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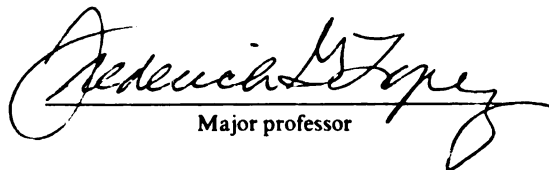
AN ATTACHMENT THEORETICAL PERSPECTIVE ON
CHILDHOOD SEXUAL ABUSE AND ADULT
PSYCHOLOGICAL ADJUSTMENT

presented by

Kimberly M. Thomas

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Counseling Psychology


Major professor

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AN ATTACHMENT-THEORETICAL PERSPECTIVE ON
CHILDHOOD SEXUAL ABUSE AND ADULT PSYCHOLOGICAL ADJUSTMENT

by

Kimberly Marie Thomas

A DISSERTATION

Submitted to
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in partial fulfillment of the requirements
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Department of Counseling and Educational Psychology
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ABSTRACT

AN ATTACHMENT-THEORETICAL PERSPECTIVE ON CHILDHOOD SEXUAL ABUSE AND ADULT PSYCHOLOGICAL ADJUSTMENT

By

Kimberly M. Thomas

The present study sought to advance our understanding of why some survivors of childhood sexual abuse exhibit severe psychological symptoms in adulthood, while others remain relatively symptom-free. Using attachment theory as the theoretical framework, the following three groups of survivors were compared: 1) women abused by primary caregivers (i.e., father, mother, step-parent), 2) women abused by other family members (i.e., uncle, brother, grandparent), and 3) women abused by non-family perpetrators (i.e., neighbor, babysitter, stranger). The groups were compared on a number of variables, including severity of abuse, parent-child emotional bonds, adult attachment orientations, and current psychosocial adjustment. Results indicate that women abused by a primary caregiver reported experiencing a more severe history of abuse and the weakest emotional bonds with caregivers, as compared to their counterparts. In addition, findings suggest that adult attachment orientations differ among groups and mediate the relationship between abuse and psychological adjustment in adulthood.

ACKNOWLEDGMENTS

Several people have contributed greatly to the development and completion of this project. Above all else, I want to thank my advisor and committee chair, Frederick Lopez, Ph.D., for providing me with years of invaluable support and guidance. The amount of time and energy he has devoted not only toward this project, but also toward my training and development as a professional in this field is extraordinary; I will be eternally grateful.

I would also like to thank my other committee members, Ken Rice, Ph.D., Ellen Strommen, Ph.D., Ann Flescher, ACSW, and Ruth Worthington, D.O., for their statistical expertise, conceptual guidance, theoretical knowledge, and encouragement along the way. Given the diversity of disciplines, each member offered something unique and valuable to this process for me.

Finally, I would like to thank my friends and family for their continued support. Completing this process would not have been possible without the encouragement of my parents, brother, and cohort. My friendships with Karyn Boatwright, Eric Sauer, Judy Ferris, and Jim Wyssmann, in particular, have been essential to my life and to completing this process.

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INTRODUCTION

Researchers have estimated the incidence of childhood sexual abuse to be alarmingly high. Prevalence rates for sexual abuse occurring to a child before the age of 18 range from 6% to 62% for females and 3% to 31% for males, depending on the population studied and the definition of child sexual abuse used (Peters, Wyatt, & Finkelhor, 1986; Wyatt & Peters, 1986a; 1986b; Wyatt, 1985). According to Finkelhor (1979), among the general population, as many as one out of three girls, and one out of six boys, are thought to experience some form of unwanted sexual contact before the age of 18.

In the last decade considerable research on the long-term impact of childhood sexual abuse has been published. Thusfar, much of the research has focused on the experience of abuse to female victims, however, research on male victims is increasing. Results suggest that victims of abuse frequently display serious psychological symptoms and diagnoses in adulthood. Specifically, adult female survivors tend to report higher rates of depression, anxiety, post-traumatic stress disorder, borderline personality disorder, low self-esteem, substance abuse, sexual maladjustment, revictimization, feelings of powerlessness, relationship difficulties, eating disorders, and suicidality, as compared to non-abused women (Braver,

Bumberry, Green, & Rawson, 1992; Browne & Finkelhor, 1986; Briere & Runtz, 1988; Green, 1993; Kinzl & Biebl, 1992; Mallinckrodt, McCreary, & Robertson, 1995; Paris, Zweig-Frank, & Guzder, 1994; Russell, 1986).

This literature indicates that a history of sexual abuse is often associated with serious long-term sequelae; however, it also demonstrates that a significant minority of individuals (20-40%) exhibits normal adult functioning and/or no symptomatology at the time of assessment, despite the experience of childhood sexual abuse (Finkelhor, 1990; Kendall-Tackett, Williams, & Finkelhor, 1993). According to Finkelhor (1990), "almost every study of the impact of sexual abuse has found a substantial group of victims with little or no symptomatology" (p. 327). Thus, in the long-run, it appears that some individuals are less affected overall by the experience of childhood sexual victimization than are others.

Speculations about why these individuals remain symptom-free or are able to adjust adequately to sexual trauma are numerous. The explanation which has received the most empirical support, however, is that asymptomatic or resilient individuals are more likely than maladjusted survivors to have been abused for a shorter period of time, by someone other than a primary caregiver, and without force or penetration (Browne & Finkelhor, 1986; Finkelhor, 1990; Kendall-Tackett et al., 1993). In addition, asymptomatic or

adjusted individuals tend to have received more support from family members and/or to have lived in healthier family environments than symptomatic victims (Browne & Finkelhor, 1986; Fromuth, 1986; Harter, Alexander, & Neimeyer, 1988; Wyatt & Mickey, 1987). Therefore, past research has found that both characteristics of abuse and characteristics of the victim's family are related to the impact of abuse.

Attempts to identify which factors best explain the variation in symptoms reported by survivors are numerous and consistent. Based on the findings, researchers have declared the family environment of the victim to be a better predictor of later adjustment than the abuse itself. Findings specifically indicate that the occurrence of sexual abuse is only minimally related to later psychosocial adjustment. Family variables, on the contrary, are significantly related to adjustment and explain more variance in survivor functioning than any other assessed predictor (Conte & Schuerman, 1987; Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Friedrich, Urquiza, & Beilke, 1986; Fromuth, 1986; Harter et al., 1988). Consequently, researchers have concluded that family variables may mediate the relationship between sexual abuse and future adjustment, and therefore, may potentially mitigate or nullify the harmful effects of abuse (Alexander, 1992; Brock, Mintz, & Good, 1997; Fromuth, 1986; Harter et al., 1988).

Regardless of whether a victim is sexually abused by a

family member (intra-familial abuse) or a non-relative (extra-familial abuse), studies indicate that families of victims are frequently rated as more dysfunctional than families of non-abused individuals (Long & Jackson, 1991; Mian, Marton, LeBaron, & Birtwistle, 1994; Ray, Jackson, & Townsley, 1991). Consequently, it has been suggested that family dysfunction or disruption (1) increases a child's risk for sexual victimization, (2) follows the disclosure of sexual abuse, and (3) interferes with a victim's ability to cope and heal from sexual trauma (Alexander, 1992; Finkelhor & Baron, 1986). Regardless of whether family dysfunction precedes or follows the occurrence of sexual abuse, studies indicate that many families are unable to function as a source of support to the victim (Everson et al., 1989; Herman, 1981; Wyatt & Mickey, 1988). This is especially true of incestual families, whereby some of the victim's closest social supports are the cause of her/his distress (Cole & Putnam, 1992).

The current study continues to explore the relationship between family characteristics and victim adjustment in adulthood, with a specific focus on the victim's early emotional bonds with parents and current adult attachment orientations. Attachment theorists have predicted that a secure bond between a child and his/her caregiver(s) may serve to protect the child from serious maladjustment. Specifically, Bowlby (1988) asserted that children raised in

favorable conditions are expected to follow a path of normal, healthy, and resilient development, while children born into unfavorable conditions (e.g., sexually abusive family environment) may deviate toward a more disturbed or vulnerable path of development.

In the case of a sexually abused child, access to a meaningful attachment relationship may allow him/her to work through sexual trauma, escaping severe pathology in the long-run (Bowlby, 1988; Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon, & Target, 1995). The outcome is expected to be more harmful, however, for victims without access to a secure emotional base or supportive attachments. Such is the case for many victims, particularly victims of incest or those abused by trusted caregivers. Mallinckrodt et al. (1995) found adult incest survivors reported poorer early bonds with caregivers and more current symptomatology than did either non-abused women or participants with a history of extra-familial childhood sexual abuse.

The current study also examines the relationship between survivors' current adult attachment orientations and present psychosocial functioning. Bowlby (1973) argued that attachment patterns formed in childhood tend to persist into adulthood, remaining relatively stable over time. More recently, however, Bowlby (1988) also acknowledged that significant life experiences, positive or negative, can potentially lead to modifications in an individual's

attachment orientation. In support of this, several researchers have found current circumstances or relationships to play a more significant role in adult functioning than early experiences (Carnelley, Pietromonaco, & Jaffe, 1994; Lopez, 1996; Parker, Barrett, & Hickie, 1992). Consequently, rather than focusing solely on the predictive value of childhood bonds, it seems propitious to consider the influence of both early and current attachment orientations on adult functioning in this population.

Given the high prevalence of child sexual abuse and the risk of ensuing psychological distress, this field of study deserves significant attention. Yet research in this area has just recently begun to flourish and continues to lag behind other research domains in terms of conceptual and methodological sophistication (Briere, 1992; Buetler & Hill, 1992). To date, research on childhood sexual abuse has been primarily atheoretical and descriptive. This is expected given the recency of scientific interest in this domain; however, Briere (1992) argues that "it is time for the second wave" of sexual abuse research (p. 202). Specifically, there is demand for theory-driven research, which employs more advanced methodological and design procedures (Briere, 1992).

Researchers continue to debate over which theoretical framework offers the best conceptualization of sexual abuse and its consequences. Some experts argue for the

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application of a developmental theoretical perspective (Cole & Putnam, 1992; Kendall-Tackett et al., 1993), while others argue for theory which also considers the family context (Alexander, 1992). Attachment theory, developed by John Bowlby (1973), addresses both familial and developmental issues, and therefore has recently served as a powerful theoretical base for conducting abuse research. Few empirical studies, however, have applied this theory to the study of childhood sexual abuse specifically.

Problem Statement

Research has demonstrated that the long-term effects of sexual abuse are best measured on a continuum, ranging from minimal symptomatology to severe psychopathology. The fact that not all victims suffer serious consequences, and that this population tends not to exhibit a unique set of symptoms, suggests that factors other than the abuse play a role in later adjustment and functioning (Alexander, 1992). This study sought to advance our understanding of why some individuals are able to escape the harmful effects of childhood sexual abuse, while others are not.

It was proposed that early emotional bonds and ensuing adult attachment orientations would mediate the relationship between sexual abuse and long-term adjustment. Thus, a healthy emotional bond between the victim and a caregiver and/or secure adult attachment orientations should serve to protect the victim from the potential long-lasting effects

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of childhood sexual trauma. More generally, this study also explored the relationships between childhood sexual abuse, parent-child bonds, adult attachment, and current psychological adjustment within a sample of sexually abused participants. Based on prior research findings and the tenets of attachment theory, survivors were divided into the following three groups and compared: 1) women abused by primary caregivers (i.e., father, mother, step-parent), 2) women abused by other family members (i.e., uncle, brother, grandparent), and 3) women abused by non-family members (i.e., neighbor, babysitter, stranger).

In conclusion, the specific purposes of the present study were to a) extend attachment theory to the study of childhood sexual abuse, b) to examine the attachment characteristics of adult survivors of sexual abuse, c) to compare three groups of survivors' of childhood sexual abuse (i.e., women abused by primary-caregivers, other family members, or non-family members) on the following variables: severity of abuse, parent-child emotional bonds, adult attachment orientations, and current psychosocial adjustment, and d) to examine the respective contributions of parent-child emotional bonds and adult attachment orientations to current psychological adjustment.

REVIEW OF THE LITERATURE

Childhood sexual abuse is occurring at a significant rate. Current prevalence rates for sexual abuse occurring to a child before the age of 18 range from 6% to 62% for females and from 3% to 31% for males (Peters, Wyatt, & Finkelhor, 1986; Wyatt & Peters, 1986a; 1986b; Wyatt, 1985). The rates tend to vary significantly from study to study depending on the population under investigation and the definition of childhood sexual abuse used (Briere, 1992; Wyatt & Peters, 1986a; 1986b).

Among the general population, Finkelhor (1979) contends that as many as one out of three girls, and one out of six boys, are sexually abused before the age of eighteen. Stinson and Hendrick (1992) estimate that 30-40% of women who seek services at university counseling centers have experienced some form of sexual abuse during childhood or adolescence. Furthermore, among adult female psychiatric populations, the prevalence of sexual abuse is reported to be as high as 50% or more (Bryer, Nelson, Miller, & Krol, 1987).

The definition of "childhood sexual abuse" employed by researchers also affects prevalence rates (Briere, 1992; Wyatt & Peters, 1986a; 1986b). While some researchers have used a broad definition (i.e., any unwanted sexual experience before the age of 18), others have defined this

type of abuse more conservatively (i.e., sexual contact between family members; genital contact before the age of 14 with someone at least 5 years older). Obviously, the broader the definition used, the higher the incidence rate of sexual abuse reported (Briere, 1992).

Definition of Childhood Sexual Abuse

Experts have not agreed upon a standard definition of "childhood sexual abuse;" therefore, this construct has been defined in a variety of ways across studies. A myriad of factors are associated with the experience of sexual abuse making it difficult to establish boundaries around this construct. Variables such as (1) the type/nature of abuse (i.e., exhibitionism to intercourse), (2) the duration and frequency of abuse, (3) the age of the victim at the time of abuse, (4) the relationship between the victim and perpetrator, and (5) whether or not force/aggression was used are considered to be important to the definition and measurement of childhood sexual abuse (Browne & Finkelhor, 1986; Courtois, 1988). In order to capture the experience of sexual victimization in its entirety, all of these variables must be assessed.

The Effects of Childhood Sexual Abuse

Studies describing the initial and long-term effects of childhood sexual abuse have recently been reviewed (Browne & Finkelhor, 1986; Green, 1993; Kendall-Tackett et al., 1993). Findings indicate that samples with a history of sexual

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abuse frequently display more symptoms, more psychopathology, and lower functioning than non-abused samples. It is important to note, however, that there is no unique set of symptoms associated with the experience of sexual abuse. Survivors display a variety of symptoms, with a wide range of severity. Moreover, some victims (between 20-40%) have shown no symptoms or harmful effects at the time of assessment (Caffaro-Rouget, Lang, & vanSanten, 1989; Conte & Schuerman, 1987). Therefore, the effects of sexual abuse are best measured on a continuum, ranging from no symptomatology to severe psychopathology (Browne & Finkelhor, 1986; Courtois, 1988).

Short- and Long-Term Effects of Sexual Abuse

Children who have experienced sexual abuse frequently display more anxiety, fear, post-traumatic stress disorder, depression, somatic complaints, aggression, delinquent behavior, sexualized behavior, school problems, withdrawn behavior, and self-destructive behavior, as compared to non-abused children (Kendall-Tackett et al., 1993). In addition, adults with a history of childhood sexual abuse tend to report higher rates of depression, anxiety, fear, anger, guilt, substance abuse, eating disorders, sexual disinterest and dissatisfaction, low self-esteem, relationship difficulties, borderline and multiple personality disorders, somatoform disorders, post-traumatic stress disorder, phobias, panic disorder, and suicidality in

adulthood (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Bryer, et al., 1987; Kinzl & Biebl, 1992; Mallinckrodt et al., 1995; Russell, 1988). The present study will continue to examine the long-term impact of childhood sexual abuse, focusing solely on adult women with a history of this type of abuse.

Although this area of research indicates that a history of sexual abuse is often associated with serious long-term sequelae, this same line of inquiry also demonstrates that some victims display no symptoms or relatively few symptoms at the time of assessment. According to Finkelhor (1990), "almost every study of the impact of sexual abuse has found a substantial group of victims with little or no symptomatology" (p. 327).

Victims of Sexual Abuse With No Symptoms

Studies have shown that an average of 20-40% of victims participating in research are symptom free at the time of assessment. Explanations for this phenomenon have been offered. Some authors argue that asymptomatic individuals are more likely to have experienced less trauma or less severe abuse than maladjusted victims (Finkelhor, 1990; Kendall-Tackett et al., 1993). Other researchers contend that asymptomatic individuals received more support from others and/or possess more psychological and social resources to cope with the abuse, as compared to symptomatic persons (Fromuth, 1986; Harter et al., 1988; Kendall-Tackett

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et al., 1993; Wyatt & Mickey, 1987). Research regarding the impact of abuse will be explored throughout this paper with a specific focus on adult survivors and the variables which significantly influence their adjustment.

Applying Theory to the Study of Sexual Abuse

A major limitation with current sexual abuse literature is that much of it is atheoretical. Researchers continue to debate which theoretical framework offers the most accurate conceptualization of sexual abuse (Finkelhor, 1990). Alexander (1992) argued for the application of attachment theory, suggesting that it may explain the occurrence of sexual abuse, as well as help to predict the short- and long-term consequences of abuse. In this theoretical article, she specifically hypothesized that incest is preceded by insecure parent-child attachments and that the long-term effects of sexual abuse are mediated by early attachment experiences.

In keeping with Alexander's proposal, the present study extends attachment theory to the study of childhood sexual abuse. To date, few researchers have applied this theory specifically to the study of sexual abuse; however, numerous empirical studies have found attachment theory to be valuable in understanding the effects of other types of childhood maltreatment, particularly physical abuse and neglect. In the following paragraphs, a brief review of the main tenets of attachment theory and research regarding

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parent-child relationships and adult romantic relationships will be presented.

Attachment Theory and Research

According to Bowlby (1973; 1977), human beings are innately programmed to seek and form attachments to others. The attachment process starts at birth and serves an evolutionary purpose. In order to survive, infants depend on caregivers to meet their basic needs, to provide them with security, safety, and support. Children also yearn to explore the world around them, to gain mastery and autonomy. Therefore, if encouraged by parents, children will engage in exploratory behavior, as well as seek proximity to caregivers, throughout childhood and adolescence.

Caregivers may respond adequately or inadequately to an infant's needs, which subsequently affects the quality of the attachment bonds. Responsive, nurturant and sensitive parental care provides the child with a sense of felt security and comfort. Children who receive this type of care usually form "secure" attachments to parents. On the contrary, inconsistent, unresponsive or neglectful care hinders the attachment process, leading children to form "insecure" attachments to parents (Ainsworth, Blehar, Waters, & Wall, 1978).

Internal Working Models

An important aspect of Bowlby's theory is his concept of the "internal working model" (Bowlby, 1973). Based on

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early attachment experiences, children form cognitive and emotional expectations about their own self worth (self model) and the accessibility or responsiveness of others (other model). Bowlby proposed that these mental models of "self" and "other" consequently organize and guide a child's internal thoughts, interpersonal behaviors, and social experiences throughout life.

