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Psychopathology and childhood sexual abuse: an investigation of the relationship between sexual arousal, attributional style, attributions of blame for CSA and psychological adjustment.

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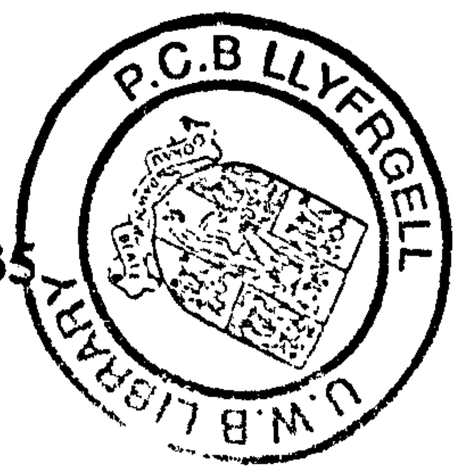

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Abstract

The relationships between sexual arousal, attributional style, attributions of blame for child sexual abuse (CSA) and psychopathology were investigated in a non-clinical sample. One hundred female undergraduates completed a questionnaire incorporating the Rosenberg Self-Esteem Scale, (Rosenberg, 1965), the Symptom Checklist 90-R (Derogatis, 1996), the Extended Attributional Style Questionnaire (Peterson et al., 1988) and questions about CSA experiences. Participants reporting CSA also completed the Attributions of Responsibility and Blame Scales (McMillen and Zuravin, 1997), and were asked if they had experienced sexual arousal during their CSA. Twenty five per cent of participants reported a history of CSA, and of this group, 32% reported experiencing sexual arousal during CSA. The CSA group had higher levels of symptomatology and negative attributional style than the Comparison non-abused group. Within the CSA group, symptomatology was positively associated with self-blame and negative attributional style, and negatively associated with self-esteem. Self-blame for CSA was positively associated with family/other blame, and negatively associated with self-esteem. The Aroused group experienced greater frequency and severity (number of types) of CSA, and showed higher levels of self-blame for the CSA than the Non-Aroused group. No evidence was found in the current study for a connection between sexual arousal and psychopathology. Further research using a larger sample size is indicated. The importance of including frequency, severity and sexual arousal as possible characteristics of CSA experiences during clinical assessment and interventions with adult survivors and focussing treatment strategies accordingly is discussed.

INTRODUCTION

Background to Research Aims

The research questions in this study have arisen primarily from the author's clinical observations of the psychological problems of adult clients who experienced sexual arousal during childhood sexual abuse (CSA), and their particular difficulties in relinquishing beliefs in their responsibility and blameworthiness. In order to provide a context for consideration of the particular research questions, this introduction will give an outline of existing empirical and theoretical knowledge about the relationship between CSA and psychopathology.

Prevalence of CSA

The recognition of CSA as a potential contributor to subsequent psychopathology began in the 1980s, with the identification of CSA in the histories of women receiving psychiatric services. Bryer, Nelson, Miller and Krol, (1987) for example, found that 44% of a sample of female psychiatric inpatients reported CSA, whilst Briere and Runtz (1987) found a 77% rate for CSA amongst female outpatient clinic attendees. In a British study by Sheldon (1988) 16% of women attending an outpatient psychotherapy centre gave a history of CSA.

Estimates of prevalence vary within and between countries according to differences in definitions of CSA, sample characteristics and methodology used in particular studies (Wyatt and Peters, 1986). Definitions of CSA can vary according to the upper age limits adopted, contact versus non-contact abuse, familial versus extra-familial status of the perpetrator, and in criteria for defining a sexual encounter as abusive, including

the required age discrepancy between victim and perpetrator. Studies use a variety of samples drawn from clinical, community and student populations, so that variations in age, educational level, socio-economic status may also contribute to the differences in reported prevalence rates. Methodological differences between studies, such as the type and number of CSA questions asked, the use of questionnaire, face-to-face interview or telephone interview format are also likely to affect prevalence figures.

A British community survey by Baker and Duncan (1985) of over 2000 men and women found that 12% of women had experienced CSA. A recent study of British female undergraduates by Henderson, Hargreaves, Gregory and Williams (1999) found a prevalence rate of 28% for CSA. In a random community sample of 930 women in Los Angeles, Russell (1983) found a prevalence rate of 38% reporting at least one experience of CSA before 18 years; 16% reported at least one experience of intra-familial abuse , and 4.5% reported CSA by their biological fathers or stepfathers. Finkelhor et al (1990) found that 27% of women in a national American survey reported CSA.

Polusny and Follette (1995) have summarised CSA prevalence rates in American community studies as ranging from 15 - 33%, whilst rates for clinical samples range from 35 - 75%. Kuyken (1995) has concluded that in spite of the difficulties inherent in prevalence studies, such as variations in definitions of CSA, a significant proportion of women living in the community and a high proportion of women seeking psychiatric help have experienced CSA. Similarly, Jehu concludes that it is evident that CSA is common among females in the general populations of several countries, and that clinicians are "virtually certain" to encounter women with a history of CSA among their clients (1988).

CSA and Psychopathology

The high prevalence rates for CSA in non-clinical populations have led a few researchers (e.g. Henderson, 1983) to question the validity of linking CSA to subsequent psychopathology. However, as Waller and Smith (1994) point out, studies of the long term consequences of CSA in non-clinical populations generally report higher levels of disturbance than in comparison groups of non-abused women, thereby supporting the association of CSA and psychopathology. A recent study of the long-term effects of CSA by Lange, de Beurs, Dolan, Lachnit, Sjollema and Hanewald (1999) states that there is abundant evidence that victims of CSA are at high risk of developing psychological problems. A review article by Polusny and Follette (1995) concludes that there is support for an association between a history of CSA and increased levels of general psychological distress. Compared to non-abused participants in research studies, CSA survivors appear to be at greater risk for the development of psychological disorders, including major depression and anxiety disorders. In a review of the psychological sequelae of CSA Kuyken (1995) notes that data comparison between studies is made difficult by differences in the samples used (e.g. volunteer, university student, community, psychiatric etc). He concludes, however, that the robustness of the association between CSA and psychological sequelae is demonstrated by the finding of the same long-term effects across these different populations.

Most introductions to research and review papers on CSA and psychopathology now incorporate a list of psychological problems that have been repeatedly found in research with women who have experienced CSA. Lange et al (1999), for example, includes depression, anxiety, sexual disorders, self-harm, eating disorders, alcohol and substance abuse, low self-esteem, feelings of isolation and stigmatization, excessive distrust, anger problems and prostitution as psychological problems for which CSA victims are at high risk. They also note that associations have been found between

CSA and borderline personality disorder, dissociative disorders and psychotic symptoms.

CSA Characteristics and Psychopathology

Much research has focussed on whether and how particular characteristics of CSA might influence subsequent adjustment and symptomatology. This has involved examination of factors such as the age of the child at onset, duration of and severity of abuse, the relationship of the child to the perpetrator, the type of coercion used, whether physical force was used, and reactions to disclosure. This research has produced some contradictory findings. Several authors (e.g. Kuyken, 1995; Ussher and Dewberry, 1995) provide summaries of the research on effects of type of CSA and comment that the equivocal results prevent conclusive answers being drawn. Some studies, for example, have found that prolonged and frequent abuse is associated with a poorer prognosis and more severe psychological symptoms (Bagley and Ramsey, 1986; Russell, 1986; Hoagwood, 1990), but others have not found this association. Whilst the same studies also found penetration to be the most powerful predictor of subsequent effects, other researchers have failed to replicate this. (Finkelhor, 1979; Fromuth, 1983). The recent study by Lange et al (1999) of the association between objective and subjective characteristics of CSA and subsequent psychopathology may add some clarity to this area. Using a large community sample of 404 adult women, they found that more severe psychopathology was associated with longer duration, severity (number of different types of CSA) and higher frequency of abuse. The study also found that these characteristics were more important predictors of psychopathology than the relationship with the perpetrator.

Theoretical models for CSA sequelae

The emphasis on searching for characteristics of CSA which are associated with subsequent psychological difficulties has left unaddressed the questions of why there is differential psychological adjustment amongst CSA survivors, or by what mechanisms CSA affects psychological functioning. Kuyken (1995) described research on the long-term effects of CSA as having been conducted in a theoretical vacuum. This section attempts to briefly summarize existing theoretical models.

Psychoanalytic Theories

Freud's seduction theory was developed on the basis of his patients' reports of sexual abuse during childhood, and originally proposed that hysterical and other neurotic symptoms in adulthood were the result of repression of these traumatic experiences. He subsequently rejected this theory, arguing instead that patients' recollections of CSA were internalized infantile fantasies which re-emerged in adulthood as memories of actual events (Freud, 1915, 1955). It is generally accepted now that Freud's rejection of his seduction theory was a socially and politically motivated response to the hostile reception he received from the academic and medical community. Although Freud later accepted that some patients' accounts of CSA were likely to be true, his original rejection is thought to still influence the attitude of disbelief and scepticism which many children and adults experience when disclosing CSA.

Later psychoanalytic writers like Ferencsi (1949) and Williams (1987) have proposed that CSA is a pathogenic factor, and described psychopathology in terms of introjected guilt and anger about the abuse being repressed from conscious awareness, affecting psychic equilibrium and creating additional trauma when repression breaks down and memories surface. As Kuyken (1995) has pointed out,

whilst these theories have some appeal, they are not readily testable and have received little empirical support.

Attachment Theory

Attachment theory incorporates the contention that sexual and physical abuse, neglect and hostile rejection of the child have damaging psychological effects (Bowlby, 1989). Alexander (1992) proposes that CSA sequelae are mediated by the survivor's attachment history, and that attachment-related psychological conflicts underlie them. Neglect and rejection result in an internal working model of the self as unworthy, undeserving and bad. CSA survivors with a pre-occupied and fearful attachment style are considered particularly prone to problems involving low self-esteem. They tend to idealize partners and have negative perceptions of self. The consequence of their relationship style is often disappointment or even revictimization (Russell, 1986). Avoidant individuals would be more likely to experience a sense of social isolation and estrangement from others, resulting in the simultaneous dependency and lack of trust commonly seen in adult survivors (Wooley and Vigilanti, 1984). Alexander proposes that borderline personality disorder (BPD) symptoms, including intense affective reactivity and emotional involvement, self-destructive behaviours, idiosyncratic and disorganized thinking, also describe an adult with a history of resistant or disorganized attachment. Sexual abuse has increasingly been found in the histories of individuals with BPD (Briere and Runtz, 1987). Alexander also proposes that a history of insecure attachment leads to the parenting difficulties often experienced by survivors.

Attachment theory provides an interesting perspective for understanding the differential effects of CSA, although most writers acknowledge that its utility and relevance needs to be demonstrated through research that tests out these hypothesized relationships between attachment style and psychopathology. The effects of general family dysfunction and poor relationships between other family

members which often feature in the background of CSA survivors also need to be considered.

Developmental deficits

Cole and Putnam (1992) have proposed a theory involving developmental deficits. They argue that impairments in self and social functioning experienced by some CSA survivors arise from CSA disrupting the developmental processes of self-definition, integration, and self-regulation and interfering with the development of trust and security in early relationships. Kuyken points out that this is consistent with his own findings (1992) of higher levels of depression amongst women reporting CSA by a primary caregiver, and also that abuse which occurred through more developmental stages was associated with greater distress and poorer self-esteem. Kuyken offers an interpretation of his findings in terms of Cole and Putnam's model; children whose abuse begins at a younger age and continues through more developmental stages have not fully integrated their personality and formed a coherent sense of self. This might cause distress in itself, or lead to other interpersonal problems, which increase abuse-related distress. The difficulties and/or the distress serve to make the individual more vulnerable to depression, and to engage in self-blaming and avoidance coping. The finding by Lange et al (1999) that more severe psychopathology was associated with CSA of longer duration, greater severity and frequency also fits with the developmental deficits model.

Post Traumatic Stress Disorder (PTSD) Model

The similarities between some of the psychological difficulties associated with CSA and PTSD symptomatology have led some researchers (e.g. Lindberg and Distad, 1985) to propose that PTSD is an appropriate diagnosis for CSA survivors. Diagnostic criteria for PTSD include symptoms observed in CSA survivors, such as flashbacks, intrusive thoughts, avoidance of trauma-related stimuli, dreams and

nightmares, reduced affect and numbing, hypervigilance, and feelings of detachment and estrangement from others.

The post-sexual abuse trauma theory (Briere and Runtz, 1987) proposes that the child's perceptions of and reactions to abuse, and the coping strategies they adopt are initially adaptive responses. CSA symptomatology is the result of these responses becoming fixed, elaborated and generalized over time so that they become "contextually inappropriate components of the victim's adult personality".

Finkelhor (1987) has argued, however, that although these CSA and PTSD symptoms may be analogous, the aetiological processes and treatment are not. A further problem with the PTSD model is that it focuses on affect, and fails to account for many other emotional, behavioural and cognitive difficulties experienced by CSA survivors. These include depression, guilt, self-blame, low self-esteem, sexual and relationship problems, suicidal ideation, self-destructive behaviour. Despite its limitations as an explanatory model, Sanderson (1995) has commented that viewing CSA within a PTSD model has increased the general recognition of CSA as a major psychological stressor, which may help to reduce some of the stigma attached to it.

Traumagenic Dynamics Model

The Traumagenic Dynamics Model (Finkelhor and Browne, 1986) attempts to incorporate PTSD concepts and developmental issues to explain the impact of CSA, and specifies causal links between CSA and long-term psychological difficulties. Finkelhor and Browne propose that four traumagenic dynamics arise from CSA experiences; traumatic sexualization, stigmatization, betrayal and powerlessness. It is argued that their combination is unique to the experience of CSA. These traumagenic dynamics are considered to distort children's perceptions of themselves, their self-efficacy and their world, and affect their capacity to experience certain emotions. The cognitive distortions are also proposed to affect children's ability to cope with the world.

Traumatic sexualization occurs as a result of the child being rewarded with attention and affection for developmentally inappropriate sexual behaviour, fetishization of sexual parts of the child's body, misconceptions transmitted to the child about sexual behaviour and morality and conditioning of sexual activity with negative emotions and memories. Specific problems proposed to arise from traumatic sexualization include aversion to sexual intimacy, sexual dysfunction, compulsive sexual behaviours, prostitution and confusion about sexual identity. Stigmatization occurs through the child being blamed, denigrated and pressured into secrecy by the perpetrator, the child inferring attitudes of shame about the sexual activity, reactions of shock or blame to disclosure, and the child being stereotyped as 'damaged goods'. Stigmatization is proposed to result in guilt and shame, low self-esteem, a sense of differentness from others, substance abuse and self-harm. The dynamic of betrayal arises from the child's trust and vulnerability being manipulated and their well-being disregarded, and violation of expectations of care and support by others. Betrayal is proposed to lead to depression, dependency, anger, mistrust, and impaired judgement of others' trustworthiness. Finally, powerlessness occurs as a result of repeated invasion of the child's body against the child's wishes, repeated experience of fear, the use of force or deception, the child's inability to protect themselves, stop the abuse or make others believe them. Powerlessness is proposed to result in anxiety, lowered sense of efficacy, perception of self as a victim, phobias, nightmares, dissociation, and identification with the aggressor.

This model continues to provide a very useful and systematic framework for understanding the psychological effects of CSA, although Kuyken (1995) concludes that its specific chains of causality on the basis of data from retrospective studies may not be justified.

Emotional Avoidance

Polusny and Follette (1995) have proposed a theoretical model based on the idea of emotional avoidance, whereby the CSA sequelae are conceptualized as psychological and/or behavioural attempts to avoid or alleviate negative CSA-related internal experiences, i.e. thoughts, memories, emotions and flashbacks. Dissociation, substance abuse, eating disorders and self-mutilation, for example, are seen as emotional avoidance behaviours, which are negatively reinforced by the short-term reduction in anxiety and tension they provide. They then become chronic coping strategies, which interfere with optimum levels of functioning.

One of the problems with the emotional avoidance model is its failure to account for the role of cognitions such as guilt and self-blame. Self-injury, for example, is often described by CSA survivors as tension reducing, but also as an effective means of punishment for their perceived badness. Similarly, eating disorders are often accompanied by beliefs that the survivor's body is a source of shame and disgust and does not deserve nurture, and that extreme thinness or obesity is a form of protection against sexual interest from others.

Cognitive perspectives

There has been an increasing research emphasis in recent years on the role of cognitive factors in the development of psychopathology following CSA. This research has included exploration of attributional style, dysfunctional cognitions, autobiographical memory, and attributions of blame and responsibility for CSA. There are indications in the research literature that these cognitive variables may act as mediators between CSA and symptoms of psychopathology.

Attributional Style

The reformulated learned helplessness model, (Abramson, Seligman and Teasdale, 1978) proposes that people who experience negative events that they perceive as uncontrollable may develop internal, stable and global attributions for subsequent negative events which will influence how they react. Attributions have three dimensions; they may be internal to the person or external, referring to something about the situation; they may be either stable and persistent over time or unstable and transient; lastly, they may be either global, affecting a variety of outcomes or specific, and limited to the particular situation. Each dimension is thought to play a specific role in producing depression; internal attributions for bad events are associated with a loss of self-esteem, stable attributions with long-lasting helplessness deficits and global attributions with generalized and pervasive deficits. This negative attributional style is thought to put individuals at greater risk for depression when negative events occur.

Gold (1986) draws a parallel between CSA and PTSD in proposing that CSA is usually perceived as uncontrollable and can therefore be conceptualized as a helplessness experience; according to the learned helplessness theory, CSA survivors' post-traumatic symptoms may be related to internal, stable and global attributions and to expectations of having no control over future negative events. Gold has found that CSA survivors were more likely to attribute negative events to more internal, stable and global causes than non-abused participants were. This self-blaming (depressogenic) explanatory style was also related to higher levels of psychological distress, and lower levels of self-esteem.

These findings are partially supported by Wenninger and Ehlers (1998), who found that CSA survivors' attributions of negative events were more internal, stable and global than those of non-abused participants. The CSA survivors also scored highly on the depression subscale of the Trauma Symptom Checklist, and 77% were depressed according to the Beck Depression Inventory. The authors interpret this as indicating that this negative attributional style makes CSA survivors more prone to

depression. Within the CSA group, however, only the globality scale was significantly related with severity of long-term symptoms. The failure to replicate Gold's finding of a significant relationship between internal attributions and adult psychological functioning is attributed to differences in methodology, the PTSD symptom focus and measures used. Wenninger and Ehlers conclude that there is a relationship between "inflexible attributional style" and posttraumatic symptoms, but recommend further research into the other dimensions of attributional style amongst CSA survivors, and whether self-blaming attributions are more directly related to post-trauma symptoms than a general attributional style for negative events.

CSA Cognitions and Beliefs

Research on trauma-related cognitions points to their importance in the differential adaptation of CSA survivors to their abuse. Drauker (1989) found that lower levels of depression, and better self-esteem and social adjustment among CSA survivors were related to better cognitive adaptation i.e. finding a meaning in their CSA experience, regaining a sense of mastery over this and their life generally, and enhancing their self-esteem through social comparisons.

Hazzard (1993) investigated trauma-related beliefs as mediators of CSA impact using a 56-item measure to assess beliefs reflecting Finkelhor and Browne's Traumagenic Dynamics model. Amongst a clinical sample of 59 adult CSA survivors, she found that beliefs reflecting self-blame/stigmatisation for CSA, difficulty in finding meaning for CSA experiences and perceptions of coping poorly by comparison with others were associated with lower self-esteem, interpersonal problems, greater depression and overall psychological distress. These results are consistent with studies by Gold (1986) and Drauker (1989) mentioned earlier. Self-blaming beliefs were also related to anxiety, and Hazzard proposes that CSA survivors who self-blame may anticipate that further negative events are likely to happen. Beliefs in powerlessness and personal vulnerability were associated with depression, external locus of control and

lower self-esteem. Betrayal beliefs and expectations of future betrayal were associated with interpersonal and sexual problems.

Wenninger and Ehlers (1998) have looked at the relationship between dysfunctional cognitions and adult psychological functioning in CSA survivors. They examined maladaptive beliefs about issues of safety, trust, power, esteem, intimacy, self and others. Examples of such beliefs include "the world is very dangerous", "men cannot be trusted" or "I avoid other people because they might hurt me". High correlations were found between maladaptive beliefs concerning these issues and post-trauma symptoms, including anxiety, depression, dissociation, sleep disturbance and other post-sexual abuse trauma. These results were replicated in a separate sample even when frequency of abuse was controlled for. The authors propose that the results provide support for cognitive models of post-trauma adaptation which link the development and maintenance of symptomatology to distortions in cognitive schemas. Furthermore, it is suggested that targeting maladaptive cognitions may be an essential component of treatment for CSA survivors.

Cognitive behavioural theory proposes that an individual's appraisal of an event will greatly influence its psychological impact (Beck, 1976). Beck's cognitive model proposes that distorted or dysfunctional thinking underlies psychological disturbances, and influences both mood and behaviour. Core beliefs about the self, the world and the future begin to develop in childhood through attempts to make sense of the environment, to organize experience and function adaptively. Interactions with the world and other people influence the nature of these core beliefs, which can vary in accuracy and functionality. Core beliefs influence the development of particular attitudes, rules and assumptions which, in turn, influence perceptions of situations, and can lead to certain cognitive processing errors such as selective abstraction, overgeneralization, and dichotomous thinking. These give rise to automatic thoughts which then influence emotions and behaviour.

In line with the cognitive model, Jehu (1992) has proposed that schema theory can provide a useful explanatory link between CSA and subsequent personality problems.

He considers that traumatic life experiences such as CSA are likely to lead to the establishment of maladaptive and lasting schemata containing core beliefs about oneself, other people and the world in which one lives. These beliefs influence thoughts, feelings and actions, and are maintained by cognitive distortions, self-defeating behaviour patterns, and anxiety and hopelessness about changing such beliefs. Jehu considers that these schemata contribute to the mood disturbances and other psychological difficulties associated with CSA.

Schemata are activated when the individual is confronted by life events perceived as relevant to a particular schema, and are then accompanied by negative automatic thoughts, self-defeating behaviour, and unpleasant or distressing emotions. In order to avoid or alleviate such unpleasant feelings, Jehu proposes that several cognitive and behavioural processes may occur. Assimilation describes the interpretation of input as consistent with an individual's schemata; input which confirms a schema is likely to be emphasized and exaggerated, whereas schema-discrepant input tends to be denied, minimised or rationalized. Individuals may also behave in schema-confirmatory ways; for example, the core belief that self-protection is impossible may result in an individual failing to mobilize coping resources to deal with real threats, and therefore suffering further harm, which confirms the core belief. Accommodation occurs when schemata are modified so that they are more consistent with input from life events. Cognitive, emotional and behavioural avoidance can also be employed in order to evade the distress associated with activation of schemata. Finally, compensation may occur, whereby individuals attempt to challenge their own schemata by deliberately behaving in ways which seem opposite to them. Jehu gives the example of acting in reckless and risky ways when the underlying core beliefs reflect anxieties about personal safety.

Jehu (1988) has also proposed that dysfunctional beliefs themselves (such as being to blame for CSA occurring) lead to mood disturbances and inappropriate or self-defeating behaviour. Observations of the extent of self-denigratory and self-blaming beliefs amongst CSA survivors led to the design of the Belief Inventory, which can be used in their assessment and in cognitive-behavioural treatment. Waller and Smith

(1994) have found that women CSA survivors with psychological disorders had higher levels of self-denigratory beliefs than CSA survivors with no psychological disorder. Jehu (1989) found that a reduction in the severity of depression amongst CSA survivors is associated with reduction in levels of these dysfunctional beliefs.

