Attributions as Predictors of Symptomatology in Sexual Abuse Survivors

by

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ATTRIBUTIONS AS PREDICTORS OF SYMPTOMATOLOGY IN SEXUAL ABUSE SURVIVORS

BY

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A Thesis submitted to the Faculty of Gradu_ Studies of the University of Manitoba in partial fulfillment of the requirements for the _gree of

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Abstract

The literature documents the varied nature of the impact of sexual abuse. Victimization-related attributions have been identified as one of the potential mediating variables accounting for the differential impact. This study examined the relationship between sexual abuse survivors' abuse-related attributions and their degree of distress symptomatology. The attributions investigated were based on Weiner's Attributions Theory. Attributions were represented by four attributional dimensions: locus of causality, stability, personal control, and external control. Subjects' abuse-related and nonabuse-related attributions were assessed. Perceived family, community, and society abuse-related attributions were also assessed. Distress symptoms included global distress, anxiety, depression, somatization, and post-traumatic stress disorder. Subjects consisted of 833 introductory psychology females, age 17-24 years. Approximately 33% of the sample reported having experienced some form of sexual abuse. Analyses were completed for three separate sexual abuse groups: child sexual abuse, peer sexual abuse, and adult sexual assault. T-tests indicated significant differences between abuse-related and nonabuse-related attributions of stability and personal control for all three abuse groups. No differences were found for attributions of locus of causality. Attributions were more predictive of adjustment to recent trauma such as adult sexual assault than to past trauma such

as child and peer sexual abuse. Multiple regression procedure revealed that attributional dimensions accounted for 2%-5% of distress variance for child sexual abuse survivors, 3%-7% of the distress variance for peer sexual abuse survivors, and 5%-12% of the distress variance for adult sexual assault survivors. Further analysis of the adult sexual assault group indicated that perceived community attributions accounted for 5% of global distress variance and 23% of anxiety variance. Perceived family attributions accounted for 11% of global distress variance. Society attributions accounted for 5% of global distress and depression variance and 6% of anxiety variance. These findings suggest that the individuals' developmental stage may determine which social elements are more influential. T-tests indicated no difference between personal attributions and perceived family, community, and societal attributions. In general, attributions of internal locus of causality, stability, high personal control, and high external control were associated with greater symptomatology. These findings corroborate the abuse literature and have important implications for the treatment of victims of sexual abuse.

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Long-Term Sequelae of Sexual Abuse

Approximately one third of all children have at one time in their life experienced sexual abuse (Bagley & Ramsey, 1986; Finkelhor, Hotaling, Lewis, & Smith, 1990; Herman, Russell, & Trocki, 1986; Koverola, 1992; Painter, 1986). Browne and Finkelhor (1986) define child sexual abuse as "a) forced or coerced sexual behavior imposed on a child, and b) sexual activity between a child and a much older person, whether or not obvious coercion is involved (a common definition of "much older" is 5 or more years)" (pp. 66). It can include a wide variety of activities ranging from forced sexual kissing and fondling to oral sex and anal and vaginal penetration.

Sexual abuse may impact on individuals in a number of ways across their life span. Abused children have been found to have more cognitive, affective, developmental, interpersonal and behavioral problems than nonabused children (Conte & Schuerman, 1988; Tong, Oates & McDowell, 1987). In order to understand the short-term sequelae and the underlying dynamics of child sexual abuse, Finkelhor and Browne (1986) proposed the Traumagenic Dynamics Model. This model conceives of trauma as operational on four major dimensions. The first dynamic is traumatic sexualization. An abused child who is rewarded for sexual behavior may begin to associate attention and affection with sex. Misconceptions and negative perceptions about sex may be

formed. The psychological impact of traumatic sexualization includes confusion about sexual identity and norms, confusion between sex and nurturance and love, negative emotions regarding sex, and an increase in the emphasis of sexual issues (Finkelhor & Browne, 1985). Traumatic sexualization can lead to sexualizing behaviors and role reversal. Sexualizing behaviors include inappropriate or precocious sexual behavior, promiscuity, and loose or inappropriate boundaries between self and others. Role reversal occurs when the victim of incest takes on the role and responsibilities of a parent who is either physically or psychologically absent (Cavaiola & Schiff, 1988; Einbender & Friedrich, 1989; Browne & Finkelhor, 1986; Wolfe & Wolfe, 1988).

The second traumagenic dynamic is stigmatization. This category includes blaming the victim, thereby making them feel damaged and ashamed. The psychological impact of stigmatization consists of shame, guilt, feeling different from others, and lowered self-esteem (Finkelhor & Browne, 1985). Behavioral characteristics stemming from stigmatization include illegal activities such as theft, vandalism, arson, and delinquency, and self-destructive behaviors such as substance abuse, self-mutilation, self-neglect, and suicide. Exposure to an abusive environment and the disregard of others may also lead to physical and emotional withdrawal through isolation, fantasy, and sleep

(Browne & Finkelhor, 1986; Conte & Schuerman, 1988; Einbender & Friedrich, 1989).

The third traumagenic dynamic involves betrayal of the child's trust by someone who is expected to protect, love, and support the child. The psychological impact encompasses grief, depression, dependency, mistrust, anger, and hostility (Finkelhor & Browne, 1985). Betrayal of a child's trust and vulnerability can result in aggression towards self and others, and regression to an earlier developmental stage (Browne & Finkelhor, 1986; Cavaiola & Schiff, 1988; Conte & Schuerman, 1988; Damon, Todd, & MacFarlane, 1987; Gelardo & Sanford, 1987; Wolfe & Wolfe, 1988).

The fourth traumagenic dynamic is powerlessness. This final category involves issues of vulnerability, invasion of personal space, and feelings of helplessness and powerlessness. The psychological factors resulting from these dynamics consist of identifying oneself as a victim, fear, anxiety, helplessness, and a need to regain control (Finkelhor & Browne, 1985). Behaviors resulting from these factors include physiological problems such as somatoform complaints, hyperactivity, developmental delays, and learning disabilities, and interpersonal problems such as poor peer relations, social withdrawal, provoking behaviors, oppositional behaviors, overcompliance, and manipulativeness. Powerlessness can also lead to fears and phobias, states of hypervigilence, sleep disturbances, and

post-traumatic stress disorder. Also common are depression, learned helplessness, and dissociation (Browne & Finkelhor, 1986; Conte, 1987; Einbender & Friedrich, 1989; Gelardo & Sanford, 1987; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989).

In many instances, the problems resulting from the traumagenic dynamics continue on into adulthood (Browne & Finkelhor, 1986). Approximately 80%-85% of sexual abuse survivors report some negative long-term effects of their abuse (Brunngraber, 1986; Finkelhor, 1979; Russell, 1986). These effects can be conceptualized into cognitive, affective, interpersonal, and post-traumatic stress disorder (PTSD) symptomatology categories (Briere, 1989).

Cognitive Effects

Cognitive effects of sexual abuse include: impaired memory, perceptual changes, and distrust of others. Some sexually abused individuals repress the abuse, particularly if episodes were frightening or traumatic (Briere, 1989). The abusive incidence may be recalled through memory triggers such as discussions, readings, and films on sexual abuse, or through therapy.

Sexual abuse survivors are susceptible to perceptual alterations. Among these alterations are low self-esteem, guilt and self-blame (Briere, 1989; Briere & Runtz, 1986; Browne & Finkelhor, 1986; Ellenson, 1989; Janoff-Bulman, 1979; Herman, et. al., 1986; Wiehe, 1990). Low self-esteem

is common in sexually abused children (Browne & Finkelhor, 1986), and in adult survivors of sexual abuse (Bagley & Ramsey, 1986; Briere, 1989; Brunngraber, 1986; Dyck, Proulx, Quinonez, Chohan, & Koverola, 1991: Rew 1989b; Russell, 1986). Low self-esteem tends to increase with time, resulting in self-hate and self-destructive behaviors (Briere, 1989). Many sexually abused children experience a sense of responsibility for their abuse resulting in self-blame and guilt (Browne & Finkelhor, 1986). This self-blame and guilt can continue on into adulthood (Maltz, 1988; Wiehe, 1990). Accepting responsibility for their own abuse would undoubtedly contribute to the lowered self-esteem of sexual abuse survivors.

Several factors have been proposed as constituents of self-blame, lowered self-esteem, and guilt. One such factor is others' reaction to the abuse. Some parents disbelieve the child's disclosure of abuse, or blame the child for the abuse, particularly if that abuse has occurred at the hands of a parent or family member. North American society tends to take a very sceptical position when confronted with individual's disclosures of abuse (Briere, 1989). This scepticism increases if the alleged perpetrator is a respected member of the community and if the alleged victim is a very young child (Friedrich, 1990).

Another factor contributing to the victim's lowered self-esteem, self-blame, and guilt is what Butler (1978)

terms the "conspiracy of silence". This stems from the secretive nature of abuse experiences. The silence surrounding the abuse may begin with threats against the disclosure. Through the tendency to discredit the child's disclosure, or to cover up the abuse, society and the community are also part of this "conspiracy of silence" (Briere, 1989).

Abused individuals are also subjected to stigmatization (Browne & Finkelhor, 1985). Stigmatization involves labelling the individual as a participant in sexual abuse. This label can become the focus of the individual's identity in the community and in society. Because sexual abuse is an emotionally charged event of a sexual nature, it carries adverse connotations which reflect negatively on the abused individual. The stigma carries a sense of being dirty and damaged (Browne & Finkelhor, 1986). Individuals' may come to feel that the abuse is somehow a visible part of them. This increases their sense of shame and lowers their self-esteem (Briere, 1989).

Abused individuals may blame themselves for the abuse in an effort to maintain a sense of power and control. Most individuals believe in a "just world hypothesis". The essence of this hypothesis is that a) good things happen to those who have been good, and b) bad things happen to those who have been bad. Rejection of the "just world hypothesis" implies a belief that events occur randomly. This in turn

leads to a sense of powerlessness and lack of control (Briere, 1989; Kelley, 1986; Wiehe, 1990). Abused individuals may blame themselves in an attempt to retain their belief in a just world and in their own sense of power and control.

Finally, the abused individual may come to distrust others (Brunngraber, 1986). Sexual abuse occurs at the hands of trusted adults who are often sources of support and comfort for the children (Finkelhor, 1986; Herman, et. al., 1986; Kelley, 1986). Betrayal of trust by these adults instills a sense of distrust in abused children and sexual abuse survivors.

Emotional Effects

In addition to the cognitive effects of sexual abuse, there are emotional effects. These include anxiety, depression, emotional withdrawal, and dissociation. Anxiety is a common symptom of sexual abuse (Bagley & Ramsey, 1986; Briere & Runtz, 1988); Browne & Finkelhor, 1986; Herman et. al., 1986) which involves both physiological and psychological reactions. Physiological reactions include shortness of breath, sweating, trembling, and heart palpitations. These physiological symptoms can lead to more overt behavioral symptoms such as sleep disturbances, somatization, headaches, stomach problems, anxiety attacks, and eating disorders (Briere, 1989; Briere & Runtz, 1988; Browne & Finkelhor, 1986; Brunngraber, 1986;

Rew, 1989a). Psychological reactions include feelings of powerlessness, a sense of doom, tension, hypervigilence, and a preoccupation with fears and worries (Briere, 1989; Briere & Runtz, 1987; Browne & Finkelhor, 1986; Sedney & Brooks, 1984).

