no” but really mean “yes”. | O | O |
| 8 | (a) | I like to flirt with men. | | |
| | (b) | I enjoy an interesting conversation with a man. | O | O |
| 9 | (a) | I seldom consider a relationship with a man as more important than my friendship with women. | O | O |
| | (b) | I have broken dates with female friends when a guy has asked me out. | | |
| 10 | (a) | I usually pay for my expenses on a date. | | |
| | (b) | I expect the men I date to take care of my expenses. | O | O |
| 11 | (a) | Sometimes I cry to influence a man. | | |
| | (b) | I prefer to use logical rather than emotional means of persuasion when necessary. | O | O |
| 12 | (a) | Men need sex more than women do. | | |
| | (b) | In general, there is no difference between the sexual needs of men and women. | O | O |

| | | | A | B |
|---|---|---|---|---|
| 13 | (a)<br>(b) | I never use my sexuality to manipulate men.<br>I sometimes act sexy to get what I want from a man. | O | O |
| 14 | (a)<br>(b) | I feel anger when men whistle at me.<br>I feel a little flattered when men whistle at me. | O | O |
| 15 | (a)<br>(b) | It's okay for a man to be a little forceful to get sex.<br>Any force used during sex is sexual coercion and should not be tolerated. | O | O |
| 16 | (a)<br>(b) | Effeminate men deserve to be ridiculed.<br>So-called effeminate men are very attractive. | O | O |
| 17 | (a)<br>(b) | Women who are good at sports probably turn men off.<br>Men like women who are good at sports because of their competence. | O | O |
| 18 | (a)<br>(b) | A "real" man is one who can get any woman to have sex with him.<br>Masculinity is not determined by sexual success. | O | O |
| 19 | (a)<br>(b) | I would rather be president of the U.S. than the wife of the president.<br>I would rather be the wife of the president of the U.S. than the president. | O | O |
| 20 | (a)<br>(b) | Sometimes I care more about my partner's feelings than my own.<br>It is important to me that I am as satisfied with a relationship as my partner is. | O | O |
| 21 | (a)<br>(b) | Most women need a man in their lives.<br>I believe some women lead happy lives without male partners. | O | O |
| 22 | (a)<br>(b) | When a man I'm with gets really sexually excited, it's no use trying to stop him from getting what he wants.<br>Men should be able to control their sexual excitement. | O | O |
| 23 | (a)<br>(b) | I like to have a man "wrapped around my finger."<br>I like relationships in which both partners are equal. | O | O |
| 24 | (a)<br>(b) | I try to avoid jealousy in a relationship.<br>Sometimes women need to make men feel jealous so they will be more appreciative. | O | O |
| 25 | (a)<br>(b) | I sometimes promise to have sex with a man to make sure he stays interested in me.<br>I usually state my sexual intentions honestly and openly. | O | O |
| 26 | (a)<br>(b) | I like to feel tipsy so I have an excuse to do anything with a man.<br>I don't like getting too drunk around a man I don't know very well. | O | O |

# Appendix G

*The Experiences in Close Relationships Inventory*

The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. **Please place a cross (X) through the appropriate circle, using the following rating scale:**

| | | **1 Disagree Strongly** | **2** | **3** | **4 Neutral / Mixed** | **5** | **6** | **7 Agree Strongly** |
|---|---|---|---|---|---|---|---|---|
| 1 | I prefer not to show a partner how I feel deep down. | O | O | O | O | O | O | O |
| 2 | I worry about being abandoned. | O | O | O | O | O | O | O |
| 3 | I am very comfortable being close to romantic partners. | O | O | O | O | O | O | O |
| 4 | I worry a lot about my relationships. | O | O | O | O | O | O | O |
| 5 | Just when my partner starts to get close to me I find myself pulling away. | O | O | O | O | O | O | O |
| 6 | I worry that romantic partners won't care about me as much as I care about them. | O | O | O | O | O | O | O |
| 7 | I get uncomfortable when a romantic partner wants to be very close. | O | O | O | O | O | O | O |
| 8 | I worry a fair amount about losing my partner. | O | O | O | O | O | O | O |
| 9 | I don't feel comfortable opening up to romantic partners. | O | O | O | O | O | O | O |