Autobiographical Memory

Henderson et al (1999) have investigated autobiographical memory amongst CSA survivors. Using the Autobiographical Memory Test (Williams and Broadbent, 1986), they found that a non-clinical sample of CSA survivors could retrieve significantly fewer specific autobiographical memories from the list of positive, negative and neutral cue words, than a comparison group of non-abused participants. This overgenerality or non-specific style of memory recall was independent of mood disturbance or reported attempts to avoid abuse-related memories. Henderson et al. propose that the trauma of CSA results in children failing to develop specific processing in an unconscious attempt to control and minimise the negative emotional consequences of the CSA. The maintenance of the more non-specific mode of memory retrieval into adulthood affects other positive, neutral and negative non-abusive memories. Non-specific processing is also thought to contribute to and maintain psychological disturbance in adulthood. Reappraisal of a CSA survivor's dysfunctional cognitions such as belief in blameworthiness may be hindered by this over-general mode of memory retrieval preventing their disconfirmation.

Causal attributions for CSA: Self, family/other and perpetrator blame

It is widely believed in the field of sexual abuse treatment that CSA survivors who make internal causal (i.e. self-blaming) attributions for their abuse are more symptomatic than those who make external attributions. Accordingly, a common goal of CSA treatment approaches is the alleviation of self-blame and guilt through cognitive restructuring. Self-blame has been identified as an important variable in studies of psychological adjustment following rape, sexual and physical assault.

Theoretical explanations for the assumption of responsibility by such victims have included the need to incorporate an aversive experience into their understanding of the self and the world and give meaning to otherwise incomprehensible events (Thompson, 1981). Lerner and Miller (1978) describe it in terms of the need to believe in a just world, where negative events do not happen fortuitously. Whilst self-blame is commonly found amongst clinical populations of CSA survivors (Jehu, 1988), the contribution of causal attributions to subsequent psychopathology remains unclear. The following section outlines studies that have looked specifically at causal attributions of blame and responsibility amongst by CSA survivors.

Morrow and Sorrell (1989) studied factors affecting self-esteem, depression and negative behaviours (e.g. attempted suicide, self-injurious behaviour, promiscuity, running away from home) amongst 101 female adolescents aged between 12 and 18 years whose CSA had been reported to child protection agencies, and who had then been routinely assigned to group therapy. Self-blame was measured using a single item indicator: possible answers to the question "During the time that the sexual contact situation was going on, I felt that the sexual contact situation was..." ranged from "all my fault" to "in no way my fault". Morrow and Sorrell found that those girls who had blamed themselves during the period of abuse (i.e. prior to disclosure) reported more negative behaviours than those had not blamed themselves. The authors propose that this may reflect a process of labelling self as deviant and behaving in ways, which confirm the label. Self-blame during the period of abuse was not found to be significantly related to self-esteem or depression. This is not consistent with findings of subsequent studies, and may reflect the question referring only to self-blame during the period of abuse, rather than currently. There are inherent problems with the accuracy of retrospective recall of the intensity and direction of blame experienced during CSA.

In a subsequent study by Morrow (1991) of 12 – 18 year old CSA survivors in weekly therapy groups, causal attributions for CSA were elicited in response to the open-ended query "When I ask ...why this has happened to me, the answer I come up with is...". Results indicated that survivors who attributed their CSA to something

about themselves were more depressed and had lower self-esteem than those attributing CSA to external causes. There were no differences in levels of depression or self-esteem between survivors who made any causal attribution for the CSA and those unable to find any answer. Morrow concludes that making internal causal attributions for CSA is associated with low self-esteem and depression in adolescent survivors, whereas making external attributions, or failing to find an explanation, is not. The finding provides further support for the clinical focus on alleviation of self-blame through cognitive restructuring.

Wyatt and Newcomb (1990) have also shown that causal attributions mediated the severity of the sexual abuse sequelae. Self-blame was associated with poorer adjustment and other-blame with better adjustment in a community sample of 111 adult female CSA survivors. The findings by Wyatt and Newcomb, and those of Morrow (1991) are consistent with Hazzard's findings that self-blame was associated with poorer adjustment (1993).

The intensity, direction and type of causal attributions in relation to psychological adjustment has been examined by Hoagwood (1990), using a clinical sample of 31 women reporting CSA. Participants were asked questions which distinguished between characterological self-blame (blame for having a particular quality or trait) and behavioural self-blame (blame for engaging in a particular act or behaviour). Characterological self-blame can be considered as an internal, stable and global attribution, whilst behavioural self-blame is internal, unstable and specific. Participants were asked about feelings of self-blame and other blame (mother, father, abuser and other) both during childhood and currently. Hoagwood found that whilst women blamed themselves more as children than they did as adults, characterological self-blame in adulthood was significantly more intense than behavioural self-blame. As adults, the women blamed their abuser, their mother and their father more than they had done as children. Significant relationships were found between the direction of blame and adult functioning. Women who blamed themselves in childhood for CSA and those who currently blamed themselves were more depressed and had lower

self-concept. Women who currently blamed their abuser were less depressed and had higher self-concept and self-esteem.

Hoagwood also found relationships between self-blame, age at onset and duration of CSA. The younger the participants were when CSA began, the less they blamed the abuser. The longer the abuse persisted, the more self-blame participants experienced both as children and adults, and the less they blamed their abuser. These findings provide support for links between CSA characteristics and the development of a negative, self-blaming attributional style which may act as a mediating factor in the development of subsequent symptomatology.

Hoagwood suggests that the shortcomings of the study include the small sample size, the greater duration and severity of CSA in the sample used and the difficulties of retrospectively assessing blame. However, she suggests that the finding of better adjustment amongst women who were able to externalise blame for CSA in adulthood supports this as a therapeutic goal. Self-blame in childhood appears to become integrated into the self-image, and women with the strongest feelings of self-blame were the most depressed. Therapy that encourages women to reframe their experiences as attributable to factors not dependent on their own character or abilities may therefore be beneficial.

Hunter, Goodwin and Wilson (1992) compared attributions of blame amongst small community samples of child, adolescent and adult CSA survivors. In contrast with the previous study, where adult participants rated themselves retrospectively as self-blaming during childhood, Hunter et al. found that the majority of children rated themselves as not at all to blame for their abuse and totally blaming of the perpetrator. Approximately half the adult participants, however, blamed themselves to some extent. Wyatt and Newcomb (1990) found that 46% of a their sample of adult female CSA survivors cited some self-blame.

Peters and Range (1996) compared self-blame in a clinical and a college sample of CSA survivors and found that women with higher self-blame in both groups also had higher levels of depression, suicidal behaviour, and weaker reasons for living (i.e. not

committing suicide). In the clinical sample, women with higher self-blame were more likely to have self-mutilated. Although no association was found between self-blame and self-mutilation, a prevalence rate of 13% for self-mutilation was found in the student sample. The authors suggest that non-clinical samples may participate in less obvious self-destructive behaviours such as over-eating, sexual risk-taking, and substance abuse.

Lange et al. (1999) found that higher scores on measures of general psychopathology were associated with greater feelings of guilt in a non-clinical sample of 404 adult women survivors. 80% of participants attributed responsibility to the perpetrator, but 80% experienced guilt both in the past and present. Lange et al. propose that victims may know rationally that they are not to blame for CSA but still feel guilty about it. They comment that attribution of responsibility involves a cognitive process whereas development of guilt feelings appears to be mostly an emotional process. Whilst feelings of guilt were found to be significant predictors of symptomatology, feeling responsible for the abuse was not found to be related to later psychopathology, although it was associated with identity confusion.

Shame

Several authors have investigated the role of shame in their studies of self-blame. Using a large community sample of 192 adult CSA survivors, Coffey, Leitenberg, Henning, Turner and Bennett (1996) found that self-blame and perceived stigma mediated the relationship between CSA and adult adjustment, and were particularly affected by the level of sexual activity involved (CSA involving penetration). They propose that feelings of blameworthiness and shame may affect survivors' core beliefs about self-worth, thereby resulting in heightened levels of psychological distress. Higher levels of sexual activity are proposed to increase the sense of personal and societal violation, whilst higher frequency of sexual contact may have provided survivors with more perceived opportunities for stopping the abuse and subsequent higher levels of self-blame.

Feiring, Taska and Lewis (1996) propose that in sexually abused children and adolescents, cognitive attributions about sexual abuse lead to shame and stigmatization, which in turn lead to poor adjustment and mental health problems. They have subsequently found that shame and self-blaming attributions were related to depression and self-esteem in sexually abused children and adolescents. (Feiring, Taska and Lewis, 1998).

Andrews (1998) has proposed that characterological self-blame is linked to shame, which plays a mediating role in the link between early abuse and disorder by acting as a vulnerability factor, as well as being related to a more persistent and chronic course. Early abusive experiences are thought to produce a propensity for self-blame, shame and pathological guilt. The frequency with which abused children are told that they are bad and unlovable may make it more likely that they respond to subsequent negative events by blaming their character. Characterological self-blame may evoke feelings of helplessness about the unmodifiable (stable) nature of the perceived deficiencies, which together with feelings of badness lead to the experience of shame. Alternatively, Andrews proposes that internal, stable and global ("characterological") attributions for negative events may be the precursors of shame. Guilt is considered to involve self-punitive behaviour and anticipation of punishment, whereas shame is proposed to involve anticipation of rejection and scorn for supposed deficiencies. Andrews concludes that further research is needed into the complex relationships between self-blaming attributions, shame and pathological guilt.

The range of definitions and measures of blame and responsibility used in this research area makes comparisons difficult and limits the conclusions that can be drawn. Dalenberg and Jacobs (1994) have questioned the assumption that research questions using the words 'blame' and 'responsibility' evoke the same emotions or cognitions across different age groups, situations or studies. Minor differences in wording such as 'how much *were you to blame for....*', 'how much do you *feel to blame for....*', how much do you *think you were to blame for....*' might produce different responses, and adults are more likely than children to understand that admitting feeling to blame does not necessarily mean admitting being to blame.

McMillen and Zuravin (1997) point out that the use of single item indicators of blame (Morrow and Sorrell, 1989; Hoagwood, 1990) or mutually exclusive blame categories (Morrow, 1991; Hunter et al., 1992) does not reflect the many ways in which people blame themselves or others. Celano (1992) has developed a typology of children's self-blaming attributions related to CSA which includes actively participating in CSA, failing to avoid or control CSA, failing to seek help, failing to protect siblings and pleasure gained.

McMillen and Zuravin incorporated these in the 40 item Attributions of Responsibility and Blame Scales (ARBS). These were developed in order to examine in greater detail the relationships between self-blame, family/other blame and perpetrator blame and adult adjustment following CSA. Results from a non-clinical sample of 154 adult CSA survivors indicated that high levels of self-blame were rare, most participants reporting high perpetrator blame. This is consistent with the findings of Hunter et al. (1992). However, women with higher self-blame tended to have lower self-esteem, less comfort with closeness and more relationship anxiety than those with lower self-blame. Family/other blame was also positively associated with relationship anxiety, as well as increased probability of having a maltreated child. Perpetrator blame was not found to be related to any of the adjustment measures used. Interactions were found between patterns of blame attributions and views of others. Survivors with low levels of blame towards self, family/other and perpetrator had the most positive views of others, whilst those with high levels of blame in all three categories had the least positive views of others. McMillen and Zuravin conclude that the relationship between attributions for CSA and subsequent adjustment is interactional and more complex than has previously been thought. An acknowledged shortcoming of their research is that, with the exception of the Rosenberg Self-Esteem Scale, the idiosyncratic adjustment measures used prevent comparisons with existing literature regarding psychological adjustment. In addition, self-esteem, relationship anxiety, intimacy/dependency problems and views of others represent only a few areas of psychological adjustment, and only a few of the problems experienced by CSA survivors.

Sexual arousal during CSA

Handbooks on clinical work with CSA survivors describe the experience of sexual arousal during abuse as "associated with considerable guilt and distress" (Jehu, 1988), "a potent source of guilt and shame" (Hall and Lloyd, 1993), and generating "powerful feelings of guilt and shame, which cause the survivor falsely to attribute blame and responsibility to herself" (Sanderson, 1995). These texts also include advice on methods of dealing with the issue of sexual arousal in clinical work. Sexual arousal has not previously been included in research on the association of abuse characteristics such as duration, severity and relationship with the perpetrator to subsequent adjustment difficulties. As described above, recent research on cognitive processes mediating poor adjustment has concentrated on issues of blame, guilt and shame, but does not appear to have addressed the role of sexual arousal, or the extent to which it might influence subsequent psychopathology. Its absence from research studies may be due to fear that questions would be perceived as intrusive and distressing to CSA survivors, or implying that arousal is synonymous with enjoyment and therefore complicity in the sexual abuse process.

To conclude this introductory section, it is clear from the studies reviewed above that factors contributing to psychopathology associated with CSA are diffuse, and that complex relationships exist between them. The theoretical models described above have moved research forward by providing a springboard for further research ideas and hypothesis testing, and there is an increasing research emphasis on cognitive factors as mediators of symptomatology associated with CSA.

Although there is no prior research on the potential contribution of sexual arousal to this multidimensional picture, the research on cognitive variables appears to provide an appropriate context for investigation, and one which encompasses the author's clinical observations of increased feelings of guilt and self-blame amongst CSA

survivors who experienced sexual arousal. The study was therefore designed with the aim of investigating the relationships between sexual arousal, attributional style, causal attributions for CSA and psychological adjustment.

Description of Present Study

The current study compared attributional style, self-esteem and psychological adjustment in a non-clinical sample of female CSA survivors and a comparison group of non-abused women. Attributions of responsibility and blame were also examined amongst CSA survivors who reported experiencing sexual arousal during their abuse, and those who did not. The study was confined to female participants so that comparisons could be made with existing research, most of which has been based on female populations.

The definition of CSA used in the study follows that of Baker and Duncan (1985): - "A child (anyone under 16 years) is sexually abused when another person, who is sexually mature, involves the child in any activity which the other person expects to lead to their sexual arousal."

All participants were given a questionnaire booklet (Appendix 3) containing the following measures: - Expanded Attributional Style Questionnaire (Peterson et al, 1988); Symptom Checklist (Derogatis, 1996); Self-Esteem Scale, (Rosenberg, 1965); Attributions of Responsibility and Blame Scales (McMillen and Zuravin, 1997) Specific questions regarding CSA experiences and sexual arousal were included.

Hypotheses

1. Symptomatology

a) There will be higher levels of symptomatology in the CSA group than in the Comparison group.

b) There will be higher levels of symptomatology in the Aroused group than in the Non-Aroused group.

2. Self-Esteem

a) There will be lower levels of self-esteem in the CSA group than in the Comparison group.

b) There will be lower levels of self-esteem in the Aroused group than in the Non-Aroused group.

3. Negative Attributional Style

a) There will be greater internal, stable and global attributions for negative events (negative attributional style) in the CSA group than in the Comparison group.

b) There will be greater internal, stable and global attributions for negative events (negative attributional style) in the Aroused group than in the Non-Aroused group.

4. Self-Blame (CSA group only)

a) There will be higher levels of self-blame in the Aroused than in the Non-Aroused group.

b) There will be positive correlations between self-blame and psychopathology (i.e. symptomatology, negative attributional style and low self-esteem) in the CSA group.

5. Family/other Blame (CSA Group only)

a) There will be higher levels of family/other blame in the Aroused than in the Non-Aroused group.

b) There will be positive correlations between family/other blame and psychopathology (i.e. symptomatology, negative attributional style and low self-esteem) in the CSA group.

6. **Sexual Arousal (Aroused group only)**

There will be positive correlations between self-blame for sexual arousal and psychopathology (i.e. symptomatology, negative attributional style and low self-esteem) in the Aroused group.

METHOD

Study Design

This study was a between and within groups design, where the independent variable was presence or absence of a reported history of CSA. Within the CSA group, a further independent variable was the reported presence or absence of sexual arousal during CSA. A self-report questionnaire (Appendix 3) was used to derive the three study groups, which were compared on several different measures. The dependent variables were: -

<u>All Study Groups</u>

1) Attributional style, measured by the Expanded Attributional Style Questionnaire, (EASQ; Peterson et al., 1988)
2) Level of self-esteem, measured by the Rosenberg Self-Esteem Scale, (RSES; Rosenberg, 1965)
3) Evidence of psychological disturbance, measured by the Symptom Checklist (SCL90-R, Derogatis, 1996)

<u>CSA Group Only</u>

4) Attributions of responsibility and blame for sexual abuse, using the Attributions of Responsibility and Blame Scales, (ARBS, McMillen and Zuravin, 1997).
5) Occurrence of sexual arousal, indicated by Yes/No tick boxes

Aroused Group only (those answering Questionnaire item 5 affirmatively)

6) Frequency with which sexual arousal was experienced, measured by means of a visual analogue scale
7) Attributions of blame and responsibility for sexual arousal, devised for the present study by the author, using questions created in the style of the ARBS

Power Analysis

The author is not aware of any published research in which the experience of sexual arousal during CSA is an independent variable. A power analysis to determine the minimum number of subjects required for the present study to have adequate statistical power could therefore not be calculated in advance. As large a sample as possible was therefore collected in the time available. A post hoc power analysis on the basis of the present study would be included, so that sample sizes for future research on sexual arousal could be estimated.

Participants

Participants were female arts faculty undergraduates at a British university, who volunteered to take part in the study.

Measures

The questionnaire booklet (Appendix 3) comprised demographic questions (age and marital status), standard scales and measures, and individual questions regarding CSA experiences.

Expanded Attributional Style Questionnaire (EASQ)

The EASQ provides a measure of individual attributions regarding the causes of commonly occurring events involving the self. (Appendix 3, p. 3). Participants are presented with 24 hypothetical bad events, and asked to imagine the event happening to them. They then write "the one major cause of the event", and rate this cause in terms of internality (7) versus externality (1), stability (7) versus instability (1) and globality (7) versus specificity (1). A composite score is derived for each of the three dimensions by averaging the ratings over the 24 events. Individuals who habitually give internal, stable and global explanations are said to have a negative attributional style that puts them at risk for depression when bad events occur.

Peterson and Villanova (1988) describe the EASQ as a new and reliable measure of explanatory style, which differs from the original Attributional Style Questionnaire (ASQ) in that it includes only negative events. Reported internal consistencies are .66 for internality, .85 for stability and .88 for globality, and these are described as substantially higher than those for the ASQ. Despite these improvements in the reliability of EASQ, however, the authors point out that internality is the least coherent dimension of the scale, and that the stable and global dimensions of the EASQ remain substantially correlated, and may not be independent dimensions of explanatory style. The procedures adopted by researchers using the ASQ, who combined the scores from all three dimensions to produce a composite score for explanatory style (Peterson and Seligman, 1984) was therefore used in the present study.

Rosenberg Self-Esteem Scale (SES)

The SES (Appendix 3, p.15) asks participants to strongly agree, agree, disagree, or strongly disagree with 10 statements reflecting self-esteem, or global self-attitude. Five of the statements are positively worded so that their endorsement indicates high

self-esteem, whilst five are negatively worded, their endorsement indicating low self-esteem. The test was scored so that a high score indicates high self-esteem.

Rosenberg reports the SES as having a coefficient of reproducibility of 92%, and a coefficient of scalability of 72%, and proposes that these figures suggest satisfactory internal reliability. Two week test- retest reliability coefficients of r = .85 and r = .88 are also reported.

Construct validity for the SES is examined by investigating its relationship between the SES and a 6-item scale of depressive affect. Rosenberg reports that only four per cent of those with the highest self-esteem scores were rated as "highly depressed", as compared with 80% of those with the lowest self-esteem scores (r = .3008). A coefficient of .4848 is reported between the SES and anxiety symptoms in soldiers. 69% of those with lowest self-esteem compared with only 19 % of those with the highest reported a relatively large number of anxiety symptoms.

Symptom Checklist - (SCL90-R)

The SCL-90-R (Derogatis, 1994) is a 90 item self-report symptom inventory designed to measure current psychological symptom status (Appendix 4). Each item is rated on a five-point scale of distress (0 - 4) ranging from "Not at all" to "Extremely". The SCL-90-R is scored and interpreted in terms of nine primary symptom dimensions and three global indices of distress. The primary symptom dimensions are labelled as follows: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation. The global indices are Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total. These three global scores are highly correlated, and the present study uses the Global Severity Index (GSI) as a single summary measure, as proposed by Derogatis. The GSI reflects the number of symptoms and the intensity of perceived distress.

Derogatis (1994) reports the findings of several studies regarding psychometric properties of the SCL-90-R. A reliability study by Horowitz, Rosenberg, Baer, Ureno and Villasenor (1988), who administered the SCL-90-R to a group of 103 psychiatric outpatients, produced internal consistency coefficients for the nine symptom dimensions ranging from .79 to .90. Test-retest reliability coefficients for this group with 10 weeks between test ranged from .68 to .83. Derogatis, Rickels and Rock (1976) report test-retest reliability coefficients for a sample of 94 psychiatric outpatients with one week between tests ranging from .78 to .90. These coefficients are considered by Derogatis as quite satisfactory.

The SCL-90-R has been validated through its use as a screening device and an outcome measure in many different clinical and research contexts. Derogatis and Cleary (1977) have demonstrated good construct validity. Data from their factor analytic study of scores of 1002 psychiatric outpatients demonstrate that the hypothetical symptom constructs of the SCL-90-R can be recovered from real clinical data, and that the measures correlate well with accepted external criterion measures. Concurrent validity of the SCL-90-R has been established in several studies. Weissman, Sholomkas, Pottenger, Prusoff and Locke (1977) for example showed high correlations between the Depression subscale and the Hamilton Rating Scale. Peveler and Fairburn (1990) found a correlation of .80 between the Depression subscale and the Beck Depression Inventory. These researchers also examined content validity by correlating the global indices of the SCL-90-R with the global indices of the Present State Examination (PSE). All the correlations were significant and ranged from .60 to .82. Koeter (1992) compared the anxiety and depression subscales of the SCL-90-R and General Health Questionnaire (GHQ-28), and concluded that whilst both scales showed good convergent and discriminant validity, the SCL-90-R was the superior multidimensional measure of psychopathology.

CSA Experiences

Questions about past experiences of CSA were based on the definition of CSA (Baker and Duncan, 1985) given earlier. Questions were adapted from those used by Henderson et al. (1999), which followed those in Ussher and Dewberry's (1995) survey of the prevalence of CSA. Participants were asked about CSA experiences in the following manner: -

"When you were a child did an adult -

a) sexually expose themselves to you?

b) watch you bathing/dressing in a voyeuristic way?

c) make you touch them in a sexual way?

d) touch you in a sexual way without genital contact?

e) touch you in a sexual way including genital contact?

f) have sexual intercourse with you?

g) I have not experienced any of the above

Participants reporting no history of CSA were asked to discontinue the questionnaire booklet at this point. Participants who did report a history of CSA were asked further questions about their CSA experiences. These included the identity of the abuser(s), age at onset and cessation of CSA, number of times abused, whether physical force was used, whether the abuser tried to prevent disclosure, whether disclosure occurred, at what age, and whether participants were believed. Questions were also asked about perceived effects, and whether participants had received or were currently receiving professional help for psychological distress or problems.

Attributions of Responsibility and Blame Scales (ARBS)

Participants were then asked to complete the Attributions of Responsibility and Blame Scales, a 40-item questionnaire designed to provide a measure of the direction and intensity of attributions of responsibility and blame for CSA experiences

(Appendix 3, p. 20). Items were designed to assess three directions of blame attributions - self, family/other and perpetrator.

As the ARBS is a relatively new assessment measure, psychometric data is limited. McMillen and Zuravin report internal consistency reliability coefficients of .91 for both the self-blame and family/other blame scales, and .68 for the perpetrator blame scale. The sample used was 154 low-income mothers. Construct validity was confirmed by factor analysis. The authors confirmed the existence of three factors - self-blame, family/other blame and perpetrator blame, and state that most items had excellent to satisfactory item-total correlations. Only three out of the 40 items had item-total correlations of less than .30.

Sexual Arousal

Participants were asked to answer Yes or No as to whether they had experienced any sexual arousal during their abuse. Participants answering negatively were asked to discontinue the questionnaire at this point. Those answering affirmatively were subsequently asked to indicate the frequency with which they had experienced sexual arousal during CSA on a visual analogue scale marked Never to Always. (Appendix 3, p.22).