Depression is common in children who have been sexually abused (Koverola, Pound & Heger, in press; Orr & Downes, 1988; Vargo, Stavrakaki, Ellis, & Williams, 1988) and has been cited as the most common symptom of adult sexual abuse survivors (Bagley & Ramsey, 1986; Briere & Runtz, 1988; Browne & Finkelhor, 1986; Rew, 1989b). Depression stems from cognitions of helplessness and hopelessness and from negative self-perceptions (Briere, 1989; Wiehe, 1990). Severe depression is highly correlated with self-destructive behavior and suicide (Briere & Runtz, 1986). Suicide ideation and attempts have been linked to a history of sexual abuse (Bagley & Ramsey, 1986).

Survivors of sexual abuse may become emotionally withdrawn (Briere, 1989). Emotions are experienced, but not overtly displayed. Constriction of affect may be a behavior learned when abuse related emotions were met with indifference, anger, or intolerance in the past. The abuse survivor concludes that expressing emotions does not produce comfort or support.

When emotions and experiences become overwhelming, abused individuals may dissociate themselves from the

situation. Dissociation involves cognitively and emotionally removing one's self from ongoing events. During abusive episodes children may pretend they are not in the room, or that they are observing, not experiencing the abuse. Afterwards they may pretend that the abuse did not happen or that it happened to someone else. This pretence helps them to cope with the situation by allowing them to distance themselves from the abuse and go on with their lives. Continued dissociative episodes can result in multiple personality disorder (Coons, 1986). Dissociation may also continue as a coping mechanism into the adult life of sexual abuse survivors (Briere, 1989; Briere & Runtz, 1988; Maltz, 1988).

Interpersonal Effects

The third category of long-term effects of sexual abuse centers around interpersonal problems (Briere, 1989). Interpersonal problems stem from negative relationships with others (Herman et. al., 1986). As mentioned, abused individuals often have feelings of anger and distrust towards others (Browne & Finkelhor, 1986). This lack of trust may carry through into adulthood and become a characteristic of the sexual abuse survivor.

A lack of trust, particularly in the primary adults in their lives, may create unhealthy attachment patterns within abused children. The children may form insecure attachments. Children with insecure attachments can acquire

a distorted sense of self and a reduced ability to communicate cognitions and affect (Friedrich, 1990). Further, in families with intrafamilial abuse the mother often suffers from depression. Depressed mothers have been found to have poor or insecure attachments with their children. Children with depressed mothers are susceptible to difficulties in self-control and relationship formation (Friedrich, 1990). Left unaddressed these problems could conceivably perpetuate into adulthood.

Sexual problems are another area of interpersonal dysfunction characteristic of sexual abuse survivors. Maltz (1988) reported that 80% of incest survivors experienced some form of sexual dysfunction. Becker, Skinner, Abel and Treacy (1982) found that 52% of their sample had arousal dysfunctions and a general fear of sex. Sexual problems are varied and can include an ambivalent attitude towards sexual relationships, sexual dysfunctions, promiscuousness, and prostitution (Browne & Finkelhor, 1986; Brunngraber, 1986; Daie, Witztum, Eleff, 1989; Herman et. al., 1986; Russell, 1986; Vargo et. al., 1988). Ambivalence towards sex and sexual dysfunction may originate from an association of sex with pain, and humiliation. Promiscuousness and prostitution may stem from a confusion between sex and affection and a need to maintain control over one's life and body (Briere, 1989; Maltz, 1988). During the abuse sex is often disguised as love. The victim

may come to see sex as a means of obtaining affection or attention (Browne & Finkelhor, 1986). Sexual abuse displaces the child's power and control over their body into the hands of the perpetrator. Thereafter, the child, and eventually the adult, may see sex as a means of maintaining power and control over themselves and others (Briere, 1989; Wiehe, 1990).

Revictimization is a common occurrence in sexual abuse survivors (Briere, 1989; Browne & Finkelhor, 1986; Russell, 1986; Vargo et. al., 1988). Sexual abuse survivors who use sex as means of trying to control others set themselves up for further exploitation. Exploitation reinforces their distrust and escalates their chances for revictimization (Herman et. al., 1986). Low self-esteem and a self-punishing attitude can also lead to revictimization. The individual may either consciously or unconsciously transmit the message that they are worthless and place themselves in potentially dangerous situations (Briere, 1989; Wiehe, 1990). Sexual abuse survivors suffering from learned helplessness may be less likely to fight back when attacked, and more likely to remain in an abusive relationship than individuals who have maintained a sense of personal control over events in their lives (Briere, 1989). It has been suggested that sexual abuse survivors choose partners who are abusive due to the familiarity of the relationship (Alexander & Follette, 1987).

Many survivors of sexual abuse feel that the manipulation of others is the only means of obtaining desired objects, or required needs. For abused children simple requests do not always deliver desired events. Perpetrators sometimes barter sexual favors, cooperation, and compliance for love, support, and desired objects. Low self-esteem may also contribute to the manipulativeness of sexual abuse survivors. Abuse survivors who perceive themselves as undeserving of others' attention, affection, or help may seek to obtain desired objects and satisfy needs through deception and manipulation.

Sexual abuse survivors tend to display a number of acting out or externalizing behaviors, such as truancy and school problems, running away, aggression, substance abuse, delinquency and criminal behavior, promiscuity and prostitution, and self-destructive behaviors (Browne & Finkelhor, 1986; Vargo et. al., 1988). Some of these behaviors were adaptive during the abuse, but have since lost their utility (Briere, 1989). For some, these are the only known means of coping with problems. For example, self-mutilation has been reported by abuse survivors as a method of terminating a dissociative episode, as a distraction from memories of the abuse, as a cue to reality and reassurance of being alive, as a sense of release of emotion, and a sense of control over self and body (Briere, 1989; Russell, 1986). Suicide may be a cry for help or an

attempt to escape a threatening situation. Substance abuse too may be a means of escaping painful memories.

In contrast to acting out behaviors, sexual abuse survivors can also display acting in or internalizing behaviors such as withdrawal, alienation, and isolation (Browne & Finkelhor, 1986; Vargo, et. al., 1988). Abused individuals perceive themselves as different from nonabused individuals. They feel a lack of common interests, problems, or experiences with others. Therefore withdrawal from social interactions and relationships is common. Their low self-esteem and stigmatization also set them apart from others (Briere, 1989). These behaviors and their underlying emotions tend to continue on into adult life. Once isolated from others, it becomes difficult to resume social interactions.

Sexual abuse survivors tend to be other directed. Their self-perceptions are often based on others' perceptions of them. Abused children may assimilate their abusers' opinions about themselves and the world. They focus on the moods and attitudes of their abuser as a means of preparing themselves for interactions with him. They may begin to believe the abuser's declarations of love or his implication that they wanted and/or enjoyed the sexual contact. These children stop relying on their perceptions of reality and begin to incorporate the perpetrator's perceptions of reality as their own. When the abuse is

disclosed, others' opinions and attitudes about them and their status as an abused person becomes a source of concern. A low sense of self-esteem hinders confidence in perceptions of the self. In extreme cases self-identity may not exist when the boundary between self and others becomes blurred (Briere, 1989). The exaggerated focus on others makes the individual hypersensitive to these others' reactions, especially rejection or abandonment. It also leads to gullibility and suggestibility, leaving the individual open to further exploitation.

Post-traumatic Stress Disorder (PTSD)

The term PTSD refers to a set of psychological symptoms which arise in response to a traumatic event. The symptoms include: a) A mental re-experiencing of the event through flashbacks, b) Decreased responsiveness to the environment characterized by dissociation, withdrawal, restricted affect, and apathy, c) Various problems such as sleep disturbance, memory and concentration problems, guilt and hypervigilence, d) A general intensification of the above symptoms when an event or situation reminiscent of the traumatic event occurs (Briere, 1989).

Recently PTSD symptoms have been identified in sexual abuse victims and survivors (Briere & Runtz, 1988; Burgess, Hartman, Wolbert, & Grant, 1987; Koverola, Foy, & Heger, 1991; Koverola & Foy, in press; Russell, 1986). Sexual abuse is a traumatic event for most abused individuals. The

flashbacks experienced by sexual abuse survivors include explicit or symbolic mental reenactments of the abuse. These reenactments occur in daydreams, nightmares, and imagined sensations. Emotional and physical withdrawal provides a means of escape from painful memories and from distrusted others (Briere, 1989). Dissociation is one of the most severe forms of withdrawal. Sleep disturbances such as nightmares, restlessness, and insomnia were found to occur twice as often in sexual abuse survivors as in nonabused controls (Briere & Runtz, 1987; Sedney & Brooks, 1984). Sleep disturbances may result from a fear of the dark or of bed, since most abuse occurs in the night, in bed (Briere, 1989). Hypervigilence and chronic fear interfere with concentration.

Many sexual abuse survivors display some of the various symptoms subsumed under the PTSD category. It is only when all of these symptoms occur together that a diagnosis of PTSD can be made. The literature has found evidence for the occurrence of PTSD in sexually abused children and in adult survivors of child sexual abuse (Briere, 1989; Koverola et. al., 1991; Koverola & Foy, in press; Lyons, 1987; Wolfe, Gentile, & Wolfe, 1989). In clinical populations incidence of PTSD in sexual abuse survivors has been as high as 100% (Donaldson & Gardner, 1985; Lindberg & Distad, 1985). In nonclinical populations the incidence appears considerably lower at 2%-20% (Greenwald & Leitenberg, 1990). The

incidence of PTSD increases when fathers rather than strangers are the perpetrators (Greenwald & Leitenberg, 1990), and when the abuse involves penetration rather than genital fondling or nongenital contact (Greenwald & Leitenberg, 1990; Koverola et. al., 1991; Koverola & Foy, in press).

The above section has outlined some of the negative long-term effects of sexual abuse. It is important to note, however, that not all sexual abuse survivors have negative long-term effects. Finkelhor (1990) reports that some sexually abused children experience a decrease in symptoms following disclosure, while others worsen, and some sexually abused children display a variety of symptoms while others have little or no symptoms. In Herman et. al.'s (1986) sample of incest survivors, one half reported having recovered well from their abuse. It has been suggested that some abused individuals cope better and are more resilient than others (Finkelhor, 1987). This leads one to wonder what factors are involved in determining whether an abused individual will adjust positively or negatively to the abuse. In an attempt to answer this question several different theories and models will be examined. These theories and models will clarify the development of long-term sequelae of sexual abuse and point out factors involved in adjustment to sexual abuse.

Symbolic Interactionism

One of the theories employed in the understanding of adjustment to sexual abuse is symbolic interactionism. Symbolic interactionism stems from the philosophical search for reality. Early contributors to this theory include Immanuel Kant, Georg Simmel, and Georg Hegel. For these theorists, reality stemmed from individuals' interactions, which were based on the individuals' perceptions of reality.

In the twentieth century, theorists such as William James, C.H. Cooley, John Dewey, and George Herbert Mead from the Chicago School were influenced by the philosophy of Kant, Simmel, Hegel, and Darwin. This combined influence led to the formulation of symbolic interactionism.

Symbolic interactionism is a broad perspective containing several different subtheories. The goal or purpose of the symbolic interactionist perspective is the understanding of individuals' ability to generate, maintain, and transform their perceptions of reality through their interactions with others (Berger & Luckman, 1966; Stone & Farberman, 1981).