| | | 1 Disagree Strongly | 2 | 3 | 4 Neutral / Mixed | 5 | 6 | 7 Agree Strongly |
|---|---|---|---|---|---|---|---|---|
| 10 | I often wish that my partner's feelings for me were as strong as my feelings for him/her. | O | O | O | O | O | O | O |
| 11 | I want to get close to my partner, but I keep pulling back. | O | O | O | O | O | O | O |
| 12 | I often want to merge completely with romantic partners, and this sometimes scares them away. | O | O | O | O | O | O | O |
| 13 | I am nervous when partners get too close to me. | O | O | O | O | O | O | O |
| 14 | I worry about being alone. | O | O | O | O | O | O | O |
| 15 | I feel comfortable sharing my private thoughts and feelings with my partner. | O | O | O | O | O | O | O |
| 16 | My desire to be very close sometimes scares people away. | O | O | O | O | O | O | O |
| 17 | I try to avoid getting too close to my partner. | O | O | O | O | O | O | O |
| 18 | I need a lot of reassurance that I am loved by my partner. | O | O | O | O | O | O | O |
| 19 | I find it relatively easy to get close to my partner. | O | O | O | O | O | O | O |
| 20 | Sometimes I feel that I force my partners to show more feeling, more commitment. | O | O | O | O | O | O | O |

| | | 1 Disagree Strongly | 2 | 3 | 4 Neutral / Mixed | 5 | 6 | 7 Agree Strongly |
|---|---|---|---|---|---|---|---|---|
| 21 | I find it difficult to allow myself to depend on romantic partners. | O | O | O | O | O | O | O |
| 22 | I do not often worry about being abandoned. | O | O | O | O | O | O | O |
| 23 | I prefer not to be too close to romantic partners. | O | O | O | O | O | O | O |
| 24 | If I can't get my partner to show interest in me, I get upset or angry. | O | O | O | O | O | O | O |
| 25 | I tell my partner just about everything. | O | O | O | O | O | O | O |
| 26 | I find that my partner(s) don't want to get as close as I would like. | O | O | O | O | O | O | O |
| 27 | I usually discuss my problems and concerns with my partner. | O | O | O | O | O | O | O |
| 28 | When I'm not involved in a relationship, I feel somewhat anxious and insecure. | O | O | O | O | O | O | O |
| 29 | I feel comfortable depending on romantic partners. | O | O | O | O | O | O | O |
| 30 | I get frustrated when my partner is not around as much as I would like. | O | O | O | O | O | O | O |
| 31 | I don't mind asking romantic partners for comfort, advice, or help. | O | O | O | O | O | O | O |
| 32 | I get frustrated if romantic partners are not available when I need them. | O | O | O | O | O | O | O |

| | | 1 Disagree Strongly | 2 | 3 | 4 Neutral / Mixed | 5 | 6 | 7 Agree Strongly |
|---|---|---|---|---|---|---|---|---|
| 33 | It helps to turn to my romantic partner in times of need. | O | O | O | O | O | O | O |
| 34 | When romantic partners disapprove of me, I feel really bad about myself. | O | O | O | O | O | O | O |
| 35 | I turn to my partner for many things, including comfort and reassurance. | O | O | O | O | O | O | O |
| 36 | I resent it when my partner spends time away from me. | O | O | O | O | O | O | O |

Appendix H

*The Relationship and Sexual History Questionnaire*

**For each question, please place a cross (X) through the circle, which is correct for you.**

**1) What <u>Age</u> were You When You <u>First Had Consensual Sexual Intercourse</u>: ______ years.**

**2) Please indicate the <u>Number of Sexual Partners</u> You Have Had <u>in Your Lifetime:</u>**

| | | | | | |
|---|---|---|---|---|---|
| 1 | O | 3 to 5 | O | 10 to 20 | O |
| 1 to 3 | O | 5 to 10 | O | More than 20 | O |

**3) Have you ever been in a relationship with a male partner for 6 months or longer?**

**Yes** O **No** O (if you answered "Yes" please indicate how many relationships of this type you have experienced)

**Number: _____________**

**4) Have you ever been married?**

**Yes** O **No** O (if you answered "Yes" please indicate how many times you have been married)

**Number: _____________**

**5) Have you ever been separated from a husband?**

**Yes** O **No** O (if you answered "Yes" please indicate how many times you have separated from a husband)

**Number: _____________**

**6) Have you ever been divorced?**

**Yes** O **No** O (if you answered "Yes" please indicate how many times you have been divorced)

**Number: _____________**

Appendix I

*The Alcohol Use Disorders Identification Test*

**For each question, please place a cross (X) through the circle, which is correct for you.**

| | NEVER | MONTHLY OR LESS | 2-4 TIMES A MONTH | 2-3 TIMES A WEEK | 4 OR MORE TIMES A WEEK |
|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | O | O | O | O | O |