In general, if the primary caregiver is available and responsive to the child's needs, the child will internalize a basic view of others as trustworthy and dependable and a view of self as worthy of love and attention. On the contrary, if the primary caregiver is unavailable, rejecting or inconsistent, the child may internalize a view of others as undependable and untrustworthy and/or a view of self as unlovable. It has been proposed that these internal working models form gradually throughout infancy and childhood and tend to persist into adulthood (Bowlby, 1977).

Patterns of Attachment in Infancy/Childhood

In order to measure infant-mother attachment bonds, Ainsworth developed the "Strange Situation" observational methodology whereby the infant's emotional and behavioral reactions were recorded during the following situations: (1) mother and child are separated and reunited, (2) child is exposed to a strange adult figure, and (3) child is left alone briefly with no one else present. Through these controlled observations, Ainsworth et al. (1978) were able

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to identify three principal styles of attachment: secure, anxious-avoidant, and anxious-ambivalent. Other researchers have replicated the original study and have identified similar patterns of attachment between mother and child (Egeland & Sroufe, 1981; Main, 1990; Matas, Arend, & Sroufe, 1978); however, others have added a fourth category of attachment, the Type D or disorganized style (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Main & Solomon, 1990).

"Secure" infants tend to experience the caregiver as accessible and responsive and view the self as worthy and competent. During the Strange Situation, secure infants engage in exploratory activity with or without the presence of the caregiver, show minimal distress when left alone or with a stranger, and accept mother's comfort upon reunion. Bowlby and Ainsworth concluded that secure infants experience the attachment relationship as a "secure base" from which to gain support during periods of exploration and emotional distress.

"Anxious-ambivalent" infants, on the other hand, experience the caregiver as inconsistently responsive. The caregiver who responds to the infant's needs erratically or gives the infant "conditional" love and attention, forces the child to view her/himself as unworthy and others as unpredictable or potentially unreliable. During the Strange Situation, ambivalent infants are unable to engage in

exploratory behavior without mother's presence, are seriously distressed when left alone, and exhibit clingy behavior upon reunion. In summary, anxious-ambivalent infants are dependent on mother for comfort and are unable to manage their emotions in her absence.

"Anxious-avoidant" infants experience the caregiver as emotionally cold and unavailable. Efforts to solicit the support and attention of mother are often ignored or rebuffed, promoting a view of others as rejecting. During the Strange Situation, avoidant infants are uninterested in mother's presence or absence, play/explore independently of her whereabouts, and do not seek proximity to her upon reunion. Bowlby and Ainsworth concluded that avoidant children learn to deactivate attachment needs and consequently adopt compulsive self-sufficient behaviors.

The fourth category of attachment is the "disorganized/disoriented" style. Infants classified as disorganized commonly evidence a history of maltreatment or abuse (Carlson et al., 1989). Consequently, these infants exhibit behaviors and emotions marked predominantly by fear and apprehension, and experience caregivers as threatening (abusing parent) or incompetent (non-abusing parent). Disorganized children possess no coherent coping mechanisms; rather, they blend contradictory features of all insecure strategies. During the Strange Situation, these infants demonstrate slow and incomplete movements, depressed affect,

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and proximity seeking mixed with avoidance.

In conclusion, secure infants are exposed to high-quality care allowing the infant to form a positive view of self and other. Subsequently, healthy personality development is promoted. Anxious-ambivalent, anxious-avoidant, and disorganized infants, on the contrary, are exposed to inconsistent, rejecting or abusive parental care leaving them particularly vulnerable to undesirable developmental outcomes.

Patterns of Attachment in Adulthood

Recently, a plethora of studies exploring adult attachment have been published. Some of these investigators employ a three category model of attachment (i.e. secure, ambivalent, & avoidant), however, many have moved to the four category model developed by Bartholomew and Horowitz (1991). These researchers have proposed that adult views of "self" and "other" can be conceptualized dichotomously (positive or negative), and consequently, adults can be classified into one of the following four categories: secure, dismissive, preoccupied, or fearful.

Secure individuals internalize a positive model of self and other, allowing them to be comfortable with both closeness and separateness in interpersonal relationships. Dismissive individuals internalize a positive view of self, but a negative view of others. They prefer greater independence in relationships and feel uncomfortable with

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high levels of intimacy. Preoccupied adults, on the contrary, internalize a positive view of others, but a negative view of self. They prefer to maintain close proximity to their romantic partners and often exhibit clingy and dependent behavior in order to maintain closeness. And finally, fearful individuals incorporate a negative view of both self and other. They exhibit low self-esteem, little trust of others, and a fear of intimacy in relationships.

Recent research has focused on the application of attachment theory to the study of adult relationships. Researchers believe that adult relationships, especially those involving romantic love, can be conceptualized as an attachment process similar to the bond between a parent and child (Hazan & Shaver, 1987). Findings indicate that secure individuals report higher levels of trust, self-confidence, and relationship satisfaction than insecure persons (Collins & Read, 1990; Pistole, 1989a; Simpson, 1990). Dismissive and fearful individuals, in particular, report lower levels of trust and intimacy in relationships (Bartholomew, 1990), while preoccupied individuals report higher levels of anxiety in the absence of intimacy (Kobak & Sceery, 1988).

The present study drew heavily from the attachment literature, as well as from the body of research regarding sexual abuse. Three groups of survivors of childhood sexual abuse were compared on measures of severity of abuse,

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parent-child emotional bonds, adult attachment orientations, and current psychosocial functioning. Therefore, studies exploring (1) the relationship between characteristics of sexual abuse and victim adjustment, (2) the relationship between the victim's family environment and victim adjustment, (3) the role early emotional bonds with parents might play in functioning, and (4) the relationship between attachment and child abuse are germane to the current study and will be reviewed.

Characteristics of Childhood Sexual Abuse

Researchers have determined that various types of sexual abuse impact victims differently. The relationship between impact and the following characteristics of sexual abuse has been investigated: (1) the nature of abuse (i.e. intercourse, fondling, exhibitionism), (2) the duration and/or frequency of abuse, (3) the age of the victim at the time of abuse, (4) the relationship between perpetrator and victim, (5) the use of force or aggression, (6) victim disclosure of abuse, and (7) parental/familial reaction to disclosure (Browne & Finkelhor, 1986).

In a review of the literature on long-term effects and types of abuse, Browne and Finkelhor (1986) concluded that the most damaging experience of sexual abuse involves a father figure, penetration, and force. Variables such as age of onset, duration of abuse, and disclosure of abuse were not consistently related to a traumatic outcome. In a

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more recent literature review, however, Kendall-Tackett et al. (1993) concluded that molestations involving a close perpetrator, a high frequency or long duration of abuse, the use of force, and penetration were all significantly related to increased symptomatology. The variables age at onset and number of perpetrators were not related to impact in this review.

It appears that the relationship between the victim and abuser is particularly important. Research shows that abuse perpetrated by a father-figure is more often related to a negative outcome than abuse perpetrated by either an extended family member (i.e. uncle, grandfather) or a non-family member (i.e. teacher, neighbor). According to Browne and Finkelhor (1986), father-daughter incest is often the most traumatic type of abuse due to (1) the high degree of betrayal felt by the victim and (2) the extreme severity of abuse. Abuse occurring between fathers and daughters, taking place inside the home, frequently lasts longer, involves a higher frequency of sexual activity and starts earlier than abuse occurring outside the home (Courtois, 1988; Wyatt & Newcomb, 1990).

Because the relationship between the perpetrator and victim is critical, the present study utilized this particular variable to categorize participants. While prior studies have examined the differences between survivors of intra-familial and extra-familial abuse, the present study,

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in adherence with the principles of attachment theory, examined the differences between three groups of survivors: 1) women abused by primary caregivers (i.e., mother, father, step-parent), 2) women abused by other family members (i.e., brother, uncle, grandparent), and 3) women abused by non-family members (i.e., neighbor, babysitter, stranger).

In summary, empirical findings regarding impact and the severity of sexual abuse have yet to identify many variables which are consistently associated with a worse prognosis (Browne & Finkelhor, 1986). Although a preponderance of studies has indicated that forced intercourse by a father-figure is often the most traumatic type of abuse, this has not been true in all cases or studies. Consequently, researchers have looked to factors other than the abuse to predict degree of impact. The family environment of the victim has proven to play a significant role in later adjustment; relevant studies will be reviewed below.

Characteristics of Sexually Abusive Families

Families characterized by incest or intra-familial sexual abuse have been studied extensively. Incestual families have long been described as traditional and Patriarchal (Herman, 1981), chaotic and enmeshed (Will, 1983), controlled and inflexible (Alexander & Lupfer, 1987; Alexander, 1985), and isolatory (Finkelhor, 1979). Incestual families have also demonstrated patterns of role reversal or parentification, whereby one or more of the

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children is expected to fulfill a parental role in the family system (Gelinas, 1983; Levang, 1989). And lastly, Mian et al. (1994) found parents of incestual families to report more personal inadequacies (i.e., alcohol abuse, maternal history of sexual abuse in childhood, paternal history of physical abuse as a child and violent behavior as an adult, and maternal disapproval of daughter) than a control group of parents.

Much less has been written about the families of victims of extra-familial sexual abuse or abuse perpetrated by a non-family member. Finkelhor (1979; 1984) found marital conflict, poor mother-child relations, and the absence of a parent (particularly mother) to increase a child's risk for victimization outside of the home. Although there is a trend for incestual families to be rated as slightly more dysfunctional than families associated with extra-familial abuse, the two types of families have been found to share some common characteristics. Regardless of the perpetrator, victim families have been described as less cohesive and expressive (Alexander & Lupfer, 1987; Long & Jackson, 1991), less harmonious and stable (Mian et al., 1994), less adaptable (Harter et al., 1988), more conflictual (Edwards & Alexander, 1992; Ray et al., 1991), and less organized (Long & Jackson, 1991) than families of non-abused children.

In summary, existing studies suggest that family

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disruption is significantly associated with the occurrence of sexual abuse, both inside and outside of the home. It is suggested that family dysfunction precedes the abuse, and therefore, poses as a risk factor for sexual victimization (Alexander, 1992; Finkelhor & Baron, 1986). In addition, researchers have also argued that family functioning influences the impact of abuse.

How Family Functioning Influences Adjustment

Research has recently shown that family functioning may mediate the relationship between sexual abuse and symptomatology (Alexander, 1992; Briere & Elliott, 1993). The initial and long-term effects of sexual abuse have been shown to be significantly related to the victim's family environment, as well as to the amount of support she/he receives from family after the abuse is revealed. In short, individuals who receive more support from family members and live in more functional family environments are better adjusted psychologically than other victims (Adams-Tucker, 1982; Conte & Schuerman, 1987; Everson et al., 1989; Fromuth, 1986; Herman, 1981). Empirical studies supporting the relationship between family functioning and the impact of abuse will be reviewed below.

Measuring Short-Term Effects. Adams-Tucker (1982) found that sexually abused children who received support from adult family members were diagnosed with fewer emotional disturbances than non-supported children.

Similarly, Conte and Schuerman (1987) found that young victims surrounded by supportive relationships and living with families rated as less pathological were rated as less traumatized than other victims. In fact, supportive relationships with others and family environment variables explained more of the variance in victim functioning than the sexual abuse itself (Conte & Schuerman, 1987).

Everson et al. (1989) found children who received low levels of support or no support at all to display significantly higher levels of psychopathology than children receiving more support. Moreover, level of maternal support was a better predictor of psychological adjustment than the type of abuse, the length of abuse, or the relationship between perpetrator and victim. Clearly, this line of research suggests that family and other forms of social support play powerful roles in reducing the initial impact or short-term effects of sexual abuse on children.

Measuring Long-Term Effects. Researchers have also investigated the role that family characteristics and support play in the adjustment of adult survivors of childhood sexual abuse. Fromuth (1986) explored the relationship between childhood sexual abuse, family environment, and psychological and sexual adjustment among female college students. She determined that parental supportiveness was a better predictor of psychological adjustment than was the history of sexual abuse. She

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concluded that survivor maladjustment is likely due to the lack of parental supportiveness, which frequently characterizes the home of the sexually abused, rather than to the abuse itself.

Wyatt and Mickey (1988) recruited adult women from the community with a history of childhood sexual abuse and hypothesized that support from a non-abusing parent would ameliorate the effects of abuse. Results showed that a majority of the women who received positive support from family members had no negative lasting effects, again suggesting that the harmful effects of abuse are alleviated by the support of others. Interestingly, severity of abuse was not significantly related to the victims' overall adjustment.

Peters (1988) assessed the contributions of maternal warmth and severity of abuse to psychological outcome measures among a sample of adults who had experienced unwanted sexual contact as a child. In a stepwise regression, maternal warmth emerged as the strongest predictor of psychological difficulties in adulthood. Duration of abuse and number of incidents were also added to the equation, in order to explain more of the variance.

Finally, Harter, Alexander, and Neimeyer (1988) compared incest survivors and non-abused college women on measures of social adjustment, family characteristics, and social cognition. Results indicate that abused subjects

1. The first step is to identify the problem. This involves understanding the current situation and the goals that need to be achieved.

2. Next, it is important to gather information. This can be done through research, interviews, or data analysis.

3. Once the information is gathered, the next step is to analyze it. This involves looking for patterns, trends, and potential solutions.

4. After analysis, the next step is to develop a plan. This plan should outline the steps that need to be taken to achieve the goals.

5. The final step is to implement the plan. This involves putting the plan into action and monitoring progress.

reported less cohesive families-of-origin, greater social isolation, and poorer social adjustment than non-abused peers. Consistent with prior findings, family characteristics were found to be more predictive of social maladjustment than were abuse characteristics. Only abuse by a paternal figure and abuse involving intercourse contributed significantly to maladjustment, after family structure was controlled.

In conclusion, empirical research suggests that while the victim's family environment is primary, severity of abuse should also be considered when examining the impact of childhood sexual abuse. There is a trend, however, for family variables to explain the largest amount of variance in adjustment, as compared to other assessed predictors. Continued theoretical and empirical research regarding the relationship between family variables and adjustment is needed. One aspect of the family environment which has received little attention thusfar is the parent-child bond or attachment. The role that parent-child attachment may play in the adjustment to sexual trauma will be discussed below.

Quality of Parent-Child Bonds

According to Bowlby (1988), the development and organization of the parent-child bond is a major determinant of the child's future mental health. As mentioned previously, responsive, nurturant and sensitive parental

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care provides the child with a sense of security and comfort. Healthy parental care involves caregivers who promote and tolerate both independence and dependence, whereby the child is encouraged to explore the world around him/her but is also prompted to return to the "secure base" for support as needed.

A person's need for attachment is expected to increase during times of crisis or stress (Bowlby, 1973). Thus, it can be assumed that after experiencing sexual trauma, a victim might attempt to return to the "secure base" in order to seek reassurance and support. The role that a primary caregiver plays when a victim discloses that he/she has been sexually abused is critical. A supportive initial reaction, as well as ongoing or long-term support, has been shown to ameliorate the harmful effects of abuse (Adams-Tucker, 1982; Conte & Schuerman, 1987; Everson et al., 1989; Fromuth, 1986; Harter et al., 1988; Wyatt & Mickey, 1988). Yet, studies show that many caregivers respond with disbelief, rejection or blame to the disclosure of abuse (Herman, 1981), and still others offer little to no support after acknowledging that abuse has occurred (Everson et al., 1989; Wyatt & Mickey, 1987).

Another tragic situation occurs when the victim chooses not to disclose the abuse to anyone. This may be primarily due to fear as some perpetrators threaten and intimidate victims to remain silent (i.e. perpetrator tells victim he

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will hurt/kill someone if victim reveals abuse); however, in some cases, it may be that the victim does not regard the parent-child "base" as a secure or supportive one to which to return. Perhaps, some victims sense that the caregiver(s) responsible for her/his well-being is(are) incompetent to some degree (Mian et al., 1994).

"The extent to which an individual becomes resilient to stressful life events is determined to a very significant degree by the pattern of attachment he/she develops during the early years" (Bowlby, 1988, p. 7). Thus, in theory, children who are raised by caring and responsive parents and who are provided with a "secure base" to which they can return during stressful times are more likely to prevail and adjust, despite the experience of childhood sexual abuse. On the contrary, children who are raised by rejecting, inconsistent, or unresponsive parents are more likely to become and/or remain vulnerable after experiencing sexual trauma, resulting in mental illness. Thus, secure parental bonds may serve as a protective mechanism for children suffering traumatic events.

Attachment and Childhood Maltreatment

Few empirical studies regarding attachment and sexual abuse exist. To date, researchers have more commonly examined the relationship between attachment and other forms of child abuse (i.e., physical abuse and neglect). Results consistently indicate that individuals with a history of

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abuse exhibit insecure attachments to others more often than non-abused individuals. Studies focusing on attachment patterns and abuse will be reviewed below.

Attachment Measured in Child Samples

A relationship between childhood maltreatment and insecure attachment has been established by numerous researchers. Egeland and Sroufe (1981) found populations of physically abused and/or neglected children to exhibit insecure attachment styles more often than children exposed to adequate parental care. Additionally, Carlson, Barnett, Cicchetti and Braunwald (1989) found that maltreated infants were more likely than matched comparison infants to be rated as insecurely attached. A majority of the maltreated infants demonstrated the disorganized (type D; fearful) style of attachment, in particular.

In a recent study, Lyons-Ruth and Block (1997) examined the relationships between maternal childhood experiences of physical and/or sexual abuse, adult caregiving behaviors, and infant affect and attachment. Participants were 45 mothers and their 18 month-old infants from primarily low-income family backgrounds. Although a majority of the infants were rated as "insecure," the form of observed insecure behavior was significantly different between groups. Insecure infants raised by mothers with a history of abuse were more likely to display a disorganized (fearful) style of attachment, whereas infants raised by

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mothers with a "benign" history (i.e. no history of abuse or violence) were more likely to display avoidant strategies.

A particular strength of the above study is that the methodology used to measure child attachment and parental caregiving was naturalistic; mother-infant interactions were videotaped and rated by experts. A critical limitation is that the sample size was small; only nine percent (N=4) of the mothers were found to have a "benign" childhood, making this comparison group extremely small. Thus, generalizability is limited. Results should best generalize to similar low-income mother-infant dyads.

To date, only two empirical studies exploring attachment within a sexually abused population of children have been published. Both studies examine the impact of previous sexual abuse on the adjustment of children in adoptive placement. Groze and Rosenthal (1993) found that children with a history of physical and/or sexual abuse (before the adoption) experienced greater attachment difficulties than did children without such a history. In addition, Livingston-Smith and Howard (1994) found sexually abused adoptees to resist attachment or exhibit more attachment difficulties in adoptive placement than did non-abused children.

The prior two studies must be considered within the context of some serious limitations. First, Livingston-Smith and Howard (1994) gathered data from case records;

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10. The tenth part of the document is a list of names and addresses, which appears to be a directory or a list of contacts. The names are written in a cursive script, and the addresses are listed below them. The list includes names such as "Mr. J. H. Smith", "Mrs. A. B. Jones", and "Mr. C. D. Brown".

thus, the results are directly dependent on the accuracy and completeness of the social worker's documentation.

Secondly, both studies examine attachment specifically within a special needs adoptee sample. Although the results are important and interesting, they cannot be generalized outside of this population given the uniqueness of this group. Finally, one cannot conclude that the experience of sexual abuse is the sole or primary cause of attachment disturbances; too many other variables which tend to influence attachment exist and were not measured or controlled (e.g., birth family environment, adoptive family environment).