Symbols

One means of facilitating the interactions upon which self and society are based is through universally understood and accepted symbols (Hewitt, 1980; Lauer & Handel, 1983; Lewis & Smith, 1980; Manis & Meltzer, 1967; Rose, 1962; Stryker, 1980; Turner, 1982). The two primary symbol

systems used by humans are movements and gestures, and language. Movements and gestures form the basis for nonverbal communication. The meanings of these symbols are dependent upon the contextual environment. Language represents a shared system of symbols between members of a society. Meaning is not dependent on the contextual environment (Heiss, 1981; Jones & Day, 1977; Lauer & Handel, 1983). Language is used by individuals to communicate perceptions of reality. Experiences and information are categorized, shaped, and filtered through the language used to describe them, thereby forming individualized perceptions of reality. Language is only effective when it's meaning is shared by interactants (Davis, 1990). Shared language allows for effective communication between individuals and a cohesive basis for the structures forming society.

Self

The symbolic interactionist perspective regards the individual as a two component process. The first component is the mind; the second is the self. The mind forms through the individual's encounters with problems, and provides a problem solving function. The mind formulates hypotheses about the environment, tests these hypotheses against others' perceptions of the environment, and then alters the hypotheses based on these observations (Davis, 1990).

The self contains two components: the "I" and the "me". The "I" is the subjective component which is responsive to

others. It is the innovative and impulsive part of the self. The "me" is an organized set of attitudes imposed by generalized others or reference groups (Manis & Meltzer, 1967; Rose, 1962). It includes norms, ideals, and the generalized beliefs and practices of society. The "me" limits the "I"'s impulses and encourages normative behavior. The "I" introduces novelty to prescribed behaviors. If new role behaviors become recognized by others as acceptable, then behavioral norms will change. These normative changes will be reflected in the "me" component of the self. The components of the self are in a constant state of reformulation and growth (Charon, 1989; Goff, 1980; Hewitt, 1984; Jones & Day, 1977; Lauer & Handel, 1983; Stone & Farberman, 1981; Stryker, 1980; Turner, 1982).

Development of Self

The self is formed through the role-taking process. Individuals are constantly observing themselves through the eyes of others. Evaluations of these observations are made. Approved aspects of the self are retained. Disapproved of aspects are eliminated. Because this process is perpetual, the self is in a constant state of modification.

The process of self development begins at birth. Symbolic interactionism proposes four stages in the development of the self, and consequently in the development of role-taking ability. The first stage is the prepatory stage. This stage precedes the ability to take on roles and

is characterized by childrens' imitation of others (Goff, 1980; Hewitt, 1984; Lauer & Handel, 1983). The second stage is the role play stage. Children are now able to assume the role of another by imitating role behaviors (Goff, 1980; Lauer & Handel, 1983; Peevers & Secord, 1973; Signell, 1966). The third stage is the game playing stage. Children now have the capacity to role-take. This capacity proves useful in knowing the intents and purposes of competitors when playing games (Goff, 1980; Jones & Day, 1977; Lauer & Handel, 1983). The final stage is the generalized other stage. Individuals can now place themselves in the role of generalized others such as a community, social group, or society, and observe how these others evaluate them. Reference group perspectives are also apparent at this stage (Blummer, 1962; Goff, 1980; Hewitt, 1984; Jones & Day, 1977; Lauer & Handel, 1983; Turner, 1982).

Self-Concept, Self-esteem, and Self-control

Through the role-taking process judgements made by others about the self are internalized and incorporated into the self. Individuals most often look to significant others for self-validation. Significant others are the subject of individuals' affection, respect, fears, and need for approval and acceptance. They provide role models upon which individuals pattern and judge their behavior and formulate their ideas of social reality (Charon, 1989; Lauer & Handel, 1983). Significant others include parents,

spouses, family, heros, and idols.

Reference groups are also sought for self-validation. Reference groups are collections of individuals characterized by a shared perspective of reality and bound by specific interaction and communication patterns. Such groups include social class, ethnic and cultural groups, social clubs, and communities. An individual holding a membership to such a group or who anticipates a future membership will apply the group perspective to define and interpret social reality and self-perceptions (Charon, 1989).

Finally, the individual may look to generalized others for self-validation. Generalized others represent individuals' internalization of societal norms. Through the application of society's moral, legal, and social systems, generalized others provide information about the appropriateness and acceptability of individuals' behavior.

Individuals are active agents in interpreting and acting upon the perceptions of significant others, reference groups, and generalized others. The modification of their behavior in response to the perceptions of these others represents self-control. Individuals' perception of themselves as a result of their interactions with others represents their self-concept. The value judgement they place on their self-perception represents their self-esteem.

Roles and Role-taking

Roles are the normative behaviors prescribed by society for specific situations. They facilitate interactions by delineating appropriate modes of action specific to the existing situation (Lauer & Handel, 1983; Stryker, 1980). Throughout their lives individuals play many different roles. These roles can become incorporated into individuals' self-definition.

Role-taking is the primary component of the interactive process. Individuals utilize symbols as well as past and present experiences to interpret another person's perspective or role. Expectations of the other's behavior within that role are then formed. Individuals then take on the perspective of the other. Individuals view themselves and their environment through the eyes of these others (Heiss, 1981; Hewitt, 1984; Jones & Day, 1977; Lauer & Handel, 1983). If individuals find fault with themselves or their perceptions, changes are made. Role-taking is a perpetual process which allows for the redirection of interactive behavior towards more meaningful and normative forms.

Self and Society

Interactions between individuals lead to a sharing of information and mutual influence. Ultimately interactions result in shared perspectives of reality. Shared reality perspectives in turn facilitate and regulate interactions.

Patterned interactions lead to the formation of the social structures which make up society. Society's norms prescribe appropriate interactive patterns. These behavioral prescriptions regulate and facilitate interactions, and promote shared reality perspectives (Hewitt, 1984; Jones & Day, 1977; Stryker, 1980). Changes in individual interactions can alter behavioral norms, thereby changing interactive patterns. Individuals and society form a self-perpetuating and self-modifying system.

Pathology

In terms of symbolic interactionism, pathological behavior can stem from individual perceptions and from the information obtained from significant others, reference groups and generalized others. If individuals' perceptions of reality are not validated by others then these individuals may come to be labelled as pathological. By accepting these evaluations, individuals may come to see themselves as pathological. Since action is based on perceptions (Charon, 1989), pathological behavior may follow perceptions of pathology. Individuals' pathological behavior confirms others' perceptions of their pathology. The individual will perceive and incorporate the perceptions of these others, thereby reinforcing their perceptions and behavior. Pathology therefore, may result from a self-fulfilling prophesy. Pathology can also result if the perceptions and behaviors of individuals' reference groups

are perceived as pathological by society and generalized others. The individual, as a member of the group, will also be judged pathological (Davis, 1990). In both cases pathology is defined as a social phenomena.

Symbolic Interactionism and Sexual Abuse

From the discussion on the long-term sequelae of sexual abuse it has been established that many sexual abuse survivors suffer a host of psychological problems. These include: guilt, self-blame, powerlessness, a negative self-concept, sexual dysfunctions, sexualizing behavior, other-directedness, and isolation. It has been proposed that abused individuals are more likely to experience guilt and self-blame if they received any enjoyment or gratification from the abuse such as being made to feel special, receiving gifts for their cooperation, sexual arousal, and enhanced self-esteem (Sgroi, 1982). From a symbolic interaction point of view, abused individuals perceive themselves as having contributed to the abuse by virtue of participation. In some instances, participation in an experience implies partial responsibility (Davis, 1990).

Powerlessness is another characteristic of abused individuals. At the time of the abuse individuals may perceive themselves as powerless against the strength, threats, and authority of the perpetrator. Thereafter, they may continue to perceive themselves as powerless and cease attempts at exerting control over their environment.

Sexual abuse incurs changes in individuals' self-definition (Davis, 1990). Symbolic interactionism suggests that self-perceptions are based on individuals' perceptions of the abuse and their role in it's occurrence. If the abuse is viewed negatively and individuals perceive themselves as active participants, they will likely experience negative self-perceptions. Self-esteem will decrease. Low self-esteem, feelings of being dirty and bad, and a sense of responsibility for the abuse are all characteristics of abused individuals (Browne & Finkelhor, 1986; Conte & Schuerman, 1988; Russell, 1986; Sgroi, 1982).

Many abused children display sexualizing behaviors. Similarly, many adult survivors experience problems with their sexuality. After being subjected to an abusive sexual relationship these individuals experience a heightened awareness of their sexuality. Significant others, reference groups, generalized others, and perpetrators may reinforce these perceptions by perceptually and behaviorally emphasizing the individuals' sexuality. Symbolic interactionism suggests that individuals seek experiences which validate their perceptions. Sexually abused individuals may focus on experiences that validate their perception of themselves as sexual beings. Symbolic interactionism also proposes that actions are based on perceptions. If abused individuals perceive themselves as sexual, their behavior may become increasingly sexual.

Others perceptions of them as highly sexualized would validate their self-perceptions and reinforce their sexualizing behaviors.

Briere (1989) noted that sexual abuse survivors are often other-directed. Abused children role-take in order to ascertain the perpetrator's intentions and needs. They also use role-taking to gauge others' perceptions of and reactions to the abuse. These children become accomplished at anticipating others' attitudes and behaviors in order to appease, please, or escape their abuser and/or their significant others. This other-directedness may become habitual and continue on into adulthood.

As stated by symbolic interactionists, individuals need symbols, particularly language, to organize their experiences (Charon, 1989). Many abused children cannot speak about their abuse due to perpetrator threats or others' aversion to the issue. This silence may continue into adulthood. The abuse experience remains vague and disorganized within the victims' minds. This confusion and disorganization hinders the resolution of the abuse experience.

Comprehensive Model of Trauma Impact

A model which can be used to examine how and why long-term sequelae develop in sexual abuse survivors is the Comprehensive Model of Trauma Impact (CMTI) (Koverola, 1991). The CMTI was constructed to organize existing

research, guide future research, and provide a comprehensive understanding of the various aspects and factors involved in sexual abuse. The basic structure of the CMTI is circular (see Appendix A). Making up the center or core of the structure is the individual. The individual component includes cognitive, emotional, interpersonal, moral, sexual, and physical elements. The second ring represents the individual's family. The third ring represents the community within which the individual resides. It includes social groups, school, church, hospitals, social and family services, neighbours, and community members. The fourth ring represents the society in which the individual lives. It includes the culture, beliefs, taboos, attitudes, mores, and norms which prescribe, guide, condone, and condemn individuals' behavior. These levels are reciprocally interactive, as each level affects and is affected by all the other levels.

The CMTI conceptualizes life as a continuum beginning at birth and ending at death. The individual embedded within family, community, and society proceeds along life's continuum. Life events exert their influence upon the individual within this social system. The effect of these events is dependent upon the nature of the events and the point at which they occur in the individual's life. Individuals' cognitive, moral, emotional, interpersonal, sexual, and physiological development determines their

capacity to cope with life events. It also affects the reactions of the various elements within the social system to these events.

Comprehensive Model of Trauma Impact and Sexual Abuse

Sexual abuse impacts on the individual and the elements of their social system. The effect the abuse has on the system will depend on the nature of the abuse. Factors such as frequency, duration, age at onset, number of perpetrators, relationship to perpetrator, and type of abuse have been linked to differential effects on the abused individual (Browne & Finkelhor, 1986; Russell, 1986; Wiehe, 1990). In general, the greater the frequency, duration, number of perpetrators, relationship to the perpetrator, and intrusiveness of the abuse, the more severe are the effects of the abuse (Briere, 1989; Briere & Runtz, 1986; 1988; Browne & Finkelhor, 1986; Hartman, Finn, & Leon, 1987; Herman, et. al., 1986). Research on age at onset has been equivocal (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Hartman et. al., 1987). There is also evidence that concurrent physical abuse compounds the trauma experienced by the child and exacerbates the effects of sexual abuse (Bagley & McDonald, 1984; Briere, 1988; Briere & Runtz, 1990; Courtois, 1979).