In order to examine the potential relationship between sexual arousal and blame, six questions assessing direction and intensity of blame for sexual arousal during CSA followed. (Appendix 3, p.23). The questions were created in the style of the ARBS, and were equally balanced between self-blame, family/other blame, and perpetrator blame. These had been previously piloted amongst 6 clinicians experienced in working with adults with a history of CSA.

Procedure

Female arts faculty undergraduates were asked to stay behind at the end of a number of lectures. The researcher gave a verbal introduction to the area of study, followed by an Information Sheet to read through (Appendix 2). Voluntary participation and complete anonymity were stressed. The undergraduates were informed that they could earn a course credit for returning a completed questionnaire. Those choosing to take part were asked to take a questionnaire booklet to complete at home, and to return it in a sealed envelope to the researcher. Information was provided about dates and times when the researcher would be available to receive questionnaires, to discuss any issues arising from participation, and to give information about obtaining professional help if required.

The number of undergraduate women comprising the three academic year groups sampled was 333, although full attendance by each year group at the lectures in question is unlikely. Questionnaires were taken by 183 women, and 102 completed questionnaires were returned. This constituted a return rate of 56%. Return rates of more than 50 % are considered "adequate" for analysis and reporting (Babbie, 1990). Two questionnaires were excluded from the analysis, as the abuse they described did not meet the definition of sexual abuse used in the present study. (One participant had been raped at age 17; the other described sexual activity at age 14 with a cousin of the same age).

RESULTS

One hundred female undergraduates aged 18 years and over, returned completed questionnaires suitable for analysis. Statistical analysis was performed using SPSS Release Version 8 (SPSS Inc). An alpha level of .05 was used for all statistical tests.

Twenty five per cent of the women who returned questionnaires indicated a history of CSA, as defined by criteria described earlier. Eight women (32%) within this group reported experiencing sexual arousal during their abuse.

Study Groups

All participants giving a history of CSA (n=25) will be known as the CSA group. Participants within the CSA group indicating sexual arousal during their abuse (n=8) will be known as the Aroused group. Those not indicating sexual arousal during their abuse (n=17) will be known as the Non-Aroused group. Participants who did not give a history of sexual abuse (n=75) will be known as the Comparison group.

The following sections report demographic information, CSA characteristics for the CSA group, CSA characteristics compared between the Aroused and Non Aroused groups, and then the study hypotheses.

Demographic Characteristics of Study Groups

Age

The mean ages and age ranges of the three groups are illustrated in Table 1 below.

Table 1: Means, Standard Deviations and Age Ranges for All Study Groups

	Mean	S. D.	Range
Comparison Group (n=73)	21.25	5.88	18 - 49
CSA Group (n=25)	24.44	8.19	18 - 49
- Aroused Group (n=8)	20.75	2.49	19 - 26
- Non-Aroused Group (n=17)	26.18	9.37	18 - 49

Independent t-tests (Appendix 6) revealed that there was no significant difference in age between the CSA group and the Comparison group ($t = 1.80$; $p = .082$). Within the CSA group, however, there was a significant difference in age between the Aroused and Non-Aroused groups, with the Non-Aroused group being significantly older ($t = 2.23$; $p = .038$) (Appendix 7).

Marital Status

80% of the CSA group (20 participants) and 92% of the Comparison group (67 participants) indicated that they were single. Table 2 below illustrates the marital status of all participants in the study.

Table 2: Marital Status of All Study Groups

	Single	Married	Cohabiting	Divorced	Widowed
Comparison Group (n=73)	92% (67)	1% (1)	6% (4)	0%	1% (1)
CSA Group (n=25)	80% (20)	8% (2)	8% (2)	4% (1)	0
- Aroused Group (n=8)	87.5% (7)	0%	12.5% (1)	0%	0%
- Non-Aroused Group (n=17)	76% (13)	12% (2)	6% (1)	6% (1)	0%

Characteristics of CSA Experiences

Type of CSA

Participants reported a variety of types of CSA. The following table illustrates the numbers of participants reporting different types of CSA.

Table 3: Type of CSA reported

Type of CSA	% of CSA Group (n=25)	n
Abuser touched participant in sexual way including genitals	60%	15
Abuser sexually exposed self to participant	56%	14
Abuser touched participant in sexual way excluding genitals	48%	12
Abuser made participant touch them in sexual way	44%	11
Abuser watched participant bathe/dress in voyeuristic way	20%	5
Abuser had sexual intercourse with participant	20%	5

The majority of the CSA Group (88%) experienced contact CSA, in which they were made to touch or were touched by the abuser in a sexual way. Within this group, 28% of participants experienced one type of contact CSA only. 16% experienced two types of contact CSA, 8% experienced three types, 24% experienced four types and 12% experienced five types. Three participants in the CSA group (12%) experienced non-contact CSA only (sexual exposure or voyeuristic activity).

Severity

Table 4 below illustrates the severity (number of different types) of contact and non-contact CSA reported by participants.

Table 4: Severity (Number of Different Types) of CSA

Number of types of CSA experienced	% of CSA Group (n = 25)	n
1	32%	8
2	20%	5
3	12%	3
4	24%	6
5	12%	3

Identity of abuser

Nine of the CSA group participants (36%) had experienced familial CSA, involving fathers, stepfathers, brothers, cousins and uncles. The majority of CSA group participants (72%) had experienced non-familial CSA . Participants describing CSA by a father, parent figure and/or relative were categorised as experiencing familial CSA, even if they also reported non-familial CSA; the latter comprised CSA by a family friend/acquaintance and/or other (stranger).

Eleven participants (44%) reported being sexually abused by family friends or acquaintances, and five (20%) reported sexual abuse by specified "others". Individuals in this category were all male, and included local teenage boys, a hospital carer, piano teacher, school busdriver, electrician, and nurse. Four participants (16%) described their abusers as strangers.

The relationship of the abuser to the participants is illustrated in the table below. The counts per type of abuser are not mutually exclusive, as they include four participants (16%) who reported sexual abuse by more than one abuser; three participants reported CSA by two abusers, and one participant reported CSA by three abusers.

Table 4: Identity of Abuser

Relationship of abuser to participant	% of CSA Group	n
Family friend/acquaintance	44%	11
Other (stranger)	36%	9
Other relative	28%	7
Father	4%	1
Other parent figure	4%	1
Mother	0%	0

Age at Onset

The reported range of ages at the onset of CSA was 4 to 15 years. Table 5 below shows levels of age at onset and the percentages of participants reporting CSA beginning within them. Data was missing for one respondent.

Table 5: Age at onset of CSA

Age at Onset	% of CSA Group	n
4 - 6	37%	9
7 - 9	25%	6
10 - 12	17%	4
13 - 15	21%	5

Frequency of Abuse

Just under half the participants in the CSA group (48%) reported having experienced CSA on up to five occasions. The remainder of the group (52 %) reported having experienced CSA on six or more occasions, as shown in Table 6 below.

Table 6: Number of incidents of sexual abuse.

Number of times abused	% of CSA Group	n
< 5 times	48%	12
6 - 10 times	12%	3
11 - 20 times	24%	6
> 20 times	16%	4

Question 9 did not ask for actual number of times participants experienced CSA; the "< 5 times" category could not therefore be subdivided.

Duration of Abuse

The period of time over which sexual abuse occurred ranged from less than one year to 12 years. Just under half of participants (43.5%) reported CSA over a period of less than one year. This is consistent with the previous data indicating that 48% of participants experienced CSA on up to five occasions. Four participants (17.4%) reported duration periods of one to two years, three to five years and six to ten years, whilst one participant's abuse went on for more than ten years. Data was missing for 2 respondents. Table 7 shows the periods of time over which participants reported experiencing CSA.

Table 7: Duration of CSA

Duration	% of CSA Group	n
Less than 1 year	43.5%	10
1 - 2 years	17.4%	4
3 - 5 years	17.4%	4
6 - 10 years	17.4%	4
More than 10 years	4.3%	1

Other Characteristics of Abuse Experience

Ten respondents (40%) reported that physical force had been used during their sexual abuse. Thirteen respondents (54%) reported that their abuser(s) had tried to prevent them from disclosing. The most frequently used methods for prevention of disclosure were being told by the abuser that nothing was wrong, that the participant's family would split up if she told, that the participant would be blamed and/or not believed.

Thirteen respondents (54%) had told someone (not necessarily a family member) about their abuse. Nine of these respondents (64%) had been believed.

Psychological Problems

In answer to the checklist provided for question "How has the abuse affected you?", two participants indicated that they had felt no effects. The majority of the group (92%), however, reported experiencing problems as a result of the CSA. Low self-

esteem was the most frequently endorsed item on the checklist, indicated by 60 % (15) respondents. Just over half the group (13 participants) indicated having sexual problems, and 12 participants (48%) indicated feeling ashamed. Depression was indicated by 44% (11) participants, whilst anxiety, phobias and feelings of anger were reported by 40% (10) participants. Nine participants (36%) reported eating problems and sleep problems. Eight participants (32%) endorsed the items fear of men, feelings of guilt and suicide attempts. Six participants (24%) indicated self-injury, whilst the substance abuse item was endorsed by five participants (20%).

Characteristics of CSA Experiences between Aroused and Non-Aroused Groups

Fisher's Exact Test allows analysis of nominal data for significant differences between small groups, and was used in order to examine the comparability of the Aroused and Non-Aroused groups with regard to type of CSA, identity of abuser, familial versus non familial CSA, psychological problems reported and other questionnaire items. The percentages of participants in each group are illustrated in the following tables and figures, followed by results of the statistical analyses.

Type of CSA

Table 8 below illustrates the proportions of Aroused and Non-Aroused participants indicating different types of CSA.

Table 8: Type of CSA experienced

Type of CSA	% Aroused Group (n = 8)	% Non-Aroused Group (n = 17)
Abuser touched participant in sexual way including genitals	75% (6)	53% (9)
Abuser sexually exposed self to participant	75% (6)	53% (9)
Abuser touched participant in sexual way excluding genitals	37.5% (3)	53% (9)
Abuser made participant touch them in sexual way	75% (6)	30% (5)
Abuser watched participant bathe/dress in voyeuristic way	50% (4)	6% (1)
Abuser had sexual intercourse with participant	37.5% (3)	12% (2)

The categories above are not mutually exclusive, as the majority of participants had experienced more than one type of CSA. Inspection of these figures indicates that a higher proportion of participants in the Aroused group than in the Non-Aroused group had been made to touch the abuser in a sexual way, had been watched voyeuristically and/or had sexual intercourse.

In order to make a statistical comparison using Fisher's Exact Test this data was collapsed into contact versus non-contact CSA, illustrated in the Table 9 below. Non-contact CSA comprised sexual exposure and voyeurism by the abuser. All other categories were classified as contact CSA.

Table 9: Contact vs Non-Contact CSA between Aroused and Non-Aroused Groups

	Aroused Group (n=8)	Non-Aroused Group (n=17)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Contact CSA	8	15	1.000 (n.s.)	.453 (n.s.)
Non-Contact CSA	0	2		

All participants in the Aroused group had experienced contact CSA, as would be expected. The majority (88%) of the Non Aroused group had also experienced contact CSA. Fisher's Exact Test (Appendix 8) indicated no significant difference between the Aroused and Non-Aroused groups in the proportion of contact or non-contact CSA experienced.

Identity of Abuser

Table 10 illustrates the relationship of abusers to participants in the Aroused and Non-Aroused groups.

Table 10: Identity of Abuser

Relationship of abuser to participant	% Aroused Group (n = 8)	% Non-Aroused Group (n = 17)
Family friend/acquaintance	37.5% (3)	53% (9)
Other (stranger)	25% (2)	41% (7)
Other relative	50% (4)	18% (3)
Father	12.5% (1)	0
Other parent figure	12.5% (1)	0

The categories above are not mutually exclusive, since four participants indicated CSA by more than one abuser. Inspection of the figures suggests that more than twice the percentage of participants in the Aroused group than in the Non-Aroused group indicated abuse by a relative. CSA by a family friend, acquaintance or other person was indicated more often by the Non-Aroused group, although not exclusively.

This data was collapsed into familial versus non-familial CSA, illustrated in Table 11 below.

Table 11: Familial vs Non-Familial CSA between Aroused and Non-Aroused Groups

	Aroused Group (n=8)	**Non-Aroused Group (n=17)**	**Exact Sig. (2-sided)**	**Exact Sig. (1-sided)**
Familial CSA	4	3	.156 (n.s)	.116(n.s)
Non-Familial CSA	4	14		

Table 11 shows that 50% of the Aroused group experienced familial CSA by comparison with only 18% of the Non-Aroused group. Non-familial CSA was experienced by 50% of the Aroused group by comparison with a larger proportion (82%) of the Non-Aroused group. Fisher's Exact Test (Appendix 10) indicated no significant difference, however, between the proportions of the Aroused and Non-Aroused groups experiencing familial and non-familial CSA.

Although hypotheses were not made in the present study about familial versus non-familial CSA as an independent variable, a post-hoc analysis (MANOVA) was carried out to explore any differences in symptomatology, self-esteem, negative attributional style or blame between these two groups. The result yielded a non-significant group

main effect (Wilks' Lambda F (1,21) = .796; p=.587) obtained by the familial and non-familial groups on these variables together. Further inspection of the individual ANOVAs also showed no significant differences between the two groups in symptomatology, self-esteem, negative attributional style or blame. (Appendix 11)

Frequency of CSA

Figure 1 below illustrates the reported number of times participants in the Aroused and Non-Aroused groups experienced CSA.

Figure 1: Frequency of CSA for Aroused and Non-Aroused groups

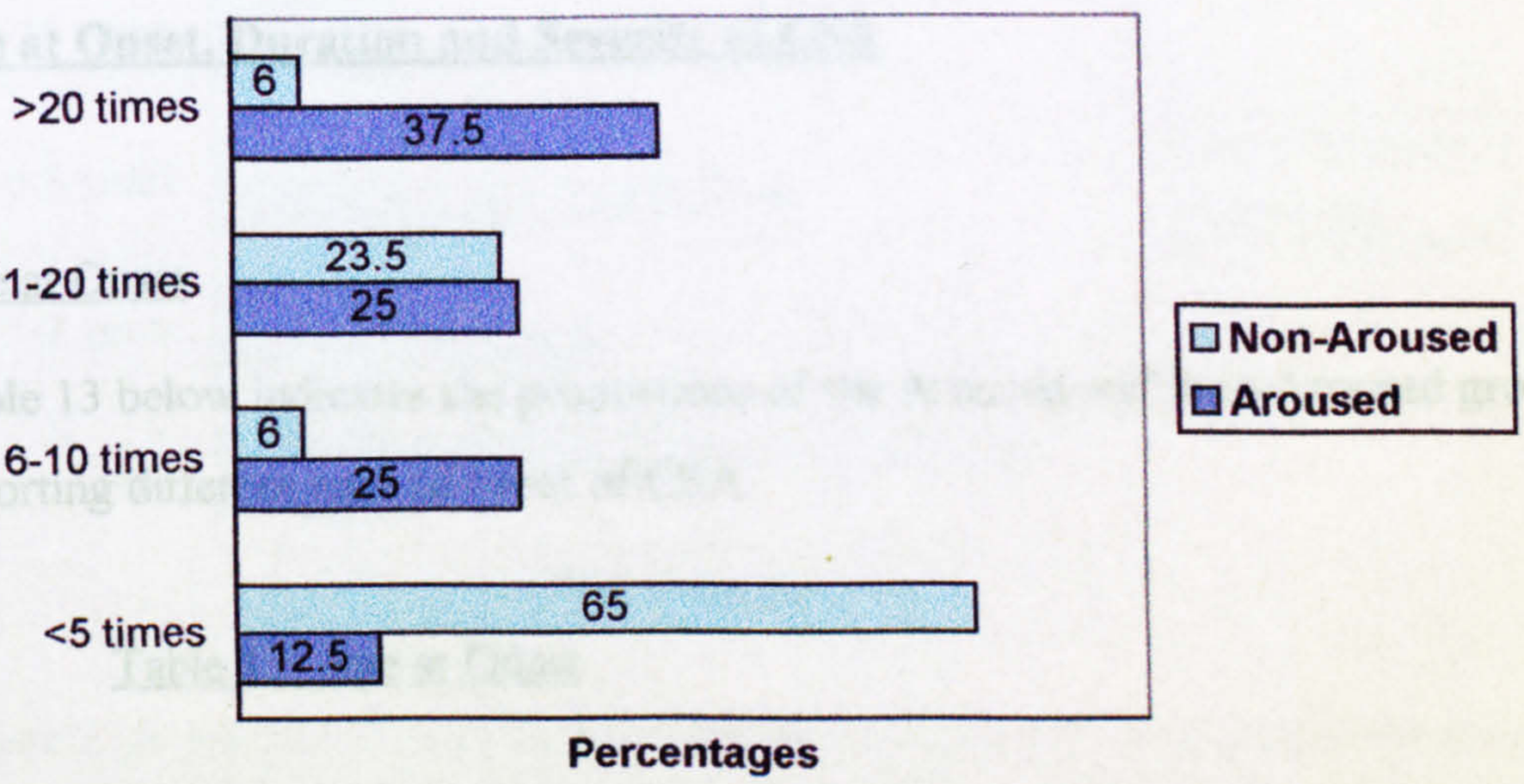


Figure 1 indicates that 62.5 % of the Aroused group experienced CSA more than ten times, by comparison with 29.5% of the Non Aroused group. Two thirds of the Non-Aroused group experienced CSA less than five times. As the questionnaire data for frequency of experiencing CSA was grouped in categories rather than actual number of times, an initial analysis was carried out using the Mann-Whitney U Test, which tests for significance of differences between categories. The results of this analysis (Appendix 12) are given in the following table.

Table12: Mann-Whitney Test for Frequency of CSA for Aroused and Non-Aroused Groups

		Aroused Group (n=8)	Non-Aroused Group (n=17)	Mann-Whitney U	Z	p
FREQUENCY OF CSA	Mean Rank	17.75	10.76	30.00	-2.372	.027

This result indicates that there was a significant difference between the Aroused and Non-Aroused groups in terms of the frequency of CSA. The Aroused group were significantly more likely to have experienced CSA more frequently than the Non-Aroused group.

Age at Onset, Duration and Severity of CSA

Age at Onset

Table 13 below indicates the proportions of the Aroused and Non-Aroused groups reporting different ages of onset of CSA.

Table 13: Age at Onset

Age at Onset	% Aroused Group (N = 8)	% Non-Aroused Group (n = 17)
0 - 4	12.5% (1)	12% (2)
5 - 9	62.5% (5)	47% (8)
10 - 14	12.5% (1)	29% (5)
15+	12.5% (1)	12% (2)

Inspection of these figures in Table 13 indicates that the age of onset was comparable for both the Aroused and Non-Aroused groups, with most abuse starting between the ages of five and nine years.

Duration

Figure 2 below illustrates the reported time period over which participants in the Aroused and Non- Aroused groups experienced CSA.

Figure 2: Duration of CSA for Aroused and Non-Aroused Groups

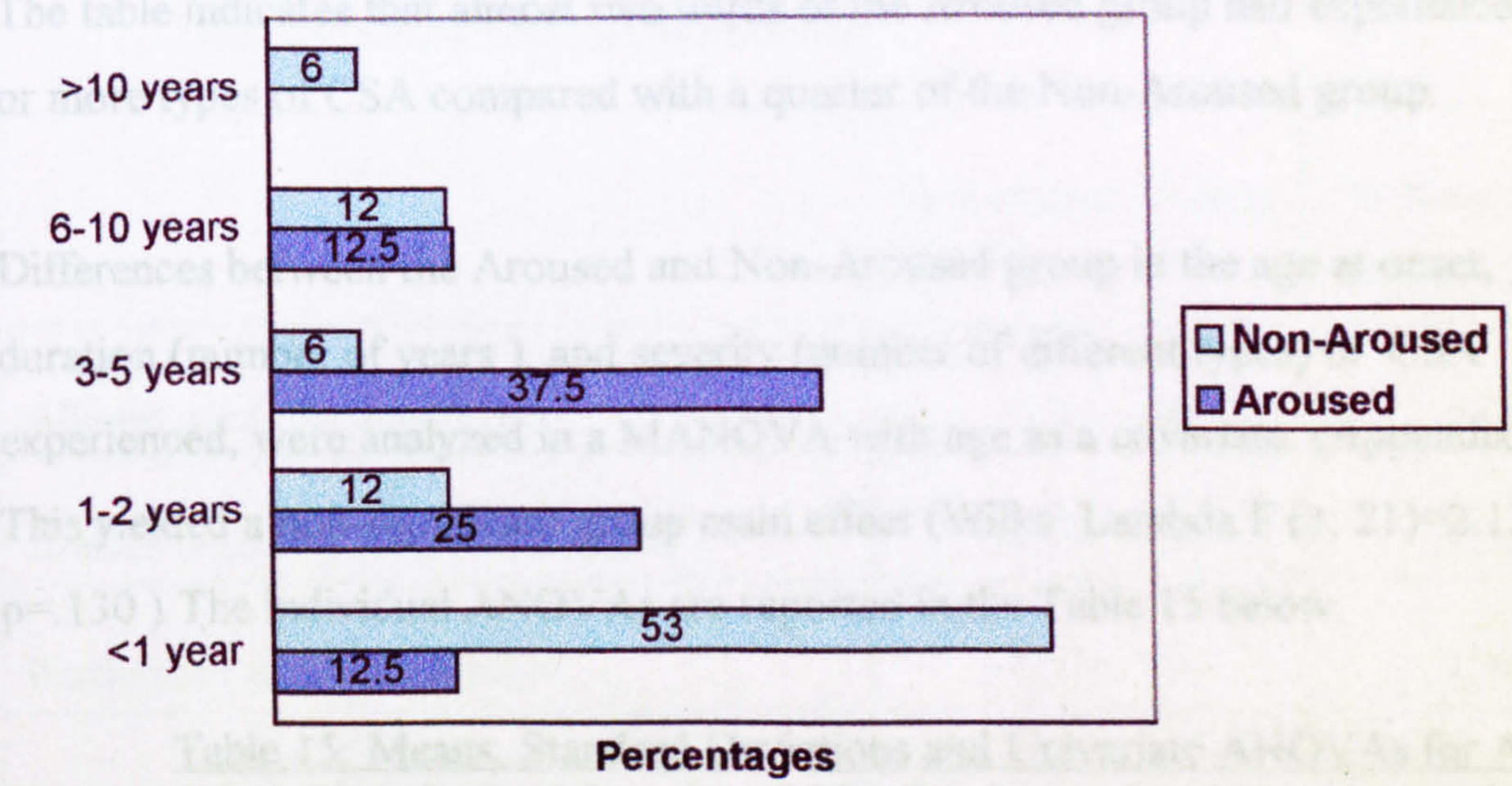


Figure 2 shows that 75% of the Aroused group indicated being abused for more than one year, and 50% indicated abuse occurring for three or more years. By comparison, 53% of the participants in the Non-Aroused group indicated the time period of their abuse as being less than one year.

Severity

Table 14 below indicates the numbers of different types of CSA reported by participants in the Aroused and Non-Aroused groups.

Table 14 : Severity (Number of Types) of CSA

NUMBER OF TYPES OF CSA	% Aroused Group (N = 8)	% Non-Aroused Group (n = 17)
1	12.5% (1)	41% (7)
2	12.5% (1)	23.5% (4)
3	12.5% (1)	12.% (2)
4	25% (2)	23.5% (4)
5	37.5% (3)	0

The table indicates that almost two thirds of the Aroused group had experienced four or more types of CSA compared with a quarter of the Non-Aroused group.

Differences between the Aroused and Non-Aroused group in the age at onset, duration (number of years), and severity (number of different types) of CSA experienced, were analyzed in a MANOVA with age as a covariate. (Appendix 9). This yielded a non-significant group main effect (Wilks' Lambda F (1, 21)=2.13; p=.130) The individual ANOVAs are reported in the Table 15 below.