The studies discussed thusfar have examined the relationship between childhood maltreatment and attachment in infancy or childhood. Numerous studies focusing on the relationship between childhood abuse and adult attachment have recently been published and will be presented below.

Attachment Measured in Adult Samples

Clark and Shaver (1994) explored the relationship between adult attachment, self-concept, and a history of child abuse. Results indicated that a history of severe punishment, parental violence, psychological abuse and/or sexual abuse was significantly correlated with a fearful style of attachment, especially among female participants. The authors concluded that females experiencing childhood abuse are more likely to exhibit fearful styles of

attachment and poor self-concept structure, as compared to non-abused women.

A limitation of the above study is that a very narrow definition of sexual abuse was used. Participants were simply asked to indicate whether or not they had been exposed to an adult's genitals during childhood. No other information regarding a past history of sexual abuse was collected, making it difficult to determine if varying experiences of sexual abuse affected adult attachment indexes differently.

Schachere (1988) also examined the relationship between child abuse and adult attachment. He surveyed a sample of young adults to determine their past history of childhood abuse, and subsequently, categorized participants into one of the following five groups: no abuse, physical abuse, emotional abuse, sexual abuse, and physical & sexual abuse. The study sought to determine if individuals who reported childhood sexual abuse differed in their attachment and separation responses from individuals who reported other types of abuse or no abuse.

Overall, the five groups did not differ significantly in their attachment/separation responses. In fact, individuals who reported sexual abuse only (without physical abuse) perceived themselves similarly to the no abuse group. Schachere noted that a majority of the sexually abused only participants reported a relatively less severe history of

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abuse (e.g., fondling on one occasion). Thus, future research is needed to determine if the magnitude or severity of sexual abuse influences adult attachment. Secondly, a majority of the sexually abused respondents indicated experience in therapy. It is possible that the influence of therapy may explain the apparent lack of pathology among the sexually abused participants.

Schachere's study is limited in several respects. Most importantly, his operational definition of sexual abuse appears to be inadequate or unsuitable. Victims exposed to exhibitionism on one occasion were clustered into the same group as victims forced to have intercourse over a period of several years. Including such a broad variety of sexual experiences under the rubric of "sexual abuse" may conceal some distinct results. Future studies should consider more refined definitions of sexual abuse.

In a theoretical article, Alexander (1992) proposed that attachment theory would be a useful framework for studying the antecedents and consequences of sexual abuse. First, she proposed that the occurrence of sexual abuse is frequently preceded by insecure parent-child attachments. Specifically, insecure attachment "precludes impulse control in the abuser, interferes with protectiveness and responsivity of the non-abusive parent(s), or increases the vulnerability of the child to abuse in and outside the home" (p. 189). Secondly, she hypothesized that attachment

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mediates the long-term effects associated with abuse. She suspected that effects such as interpersonal problems, poor affect regulation, and disturbances of "self" are better explained by the attachment relationships surrounding the abuse than from the actual abuse itself.

Subsequently, Alexander (1993) empirically tested the second hypothesis described above, predicting specifically that sexual abuse and family variables "would each have significant but distinct effects on the long-term functioning of incest survivors" (p. 346). Participants, recruited from the community, tended to report severe cases of abuse (i.e. two or more perpetrators, forced intercourse, and/or father-figure perpetrator). Results indicated that a majority (86%) of the abused participants described themselves as insecure, with 58% reporting a Fearful style of attachment, in particular. Regression analyses indicated that post-traumatic stress disorder (PTSD) symptoms such as depression and intrusive thoughts were predicted by abuse characteristics (age of onset, in particular), while personality dysfunction was predicted by adult attachment (fearful attachment, in particular). Thus, Alexander concluded that symptoms associated with PTSD are best predicted by abuse severity, while basic personality structure is best predicted by adult attachment.

The previous study offers compelling information regarding the relationship between a history of sexual abuse

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and adult attachment. Further, it is a strong empirical study with few limitations. The primary weakness is that adult attachment was measured retrospectively and by survey, leaving room for self-report bias and/or error. In addition, the sample was limited to the experience of incestuous abuse (i.e., perpetrator and victim living in same household), and thus, the results may not be generalizable to women experiencing extra-familial abuse.

Stalker and Davies (1994) also explored the relationship between adult attachment organization, current functioning, and childhood sexual abuse in a sample of 40 female psychiatric patients. Consistent with Alexander (1993), a majority (60%) of the women were classified as Fearful or Unresolved in respect to loss/trauma. Furthermore, 88% of the subjects met the criteria for an Axis II personality disorder, with over half of the participants being diagnosed with avoidant/self-defeating personality disorder.

This study offers important information regarding adult attachment within a sexually abused psychiatric population. A particular strength of the study is that attachment was measured using the Adult Attachment Interview (AAI), which has been deemed a more sensitive assessment of attachment styles than self-report measures. Limitations of the study must also be noted. Most importantly, the authors did not use a control group; future researchers need to compare

abused and non-abused psychiatric groups to determine how the groups differ in attachment and if differences are due to abuse or other characteristics. Further, the results of this study cannot be generalized to non-psychiatric populations with confidence. Lastly, the small sample size (n=40), or more specifically the small number of subjects per cell, restricts the study's statistical power.

Mallinckrodt, McCreary and Robertson (1995) examined the relationships among history of sexual abuse, eating disorders, family environment, parent-child attachment, and social competencies. Participants were selected from both university and clinical settings and were initially classified into one of the following three groups: no abuse, childhood sexual abuse (extra-familial abuse only), or incestual abuse. A comparison of these groups indicated eating disorder rates of 17%, 18%, and 39%, respectively. Because women in the childhood sexual abuse (CSA) group showed eating disorder rates almost equal to the non-abused group, the authors excluded the CSA group from further analysis to compare incest survivors and non-abused women only. This analysis revealed that incest survivors reported more dysfunctional family environments, less emotional warmth from parents, and lower social competencies than the non-abused group. Furthermore, the incest survivors who reported the poorest parent-child bonds and the lowest level of social competencies also reported the highest number of

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eating disorder symptoms.

The limitations of this study are limitations inherent in most sexual abuse studies. First, retrospective methods were used to assess history of sexual abuse, family environment and parent-child bonds and thus are suspect due to self-report bias and error. The authors also warn readers against generalizing results, stating the sample is small and selective.

Anderson and Alexander (1996) sought to demonstrate a relationship between fearful attachment patterns and dissociation among a sample of incest survivors. Participants were recruited through a newspaper advertisement and all had been abused by a family member. A semi-structured interview, as well as several paper and pencil surveys were administered to the study participants. Women were categorized into one of the four attachment categories: 51% fearful, 20% preoccupied, 12% dismissing, and 9% secure.

It was predicted that individuals with a fearful attachment style would exhibit more dissociation than participants in the other three categories; the hypothesis was supported. Furthermore, attachment style explained 14% of the variance in dissociation, while the abuse variables (i.e., age of onset, duration, nature of abuse, etc.) did not significantly predict dissociation when entered into the equation alone. The authors concluded that "dissociation

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may be explained by the family context (specifically, the attachment relationship which the child experienced), as well as by specific aspects of the abuse experience" (p. 249).

This study demonstrated a significant relationship between dissociative symptoms and a fearful style of attachment, both of which are characteristic of an abuse survivor. Particular strengths of this study are that a semi-structured interview was conducted, increasing the reliability of responses, and the sample size was adequate (n=92). The results are generalizable to women abused by family members only; thus, study limitations include limited generalizability, as well as the possibility of memory and/or self-report bias.

Brock, Mintz, and Good (1997) reported that to date the research on the effects of childhood sexual abuse has neglected to acknowledge a hidden group of survivors, those who report positive perceptions of their family environment. Brock et al. focused on whether the psychological problems reported by adult survivors are related to the abuse itself or more to the experience of growing up in a dysfunctional family. They examined the differences among four groups: abused women from functional families (N=19), abused women from dysfunctional families (N=20), non-abused women from functional families (N=20), and non-abused women from dysfunctional families (N=21). Participants, 80 female

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university students, were compared on measures of depression, anxiety, interpersonal problems, and overall distress.

The two abuse groups did not differ in terms of abuse or perpetrator characteristics reported. On all four measures the abused-dysfunctional group reported the highest level of psychological distress. Most importantly, no differences were found between abused-functional and non-abused functional groups. Thus, if participants perceived that their families were functional, the experience of sexual abuse did not make a difference with regards to symptomatology.

The authors concluded that "having a functional family, or at least the perception that one's family environment is functional, serves as a protective factor with respect to psychological symptomatology, even if one is sexually abused" (p. 430). Limitations of the study were offered by the authors. Most importantly, childhood physical abuse and adulthood sexual trauma (i.e., rape) were not assessed, which might have confounded the results. In addition, the questionnaires were not administered in a counterbalanced order and the sample size was considered to be small.

Most recently, Schreiber and Lyddon (1998) applied attachment theory to the study of childhood sexual abuse and conducted a study very similar to the current investigation. They examined the parental bonds and psychological

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functioning among a group of childhood sexual abuse survivors. Specifically, the authors hypothesized that survivors of sexual abuse reporting optimal bonding with parents in childhood (i.e., high parental care and low parental overprotection scores on the Parental Bonding Instrument) would exhibit significantly better psychological functioning in adulthood than those reporting weaker bonds with parents.

Results indicated that high paternal care was significantly associated with better functioning. In other words, women who perceived their fathers to be more caring indicated less psychological disturbance in adulthood, as compared to women reporting low father care. Surprisingly, no significant effects were found for maternal care, maternal overprotection, or paternal overprotection. Optimal bonding with mother, therefore, was not related to better psychological functioning.

Limitations of Schreiber and Lyddon's study (1998) were mentioned by the authors. First, cause and effect conclusions cannot be inferred from the data because all variables were assessed at the same time. In addition, the external validity of the study was limited given that all participants were female undergraduate students and thus not representative of the larger survivor population.

Finally, in the last three years several doctoral students have applied attachment theory to the study of

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sexual abuse as a dissertation focus. A brief description of the most relevant studies will be outlined here. Fossel (1997) investigated attachment style as a potential moderator of the relationship between abuse severity and adjustment among a large sample of female undergraduate students. Both severity of abuse and attachment were found to be consistent predictors of adjustment. Specifically, women with a more severe history of childhood sexual abuse and/or women who endorsed a more insecure attachment orientation (i.e., fearful, in particular) also demonstrated poorer adjustment and more symptomatology in adulthood.

MacNab (1996) examined key relationships between variables associated with childhood incest and adult psychosocial functioning. Incest survivors were compared to a group of women without a history of sexual abuse on the following variables: childhood experiences, adult attachment patterns, adult interpersonal problems, and adult psychological symptoms. The incest group reported more physical and emotional abuse in childhood, less healthy attachment bonds with mother, less comfort with emotional intimacy in adulthood, decreased ability to trust others in adulthood, and more psychological symptoms in adulthood, as compared to the no incest group.

Finally, using qualitative methods, Kane (1997) explored the "working models" or representations of self and other of 12 women with a history of childhood sexual abuse.

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During an interview, participants were asked to describe their childhood relationships with adults, past and present romantic relationships, and past and present views of self. A majority of the participants reported having had problems with trust, respecting others, intimacy difficulties, insecurity, and poor self-esteem in adulthood. With regards to internal working models, Kane reported that many participants were "ambivalent" (not positive or negative) when discussing their views of self and other, making it difficult to assign them to one of four attachment styles. The author concluded that although attachment theory served as a useful framework to understand the participants' interpersonal relationships, the four category model of attachment (Bartholomew and Horowitz, 1991) proved to be inadequate, unable to capture the attachment history and experience of the participants in her study.

The most recently published studies (1997-present), as well as the dissertation papers, were only available for review after the current study had been conducted. Therefore, this researcher was not privy to these results before forming and testing the following hypotheses. However, reviewing these recent relevant studies provides an opportunity to compare findings and draw comprehensive conclusions.

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THE PROBLEM STATEMENT

The present study sought to explore the parent-child bonds and adult attachment patterns of women with a history of childhood sexual abuse. The three following groups were analyzed: 1) women abused by a primary caregiver(s), 2) women abused by other family members, and 3) women abused by non-family perpetrators. These groups of survivors were compared on measures of abuse severity, symptomatology, early parent-child bonds, and adult attachment orientations.

Past studies have shown that victims of incest are often abused more frequently, for a longer duration, or to a greater degree than victims abused by non-relatives. Therefore, it was hypothesized that the three groups of survivors' would report differences in the severity of their abuse histories. Specifically, women abused by a primary caregiver were expected to report the most severe history of abuse (i.e., more cases of intercourse, higher frequency, more incidents, longer duration, etc.) followed by women abused by other and non-familial perpetrators, respectively. If confirmed, a severity index was to be created in order to control for severity of abuse in subsequent analyses.

Researchers have argued that abuse perpetrated by a close or trusted adult often results in a more devastating outcome than abuse perpetrated by an unknown or less trusted individual. In the present study, therefore, it was

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hypothesized that women abused by a primary caregiver would exhibit lower levels of psychological adjustment as compared to their peers in the other abuse groups. Specifically, controlling for abuse severity, women abused by a primary caregiver were expected to exhibit more symptomatology at the time of assessment, followed by women abused by other and non-familial perpetrators, respectively. Furthermore, it was expected that, controlling for abuse severity, survivors of parental sexual abuse would report more difficulties with attachment in adulthood and more overall insecurity than their counterparts in the other abuse groups.

The present study was also designed to explore the early parent-child emotional bonds reported by a group of childhood sexual abuse survivors. Studies have shown that victim families in general are commonly described as dysfunctional; however, there is still a trend for incestual families to be rated as slightly more dysfunctional than families of victims of extra-familial sexual abuse. In the present study, it was expected that women abused by a primary caregiver would report the weakest early emotional bonds with caregivers, followed by women abused by other and non-familial perpetrators, respectively. Survivors of non-familial abuse were expected to report the strongest/healthiest bonds with parental caregivers.

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bond with a caregiver might buffer or protect a victim from some of the long-lasting harm associated with abuse. Specifically, it was predicted that parent-child emotional bonds would moderate the relationship between a history of childhood sexual abuse and survivors' current psychological adjustment. Furthermore, prior research has shown that adult attachment orientations often predict outcome measures better than early emotional bonds. Thus, it was also hypothesized that adult attachment orientations would mediate the relationship between early parent-child emotional bonds and current psychological adjustment reported by survivors.

METHOD

The methodological procedures associated with this study will be outlined in the following section. First, the operational definition of childhood sexual abuse will be discussed. Next, a detailed description of the research participants surveyed, the data collection procedures followed, and the questionnaires/instruments employed will be offered. Finally, a description of the statistical analyses conducted will be summarized.

Definition of Childhood Sexual Abuse (CSA)

In the present study, childhood sexual abuse was operationally defined to include the following: (1) a victim younger than 15 years of age, (2) experiencing any unwanted sexual contact (i.e., kissing to forced intercourse), (3) of any magnitude, duration, or frequency (i.e., one time occurrence to abiding abuse), (4) by any perpetrator (i.e., family member to stranger) who was at least five years older than the victim at the time of abuse. Following Briere and Runtz (1988), this definition excludes aversive experiences occurring between same-age peers, victimization during later adolescence, and non-contact events (i.e., exhibitionism).

Childhood Sexual Abuse (CSA) Groups

Given that many participants were abused by multiple perpetrators, the following system was used to categorize individuals. If a participant indicated abuse by any

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parental figure (i.e., mother, father, step-parent) she was placed into the "parental abuse" group, regardless of her relationship to any other perpetrator(s). Participants who indicated abuse by a sibling or extended family member (i.e., uncle, grandfather, or cousin), but denied abuse by a parental figure, were placed into the "other-familial abuse" group. And finally, those women who indicated abuse outside of the family only, denying any experience of familial sexual abuse, were assigned to the "non-familial abuse" group.

Participants

A total of 80 female adults with a history of childhood sexual abuse volunteered to participate in the study. Thirty-eight percent (N=31) of the participants were abused by a primary caregiver or parental figure (71% abused by father; 19% by step-father; 10% by mother); 34% (N=27) were abused by another family member; 28% (N=22) were abused by a non-family member. Participants were recruited from four different sources: therapists, newspaper advertisements, undergraduate courses, and an email listserve advertisement.

The age of participants ranged from 19 to 76 years old (M=34, SD=13). The racial-ethnic breakdown of the sample was 83% Euro-American/Caucasian, 9% African-American/Black, 1% Asian-American, 3% Latina/Hispanic/Chicana, and 4% Multi-racial. Twenty-nine percent of the participants were married, 5% living with a partner, 18% divorced or

separated, 48% never married, and 1% widowed. Of those not married or living with a partner, 53% were not dating and 47% were either dating or in a committed relationship.

Procedures

The recruitment and data collection procedures were managed in the following way. Approximately 70 therapists were contacted by letter to request assistance in recruiting research participants. Interested therapists were then asked to contact this researcher to discuss procedures for selecting clients and to make arrangements for obtaining survey packets; questions and concerns were addressed during this conversation as well. Most importantly, therapists were instructed to use their ethical and clinical judgment when selecting and approaching potential participants.

Qualified clients were given the option of participating "in an anonymous and voluntary study regarding sexual abuse, relationships, and current adjustment". Interested clients were given a survey packet. To minimize the risk that clients would feel pressured to participate and to preserve their option to simply discard the packet if desired, therapists were specifically instructed not to follow up with clients or to inquire about completion of the packet.

Many of the therapists who agreed to participate in the study were interested in receiving information regarding the final results of the study. Therefore, a letter of

appreciation was mailed to all participating therapists at the completion of the study. This letter included a discussion of the major results with a specific focus on the application of findings to a client population.

Second, the investigator obtained permission to recruit qualified volunteers from several undergraduate classes. A brief overview of the study was provided to all students, along with a flyer including the researcher's name, phone number, and e-mail address. Women interested in participation were given the choice of obtaining a survey packet anonymously at the university library reference desk or by mail.

Third, several advertisements were posted in local city and student/campus newspapers (See Appendix A), as well as on an email list serve for women in the field of psychology (entitled POWER), to request the participation of qualifying women. Volunteers were instructed to contact the researcher by phone or email to obtain a survey packet.

All survey packets included an informed consent and five survey instruments (see Appendix B). Given the potential for participants to feel some discomfort while completing the survey packet, a listing of phone numbers for several local mental health agencies, therapists, and 24-hour crisis hotlines was also included in the packet (see Appendix C). All participants were instructed to return completed packets to the researcher by mail in a self-

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Twenty one percent of the sample was recruited by their own therapist, 16% were enrolled in undergraduate courses in counseling, nursing, or women's studies at either a midwestern or southwestern university, 51% responded to a newspaper advertisement in either a college campus or local city newspaper, and 11% responded via email to a message sent out to female POWER listserve subscribers.

Instruments

Demographic and History of Sexual Abuse Questionnaire

This brief questionnaire was designed to gather background information on the participants' age, ethnic/racial membership, marital or partnership status, present or past experience in psychotherapy, current stress level, and history of childhood sexual abuse. Rather than using an existing instrument to measure childhood sexual abuse, past researchers have more often asked participants to answer specific questions regarding their history of abuse. Subsequently, the sexual abuse characteristics measured in this study were chosen to match the variables measured in relevant prior studies. Items regarding the number of perpetrators, the relationship(s) between victim and perpetrator(s), the nature of abuse, the duration and frequency of abuse, the victim's age at the onset and conclusion of abuse, the use of harm/coercive tactics, and the disclosure of abuse were included.