The CMTI identifies the following stages of abuse: pre-abuse, abuse, postabuse, and recovery. The reactions of the individual and the elements of their social system will

differ depending at which point along life's continuum these abuse stages occur. The reactions of the system will also vary at different stages of the abuse.

The Comprehensive Model of Trauma Impact and Symbolic Interactionism

One of the most obvious similarities between the CMTI and symbolic interactionism is the importance placed on the effect of social elements on the lives of individuals. The categorization of these elements is also carried out in a similar manner. The second ring in the structure of the CMTI, representing the individual's family is analogous to the symbolic interactionist concept of significant others. The third ring in the CMTI, representing the community, is analogous to the symbolic interactionist concept of reference groups. The fourth ring of the CMTI, representing society, is analogous to the symbolic interactionist concept of generalized other.

In both models, individuals are considered parts of a larger social context. The CMTI presents the individual as embedded within a systemic whole made up of family, community, and society. The elements of this system exert influence over one another through their perceptions and behavior. This structure mirrors symbolic interactionism's self-society whole where self and society are influenced and shaped by each other. Individual life events reflect upon the family. The family's responses affect individuals'

views of the events and of themselves. The community may exert influence over the individual and their family through supportive or condemning behaviors and attitudes. Individuals are influenced by the behavioral norms and mores prescribed by society. Individual events and behaviors can influence society by setting a new precedence, thereby changing certain norms.

Finally, both models are perception based. It is individual's perceptions of others' beliefs, attitudes, opinions, and behavior that are the basis for their own perceptions and behavior. In the CMTI the occurrence of an event is the catalyst for individuals and social systems to exert their influence over each other. In the symbolic interactionist perspective interactions with others form the basis for mutual influence. For both models, it is the perceptions of events, behavior, self, and others which form the basis for individual's perceptions and behavior. These perceptions and behaviors influence other elements in the individual's life.

Although the concepts and premises of the CMTI and symbolic interactionism are similar, the focus of these two models differ. The CMTI's emphasis is on the individual. It is primarily used to examine the effects of traumatic events such as sexual abuse on the individual and the elements of their social system. Symbolic interactionism has a much broader scope. It examines the development and

mutual influence of self and society.

Attribution Theory

In 1972 Bernard Weiner created a theory of attributions to explain achievement based outcomes. According to this theory, the outcome of an event is followed by an immediate evaluation of success or failure. This evaluation leads to either a positive or negative emotional response, termed an attribution independent emotion. Individuals then engage in a causal search to answer the question: "Why did this outcome occur?". The more novel, important, and aversive an outcome is, the more likely a causal search will take place. The causal search results in certain attributions about the cause of the outcome.

Weiner (1972) outlined three attributional dimensions upon which the cause of the outcome is judged. Locus of causality, the first dimension, refers to whether the cause is perceived as coming from within the attributor, or as external to the attributor. Stability, the second dimension, refers to whether the cause is perceived as constant over time or variable over time. Controllability, the third dimension, refers to whether the cause is perceived as being controllable or beyond anyone's control.

Causal attributions along these dimensions are associated with certain cognitions. These cognitions lead to certain emotions, termed attribution dependent emotions. Locus of causality affects self-esteem and induces either

pride or guilt and shame. A positive outcome attributed to an internal cause will increase self-esteem and lead to feelings of pride. A negative outcome attributed to an internal cause will decrease self-esteem and lead to feelings of guilt and shame. Attributing an outcome to an external cause will not affect self-esteem. Stability affects future expectations and induces either hope or hopelessness. A negative outcome attributed to a stable cause will create expectations of situation permanence and lead to feelings of hopelessness. A negative outcome attributed to an unstable cause will create expectations of change and feelings of hope. Controllability affects perceptions of mastery and control and induces various emotions including helplessness, guilt, and hope. Attributing an outcome to a controllable cause will increase perceptions of mastery and control and lead to feelings of hope and pride. Attributing an outcome to an uncontrollable cause will decrease perceptions of mastery and control and lead to feelings of helplessness. These emotions derived through the attributional process create particular motivational states which then go on to affect behavior (Weiner, 1985).

The relationship between attributions, emotions, and behaviors is interactive and reciprocal (Weiner, 1986). Each of the factors of the attributional process influence and are influenced by the other factors in the process. The

literature has verified some of these interactive relationships. Weiner (1986) and Major, Mueller, and Hildebrant (1985) discovered that there tends to be a congruency between expectations and future outcomes. Expectations result from attributions along the stability dimension. Therefore attributions affect future outcomes. Positive emotions tend to increase attention to positive information and negative emotions increase attention to negative information (Weiner, 1986). Direction of attention then, is a behavior resulting from attribution dependent emotions. Research on cognitive dissonance has found that behaviors affect cognitions in such a way that the cognitions come to be consistent with the behavior (Festinger, 1957). Attributions are evaluative cognitions about an event, and according to dissonance theory they should become consistent with behavior and this behavior will then support and perpetuate these attributions. Thus, attributions, emotions, and behaviors are related through feedback loops where each influences the other.

In 1978 Abramson, Seligman, and Teasdale proposed a reformulation of Weiner's theory. These authors focused on the role of learned helplessness in depression. They eliminated the controllability dimension and added the globality dimension. Globality refers to perceptions of the outcome's specificity to the situation. Attributions are global when the cause is perceived as generalizing to other

situations, and specific when the cause applies only to the immediate situation. This dimension affects expectations about situational changes. The stability and globality dimensions are related to future expectations. These are the dimensions involved in learned helplessness.

This reformulation introduced the view of attributions as styles or traits which are consistent across time and situations. Weiner's theory conceptualizes attributions as situation specific. The state view of attributions examines individuals' attributions about a specific event. The trait view examines attributions as a general means of approaching life events. Both of these positions have received empirical support.

Depression and illness have been associated with attributional style (Anderson, Horowitz & French, 1983; Kamen & Seligman, 1987; Peterson, 1988; Peterson Schwartz, & Seligman, 1981; Peterson & Seligman, 1987; Peterson, Seligman, & Valliant, 1988; Peterson & Villanova, 1988; Russell, 1991). More specifically, attributions of internal locus of causality, stability, and globality were found to be related to greater depression and higher risk for illness. Ickes and Layden (1978) found that attributional style was linked to self-esteem. High self-esteem individuals tend to attribute negative events to external locus of causality and positive events to internal locus of causality, while low self-esteem individuals tend to

attribute negative events to internal locus of causality and positive events to external locus of causality. Burns and Seligman (1989) found that attributions remained stable over a 52 year span and that these attributions created a risk factor for illness, depression, and low achievement. It is important to note that attributional style is a broad and abstract concept. It considers attribution as a general trait. Therefore it leaves one unable to predict attributions for a specific event (Russell, 1991).

The state view of attributions is appropriate when the focus is on predicting attributions for specific events. Individuals have been found to have different attributions for different events (Bagby, Atknison, Dickens & Gavin, 1990; Cutrona, Russell & Jones, 1985; Proulx, Dyck, Quinonez, Chohan, & Koverola, 1991). Bagby et. al. (1990) found that except for locus of causality, which was only minimally consistent, there is no evidence of cross situation consistency in any of the dimensions. The nature of the event had more influence over attributions and causal thought than did attributional style.

In further support of the situational nature of attributions, Chochran and Hammen (1985) failed to find a relationship between depressive symptoms and attributional style.

Attributions are determined by many factors which vary across situations. Situational factors such as social norms

and the uniqueness of the event, and past experiences such as encounters with the same or similar situation, success or failure in similar situations, and types of situations encountered in the past, have been found to influence attributions (Feather & Simon, 1971; Frieze & Weiner, 1971). The manner in which information about an event is presented will determine individuals' cognitions and emotions about the event. It is the perceived cause of an event, rather than the objective cause that influences attributions. Individuals' perceptions of an event will depend on their past experience, the situational factors, and the manner in which the event occurs. Therefore, individuals may have different perceptions of the event each time it occurs, and different individuals may have different perceptions of the same event. The many variables impinging upon attributions contribute to their situational uniqueness.

The separate attributional dimensions have received various degrees of support. The locus of causality dimension has received the most support. Through factor analysis, locus of causality was identified as a factor underlying the evaluations of an event (Russell, 1991). Attribution theory states that locus of causality is related to self-esteem and induces emotions such as pride, guilt, and shame. A positive event attributed to an internal cause should increase self-esteem and create positive emotions such as pride. Research has found that subjects who

attribute success to an internal cause experience a decrease in negative emotions such as shame, depression and guilt and an increase in positive emotions such as satisfaction, confidence, competence, and pleasure (McAuley, Duncan & Russell, 1990). A negative event attributed to an internal cause should decrease self-esteem and create negative emotions such as guilt and shame. Internal attributions for failure have been associated with low self-esteem (Brewin & Shapiro, 1984; Ickes & Layden, 1978). Subjects with low self-esteem were found to attribute poor task performance to internal causes more often than were subjects with high self-esteem (Brewin & Furnham, 1986; Mitchell, 1988; Burke, Hunt, & Bickman, 1985). Subjects attributing failure to internal causes have been found to experience a decrease in confidence (McAuley, et. al., 1990). Attribution of internal locus of causality were associated with lower self-esteem and a higher degree of distress symptomatology in sexual abuse survivors (Dyck, et. al., 1991; Proulx et. al., 1991; Gold, 1986; Morrow, 1991). Internal attributions for failure have also been linked to depression (Abramson, et. al., 1978; Ickes & Layden, 1978; Kuiper, 1978; Peterson, 1979; Peterson, et. al., 1981; Rizley, 1978; Seligman, Abramson, Semmel, & Von Baeyer, 1979; Sweeney, Anderson, & Bailey, 1986). The locus of causality dimension has found supporting evidence in both state and trait approach research.

The stability dimension has also found research support in both the state and trait literature. Attribution theory states that attributions along the stability dimension affect future expectations and create feelings of hope or hopelessness. Attributing a positive event to a stable cause will lead to expectations of situation permanence and positive emotions such as hope. McAuley, Duncan and Russell (1990) found that stable attributions for successful outcomes were associated with feelings of satisfaction, pride, and lessened anger. Attributing a negative event to an unstable cause will lead to expectations of situation change and positive emotions such as hope. Subjects with a low success rate at task performance and with attributions of instability expected to improve their performance in the future (McAuley, et. al., 1990). Attributions of instability to sexual abuse were found to be associated with higher self-esteem and less distress symptomatology than attributions of stability (Dyck et. al., 1991; Proulx et. al., 1991). Attributing a negative event to a stable cause will lead to expectations of situation permanence and negative emotions such as hopelessness and despair. A stable attributional style for negative events has been linked to learned helplessness and high levels of depression (Abramson, et. al., 1978; Seligman et. a., 1979). Learned helplessness is associated with a sense of hopelessness regarding the future (Seligman, 1975). Attributions of

stability have been related to depression in children (Robins & Hinkley, 1989), and distress symptoms (Proulx et. al., 1991; Gold, 1986) and low self-esteem (Dyck et. al., 1991; Gold, 1986) in sexual abuse survivors.

The globality dimension is supported by attributional style research. Globality is linked to future expectations and emotions such as hope, hopelessness and helplessness. It contributes to learned helplessness (Abramson et. al., 1978). Global attributions for negative events lead to expectations of situation generality and negative emotions such as hopelessness and helplessness. Depressed subjects have been found to make more global attributions for negative events than nondepressed subjects (Abramson et. al., 1978; Seligman, et. al., 1979). Gold (1986) found that sexually abused subjects having global attributions had lower self-esteem and a greater degree of distress than subjects with more specific attributions.