Table 15: Means, Standard Deviations and Univariate ANOVAs for Age at Onset, Duration and Severity of CSA for Aroused and Non-Aroused Groups

		Aroused Group (n=8)	Non-Aroused Group (n=17)	df	F	p
Age at onset	Mean *S.D.*	8.57 3.95	9.06 4.19	1,22	.069	.795 (n.s.)
Duration (years)	Mean *S.D.*	3.07 *2.20*	2.82 *3.97*	1,22	.024	.879 (n.s.)
Severity (number of types)	Mean *S.D.*	3.62 *1.51*	2.17 *1.23*	1,22	6.51	.018

These results indicate that there was a significant difference between the Aroused and Non-Aroused groups in terms of the severity (number of types of CSA) experienced. The Aroused group had experienced more types of CSA than the Non-Aroused group. Differences between the Aroused and Non-Aroused groups on age at onset and duration of CSA were not statistically significant however.

Other Questionnaire Items

Table 16 includes the proportions of the two groups experiencing particular events connected with CSA.

Table 16: Other Questionnaire Items

	% Aroused Group (n = 8)	**% Non-Aroused GROUP (N = 17)**
Abuser used physical force	50% (4)	35% (6)
Abuser tried to prevent disclosure	62.5% (5)	53% (9)
Participant disclosed abuse	62.5% (5)	41% (7)
Participant was believed	37.5% (3)	35% (6)
Participant had professional help in past	62.5% (5)	41.2% (7)
Participant currently receiving professional help	25% (2)	6% (1)

Inspection of these figures indicates that the Aroused group tended to report experiencing physical force during abuse, disclosing abuse and having professional help somewhat more often than the Non-Aroused group. Fisher's Exact Test was used to examine whether there were significant differences on the variables in Table 16. Past and current professional help were collapsed into a single variable called help-seeking. The results of these analyses (Appendix 13) indicated no significant

differences between the proportions of the Aroused and Non-Aroused groups reporting these experiences.

Psychological Problems

Figure 3 below shows the proportions of participants in the Aroused and Non-Aroused groups reporting psychological problems following CSA (Question 17).

Figure 3: Proportion of Aroused and Non-Aroused Groups reporting Psychological Problems

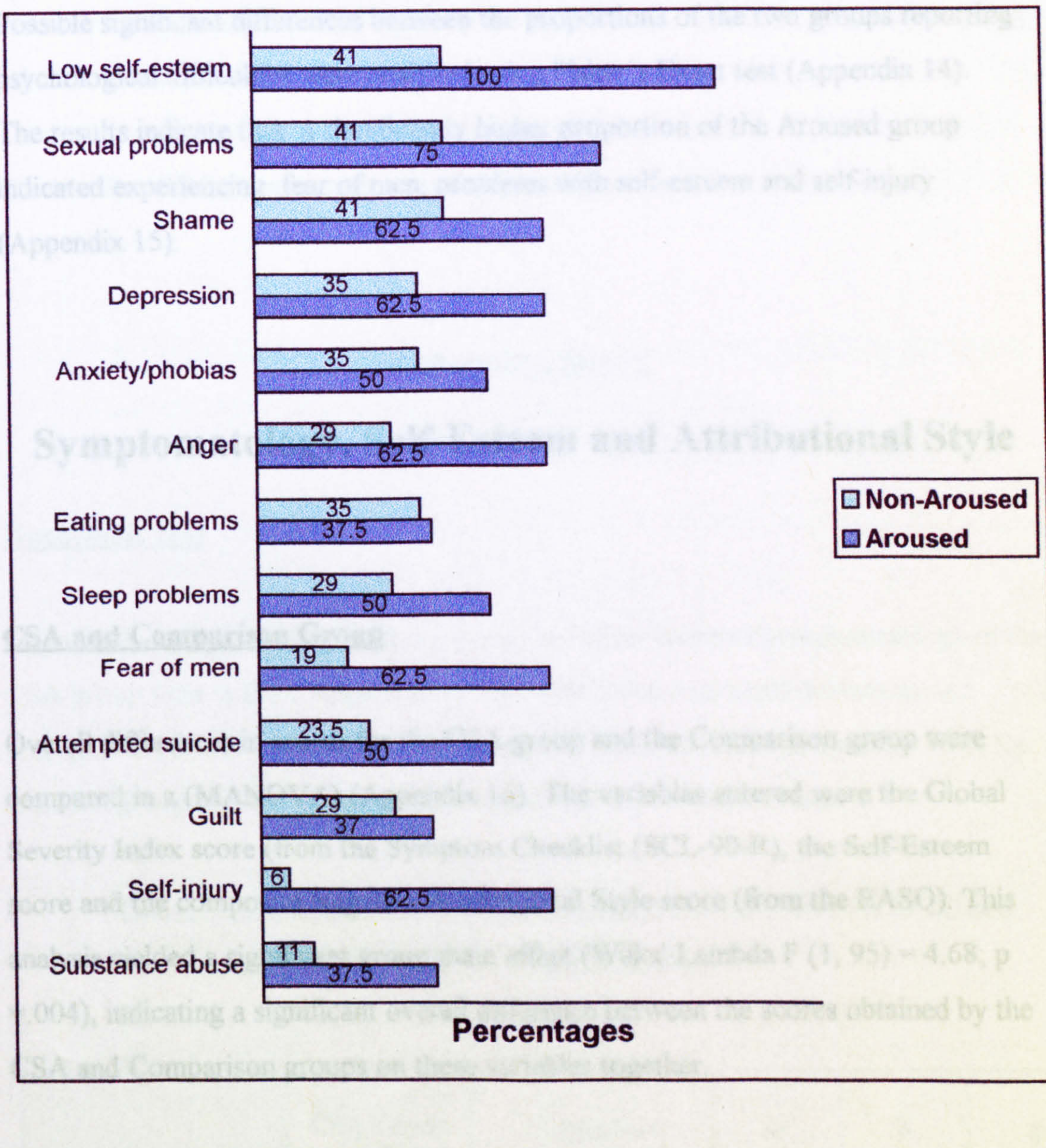


Figure 3 illustrates that the Aroused group indicated proportionally more psychological difficulties than the Non-Aroused group. All participants in the Aroused group indicated having low self-esteem compared with 41% of the Non-Aroused group. Self-injury and fear of men were reported by two thirds of the Aroused group, as compared with 6% and 19% respectively of the Non-Aroused

group. Approximately twice the percentage of participants in the Aroused group reported sexual problems, anger, attempted suicide and self-injury than in the Non-Aroused group. Shame, depression, anxiety, sleep problems and guilt were also reported proportionally more often by the Aroused group.

Possible significant differences between the proportions of the two groups reporting psychological difficulties were analyzed using Fisher's Exact test (Appendix 14). The results indicate that a significantly higher proportion of the Aroused group indicated experiencing fear of men, problems with self-esteem and self-injury (Appendix 15).

Symptomatology, Self-Esteem and Attributional Style

CSA and Comparison Group

Overall differences in scores for the CSA group and the Comparison group were compared in a (MANOVA) (Appendix 16). The variables entered were the Global Severity Index score (from the Symptom Checklist (SCL-90-R), the Self-Esteem score and the composite Negative Attributional Style score (from the EASQ). This analysis yielded a significant group main effect (Wilks' Lambda $F(1, 95) = 4.68$; $p = .004$), indicating a significant overall difference between the scores obtained by the CSA and Comparison groups on these variables together.

Aroused and Non-Aroused Group

Overall differences in Global Severity Index, Self-Esteem, Negative Attributional Style, Self-blame, Family Blame and Perpetrator Blame scores for the Aroused group and the Non-Aroused group were compared in a separate MANCOVA (Appendix

17). In view of the significant differences found between the two groups in age, frequency and severity of CSA, these were entered as a covariates. This yielded a non-significant group main effect (Wilks' Lambda F (1, 18) =1.25; p=.344) for the Aroused and Non-Aroused groups on these variables together. Further inspection of the univariate ANCOVAs showed a significant difference in self-blame scores between the Aroused and Non-Aroused groups, but no significant differences on any other of the variables.

The results of these two analyses are reported below.

Symptomatology

Hypothesis 1(a)

Hypothesis 1(a) predicted that there would be higher levels of symptomatology in the CSA group than in the Comparison group. The means, standard deviations and results of the univariate ANOVA for the Global Severity Index of the SCL-90-R for the CSA group and the Comparison group are given in Table 17 below.

Table 17: Means, Standard Deviations and univariate ANOVA for Global Severity Index for CSA and Comparison Groups

		CSA Group (n =23)	Comparison Group (n =74)	df	F	p
Global Severity Index (GSI)	Mean *S.D.*	1.242 *.8667*	.7192 *.5004*	1, 95	13.08	.0001

The univariate ANOVA for the Global Severity Index indicated a significant difference between the two groups (F (1, 95) = 13.08; p = .0001), with Global

Severity Index scores being higher in the CSA group. This finding confirms hypothesis 1(a), that there would be higher levels of symptomatology in the CSA group than the Comparison group.

Hypothesis 1 (b)

Hypothesis 1 (b) predicted that there would be higher levels of symptomatology in the Aroused group than in the Non-Aroused group. The means, standard deviations and univariate ANCOVA results for the Global Severity Index for the Aroused and Non-Aroused groups are given in Table 18 below.

Table 18: Means, Standard Deviations and Univariate ANCOVA for Global Severity Index for Aroused and Non-Aroused Groups

		Aroused Group (n=8)	Non-Aroused Group (n=15)	df	F	p
Global Severity Index (GSI)	Mean *S.D.*	1.825 *.6214*	.9307 *.8302*	1,18	1.466	.242

The univariate ANCOVA for the Global Severity Index score was not significant ($F(1, 20) = 4.12$; $p = .056$) and hypothesis 1(b) could not be confirmed.

The Aroused group mean GSI score was twice as high as the Non-Aroused group mean, however, and a statistical power analysis (Borenstein and Cohen, 1988) indicated an effect size of .77 for the difference in Global Severity Index scores between the two groups. An effect size of .80 is defined as large in social science studies (Cohen, 1988). Obtaining an effect size of this magnitude suggests that there may be a clinically important difference between these two groups in terms of symptomatology.

The following list is included to illustrate the comparison of Global Severity Index scores obtained by all three groups in the current study with normative data (italicized) (Derogatis, 1994): -

Aroused Group	1.82	(S.D.= .62)
Female Psychiatric In-Patients	*1.43*	*(S.D.= .83)*
Female Psychiatric Out-Patients	*1.35*	*(S.D.= .69)*
CSA Group	1.24	(S.D.= .87)
Non-Aroused Group	0.93	(S.D.= .83)
Female Adolescent Non-Patients	*0.85*	*(S.D.= .54)*
Comparison Group	0.72	(S.D.= .50)
Female Non-Patients	*0.36*	*(S.D.= .37)*

It is of note that the mean GSI score for the Aroused group is above that found for female psychiatric in-patients. It is also of note that the mean GSI score for the CSA group as a whole is closer to the mean for Female Psychiatric Out-Patients than to the mean for Female Adolescent Non-Patients.

SCL-90-R Subscale Scores

1. CSA versus Comparison group

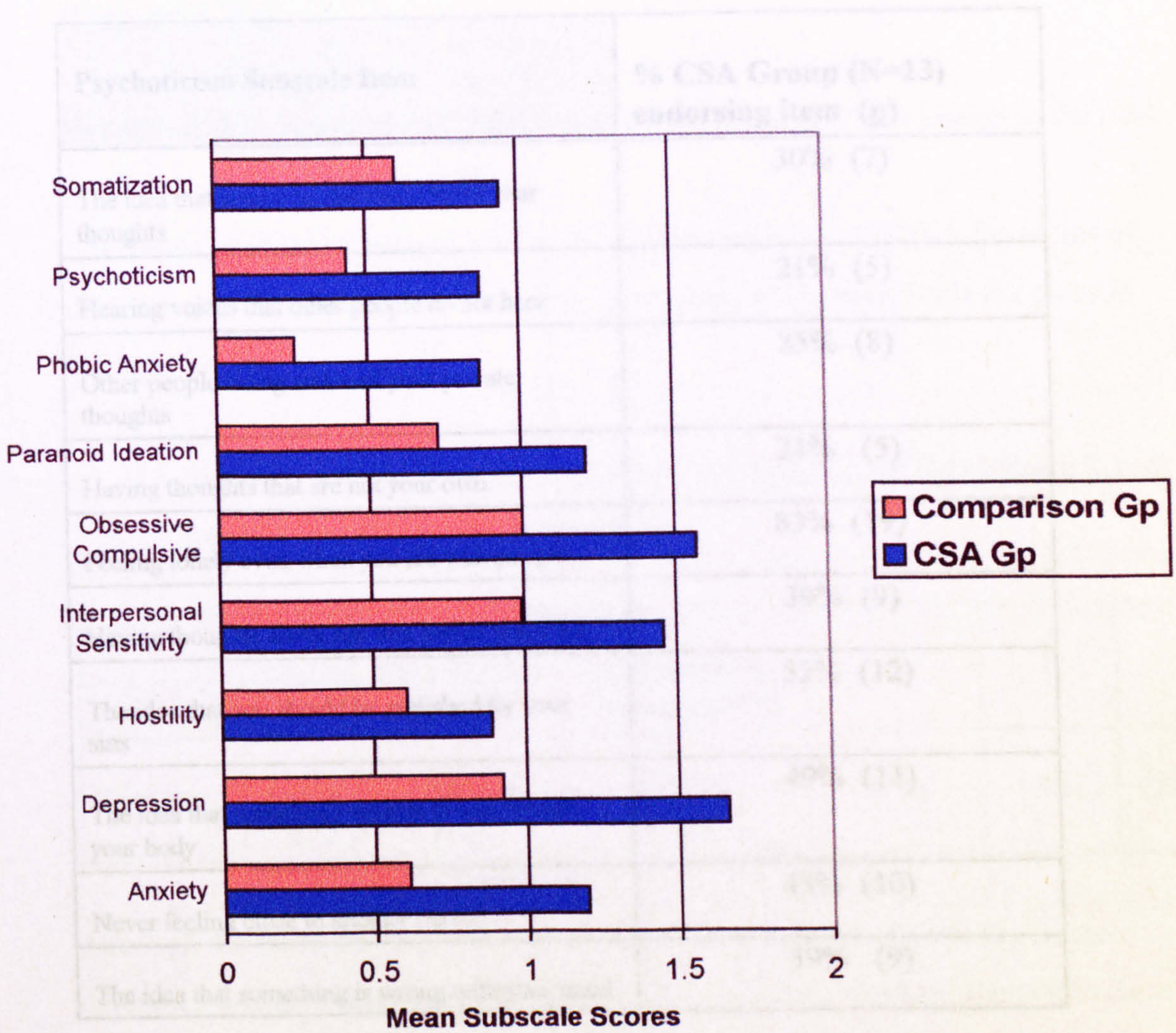
In order to explore particular subscales differentiating the CSA group from the Comparison group a further analysis was carried out. The nine subscales were entered into a MANOVA (Appendix 18). The obtained significant group main effect, (Wilks' Lambda F (1,95) = 2.84; p=.006) indicated a significant overall difference between scores obtained by these two groups on the subscale scores together. Means, standard deviations and univariate ANOVA results are given in the following table.

Table 19: Means, standard deviations and univariate ANOVAs for SCL-90-R subscale scores for CSA and Comparison groups

	CSA Group (n=23)	**Comparison Group (n=74)**	**F (df = 1,95)**	**p**
Anxiety	1.196 *(1.024)*	.6122 *(.5632)*	12.28	.001
Depression	1.662 *(1.112)*	.9203 *(.6774)*	15.09	.000
Hostility	.8896 *(8813)*	.6086 *(.6355)*	2.82	.096
Interpersonal Sensitivity	1.457 *(1.015)*	.9916 *(.7754)*	5.43	.022
Obsessive Compulsive	1.570 *(.9871)*	1.000 *(.6264)*	10.47	.002
Paranoid Ideation	1.211 *(1.035)*	.7265 *(.6153)*	7.65	.007
Phobic Anxiety	.8691 *(1.035)*	.2580 *(.4181)*	17.13	.000
Psychoticism	.8743 *(.9034)*	.4357 *(.5761)*	7.6	.000
Somatization	.9422 *(.7836)*	.6014 *(.5680)*	5.23	.024

It can be seen that the mean scores for the CSA group were significantly higher than those of the Comparison group on all subscale scores except for Hostility. The differences in scores obtained by the two groups are illustrated in Figure 4 below.

Figure 4: Mean SCL-90-R Subscale Scores for CSA and Comparison Groups



The scores of the CSA group on the Psychoticism subscale were unexpected, and these were re-examined to establish which particular questions in this scale were contributing to the high scores. Table 20 below illustrates the proportion of participants in the CSA group endorsing items on this subscale.

Table 20: Proportions of CSA group endorsing Psychoticism subscale items

Psychoticism Subscale Item	**% CSA Group (N=23) endorsing item (n)**
The idea that someone else can control your thoughts	30% (7)
Hearing voices that other people do not hear	21% (5)
Other people being aware of your private thoughts	35% (8)
Having thoughts that are not your own	21% (5)
Feeling lonely even when you are with people	83% (19)
Having thoughts about sex that bother you a lot	39% (9)
The idea that you should be punished for your sins	52% (12)
The idea that something serious is wrong with your body	49% (11)
Never feeling close to another person	43% (10)
The idea that something is wrong with your mind	39% (9)

The table above shows that the majority of the CSA group endorsed feeling lonely even when in company, and that half of the group endorsed the idea of deserving punishment for their sins and having something seriously wrong with their bodies. Never feeling close to another person, having troublesome thoughts about sex and having something wrong with their mind were endorsed by about two fifths of the group. A third of the group endorsed the idea that someone could control their thoughts and other people being aware of their private thoughts. A fifth of the group endorsed hearing voices and having thoughts that were not their own.

Self-Esteem

Hypothesis 2(a)

Hypothesis 2(a) predicted that there would be lower levels of self-esteem in the CSA group than in the Comparison group.

The means, standard deviations and results of the univariate ANOVA for scores of the CSA and Comparison groups on the Rosenberg Self-Esteem Scale are given in Table 21 below.

Table 21: Means, Standard Deviations and ANOVA for Self-Esteem Scores for CSA and Comparison Groups

		CSA Group (n = 25)	Comparison Group (n=75)	df	F	p
Esteem	Mean *S.D.*	27.32 *6.46*	29.03 *5.43*	1, 95	1.211	.274 (ns)

Although the mean self-esteem score for the CSA group was slightly lower, the difference was non-significant ($F(1,95) = 1.21$; $p = .274$). The hypothesis that there would be lower levels of self-esteem in the CSA group than in the Comparison group could therefore not be confirmed. The calculation of Cohen's d produced a negligible effect size of .09.

Hypothesis 2(b)

Hypothesis 2(b) predicted that there would be lower levels of self-esteem in the Aroused group than in the Non-Aroused group.

The means, standard deviations and results of the univariate ANCOVA for scores of the Aroused and Non-Aroused groups on the Rosenberg Self-Esteem Scale are given in the following table.

Table 22: Means, Standard Deviations and ANCOVA for Self-Esteem Scores for Aroused and Non-Aroused Groups

		Aroused Group (n=8)	Non-Aroused Group (n=17)	df	F	p
Esteem	Mean *S.D.*	24.87 *5.84*	28.47 *6.58*	1,18	.509	.485 (ns)

Although the mean self-esteem score for the Aroused group was lower, the difference was non-significant. The hypothesis that there would be lower levels of self-esteem in the Aroused group than in the Non-Aroused Group could therefore not be confirmed.

However, calculation of Cohen's d indicated an effect size of .76 for the difference in self-esteem between the Aroused and Non-Aroused groups. This would indicate a clinically important difference in levels of self-esteem between these two groups, even though the difference failed to reach statistical significance.

Negative Attributional Style

Hypothesis 3(a)

Hypothesis 3(a) predicted that there would be higher levels of internal, stable and global attributions for negative events (negative attributional style) in the CSA group than in the Comparison group.

The means, standard deviations and univariate ANOVA for Negative Attributional Style scores for the CSA and the Comparison group are given in the table below.

Table 23: Means, Standard Deviations and univariate ANOVA for Negative Attributional Style for CSA and Comparison Groups

		CSA Group (n = 25)	Comparison Group (n=75)	df	F	p
Negative Attributional Style	Mean S.D.	4.433 *.681*	4.069 *.679*	1,95	4.27	.042

The finding of a significant difference confirms hypothesis 3 (a), that there would be greater internal, stable and global attributions (negative attributional style) in the CSA group than in the Comparison group.

Hypothesis 3(b)

Hypothesis 3(b) predicted that there would be higher levels of internal, stable and global attributions for negative events (negative attributional style) in the Aroused group than in the Non-Aroused group. Table 24 below shows the means, standard

deviations and univariate ANCOVA for negative attributional style scores for the Aroused and Non-Aroused group.

Table 24: Means, Standard Deviations and univariate ANCOVA for Negative Attributional Style for Aroused and Non-Aroused Groups

		Aroused Group (n= 8)	Non-Aroused Group (n=17)	df	F	p
Negative Attributional Style	Mean S.D.	4.813 .686	4.255 .620	1, 18	.563	.463 (ns)

Although the mean Negative Attributional Style score for the Aroused group was higher, the difference was non-significant. The hypothesis that there would be greater internal, stable and global attributions (negative attributional style) in the Aroused group than the Non-Aroused group could therefore not be confirmed. The calculation of Cohen's d produced a small effect size of .25.

Causal Attributions for CSA

The means, standard deviations and univariate ANOVA for self-blame scores on the Attribution of Responsibility and Blame Scales (ARBS) for the Aroused and Non-Aroused groups are given in Table 25 below. The scoring range for self-blame scores is 20 – 100.

Table 25: Means, Standard Deviation and ANCOVA for Self-Blame scores for Aroused and Non-Aroused Groups

		Aroused group (n=17)	Non-Aroused Group (n=8)	df	F	p
Self-blame	Mean *S.D.*	66.75 *10.75*	44.94 *17.11*	1, 18	4.47	.043

Hypothesis 4 (a) predicted that there would be higher levels of self-blame in the Aroused than in the Non-Aroused group. These results indicate that there was a significant difference in self-blame scores between the Non-Aroused and Aroused groups even when the effects of age, severity and frequency were co-varied out. The finding of higher self-blame in the Aroused group than in the Non-Aroused group confirms hypothesis 4(a).

The means, standard deviations and univariate ANCOVA for family/other blame scores on the Attribution of Responsibility and Blame Scales (ARBS) for the Aroused and Non-Aroused groups are given in Table 26 below. The scoring range for family/other blame scores is 10 – 50.