At this time, there is no psychometric information available on the sexual abuse questionnaire (as is true for other instruments measuring sexual abuse).

Parental Bonding Instrument (PBI)

This 50-item questionnaire was designed to measure the quality of childhood bonds with parents based on participants' memories of the first 16 years of life (Parker, Tupling, & Brown, 1979). Statements describing parental behavior are presented and participants are asked to rate how much each statement describes each parent on a four point Likert scale (1=very like, 4=very unlike). Two dimensions of parental behavior are assessed, Care and Overprotection. The Care scale contrasts warm, responsive care with indifferent, unresponsive care. The Overprotection scale contrasts a controlling and intrusive parenting style with parental behavior that encourages autonomy and independence. Separate ratings for each parental relationship are made, yielding four subscale scores: mother care, father care, mother overprotection and father overprotection. Higher scores on the Care scale indicate greater levels of parental care and warmth, while higher scores on the Overprotection scale indicate greater parental intrusiveness and control.

"Studies investigating the psychometric properties of the PBI have found support for its validity as a measure of both perceived and actual parenting over time" (Parker et

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al., 1992, p. 883). Factor analyses support the two-factor model. The Care and Overprotection scales have yielded test-retest reliabilities of .76 and .63 and split half reliabilities of .88 and .79, respectively (Parker, et al., 1979). Additionally, this measure has shown adequate concurrent validity; PBI scores have been highly to moderately correlated with mothers' and independent judges' ratings of parental behaviors and parent-child bonds (Parker, 1981; Parker, et al., 1979). In the current study, the Cronbach alphas for Care and Overprotection Scales were .92 and .77, respectively.

Relationship Questionnaire

This self-classification measure of adult attachment is based on the four category model of adult attachment styles proposed by Bartholomew and Horowitz (1991). Participants are asked to choose one of four descriptive paragraphs that best describes their level of comfort with closeness or intimacy in romantic relationships. The four paragraphs represent secure, preoccupied, dismissive and fearful attachment styles.

Bartholomew and Horowitz (1991) found the four attachment styles to correlate in theoretically consistent ways with self and other reports of respondents' self-esteem and sociability ratings. Scharfe and Bartholomew (1994) found this measure to demonstrate moderate stability over an eight month time period. And finally, Griffin and

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Bartholomew (1994) found evidence to support the validity of the self- and other models which underlie the four-group classification system.

In the current study, participants endorsed the following attachment styles, 11% secure, 19% dismissive, 14% preoccupied, and 56% fearful. The fact that a majority of these survivors endorsed a fearful style of attachment is consistent with past research on this population.

Adult Attachment Indexes

This 13-item self-report form measures adult attachment on two factor-analytically-derived subscales (Simpson, 1990). Participants rate statements regarding romantic relationships on a seven point Likert scale ranging from "strongly disagree" (1) to "strongly agree" (7). The avoidance/security subscale assesses the individual's level of comfort with interpersonal closeness and dependence (i.e., "I'm somewhat uncomfortable being too close to others."). Higher subscale scores indicate greater avoidance. The Cronbach alpha for this subscale has been reported at .81 (Simpson et al., 1992), .77 (Lopez, 1996) and .80 (Lopez et al., 1997).

The anxiety subscale measures the level of tension an individual experiences in romantic relationships (i.e., "I rarely worry about being abandoned by others"). Higher scores indicate higher levels of anxiety. The Cronbach alpha on the anxiety index has been reported at .58 (Simpson

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et al., 1992), .74 (Lopez, 1996), and .71 (Lopez et al., 1997). The Cronbach alphas in the present study were .81 and .79 for the avoidance/security and anxiety indices, respectively.

Brief Symptom Inventory (BSI)

This 53-item questionnaire was designed to measure the psychological symptoms of either psychiatric patients or normal, non-clinical individuals (Derogatis, 1975). It constitutes a short form of the Symptom Distress Checklist (SCL-90; Derogatis) and is an adequate substitute. The inventory assesses the following nine symptom patterns: hostility, anxiety, somatization, depression, obsessive-compulsive, interpersonal sensitivity, paranoid ideation, psychoticism, and phobic anxiety. In addition, the instrument provides information regarding a participant's overall level of functioning or symptomatology. This index, entitled the Global Severity Index, is the overall mean score. Higher scores suggest more disturbances in functioning or more symptomatology.

Respondents are asked to rate their level of distress on a five-point Likert scale (0=not at all; 4=extremely distressed) in regards to the 53 listed symptoms (e.g. "thoughts of ending your life," "trouble falling asleep"). The BSI is a reliable and valid measure. Derogatis and Melisaratos (1983) reported a test-retest coefficient of .90 for the Global Severity Index and test-retest reliability

ranging from .68 to .91 across the nine subscales. Convergent validity has also been established by showing high correlations between BSI subscales and like dimensions of the MMPI. Finally, Cronbach alphas for the nine dimensions of the BSI were found to range from .71 (psychoticism) to .83 (depression) (Derogatis & Melisaratos, 1983). In the current study, the Cronbach alpha for the Global Severity Index was .96, indicating excellent internal consistency.

Hypotheses

It was hypothesized that the three groups of survivors would report differences with regard to the level of abuse severity they experienced. Specifically, women abused by a primary caregiver (Group 1) were expected to report the most severe history of abuse (i.e., more perpetrators, longer duration, more incidents, earlier onset and later conclusion of abuse, etc.), followed by women abused by other family members (Group 2) and non-family perpetrators (Group 3), respectively.

Secondly, it was hypothesized that, controlling for abuse severity, women abused by primary caregivers would indicate receiving the least amount of care from parents, followed by women in Groups 2 and 3, respectively. Additionally, it was hypothesized that women abused by a primary caregiver would exhibit more current symptomatology and report more insecure attachment orientations in

adulthood, as compared to their counterparts. More specifically, Group 1 women were expected to report higher levels of avoidance and anxiety in their adult relationships, as compared to women in Groups 2 and 3.

It was also proposed that parent-child emotional bonds would moderate the relationship between abuse severity and current adjustment, with those participants recollecting more favorable early bonds demonstrating higher current adjustment levels. Finally, given that prior research has shown that adult attachment orientations often predict outcome measures better than early bonds, it was hypothesized that adult attachment orientations would significantly and uniquely predict symptomatology and would mediate observed relationships between early bonds and survivors' current adjustment scores.

Analyses

First, descriptive statistics were calculated for the entire sample. Frequencies for all variables related to demographics and childhood sexual abuse were calculated. In addition, a correlational matrix was computed in order to examine the relationships between abuse variables and symptomatology.

Second, a comparative analysis was conducted to determine if the three groups of survivors differed on demographic and sexual abuse variables. Several chi-squared and ANOVA tests were completed. It was decided that if the

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groups differed significantly on a majority of the abuse characteristics a "severity index" would be created. To create this index, a factor analysis was conducted, a factor accounting for a majority of the variance was identified, and factor scores were calculated for each participant. Subsequently, severity of abuse was controlled in the remaining analyses.

A between groups comparison was then conducted to determine if the three groups exhibited different levels of symptomatology. An ANCOVA was run; severity of abuse was controlled, group membership served as the independent variable and BSI scores as the dependent variable. It was expected that participants abused by a primary caregiver would exhibit higher scores on the BSI than their counterparts.

A series of tests was then conducted to determine if the three groups differed in their responses to attachment related measures. First, a MANCOVA was run to determine if the three groups reported significantly different emotional bonds (care, overprotection) with parents; severity of abuse was controlled, group membership was the independent variable and mother care, father care, mother overprotection and father overprotection served as the dependent variables. It was expected that women abused by a parental figure would report less warmth/care from caregivers, followed by those abused by another family member and by non-family,

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respectively. Between group differences on the overprotection scales were not predicted.

Following these analyses, another MANCOVA was conducted to determine if the three groups differed in their responses on the two adult attachment orientations subscales, controlling for the severity of abuse. It was expected that women abused by a primary caregiver would display lower security and higher anxiety scores, followed by survivors of other familial abuse and non-familial abuse, respectively.

Next, a chi-squared analysis was conducted to compare the number of participants endorsing a secure, dismissive, preoccupied, or fearful style of attachment between groups. Although a majority of women in all three groups were expected to report a fearful style of attachment, it was predicted that survivors of non-familial abuse would endorse a secure style of attachment more frequently than women abused by either primary caregivers or other family members.

Finally, two regression models were tested to determine if early parental bonds moderated the relationship between abuse severity and adjustment in adulthood. Prior to their entry in the model, predictors were transformed into standardized scores. Severity of abuse, parental care scores, and an interaction of the two were then sequentially entered into the regression model to predict symptomatology. It was expected that, controlling for severity, parental care would best predict BSI scores.

Furthermore, to determine if adult attachment orientations mediated the relationship between early emotional bonds and current symptomatology, another series of regression equations was conducted. Initially, mother and father care scores were entered as a block into a regression predicting BSI scores, controlling for severity. Secondly, separate regressions were conducted to determine if parental care predicted adult attachment avoidance and anxiety scores, again controlling for severity of abuse. And lastly, early parental care and adult attachment avoidance/anxiety scores were entered into a final regression equation to predict BSI scores, controlling for severity. It was expected that early parental care would have no effect on symptomatology (BSI scores) when adult attachment scores were controlled.

RESULTS

In the following section a detailed description of the data analyses conducted and subsequent findings will be presented. Specifically, sample descriptives are offered, followed by a correlational matrix of selected demographic variables and the key measures under investigation, and a comparative analysis of the three groups of survivors. Finally, the key hypotheses are addressed by presenting the findings associated with several regression models.

Preliminary Analyses

Sample Descriptives: Demographic and Abuse Variables

Living Arrangements. Participants were asked whom they lived with while growing up; 71% lived with both parents, 13% with mother only, 15% with a parent and step-parent, and 1% of the sample was raised by an extended family member. Fifty-five percent of the sample lived with their abuser at the time of abuse; this obviously differed between groups with incest survivors living with an abuser more often than others.

Number of Perpetrators. Overall, this sample indicated a severe history of abuse with 38% of the sample reporting abuse by multiple perpetrators. Number of perpetrators ranged from one to five ($M = 1.6$).

Nature of Abuse. Information on five types of sexual contact was gathered: intercourse, oral contact with

genitals, fondling over clothes, fondling under clothes, and kissing. Respondents were asked to mark all types of contact endured. Forty-three (43%) percent of participants reported abuse that included intercourse, 43% indicated oral contact with genitals, 80% reported stimulation/fondling of genitals under clothes, 64% noted fondling over clothes, and 45% reported kissing.

In addition, participants were assigned an overall "contact score" by coding type of contact (intercourse=5, oral contact=4, fondling under clothes=3, fondling over clothes=2, and kissing=1) and summing items for a total score (range 1-15). This variable was created in order to compare groups on type of contact endured, as well as to include this abuse characteristic in the overall severity index. It should be noted, however, that there is no prior research to support categorizing sexual contact hierarchically; thus, this variable should be interpreted with caution.

Age at Onset and Conclusion of Abuse. Participants were asked to indicate their age both at the time the abuse started and ceased. The age of onset for victims ranged from 1 to 14 years old ($M = 5.88$, $SD = 3.13$) and the age when abuse concluded ranged from 5 to 22 ($M = 11.96$, $SD = 3.98$).

Duration and Frequency of Abuse. The average duration of abuse was 6.1 years ($SD = 5.1$) with considerable

variation among participants. In addition, the average estimated number of incidents reported was 50 ($SD = 69.7$), with similar variation.

Harm/Threat. Of all survivors, 53% indicated that they were threatened, harmed or coerced by their perpetrator(s).

Other Types of Abuse. In terms of other types of abuse, 39% of the sample indicated a history of physical abuse, 33% felt neglected during childhood, and 78% reported emotional abuse.

Perceived Severity of Abuse. All participants were asked to rate the severity of their abuse on a scale from one (not too severe) to five (very severe) in order to gain an understanding of each participant's perception of severity. The average rating for all participants was 3.5 indicating moderate severity ($SD = 1.2$).

Disclosure of Abuse. Forty-four percent (44%) of the sample disclosed the abuse to an adult figure; a majority of the victims told their mother, followed by father and/or a trusted adult figure (i.e., teacher, family friend). These survivors received a range of reactions, from very supportive/protective (18%) to somewhat supportive (27%) to unsupportive/rejecting (22%) to very unsupportive/blamed/abandoned (32%).

Experience with Therapy. A majority of the sample (81%) indicated that they had received or were receiving professional counseling or therapy, with an overall average

of 145 sessions attended ($SD = 194$) and a range from six to 1000 sessions.

Correlational Analysis

Table 1 presents a correlation matrix, showing the relationships between relevant abuse variables, PBI Care and Overprotection scores, Adult Attachment avoidance and anxiety scores, and BSI/symptomatology scores. As expected a majority of the abuse characteristics were strongly correlated with one another. Nature of abuse (i.e., contact scores) was correlated with all other abuse variables. Age of onset and age of conclusion were significantly correlated with number of incidents reported and duration of abuse, as well. Finally, participants' perception of severity was significantly correlated with all abuse characteristics except age of onset.

Symptomatology or BSI scores were correlated with some abuse variables. Specifically, BSI scores were significantly correlated with duration of abuse and participants' perceptions of abuse severity. In short, the longer the abuse lasted and the more severe participants rated their abuse history, the higher the BSI scores or more symptomatology reported.

Similar to past studies, parental care scores were negatively correlated with adult attachment avoidance and anxiety scores, while overprotection scores were positively related to these adult attachment indexes. Overall, higher

Table 1

Intercorrelations of abuse severity characteristics, PBI care and overprotection scales, Simpson adult attachment scales, and total BSI scores

1. Age Start	2. Age Stop	3. No. of incident	4. Duration	5. Perc'd Severity	6. Mother Care	7. Father Care	8. Mother Prot	9. Father Prot	10. Avoid.	11. Anxiety	12. BSI Total
1. 1.00	.05	-.27*	-.58**	-.21	.28*	.09	.08	-.24*	-.10	.03	-.16
2.	1.00	.36**	.75**	.25*	.08	-.10	-.07	.08	.09	.02	.21
3.		1.00	.46**	.23*	-.24*	-.10	-.02	.09	.21	.11	-.16
4.			1.00	.34**	-.12	-.18	-.06	.21	.12	-.03	.26*
5.				1.00	-.23*	-.01	.07	.08	.14	.13	.25*
6.					1.00	.25*	-.38**	-.17	-.25*	-.09	-.29*
7.						1.00	-.23	-.43**	-.38**	-.23	-.20
8.							1.00	.14	.06	.25*	.27*
9.								1.00	.23*	.14	.24*
10									1.00	.29**	.44**
11										1.00	.42**
12											1.00

Note: ** $p < .01$; * $p < .05$

care scores were related to lower avoidance, lower anxiety, and lower BSI scores; in contrast, higher overprotection scores were related to more attachment avoidance and anxiety and more symptomatology (higher BSI scores).

CSA Groups: Preliminary Comparative Analysis

To determine if and how the three groups differed on the measured variables, a series of Chi-squared and ANOVA analyses were conducted.

Demographic Variables. The three groups of survivors did not differ significantly on the following demographic variables: age, race, marital and dating status, or source of referral (i.e., therapist, newspaper ad, classroom, listserve). Groups did differ significantly, however, on childhood living arrangements, $X^2 (10, N = 80) = 22.06, p < .015$. A majority of women in all three groups indicated living with both parents; however, women abused by a primary caregiver were more likely to report living with mother and step-father and women abused by an other/extended family member were more likely to indicate living with mother only during childhood, as compared to the other groups.

Number of Perpetrators. Consistent with prior research there was a significant difference between groups on the number of perpetrators reported, $X^2 (2, N = 80) = 22.16, p < .001$; 68% ($N = 21$) of the women included in the parental-abuse group reported multiple perpetrators as compared to 33% ($N = 9$) in the other familial and 4% ($N = 1$) in the non-

familial abuse groups.

Nature of Abuse. The three groups did not differ significantly in reported cases of intercourse or fondling over or under clothes; however, experiences of oral contact, $X^2 (2, N = 80) = 7.8, p < .02$, and kissing, $X^2 (2, N = 80) = 6.33, p < .04$, differed significantly between groups. Fewer women abused by a parental figure reported oral contact as compared to their counterparts. Furthermore, women in the other-familial abuse group reported kissing more frequently than other group members. It was expected that those abused by a primary caregiver would report a more severe history of abuse, which would specifically include more cases of intercourse; this was not supported.

It does appear, however, that the three groups differed significantly in overall contact scores, $F(2, 77) = 6.946, p < .002$ with those abused by primary caregivers (Group 1) reporting the highest score, followed by women abused by non-family (Group 2) and other family (Group 3), respectively. Results of Scheffe's post-hoc group comparison indicates significant differences between Group 1 and Groups 2 and 3 (See Table 2).

As mentioned, this variable should be interpreted with caution as some would argue that sexual contact should not be rank ordered hierarchically; however, with this precaution in mind, the above results are in line with the expectation that women abused by a parental figure endured a

Table 2

Means, standard deviations, and ANOVA (F-test) analyses for abuse characteristics among three groups of survivors

	Group 1 (n=31)		Group 2 (n=27)		Group 3 (n=22)		F (2, 77)	Scheffe's Tests
	M	SD	M	SD	M	SD		
Onset Age (years)	4.80	3.57	5.50	2.09	7.70	2.83	6.56**	1 & 2 < 3
Termination Age (years)	14.34	3.35	10.63	3.95	10.25	3.26	11.48**	1 > 2 & 3
Contact Score	10.19	4.21	6.63	3.62	7.23	3.74	6.95**	1 > 2 & 3
Duration (Years)	9.67	5.25	4.80	3.60	2.50	2.33	20.99**	1 > 2 & 3
Number of Incidents	82.30	94.50	29.30	37.80	28.90	33.10	6.06**	1 > 2 & 3
Perceived Severity	4.00	1.06	3.15	1.30	3.27	1.08	4.62**	1 > 2

Note: Significant differences were found between three groups on each variable.

**p<.01

history marked by more intrusive sexual contact than the other survivors.

Age of Onset/Conclusion. There were significant differences between groups in terms of age of onset, $F(2, 77) = 6.56, p < .002$. Scheffe's post-hoc test indicated that those abused by parents and other family members were significantly younger than those abused by non-family perpetrators (See Table 2). Additionally, the groups differed significantly in age of conclusion, $F(2, 77) = 11.48, p < .001$. Scheffe's multiple group comparison demonstrated that women abused by a parental figure were considerably older when the abuse stopped as compared to Groups 2 and 3 (See Table 2).

Duration/Frequency. As can be inferred from the above information, the three groups differed significantly in terms of duration of abuse, $F(2, 77) = 20.99, p < .001$. Scheffe's post-hoc test indicated significant differences between Group 1 and Groups 2 and 3; individuals victimized by a parent were abused for a longer period of time as compared to those abused by other family and non-family (See Table 2). Additionally, there were significant differences between the three groups in terms of number of incidents reported, $F(2, 77) = 6.058, p < .004$. Again, Scheffe's group comparison demonstrated significant differences between Group 1 and Groups 2 and 3; women abused by a parental figure indicated experiencing a higher number of

abusive incidents as compared to those abused by other family or non-family perpetrators (See Table 2). It should be noted that participants may have had a difficult time remembering or estimating the exact number of incidents endured, thus this variable should be interpreted with caution.