The controllability dimension has had varying degrees of empirical support. Attribution theory states that attributions of controllability affect one's sense of self-efficacy and control and creates emotions such as pride, hope, and helplessness. Attributing events to controllable causes lead to an increased sense of control and self-efficacy and positive emotions such as hope and pride (Weiner, 1985). Attributions to controllable factors have been found to reduce feelings of helplessness (Anderson &

Arnoult, 1985; Anderson, et. al., 1983; Anderson, Jennings & Arnoult, 1988). An event attributed to an uncontrollable cause would lead to a decreased sense of control and self-efficacy and negative emotions such as hopelessness and helplessness (Weiner, 1985). Depressed, lonely, and shy people tend to attribute negative events to uncontrollable causes (Anderson & Arnoult, 1985; Anderson et. al., 1983; Anderson et. al., 1988). Attributions of uncontrollability have also been associated with increased physical and mental symptoms (Abramson, Garber & Seligman, 1980; Abramson et. al., 1978).

The controllability dimension is often combined with the locus of causality dimension to determine personal or external control. Internal and controllable attributions indicate personal control, while external and controllable attributions indicate external control. Attributions of personal control for negative events has been associated with self-blame and negative emotions such as guilt and shame (Brown & Weiner, 1984; Covington & Omelich. 1984; Jagacinski & Nicholls, 1984). Although the implication is that these two dimensions are often associated there is little research investigating this specific association. McAuley, Duncan, and Russell (1990) see this association as problematic. They propose separating the controllability dimension into personal control and external control in order to clarify the attributions along this dimension.

Attribution Theory and Sexual Abuse

The application of attribution theory has gone far beyond it's original scope of achievement motivation. It has been applied in areas such as sports, dieting, interpersonal relationships, health, depression, and sexual victimization. Janoff-Bulman (1979) was the first to propose the application of attribution theory to sexual victimization. She suggested that self-blame for negative events may be conducive to positive psychological functioning. Self-blame increased one's sense of personal control. Attributing an event to uncontrollable causes would lead to a decrease in one's sense of personal control and increased feelings of helplessness (Weiner, 1985). Learned helplessness reduces one's motivation to act (Seligman, 1975). Retaining a sense of control, therefore, is important in motivating one to act and take charge of the situation (Janoff-Bulman, 1979; Wortman, 1976). However, there is a body of literature suggesting that self-blame is damaging to the victim (Beck, 1967; Burgess & Holmstrom, 1974; Brownmiller, 1975; Morrow, 1991; Shapiro, 1989).

Janoff-Bulman therefore suggested that a distinction be made between different types of self-blame. She divided self-blame into characterological self-blame and behavioral self-blame. Characterological self-blame involved attributions of internal locus of causality, stability, and uncontrollability for negative events such as victimization.

Characterological self-blame led to maladaptive and self-deprecating responses. Behavioral self-blame involved attributions of internal locus of causality, instability, and controllability for negative events such as victimization. Behavioral self-blame led to adaptive, control-oriented responses.

Janoff-Bulman tested her theory and found that behavioral self-blame was associated with positive psychological functioning, lower depression, and higher self-esteem in victims of rape, while characterological self-blame was associated with negative psychological functioning, higher depression, and lower self-esteem in victims of rape. Studies in the medical field found behavioral self-blame to be linked to successful coping (Janoff-Bulman & Wortman, 1977; Silver & Wortman, 1980). Behavioral self-blame has been associated with low levels of depression (Peterson et. al., 1981), lower perceived cancer relapses (Timko & Janoff-Bulman, 1985), higher self-esteem, and higher perceived ability to avoid future victimization (Janoff-Bulman, 1982). Characterological self-blame has been associated with higher levels of depression, lower self-esteem (Anderson et. al., 1983; Janoff-Bulman, 1979; Janoff-Bulman, 1982; Peterson et. al., 1981; Stoltz & Galassi, 1989), and psychological distress in rape victims (Hill & Zauto, 1989).

In 1986 Lamb expressed concern with the interventions

provided to child sexual abuse victims. Interventions tended to focus on the child's blamelessness. She suggested that this may exacerbate, rather than alleviate the problem. There is evidence suggesting that reduced self-blame increases individuals' sense of helplessness through a decreased sense of personal control. Shapiro (1989) also suggested the possible value in using Janoff-Bulman's distinction between behavioral and characterological self-blame to modify intervention with sexual abuse victims and survivors.

There has however been conflicting evidence regarding Janoff-Bulman's (1979) self-blame dichotomy and the benefits of behavioral self-blame. Madden (1988) found that behavioral self-blame was associated with depression in women who had recently miscarried. Meyer and Taylor (1986) found that both behavioral and characterological self-blame were linked to poor adjustment in rape victims. Major, Mueller and Hildebrandt (1985) reported that behavioral self-blame was not related to overall adjustment.

In a study on attributions of sexual abuse survivors, Dyck et. al. (1991) found that subjects displaying behavioral self-blame and subjects displaying characterological self-blame did not differ in terms of their self-esteem. However, these authors did find that subjects who attributed their abuse to an internal, stable, and controllable cause had lower self-esteem than subjects

who attributed their abuse to an external, unstable, and uncontrollable cause. These authors also found that subjects who attributed their abuse to an internal, stable, and controllable cause had greater distress symptomatology than subjects who attributed their abuse to an external, unstable, and uncontrollable cause. This indicates that self-blame for a negative event leads to negative cognitions and emotions.

In general, attribution theory provides a medium with which to examine cognitions and emotions of sexual abuse survivors. Low self-esteem is a prominent characteristic of sexual abuse survivors (Briere, 1989; Russell, 1986; Shapiro, 1989). Attribution theory addresses self-esteem through the locus of causality dimension. Many sexual abuse survivors blame themselves for the abuse (Briere, 1989). Attribution theory addresses self-blame through the locus of causality and controllability dimensions (Janoff-Bulman, 1979; Lamb, 1986; Shapiro, 1989). Sexual abuse survivors often experience a sense of powerlessness, feelings of helplessness, and hopelessness (Briere, 1989; Browne & Finkelhor, 1986; Kelley, 1986). Attribution theory addresses these feelings through the controllability and stability dimensions.

Other characteristics of sexual abuse survivors may also be linked to attributional dimensions. Depression, stems from self-blame, and/or feelings of helplessness and

loss of hope (Abramson et. al., 1978; Janoff-Bulman, 1979). Anxiety may also be associated with feelings of helplessness and powerlessness. PTSD, a characteristic of sexual abuse victims and survivors, has been linked to attributional style in addicted patients. Patients who were diagnosed with PTSD had more internal, stable, and global attributions for negative events than non-PTSD patients. PTSD patients had less internal, stable, and global attributions for positive events than non-PTSD patients (McCormick, Taber, & Kruedelbach, 1989).

Recent studies have shown attributions to be related to long-term sequelae in sexual abuse survivors. Attributions of internal locus of control, stability, and globality have been associated with increased psychological distress and decreased self-esteem in sexual abuse survivors (Gold, 1986). Attributions of internal locus of causality, stability, and controllability have been associated with lower self-esteem and greater distress symptomatology, while attributions of external locus of causality, instability, and uncontrollability have been associated with higher self-esteem and lower distress symptomatology (Dyck, et. al., 1991; Proulx et. al., 1991). The current literature indicates that attribution theory is helpful in understanding adjustment to sexual abuse and in ascertaining what factors are involved in the development of long-term sequelae in sexual abuse survivors.

Attribution Theory and Symbolic Interactionism

One of the most basic similarities between attribution theory and symbolic interactionism is their emphasis on perceptions. In symbolic interactionism, perceptions represent an individual reality upon which cognitions, emotions, and behavior are based. In attribution theory, perceptions are personalized cognitions about events and their causes (McAuley et. al., 1990; Weiner, 1985). Attribution theory views perceptions as products of past experience and learning. Symbolic interactionism views perceptions as products of interactions with others. Interactions with others typically play a major role in individuals' past experiences and learning.

Both attribution theory and symbolic interactionism are cognitive theories. They view individuals as actively processing information from their environment. In symbolic interactionism the "I" and the "me" of self are constantly incurring changes upon one another. Through role-taking, individuals are constantly collecting information from others and utilizing the information to form their perceptions. In attribution theory, when individuals are faced with a novel, important, or aversive situation they begin a cognitive process that involves a search for the cause of the event, making cognitive decisions about the cause, and then reacting to these decisions.

Finally, both theories view pathology as stemming from

individual perceptions. Symbolic interactionism proposes that pathology results when others believe that an individual is pathological. Through interaction and role-taking others' perceptions get transmitted to the individual. The individual incorporates these perceptions. Pathological behavior follows and reinforces these perceptions (Davis, 1990). Attribution theory proposes that pathology stems from attributions of an event or events in the individual's life. Individuals who perceive the cause of a negative event to be due to personal, controllable, and stable factors will experience more pathological emotions and cognitions and display more pathological behavior than individuals who perceive the cause of a negative event to be due to external, uncontrollable, and unstable factors (Weiner, 1985; Gold, 1986; Dyck et. al., 1991; Proulx et. al., 1991).

Attribution Theory and the Comprehensive Model of Trauma Impact

The CMTI views the individual as made up of cognitive, emotional, sexual, moral, physical, and interpersonal aspects. Attribution theory addresses the cognitive aspect of the individual. The CMTI places the individual within a system of social elements including family and friends, community, and society. These elements influence the individual's behavior, emotions, and cognitions. Attributions, as cognitions, would be influenced by these

social elements.

Attributions are cognitions which occur after an event. The CMTI views sexual abuse as an event that impinges upon the individual and the elements of their social system. Sexual abuse is conceptualized as impacting on the individual along a continuum of stages ranging from pre-abuse to recovery. Attributions would begin after the first abusive incident. Their effects on the individual's behavior and emotions would continue on into the recovery stage. It is in the recovery stage that long-term sequelae of sexual abuse arise. Attributions about the abuse may be helpful in understanding adjustment to abuse and the development of the long-term effects of abuse.

Attributions and Adjustment to Sexual Abuse

The purpose of the current study was to examine the role attributions play in the adjustment of sexual abuse survivors. A review of the literature has demonstrated that perceptions of reality and of self are thought to form the basis for emotions and behavior. Perceptions are cognitions about the real world. Attributions are cognitions about certain real world events. Therefore, attributions are likely to affect emotions and behaviors. Attributions about abuse will likely affect abused individuals' emotions and behaviors. These attributions may have effects lasting well into the recovery stage of abuse, and therefore prove influential in individuals' adjustment to sexual abuse.

Symbolic interactionism and the CMTI indicate that others are important in the formation of individuals' perceptions. The primary sources of influence are family or significant others, community groups or reference groups, and society or generalized others. Symbolic interactionism states that it is these others' perceptions of reality which influence individuals' perceptions. Others' perceptions are ascertained through interactions and role-taking. Therefore, individuals' cognitions are affected by their perceptions of influential others' sense of reality. Cognitions affect emotions and behaviors. Attributions represent cognitions about a specific event. Attributions of abuse are likely to be affected by the abused individuals' perceptions of influential others' attributions about the abuse. Individuals' perceptions of others' attributions about the abuse will likely affect their own attributions as well as their adjustment to the abuse.