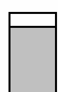
| | 1 OR 2 | 3 OR 4 | 5 OR 6 | 7 TO 9 | 10 OR MORE |
|---|---|---|---|---|---|
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | O | O | O | O | O |

| | NEVER | LESS THAN MONTHLY | MONTHLY | WEEKLY | DAILY OR ALMOST DAILY |
|---|---|---|---|---|---|
| 3. How often do you have six or more drinks on one occasion? | O | O | O | O | O |
| 4. How often during the last six months have you found it difficult to get the thought of alcohol out of your mind? | O | O | O | O | O |
| 5. How often during the last six months have you been unable to remember what happened the night before because you had been drinking? | O | O | O | O | O |

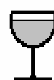
| | NEVER | LESS THAN MONTHLY | MONTHLY | WEEKLY | DAILY OR ALMOST DAILY |
|---|---|---|---|---|---|
| 6. How often during the last six months have you found that you were not able to stop drinking once you had started? | O | O | O | O | O |
| 7. How often during the last six months have you needed a first drink in the morning to get yourself going after a heavy drinking session? | O | O | O | O | O |
| 8. How often during the last six months have you had a feeling of guilt or remorse after drinking? | O | O | O | O | O |

| | NO | YES, BUT NOT IN THE LAST SIX MONTHS | YES, DUR ING THE LAST SIX MONTHS |
|---|---|---|---|
| 9. Have you or someone else been injured as a result of your drinking? | O | O | O |
| 10. Has a relative or friend or a doctor or other health worker, been concerned about your drinking or suggested you cut down? | O | O | O |

**ONE STANDARD DRINK EQUALS APPROXIMATELY:**

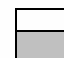


Pot of beer



Small glass of wine

Small glass of sherry/port



Nip of spirits

Appendix J

*The Social Support Questionnaire – Short Form*

INSTRUCTIONS: The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, **list all the people you know**, excluding yourself, whom you can count on for help or support in the manner described. Give each person's initials and **their relationship to you** (see example). Do not list more than one person next to each of the numbers beneath each question. Do not list more than nine people per question.

For the second part, using the scale below, **place a cross (X) through the circle** indicating how satisfied you are with the overall support you have.

| 6 | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|
| **Very Satisfied** | **Fairly Satisfied** | **A Little Satisfied** | **A Little Dissatisfied** | **Fairly Dissatisfied** | **Very Dissatisfied** |

If you have no support for a question, **tick the words 'No one'**, but still rate your level of satisfaction. The example below has been completed to help you.

***Example***

*Who do you know whom you can trust with information that could get you in trouble?*

| *(a) No-one* | *3) ASS (Friend)* | *6)* | *9)* |
|---|---|---|---|
| *1. TEN (Brother)* | *4) PEN (Father)* | *7)* | |
| *2. LM (Friend)* | *5) LM (Employer)* | *8)* | |

| *(b)How Satisfied?* | ***6*** | ***5*** | ***4*** | ***3*** | ***2*** | ***1*** |
|---|---|---|---|---|---|---|
| X | O | O | O | O | O | O |

**1. Whom can you really count on to distract you from your worries when you feel under stress?**

| (a) No-one | 3) | 6) | 9) |
|---|---|---|---|
| 1) | 4) | 7) | |
| 2) | 5) | 8) | |

| (b) How Satisfied? | **6** | **5** | **4** | **3** | **2** | **1** |
|---|---|---|---|---|---|---|
| | O | O | O | O | O | O |

**2. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?**

| (a) No-one | 3) | 6) | 9) |
|---|---|---|---|
| 1) | 4) | 7) | |
| 2) | 5) | 8) | |

| (b) How Satisfied? | **6** | **5** | **4** | **3** | **2** | **1** |
|---|---|---|---|---|---|---|
| | O | O | O | O | O | O |