Table 26: Means, Standard Deviation and ANCOVA for Family/other Blame scores for Aroused and Non-Aroused Groups

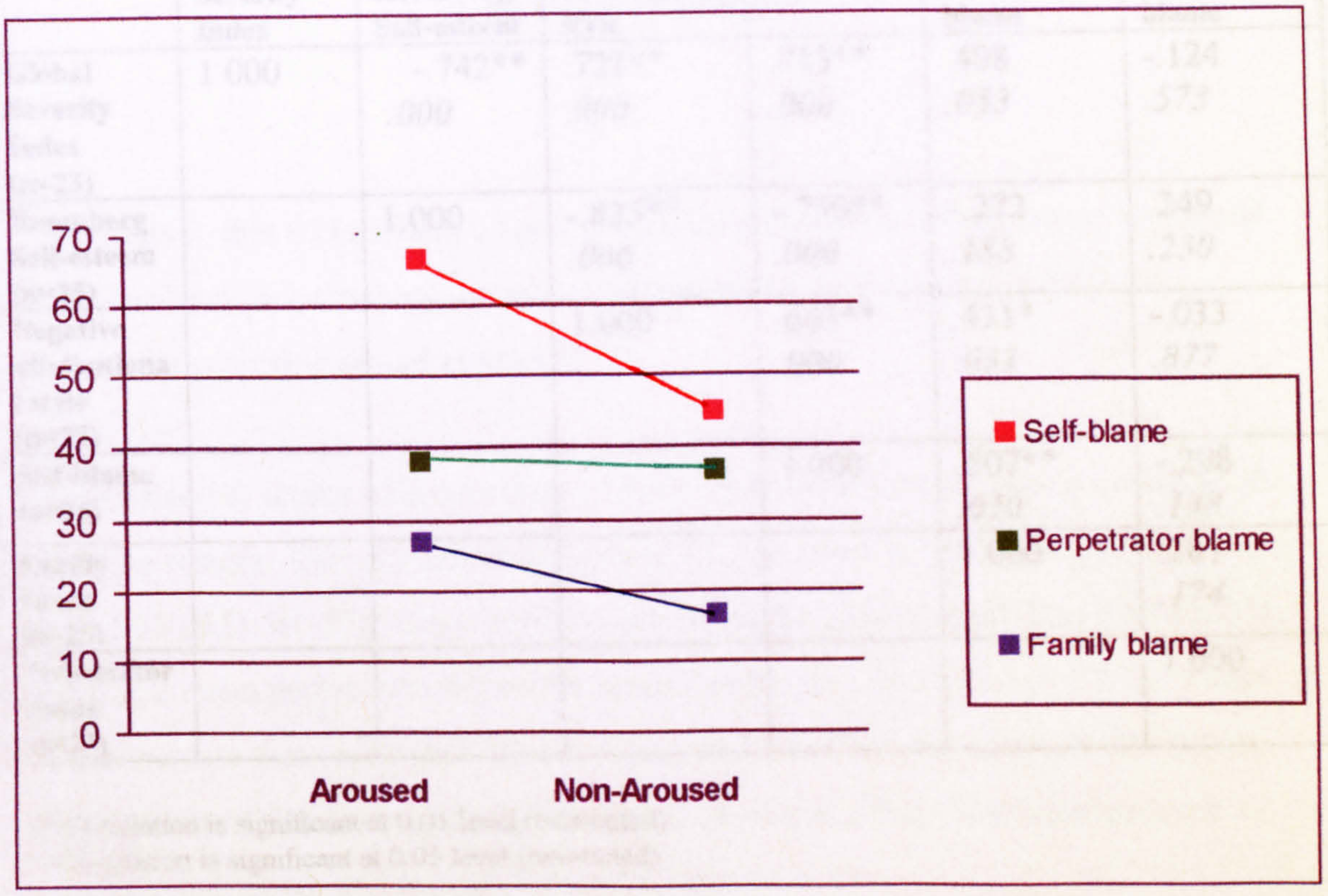
		Aroused group (n=17)	Non-Aroused Group (n=8)	df	F	p
Family/other Blame	Mean *S.D.*	27.13 *11.23*	16.76 *7.96*	1, 18	2.88	.107 (n.s)

Hypothesis 5 (a), which predicted that there would be higher levels of family/other blame in the Aroused than in the Non-Aroused group, could not be confirmed. The calculation of Cohen's d produced a moderate effect size of .65.

There was no significant difference in perpetrator blame scores between the Aroused group (mean 38.5; S.D. 7.6) and the Non-Aroused group (mean 36.71; 5.67) (F (1, 20) = 1.23; p = .281). The scoring range for perpetrator blame scores is 10 – 50.

Figure 5 below illustrates mean self-blame, family/other blame and perpetrator blame scores for the Aroused and Non-Aroused groups.

Figure 5: Mean self-blame, family/other blame and perpetrator blame scores for Aroused and Non-Aroused groups.



CSA Group Correlations

Hypotheses 4 (b) predicted that there would be positive correlations between self-blame and psychopathology (symptomatology, negative attributional style and low self-esteem) in the CSA group as a whole. Hypothesis 5 (b) predicted that there

would be positive correlations between family/other blame and these variables. Pearson correlation coefficients were calculated to examine these associations, and presented in the table below.

Table 27: Correlational table (Pearson Correlations) for CSA Group

	Global Severity Index	Rosenberg Self-esteem	Negative attributional style	Self-blame	Family blame	Perpetrator blame
Global Severity Index (n=23)	1.000 .	-.742** *.000*	.721** *.000*	.713** *.000*	.408 *.053*	-.124 *.573*
Rosenberg Self-esteem (n=25)		1.000 .	-.825** *.000*	-.750** *.000*	-.272 *.188*	.249 *.230*
Negative attributional style (n=25)			1.000 .	.663** *.000*	.431* *.031*	-.033 *.877*
Self-blame (n=25)				1.000 .	.507** *.010*	-.298 *.148*
Family blame (n=25)					1.000 .	.281 *.174*
Perpetrator blame (n=25)						1.000 .

** Correlation is significant at 0.01 level (two-tailed)
* Correlation is significant at 0.05 level (two-tailed)

Hypothesis 4(b), predicting positive correlations between self-blame and psychopathology in the CSA group, was confirmed. There were significant positive correlations between self-blame and symptomatology ($r = .713$; $p < .001$), low self-esteem ($r = -.750$; $p < .001$) and negative attributional style ($r = .663$; $p < .001$) in the CSA group.

Hypothesis 5 (b), which predicted positive correlations between family/other blame and psychopathology in the CSA group, was only partially confirmed. There was a significant positive correlation between family/other blame and negative attributional

style ($r = .431$; $p < .031$), but no significant correlations with symptomatology or low self-esteem.

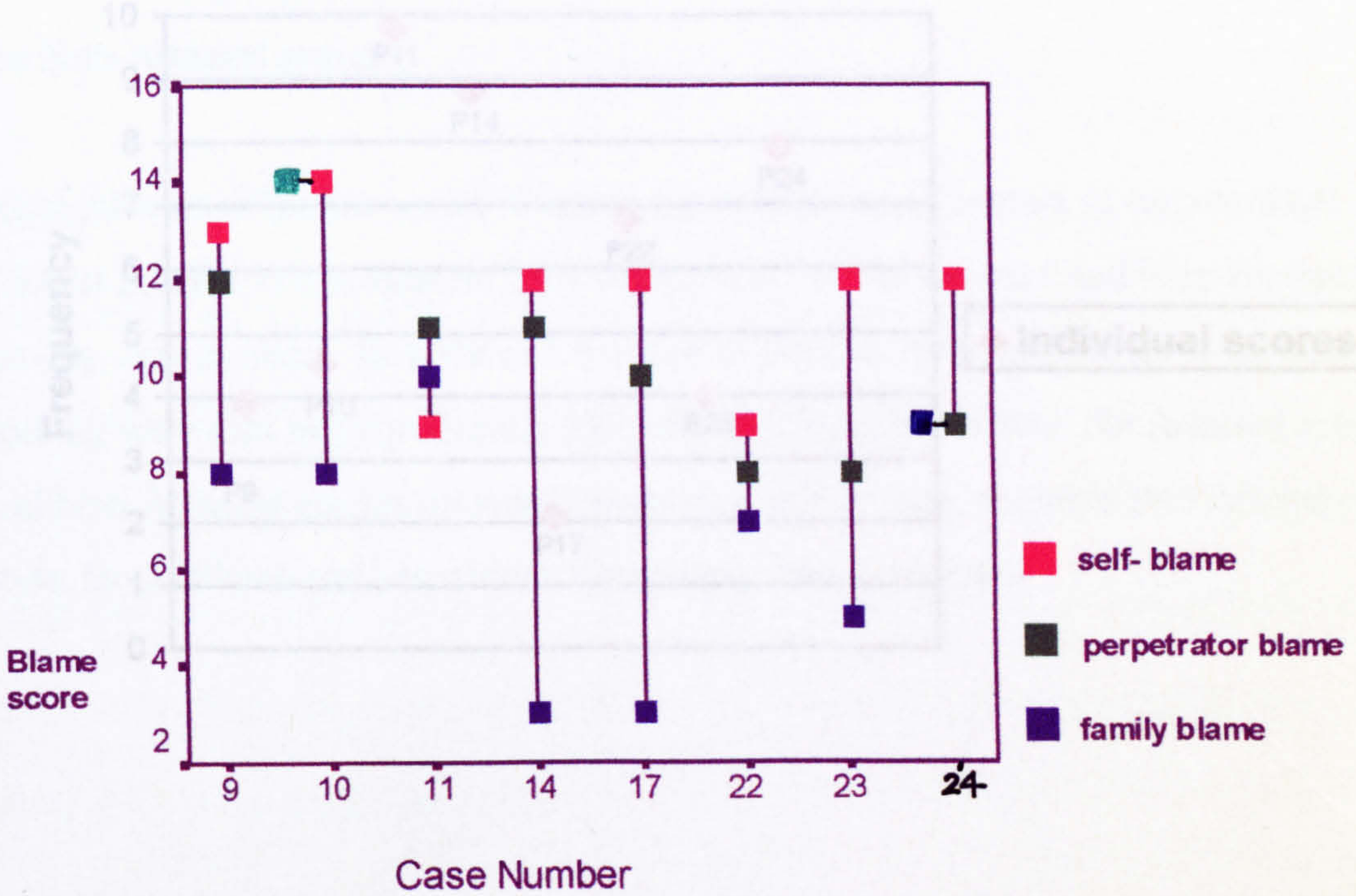
There were no significant correlations between perpetrator blame and any of the other variables.

Sexual Arousal

Hypothesis 6, that there would be positive correlations between self-blame for sexual arousal and psychopathology, could not be tested due to the small number of participants reporting sexual arousal (n=8).

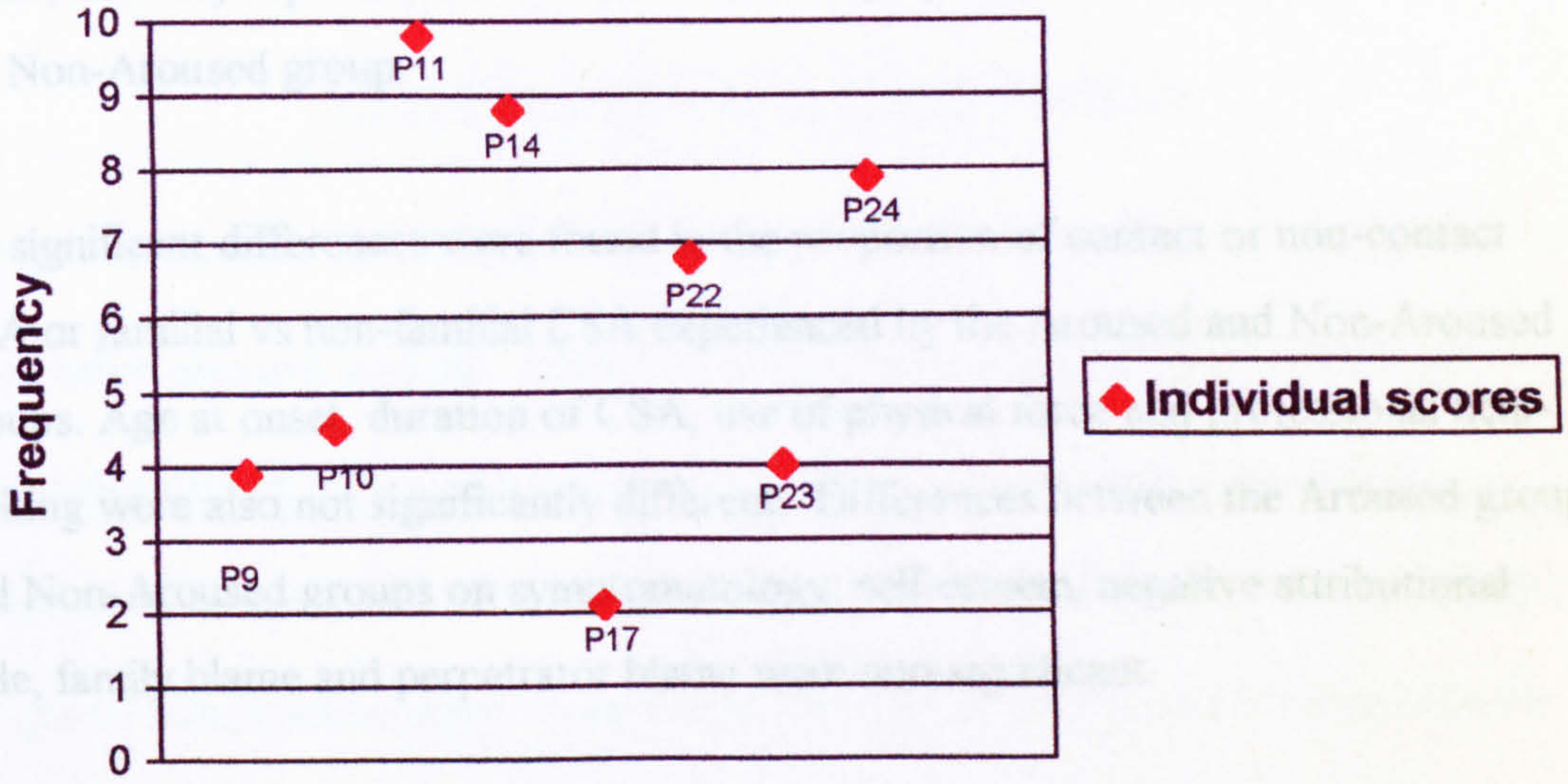
Examination of scores of attributions of blame for sexual arousal scores produced the following results. Out of a possible score of 15, the mean self blame for arousal score was 11.63 (S.D. =1.77), mean family/other blame for arousal score was 6.63 (S.D.= 2.67), and mean perpetrator blame for arousal score was 10.38 (S.D.= 2.07). These results indicate that self-blame for sexual arousal was the most common attribution, but perpetrator blame attributions were made almost as often. The score patterns were also examined, and are plotted in the Figure 6 below.

Figure 6: Causal attributions for sexual arousal



The small group size also prevented statistical analysis of the data from the visual analogue scale, where participants indicated how often they had experienced sexual arousal during their abuse. The extremes of the scale were Never and Always, and the position marked on the visual analogue scale was measured and converted into a score between 0 (Never) and 10 (Always). Obtained scores had a mean of 5.97 (S.D. = 2.73), a range of 7.77, with a minimum score of 2.1 and a maximum score of 9.8. These are illustrated in Figure 7 below.

Figure 7: Reported frequency of sexual arousal during CSA



Summary of Results

The results of the present study indicated that (25%) of participants had experienced some form of CSA. Women reporting a history of CSA had higher levels of symptomatology and a more negative attributional style than the Comparison non-abused group. No significant difference was found in levels of self-esteem between these two groups.

Within the CSA group, higher levels of symptomatology were associated with higher levels of self-blame for CSA, negative attributional style and lower self-esteem. Higher levels of self-blame were associated with negative attributional style, lower self-esteem and family/other blame for CSA. Higher levels of family/other blame for CSA were associated with negative attributional style and lower self-esteem.

Thirty two percent of the CSA group reported experiencing sexual arousal during CSA. Women reporting sexual arousal had experienced more frequent and severe CSA than the Non-Aroused group. The Aroused group had higher levels of self-blame, and they reported low self-esteem, self-injury and fear of men more often than the Non-Aroused group.

No significant differences were found in the proportion of contact or non-contact CSA or familial vs non-familial CSA experienced by the Aroused and Non-Aroused groups. Age at onset, duration of CSA, use of physical force and professional help-seeking were also not significantly different. Differences between the Aroused group and Non-Aroused groups on symptomatology, self-esteem, negative attributional style, family blame and perpetrator blame were non-significant.

DISCUSSION

Prevalence of CSA in Study Sample

The prevalence rate for CSA of 25% in this non-clinical sample is consistent with many other research findings. Finkelhor, Hotaling, Lewis and Smith (1990) reported a prevalence rate of 27% in a non-clinical sample of 1481 women. Henderson, Hargreaves, Gregory and Williams (1999) found a 28% prevalence rate for CSA in a sample of female social sciences students. The current finding of a 25% prevalence rate reinforces the need for continued awareness that CSA is not an uncommon experience in the general population.

Prevalence of Sexual Arousal during CSA

Thirty two per cent of women in the current study who reported CSA also reported experiencing sexual arousal during their abuse. This finding is unique in two respects: to the author's knowledge, the prevalence of sexual arousal during CSA has only been reported once, and in a clinical sample. Jehu (1988) reported that 58% of women in a CSA treatment programme had experienced sexual arousal during their abuse. The finding that a third of women in a non-clinical sample reported sexual arousal during CSA suggests that the experience is not uncommon. The possibility that participants may have been under-reporting sexual arousal also needs to be borne in mind. The finding also suggests that it may be important in clinical settings to include the possibility of sexual arousal during assessment, formulation and treatment.

The issue of sexual arousal is, to the author's knowledge, absent from research

literature. Clinical handbooks mention sexual arousal with reference to current sexual dysfunction, and also in terms of the likelihood of increased guilt and self-blame. Strategies for helping clients deal with the experience of sexual arousal during CSA are also included, but arousal is not presented as a CSA characteristic for consideration at the assessment stage. The issue of sexual arousal is highly sensitive, and reluctance by clinicians to ask about it may be due to fear that clients may interpret the question as meaning they were complicit in the abuse. It may also be due to discomfort with the concept of sexual arousal in children. These factors may also have played a part in its absence from the CSA research literature, together with assumptions that participants would not be prepared to give information about this aspect of CSA.

Familial and Non-Familial CSA

Just over a quarter of participants in the current study (28%) had experienced familial CSA, a lower rate than in other studies using student samples. Peters and Range (1996), for example, studied a college sample and reported that perpetrators were "equally divided between family and non family". Henderson et al (1999), using the same methodology as in the current study to sample an undergraduate population, found a substantially higher prevalence rate for familial abuse of 73%.
Gold (1986), however, found that 37% of her sample of women recruited from a combination of university and community sources had experienced familial CSA.

Studies of community samples also report higher rates of familial abuse than was found in the current study. Coffey et al (1996) found a prevalence rate of 43% for familial CSA amongst a sample of adult women recruited from voter registration lists. Lange et al (1999) found a 68% prevalence rate for familial CSA in a sample of women invited to participate through magazine and newspaper articles. Ussher and Dewberry (1995) found that 80% of a non-clinical sample filling in a magazine questionnaire survey reported familial CSA. Since variations in prevalence rates for CSA are considered to be due to a combination of differences in variations in definition, sampling and methodology (Wyatt and Peters, 1986) it is reasonable to

assume that prevalence of familial vs non-familial CSA might vary for similar reasons. However, the relatively low prevalence rate in the current study does bring into question the representativeness of the sample.

The finding of high levels of symptomatology and negative attributional style amongst a group in which non-familial CSA was predominant is nevertheless important, as it suggests that psychological difficulties can occur following both types of CSA. The post hoc analysis of measures of psychopathology and self-blame between participants experiencing familial and non-familial CSA indicated no significant differences. This is consistent with the study by Lange et al (1999), which found no differences in psychopathology (SCL-90-R) between the familial and non-familial study groups. Together with other non-significant findings in the current study, the result must be treated cautiously however, because it is possible that the small size of the Aroused group may be masking differences which might achieve statistical significance in an analysis using larger group numbers. Greater confidence about representativeness could be achieved in further research using a larger sample with a higher proportion of familial CSA, which would also allow the contribution to psychopathology of familial vs non-familial CSA to be more rigorously examined.

Research Hypotheses

1. Symptomatology

a) CSA versus Comparison Group

Hypothesis 1 (a), predicting higher levels of symptomatology amongst women giving a history of CSA than in the Comparison group of non-abused women was confirmed. The finding is consistent with previous research findings supporting an association between CSA and psychopathology. Studies of the CSA sequelae in non-

clinical populations generally report that CSA survivors experience greater levels of psychopathology than non-abused comparison women (Kuyken, 1995; Lange et al, 1999; Waller and Smith, 1994; Ussher and Dewberry, 1995). Lange et al. (1999) report that compared with norms for the general population, respondents in their non-clinical sample had substantially higher mean scores on the SCL-90-R.

The finding of greater symptomatology amongst the CSA group is also consistent with research in clinical populations regarding links between CSA and symptomatology . A large proportion of women with formal psychological and psychiatric disorders report a history of CSA (Palmer, Challoner and Oppenheimer 1992; Waller and Smith, 1994; Kuyken, 1995). The finding that the mean GSI score obtained by the CSA group as a whole is closely comparable with that of a female psychiatric outpatient referent group (Derogatis, 1994) also concurs with findings by Lange et al.(1999) that mean scores on psychopathology variables were close to those of psychiatric populations.

Symptomatology in the current study was found to be significantly associated with frequency and severity of CSA. This is consistent with previous research findings that prolonged and frequent abuse was associated with increased severity of psychological symptoms and poorer prognosis (Bagley and Ramsay, 1986; Hoagwood, 1990). The studies by Ussher and Dewberry, (1995) and Lange et al. (1999) also found that more severe symptomatology was associated with CSA of longer duration, severity and higher frequency.

The comparison of normative data for the SCL-90-R, presented in the Results section above, shows that a substantially higher mean GSI score was obtained by the CSA group (1.24; mean age 24) than that for Adolescent Non-patients (.85; mean age 15.6), and even further above that for Female Non-patients (.36; mean age 46). The CSA group's mean GSI score is most closely comparable with the mean score obtained by Female Psychiatric Outpatients (1.35; mean age 31.2). This is a notable finding, and suggests that levels of psychological distress experienced in this non-clinical sample may be comparable with those experienced by women receiving out-

patient psychiatric services. Since 75% of respondents in the current study were aged between 19 and 21 years, their scores might be more comparable with an adolescent referent group. Comparisons of these findings with norms for Adolescent Psychiatric Out-Patients or In-Patients would be useful, but these are unfortunately not available.

The mean GSI obtained by the Comparison non-abused group (.72; mean age 21) was slightly below that for the Adolescent Non-patient referent group, suggesting that the level of symptomatology indicated by this group might not be unusual in a non-clinical population of this age.

b) Aroused versus Non-Aroused Group

Hypothesis 1(b), which predicted that there would be higher symptomatology in the Aroused group than the Non-Aroused group, was not confirmed. Higher symptomatology in the Aroused group might be expected given the significant associations in the CSA group as a whole between symptomatology, frequency and severity of CSA, together with the significantly higher frequency and severity of CSA in the Aroused group. When frequency and severity were co-varied out, however, no significant difference was found in levels of symptomatology between the two groups. There is no evidence in the current study therefore of any connection between symptomatology and the experience of sexual arousal. The absence of prior research on sexual arousal as a CSA characteristic precludes comparisons with other data.

The finding that the mean GSI score for the Aroused group was twice as high as that of the Non-Aroused group is notable, however. The large effect size of .77 indicates that there may be a clinically important difference between the Aroused and Non-Aroused groups, and that in clinical settings CSA clients exhibiting high levels of symptomatology may be more likely to have a history involving frequent and severe CSA . This points to the importance of assessing frequency and severity of CSA so that these characteristics of CSA can be addressed during treatment .

The large effect size also suggests that the lack of statistical significance might have been due to Type II error arising from the small sample size of the Aroused group (n=8). A statistical power analysis (Borenstein and Cohen, 1988) carried out on the basis of the current results indicated that both the Aroused and Non-Aroused groups would need a minimum of 14 participants for dependent variables between the groups to achieve significance using a two-tailed test.

Mean GSI scores of the Aroused group (1.82) were compared with the normative data. The Aroused group's mean GSI score was higher than that obtained by Female Psychiatric Outpatients (1.35, S.D. = .69) and was also higher than that of Female Psychiatric Inpatients (1.44, S.D. = .83) This finding is of particular concern as it suggests that levels of psychological distress experienced in this non-clinical sample may be comparable with those experienced by women receiving in-patient psychiatric services.

Mean GSI scores of the Non-Aroused group (.93) were lower than those given for the Female Psychiatric Outpatient referent group, but higher than those for the Female Non-patient referent group.

It is of interest and concern that the CSA group answered affirmatively to Psychoticism subscale questions regarding having their thoughts controlled, other people being aware of their thoughts, having thoughts that were not their own and the idea that something is wrong with their mind. These experiences are traditionally thought of as being diagnostic of psychosis, and raise concerns about the nature of the psychological disturbance experienced by CSA participants in the current study.