In this study long-term adjustment to sexual abuse was determined by examining current distress symptoms such as global distress, depression, anxiety, somatization, and PTSD. These symptoms are characteristic of sexual abuse survivors (Briere, 1989), and have been found to be related to survivors' attributions about their abuse (Proulx, et. al., 1991). The absence of these symptoms was considered to be indicative of positive adjustment to sexual abuse, while their presence was considered to be indicative of a more

negative adjustment.

The current study utilized a state approach to attributions. Weiner's causal dimensions, as measured by the CDSII (McAuley et. al, 1990), was used to assess attributions. The concern at this time was to examine attributions about a specific event. The goal was to predict behaviors and emotions based on these specific attributions. Russell (1991) has indicated that utilizing the trait approach to attributions and employing an instrument assessing attributional style does not allow for the prediction of specific behaviors. Furthermore, Proulx et. al. (1991) found that attributions of abuse differed from attributions about other traumatic events. These authors measured attributions along Weiner's three dimensions and used Russell's (1982) CDS to assess these dimensions. The current research was an attempt to replicate and expand upon the results of this previous study.

Hypotheses

Based on the state approach to attributions, and on the Proulx et. al. (1991) study which reported a difference between the abuse related and nonabused related attributions of sexual abuse survivors, it was predicted that sexual abuse survivors would differ in their attributions about abuse related and nonabuse related trauma.

Based on the attribution literature and on the Proulx

et. al. (1991) study which found a relationship between abuse related attributions and distress symptomatology in sexual abuse survivors, it was predicted that attributions of internal locus of causality, stability, and high personal control would be associated with greater symptomatology, while attributions of external locus of causality, instability, and low personal control would be associated with lower symptomatology. The effects of high and low external control were also investigated.

Based on the symbolic interactionist perspective, and the attribution literature, it was predicted that abuse survivors' perceptions of their family, community, and society's attributions about the abuse would be linked to their distress symptomatology. Specifically, the more that survivors perceived these social elements as attributing the abuse to internal locus of causality, stability, and high personal control, the greater their distress symptomatology, while the more that survivors' perceived these social elements as attributing the abuse to external locus of causality, instability, and low personal control, the lower their distress symptomatology. The effect of external control was also examined. Differential effects of family, community, and society's attributions were noted. Hypotheses were tested on survivors of child sexual abuse, peer sexual abuse, and adult sexual assault.

Exploratory Analysis

Exploratory analysis were done to compare sexual abuse survivors' perceptions of the abuse related attributions of their family, community, and society with their own abuse related attributions. The incidence of concurrent physical and sexual abuse are reported. The exploratory analyses compared the degree of distress symptomatology in physically abused individuals, individuals sexually abused in childhood, individuals with concurrent childhood physical and sexual abuse, revictimized individuals, and nonabused individuals. A comparison of the attributions of physically abused individuals, individuals sexually abused in childhood, individuals with concurrent childhood physical and sexual abuse, revictimized individuals, and nonabused individuals was completed.

Method

Subjects

Subjects were 833 female introductory psychology students. All subjects were between the ages of 17-24 years. Females were chosen as they are more likely than males to disclose experiences of sexual abuse, thereby maximizing the potential number of abuse survivors obtained for the study. Males and females have different experiences and reactions to abuse (Peake, 1987; Rogers & Terry, 1982). To obtain a comparable number of abused males, many more subjects would have been required. The age restriction

allowed for the investigation of a specific cohort.

Procedure

Before subjects sign up for participation, they were informed that the study pertained to students' feelings, values, and ideas about self, friends, family, society, and life events including topics of sexual and physical abuse. Participation involved filling out a series of questionnaires addressing these issues. It took two hours to complete the questionnaires, for which subjects received two credit hours. Responses were anonymous and confidential, and consent to participate may have been withdrawn at any time. This information was verbally expressed at the time subjects sign up for the study and it was written on the inside cover of the sign up booklets (see Appendix B).

Subjects were asked to read and sign a consent form before beginning the two hour experimental session. This consent form outlined the study's areas of interest and the type of information that was required. It also assured participants of the anonymity and confidentiality of their responses (see Appendix C). Subjects filled out a series of questionnaires assessing clinical symptomatology, attributional dimensions, abuse history, and demographic information. Instructions on the appropriate manner of responding to each questionnaire were given at the beginning of each session by the researcher. All questionnaires were

number coded. Subjects were not required to place their name on any questionnaire. Completed questionnaire packages and consent forms were handed in separately. Therefore, responses were both anonymous and confidential.

At the time subjects handed in their completed questionnaire packages and their consent forms, they received written feedback (see Appendix D). This feedback included information on the purpose of the study. It also provided the phone numbers for the on campus Psychological Services Center and Student Health Services. Finally, subjects were thanked for their participation and informed that a copy of the general results of the study would be made available through Dr. Koverola or Jocelyn Proulx upon completion of the study.

Measures

Demographic Information Questionnaire. This questionnaire was constructed for the study. It assess information on ethnic identity, socioeconomic status, and family background (see Appendix E).

Physical Abuse Scale. This scale, constructed by Runtz in 1987, operationally defines physical abuse in terms of frequency and severity (see Appendix F). Both of these components are presented on a continuum. Frequency is measured through the number of times subjects experienced any of eight possible abusive behaviors at the hands of parents, step-parents, and/or guardians. The response range

is from 0-20. Severity is measured through 'yes' or 'no' responses to a list of possible injuries resulting from the abuse. The greater the number of injuries, the more severe the abuse. Presence or absence of injuries as well as a total injury score may be calculated. Runtz (1990) reports a Chronback alpha of .85 for the scale. In order to reduce the salience of the abuse issue this scale was titled the Family Conflict Questionnaire.

History of Unwanted Sexual Contact. This scale was constructed for this study. It assesses child sexual abuse, operationally defined as sexual assault which occurred when the subject was 16 years of age or younger and the perpetrator was at least 5 years older than the victim. Peer sexual abuse is defined as sexual assault which occurred when the subject was 16 years of age or younger and the perpetrator was less than 5 years older than the victim. Adult sexual assault is defined as sexual assault which occurred when the subject was 17 years of age or older. For each sexual abuse category, information on five separate incidence of assault is requested. The information requested includes type of abuse, age of the victim, age of the perpetrator, victim's relationship to the perpetrator, duration of the abuse, whether or not force was used, and which experience was considered the most traumatic (see Appendix G).

The Causal Dimension Scale II (CDSII). This scale is a

revised version of the Causal Dimension Scale (Russell, 1982). It was constructed by McAuley, Duncan and Russell (1990) and is based on Weiner's attribution theory. It measures causal attributions along controllability, locus of causality and stability dimensions. The controllability dimension is divided into personal controllability and external controllability. Subjects are provided with, or are asked to provide an outcome or event such as a car accident or an illness. They are then asked to list reason(s) or cause(s) for the outcome. For each cause, subjects respond to twelve semantic differential scales which assess perceptions of personal controllability, external controllability, locus of causality, and stability. The scale's preliminary instructions were altered to instruct the subject to respond to her own attributions, her family's attributions, her community's attributions, and society's attributions (see Appendix H). Responses to questions within each dimension are added, resulting in a score for each causal dimension. Lower scores indicate perceptions of external locus of causality, instability, and personal and external uncontrollability, while higher scores indicate perceptions of internal locus of causality, stability, and personal and external controllability. The scale is a structured direct-rating measure, the most reliable and valid means of measuring attributions (Elig & Frieze, 1979; Benson, 1989). McAuley, Duncan, and Russell

(1990) report alpha coefficients ranging from .60 to .92 for the scale. The average internal consistencies of each of the four dimensions across four evaluative studies were: locus of causality .67, stability .67, personal control .79, and external control .82.

Beck Depression Inventory (BDI). This 21-item inventory assesses the presence and degree of depression in adolescents and adults. Each item contains four statements regarding the respondent's state of mind, thoughts, and emotions within the past week. Subjects respond to the items by indicating which of the statements best apply to them. Any number of the four statements may be chosen (see Appendix I). Each statement is given a number from 0-3. Responses are summed. Scores may range from 0-63. Higher scores indicate greater depression. A score of 10 is the cut off point between depressed and nondepressed individuals (Bumberry, Oliver, & McClure, 1978). The construct validity of the BDI has been demonstrated through correlations of .65-.77 with clinical judgements of depth of depression (Beck, 1972; Bumberry et. al., 1978), correlations of .75 with the Hamilton Rating Scale, correlations of .40-.66 with the Depression Adjective Checklist (Beck, 1972), and correlations of .66 with clinical assessments of depression (Green, 1982). It's ability to discriminate between psychiatric patients having different types of depression (Steer, Beck, & Garrison, 1986) is indicative of the scale's

discriminant validity. Studies on content validity have found that subjects' scores on each of the BDI's 21 items correlate highly with their overall scores (Beck, 1972). Split-half reliability correlation coefficients of .86 were found using Pearson Product Moment Correlations (Green, 1982) and coefficients of .93 were found using Spearman-Brown Correlations (Beck, 1972).

Taylor Manifest Anxiety Scale (MAS). This scale, constructed by Taylor (1953), assesses the presence and degree of anxiety symptoms. The questionnaire has 50 true/false items. Item content includes references to anxiety or nervousness, restlessness and difficulty sleeping, and somatic symptoms (see Appendix J). Items are paired for high and low anxiety responses. High anxiety responses are tallied. Scores may range from 0-50. The higher the score, the greater the anxiety. The median split of the distribution is 14.56. Reliability coefficients of .82-.89 have been reported (Taylor, 1953). Content validity has been demonstrated (Taylor, 1953; Worchel & Bryne, 1964; Sechrest, 1968). The MAS has been found to correlate highly with other anxiety measures such as the Welsh Anxiety Index, the MMPI, the Saslow Screening Test of Anxiety Proneness, and the Elizur Rorschak Content Anxiety Measurement (Worchel & Bryne, 1964), thereby supporting it's construct validity.

Symptom Checklist-90-Revised (SCLR90). This questionnaire, constructed by Derogatis (1977), is a 90-item

self report measure assessing global distress as well as more specific symptomatology such as depression, anxiety, somatization, hostility, psychoticism, obsessive/compulsive, interpersonal sensitivity, phobic anxiety, and paranoid ideation. The measure presents subjects with 90 symptoms. Subjects indicate on a scale of 0 or "not at all" to 4 or "extremely", how much distress each symptom has caused them (see Appendix K). Items representing each symptom are summed and averaged. Global distress is measured by the total averaged score. Higher scores are indicative of greater distress. The subscales were derived through factor analysis, and correlate highly with MMPI scales (Derogatis, Rickels, & Rock, 1976; Derogatis & Cleary, 1977).

PTSD Questionnaires. PTSD was assessed through two questionnaires. The first questionnaire was constructed for this study. It's items are representative of DSM-III-R's criteria for PTSD. Instructions and wording of the items are altered for responses based on physical abuse, sexual abuse, and other traumatic events (see Appendix L). The second questionnaire was the aforementioned SCL-90-R. Saunders, Arata, and Kilpatrick (1990) have created a PTSD subscale from the items on the SCL-90-R. The items of this subscale have an internal consistency coefficient of .93. An average score is obtained across the 28 items representing the PTSD subscale. The authors found that the scale correctly classified 89.3% of PTSD and non-PTSD

subject. The subscale has high negative predictive power, but low positive predictive power.

Results

Demographic Information

The average age of subjects was 19 years. Subjects reported their average family income to be $35,000 to $55,000. Examination of the ethnic origins of participants revealed that 78% of the sample were caucasian; 12.1% were Asian, and the remaining 9.7% were of other ethnic origin. Within the sample 68.6% of subjects were still living with their parents; 31.4% were no longer living with their parents.