Harm. The three groups did not differ significantly in their reports of experiencing harm, threat, or coercion by the perpetrator(s).

Other Types of Abuse. Although groups did not differ in their reports of parental neglect, the three groups differed significantly with regards to reports of physical abuse $X^2 (2, N = 80) = 13.07, p < .001$ and emotional abuse $X^2 (2, N = 80) = 9.19, p < .01$. Survivors abused by primary caregivers and other family members reported physical and emotional abuse more frequently than did those abused by non-family members (See Table 3).

Perceived Severity. As mentioned, participants were asked to rate the severity of their experience on a scale from one to five. The three groups differed significantly in their perceptions of severity, $F(2, 77) = 4.62, p < .01$. Scheffe's test indicated significant differences between Group 1 and Group 2 participants; women abused by parental figures rated their overall experience as more severe than those abused by other family members (See Table 2).

Table 3

Between group frequencies in reporting childhood physical abuse, emotional abuse, and/or neglect

Group	Physical Abuse	Emotional Abuse	Neglect
Group 1 (N=31)			
n	18	27	14
%	(58%)	(87%)	(45%)
Group 2 (N=27)			
n	11	23	8
%	(41%)	(85%)	(30%)
Group 3 (N=22)			
n	2	12	4
%	(9%)	(55%)	(18%)

Disclosure. The groups did not differ with regard to making a disclosure, however, the reactions received following a disclosure were significantly different between groups, $F(2, 34) = 3.79, p < .03$. Scheffe's post-hoc test indicated significant differences between Group 1 and Group 3. Consistent with prior research, individuals abused by a parental figure reported receiving the least supportive reaction whereas women abused by non-family received the most supportive response.

Therapy/Sessions. The three groups differed significantly with regard to seeking out therapy, $X^2 (2, N = 80) = 8.28, p < .02$. Women abused by a primary caregiver (97%) were more likely to indicate experience with counseling/therapy as compared to their peers abused by other family (74%) and non-family perpetrators (68%), respectively. Differences between groups on the number of counseling sessions attended approached but did not reach statistical significance, $F(2, 60) = 2.985, p < .058$, indicating a trend for women abused by a primary caregiver to report more therapy experience as compared to the other two abuse groups (See Table 4). Standard deviations associated with this variable did not appear to be equal across groups, possibly hindering our ability to detect between group differences on sessions attended.

Construction of a Composite Severity Index

As expected, the three groups differed significantly

Table 4

Between group frequencies in reporting therapy experience and means and standard deviations of number of sessions attended

Group	Experience in Therapy		Number of Sessions Attended	
	n	%	M	SD
Group 1	30	97%	210	255
Group 2	20	74%	98	124
Group 3	15	68%	87	74

with regard to severity measures (See Table 2). Women abused by a primary caregiver reported a higher number of perpetrators, an earlier age of abuse onset and later age of conclusion, a longer duration of abuse, a higher number of incidents, a higher score on types of sexual contact, a higher self-rating of severity, more blaming and unsupportive reactions to a disclosure, and more cases of physical and emotional abuse, as compared to the other two groups. As expected, it appears that women abused by a parental figure endured the most severe history of abuse followed by women abused by other family members and by non-family perpetrators, respectively.

In order to more sensitively test the remaining hypotheses it was deemed desirable to control for these between group differences with regard to abuse severity; therefore, a "composite severity index" was created. A principal components factor analysis was conducted to determine whether one or more factors explained significant variation among these demographic items. Five severity variables were entered into the analysis: age of onset, duration, number of incidents, contact scores, and perceived severity. The results indicated that all variables loaded significantly onto one factor and this factor accounted for 51% of the total variance (See Table 5).

According to Stevens (1996), the critical value for testing the significance of a loading for a sample of 80 is

Table 5

Factor analysis of demographic variables assessing abuse severity

Descriptive Statistics for all groups

	Age Start (years)	# of Incidents	Duration (years)	Contact Score (1-16)	Perceived Severity (1-5)
M	5.90	49.84	6.17	8.30	3.49
SD	3.17	69.66	5.13	4.14	1.21

Variable **Component Matrix (Weights)**

Age Start	-.668
# Incidents	.774
Duration	.832
Contact Score	.646
Perceived Severity	.635

.572. All five variables loaded strongly onto Factor 1 (range: Age of onset = .832 to Perceived Severity = .635). Furthermore, item loadings indicated that this factor was characterized by an earlier onset, more incidents or a higher frequency of abuse, a longer duration, higher contact scores, and higher perceived severity ratings. As a result, factor-derived weights were assigned to each variable and a factor score representing a composite severity score for each participant was created.

Composite severity scores were significantly different between groups, $F(2, 74) = 16.99, p < .001$. Scheffe's post-hoc test indicated significant differences between Group 1 participants and participants in Groups 2 and 3; in other words, women abused by primary caregivers demonstrated significantly higher severity scores ($M = .69, SD = 1.06$), than either women abused by other family ($M = -.32, SD = .66$) or non-family perpetrators ($M = -.59, SD = 1.00$). Based on these findings, severity scores were used as a covariate in the following analyses.

Analysis of CSA Groups and Psychological Adjustment

It was hypothesized that the three groups would differ in levels of symptomatology reported; specifically, survivors of parental abuse were predicted to report the highest BSI scores, followed by women abused by other family and non-family members, respectively. An ANCOVA was conducted with group membership serving as the independent

variable, composite severity scores as the covariate, and BSI scores as the dependent measure.

Holding abuse severity constant, an ANCOVA showed no significant differences between groups on the BSI, $F(2, 72) = .637, p < .53$; therefore, the above hypothesis was not supported.

Analysis of CSA Groups and Attachment Measures

A series of tests was run to compare the three groups on their responses to the attachment-related measures. It was expected that the three groups would differ in their reports of early bonds with primary caregivers. Women abused by a primary caregiver were expected to report the weakest bonds with caregivers followed by women abused by other family and non-family perpetrators, respectively. More specifically, it was hypothesized that women in the parental abuse group would report lower Care scores than the other two groups; no differences in Overprotection scores were predicted.

In addition, adult attachment orientations were expected to differ between groups. It was expected that survivors of parental abuse would display the highest levels of attachment-related avoidance and anxiety scores, followed by survivors of other-familial and non-familial sexual abuse, respectively. Additionally, it was expected that a majority of the participants overall would report a fearful style of attachment; however, fewer survivors abused by

primary care-givers and/or other family members were expected to report a secure style of attachment as compared to participants abused by non-family perpetrators.

Family Bonds

A MANCOVA was conducted to determine if the groups reported differences in their emotional bonds with caregivers. Group membership was the predictor variable, the four scales on the Parental Bonding Inventory (PBI) were the dependent measures (mother care, father care, mother overprotection, father overprotection), and composite severity scores served as the covariate. Due to missing data, only 71 participants were included in this analysis; it appears that several participants had no relationship with a father figure and were unable to complete this portion of the PBI.

As predicted, the MANCOVA produced a significant multivariate effect, Wilks' $F(8, 128) = 2.56, p < .013$. Univariate tests indicated that the three groups differed significantly on parental care scores: mother care, $F(2, 67) = 3.51, p < .035$, and father care, $F(2, 67) = 5.97, p = < .004$. Results of Scheffe's post-hoc test indicated participants in Groups 1 and 2 scored significantly lower than Group 3 participants on mother care; in other words, women abused by a parent or other family member reported receiving less maternal warmth and care than women abused by non-family members. On father care, Scheffe's test

demonstrated significant differences between Group 1 and Group 3 only; women abused by a parental figure indicated receiving less paternal warmth and care than women abused by other familial and/or non-family perpetrators (See Table 6).

As expected, no differences between groups were noted on Overprotection scores: mother overprotection, $F(2, 67) = .01$, $p < .99$, and father overprotection, $F(2, 67) = 1.16$, $p < .32$ (See Table 6).

Adult Attachment Orientations

To compare the three groups of survivors with regard to their adult attachment orientations, another MANCOVA was run (See Table 6). Group membership was the predictor variable, composite severity scores were held constant, and each attachment score on the Adult Attachment Survey (i.e., avoidance and anxiety) served as a dependent measure.

Results of the second MANCOVA indicate another significant multivariate effect, Wilks' $F(4, 142) = 2.42$, $p < .05$. A univariate test indicated significant between group differences on the anxiety scale, $F(2, 72) = 4.18$, $p < .02$; however, the direction of this difference was not predicted. Scheffe's post-hoc test indicated significant differences between Group 2 and Group 3 only; women abused by a non-family perpetrator indicated more attachment-related anxiety than women abused by an other family member (See Table 6).

No significant differences between groups were found on

Table 6

Abuse group means and standard deviations of scores on the Parental Bonding Inventory (PBI) and Simpson Adult Attachment Subscales

	Group 1 (n=30)		Group 2 (n=27)		Group 3 (n=22)			Scheffe's
	M	SD	M	SD	M	SD	F (2,67)	Test
PARENTAL BONDING INVENTORY								
Mother Care	27.32	9.77	27.15	11.01	35.73	8.77	3.51**	1 & 2 < 3
Father Care	23.29	9.48	28.62	11.54	31.55	11.11	5.97**	1 < 3
Mother Protection	29.58	8.23	30.85	9.67	29.82	7.63	.01	ns
Father Protection	33.87	9.08	28.29	8.42	28.91	14.36	1.16	ns
SIMPSON AAI								
Avoidance	35.68	9.74	36.50	9.17	34.77	8.89	.25	ns
Anxiety	20.19	7.04	17.92	6.41	22.59	7.39	4.18**	2 < 3

Note: n=71. The multivariate analysis of variance examining PBI scores is $F(8, 128) = 2.56, p < .013$ and the multivariate analysis of variance Examining Adult Attachment Indexes is $F(4, 142) = 2.42, p < .05$.
****p < .01**

the avoidance/security measure, $F(2, 72) = .25, p < .78$. It was expected that groups would differ on this measure of attachment security, as well as on the anxiety subscale. Therefore, this hypothesis was not supported.

Attachment Style Classifications

Lastly, a Chi-squared analysis was conducted to compare the number of secure, dismissive, preoccupied, and fearful participants within each abuse group. The results of the chi-squared test showed no significant differences between the three groups $X^2 (6, N = 79) = 6.22, p < .40$. However, consistent with prior studies, a majority (56%) of the participants overall endorsed a fearful style of attachment. Furthermore, 18% of women abused by non-family endorsed a secure style of attachment as compared to only 6% of the parental abuse and 12% of the other familial abuse groups (See Table 7).

Summary

A series of hypotheses was tested to determine if the three abuse groups differed in their responses to attachment-related measures. As expected, women abused by a primary caregiver(s) reported receiving the least amount of care and/or having the weakest early emotional bonds with caregivers, followed by survivors of other familial and non-familial abuse. With regard to adult attachment orientations, the three groups did not report different avoidance scores, but did differ significantly with regard

Table 7

Number of participants endorsing secure, dismissive, preoccupied or fearful style of attachment

Group	Secure	Dismissive	Preoccupied	Fearful	Row Total
Group 1	2	4	5	20	31
Group 2	3	8	2	13	26
Group 3	4	3	4	11	22
Column Total	9 (11.4%)	15 (19%)	11 (13.9%)	44 (55.7%)	79 (100%)

to anxiety scores. Women abused by non-familial perpetrators reported the most anxiety interpersonally, followed by women abused by a primary care-giver and other family, respectively. Lastly, a majority of participants (56%) endorsed a fearful style of attachment, which is consistent with prior research findings.

Regression Analyses

Contributions of Abuse Severity, Parental Bonds, and Adult Attachment Orientations to Psychological Adjustment

Three final statistical tests were conducted to answer the following questions: 1) "Do early parental bonds protect or buffer victims from the long-lasting effects of childhood sexual abuse?," 2) "Do adult attachment orientations predict survivors' adjustment in adulthood?," and 3) "Do adult attachment orientations mediate the relationship between early bonds and current symptomatology?".

Table 8 presents the results of the first regression equation. Severity of abuse, care (mother care and father care) and their interaction were entered into the equation to predict symptomatology. Following the recommendations of Holmbeck (1997), all predictors were transformed into standardized scores prior to their entry into regression equations. Results indicate that the regression model including both abuse severity and parental care best predicted psychological adjustment, explaining 17% of the variance in symptomatology, $F(3, 69) = 4.49, p < .01$.

Table 8

Summary of hierarchical regression analysis of severity and care variables in predicting BSI scores (N = 69)

Variable	B	Standard Error	Beta
Step 1:			
Severity of Abuse	9.35	4.28	.26
Step 2:			
Mother Care	-7.21	4.48	-.20
Father Care	-4.93	4.24	-.14
Step 3:			
Severity X Mother Care	-1.72	4.47	-.05
Severity X Father Care	1.33	4.14	.04

Note: $\bar{R}^2 = .096$ for step 1 ($p < .01$), $\bar{R}^2$ change = .073 for step 2 ($p < .10$), and $\bar{R}^2$ change = .003 for step 3 (n.s.).

specifically, severity of abuse accounted for 10% of the variance in symptomatology ($p < .01$) and parental care explained another seven percent (7%) of the variance ($p < .06$).

Overall, severity of abuse was the best sole predictor of BSI scores. Parental care scores marginally increased the prediction of psychological adjustment, enhancing the overall predictive power of the model. It should be noted, however, that the unique contribution of parental care scores approached but did not meet the conventional .05 level of significance. Furthermore, the interactions of care and severity scores did not incrementally enhance the prediction of adjustment.

Table 9 presents the results from the second regression equation which examined the role of adult attachment orientations in predicting psychological adjustment. Adult attachment scores (i.e., anxiety and avoidance) were transformed into standardized scores and added to the prior equation to determine if their inclusion increased the predictive power of the model. Results indicated that adult attachment significantly predicted adjustment, accounting for 20% of the variance in BSI scores ($p < .001$). Therefore, the final model (severity, care, care x severity, and adult attachment indexes) accounted for 36% of the variance in current adjustment, $F(7, 69) = 5.28, p < .001$.

Table 9

Summary of hierarchical regression analysis of severity, care, severity X care interactions, and adult attachment anxiety and avoidance scores in predicting BSI scores (N = 69)

Variable	B	Standard Error	Beta
Step 1:			
Severity of Abuse	7.94	3.85	.22
Step 2:			
Mother Care	-6.15	4.02	-.17
Father Care	.77	4.00	.02
Step 3:			
Severity X Mother Care	-1.12	4.03	-.03
Severity X Father Care	.13	3.68	.01
Step 4:			
Avoidance	7.74	4.32	.21*
Anxiety	13.42	4.04	.37***

Note: $R^2 = .096$ for step 1 ($p < .01$), R^2 change = .073 for step 2 ($p < .10$), R^2 change = .003 for step 3 (n.s.), R^2 change = .201 for step 4 ($p < .01$).

*.05 < $p < .10$; ** $p < .05$; *** $p < .01$

Mediational Analyses

It was also expected that the adult attachment indexes would mediate the relationship between early emotional bonds and current symptomatology. In order to explore this hypothesis a series of regression equations was tested based on the recommendations of Baron and Kenny (1986).

Initially, mother and father care scores were entered as a block into a regression equation of BSI scores, controlling first for severity of abuse. Results indicated that parental care marginally enhanced the prediction of symptomatology (R^2 change = .07; $p < .06$) (See Table 10 - Model 1). Secondly, separate regressions were conducted to determine if parental care predicted adult attachment avoidance and anxiety scores, again controlling for severity of abuse. In these equations, parental care significantly enhanced the prediction of avoidance (R^2 change = .144; $p < .01$), but did not predict anxiety scores (R^2 change = .062; $p < .12$) (See Table 10 - Model 2a and 2b).

Controlling for severity, early parental care and adult attachment avoidance/anxiety scores were entered into the third and final equation to predict BSI scores (See Table 10 - Model 3). Results indicated that adult attachment orientations significantly predicted BSI scores (R^2 change = .25; $p < .01$), while care scores did not (R^2 change = .03; $p < .26$). Consequently, once adult attachment orientations were controlled, parental care no longer predicted

Table 10

Summary of regression analyses of the role of adult attachment orientations in mediating the relations between childhood sexual abuse and psychological adjustment (N=69)

Model 1. Severity of abuse and parental care effects on BSI scores.

Variable	B	Standard Error	Beta
Step 1:			
Severity	9.01	4.15	.25**
Step 2:			
Mother Care	-.72	.41	-.21*
Father Care	-.45	.38	-.14

Note: $R^2 = .096$ for step 1 ($p < .01$); R^2 change = .073 for step 2 ($p < .10$).

Model 2a. Severity of abuse and parental care effects on avoidance.

Variable	B	Standard Error	Beta
Step 1:			
Severity of Abuse	1.62	1.03	.18
Step 2:			
Mother Care	-.11	.10	-.13
Father Care	-.27	.09	-.33***

Note: $R^2 = .050$ for step 1 ($p < .10$); R^2 change = .144 for step 2 ($p < .01$).

Table 10 (continued)

Model 2b. Severity of abuse and parental care effects on anxiety.

Variable	B	Standard Error	Beta
Step 1:			
Severity of Abuse	-1.12E-02	.85	-.01
Step 2:			
Mother Care	7.63E-03	.08	.01
Father Care	-.16	.08	-.25**

Note: $R^2 = .001$ for step 1 (n.s.); R^2 change = .062 for step 2 (n.s.).

Model 3. Severity of abuse, adult attachment orientations, and parental care effects on BSI scores.

Variable	B	Standard Error	Beta
Step 1:			
Severity of Abuse	7.87	3.74	.22**
Step 2:			
Avoidance	.82	.45	.20*
Anxiety	1.92	.55	.37***
Step 3:			
Mother Care	-.61	.37	-.18*
Father Care	7.21E-02	.36	.02

Note: $R^2 = .096$ for step 1 ($p < .01$); $R^2 = .250$ for step 2 ($p < .01$); $R^2 = .027$ for step 3 (n.s.).

*.05 < p < .10; ** p < .05; *** p < .01

symptomatology. The modest relationship observed in the first equation between care and BSI scores is explained entirely by the mediator. Thus, the hypothesis that adult attachment orientations mediate the relationship between early bonds with caregivers and long-term adjustment for survivors is confirmed for this sample.

In conclusion, of all the assessed variables, adult attachment was the best predictor of survivor adjustment, explaining the largest portion of variance. Furthermore, adult attachment orientations functioned as a significant mediator, mediating the relationship between early bonds and long-term adjustment.

Post-Hoc Analyses

In light of the above findings, two series of post-hoc analyses were conducted in the hopes of further illuminating unexpected results. The first series continued to explore BSI scores among the three abuse groups. The second series of post-hoc tests examined the impact that additional support from an adult figure had on certain variables.

Symptomatology Scores Across Groups

The finding that the three groups did not differ with regards to BSI scores was surprising and not expected. As mentioned, the three groups reported similar total scores or similar scores on the Global Severity Index of the BSI. The BSI also consists of the following nine subscales: somatization, obsessive-compulsive, interpersonal,

depression, anxiety, hostility, phobia, paranoia, and psychoticism. To determine if the three groups differed on any of the nine symptom dimensions, nine additional ANOVA's were conducted.