**3. Who accepts you totally, including both your worst and best points?**

| (a) No-one | 3) | 6) | 9) |
|---|---|---|---|
| 1) | 4) | 7) | |
| 2) | 5) | 8) | |

| (b) How Satisfied? | **6** | **5** | **4** | **3** | **2** | **1** |
|---|---|---|---|---|---|---|
| | O | O | O | O | O | O |

**4. Whom can you really count on to care about you, regardless of what is happening to you?**

| (a) No-one | 3) | 6) | 9) |
|---|---|---|---|
| 1) | 4) | 7) | |
| 2) | 5) | 8) | |

| (b) How Satisfied? | **6** | **5** | **4** | **3** | **2** | **1** |
|---|---|---|---|---|---|---|
| | O | O | O | O | O | O |

**5. <u>Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?</u>**

| (a) No-one | 3) | 6) | 9) |
|---|---|---|---|
| 1) | 4) | 7) | |
| 2) | 5) | 8) | |

| (b) How Satisfied? | **6** | **5** | **4** | **3** | **2** | **1** |
|---|---|---|---|---|---|---|
| | O | O | O | O | O | O |

**6. <u>Whom can you count on to console you when you are very upset?</u>**

| (a) No-one | 3) | 6) | 9) |
|---|---|---|---|
| 1) | 4) | 7) | |
| 2) | 5) | 8) | |

| (b) How Satisfied? | **6** | **5** | **4** | **3** | **2** | **1** |
|---|---|---|---|---|---|---|
| | O | O | O | O | O | O |

Appendix K

*The Behavioural Self-Regulation for Effective Relationships Scale (Self Version)*

**INSTRUCTIONS:** For each question mark with a cross (X) the circle below the number that best describes to what extent each of the follow statements are true of YOU in your current relationship. PLEASE REMEMBER TO ANSWER EACH QUESTION

| | **1 Not at all True** | **2** | **3 Somewhat True** | **4** | **5 Very True** |
|---|---|---|---|---|---|
| 1. I make an effort to seek out ideas about what makes for an effective relationship. | O | O | O | O | O |
| 2. I try to apply ideas about effective relationships to improving our relationship. | O | O | O | O | O |
| 3. I discuss the appropriateness of my goals for our relationship with my partner. | O | O | O | O | O |
| 4. If things go wrong in the relationship I tend to feel powerless. | O | O | O | O | O |
| 5. I tend to put off doing anything about problems in our relationship in the hope that things will get better by themselves. | O | O | O | O | O |
| 6. I tend to fall back on what is comfortable for me in relationships, rather than trying new ways of relating. | O | O | O | O | O |
| 7. I work out practical ways or strategies to achieve the goals I set for myself. | O | O | O | O | O |
| 8. I actually put my intentions or plans for personal change into practice. | O | O | O | O | O |
| 9. Even when I know what I could do differently to improve things in the relationship, I cannot seem to change my behaviour. | O | O | O | O | O |
| 10. I persist with my plans for personal change efforts even in the face of difficulties. | O | O | O | O | O |
| 11. If my partner doesn't appreciate the change efforts I am making, I tend to give up. | O | O | O | O | O |
| 12. I give my partner helpful feedback on the ways they can help me achieve my goals. | O | O | O | O | O |
| 13. When I have difficulty making a change, I tend not to ask for support from my partner. | O | O | O | O | O |

| | 1<br>Not at all True | 2 | 3<br>Somewhat True | 4 | 5<br>Very True |
|---|---|---|---|---|---|
| 14. I adjust my goals or strategies for personal change in the light of feedback from my partner. | O | O | O | O | O |
| 15. If the way I'm approaching change doesn't work, I can usually think of something different to try. | O | O | O | O | O |
| 16. When things are not going so well in our relationship, I can usually think of something I can do to make it better. | O | O | O | O | O |

Appendix L

*The Sexual Assertiveness Scale*

Think about your current sexual partner or your last steady partner and to answer the next 18 questions with this person in mind. For the following questions please **place a cross (X) through the circle that best represents your answer**.