Sexual abuse or sexual assault was reported by 33% of the subjects. Child sexual abuse included incidents of unwanted sexual contact which occurred when the victim was 16 years of age or younger and the perpetrator was at least 5 years older than the victim. Incidents which occurred when the victim was 13-16 years of age with a boyfriend or friend and were classified as positive by the respondent were excluded. One hundred and thirty one individuals or 15.7% of the sample reported having experienced child sexual abuse. Peer sexual abuse included incidents of unwanted sexual contact which occurred when the victim was 16 years of age or younger and the perpetrator was less than 5 years older than the victim. Incidents occurring with a boyfriend or a friend were considered abusive only if force was used.

One hundred twenty seven individuals or 15.2% of the sample reported having experienced peer sexual abuse. Adult sexual assault included incidents of unwanted sexual contact which occurred when the victim was 17 years of age or older. Incidents which occurred with a boyfriend or friend were considered abusive only if force was used. Ninety two individuals or 11% of the sample reported having experienced adult sexual assault.

Physical abuse included incidents where a parent or guardian engaged in hitting or slapping the individual hard enough to cause injury, beating or kicking the individual, pushing or throwing the individual, hitting the individual with an object, pulling the individual's hair, burning or scratching the individual or twisting the individual's arm or leg. These incidents must have occurred before the individual was 17 years of age. Physical abuse was reported by 40% of the subjects. One hundred and fifty five subjects or 19% of the sample reported having experienced physical abuse concurrently with sexual abuse or assault. One hundred and seventy six subjects or 21% of the sample reported having experienced only physical abuse.

Of the entire sample of 833 subjects, 45% had never experienced any type of abuse or assault.

Test of Assumptions

Univariate tests were used to test for violation of assumptions. Multivariate assumptions were inferred from

univariate results.

Missing data were excluded from analyses. The two outliers found on Manifest Anxiety scores were excluded from analyses. Assumptions of multicollinearity, linearity, and homoscedasticity were not violated. The sample distribution was skewed towards external locus of causality and low personal control for nonabuse related attributions. Most subjects cited death of a loved one as a traumatic nonabuse event, accounting for skewness direction. The distribution was also skewed towards low distress symptomatology scores. The distribution of symptomatology scores are within an expected range for a high functioning university population. Transformations were not conducted since the abused groups primarily involved in analysis generally did not violate normality assumptions. Nonabused and physically abused groups which did violate assumptions of normality were involved in MANOVA procedure which is robust to non-normality when cell sizes are larger than 20 (Tabachnick & Fidell, 1983). All cells in the MANOVA contained more than 20 subjects. Further, some of the scales used were meaningful rather than arbitrary and therefore transformations may have been compromised (Tabachnick & Fidell, 1983).

Hypothesis 1

The first hypothesis predicted that sexual abuse survivors would differ in their attributions about abuse

related and nonabuse related trauma. Separate analyses were done for child sexual abuse, peer sexual abuse, and adult sexual assault groups. A set of t-tests were used to test the hypothesis for each group. Matched pair t-tests compare the means of two responses from the same individual taken at different times or under different circumstances. Subjects' abuse related and nonabuse related attributions are measures of the same subject in different situations. The alpha level for each set of t-tests was adjusted to .01.

Child Sexual Abuse. Differences were found between abuse related and nonabuse related attributions of stability ($T = -5.54$, $p<.001$), personal control ($T = 2.67$, $p<.009$), and external control ($T = 3.83$, $p<.0002$). No differences were found for locus of causality ($T = 1.45$, $p<.15$) (see Appendix M, Table 1).

Peer Sexual Abuse. Differences were found between abuse related and nonabuse related attributions of stability ($T = -4.14$, $p<.0001$), and personal control ($T = 2.71$, $p<.008$). No differences were found for external control ($T = 1.99$, $p<.05$) and locus of causality ($T = 1.71$, $p<.09$) (see Appendix M, Table 1).

Adult Sexual Assault. Differences were found between abuse related and nonabuse related attributions of stability ($T = -4.51$, $p<.001$), personal control ($T = 2.73$, $p<.008$), and external control ($T = 2.96$, $p<.004$). No differences were found for locus of causality ($T = 1.56$, $p<.12$) (see Appendix

M, Table 1).

Hypothesis 2

The second hypothesis stated that attributions of internal locus of causality, stability, and personal control would be associated with greater symptomatology, while attributions of external locus of causality, instability, and low personal control would be associated with lower symptomatology. Multivariate backward regression was used to test this hypothesis for three abuse groups: child sexual abuse survivors, peer abuse survivors, and adult sexual assault survivors. The regression procedure is best applied when the intent of the analysis is prediction (Tabachnick & Fidell, 1983). Multivariate regression tests the predictability of several independent variables against several dependent variables. The procedure is equally applicable to continuous and dichotomous independent variables and it is robust to nonorthogonal independent variables. Multivariate regression is applicable to real world and complicated issues where nature or circumstances rather than the experimenter have manipulated the independent variables (Tabachnick & Fidell, 1983). The four attributional dimensions of locus of causality, stability, personal control, and external control served as the independent variables, while the symptoms of depression, anxiety, somatization, and PTSD served as the dependent variables.

The backward elimination procedure was chosen since it provides the opportunity for all variables to perform as predictors. This procedure begins with the full model and proceeds to drop the weakest variables until there are no longer any variables weak enough to be dropped. Important variables are unlikely to be overlooked in the backward procedure (Younger, 1985). An entry level of .25 was selected to provide each variable the opportunity to remain in the model (Younger, 1985).

Child Sexual Abuse. Multiple regressions indicated that attributional dimensions accounted for 2%-5% of the variance of distress symptoms. The personal control dimension accounted for the predominant portion of this percentage (see Appendix M, Table 2a). Greater personal control was associated with greater distress. The overall set of attributional dimensions were not statistically significant predictors of the set of distress symptoms (Wilk's Lambda=.77, $F(32,315.06)=.72$, $p< .87$).

Peer Sexual Abuse. Multiple regressions indicated that attributional dimensions accounted for 3%-7% of the variance of distress symptoms. Locus of causality and external control dimensions accounted for the predominant portion of this percentage (see Appendix M, Table 2b). Internal locus of causality and greater external control were associated with greater distress. The overall set of attributional dimensions were not statistically significant

predictors of the set of distress symptoms (Wilk's Lambda=.70, F(32,259.742)=.81, p< .76).

Adult Sexual Assault. Multiple regressions indicated that attributional dimensions accounted for 5%-12% of the variance of distress symptoms. Locus of causality and stability dimensions accounted for the predominant portion of this percentage (see Appendix M, Table 2c). Internal locus of causality and greater stability were associated with greater distress. The overall set of attributional dimensions were not statistically significant predictors of the set of distress symptoms (Wilk's Lambda=.59, F(32,219.176)=1.06, p< .39).

Hypothesis 3

The third hypothesis predicted that sexual abuse survivors who perceived their family, community, and society as attributing the abuse to internal, stable, and personally controllable causes would display greater symptomatology, while sexual abuse survivors who perceived their family, community, and society as attributing the abuse to external, unstable, and personally uncontrollable causes would display lower symptomatology.

This hypothesis was tested only on adult sexual assault survivors. Further, the Beck Depression Inventory, the Taylor Manifest Anxiety Scale, and the SCL-90-R global distress scale were the only symptom measures used in the analysis. The reason for the reduction of focus was the

minimal number of subjects who completed Causal Dimension Scale Questionnaires on family, community, and society abuse-related attributions. More extensive analysis, in view of the reduced sample size would have compromised both the accuracy and interpretability of the results. Further, in view of the fact that the results of the second hypothesis revealed that attributions played a more significant role in predicting distress for recent rather than past sexual assault, subjects experiencing adult sexual assault were chosen as the focus of this analysis. The Beck Depression Inventory, the Taylor Manifest Anxiety Scale, and the SCL-90-R global distress scale were chosen because of their wide range of possible responses. It was anticipated that a wider potential response range would produce an increased likelihood of detecting response differences. These measures also represent the symptoms of primary interest: depression, anxiety, and general distress.

Multivariate backward regression was employed to test this hypothesis. Three regressions were completed: one for family attributions, one for community attributions, and one for society attributions. The application of multivariate backward regression is parallel to it's use in analysing the second hypothesis. Justification for the use of this technique has been previously stated. Attributional dimensions served as the independent variables. Distress symptoms served as the dependent variables.

Family Attributions. Multiple regression analysis revealed that although family attributions did not account for any of the variance of depression or anxiety, they did account for 11% of the variance of global distress. The external control dimension was responsible for the accounted variance. Specifically, perceived family attributions of high external control were associated with greater global distress (see Appendix M, Table 3). The overall set of attributional dimensions was not predictive of the set of distress symptoms (Wilk's Lambda=.72, $F(12,53.21)=.58$, $p< .85$).

Community Attributions. Multiple regression analysis revealed that community attributions did not account for any of the variance of depression. Community attributions did account for 5% of the variance of global distress, and 23% of the variance of anxiety. Locus of causality and stability dimensions were responsible for the accounted variance. Stability was associated with greater global distress and anxiety, and internal locus of causality was associated with greater anxiety (see Appendix M, Table 3). The overall set of attributional dimensions was not predictive of the set of distress symptoms (Wilk's Lambda=.69, $F(12,95.54)=1.22$, $p< .28$).

Society Attributions. Multiple regression analysis revealed that society attributions accounted for 5% of the variance of global distress, 5% of the variance of

depression, and 6% of the variance of anxiety. External control, personal control, and stability dimensions were responsible for the accounted variance. High external control was associated with greater global distress. High personal control was associated with greater depression. Stability was associated with greater anxiety (see Appendix M, Table 3). The overall set of attributional dimensions was not predictive of the set of distress symptoms (Wilk's Lambda=.78, F(12,69.09)=,55, p< .87).

Exploratory Analysis

Exploratory Analysis 1

The first area of exploratory analysis examined the relationship between the abuse related attributions of the subjects' family, community, and society, and the subjects' own abuse related attributions. Separate analyses were done for child sexual abuse, peer sexual abuse, and adult sexual assault groups. Matched pair t-tests were used to analyze the relationship. Matched pair t-tests compare the means of two responses from the same individual taken at different times or under different circumstances. Subjects' abuse related and their perceptions of family, community, and society attributions are measures of the same subject in different situations. The alpha level for each set of t-tests was adjusted to .01.

Child Sexual Abuse. No differences were found between subjects' own attributions and their perceptions of family

attributions of locus of causality (T= .52, p<.61), stability (T= -.16, p<.87), personal control (T= -.95, p< .35), or external control (T= 1.63, p<.11) (see Appendix M, Table 4a). No differences were found between subjects' own attributions and their perceptions of community attributions of locus of causality (T= -.51, p<.62), stability (T= -.71, p<.48), personal control (T= -1.15, p< .25), or external control (T= 1.10, p<.28) (see Appendix M, Table 4b). No differences were found between subjects' own attributions and their perceptions of societal attributions of locus of causality (T= .13, p<.89), stability (T= -1.29, p<.20), personal control (T= -1.26, p< .22), or external control (T= .24, p<.81) (see Appendix M, Table 4c).