Results indicated that groups did not differ significantly on any of the symptom subscales: Somatization, $F(2, 76) = 2.33, p < .10$; Obsessive-Compulsive, $F(2, 76) = .202, p < .82$; Interpersonal, $F(2, 76) = .365, p < .70$; Depression, $F(2, 76) = .525, p < .43$; Anxiety, $F(2, 76) = .610, p < .546$; Hostility, $F(2, 76) = 1.05, p < .36$; Paranoia, $F(2, 76) = 1.04, p < .36$; Psychoticism, $F(2, 76) = .721, p < .50$ (See Table 11).

In continuing to explore the reported symptomatology scores among this sample of survivors, a second post-hoc analysis was conducted. Participants were separated into LOW and HIGH severity groups to determine if severity of abuse was directly related to symptomatology scores. The median score on the composite severity index variable was identified ($Mdn = -.23052$) and two new groups were created: Low and High severity groups.

Next, an ANOVA was conducted to test for differences on the BSI between LOW and HIGH severity groups. Results indicate that the differences between groups approached but did not reach statistical significance, $F(1, 74) = 3.70, p < .058$, indicating a trend for the participants assigned to the high severity group to report higher BSI scores than

Table 11

Post-hoc analysis: Between groups means and standard deviations on nine BSI symptom subscales

Group	SOM	OBS	INT	DEP	ANX	HOS	PHO	PAR	PSY
Grp1									
M	14.77	16.00	10.97	16.06	14.55	10.26	9.06	12.03	11.16
SD	6.67	5.23	4.18	5.71	5.86	3.75	3.97	4.04	4.13
Grp2									
M	12.08	15.12	10.08	13.96	13.23	9.54	7.73	10.58	9.96
SD	3.19	5.32	3.79	5.76	3.84	4.32	2.61	3.26	3.07
Grp3									
M	12.14	15.81	10.86	14.68	14.36	10.86	8.09	10.86	10.41
SD	5.37	5.77	4.56	7.12	5.25	4.53	4.03	4.82	4.15

Note: SOM = Somatization, OBS = Obsessive-Compulsive, INT = Interpersonal, DEP = Depression, ANX = Anxiety, HOS = Hostility, PHO = Phobia, PAR = Paranoia, and PSY = Psychoticism. None of the between group comparisons were significant.

those women assigned to the low severity group.

Finally, the relationship between severity of abuse and symptomatology was examined within each of the three abuse groups. Simple correlations of severity and BSI scores were calculated (Group 1: $r = .45$, $p > .01$; Group 2: $r = .23$, $p > .27$; Group 3: $r = -.18$, $p > .45$). A strong relationship between severity and symptomatology was noted for Group 1 only. Next, correlations were transformed into z-scores and between group comparisons of transformed scores were conducted using Fisher's exact tests. These results revealed a significant difference between Groups 1 and 3, ($z = 2.19$, $p < .05$). Thus, the relationship between severity and symptomatology was significantly stronger for women abused by primary caregivers relative to those abused by non-familial perpetrators.

The Impact of Additional Social Support

Another series of post-hoc analyses was conducted to explore the impact of receiving additional social support. As mentioned previously, access to meaningful attachment relationships in childhood is associated with better security and adjustment in adulthood. Although parents often serve as the primary attachment figure in most children's lives, grandparents, neighbors, and teachers can also serve as a supportive attachment or a "secure base" for children.

In the present study, participants were asked to answer

the following question: "Besides your parents, was/were there any other adult figure(s) who you felt especially close to or who cared for you and supported you consistently during your childhood?". It was hypothesized that access to a supportive/caring adult figure, in addition to or besides a parent, should facilitate the healing process, resulting in higher adjustment scores and more security interpersonally.

Two groups were created, those who indicated a supportive relationship with a non-parental adult figure ($N = 44$) and those who did not endorse this item ($N = 36$). The two groups were compared on numerous measures, including severity of abuse, adult attachment anxiety and avoidance scores, and symptomatology scores. Results indicate that the two groups did not differ significantly on any of the mentioned measures. Specifically, groups reported similar scores on severity of abuse, $F(1, 75) = .64, p < .43$, attachment-related anxiety, $F(1, 78) = .80, p < .37$, attachment-related avoidance, $F(1, 78) = .132, p < .26$, and BSI scores, $F(1, 78) = .12, p < .73$.

Lastly, correlations between severity and symptomatology were calculated for women who received additional support ($r = .41, p < .01$) and those who did not ($r = .07, p < .71$). A strong relationship between severity and symptomatology was found for the additional support group. Next, correlations were transformed into z-scores

and a between group comparison of transformed scores was conducted using a Fisher exact test. Results indicate no significant differences between groups on correlation figures ($z = 1.54$, $p = n.s.$).

In conclusion, having access to a supportive non-parental adult figure was not related to experiencing a less severe history of abuse for this sample, nor did it significantly influence participants' level of attachment or adjustment in adulthood. Furthermore, although severity of abuse and symptomatology were correlated within the supported group (i.e., women who received additional non-parental support), this relation was not statistically different across the two groups.

DISCUSSION

This study explored the contributions of parent-child bonds and adult attachment orientations to the psychological adjustment of women with a history of childhood sexual abuse. It was predicted that women abused by a primary caregiver would report a more severe history of abuse, weaker emotional bonds with parents, more symptomatology in adulthood, and more adult attachment insecurity, followed by their peers in the other familial and non-familial abuse groups, respectively. It was also proposed that a healthy emotional bond with a primary caregiver would serve to buffer or protect a victim from the long-term effects of abuse. Furthermore, survivors' adult attachment orientations were expected to mediate the relationship between their early bonds with parents and current psychological adjustment.

In this section a summary of the overall findings, as well as possible explanations for certain findings will be offered. In addition, the distinctive characteristics of the current sample and the unique contribution of a "composite severity index" presented in this study are discussed. Lastly, limitations of the study and recommendations for future research will be offered.

Overview of Findings

Although not all of the original hypotheses were

supported, this study offers some unique and interesting details regarding the psychological adjustment of childhood sexual abuse survivors. Specifically, the findings contribute to our understanding of the role early emotional bonds and adult attachment orientations play in the long-term adjustment of survivors. A discussion of each of the major findings is offered below.

Severity of Abuse

A majority of the women who volunteered to participate in this study recalled experiencing a very serious history of childhood sexual abuse as compared to many other survivor samples. Overall, 38% reported having been abused by multiple perpetrators, 43% experienced intercourse, 53% experienced harm/threat, the average duration of abuse was more than six years, and 39% also indicated a history of physical abuse. Given that this particular sample tended to report a relatively severe history of abuse, the results of this study should generalize to individuals with a similar history.

As expected, women abused by a primary caregiver reported experiencing the most severe history of abuse, as compared to the other two abuse groups. Specifically, they indicated more perpetrators, an earlier age of onset and later age of conclusion, a longer duration and higher frequency of abuse, higher scores on type of contact, and more cases of physical and emotional abuse, as compared to

their counterparts.

The above finding is consistent with prior studies comparing intra-familial and extra-familial abuse survivors on abuse characteristics. Gregory-Bills and Rhodeback (1995), for example, found participants in an intra-familial abuse group to be younger at the time of initial abuse and to be abused for a longer period of time than women in an extra-familial abuse group. Furthermore, several researchers have observed that abuse occurring between fathers and daughters frequently starts earlier, lasts longer, and involves a higher frequency of sexual activity than abuse occurring between other victims and perpetrators (Courtois, 1988; Finkelhor, 1990; Wyatt & Newcomb, 1990). Consequently, it can be concluded that the potential for abuse to start earlier, to last longer, and to escalate over time is more likely when the perpetrator lives under the same roof as the victim or has greater access to the victim by being a relative.

As mentioned, women sexually abused by a primary caregiver were also more likely to report a past history of physical and emotional abuse, as compared to their counterparts. This is consistent with prior research as well which has indicated that incest survivors tend to report more physical and emotional abuse than non-incest and/or control groups (Briere & Runtz, 1990; Edwards & Alexander, 1992; MacNab & Bieschke, 1997). According to

Briere and Runtz (1990), sexual abuse (incest, in particular) seldomly occurs in a vacuum, but rather co-occurs with other types of abuse and neglect. Overall, the sexually abusive parent (i.e., more commonly, the father), as well as the non-offending parent (i.e., more commonly, the mother), are both more prone to exhibiting other types of abusive behavior in comparison to parents heading non-incestual families.

Given the high incidence of physical and emotional abuse among this sample, caution should be used when drawing conclusions and making interpretations about the long-term effects of abuse. Experiences of physical and/or emotional abuse have their own distinct effects and have been linked to a variety of problems and psychological symptoms in adulthood (Briere & Runtz, 1990). Thus, in the present study, considering the participants' overall abuse history when exploring relationships between background and reported maladjustment, rather than focusing solely on the participants' experience of sexual trauma is critical. Consistent with Briere's (1992) recommendations, future researchers are encouraged to consider all forms of maltreatment simultaneously when studying the long-term effects of abuse.

Early Emotional Bonds with Parents

As expected, women abused by a primary caregiver (Group 1) indicated receiving the least amount of care from parents

overall and/or having the weakest early emotional bonds with parents, as compared to their peers in the other abuse groups. Findings regarding parental care and overprotection scores among the three groups will be discussed.

Parental Care

Group 1: Women abused by a primary caregiver did not perceive themselves as having received adequate care or nurturance from either parent during childhood.

Specifically, Group 1 women recalled their fathers to be the least warm and nurturing of all three groups. This finding is not surprising given that a majority (71%) of these fathers were also named as the perpetrator by this group of women.

Group 1 women also rated their mothers low on care; this is consistent with prior research. For example, Mian et al. (1994) found mothers from an incest group to be more likely to abuse alcohol, to have been sexually abused themselves, and to perceive their daughters more negatively than mothers from an extra-familial abuse group, as well as a control group. Therefore, although a causal relationship cannot be inferred, one can conclude that a strong relationship between the occurrence of sexual abuse by a primary caregiver and low parental care/high parental neglect exists.

Group 2: Women abused by a family member other than a primary caregiver rated their mothers relatively low on

maternal care, as well. In fact, Groups 1 and 2 rated their mothers similarly; they indicated receiving significantly less maternal care than did their peers who were abused by non-family perpetrators (Group 3). With regards to father care, Group 2 women rated their fathers more positively on care than Group 1 women, but less caring than Group 3 women.

What is most interesting about the care scores for women abused by an other family member is that a significant number of these women indicated living with their mother only during childhood. It has been stated elsewhere that being raised in a single parent home may put some children at risk for sexual victimization (Courtois, 1988; Finkelhor, 1990; Mian et al., 1994). It might be that this group of mothers may have been less able to provide care and nurturance on a consistent basis and/or less able to protect their daughters from sexual victimization due to the difficulties and added stressors associated with being a single parent.

Additionally, a significant number of women in this group indicated that they did not have a close relationship with their father. In fact, a few participants left some or all of the father-related items on the PBI blank, remarking in the margin that they did not know their father well enough to respond to certain items. Furthermore, of those participants who were able to complete all of the items, many still seemed to perceive their fathers as uninvolved or

distant. This fits with the dynamics associated with some divorced families; distance between the non-custodial parent and child is not uncommon. Consequently, this group of fathers overall was rated relatively low on paternal care.

Group 3: As predicted, women abused by a non-family member recalled both parents to be more nurturing, as compared to their peers in the other abuse groups. Thus, this third group of women, despite an experience of extra-familial sexual abuse, felt more cared for during childhood. This finding is consistent with prior research which suggests that extra-familial abuse survivors commonly perceive their family environments to be slightly more healthy than intra-familial abuse survivors (Mian et al., 1994).

Parental Overprotection

As expected, there were no significant differences among the three groups on parental overprotection scores. Although women abused by a primary caregiver perceived their fathers to be slightly more controlling than women from the other abuse groups, this difference was not statistically significant. Furthermore, all groups rated their mothers similarly with regards to controlling and intrusive behavior.

Combining Past and Present Research on Survivors' Perceptions of Early Emotional Bonds with Parents

To date, only three other studies have specifically

examined the early attachment bonds (PBI scores) between victims of sexual abuse and their parents. MacNab and Bieschke (1997) compared women with a history of incest to women indicating no prior sexual abuse by a family member on PBI scores. Women in the incest group recalled their mothers as being less nurturing and more controlling than did women in the no-incest group. Attachment bonds with fathers, however, did not differ between groups. Mallinckrodt, McCreary and Robertson (1995) found incest survivors to report significantly poorer bonds with parents, as compared to non-abused women. Specifically, incest survivors recalled both parents to be less emotionally expressive and more intrusively controlling, as compared to a non-abused group. And finally, Schreiber and Lyddon (1998) found that survivors who perceived their fathers to be more caring reported fewer psychological symptoms in adulthood than those women reporting lower paternal care. Surprising to the authors, father overprotection, as well as mother care and overprotection scores, were not significantly related to psychological functioning.

To summarize, two past studies, as well as the current study, found intra-familial abuse survivors to rate their mothers as less caring in comparison to varying control groups (i.e., women abused by a non-family perpetrator, no-incest group, and a non-abused group). With regards to parental overprotection and father care, however, the

results have been more inconsistent. Two studies found father care to be significantly related to psychological adjustment and two studies did not. In addition, two of the four studies discovered significant relationships to exist between parental overprotection and assessed variables; the other studies did not. Overall, results may be inconsistent due to the different ways survivors have been grouped within studies.

The present study offers a detailed look at the early emotional bonds reported among varying groups of survivors. Specifically, it adds to our understanding of how survivors' perceptions of their early attachments to parents are affected by or related to the victim's relationship to the perpetrator. In conclusion, there is some preliminary support for the hypothesis that incest survivors demonstrate significantly weaker or more insecure attachment bonds with parents than do other survivor groups. However, further research is needed to confirm this hypothesis and to clarify the nature of the attachment relationships existing between survivors and certain family members.

Symptomatology Reported in Adulthood

The finding that the three groups did not differ in their reports of symptomatology was not expected. What is most surprising is that women abused by a primary caregiver reported the most severe history of sexual abuse and received the least amount of care from parents as compared

to their counterparts, yet they did not report more symptomatology at the time of assessment. This is contrary to prior research which has found both abuse severity and perceived family dysfunction to be strongly correlated with increased symptomatology in adulthood (Alexander, 1993; Brock et al., 1997; Finkelhor, 1989).

A possible explanation for this finding is that a majority of the women abused by a primary caregiver had a positive therapeutic experience. Ninety seven percent (97%) of the women in this group indicated a past experience in therapy, with an average of 210 sessions attended. These figures are remarkable; survivors from the other two abuse groups indicated a less intensive therapy history in comparison. Thus, it seems possible that the first group of survivors learned to cope with the long-term effects of abuse and to manage post-traumatic symptoms associated with abuse while in therapy.

It is also possible that the instrument used to measure adjustment, the Brief Symptom Inventory, was not the best instrument to use in this study. A few researchers studying the long-term effects of sexual abuse have argued that some survivors do not exhibit PTSD symptoms or a disturbance in functioning in adulthood (Green, 1993; Murphy et al., 1988); rather, they tend to suffer more from interpersonal problems (Conte & Schuerman, 1987) and/or more from pervasive disturbances of the self (i.e., Axis II personality

disorders) (Herman & vanderKolk, 1987). The BSI was designed to measure the overall level of distress or psychosocial symptoms reported by an individual; therefore, this particular instrument is more likely to tap into PTSD symptoms and less likely to tap into interpersonal or Axis II problems. Although other researchers have used the BSI, or a version of the original symptom checklist developed by Derogatis, as an outcome measure when studying the long-term effects of abuse (Alexander, 1993; Braver et al., 1992; Fromuth, 1986; Schreiber & Lyddon, 1998), alternative measures of adjustment might be more appropriate to use with this population.

Post-hoc Explorations of Symptomatology Across Groups

To further understand why differences were not found between the three abuse groups with regard to reported symptomatology, several post-hoc analyses were conducted. First, the three groups of survivors were compared on each of the nine BSI symptom subscales; no between group differences were found. It is most surprising that the three groups did not differ on the BSI Interpersonal subscale, given that the groups did, in fact, differ significantly on Simpson's anxiety subscale, measuring interpersonal anxiety.

Items associated with each subscale were examined closely. Overall, it appears that the two subscales tap into different interpersonal characteristics or concerns.

Simpson's anxiety index, which measures the amount of tension and worry felt in romantic relationships (i.e., I rarely worry about my partner leaving me), taps primarily into a participant's fear of abandonment. The BSI Interpersonal dimension, on the contrary, appears to highlight a participant's level of self-consciousness or perceived inferiority in interpersonal relationships (i.e., Feeling inferior to others; Feeling very self-conscious with others). Therefore, it appears that the groups differ with respect to abandonment issues, but do not differ with regard to inferiority concerns.

In another related post-hoc analysis, survivors with high severity index scores were compared to those with low severity scores on reported symptomatology. There was a trend for those with higher severity scores to report higher symptomatology scores; however, this difference was not significant at the .05 level. Neither of these post-hoc tests added much to our understanding of why the three groups of survivors reported similar levels of adjustment in adulthood, despite significant differences in their experiences of abuse; thus, a third and final post-hoc test was conducted.

The relation of severity to symptomatology was explored among the three abuse groups; a significant difference was detected between Groups 1 and 3. Specifically, the correlation was strong and positive for women abused by a

primary caregiver (i.e., as severity increases, symptomatology increases), whereas the relationship between severity and BSI scores was weak for those abused by non-family perpetrators. It might be concluded that the closer a victim is to the perpetrator, as in the case of parental abuse, the more strongly severity of abuse is related to adult adjustment.

Comparing BSI Scores to Standardized Norms

In a continued effort to simply understand the levels of symptomatology reported by this sample, current BSI scores were compared to standardized norms. Presently, four major norms have been developed for the BSI, developed from four distinct normative samples: 1,002 adult psychiatric inpatients, 974 adult non-patients, 423 adult psychiatric outpatients, and 2,408 adolescent non-patients. The BSI scores (i.e., Global Severity Index, in particular) of the present sample were compared with those scores reported by the adult psychiatric outpatient and adult non-patient normative samples.

Interestingly, the present sample scored much higher on the Global Severity Index of the BSI (GSI: Group 1 = 1.34; Group 2 = 1.10; Group 3 = 1.21) than the female adult non-patient sample (GSI = .35) and similarly to the sample of female adult psychiatric outpatients (GSI = 1.40). This indicates that the present sample was experiencing a level of distress that is close to what most clients seeking

outpatient therapy report. Thus, regardless of group assignment, survivors in the current study reported experiencing a significant level of distress at the time of assessment. This makes sense given that this sample tended to report a severe history of sexual abuse and past experience in therapy.

In conclusion, the three groups of survivors in the present study did not report differences in symptomatology, despite group differences in abuse severity. Nevertheless, a relationship between several abuse characteristics and symptomatology was noted. BSI scores were significantly correlated with duration of abuse, perceived severity, and composite severity index scores. Furthermore, the relationship between composite severity scores and symptomatology was especially strong for women abused by a primary caregiver. Overall, it can be concluded that experiencing a severe history of abuse is frequently associated with more symptomatology in adulthood and that this relationship depends in part on the relationship between victim and perpetrator.