Examination of the Psychoticism subscale data indicated that the raised scores were a function of answering affirmatively to feeling lonely even when in company, having troubling sexual thoughts, believing they deserve punishment, believing they have a serious physical problem and never feeling close to other people. In clinical work with adults sexually abused in childhood, commonly expressed themes include feelings of loneliness, isolation and difference from other people, the belief that they

deserve punishment and problems with intimacy. It is also not uncommon for people to feel that their abuser(s) continue to exert influence over their thoughts and actions, and to "know" what they are thinking and whether they have told anyone else about the abuse. The Psychoticism subscale questions may therefore be particularly pertinent for people with a history of CSA, and the scores may reflect the extent to which they experience such feelings and beliefs and the distress associated with them.

2. Self-Esteem

a) CSA versus Comparison Group

Hypothesis 2 (a), which predicted that there would be lower levels of self-esteem in the CSA group than in the Comparison group, was not confirmed. This seemed surprising at first, in view of the finding that the CSA group had significantly higher levels of symptomatology, and that low self-esteem is very frequently found to accompany symptomatology in clinical populations. Jehu (1988) found that 91% of women attending a CSA treatment programme reported significantly low self-esteem. The lack of a significant difference between levels of self-esteem in the CSA and Comparison groups may be linked with the generally higher levels of symptomatology amongst younger adults reflected in the Adolescent Non-patient norms for psychopathology (Derogatis, 1994) discussed earlier.

Consistent with other research studies (e.g. Gold (1986) low self-esteem was however associated with greater symptomatology and negative attributional style. This lends support to there being relationships amongst these variables which would merit examination in future research.

b) Aroused versus Non-Aroused Group

Hypothesis 2(b), which predicted lower levels of self-esteem in the Aroused than the Non-Aroused group was not confirmed. There is therefore no evidence from the

current data for a connection between self-esteem and the experience of sexual arousal during CSA.

Of note here is the effect size between the groups of .76, indicating that there may be clinically important differences in levels of self-esteem between the two groups. CSA clients with low self-esteem may be more likely to have a history of more frequent and severe CSA . In addition, all participants in the Aroused group indicated having low self-esteem (Question 17) by comparison with 41% of the Non-Aroused group. The large effect size raises the possibility again that the lack of statistical significance may also be due to Type II error arising from the small sample size of the Aroused group (n=8). Potential differences in self-esteem needs further examination in future research using larger sample sizes.

3. Negative Attributional Style

a) CSA versus Comparison Group

Hypothesis 3(a), that there would be greater internal, stable and global attributions for negative events (negative attributional style) in the CSA group, was confirmed. This finding is consistent with several other empirical studies of non-clinical populations. Wenninger and Ehlers (1998), for example, found that CSA survivors' attributions of negative events were more internal, stable and global than those of non-abused participants. The authors interpret this as indicating that this negative attributional style makes CSA survivors more prone to depression. This is supported by their findings that CSA survivors scored highly on the depression subscale of the Trauma Symptom Checklist, and that 77% were depressed according to the Beck Depression Inventory. Gold (1986) found higher levels of negative attributional style amongst CSA survivors, and also found that this was associated with greater psychological distress and lower self-esteem. The findings of the current study that negative

attributional style was associated with increased symptomatology and lower self-esteem and are consistent with this.

b) Aroused versus Non-Aroused Group

Hypothesis 3(b), that there would be greater internal, stable and global attributions for negative events (negative attributional style) in the Aroused group, was not confirmed. These results suggest that there is no significant difference between these two study groups in the extent to which they make internal, global and stable attributions for negative events. Greater negative attributional style in the Aroused group might be expected given the significant associations in the CSA group as a whole between negative attributional style and frequency and severity of CSA, together with the significantly higher frequency and severity of CSA in the Aroused group. Once frequency and severity were co-varied out, however, there was no difference between the two groups, and there is thus no evidence in the current data for a link between arousal and negative attributional style.

4. Self-Blame

Self-blame was found to be significantly higher in the Aroused group even when the effects of age, severity and frequency were co-varied out. This is an important finding, as it raises the possibility that sexual arousal may be a CSA characteristic which increases the likelihood of self-blame independently of severity and frequency of abuse. The finding also lends support to the previously untested proposal in clinical handbooks that the experience of sexual arousal during CSA can be accompanied by considerable self-blame and guilt (Jehu,1988; Hall and Lloyd, 1993; Sanderson, 1995). In the author's clinical experience feelings of blameworthiness are very often connected to the frequency of CSA. A commonly held belief amongst survivors experiencing many incidents of CSA is that they are blameworthy precisely because it happened so many times; the inference drawn is that they should have been able to prevent its recurrence.

The current study found a mean score for self-blame for the CSA group as a whole of 51.9 (S.D. = 18.35). This is substantially higher than the figure of 38.8 (S.D=13.9) reported by McMillen and Zuravin (1997). This may reflect the higher mean age of their sample (30.7 years). The current study found a weak but significant negative correlation between age and self-blame for CSA, suggesting that older participants blamed themselves less for CSA than the younger participants.

Hypothesis 4 (b), which predicted positive correlations between self-blame and psychopathology in the CSA group as a whole was confirmed. Higher self-blame was associated with higher symptomatology, greater negative attributional style and lower self-esteem. These findings are consistent with previous research indicating that self-blame is associated with higher levels of psychopathology in CSA survivors. Hoagwood (1990) and Morrow (1991) found that women who blamed themselves for CSA were more depressed and had poorer self-concept than those who blamed others. Morrow and Sorrell (1989) found that adolescents who attributed responsibility to themselves reported more psychiatric symptoms than those who attributed responsibility to the perpetrator. Peters and Range (1996) found that higher levels of self-blame in both clinical and college samples were associated with higher levels of depression and suicidal behaviour. Lange et al (1999) found that higher levels of symptomatology amongst a community sample of women survivors were associated with greater feelings of guilt, but not with feelings of responsibility for CSA .

5. Family/other Blame

The current study found a mean score for family/other blame for the CSA group as a whole of 20.1 (S.D. = 10.1). This is slightly lower than the figure of 27.5 (S.D=11.4) reported by McMillen and Zuravin (1997).

The lack of a statistically significant difference between the Aroused and Non-Aroused groups means that no conclusions can be drawn from the current study about arousal being related to family/other blame.

Hypothesis 5(b), which predicted that there would be positive correlations between family/other blame and psychopathology in the CSA group as a whole was only partially confirmed. Family/other blame was not significantly correlated with low self-esteem, but there was a significant positive correlation with negative attributional style. The correlation with symptomatology was approaching significance. In addition, family/other blame was significantly positively correlated with self-blame ($r=.507$; $p=.010$).

In their study of the relationship between attributions of responsibility for CSA and adult adjustment McMillen and Zuravin (1997) concluded that both self-blame and blaming family or others are linked to poorer adjustment in some areas. The findings of the current study are consistent with this, although self-blame was associated with higher symptomatology , negative attributional style and low self-esteem , suggesting that its influence on psychological adjustment might be stronger than that of family/other blame. Self-blame was found to be significantly associated with symptomatology and with family/other blame, whilst the association between family/other blame and symptomatology was approaching significance. This may suggest that blaming family or others does not preclude symptomatology. This would be consistent with McMillen and Zuravin's findings, but contrary to Hoagwood (1990), who found that women who currently blamed others were less depressed, and had higher self-esteem. The current findings support McMillen and Zuravin's view that the relationship between causal attribution of blame and psychological adjustment is more complex than previously indicated in research studies.

The raw data in the current study suggested that causal attributions were not mutually exclusive, and that blame and responsibility could be attributed simultaneously between self, family/other and perpetrator. This is consistent with Lange et al (1999) who found that strong guilt feelings co-existed with responsibility being attributed to

perpetrators rather than self. Dalenberg and Jacobs (1994) make the point that self-blame is not necessarily the opposite of perpetrator blame, and that reduction in one will not necessarily produce an upsurge in the other.

It may be important to explore the nature and differential contribution of self-blame and family/other blame to adjustment. Self-blame questions such as those used by McMillen and Zuravin and in the current study are phrased in terms of participants blaming themselves, feeling "bad" , feeling guilty and deserving punishment about what they did or failed to do with regard to their sexual abuse. Existing research (e.g. Coffey et al, 1996; Feiring, Taska and Lewis, 1998; Andrews, 1998) supports the idea that the link between CSA, self-blame and psychopathology may be mediated by cognitions involving responsibility, and the emotions of shame and guilt. Family/other blame questions, however, involve blaming others for failing to prevent the abuse occurring, failing to protect the person from it, failing to curtail it, and failing to believe or support the person when the abuse was disclosed. Blaming family or others may make its contribution to psychopathology through different mechanisms, perhaps involving cognitions about victimization and feelings of anger. In the author's clinical experience the resolution of issues of responsibility and self-blame for CSA, whereby a client begins to attribute responsibility for sexual abuse externally, is commonly followed by the question "Why me"? This in turn commonly involves exploration of feelings of victimization and anger.

Perpetrator Blame

The current study found a mean score for perpetrator blame for the CSA group as a whole of 37.3 (S.D. = 6.24). This is closely comparable with the figure of 40.3 (S.D=4.04) reported by McMillen and Zuravin (1997).

To conclude, this section has considered the results of the current study and their relation to previous research studies. There appear to be significantly higher levels of self-blame amongst women who have experienced sexual arousal, and there are also indications of important though complex relationships between symptomatology, self-

esteem, attributional style blame and causal attributions of blame for CSA. Future research with a sample sufficiently large to use regression analysis would be necessary to further examine these relationships, and to assess the relative contributions to psychopathology and blame of CSA characteristics such as frequency, severity, duration, familial CSA and sexual arousal.

The following section is speculative, and considers possible ways in which sexual arousal, frequency and severity of CSA might contribute to higher levels of self-blame.

The traumagenic dynamics model (Finkelhor and Browne, 1985) proposes that stigmatization arises from the child inferring attitudes of shame about the sexual activity through blame, denigration and pressure for secrecy by the perpetrator. Stigmatization is proposed to result in guilt, shame, lowered self-esteem and sense of differentness from others. It is possible that frequent and severe CSA, and sexual arousal where this occurs, may be particularly relevant CSA characteristics in the development of these dynamics, and may intensify guilt and shame. As mentioned above, frequency of CSA is often cited by survivors as a reason for their blameworthiness. Clinical texts (e.g. Sanderson, 1995) note that perpetrators often respond to unwillingness from an already abused child by implying that she has done it before, so therefore has no reason to refuse now. Perpetrators also use sexual arousal itself to denigrate and persuade the child of their complicity in the sexual activity. Sexual arousal might also decrease the likelihood of disclosure through greater fear of disapproval and blame by others. This would be consistent with the report by Jehu (1988) that sexual arousal during CSA was a factor contributing to non-disclosure for 30 % of women in his CSA treatment programme.

The possible contribution to self-blame of frequent and severe CSA, and sexual arousal where this occurs, might also be considered from the perspective of developmental deficits. Kuyken (1992) found that greater distress and poorer self-esteem were associated with CSA of longer duration, and proposed that CSA occurring through more developmental stages may hinder personality integration and

formation of coherent self-identity, making the individual more vulnerable to depression, self-blame and avoidance coping. Hoagwood (1990) found that the longer CSA persisted, the more self-blame participants experienced both as children and adults.

In terms of schema theory, experiencing frequent and severe CSA and/or sexual arousal might contribute to the establishment of maladaptive schemata containing negative core beliefs about the self as worthless and bad. This might lead to an increase in negative automatic thoughts, self-blaming and self-denigratory beliefs. Clinical experience indicates that survivors often believe that experiencing sexual arousal means they wanted the CSA to occur. This leads to a belief in their own complicity in the CSA and hence the perception of themselves as blame-worthy.

Several authors (Coffey et al, 1996; Feiring, Taska and Lewis, 1998; Andrews, 1998) have proposed that self-blame and shame mediate the relationship between CSA and adult psychological adjustment by affecting survivors' core beliefs about self-worth, which results in higher levels of psychological distress. The feelings of self-blame and shame observed in clinical handbooks as accompanying the experience of sexual arousal may perhaps intensify the negative core beliefs about self-worth and hence increase psychological distress. It is of interest that 62.5% of the Aroused group reported feelings of shame compared with 41% of the Non-Aroused group in the current study.

Critical Appraisal of Current Study

Initial data analysis revealed several problems in connection with the sample obtained for the current study, which are discussed below.

The first problem was the small size of the group of participants reporting sexual arousal during CSA. This precluded some statistical analyses, and also means that non-significant results need to be viewed cautiously . As discussed earlier, some variables which were compared between the Aroused and Non-Aroused groups may have failed to achieve statistical significance due to the small number in the Aroused group. Time constraints did not allow further participants to be gathered, however. The power calculation indicated that future research using arousal during CSA as an independent variable would need a minimum of 14 participants in each group.

The second problem was the higher percentage of non-familial abuse in the current sample relative to other studies using student samples. Given that Henderson et al (1999) sampled similar numbers of undergraduates from the same university faculty using the same approach and procedures, it is possible that the presence of questions about sexual arousal in the current study may have deterred women experiencing familial CSA from participation. Acknowledging and reporting sexual arousal occurring during familial CSA may be more distressing or unacceptable than arousal occurring during non-familial CSA, so that fewer questionnaires were returned by women experiencing familial CSA. Whatever the reason, the obtained sample may not adequately represent undergraduate women with histories of familial CSA. Additional sampling and methodology factors which might also have influenced results include factors differentiating those who self-selected and those who did not, the use of course credits for participation, and the use of self-report data introducing the possibility that questionnaire items were misunderstood or answered inaccurately. The sample may also have included participants who were not prepared to report sexual arousal during CSA.

These shortcomings, together with the difficulties described earlier regarding additional distinctions between the Aroused and Non-Aroused groups, mean that the study can only be considered as a preliminary investigation. Although the study found that self-blame differentiated the Aroused and Non-Aroused groups, no conclusions can be drawn regarding the existence of a relationship between sexual

arousal and symptomatology, self-esteem or negative attributional style. The relatively low prevalence of familial CSA also means that caution is needed before generalizing the current findings to a different undergraduate or community population.

The study has, however, brought sexual arousal into the research arena for the first time, and shows that some CSA survivors are prepared to acknowledge this experience if there are suitable precautions ensuring anonymity and confidentiality.

Conclusions

The current study is unique in making a preliminary investigation of sexual arousal, a previously unexplored aspect of CSA research. The study found that the Aroused group had experienced significantly greater frequency and severity of CSA, and had experienced familial CSA proportionally more often, although the latter factor was not statistically significant. The Aroused group also reported significantly higher levels of self-blame for the CSA than the Non-Aroused group. Conclusions cannot be drawn, however, regarding the existence of a relationship between sexual arousal and psychopathology. How sexual arousal might lead to increased self-blame cannot be ascertained from the current data either, and the speculative mechanisms described above would need to be tested out in future research.

The contribution of the study to clinical work with CSA survivors lies in the finding that sexual arousal is not an uncommon experience during CSA and is associated with higher levels of self-blame. Clinical assessment should perhaps include consideration of arousal as a possible characteristic of clients' CSA experiences so that cognitive strategies can be focussed appropriately.

It is hoped that the shortcomings of small sample size, attendant low power and lack of representativeness of the sample in the current study can be remedied in future research. It is the author's intention to collect further data and use regression analysis to further explore the possibility of relationships amongst CSA characteristics including sexual arousal, familial vs non-familial abuse, duration, frequency and severity of CSA and subsequent psychopathology and causal attributions. Such an analysis would allow examination of the relative contribution made by each of these characteristics to psychopathology and causal attributions for CSA.

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APPENDICES

University of Wales School of Psychology Ethics Committee

Proposed Doctoral Research Thesis

Title: **Attributions of responsibility and blame for child sexual abuse and their relationship with psychological adjustment in adulthood.**

Name of Investigator: Sarah Gregory
Consultant Clinical Psychologist
Gwynedd Community Health Trust

Supervisor: Dr Isabel Hargreaves
Clinical Director
North Wales Clinical Psychology Training Course

Address for Correspondence: Department of Clinical Psychology
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Objectives and potential value of study

The central importance of alleviating feelings of guilt, responsibility and shame in clinical work with adults who have experienced childhood sexual abuse (CSA) has been acknowledged for some time. Most clinical textbooks devote substantial space to cognitive and other therapeutic techniques for achieving this. (e.g. Hall and Lloyd, 1992: Sanderson, 1995). Empirical research regarding attributions of blame and responsibility and their possible links with psychological adjustment after CSA is, however, relatively new. Some studies (e.g. Hoagwood, 1990; McMillen & Zuravin, 1997) have reported that survivors' attributions of responsibility are related to adjustment, but methodological difficulties have limited the conclusions that can be drawn.

The proposed study aims to develop this research area by looking at the relationship between attributions of blame and responsibility and subsequent psychological adjustment in a sample of female students with a history of CSA. Attributional style, self-esteem and other measures of psychological adjustment will be measured in this group and in a comparison group of students without a history of CSA.

There has been no research to date which examines the relationship between the experience of sexual arousal during CSA and self-blaming attributions or subsequent adjustment, even though the experience of sexual arousal is not uncommon. Jehu (1988) found that 58% of his sample of women

There will be positive correlations between levels of symptomatology and self-blame and family blame in the CSA group.

There will be a negative correlation between perpetrator blame and levels of symptomatology in the CSA group.

There will be a higher number of internal, stable and global attributions for negative events in the CSA group than in the comparison group

Self-esteem will be lower in the CSA group than in the comparison group.

There will be a negative correlation between self-esteem and self-blame in the CSA group

Within the CSA group there will be higher levels of self-blame and symptomatology amongst those who report experiencing sexual arousal during CSA

Recruitment of participants

Prevalence rates for CSA vary according to operational definitions of CSA and methodological issues such as sampling procedures. Prevalence rates for non-clinical samples range from 12% of females and 8% of males reporting CSA (Baker & Duncan, 1985) to 27% of females and 16% of males (Finkelhor et al (1990). Gorey and Leslie (1997) reviewed 16 cross-sectional surveys of non-clinical populations and adjusted the findings for response rates and measurement biases. They report prevalence rates of 14.5% and 7.2% for female and male CSA respectively. Henderson (1996) found a 28% prevalence rate for CSA in a sample of female social sciences students.

Female undergraduates will be asked to stay behind at the end of a number of lectures in the first semester (1998/99). They will be given a verbal introduction to the research area, based on the contents of the Information Sheet. Voluntary participation and complete anonymity will be stressed. The Information Sheet will be then be given out, and students given 5 minutes to read it. Those choosing to take part will be asked to collect a questionnaire booklet to complete at home; and to return it in a sealed envelope at dates and times given on the Information Sheet. The researcher will be present at these times to receive questionnaires and to discuss any issues arising from their completion. This will include individual de-briefing and giving further information about professional help if required.

The researcher will give one course credit slip to each participant returning a completed questionnaire. There are approximately 320 students in the first and second years, all of whom are required to earn course credits. One course credit can be earned by taking part in one hour of research conducted by researchers in the Psychology Department, and the proposed questionnaire takes about 60 minutes to complete. There are also 128 students in the third year who will be asked to volunteer, but they will not gain course credits for participating. The researcher has been granted 150 course credits within the first semester. It is hoped that a minimum of 150 women will take part.

The recruitment procedure described above has previously been used by Dr. Dawn Henderson, following approval by the University of Wales School of Psychology Ethics Committee.

Research Design

Between and within-groups design

Group 1	Group 2
Women reporting a history of CSA	Women not reporting a history of CSA

Independent Variable

1) Reported history of CSA

Dependent variables

1) Attributional style (Expanded Attributional Style Questionnaire, Peterson et al, 1988)

2) Self-esteem (Rosenberg Self-Esteem Scale, 1965)

3) Evidence of psychological disturbance (Symptom Checklist - SCL90, Derogatis, 1996)

CSA Group only:-

4) Attributions of Responsibility and Blame Scales (McMillen and Zuravin, 1997)

Procedures Employed

All the measures used in this study are self-report questionnaires. It is hoped that this will encourage a larger number of women to participate than would be the case if individual interview methods were used.

Measures Employed

The questionnaire booklet incorporates the following questions, scales and checklists:-

Participants are asked their age and marital status.

Expanded Attributional Style Questionnaire. This 24 item scale provides a measure of an individual's attributions regarding the causes of commonly occuring events.

3. Rosenberg Self-Esteem Scale. A 10 item scale providing a measure of an individual's self esteem

4. Symptom Checklist - (SCL90). An inventory of a wide range of symptoms of psychological disturbance, providing indicators of their number and intensity

5a. Questions on past experiences of CSA. Participants reporting no history of CSA are asked to discontinue the questionnaire at this point.

5b. Questions about CSA characteristics. Questions are adapted from Henderson's questionnaire (op cit), which followed those in Ussher and Dewberry's (1995) survey of the prevalence of CSA. Participants are also asked whether they have received or are currently receiving professional help for psychological distress or problems.

6. Attributions of Responsibility and Blame Scales (ARBS) (McMillen and Zuravin, 1997). This 40 item scale provides a measure of the direction and intensity of attributions about their CSA experiences.

7. Six questions assessing direction and intensity of blame for any sexual arousal experienced during CSA. The questions have been created in the style of the ARBS , and are equally balanced between family blame, perpetrator blame and self-blame. They are currently being piloted amongst 6 clinicians experienced in working with adults with a history of CSA.

Qualifications of the investigator to use the measures

I am a Grade B Chartered Clinical Psychologist with 14 years' experience in the Health Service within the field of adult mental health. I have specialised in clinical work with adult survivors of childhood sexual abuse, both male and female, and across all age groups. I have run training courses in clinical work with adult survivors, and provide supervision, consultation and training for all mental health disciplines within Gwynedd. I provide postgraduate teaching sessions for the North Wales Clinical Psychology Course. I am also the Gwynedd Community Health Trust advisor to the Welsh Office regarding this client group.

Venue for investigation

Participants will be recruited in the UWB School of Psychology lecture halls. Questionnaires will be completed by participants in their own time at home, and then returned to the investigator, who will be in Room 1 in the Clinical Psychology Department, 43 College Road on given dates and times.

Duration of the study

The data will be gathered during the period November 1998 to January 1999. The data will be analysed and the research written up in the 12 month period ending in January 2000.

Data analysis

At this stage it is envisaged that multivariate analysis, using SPSS Version 6, will be used to compare mean scores of attributional style, self-esteem and psychological adjustment between the two groups of participants. Correlational methods will be used to investigate the relationship between psychological adjustment, attributions of responsibility for abuse, self -esteem, general attributional style and abuse characteristics within the group reporting a history of sexual abuse.

Statistical advice will be sought from School of Psychology academic staff.

Potential hazards to participants/investigator

The sensitive nature of the issue of childhood sexual abuse might make students reluctant to disclose such experiences, which would limit the number of participants. However, Henderson (1996) found that 28% of a student sample disclosed a history of CSA. It is hoped that the guaranteed anonymity and opportunity to earn a course credit will encourage participation.

Potential offence/distress to participants

Participants who have experienced sexual abuse may find some questions distressing. It is hoped that potential distress will be minimised by:-

a) Assuring participants they have the right not to answer questions and to withdraw from the research at any point

b) Indicating on the Information Sheet that there are questions about sexual abuse and arousal so that participants know what to expect

b) Providing the opportunity for participants to contact the researcher, who will give them information on how to contact the Student Counselling Service or how to refer themselves to their local Community Mental Health Team.

How consent is to be obtained

In order to ensure anonymity, participants will not be asked to sign consent forms. The return of the completed questionnaire will be considered to indicate a participant's consent to take part in the research.

Approval of relevant professionals

The researcher will submit this research proposal to the School of Psychology Ethics Committee and obtain their agreement to approach Psychology undergraduates.

Payments and equipment required

No financial payments will be made, but one course credit will be given to the first 150 participants who return completed questionnaires.

No equipment is required for this research, apart from the course credit slips and questionnaire packages. The latter will comprise:-

1. Information sheet for participants
2. Questionnaire Booklet
3. Envelope
4. List of dates and times to hand in completed Questionnaire

Arrangements for feedback to participants

When participants return their questionnaires they will be given a short written summary of the background, expected findings and the clinical value of the study. They will be invited to ask any questions or discuss general issues about the research project.

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APPENDIX 1(b)

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November 9, 1998

Dr. Isabel Hargreaves and Ms. Sarah Gregory
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Dear Colleagues

Attributions of responsibility and blame for child sexual abuse

Your research proposal (referred to above and on the attached sheet) has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines.