| | | **Never, 0% of the time** | **Sometimes, about 25% of the time** | **About 50% of the time** | **Usually, about 75% of the time** | **Always 100% of the time** |
|---|---|---|---|---|---|---|
| 1 | I begin sex with my partner if I want to. | O | O | O | O | O |
| 2 | I let my partner know if I want my partner to touch my genitals. | O | O | O | O | O |
| 3 | I wait for my partner to touch my genitals instead of letting my partner know that's what I want. | O | O | O | O | O |
| 4 | I wait for my partner to touch my breasts instead of letting my partner know that's what I want. | O | O | O | O | O |
| 5 | I let my partner know if I want to have my genitals kissed. | O | O | O | O | O |
| 6 | Women should wait for their partner/s to start things like breast touching. | O | O | O | O | O |
| 7 | I give in and kiss if my partner pressures me, even if I already said no. | O | O | O | O | O |
| 8 | I put my mouth on my partner's genitals if my partner wants me to, even if I don't want to. | O | O | O | O | O |
| 9 | I refuse to let my partner touch my breasts if I don't want that, even if my partner insists. | O | O | O | O | O |
| 10 | I have sex if my partner wants me to, even if I don't want to. | O | O | O | O | O |
| 11 | If I said no, I won't let my partner touch my genitals even if my partner, pressures me. | O | O | O | O | O |
| 12 | I refuse to have sex if I don't want to, even if my partner insists. | O | O | O | O | O |

# Appendix M

## *The Family Environment Scale*

The following statements are about families. You are to decide which of these statements are true of your family of origin (the family in which you grew up), during your childhood and adolescence and which are false. If you think the statement is True or mostly True of your family of origin, place a cross (X) through the circle labelled T (true). If you think the statement is False or mostly False of your family of origin, place a cross (X) through the circle labelled F (false). You may feel some of the statements are true for some family members and false for others. Mark T if the statement is true for most members. Mark F if the statement is false for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly. Remember, we would like to know what your family seems like to you. So do not try to figure out how other members saw your family, but do give us your general impression of your family for each statement.

| | | **True** | **False** |
|---|---|---|---|
| 1 | Family members really helped and supported one another. | O | O |
| 2 | Family members often kept their feelings to themselves. | O | O |
| 3 | We fought a lot in our family. | O | O |
| 4 | We often seemed to be killing time at home. | O | O |
| 5 | We said anything we wanted to around home. | O | O |
| 6 | Family members rarely became openly angry. | O | O |
| 7 | We put a lot of energy into what we did at home. | O | O |
| 8 | It was hard to "blow off steam" at home without upsetting somebody. | O | O |
| 9 | Family members sometimes got so angry they threw things. | O | O |
| 10 | There was a feeling of togetherness in our family. | O | O |
| 11 | We told each other about our personal problems. | O | O |

| | | True | False |
|---|---|---|---|
| 12 | Family members hardly ever lost their tempers. | O | O |
| 13 | We rarely volunteered when something had to be done at home. | O | O |
| 14 | If we felt like doing something on the spur of the moment we often just picked up and went. | O | O |
| 15 | Family members often criticized each other. | O | O |
| 16 | Family members really backed each other up. | O | O |
| 17 | Someone usually got upset if you complained in our family. | O | O |
| 18 | Family members sometimes hit each other. | O | O |
| 19 | There was very little group spirit in our family. | O | O |
| 20 | Money and paying bills was openly talked about in our family. | O | O |
| 21 | If there was a disagreement in our family, we tried hard to smooth things over and keep the peace. | O | O |
| 22 | We really got along well with each other. | O | O |
| 23 | We were usually careful about what we said to each other. | O | O |
| 24 | Family members often tried to one-up or out-do each other. | O | O |
| 25 | There was plenty of time and attention for everyone in our family. | O | O |
| 26 | There were a lot of spontaneous discussions in our family. | O | O |
| 27 | In our family, we believed you don’t ever get anywhere by raising your voice. | O | O |

Appendix N

*Questions Regarding Parental Divorce / Separation*

| | Never | Once | Twice | More than twice |
|---|---|---|---|---|
| 1. Did your parents permanently separate/divorce?* | **O** | **O** | **O** | **O** |

***If you answered "never" to this question, please go to <u>Parental Conflict Tactics Scale</u>**

| | 0-5 Years | 6-11 Years | 12-17 Years | 18 & Older |
|---|---|---|---|---|
| 2. What age were you at the time of your parents' separation? | **O** | **O** | **O** | **O** |

| | Mother | Father | Joint | Other |
|---|---|---|---|---|
| 3. With whom did you live after separation? | **O** | **O** | **O** | **O** |