Adult Attachment Orientations

Adult Attachment Styles

In the past, researchers have found a high proportion (58-60%) of sexually abused women to be classified as fearfully attached, in comparison to non-clinical and/or non-abused populations (Alexander, 1993; Stalker & Davies,

1994). Non-clinical samples, for example, typically break down in the following manner: 46% secure, 18% dismissive, 14% preoccupied, and 20% fearful (Bartholomew & Horowitz, 1991). Consistent with prior research, a majority of the current participants (56%) endorsed a "fearful" style of adult attachment. Fearful individuals incorporate a negative view of both self and other and tend to exhibit low self-esteem, little trust of others, and a fear of intimacy in relationships.

For decades, clinicians and researchers have agreed that two of the most common long-term effects exhibited by victims of sexual trauma are: (1) a poor self-concept and (2) a decreased sense of trust in others (Alexander & Lupfer, 1987; Courtois, 1988; Finkelhor, 1990; Stalker & Davies, 1995). Given that these two common long-term effects of sexual abuse are identical to the two primary characteristics of a fearful style of attachment (negative view of self and other), it is not surprising that this population frequently self-identifies as fearfully attached in adulthood.

It was also expected that women abused by a non-family perpetrator would be the most likely of the three groups to endorse a "secure" style of attachment; this finding was supported though not at a statistically significant level. To review, 6% of women abused by primary caregiver, 12% of women abused by other family, and 18% of women abused by

non-family indicated a secure style of attachment.

Interestingly, Group 3 women rated their parents as more caring and/or perceived their attachment bonds with parents to be healthier than their counterparts. Thus, a relationship, albeit weak, between the perception of having had positive childhood bonds with parents and endorsing a secure style of adult attachment in adulthood was found.

Adult Attachment Avoidance

It was also expected that the three groups would display different attachment-related avoidance and anxiety scores. The avoidance subscale specifically measures the level of comfort one feels with intimacy and closeness in relationships. Contrary to predictions, the three groups did not report significantly different avoidance scores. This means that group members indicated experiencing similar levels of discomfort with closeness in their interpersonal relationships.

In a comparable study, MacNab and Bieschke (1997) found incest and no-incest groups to differ significantly on two similar attachment-related variables: comfort with intimacy and trust. The incest group scored lower than the no-incest group on both variables, indicating less comfort with emotional intimacy and trust. This finding is consistent with clinical observations, as well as a body of research, recognizing that emotional intimacy and trust are strongly influenced by a history of sexual abuse (Alexander, 1992;

Courtois, 1988; Finkelhor et al., 1989).

The fact that the three groups of survivors in the present study did not differ on Simpson's avoidance subscale was not predicted, but is explainable. Upon close examination of the group means, it was noted that all three groups scored particularly high on this scale, higher than previously assessed samples. (Higher scores indicate more discomfort with intimacy and closeness in relationships.) For example, Lopez, Fuendeling, Thomas, and Sagula (1997) surveyed a sample of non-clinical college students on several attachment related measures. These students reported considerably lower avoidance scores ($M = 26.03$) as compared to all three groups of survivors in the present sample ($M = 35.68, 36.50, 34.77$, respectively).

Thus, consistent with past research, a majority of all survivors in the current study indicated discomfort with interpersonal intimacy. Regardless of the victim's relationship to the perpetrator, childhood sexual abuse is invariably associated with being misled, violated, or exploited by someone who "should be" safe and trustworthy; therefore, it makes sense that this population as a whole would struggle with trust and intimacy in adulthood, regardless of the victim's relationship to perpetrator.

Adult Attachment Anxiety

As expected, the three groups of survivors in the present study responded differently to the adult attachment

anxiety-related items. The anxiety subscale specifically measures the amount of tension and worry felt in romantic relationships. Findings demonstrated that women abused by a non-family member indicated the most anxiety interpersonally, as compared to their counterparts. The direction of this finding was unexpected; it had been hypothesized that women abused by a primary caregiver would report the most tension and worry in their adult interpersonal relationships. A possible explanation for this disparity is offered.

Some prior research indicates that victims abused by strangers can experience more post-traumatic fear and anxiety than other victims. According to Browne and Finkelhor (1986), "whereas abuse by a trusted person involves betrayal, abuse by a stranger or more distant person may involve more fear, and thus be rated more negatively at times" (p. 73). Specific to the current findings, one might further speculate that victimization by an unknown individual (especially a stranger) can prompt a victim to feel less empowered and less in control of her own safety. This may subsequently prohibit a victim from trusting any unknown person, leaving her feeling more anxious interpersonally, overall.

Again, it also appears that all three groups of survivors reported higher scores on the anxiety scale than past non-clinical samples. (Higher scores indicate more

tension and worry in interpersonal relationships.) The aforementioned group of college students, surveyed by Lopez et al. (1997), reported lower attachment-related anxiety ($M = 16.40$) as compared to the three groups of survivors in the current study ($M = 20.19, 17.92, 22.59$). Overall, the present sample reported more attachment-related anxiety and avoidance than past non-survivor samples.

The Prediction of Survivors' Psychological Adjustment

The final analyses may offer the most compelling information. Several regression equations were conducted in order to determine the role that severity of abuse, parental care, and an interaction of the two played in predicting the current psychological adjustment for a group of childhood sexual abuse survivors.

Initially, results indicated that severity of abuse was the best predictor of psychological adjustment, as defined by BSI total scores. Parental care, on the contrary, only marginally enhanced the prediction of adjustment after severity scores were controlled. Consequently, it can be concluded that, for this particular sample, early parental bonds did not significantly protect a victim from the long-term effects of abuse. Rather, experiencing a less severe history of abuse was more closely linked to reporting better adjustment in adulthood.

This finding was unexpected and is difficult to explain. In past studies, receiving ample parental care and

nurturance from a primary caregiver has been significantly related to better psychological adjustment for survivors. As mentioned earlier, Schreiber and Lyddon (1998) found that incest survivors who perceived their fathers as more caring reported fewer symptoms in adulthood. Furthermore, Brock et al. (1997) found survivors who rated their families as more "healthy" also reported fewer psychological symptoms than did women who perceived their families as less healthy. Thus, having positive perceptions of early familial relationships seems to have served as a protective factor against some of the long-term effects of childhood sexual abuse for some samples.

As mentioned, in the current study severity of abuse was a better predictor of current adjustment than recollections of early parental care. Although this was not predicted, the finding that severity of abuse best predicted adjustment has been supported previously. Alexander (1993), for example, found characteristics of abuse severity to significantly predict symptomatology in adulthood. More specifically, upon examining the predictive power of both abuse and attachment variables, Alexander found that PTSD symptoms were best predicted by abuse characteristics, while personality dysfunction was best predicted by adult attachment patterns.

Adult Attachment Orientations as Predictors of Adjustment

The results of Alexander's (1993) study are consistent

with the findings of our first regression equation; however, contrary to her findings, adult attachment orientations (i.e., avoidance and anxiety) were found to significantly predict BSI scores in our second regression equation. Remarkably, attachment-related avoidance and anxiety scores were the most efficient predictors of adjustment, explaining an additional 20% of the variance in symptomatology after abuse severity and parental care scores were controlled. Furthermore, adult attachment orientations were found to mediate the modest relationship between early bonds and BSI scores in this series of regression analyses.

This finding is consistent with several other studies examining the predictive power of attachment-related measures (Carnelley et al., 1994; Lopez, 1996; Parker et al., 1992). These authors all found that adult attachment orientations predicted current outcomes better than did measures of early emotional bonds with parents. Specifically, the effects of childhood emotional bonds on certain assessed variables (i.e., constructive thinking, depression) were indirect, and effectively mediated by current adult attachment orientations. Similarly, in the present study, it appears that current adult attachment orientations play a more significant role in predicting adult survivor adjustment than do early attachments with parents.

The information gleaned from the regression analyses

can be applied directly to practice or counseling with this population. Findings suggest that counselors may be able to facilitate improvements in adjustment and functioning by first exploring and assessing the quality of a client's current adult attachments with others, including family, friends and partners. Women reporting higher levels of attachment-related anxiety and/or avoidance in their current relationships may be at risk for exhibiting lower levels of functioning and for possessing fewer skills to cope with the long-term effects of sexual trauma. In addition, given that severity of abuse was also significantly related to adjustment, exploring the client's history of abuse also seems critical. Allowing a survivor to verbalize her history of abuse at an appropriate pace, connecting emotion with memory, should also facilitate the healing process and produce symptom reduction for the client.

In conclusion, counseling interventions designed to reduce post-traumatic symptoms and enhance current relationships with attachment figures may prove to be the best type of intervention to utilize with survivors in therapy. Given that past and present research in this area is somewhat inconsistent, continued research is needed in order to better understand which family and/or abuse variables best predict adjustment, and specifically for which outcome measures.

Major Contributions of the Current Study

Classifying Survivors into Three Groups

One way in which this study differs from past studies is in how the sample of survivors was organized; survivors were categorized into three groups based on their relationship to the perpetrator(s). The three groups included women abused by a primary caregiver(s), women abused by any other family member, and women abused by a non-family perpetrator. Prior researchers have tended to compare either abused and non-abused populations or intra-familial versus extra-familial abuse survivors.

Organizing survivors into three groups appears to offer several benefits, as well as several drawbacks. An obvious benefit is the ability to compare survivors with varying histories of sexual abuse on several measures. Specifically, it permitted exploration of the relationship between a critical abuse characteristic (i.e., the victim's relationship to the perpetrator) and observed attachment patterns and adjustment levels in adulthood. Researchers have documented the relationship between victim and perpetrator to be critical when exploring the long-term sequelae of sexual abuse. Furthermore, attachment theory underscores the importance of the early bond between a parent and child, making it especially important to distinguish those participants who had been abused by a parental figure from those who had not. Thus, attending to

the victim's attachment to the perpetrator, not just whether or not the victim is related to the abuser, offers additional information to this domain of research.

The most obvious drawback to creating three groups of survivors is that it becomes more difficult to compare the results of the present study to past studies. In short, between group comparisons and between study comparisons are more complicated, which may hinder the process of blending results or offering a comprehensive discussion of related findings. Given that this is the first study to categorize survivors using a three group method, future researchers are encouraged to continue to explore the value of this method over others.

The Contribution of a Composite Severity Index

As mentioned earlier, the three groups of survivors differed significantly with regard to severity of abuse. Therefore, it was deemed necessary to control for abuse severity in the subsequent analyses in order to adequately compare the three groups on measures of attachment and adjustment. This was done by creating a "composite severity index".

The utilization of a severity index is new to this domain of research. A literature review indicates that severity has not been controlled in past studies. In fact, some researchers have failed to even describe the severity of sexual abuse endured by their samples (Green, 1993). In

recent studies, it seems that most researchers tend to acknowledge between group differences in severity (often between intra- and extra-familial abuse survivors) when interpreting results, but do not control for these differences statistically. Although other researchers (MacNab & Bieschke, 1997) have recommended using a severity index, to date this is the first study to do so. The numerous benefits, as well as some potential drawbacks, to creating a severity index will be outlined below.

Most importantly, creating a composite severity index allowed variations in the experiences of sexual abuse to be quantified. By aggregating several relevant abuse characteristics into a combined index, we were able to conduct between group comparisons while controlling for the confounding effects of abuse severity. Given that abuse histories among the survivor population tend to vary drastically, controlling for severity when making between group comparisons seems like a necessary and critical statistical procedure.

Drawbacks to creating a severity index should be mentioned, as well. First, the experience of childhood sexual abuse is subjective, making it extremely difficult to quantify. Assigning participants a "score" that accurately reflects their experience or captures the seriousness of past trauma is difficult, to say the least. The system used to quantify severity in the current study is quite

rudimentary and should be refined. In order to partially account for the subjective nature of abuse, however, participants were asked to offer their own perception on severity by rating their experience on a scale from one to five. This score was included in the composite severity index score, increasing its overall validity.

In summary, given that the use of an index is novel, it is recommended that the current findings be interpreted with caution until this or similar indexes achieve appropriate validation through confirmed usage. The eventual development and use of more refined and sensitive severity indexes should enhance future research in this domain.

Limitations of the Study

There are several limitations associated with this study. First, the sample size is rather modest, entirely female, and therefore may not be representative of the larger population of childhood sexual abuse survivors. As mentioned, this sample tended to report a severe history of abuse. In addition, those who volunteered to participate in this study had full or partial memory of the abuse and also self-identified as survivors of childhood sexual abuse. These characteristics may distinguish this sample from the general survivor population, limiting the external validity of this study. Overall, the results of this study should best generalize to females with similar characteristics and/or a comparable history of abuse.

In addition, some of the sampling procedures employed may have limited the external validity of this study. Although all of the participants were volunteers, some of these women were recruited by their therapist. Therapists were instructed to use their clinical judgment when considering who to approach about the nature of the study. It is likely that those who were approached 1) had discussed their history of abuse with their therapist, 2) were considered to be well adjusted enough (i.e., functioning and coping at adequate levels) to complete a packet without decompensating, and 3) had been working with their therapist for a longer period of time, in order for the therapist to feel comfortable in broaching the topic of research. This method of selection is somewhat biased, but was implemented for ethical purposes. Consequently, the results may not generalize to all survivors in therapy.

A third limitation of this study is the possibility of self-report bias, which is inherent in all survey studies. Some participants may overestimate, underestimate, or minimize their past experiences of abuse. In addition, the experience of repression or other defenses may hinder a participant's ability to recall complete or accurate memories of abuse.

Fourth, the retrospective methods used to assess history of abuse and parental bonds are less than optimal. There is no simple way to corroborate the information

reported by participants; thus, there is no guarantee that participants' recollections are in fact entirely congruent with past events and relationships.

Lastly, limitations of this study result from the choice of instruments used. For example, the Brief Symptom Inventory may not have been the best measure of psychological adjustment to utilize. Although prior researchers have used versions of this instrument when examining survivor adjustment (Alexander, 1993; Braver et al., 1992; Fromuth, 1986), others have widened the definition of "adjustment" to include measures of social adjustment (Harter et al., 1988), social competency (Mallinckrodt et al., 1995), and interpersonal relationship concerns (Brock et al., 1997; Edwards & Alexander, 1992), as well as measures of symptom distress. It might have been beneficial to include several dependent variables or measures of adjustment, in order to detect some of the unique differences in long-term adjustment among groups.

Clinical Implications for Counseling Psychology

The findings from the current study support the application of attachment theory as a framework for both research and psychotherapy with survivors of childhood sexual abuse. According to Alexander (1992), "any attempt to predict the onset of abuse and its long-term effects must include a consideration of the family context that mediates the experience of the abuse" (p. 185). Attachment theory

speaks directly to the relational antecedents and consequences of sexual abuse, and therefore, is a useful conceptual framework when studying this research domain.

For decades, clinicians and researchers have agreed that survivors of childhood sexual abuse frequently struggle in their ability to maintain interpersonal relationships, to develop a secure sense of self, and to manage intense emotions or regulate affect. Attachment theory speaks directly to these three areas of concern. Specifically, researchers applying attachment theory to the area of sexual abuse have found that survivors frequently internalize a working model that incorporates a negative view of self and other (Alexander, 1993; Stalker & Davies, 1993). A negative view of other is subsequently associated with decreased trust and difficulty maintaining interpersonal relationships. Additionally, a negative view of self is related to low self-worth and/or more clinical disturbances of the self (Axis II diagnoses).

Finally, the affective coping strategies displayed by survivors have yet to be examined empirically, however, we do know that the strategies used by an adult are closely related to the strategies developed and used during childhood (Kobak & Sceery, 1988). Thus, we can speculate that experiencing a history of childhood abuse might significantly influence a victim's ability to cope effectively throughout life. In conclusion, attachment

theory speaks directly to the salient problems and patterns displayed by survivors, making it an excellent base from which to conduct therapy and research.

Applying Findings to the Therapy Relationship

The findings from the current study are relevant to clinicians working with survivors of sexual abuse. Most importantly, many survivors are fearfully attached in adulthood, indicating low self-esteem and low trust of others. This may make it more difficult to establish trust or to develop a strong working alliance with this type of client. Survivors may experience the therapeutic process as intimidating, threatening, and/or overwhelming. Thus, moving at a slow pace and attending to the therapeutic relationship is critical (Pistole, 1989b).

The relationship between client and therapist is an important attachment relationship and a valuable source of information. The manner in which a client attaches to her therapist, for example, is dependent on the client's internal working model of self and other, as well as her attachment history. According to Alexander (1994), "by bringing to the therapist the fears and anxieties associated with other important attachment relationships, the client acts out her/his internal working model through the process of transference and attempts to fit the therapist to that unconscious working model" (p. 667).

During the process of psychotherapy, the therapist

should serve as a "secure base," from which the client is invited to explore past and current attachment experiences and losses. From an attachment perspective, the long-term goal of therapy is to help the client develop a more favorable internal working model of self and other and to experience an increased sense of felt security (Alexander, 1994; West, Sheldon, & Reiffer, 1990). Specifically, the therapist hopes to "help the client increase the permeability and complexity of these working models by revising them both cognitively and affectively on the basis of new information" (Alexander, 1994, p. 667).

Therapists working with survivors of childhood sexual abuse, relying on a long-term therapy model, may choose to focus on the survivor's abuse history, as well as her past and present attachments to significant others. Given the recent trend towards time-limited therapy, however, many clinicians are forced to limit the scope of therapy, which tends to frustrate the process of deep exploration with some clients. Therefore, focusing primarily on the client's current attachments, including her attachment to the therapist, may prove to be the most effective type of intervention when using a brief therapy model.

Conclusions and Directions for Future Research

This investigation set out to examine the contributions of parent-child bonds and adult attachment orientations to psychological adjustment within a female sample of childhood

sexual abuse survivors. Most importantly, it was determined that women abused by a primary caregiver indicated experiencing a more severe history of abuse and receiving less care and more neglect from parents, as compared to their peers in the other abuse groups. Additionally, it was determined that survivors' adult attachment orientations significantly predicted their current symptomatic distress, after controlling for abuse severity and early emotional bonds with parents.

The present study provides support for using attachment theory as a framework to conceptualize the long-term effects of childhood sexual abuse. The application of attachment theory to this research domain, however, is a relatively new practice. Thus, future researchers are encouraged to continue to explore and expand our understanding of this population from an attachment-theoretical perspective.

More specifically, future researchers are encouraged to further explore the attachment patterns displayed among abuse survivors and their families. Overall, empirical evidence regarding the early parental bonds and adult attachment patterns measured among samples of survivors has been somewhat inconsistent. There is some support for the notion that incest survivors demonstrate significantly weaker or more insecure attachment bonds with parents, as well as more attachment-related insecurity in adulthood, as compared to control groups. However, this is not consistent

across the board; further research is needed to confirm past and future hypotheses. Additionally, in order to clarify which family and/or abuse variables best predict long-term adjustment, and specifically for which outcome measures, further investigations are needed.

It also seems important to further explore the value of utilizing a "severity index". To date, this is the first study to employ such a procedure. As mentioned, creating a severity index allowed this researcher to hold severity of abuse constant when comparing groups of survivors on attachment and adjustment-related variables. The severity index used in the current study, however, is far from polished or complete. As mentioned, a study focused solely on the creation of the finest and most objective severity index is needed and should enhance future research in this area.