If you wish to make any substantial modifications to the research project, please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if participants experience any unanticipated harm as a result of taking part in your research.

Good luck with your research.

Kath Chitty

Kath Chitty
Coordinator -School of Psychology Research Ethics Committee

Information about the research

Providing and developing effective professional help for people with emotional difficulties, particularly those who have experienced childhood sexual abuse, forms a major part of my work as a clinical psychologist. The purpose of this research is to look at factors which may be associated with the development of emotional difficulties in people with and without a history of sexual abuse. The potential benefit of the research will be that therapeutic techniques can be developed and refined so that people receive effective and appropriate help.

Your replies will be completely anonymous and confidential. No names or other means of identifying participants are recorded at any point in the research. You will not have to sign a consent form - returning a completed questionnaire and checklist will be considered to indicate your consent to take part.

One course credit will be given to the first 300 undergraduates who return a completed questionnaire pack.

Procedures

You will be given a checklist and questionnaire booklet and to complete in your own time at home. The checklist asks about any problems you might be having at present. The booklet contains questions about your typical responses to everyday social situations and general feelings about yourself.

The booklet also asks whether you experienced any sexual abuse during childhood, and if so, to answer some questions about your particular experiences and feelings. Research indicates that over 50% of children who are sexually abused sometimes experience sexual arousal, and that this can contribute to emotional difficulties later on. There are some questions related to sexual arousal experiences. We realise that these are particularly sensitive and difficult issues, but hope that the anonymity of the questionnaire will enable you to provide this very valuable information.

The questionnaire pack will take 45 - 60 minutes to complete.

Participant recruitment

Female undergraduates are being asked if they would like to volunteer

Your rights as a participant

Taking part in this research project is entirely voluntary. You can decline to take part, and

APPENDIX 3

QUESTIONNAIRE BOOKLET

Please indicate your responses to the questions in this booklet by ticking the appropriate boxes or writing in your answer.

Please return completed questionnaire packs in the envelope provided and collect a course credit from:-

Sarah Gregory, Room 1 (Ground Floor), 43 College Road

on:-

Monday 30th November - 10.00 - 11.30 am or 2.00 - 4.00 pm

OR

Tuesday 8th December - 11.00 am - 2.00 pm

Q1. **How old are you?** ☐

Q2. **Marital status**

- single ☐
- married ☐
- cohabiting ☐
- divorced ☐
- widowed ☐

Q3. **Please try to imagine yourself in the situations that follow. If such a situation happened to you, what would you feel would have caused it? While events may have many causes, we want you to pick only one - THE MAJOR CAUSE IF THIS EVENT HAPPENED TO YOU.**

Please write the cause in the blank provided after each event. Next we want you to answer 3 questions about the cause you provided. First, is the cause of this event something about you or something about other people or circumstances? Second, is the cause of this event something that will persist across time or something that will never again be resent? Third, is the cause of this event something that affects all situations in your life or something that just affects this type of event?

To summarize, we want you to:

1. **Read each situation and vividly imagine it happening to you.**

2. **Decide what you feel would be the one major cause of the situation if it happened to you.**

3. **Write the cause in the blank provided.**

4. **Answer 3 questions about the cause.**

3.1 You have been looking for a job unsuccessfully for some time.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

****

3.2 A friend comes to you with a problem, and you don't try to help.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

3.3 You give an important talk in front of a group, and the audience reacts negatively

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

****

3.4 You meet a friend who acts hostilely to you

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

3.5 You can't get all the work done that others expect of you

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

****

3.6 You go out on a date and it goes badly

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

3.7 Your steady romantic relationship ends

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

****

3.8 You experience a major personal injury

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

3.9 You are found guilty of a minor violation of the law

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

****

3.10 You and your family have a serious argument.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

3.11 You are fired from your job.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

****

3.12 After your first term at college, you are told your marks are unacceptable.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

3.13 Your best friend tells you that you are not to be trusted.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

****

3.14 You have a lot of trouble understanding what your new employer requires of you.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

3.15 You cannot sleep soundly.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

****

3.16 You experience sexual difficulties

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

3.17 You experience a serious conflict in your values.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

****

3.18 Your roommate tells you she is switching to a room down the hall

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others *1* *2* *3* *4* *5* *6* *7* *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present *1* *2* *3* *4* *5* *6* *7* *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation *1* *2* *3* *4* *5* *6* *7* *all situations*

3.19 There are few recreational activities in which you are interested

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

****

3.20 Your Christmas vacation plans are cancelled.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

3.21 You have trouble with one of your instructors.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

****

3.22 You experience financial difficulties.

A. Write down the one major cause _____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

3.23 Your attempt to capture the interest of a specific person of the opposite sex is a failure

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

****

3.24 You feel tired and sick all the time.

A. Write down the one major cause_____

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

totally due to others 1 2 3 4 5 6 7 *totally due to me*

C. In the future will this cause again be present? (circle one number)

never present 1 2 3 4 5 6 7 *always present*

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

just this situation 1 2 3 4 5 6 7 *all situations*

Q4. Please circle the response which best describes how you feel, where the letters stand for the following:

SA - Strongly agree A - Agree D - Disagree SD - Strongly Disagree

1.	On the whole I am satisfied with myself	SA	A	D	SD
2.	At times I think I am no good at all	SA	A	D	SD
3.	I feel that I have a number of good qualities	SA	A	D	SD
4.	I am able to do things as well as most other people	SA	A	D	SD
5.	I feel I do not have much to be proud of	SA	A	D	SD
6.	I certainly feel useless at times	SA	A	D	SD
7.	I feel that I'm a person of worth, at least on an equal plane with others	SA	A	D	SD
8.	I wish I could have more respect for myself	SA	A	D	SD
9.	All in all, I am inclined to feel that I am a failure	SA	A	D	SD
10.	I take a positive attitude towards myself	SA	A	D	SD

The following questions concern sensitive issues regarding experiences of sexual abuse during childhood. Your responses are <u>completely anonymous and confidential</u>, and will help to further knowledge about effective ways of helping adults who have experienced such abuse. Please tick all the responses which apply to you; remember you may tick more than one item per question.

Q5. When you were a child did an adult:-

a) sexually expose themselves to you? ☐

b) watch you bathing/dressing in a voyeuristic way? ☐

c) make you touch them in a sexual way? ☐

d) touch you in a sexual way without genital contact? ☐

e) touch you in a sexual way including genital contact? ☐

f) have sexual intercourse with you? ☐

g) I have not experienced any of the above ☐

If you have <u>not</u> experienced any of the above, please finish this questionnaire here. Return details are given on the front cover of this booklet. Thank you very much for your participation.

If you have ticked any of the items a) to f) above please continue.

Q6. Who was/were the abuser(s)?

a) biological father ☐ biological mother ☐

b) other relative (please specify) _____

c) other parent figure (e.g.step/foster) (please specify) _____

d) family friend/acquaintance ☐

e) other (please specify) _____

Q7. What age were you when the abuse started? ☐

Q8. What age were you when the abuse stopped? ☐

Q9. How many times were you abused?

a) Less than 5 times ☐

b) 5 - 10 times ☐

c) 10 - 20 times ☐

d) more than 20 times ☐

Q10. Did the abuser(s) use physical force? Yes ☐ No ☐

Q11. Did the abuser(s) try to prevent you from disclosing? Yes ☐ No ☐

If so, how?

a) threatened or actual violence ☐

b) saying nothing was wrong ☐

c) saying it was your fault ☐

d) saying it would split up the family ☐

e) saying no-one would believe you ☐

f) other - (please specify) _____

Q12. Did you experience any sexual arousal during the abuse? Yes ☐ No ☐

Q13. Did you tell anyone about the abuse? Yes ☐ No ☐

<u>If you did not tell anyone about the abuse, please go straight to Q.17</u>

Q14. How old were you when you first told someone? ☐

Q15. Were you believed? Yes ☐ No ☐

Q16. What happened when you disclosed?

a) the abuser was not confronted ☐

b) the abuse continued ☐

c) the abuser was confronted ☐

d) the abuser denied the abuse ☐

e) a family member supported/ helped you ☐

f) the abuser admitted the abuse ☐

g) you were blamed ☐

h) the authorities were informed ☐

i) the abuser was convicted ☐

j) you were taken away from your family ☐

k) other - (please specify) _____

_____

Q17. How has the abuse affected you?

a) fear of men ☐ fear of women ☐

b) problems with sex ☐

c) feeling guilty ☐

d) feeling ashamed ☐

e) feeling angry ☐

f) anxiety or phobias ☐

g) low self-esteem/disliking yourself ☐

h) depression ☐

i) attempted suicide ☐

j) eating problems (e.g. anorexia/bulimia) ☐

k) sleep disturbance/nightmares ☐

l) alcohol/drug abuse ☐

m) self-injury (e.g. cutting/burning yourself)

m) feel no effect ☐

n) other - (please specify) _____

_____

Q18. Have you had any professional help in the past for psychological distress/problems?

(e.g.seen a counsellor/psychologist/GP/psychiatrist/ taken prescribed medication)

Yes ☐ No ☐

Q19. Are you currently receiving any professional help for psychological distress/problems?

(e.g.seeing a counsellor/psychologist/GP/psychiatrist/ taking prescribed medication)

Yes ☐ No ☐

Q20. Below is a list of different attitudes and beliefs that people who have experienced sexual abuse sometimes hold. Please read each statement carefully and decide how much you agree or disagree with it. Circle the number which matches what you really believe yourself, not what you think you should believe. There are no right or wrong answers. To decide whether a given statement is typical of your views, keep in mind how you think most of the time.

1	2	3	4	5
Disagree Strongly	Disagree Moderately	Neither Agree nor Disagree	Agree Moderately	Agree Strongly

1	I blame myself for causing the sexual contact	1	2	3	4	5
2	I think the person (people) who had this sexual contact with me intended to hurt me	1	2	3	4	5
3	I blame myself for allowing the sexual contact to occur	1	2	3	4	5
4	I feel bad because in some ways I wanted or liked the sexual contact	1	2	3	4	5
5	I blame someone who may have known about the sexual contact for not stopping it	1	2	3	4	5
6	I think the person (people) who did these things deserved to be punished for doing them	1	2	3	4	5
7	I blame the person (people) who did these things for the sexual contact	1	2	3	4	5
8	I blame myself for getting into the situation where the unwanted sexual contact began	1	2	3	4	5
9	I feel bad about not fighting back or protesting more	1	2	3	4	5
10	I think the sexual contact occurred because of some characteristic of mine (like being attractive, flirtatious or naughty)	1	2	3	4	5
11	I blame myself for doing something I thought might have led to the sexual contact	1	2	3	4	5
12	I blame myself for something I failed to do that may have allowed me to avoid the sexual contact	1	2	3	4	5
13	I blame myself for not avoiding the unwanted sexual contact	1	2	3	4	5
14	I blame my family for allowing the sexual contact to occur	1	2	3	4	5
15	I blame a loved one for not protecting me from the unwanted sexual contact	1	2	3	4	5
16	I am disappointed my family did not support me more after they found out about the sexual contact	1	2	3	4	5
17	I feel as if I deserved the unwanted sexual contact	1	2	3	4	5
18	I feel as if I deserved to be punished for participating in this sexual contact	1	2	3	4	5

1	2	3	4	5
Disagree Strongly	**Disagree Moderately**	**Neither Agree nor Disagree**	**Agree Moderately**	**Agree Strongly**

19	I blame my family for not doing more to protect me from the sexual contact	1	2	3	4	5
20	I blame my family for creating the situation where the sexual contact was likely to occur	1	2	3	4	5
21	I blame myself for not telling someone about the unwanted sexual contact	1	2	3	4	5
22	I feel my family's response to learning about the sexual contact made the situation worse	1	2	3	4	5
23	I blame myself for the sexual contact progressing from milder to more serious kinds of sexual contact	1	2	3	4	5
24	I blame myself for allowing the sexual contact to continue	1	2	3	4	5
25	I feel responsible for the sexual contact continuing	1	2	3	4	5
26	I blame someone for allowing me to be in the situation where the sexual contact could occur	1	2	3	4	5
27	I blame someone for not believing me when I told them about the sexual contact	1	2	3	4	5
28	I blame myself for all the hurt the sexual contact brought upon my family	1	2	3	4	5
29	I blame myself for not doing more to protect my brothers and sisters from unwanted sexual contact	1	2	3	4	5
30	I blame someone for not doing anything after they found out about the sexual contact	1	2	3	4	5
31	I think the sexual contact was the fault of the person (people) who did these things	1	2	3	4	5
32	I feel guilty about the sexual contact	1	2	3	4	5
33	I think I encouraged the sexual contact	1	2	3	4	5
34	I think the person (people) who had the unwanted sexual contact with me intended to do these things	1	2	3	4	5
35	I blame the person (people) who did these things for hurting my family	1	2	3	4	5
36	I think the other person (people) involved in the sexual contact was the person (were the people) responsible for it	1	2	3	4	5
37	I hate the person (people) who had this sexual contact with me for doing what (he,she,they) did	1	2	3	4	5
38	I think the sexual contact was my fault	1	2	3	4	5
39	I think the person (people) who did these sexual things was (were) "sick" and needed help	1	2	3	4	5
40	I blame the person (people) for continuing to do these things after I let it be known I wanted it to stop	1	2	3	4	5

Q21. A study by Jehu (1988) found that 58% of women who were sexually abused during childhood reported experiencing sexual arousal during their abuse. We would like you to indicate whether this happened to you.

In this worked example, putting X here would indicate that you often experienced arousal:-

Never **Always**

Putting X here would indicate that you seldom experienced arousal:-

Never **Always**

Please put a cross on the line below to indicate how often you experienced sexual arousal during the abuse

Never **Always**

If you never experienced any sexual arousal during the abuse please finish the questionnaire here. Otherwise please complete Question 22.

Q22. **Below is a list of different attitudes and beliefs that people who have experienced sexual arousal during sexual abuse sometimes hold. Please read each statement carefully and decide how much you agree or disagree with it. Circle the number which matches what you really believe yourself, not what you think you should believe. There are no right or wrong answers. To decide whether a given statement is typical of your views, keep in mind how you think most of the time.**

1	2	3	4	5
Disagree Strongly	**Disagree Moderately**	**Neither Agree nor Disagree**	**Agree Moderately**	**Agree Strongly**

41	I think the person (people) who did these sexual things was (were) responsible for the sexual arousal I felt	1	2	3	4	5
42	I feel I deserve to be punished for experiencing sexual arousal	1	2	3	4	5
43	I blame my family for not protecting me from a situation where someone could sexually arouse me	1	2	3	4	5
44	I feel guilty for feeling sexually aroused when the sexual things were happening	1	2	3	4	5
45	I had no control over what was being done to my body, so I blame the person/people who did the sexual things for the sexual arousal I felt.	1	2	3	4	5
46	The sexual arousal would not have happened if my family had protected me from the person/people who did the sexual things	1	2	3	4	5
47	I think experiencing sexual arousal means I wanted the sexual things to happen	1	2	3	4	5
48	I blame the sexual arousal I experienced on someone who may have known what was happening but didn't do anything to stop it	1	2	3	4	5
49	I think the person (people) made me feel sexually aroused deliberately so that I would feel too guilty to tell anyone about what was happening	1	2	3	4	5

Thank you for filling in this questionnaire - your participation is very much appreciated. If you wish to talk about any matters it has raised, please get in touch with Sarah Gregory (Tel: 01248-682839). Any contact will be treated in complete confidence.

Please check that you have answered all the questions in the booklet and checklist. Return details are given on the front cover of this booklet.

Further information about the research

Thank you very much for taking time to fill in the questionnaire booklet. Below is some additional information about the research which was not given earlier to avoid influencing participants' responses.

Background

Attributional style is a cognitive personality variable reflecting the way people habitually explain events involving themselves. This study looks at the relationship between general attributional style, self-esteem and psychological well-being in a group of female students.

Recent research has also indicated that psychological adjustment following child sexual abuse may be influenced by the way in which people cognitively process such experiences. For those participants who have a history of sexual abuse, the study looks specifically at the relationship between self-blaming attributions, self-esteem and psychological well-being.

Expected findings

We are expecting to find that a positive attributional style will be associated with higher self-esteem and greater psychological well-being. We also expect to find that lower levels of self-blame regarding sexual abuse experiences will be related to greater psychological well-being.

Clinical value

Alleviating feelings of guilt and responsibility is an important part of therapeutic work with adults who have experienced childhood sexual abuse. Research into the development of these self-blaming attributions and their possible links with the development of emotional difficulties is relatively new, however. The clinical value of the findings will be to underline the importance of dealing with self-blaming cognitions, especially those connected with the experience of sexual arousal during abuse.

If you are experiencing emotional difficulties please contact your GP who will be able to advise you about where to go for help.

APPENDIX G

t-tests for Independent Samples of GRPSX2 csavscomp

Variable	Number of Cases	Mean	SD	SE of Mean
AGE				
all csa	25	24.4400	8.191	1.638
comparison	73	21.2466	5.883	.689

Mean Difference = 3.1934

Levene's Test for Equality of Variances: F= 5.215 P= .025

t-test for Equality of Means Variances	t-value	df	2-Tail Sig	SE of Diff	95% CI for Diff
Equal	2.11	96	.038	1.515	(.187, 6.200)
Unequal	1.80	32.89	.082	1.777	(-.422, 6.809)

APPENDIX 7

t-tests for Independent Samples of GRPSX3

Variable	Number of Cases	Mean	SD	SE of Mean
AGE				
non-aro	17	26.1765	9.376	2.274
aroused	8	20.7500	2.493	.881

Mean Difference = 5.4265

Levene's Test for Equality of Variances: F= 6.938 P= .015

t-test for Equality of Means					95%
Variances	t-value	df	2-Tail Sig	SE of Diff	CI for Diff
Equal	1.59	23	.125	3.404	(-1.616, 12.469)
Unequal	2.23	20.13	.038	2.439	(.341, 10.512)

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
non-arousedvsaroused * contactvsnon-contact CSA	25	25.0%	75	75.0%	100	100.0%

non-arousedvsaroused * contactvsnon-contact CSA Crosstabulation

Count

		contactvsnon-contact CSA		
		.00	contactCSA	Total
non-arousedvsaroused	non-aroused	2	15	17
	3		8	8
Total		2	23	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.023[b]	1	.312		
Continuity Correction[a]	.049	1	.825		
Likelihood Ratio	1.623	1	.203		
Fisher's Exact Test				1.000	.453
Linear-by-Linear Association	.982	1	.322		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is .64.

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	age started abuse	12.027[a]	2	6.013	.347	.711
	YEARSCSA	6.069[b]	2	3.034	.231	.795
	number of different CSA types experienced	14.330[c]	2	7.165	4.066	.032
Intercept	age started abuse	106.422	1	106.422	6.143	.022
	YEARSCSA	45.438	1	45.438	3.465	.077
	number of different CSA types experienced	26.265	1	26.265	14.906	.001
AGE	age started abuse	10.849	1	10.849	.626	.438
	YEARSCSA	5.764	1	5.764	.439	.515
	number of different CSA types experienced	.324	1	.324	.184	.672
NONAAROU	age started abuse	3.337E-03	1	3.337E-03	.000	.989
	YEARSCSA	3.465E-02	1	3.465E-02	.003	.959
	number of different CSA types experienced	11.589	1	11.589	6.577	.018
Error	age started abuse	363.806	21	17.324		
	YEARSCSA	275.421	21	13.115		
	number of different CSA types experienced	37.004	21	1.762		
Total	age started abuse	2284.000	24			
	YEARSCSA	482.750	24			
	number of different CSA types experienced	222.000	24			
Corrected Total	age started abuse	375.833	23			
	YEARSCSA	281.490	23			
	number of different CSA types experienced	51.333	23			

a. R Squared = .032 (Adjusted R Squared = -.060)

b. R Squared = .022 (Adjusted R Squared = -.072)

c. R Squared = .279 (Adjusted R Squared = .210)

General Linear Model

Between-Subjects Factors

		Value Label	N
non-arousedvsaroused	2	non-aroused	17
	3		7

Multivariate Tests[b]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.495	6.211[a]	3.000	19.000	.004
	Wilks' Lambda	.505	6.211[a]	3.000	19.000	.004
	Hotelling's Trace	.981	6.211[a]	3.000	19.000	.004
	Roy's Largest Root	.981	6.211[a]	3.000	19.000	.004
AGE	Pillai's Trace	.053	.356[a]	3.000	19.000	.786
	Wilks' Lambda	.947	.356[a]	3.000	19.000	.786
	Hotelling's Trace	.056	.356[a]	3.000	19.000	.786
	Roy's Largest Root	.056	.356[a]	3.000	19.000	.786
NONAAROU	Pillai's Trace	.252	2.131[a]	3.000	19.000	.130
	Wilks' Lambda	.748	2.131[a]	3.000	19.000	.130
	Hotelling's Trace	.336	2.131[a]	3.000	19.000	.130
	Roy's Largest Root	.336	2.131[a]	3.000	19.000	.130

a. Exact statistic

b. Design: Intercept+AGE+NONAAROU

APPENDIX 10.

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
non-arousedvsaroused * intrafam/extrafam	25	25.0%	75	75.0%	100	100.0%

non-arousedvsaroused * intrafam/extrafam Crosstabulation

Count

		intrafam/extrafam		
		intrafamilial	extrafamilial	Total
non-arousedvsaroused	non-aroused	3	14	17
	3	4	4	8
Total		7	18	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.824[b]	1	.093		
Continuity Correction[a]	1.448	1	.229		
Likelihood Ratio	2.713	1	.100		
Fisher's Exact Test				.156	.116
Linear-by-Linear Association	2.711	1	.100		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.24.

General Linear Model

Between-Subjects Factors

		Value Label	N
intrafam/extrafam	1	intrafamilial	7
	2	extrafamilial	16

Multivariate Tests[b]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.998	1074.546[a]	6.000	16.000	.000
	Wilks' Lambda	.002	1074.546[a]	6.000	16.000	.000
	Hotelling's Trace	402.955	1074.546[a]	6.000	16.000	.000
	Roy's Largest Root	402.955	1074.546[a]	6.000	16.000	.000
INTFEXTF	Pillai's Trace	.230	.796[a]	6.000	16.000	.587
	Wilks' Lambda	.770	.796[a]	6.000	16.000	.587
	Hotelling's Trace	.299	.796[a]	6.000	16.000	.587
	Roy's Largest Root	.299	.796[a]	6.000	16.000	.587

a. Exact statistic

b. Design: Intercept+INTFEXTF

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	Rosenberg Self Esteem	56.351[a]	1	56.351	1.388	.252
	global severity index	.351[b]	1	.351	.456	.507
	self blame for CSA	736.075[c]	1	736.075	2.347	.140
	perpetrator blame for csa	43.047[d]	1	43.047	1.104	.305
	family/other blamed for sca	224.814[e]	1	224.814	2.277	.146
	intstaglomean	.319[f]	1	.319	.638	.433
Intercept	Rosenberg Self Esteem	14185.569	1	14185.569	349.289	.000
	global severity index	32.630	1	32.630	42.366	.000
	self blame for CSA	56189.814	1	56189.814	179.144	.000
	perpetrator blame for csa	26956.090	1	26956.090	691.295	.000
	family/other blamed for sca	8970.205	1	8970.205	90.836	.000
	intstaglomean	386.234	1	386.234	772.247	.000
INTFEXTF	Rosenberg Self Esteem	56.351	1	56.351	1.388	.252
	global severity index	.351	1	.351	.456	.507
	self blame for CSA	736.075	1	736.075	2.347	.140
	perpetrator blame for csa	43.047	1	43.047	1.104	.305
	family/other blamed for sca	224.814	1	224.814	2.277	.146
	intstaglomean	.319	1	.319	.638	.433
Error	Rosenberg Self Esteem	852.866	21	40.613		
	global severity index	16.174	21	.770		
	self blame for CSA	6586.795	21	313.657		
	perpetrator blame for csa	818.866	21	38.994		
	family/other blamed for sca	2073.795	21	98.752		
	intstaglomean	10.503	21	.500		
Total	Rosenberg Self Esteem	18496.000	23			
	global severity index	51.989	23			
	self blame for CSA	67862.000	23			
	perpetrator blame for csa	33695.000	23			
	family/other blamed for sca	11619.000	23			
	intstaglomean	456.689	23			
Corrected Total	Rosenberg Self Esteem	909.217	22			
	global severity index	16.525	22			
	self blame for CSA	7322.870	22			
	perpetrator blame for csa	861.913	22			
	family/other blamed for sca	2298.609	22			
	intstaglomean	10.822	22			

a. R Squared = .062 (Adjusted R Squared = .017)

b. R Squared = .021 (Adjusted R Squared = -.025)

c. R Squared = .101 (Adjusted R Squared = .058)

d. R Squared = .050 (Adjusted R Squared = .005)

e. R Squared = .098 (Adjusted R Squared = .055)

f. R Squared = .029 (Adjusted R Squared = -.017)

NPar Tests

Mann-Whitney Test

Ranks

	non-arousedvsaroused	N	Mean Rank	Sum of Ranks
how many times were you abused	non-aroused	17	10.76	183.00
	3	8	17.75	142.00
	Total	25		

Test Statistics[b]

	how many times were you abused
Mann-Whitney U	30.000
Wilcoxon W	183.000
Z	-2.372
Asymp. Sig. (2-tailed)	.018
Exact Sig. [2*(1-tailed Sig.)]	.027[a]

a. Not corrected for ties.

b. Grouping Variable: non-arousedvsaroused

: "Other Questionnaire Items" for Aroused and Non-Aroused Groups

	Aroused Group (n=8)		Non-Aroused Group (n=17)		Exact Sig. (2-sided)	Exact Sig. (1-sided)
	Yes	No	Yes	No		
Physical force	4	4	6	11	.667 (n.s.)	.393 (n.s.)
Abuser tried to prevent disclosure	5	3	9	8	1.000 (n.s.)	.496 (n.s.)
Participant disclosed	5	3	7	10	.411 (n.s.)	.286 (n.s.)
Participant believed	3	4	1	6	.266 (n.s.)	.133 (n.s.)
Participant sought help	5	3	7	10	.411 (n.s.)	.286 (n.s.)