# Appendix O

*The Parental Conflict Tactics Scale – Short Form*

**For each of the following questions please place a cross (X) through the circle that best represents your response.**

| | **Never** | **Once** | **Twice** | **More than twice** |
|---|---|---|---|---|
| 1. Did you ever see your Mother sit down calmly with your father and discuss a problem they were having? | **O** | **O** | **O** | **O** |
| 2. Did you ever see your Mother yell at your father? | **O** | **O** | **O** | **O** |
| 3. Did you ever see your Mother threaten to hit your father? | **O** | **O** | **O** | **O** |
| 4. Did you ever see your Mother push, hit or slap your Father? | **O** | **O** | **O** | **O** |
| 5. Did you ever see your Mother punch your Father? | **O** | **O** | **O** | **O** |
| 6. Did you ever see your Father sit down calmly with your mother and discuss a problem they were having? | **O** | **O** | **O** | **O** |
| 7. Did you ever see your Father yell at your mother? | **O** | **O** | **O** | **O** |
| 8. Did you ever see your Father threaten to hit your mother? | **O** | **O** | **O** | **O** |
| 9. Did you ever see your Father push, hit or slap your mother? | **O** | **O** | **O** | **O** |
| 10. Did you ever see your Father punch your mother? | **O** | **O** | **O** | **O** |

**Overall, would you describe your parents as happy or unhappy in their marriage? (Please mark the circle below that corresponds to the most appropriate response with a cross)**

| very happy | happy | somewhat happy | neither happy nor unhappy | somewhat unhappy | unhappy | very unhappy |
|---|---|---|---|---|---|---|
| **O** | **O** | **O** | **O** | **O** | **O** | **O** |

Appendix P

*The Childhood Trauma Questionnaire – Short Form*

These questions ask about some of your experiences growing up as a child and a teenager. **For each question, please place a cross (X) through the circle that best described how you felt**. Although some of these questions are of a personal nature, please try to answer as honestly as your can. Your answers will be kept confidential.

| | | **Never True** | **Rarely True** | **Sometimes True** | **Often True** | **Very Often True** |
|---|---|---|---|---|---|---|
| 1 | When I was growing up, I didn't have enough to eat. | O | O | O | O | O |
| 2 | When I was growing up, I knew there was someone to take care of me and protect me. | O | O | O | O | O |
| 3 | When I was growing up, people in my family called me things like "stupid" or "lazy" or "ugly". | O | O | O | O | O |
| 4 | When I was growing up, my parents were too drunk or high to take care of my family. | O | O | O | O | O |
| 5 | When I was growing up, there was someone in my family who helped me feel that I was important or special. | O | O | O | O | O |
| 6 | When I was growing up, I had to wear dirty clothes. | O | O | O | O | O |
| 7 | When I was growing up, I felt that I was loved. | O | O | O | O | O |
| 8 | When I was growing up, I thought that my parents wished I had never been born. | O | O | O | O | O |
| 9 | When I was growing up, I got hit so hard by someone in my family that I had to see a doctor or go to the hospital. | O | O | O | O | O |

| | | Never True | Rarely True | Sometimes True | Often True | Very Often True |
|---|---|---|---|---|---|---|
| 10 | When I was growing up, people in my family hit me so hard that it left me with bruises or marks. | O | O | O | O | O |
| 11 | When I was growing up, I was punished with a belt, a board, or a cord (or some other hard object). | O | O | O | O | O |
| 12 | When I was growing up, people in my family looked out for each other. | O | O | O | O | O |
| 13 | When I was growing up, people in my family said hurtful or insulting things to me. | O | O | O | O | O |
| 14 | When I was growing up, I believe that I was physically abused. | O | O | O | O | O |
| 15 | When I was growing up, I got hit or beaten so badly that it was noticed by someone like a teacher, neighbour, or doctor. | O | O | O | O | O |
| 16 | When I was growing up, I felt that someone in my family hated me. | O | O | O | O | O |
| 17 | When I was growing up, people in my family felt close to each other. | O | O | O | O | O |
| 18 | When I was growing up, I believe that I was emotionally abused. | O | O | O | O | O |
| 19 | When I was growing up, there was someone to take me to the doctor if I needed to go. | O | O | O | O | O |
| 20 | When I was growing up, my family was a source of strength and support. | O | O | O | O | O |