Another possibility for future research is to consider the use of different measures. For example, past research indicates that the Adult Attachment Interview (AAI) developed by Kaplan and Main (1984), which is a one-hour semi-structured interview, is a better measure of adult attachment than most self-report inventories. During the AAI, participants are asked to describe their childhood relationships with parents, focusing specifically on any experiences of rejection, loss, abuse, and/or separation. Subsequently, researchers rate participants on attachment-

related variables and assign participants to one of four attachment categories. Given that participants completing a self-report inventory may be unable to rate themselves accurately or may rate themselves in more socially acceptable ways, interviewing procedures are recommended. Past studies should be replicated using the AAI and compared with present findings.

Finally, as mentioned, it may be beneficial to use additional and/or alternative outcome measures in future studies. Some of the more popular assessment instruments may not be particularly sensitive to many of the symptoms reported by survivors (Green, 1993) and should be used with caution. Given that survivors struggle with interpersonal relationships, self-esteem issues, and affective symptoms, measures that are sensitive to these types of concerns are recommended. Furthermore, several researchers have recommended using multiple measures to overcome the limitations of individual measures (Briere, 1992; Green, 1993).

In conclusion, it has been shown that attachment theory is a useful framework from which to conceptualize some of the long-term effects of childhood sexual abuse. Continued research is needed to confirm past findings and to explore additional hypotheses. To the extent that predictions are supported empirically, this attachment-theoretical perspective on abuse should allow researchers and clinicians

to develop theory-based counseling interventions to use in therapy with adult survivors of childhood sexual abuse.

APPENDIX A

TO ANY FEMALE:

IF YOU WERE SEXUALLY ABUSED AS A CHILD AND ARE WILLING TO PARTICIPATE IN A COMPLETELY ANONYMOUS AND CONFIDENTIAL STUDY, PLEASE CALL 886-3687 or EMAIL "thomaski@pilot.msu.edu".

If you are an adult woman who was molested or sexually abused during your childhood (0 to 15 years old) by an adult (someone who was at least five years older than you), your voluntary participation is requested. The study is designed to explore your past history of sexual abuse, past and current relationships, and current level of adjustment. If you volunteer to participate, you will be asked to complete several surveys taking approximately 30 minutes of your time. Your answers will be totally anonymous. After completing the surveys in your own home, you will be asked to return the packet to Kim Thomas in a self-addressed stamped envelope enclosed in the packet. If you are interested please call Kim Thomas at 886-3687 or email "thomaski@pilot.msu.edu" to obtain a survey packet.

*This study has been approved by the University's Committee for Research Involving Human Subjects (UCRIHS).

APPENDIX B

Dear Participant:

Thank you for your expressed interest in this study regarding experiences of childhood sexual abuse and current psychological health and adjustment. This research is being performed to fulfill the requirements for a doctoral degree in counseling psychology. The study is being conducted by Kim Thomas, M.A. and supervised by Frederick Lopez, Ph.D. at Michigan State University.

The purpose of this study is to explore the early parent-child relations, the current psychological adjustment, and current interpersonal relationships among a group of female survivors' of childhood sexual abuse. If you choose to participate in this study, you will be given a packet containing several self-report questionnaires to complete. Some questionnaires will ask about your experiences of childhood sexual abuse and early relationships with parents; others will ask about your current relationships and overall psychological health and adjustment.

It should take you about 30 minutes to complete all of the questionnaires in this survey packet. Please answer all questions as honestly as possible. Your responses to this survey will be kept completely anonymous. DO NOT put your name on any of the questionnaires. This way your name cannot be connected to any of your answers and your anonymity can be assured. After completing the survey packet, please return it to Kim Thomas in the self-addressed stamped envelope which has been provided to you.

Your participation in this survey is strictly on a volunteer basis. You are free to withdraw your consent and stop participating at any time. Returning this questionnaire will be considered your consent to participate.

The phone numbers for several agencies, 24-hour crisis lines, and therapists in the Phoenix area are being provided to you in case you should wish to talk to a professional about your responses to this survey. If answering the survey items causes you any emotional discomfort, please contact one of the names or numbers provided. If you have any questions regarding the purpose or nature of this research study, please contact the researcher, Kim Thomas, at 820-3125 or Fred Lopez at 355-8502.

Demographic and History of Sexual Abuse Questionnaire

Thank you for deciding to participate in this project. The following questions ask about your background. Please circle the appropriate number under each of the items below or enter the correct information in the blank spaces provided.

1. Your sex: (circle one) 2. Your age: _____
- (1) Male
- (2) Female
3. Your ethnic/racial background:
- (1) African-American
- (2) Asian-American or Pacific Islander
- (3) Hispanic/Latina/Chicana
- (4) Euro-American/Caucasian
- (5) Native-American
- (6) Bi-racial
4. What is your current marital or partnership status:
- (1) Married
- (2) Living with partner in fully committed relationship
- (3) Divorced or separated
- (4) Never married and not currently living with partner
- (5) Widowed
5. If you are not married or living with a partner, what is your current dating status:
- (1) Not involved in a dating relationship
- (2) Dating different people
- (3) Seeing only one person, but without a commitment
- (4) In a committed relationship (including engagement)
6. Who did you live with (adults only) during most of your childhood?
- (1) Both parents (biological or adoptive)
- (2) mother only
- (3) father only
- (4) mother and step-father
- (5) father and step-mother
- (6) parent and his/her boyfriend/girlfriend or partner
- (7) other extended family members (Please specify: _____)
- (8) Other (Please specify: _____)
7. How would you rate your current stress level?
- | Not at all | | | | | | | |
|------------|---|---|------------|---|---|-----------|--|
| Stressed | | | Moderately | | | Extremely | |
| | | | Stressed | | | Stressed | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
8. How well are you managing your stress?
- | Not at all | | | | | | | |
|------------|---|---|------------|---|---|-----------|--|
| well | | | Moderately | | | Extremely | |
| | | | well | | | well | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | |

Demographic Questionnaire, continued, pg. 2

Please answer the following questions about any past experiences of unwanted sexual contact which occurred to you before age 15 by any adult or individual who was at least 5 years older than you at the time of abuse.

9. At what age were you first sexually abused?

_____ years old

10. How old were you when the/all the abuse stopped?

_____ years old

11. What type of sexual activity were you exposed to or expected to perform?
(circle all that apply)

1. penetration or intercourse with perpetrator
2. oral contact with genitals
3. touching or stimulation of genitals under clothes
4. touching or fondling over clothes
5. kissing
6. other (Please specify: _____)

12. Who sexually abused you? (circle all that apply)

1. father
2. step-father
3. brother (including biological,
step or half sibling)
4. mother
5. step-mother
6. sister (including biological,
step or half sibling)
7. other male relative (e.g. uncle,
grandfather) specify: _____
8. other female relative (e.g. aunt,
cousin) specify: _____
9. other known individual (e.g. teacher,
babysitter, neighbor, my mother's boyfriend,
my father's girlfriend) specify: _____
10. unknown person/stranger

13. Did this person live with you during the time of abuse?

1. yes
2. no

14. How many times were you abused? (please estimate if unsure e.g. 1 time, 10 times, over 100 times, etc.)

approximately _____ times

Demographic Questionnaire, continued, pg. 3

15. How long did the/all abuse last? (please estimate if unsure)
approximately _____ years and/or _____ months
16. Did the abuser(s) ever harm you or threaten to harm you or anyone else if you did not comply during/after sexual contact and/or if you did not keep the abuse a secret?
(1) yes
(2) no
17. Did you tell or disclose the abuse to an adult during your childhood?
(1) yes
(2) no
18. If you answered yes to #17 (disclosed the abuse to someone) who did you tell and what was his/her reaction?
18. Who did you tell? _____
19. What was his/her reaction? (circle one)
(1) very supportive, protected me from further harm
(2) somewhat supportive and protective
(3) unsupportive, but did not blame or reject me
(4) very unsupportive, blamed or abandoned me
20. How would you rate the severity of your abuse. "On a scale from 1 to 5 my experience of sexual abuse was....".
Very Severe Moderately Severe Not too severe
1 2 3 4 5
21. Are you currently in therapy or have you ever seen a counselor to discuss the abuse?
(1) yes
(2) no
22. If you answered yes to #21, approximately how many sessions did you attend or have you attended?
approximately _____ sessions
23. Besides your parents, was/were there any other adult figure(s) who you felt especially close to or who cared for you and supported you consistently during your childhood?
(1) yes
(2) no

Demographic Questionnaire, continued, pg. 4

24. If you answered yes to #23, please specify who the individual was (or your relation to him/her) and tell us briefly what that relationship meant to you.

At any time during your childhood, do you also consider that you were:

- | | YES | NO |
|---|-------|-------|
| 25. Physically abused? (e.g. physically injured by another by non-accidental means) | _____ | _____ |
| 26. Neglected? (e.g. left alone for long periods of time without care) | _____ | _____ |
| 27. Emotionally/verbally abused? (e.g. regularly threatened or demeaned) | _____ | _____ |

RQ

Directions: Please read each of the descriptive paragraphs below and place a mark (X) next to the ONE that best describes how you feel about close relationships. Secondly, please rate on a scale from 1 (very much like me) to 7 (not at all like me) how much EACH of these paragraphs describes you.

Most descriptive
of me
(Mark one)

1. It is easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others not accept me. 1. _____

Very much like me Somewhat like me Not at all like me

1 2 3 4 5 6 7

2. I am comfortable without close relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have them depend on me. 2. _____

Very much like me Somewhat like me Not at all like me

1 2 3 4 5 6 7

3. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them. 3. _____

Very much like me Somewhat like me Not at all like me

1 2 3 4 5 6 7

4. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others. 4. _____

Very much like me Somewhat like me Not at all like me

1 2 3 4 5 6 7

S-AAS

Directions: Using the scale adjacent to each of the items below, indicate (by circling the appropriate number) to what extent the item describes how you have typically felt toward romantic partners in general.

	Strongly Disagree					Strongly Agree	
1. I find it relatively easy to get close to others	1	2	3	4	5	6	7
2. I'm not very comfortable having to depend on other people.....	1	2	3	4	5	6	7
3. I'm comfortable having others depend on me.....	1	2	3	4	5	6	7
4. I rarely worry about being abandoned by others.....	1	2	3	4	5	6	7
5. I don't like people getting too close to me.....	1	2	3	4	5	6	7
6. I'm somewhat uncomfortable being too close to others.....	1	2	3	4	5	6	7
7. I find it difficult to trust others completely.....	1	2	3	4	5	6	7
8. I'm nervous whenever anyone gets too close to me.....	1	2	3	4	5	6	7
9. Others often want me to be more intimate than I feel comfortable being.....	1	2	3	4	5	6	7
10. Others are often reluctant to get as close as I would like..	1	2	3	4	5	6	7
11. I often worry that my partner(s) don't really love me.....	1	2	3	4	5	6	7
12. I rarely worry about my partner(s) leaving me.....	1	2	3	4	5	6	7
13. I often want to merge with others, and this desire sometimes scares them away.....	1	2	3	4	5	6	7

PBI

Directions: This questionnaire lists various attitudes and behaviors of parents. Using the rating scale below, indicate to what extent each item describes how that parent was like in the first 16 years of your life. Circle the appropriate scale number for each of the items below.

Scale:	Items 1-25 regarding your mother:	Items 26-50 regarding your father:			
	1 = very like her 2 = moderately like her 3 = moderately unlike her 4 = very unlike her	1 = very like him 2 = moderately like him 3 = moderately unlike him 4 = very unlike him			
During my first 16 years of life, my mother.....	VERY LIKE	MODERATELY LIKE	MODERATELY UNLIKE	VERY UNLIKE	
1. Spoke to me with a warm and friendly voice.....	1	2	3	4	
2. Did not help me as much as I needed.....	1	2	3	4	
3. Let me do things I like doing....	1	2	3	4	
4. Seemed emotionally cold to me....	1	2	3	4	
5. Appeared to understand my problems and worries.....	1	2	3	4	
6. Was affectionate to me	1	2	3	4	
7. Liked me to make my own decisions.....	1	2	3	4	
8. Did not want me to grow up.....	1	2	3	4	
9. Tried to control everything I did.	1	2	3	4	
10. Invaded my privacy.....	1	2	3	4	
11. Enjoyed talking things over with me.....	1	2	3	4	
12. Frequently smiled at me.....	1	2	3	4	
13. Tended to baby me.....	1	2	3	4	
14. Did not seem to understand what I needed or wanted.....	1	2	3	4	
15. Let me decide things for myself..	1	2	3	4	
16. Made me feel I wasn't wanted.....	1	2	3	4	
17. Could make me feel better when I was upset.....	1	2	3	4	
18. Did not talk with me very much...	1	2	3	4	
19. Tried to make me dependent on her.....	1	2	3	4	
20. Felt like I could not look after myself unless she was around.....	1	2	3	4	

PBI, continued, pg. 2

During my first 16 years of life, my mother.....	VERY LIKE	MODERATELY LIKE	MODERATELY UNLIKE	VERY UNLIKE
21. Gave me as much freedom as I wanted.....	1	2	3	4
22. Let me go out as often as I wanted.....	1	2	3	4
23. Was overprotective of me.....	1	2	3	4
24. Did not praise me	1	2	3	4
25. Let me dress in any way I pleased.....	1	2	3	4
*26. When answering the above questions, who were you rating?				
1) my biological mother				
2) my adoptive mother				
3) my foster mother				
4) my step-mother				
5) another maternal figure (please specify: _____)				

During my first 16 years of life, my father.....	VERY LIKE	MODERATELY LIKE	MODERATELY UNLIKE	VERY UNLIKE
1. Spoke to me with a warm and friendly voice.....	1	2	3	4
2. Did not help me as much as I needed.....	1	2	3	4
3. Let me do things I like doing.....	1	2	3	4
4. Seemed emotionally cold to me.....	1	2	3	4
5. Appeared to understand my problems and worries.....	1	2	3	4
6. Was affectionate to me	1	2	3	4
7. Liked me to make my own decisions.	1	2	3	4
8. Did not want me to grow up.....	1	2	3	4
9. Tried to control everything I did.	1	2	3	4
10. Invaded my privacy.....	1	2	3	4
11. Enjoyed talking things over with me.....	1	2	3	4
12. Frequently smiled at me.....	1	2	3	4
13. Tended to baby me.....	1	2	3	4
14. Did not seem to understand what I needed or wanted.....	1	2	3	4
15. Let me decide things for myself...	1	2	3	4

FBI, continued, pg. 3

During my first 16 years of life, my father.....	VERY LIKE	MODERATELY LIKE	MODERATELY UNLIKE	VERY UNLIKE
16. Made me feel I wasn't wanted.....	1	2	3	4
17. Could make me feel better when I was upset.....	1	2	3	4
18. Did not talk with me very much....	1	2	3	4
19. Tried to make me dependent on him.	1	2	3	4
20. Felt like I could not look after myself unless he was around.....	1	2	3	4
21. Gave me as much freedom as I wanted.....	1	2	3	4
22. Let me go out as often as I wanted.....	1	2	3	4
23. Was overprotective of me.....	1	2	3	4
24. Did not praise me	1	2	3	4
25. Let me dress in any way I pleased.....	1	2	3	4

*26. When answering the above questions, who were you rating?

- 1) my biological father
- 2) my adoptive father
- 3) my foster father
- 4) my step-father
- 5) another paternal figure

INSTRUCTIONS:

On the next page is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	EXAMPLE
						HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	3	4	Bodyaches

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	3	4	Nervousness or shakiness inside
2	0	1	2	3	4	Faintness or dizziness
3	0	1	2	3	4	The idea that someone else can control your thoughts
4	0	1	2	3	4	Feeling others are to blame for most of your troubles
5	0	1	2	3	4	Trouble remembering things
6	0	1	2	3	4	Feeling easily annoyed or irritated
7	0	1	2	3	4	Pains in heart or chest
8	0	1	2	3	4	Feeling afraid in open spaces or on the streets
9	0	1	2	3	4	Thoughts of ending your life
10	0	1	2	3	4	Feeling that most people cannot be trusted
11	0	1	2	3	4	Poor appetite
12	0	1	2	3	4	Suddenly scared for no reason
13	0	1	2	3	4	Temper outbursts that you could not control
14	0	1	2	3	4	Feeling lonely even when you are with people
15	0	1	2	3	4	Feeling blocked in getting things done
16	0	1	2	3	4	Feeling lonely
17	0	1	2	3	4	Feeling blue
18	0	1	2	3	4	Feeling no interest in things
19	0	1	2	3	4	Feeling fearful
20	0	1	2	3	4	Your feelings being easily hurt
21	0	1	2	3	4	Feeling that people are unfriendly or dislike you
22	0	1	2	3	4	Feeling inferior to others
23	0	1	2	3	4	Nausea or upset stomach
24	0	1	2	3	4	Feeling that you are watched or talked about by others
25	0	1	2	3	4	Trouble falling asleep
26	0	1	2	3	4	Having to check and double-check what you do
27	0	1	2	3	4	Difficulty making decisions
28	0	1	2	3	4	Feeling afraid to travel on buses, subways, or trains
29	0	1	2	3	4	Trouble getting your breath
30	0	1	2	3	4	Hot or cold spells
31	0	1	2	3	4	Having to avoid certain things, places, or activities because they frighten you
32	0	1	2	3	4	Your mind going blank
33	0	1	2	3	4	Numbness or tingling in parts of your body
34	0	1	2	3	4	The idea that you should be punished for your sins
35	0	1	2	3	4	Feeling hopeless about the future
36	0	1	2	3	4	Trouble concentrating
37	0	1	2	3	4	Feeling weak in parts of your body
38	0	1	2	3	4	Feeling tense or keyed up
39	0	1	2	3	4	Thoughts of death or dying
40	0	1	2	3	4	Having urges to beat, injure, or harm someone
41	0	1	2	3	4	Having urges to break or smash things
42	0	1	2	3	4	Feeling very self-conscious with others
43	0	1	2	3	4	Feeling uneasy in crowds, such as shopping or at a movie
44	0	1	2	3	4	Never feeling close to another person
45	0	1	2	3	4	Spells of terror or panic
46	0	1	2	3	4	Getting into frequent arguments
47	0	1	2	3	4	Feeling nervous when you are left alone
48	0	1	2	3	4	Others not giving you proper credit for your achievements
49	0	1	2	3	4	Feeling so restless you couldn't sit still
50	0	1	2	3	4	Feelings of worthlessness
51	0	1	2	3	4	Feeling that people will take advantage of you if you let them
52	0	1	2	3	4	Feelings of guilt
53	0	1	2	3	4	The idea that something is wrong with your mind

APPENDIX C

RESOURCES

Hotlines & Crisis Intervention

Listening Ear.....337-1717
Emergency Services @ Community Mental Health.....346-8460
Sexual Assault Hotline (MSU).....372-6666

Local Psychotherapists and Counseling Agencies

Council Against Domestic Assault.....372-5572
Community Mental Health.....374-8000
Cristo Rey Community Center.....372-4700
Comprehensive Psychological Services.....337-2900
Frank & Associates.....332-3557
MSU Psychological Clinic.....355-9564
MSU Counseling Center (free for students).....355-8270
Professional Psychological & Rehabilitation Svcs....321-5900
Samaritan Counseling Center.....337-2338
Sparrow Sexual Assault Counseling.....483-2385
Women's Personal Growth and Therapy.....347-2126

****If you have insurance, you may want to call your insurance company to determine which mental health providers in the area the company will pay for or reimburse.**

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