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
non-arousedvsaroused * did the abuser try to prevent you from disclosing?	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * were you believed	14	14.0%	86	86.0%	100	100.0%

non-arousedvsaroused * did the abuser try to prevent you from disclosing?

Crosstab

Count

		did the abuser try to prevent you from disclosing?		
		0	1	Total
non-arousedvsaroused	non-aroused	8	9	17
	3	3	5	8
Total		11	14	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.202[b]	1	.653		
Continuity Correction[a]	.000	1	.986		
Likelihood Ratio	.203	1	.652		
Fisher's Exact Test				1.000	.496
Linear-by-Linear Association	.194	1	.660		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.52.

non-arousedvsaroused * were you believed

Crosstab

Count

		were you believed		
		0	1	Total
non-arousedvsaroused	non-aroused	1	6	7
	3	4	3	7
Total		5	9	14

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.800[b]	1	.094		
Continuity Correction[a]	1.244	1	.265		
Likelihood Ratio	2.947	1	.086		
Fisher's Exact Test				.266	.133
Linear-by-Linear Association	2.600	1	.107		
N of Valid Cases	14				

a. Computed only for a 2x2 table

b. 4 cells (100.0%) have expected count less than 5. The minimum expected count is 2.50.

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
non-arousedvsaroused * seekhelp	25	25.0%	75	75.0%	100	100.0%

non-arousedvsaroused * seekhelp Crosstabulation

Count

		seekhelp		Total
		no	yes	
non-arousedvsaroused	non-aroused	10	7	17
	3	3	5	8
Total		13	12	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.991[b]	1	.319		
Continuity Correction[a]	.321	1	.571		
Likelihood Ratio	.998	1	.318		
Fisher's Exact Test				.411	.286
Linear-by-Linear Association	.951	1	.329		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.84.

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
non-arousedvsaroused * physical force	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * tell anyone	25	25.0%	75	75.0%	100	100.0%

non-arousedvsaroused * physical force

Crosstab

Count

		physical force		Total
		0	1	
non-arousedvsaroused	non-aroused	11	6	17
	3	4	4	8
Total		15	10	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.490[b]	1	.484		
Continuity Correction[a]	.069	1	.793		
Likelihood Ratio	.486	1	.486		
Fisher's Exact Test				.667	.393
Linear-by-Linear Association	.471	1	.493		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.20.

non-arousedvsaroused * tell anyone

Crosstab

Count

		tell anyone		Total
		0	1	
non-arousedvsaroused	non-aroused	10	7	17
	3	3	5	8
Total		13	12	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.991[b]	1	.319		
Continuity Correction[a]	.321	1	.571		
Likelihood Ratio	.998	1	.318		
Fisher's Exact Test				.411	.286
Linear-by-Linear Association	.951	1	.329		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.84.

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
non-arousedvsaroused * fear of men	24	24.0%	76	76.0%	100	100.0%
non-arousedvsaroused * fear of women	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * problems with sex	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * Q17GUILT	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * Q17SHAME	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * Q17ANGER	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * anxiety or phobias	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * low self esteem	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * depression	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * attempted suicide	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * eating problems	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * Q17SLEEP	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * alcohol/drug abuse	25	25.0%	75	75.0%	100	100.0%
non-arousedvsaroused * self injury	25	25.0%	75	75.0%	100	100.0%

non-arousedvsaroused * fear of men

Crosstab

Count

		fear of men		Total
		0	1	
non-arousedvsaroused	non-aroused	13	3	16
	3	3	5	8
Total		16	8	24

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.594[b]	1	.032		
Continuity Correction[a]	2.836	1	.092		
Likelihood Ratio	4.525	1	.033		
Fisher's Exact Test				.065	.047
Linear-by-Linear Association	4.402	1	.036		
N of Valid Cases	24				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.67.

non-arousedvsaroused * fear of women

Crosstab

Count

		fear of women		Total
		0	1	
non-arousedvsaroused	non-aroused	17		17
	3	7	1	8
Total		24	1	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.214[b]	1	.137		
Continuity Correction[a]	.155	1	.694		
Likelihood Ratio	2.369	1	.124		
Fisher's Exact Test				.320	.320
Linear-by-Linear Association	2.125	1	.145		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is .32.

non-arousedvsaroused * problems with sex

Crosstab

Count

		problems with sex		Total
		0	1	
non-arousedvsaroused	non-aroused	10	7	17
	3	2	6	8
Total		12	13	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.493[b]	1	.114		
Continuity Correction[a]	1.322	1	.250		
Likelihood Ratio	2.585	1	.108		
Fisher's Exact Test				.202	.125
Linear-by-Linear Association	2.394	1	.122		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.84.

non-arousedvsaroused * Q17GUILT

Crosstab

Count

		Q17GUILT		Total
		0	1	
non-arousedvsaroused	non-aroused	12	5	17
	3	5	3	8
Total		17	8	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.164[b]	1	.686		
Continuity Correction[a]	.000	1	1.000		
Likelihood Ratio	.161	1	.688		
Fisher's Exact Test				1.000	.513
Linear-by-Linear Association	.157	1	.692		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.56.

non-arousedvsaroused * Q17SHAME

Crosstab

Count

		Q17SHAME		Total
		0	1	
non-arousedvsaroused	non-aroused	10	7	17
	3	3	5	8
Total		13	12	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.991[b]	1	.319		
Continuity Correction[a]	.321	1	.571		
Likelihood Ratio	.998	1	.318		
Fisher's Exact Test				.411	.286
Linear-by-Linear Association	.951	1	.329		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.84.

non-arousedvsaroused * Q17ANGER

Crosstab

Count

		Q17ANGER		Total
		0	1	
non-arousedvsaroused	non-aroused	12	5	17
	3	3	5	8
Total		15	10	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.482[b]	1	.115		
Continuity Correction[a]	1.294	1	.255		
Likelihood Ratio	2.468	1	.116		
Fisher's Exact Test				.194	.128
Linear-by-Linear Association	2.382	1	.123		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.20.

non-arousedvsaroused * anxiety or phobias

Crosstab

Count

		anxiety or phobias		Total
		0	1	
non-arousedvsaroused	non-aroused	11	6	17
	3	4	4	8
Total		15	10	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.490[b]	1	.484		
Continuity Correction[a]	.069	1	.793		
Likelihood Ratio	.486	1	.486		
Fisher's Exact Test				.667	.393
Linear-by-Linear Association	.471	1	.493		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.20.

non-arousedvsaroused * low self esteem

Crosstab

Count

		low self esteem		Total
		0	1	
non-arousedvsaroused	non-aroused	10	7	17
	3		8	8
Total		10	15	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.843[b]	1	.005		
Continuity Correction[a]	5.584	1	.018		
Likelihood Ratio	10.616	1	.001		
Fisher's Exact Test				.008	.006
Linear-by-Linear Association	7.529	1	.006		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.20.

non-arousedvsaroused * depression

Crosstab

Count

		depression		Total
		0	1	
non-arousedvsaroused	non-aroused	11	6	17
	3	3	5	8
Total		14	11	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.634[b]	1	.201		
Continuity Correction[a]	.716	1	.397		
Likelihood Ratio	1.637	1	.201		
Fisher's Exact Test				.389	.199
Linear-by-Linear Association	1.569	1	.210		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.52.

non-arousedvsaroused * attempted suicide

Crosstab

Count

		attempted suicide		Total
		0	1	
non-arousedvsaroused	non-aroused	13	4	17
	3	4	4	8
Total		17	8	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.752[b]	1	.186		
Continuity Correction[a]	.746	1	.388		
Likelihood Ratio	1.703	1	.192		
Fisher's Exact Test				.359	.193
Linear-by-Linear Association	1.682	1	.195		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.56.

non-arousedvsaroused * eating problems

Crosstab

Count

		eating problems		Total
		0	1	
non-arousedvsaroused	non-aroused	11	6	17
	3	5	3	8
Total		16	9	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.011[b]	1	.915		
Continuity Correction[a]	.000	1	1.000		
Likelihood Ratio	.011	1	.915		
Fisher's Exact Test				1.000	.626
Linear-by-Linear Association	.011	1	.916		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.88.

non-arousedvsaroused * Q17SLEEP

Crosstab

Count

		Q17SLEEP		Total
		0	1	
non-arousedvsaroused	non-aroused	12	5	17
	3	4	4	8
Total		16	9	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.001[b]	1	.317		
Continuity Correction[a]	.307	1	.580		
Likelihood Ratio	.983	1	.321		
Fisher's Exact Test				.394	.287
Linear-by-Linear Association	.961	1	.327		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.88.

non-arousedvsaroused * alcohol/drug abuse

Crosstab

Count

		alcohol/drug abuse		Total
		0	1	
non-arousedvsaroused	non-aroused	15	2	17
	3	5	3	8
Total		20	5	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.252[b]	1	.133		
Continuity Correction[a]	.931	1	.335		
Likelihood Ratio	2.120	1	.145		
Fisher's Exact Test				.283	.167
Linear-by-Linear Association	2.162	1	.141		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.60.

non-arousedvsaroused * self injury

Crosstab

Count

		self injury		Total
		0	1	
non-arousedvsaroused	non-aroused	16	1	17
	3	3	5	8
Total		19	6	25

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	9.560[b]	1	.002		
Continuity Correction[a]	6.708	1	.010		
Likelihood Ratio	9.363	1	.002		
Fisher's Exact Test				.006	.006
Linear-by-Linear Association	9.178	1	.002		
N of Valid Cases	25				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.92.

APPENDIX 16

General Linear Model

Between-Subjects Factors

		Value Label	N
csa vs comparison	1.00	comparison	74
	2.00	all csa	23

Multivariate Tests[b]

Effect		Value	F	Hypothesis df	Error df	Sig.	Eta Squared
Intercept	Pillai's Trace	.990	3219.227[a]	3.000	93.000	.000	.990
	Wilks' Lambda	.010	3219.227[a]	3.000	93.000	.000	.990
	Hotelling's Trace	103.846	3219.227[a]	3.000	93.000	.000	.990
	Roy's Largest Root	103.846	3219.227[a]	3.000	93.000	.000	.990
CSAVSCOM	Pillai's Trace	.131	4.683[a]	3.000	93.000	.004	.131
	Wilks' Lambda	.869	4.683[a]	3.000	93.000	.004	.131
	Hotelling's Trace	.151	4.683[a]	3.000	93.000	.004	.131
	Roy's Largest Root	.151	4.683[a]	3.000	93.000	.004	.131

a. Exact statistic

b. Design: Intercept+CSAVSCOM

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F
Corrected Model	Rosenberg Self Esteem	38.588[a]	1	38.588	1.211
	global severity index	4.791[b]	1	4.791	13.078
	intstaglomean	2.013[c]	1	2.013	4.268
Intercept	Rosenberg Self Esteem	56583.577	1	56583.577	1776.496
	global severity index	67.470	1	67.470	184.172
	intstaglomean	1257.928	1	1257.928	2666.909
CSAVSCOM	Rosenberg Self Esteem	38.588	1	38.588	1.211
	global severity index	4.791	1	4.791	13.078
	intstaglomean	2.013	1	2.013	4.268
Error	Rosenberg Self Esteem	3025.866	95	31.851	
	global severity index	34.802	95	.366	
	intstaglomean	44.810	95	.472	
Total	Rosenberg Self Esteem	83428.000	97		
	global severity index	108.542	97		
	intstaglomean	1712.981	97		
Corrected Total	Rosenberg Self Esteem	3064.454	96		
	global severity index	39.594	96		
	intstaglomean	46.823	96		

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Tests of Between-Subjects Effects

Source	Dependent Variable	Sig.	Eta Squared
Corrected Model	Rosenberg Self Esteem	.274	.013
	global severity index	.000	.121
	intstaglomean	.042	.043
Intercept	Rosenberg Self Esteem	.000	.949
	global severity index	.000	.660
	intstaglomean	.000	.966
CSAVSCOM	Rosenberg Self Esteem	.274	.013
	global severity index	.000	.121
	intstaglomean	.042.	.043
Error	Rosenberg Self Esteem		
	global severity index		
	intstaglomean		
Total	Rosenberg Self Esteem		
	global severity index		
	intstaglomean		
Corrected Total	Rosenberg Self Esteem		
	global severity index		
	intstaglomean		

a. R Squared = .013 (Adjusted R Squared = .002)

b. R Squared = .121 (Adjusted R Squared = .112)

c. R Squared = .043 (Adjusted R Squared = .033)

APPENDIX 17

General Linear Model

Between-Subjects Factors

		Value Label	N
non-arousedvsaroused	2	non-aroused	15
	3		8

Multivariate Tests[b]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.967	63.481[a]	6.000	13.000	.000
	Wilks' Lambda	.033	63.481[a]	6.000	13.000	.000
	Hotelling's Trace	29.299	63.481[a]	6.000	13.000	.000
	Roy's Largest Root	29.299	63.481[a]	6.000	13.000	.000
AGE	Pillai's Trace	.287	.871[a]	6.000	13.000	.541
	Wilks' Lambda	.713	.871[a]	6.000	13.000	.541
	Hotelling's Trace	.402	.871[a]	6.000	13.000	.541
	Roy's Largest Root	.402	.871[a]	6.000	13.000	.541
TOTTYPE	Pillai's Trace	.184	.489[a]	6.000	13.000	.805
	Wilks' Lambda	.816	.489[a]	6.000	13.000	.805
	Hotelling's Trace	.226	.489[a]	6.000	13.000	.805
	Roy's Largest Root	.226	.489[a]	6.000	13.000	.805
Q9TIMES	Pillai's Trace	.155	.397[a]	6.000	13.000	.868
	Wilks' Lambda	.845	.397[a]	6.000	13.000	.868
	Hotelling's Trace	.183	.397[a]	6.000	13.000	.868
	Roy's Largest Root	.183	.397[a]	6.000	13.000	.868
NONAAROU	Pillai's Trace	.366	1.251[a]	6.000	13.000	.344
	Wilks' Lambda	.634	1.251[a]	6.000	13.000	.344
	Hotelling's Trace	.577	1.251[a]	6.000	13.000	.344
	Roy's Largest Root	.577	1.251[a]	6.000	13.000	.344

a. Exact statistic

b. Design: Intercept+AGE+TOTTYPE+Q9TIMES+NONAAROU

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	global severity index	5.911[a]	4	1.478	2.506	.079
	Rosenberg Self Esteem	159.727[b]	4	39.932	.959	.454
	self blame for CSA	3423.353[c]	4	855.838	3.951	.018
	family/other blamed for sca	894.525[d]	4	223.631	2.867	.053
	perpetrator blame for csa	154.257[e]	4	38.564	.981	.443
	intstaglomean	4.096[f]	4	1.024	2.740	.061

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Intercept	global severity index	2.079	1	2.079	3.526	.077
	Rosenberg Self Esteem	709.578	1	709.578	17.041	.001
	self blame for CSA	2729.978	1	2729.978	12.601	.002
	family/other blamed for sca	36.853	1	36.853	.472	.501
	perpetrator blame for csa	711.550	1	711.550	18.099	.000
	intstaglomean	14.508	1	14.508	38.825	.000
AGE	global severity index	.661	1	.661	1.122	.304
	Rosenberg Self Esteem	3.233	1	3.233	.078	.784
	self blame for CSA	146.880	1	146.880	.678	.421
	family/other blamed for sca	83.520	1	83.520	1.071	.314
	perpetrator blame for csa	107.378	1	107.378	2.731	.116
	intstaglomean	9.306E-02	1	9.306E-02	.249	.624
TOTTYPE	global severity index	.524	1	.524	.889	.358
	Rosenberg Self Esteem	.471	1	.471	.011	.916
	self blame for CSA	59.669	1	59.669	.275	.606
	family/other blamed for sca	110.067	1	110.067	1.411	.250
	perpetrator blame for csa	9.647	1	9.647	.245	.626
	intstaglomean	6.256E-02	1	6.256E-02	.167	.687
Q9TIMES	global severity index	5.884E-03	1	5.884E-03	.010	.922
	Rosenberg Self Esteem	33.004	1	33.004	.793	.385
	self blame for CSA	40.374	1	40.374	.186	.671
	family/other blamed for sca	24.460	1	24.460	.314	.582
	perpetrator blame for csa	4.968E-03	1	4.968E-03	.000	.991
	intstaglomean	.760	1	.760	2.035	.171
NONAAROU	global severity index	.865	1	.865	1.466	.242
	Rosenberg Self Esteem	21.183	1	21.183	.509	.485
	self blame for CSA	1028.437	1	1028.437	4.747	.043
	family/other blamed for sca	224.569	1	224.569	2.879	.107
	perpetrator blame for csa	17.671	1	17.671	.449	.511
	intstaglomean	.210	1	.210	.563	.463
Error	global severity index	10.614	18	.590		
	Rosenberg Self Esteem	749.491	18	41.638		
	self blame for CSA	3899.516	18	216.640		
	family/other blamed for sca	1404.084	18	78.005		
	perpetrator blame for csa	707.656	18	39.314		
	intstaglomean	6.726	18	.374		
Total	global severity index	51.989	23			
	Rosenberg Self Esteem	18496.000	23			
	self blame for CSA	67862.000	23			
	family/other blamed for sca	11619.000	23			
	perpetrator blame for csa	33695.000	23			
	intstaglomean	456.689	23			

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Total	global severity index	16.525	22			
	Rosenberg Self Esteem	909.217	22			
	self blame for CSA	7322.870	22			
	family/other blamed for sca	2298.609	22			
	perpetrator blame for csa	861.913	22			
	intstaglomean	10.822	22			

a. R Squared = .358 (Adjusted R Squared = .215)

b. R Squared = .176 (Adjusted R Squared = -.008)

c. R Squared = .467 (Adjusted R Squared = .349)

d. R Squared = .389 (Adjusted R Squared = .253)

e. R Squared = .179 (Adjusted R Squared = -.003)

f. R Squared = .378 (Adjusted R Squared = .240)

General Linear Model

Between-Subjects Factors

		Value Label	N
csa vs comparison	1.00	comparison	74
	2.00	all csa	23

Multivariate Tests[b]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.729	26.034[a]	9.000	87.000	.000
	Wilks' Lambda	.271	26.034[a]	9.000	87.000	.000
	Hotelling's Trace	2.693	26.034[a]	9.000	87.000	.000
	Roy's Largest Root	2.693	26.034[a]	9.000	87.000	.000
CSAVSCOM	Pillai's Trace	.227	2.843[a]	9.000	87.000	.006
	Wilks' Lambda	.773	2.843[a]	9.000	87.000	.006
	Hotelling's Trace	.294	2.843[a]	9.000	87.000	.006
	Roy's Largest Root	.294	2.843[a]	9.000	87.000	.006

a. Exact statistic

b. Design: Intercept+CSAVSCOM

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	anxiety	5.974[a]	1	5.974	12.282	.001
	depression	9.647[b]	1	9.647	15.094	.000
	hostility	1.385[c]	1	1.385	2.825	.096
	interpersonal sensitivity	3.807[d]	1	3.807	5.432	.022
	ocd	5.520[e]	1	5.520	10.472	.002
	phobias	6.554[f]	1	6.554	17.135	.000
	paranoid ideation	4.124[g]	1	4.124	7.649	.007
	somatisation	2.038[h]	1	2.038	5.225	.024
	psychoticism	3.377[i]	1	3.377	7.605	.007
Intercept	anxiety	57.345	1	57.345	117.895	.000
	depression	116.978	1	116.978	183.039	.000
	hostility	39.385	1	39.385	80.352	.000
	interpersonal sensitivity	105.237	1	105.237	150.189	.000
	ocd	115.070	1	115.070	218.307	.000
	phobias	22.290	1	22.290	58.279	.000
	paranoid ideation	65.887	1	65.887	122.193	.000
	somatisation	41.804	1	41.804	107.161	.000
	psychoticism	30.112	1	30.112	67.820	.000

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
CSAVSCOM	anxiety	5.974	1	5.974	12.282	.001
	depression	9.647	1	9.647	15.094	.000
	hostility	1.385	1	1.385	2.825	.096
	interpersonal sensitivity	3.807	1	3.807	5.432	.022
	ocd	5.520	1	5.520	10.472	.002
	phobias	6.554	1	6.554	17.135	.000
	paranoid ideation	4.124	1	4.124	7.649	.007
	somatisation	2.038	1	2.038	5.225	.024
	psychoticism	3.377	1	3.377	7.605	.007
Error	anxiety	46.209	95	.486		
	depression	60.713	95	.639		
	hostility	46.565	95	.490		
	interpersonal sensitivity	66.567	95	.701		
	ocd	50.075	95	.527		
	phobias	36.335	95	.382		
	paranoid ideation	51.225	95	.539		
	somatisation	37.060	95	.390		
	psychoticism	42.180	95	.444		
Total	anxiety	106.820	97			
	depression	186.895	97			
	hostility	92.179	97			
	interpersonal sensitivity	188.184	97			
	ocd	180.110	97			
	phobias	58.634	97			
	paranoid ideation	124.027	97			
	somatisation	84.237	97			
	psychoticism	73.810	97			
Corrected Total	anxiety	52.182	96			
	depression	70.360	96			
	hostility	47.950	96			
	interpersonal sensitivity	70.373	96			
	ocd	55.594	96			
	phobias	42.889	96			
	paranoid ideation	55.349	96			
	somatisation	39.098	96			
	psychoticism	45.557	96			

a. R Squared = .114 (Adjusted R Squared = .105)

b. R Squared = .137 (Adjusted R Squared = .128)

c. R Squared = .029 (Adjusted R Squared = .019)

d. R Squared = .054 (Adjusted R Squared = .044)

e. R Squared = .099 (Adjusted R Squared = .090)

f. R Squared = .153 (Adjusted R Squared = .144)

g. R Squared = .075 (Adjusted R Squared = .065)

h. R Squared = .052 (Adjusted R Squared = .042)

i. R Squared = .074 (Adjusted R Squared = .064)