Peer Sexual Abuse. No differences were found between subjects' own attributions and their perceptions of family attributions of locus of causality (T= .08, p<.94), stability (T= -.73, p<.47), personal control (T= -.24, p< .81), or external control (T= -.26, p<.80) (see Appendix M, Table 4a). No differences were found between subjects' own attributions and their perceptions of community attributions of locus of causality (T= -2.0, p<.05), stability (T= -.66, p<.52), personal control (T= -2.33, p< .02), or external control (T= .17, p<.87) (see Appendix M, Table 4b). No differences were found between subjects' own attributions and their perceptions of societal attributions of locus of causality (T= -.24, p<.81), stability (T= -.25, p<.81),

personal control (T= -2.08, p< .04), or external control (T= 1.37, p<.18) (see Appendix M, Table 4c).

Adult Sexual Assault. No differences were found between subjects' own attributions and their perceptions of family attributions of locus of causality (T= .24, p<.81), stability (T= .00, p<1.0), personal control (T= -.61, p< .54), or external control (T= .70, p<.48) (see Appendix M, Table 4a). No differences were found between subjects' own attributions and their perceptions of community attributions of locus of causality (T= -.28, p<.78), stability (T= -1.05, p<.30), personal control (T= -.42, p< .67), or external control (T= .53, p<.60) (see Appendix M, Table 4b). No differences were found between subjects' own attributions and their perceptions of societal attributions of locus of causality (T= .02, p<.98), stability (T= -1.58, p<.12), personal control (T= -1.53, p< .14), or external control (T= 1.56, p<.13) (see Appendix M, Table 4c).

Exploratory Analysis 2

The second area of exploratory analysis focused on ascertaining the incidents of child sexual abuse, peer sexual abuse, adult sexual assault, physical abuse and concurrent sexual and physical abuse. One hundred and thirty one (15.7%) subjects reported having experienced child sexual abuse. One hundred twenty seven (15.2%) subjects reported having experienced peer sexual abuse. Ninety two (11%) subjects reported having experienced adult

sexual assault. Three hundred and thirty one (39.7%) subjects reported having experienced physical abuse. Seventy nine (9.5% of the total population and 60% of the child sexual abuse population) subjects reported concurrent child sexual abuse and physical abuse. Sixty one (7.3% of the total population and 48% of the peer sexual abuse population) reported concurrent peer sexual abuse and physical abuse. Fifty four (6.5% of the total population and 59% of the adult sexual assault population) subjects reported experiencing adult sexual assault and childhood physical abuse. One hundred and fifty five (18.6%) subjects reported some form of sexual abuse with concurrent physical abuse (see Appendix M, Table 5).

Exploratory Analysis 3

The third area of exploratory analysis compared the distress symptomatology of five groups of individuals. These groups included: individuals who had been sexually abused in childhood, individuals who had been physically abused in childhood, individuals with concurrent physical and sexual abuse in childhood, revictimized individuals, and nonabused individuals. Only 68% of the original sample was used for this analysis. The remainder of the sample either did not respond to required questions or could not be accurately classified into a particular category. For this analysis the child sexual abuse survivors group and peer sexual abuse survivors group from previous analysis were

combined to form the category of childhood sexual abuse. This combination was made because the numbers of child sexual abuse survivors and peer sexual abuse survivors not experiencing concurrent physical abuse were not sufficiently large enough to be separately included. This category excludes individuals who reported physical abuse during childhood. Sixty four individuals, 12% of the responding sample, were in the childhood sexual abuse category. The physical abuse category represents physical abuse exclusive of any form of childhood sexual abuse or adult sexual assault. One hundred thirty six individuals, 25% of the responding sample, were in the physical abuse category. The concurrent child abuse category includes individuals who reported child sexual abuse and/or peer sexual abuse concurrent with childhood physical abuse. Seventy six individuals, 14% of the responding sample, were in the concurrent childhood abuse category. The adult sexual assault group was divided into two groups of indivdiuals. One group consisted of individuals who had expereinced child sexual abuse and/or peer sexual abuse, adult sexual assault, and childhood physical abuse. This group comprised the revictimization category. Sixty eight individuals, 10% of the responding sample, were in the revictimization category. The second group consisted of individuals who had experienced adult sexual assault exclusive of child sexual abuse, peer sexual abuse, and physical abuse. Twenty one

individuals, 3% of the responding sample, were in the adult sexual assault category. The number of subjects in this group were not large enough for separate analysis. Finally, nonabused individuals were also used as a comparison category. Two hundred three individuals, 36% of the responding sample, were in the nonabused category. A demographic display of these categories is provided in Appendix M, Graph 1.

A multivariate analysis of variance was used to analyze differences in distress between the different abuse categories. MANOVA examines the effects of one or more independent variables on two or more dependent variables. The procedure determines the significance of the influence the independent variables have over variations in the dependent variables. The procedure first produces an overall test of significance, taking into account a linear combination of all the dependent variables. The significance of the overall test is commonly evaluated by an index called the Wilk's Lambda criteria, which is distributed as an F statistic. It also produces a separate ANOVA table for each dependent variable to determine the effect of the independent variables on that dependent variable (Tabachnick & Fidell, 1983). The abuse categories of childhood sexual abuse, physical abuse, concurrent child abuse, revictimization, and nonabuse represented the independent variable. The dependent variables were the

psychological distress symptoms of global distress, depression, anxiety, somatization, and PTSD.

MANOVA revealed a significant difference between the distress symptomatology reported by the different abuse categories (Wilk's Lambda=.86 $F(28,1872.70)=2.84$, $p< .0001$). Individual analysis of variance tables and Scheffe tests of means revealed that for all measures of distress symptoms, except the Beck Depression Inventory, individuals in the physical abuse, concurrent child abuse, and revictimization categories reported significantly more distress than nonabused individuals (see Appendix M, Table 6). For the Beck Depression Inventory, only individuals in the concurrent child abuse category reported greater depression than nonabused individuals. Although not significantly different, individuals in the childhood sexual abuse category did consistently report a greater degree of distress symptoms than nonabused individuals.

Exploratory Analysis 4

The final exploratory analysis compared the attributions of individuals who had been sexually abused in childhood, individuals who had been physically abused in childhood, individuals with concurrent childhood physical and sexual abuse, revictimized individuals, and nonabused individuals. As in the third exploratory analysis, child sexual abuse survivors and peer sexual abuse survivors, who had not been physically abused, were combined to form the

childhood sexual abuse category. This combination was performed because the number of child sexual abuse survivors and peer sexual abuse survivors who had not experienced concurrent physical abuse was not sufficient for separate analysis. The physical abuse category was exclusive of any form of childhood sexual abuse or adult sexual assault. The concurrent child abuse category included physical abuse concurrent with either child sexual abuse or peer sexual abuse. The revictimization category included individuals experiencing child sexual abuse and/or peer sexual abuse, adult sexual assault, and physical abuse. An adult sexual assault category exclusive of child sexual abuse, peer sexual abuse, and physical abuse was not large enough for separate analysis. Nonabused individuals were the final comparison category. A demographic display of these categories is provided in Appendix M, Graph 1.

Multivariate analysis of variance was employed to analyze this comparison. Justification for the use of MANOVA has been stated in exploratory analysis 3. The abuse categories represented the independent variable, while the attributional dimensions represented the dependent variables. MANOVA revealed a significant difference in attributions between the abuse categories (Wilk's Lambda=.95, $F(16,1687.03)=1.75$, $p< .03$). Individual ANOVA tables revealed that the abuse categories differed only on the stability dimension ($F(4,559)=4.02$, $p< .003$). A Scheffe

test of means indicated that the childhood sexual abuse category scored significantly lower on attributions of stability than the concurrent abuse category (see Appendix M, Table 7).

Discussion

Hypothesis 1

The first hypothesis predicted that sexual abuse survivors would differ in their attributions about abuse related and nonabuse related trauma. Abuse related and nonabuse related attributions differed on all dimensions except locus of causality.

Stability. All three abuse groups perceived the cause of the nonabuse event as more stable, than the cause of the abuse event. Both events were viewed retrospectively. The abuse and it's cause are no longer present and are therefore perceived as transitory. The most commonly listed nonabuse related event was death of a loved one. The most often cited reason for this event was terminal illnesses. The illness caused death and is therefore viewed as permanent rather than transitory.

Personal Control. All three of the abuse groups reported a higher degree of personal control over the cause of the abuse than over the cause of the nonabuse event. The abuse literature indicates that some abused individuals feel they have control over the continuation or cessation of the abuse. The results of this study corroborate these

findings. Regarding nonabuse events, death of a loved one due to illness may have left little room for subject intervention.

External Control. Child sexual abuse survivors and adult sexual assault survivors reported higher levels of external control for abuse than for nonabuse events. No difference was found in reported degrees of external control for abuse and nonabuse events for peer sexual abuse survivors. The discrepancy between survivors of child sexual abuse and adult sexual assault and survivors of peer sexual abuse may have occurred due to a power differential. In child sexual abuse perpetrators are at least five years older than the victims. These perpetrators have authority as well as a physical and intellectual advantage over the child. In adult sexual assault the perpetrator is typically an adult male who is likely to possess greater physical strength than the victim. Subjects in these abuse groups may have perceived their perpetrator as having some control over the abuse and it's cause. In peer sexual abuse the victim and the perpetrator are similar in age. The perpetrator does not have a great physical or intellectual advantage over the victim. Subjects in this group may perceive their perpetrators as not having as much control over their actions as would older perpetrators, thus accounting for the discrepancy. For nonabuse events, death of a loved one due to illness may be perceived as beyond

anyone's control.

Locus of Causality. Attributions of locus of causality for abuse and nonabuse events did not differ in any of the abuse groups. Locus of causality assesses perceptions of responsibility for an event. Scores for both abuse and nonabuse events fell in the midrange area for all three abuse groups. Subjects felt that responsibility for both events was equally shared by internal and external factors. Subjects may have seen themselves as provoking the abuse, the perpetrator as committing the abuse, and others as responsible for their lack of intervention. Nonabuse events may also have had multiple sources. Further, assignment of responsibility for complex events may be a more difficult task than judgements of stability and control. Shared responsibility may also reflect the retrospective nature of the task. Evaluating an event at a cognitive and emotional distance may create different perceptions than evaluating an event directly preceding it's occurrence. Distance can broaden one's perspective and allow for the understanding of the multidimensional nature of events. Immediate reactions may be more unipolar.

General Observations. The results obtained for the first hypothesis parallel results obtained from a 1991 pilot study. The pilot study indicated that abused subjects perceived greater stability and controllability for abuse than nonabuse events. No differences were found for locus

of causality. It would appear from these two studies that attributions are somewhat situation specific. The implication of this finding is that cognitive assessment and treatment need to address attributions specific to the distress causing event. Rather than delivering general reassurances, therapists should perhaps be more focused on event related cognitions.

Hypothesis 2

The second hypothesis stated that attributions of internal locus of causality, stability, and personal control would be associated with greater symptomatology, while attributions of external locus of causality, instability, and low personal control would be associated with lower symptomatology. Results indicated that not all of the attributional dimensions were predictive of all of the symptom measures. However, an examination of individuals multiple regressions did reveal a number of important findings.

Child Sexual Abuse. For child sexual abuse survivors, perceptions of personal control were associated with greater distress. These findings concur with the sexual abuse and attribution literature. Feelings of personal control for a negative event have been associated with feelings of guilt and shame (Weiner, 1985). Feelings of guilt and shame in sexual abuse survivors often signals their perceptions of personal responsibility for the event's continuation

(Briere, 1989; Browne & Finkelhor, 1986). Further, guilt and shame have been linked to greater general distress as well as more specific distress such as depression and anxiety (Finkelhor & Browne, 1986; Janoff-Bulman, 1979; Brier, 1989; Wiehe, 1990).

Results also indicated that attributions of high external control were associated with greater depression. The perception that someone could have ended or prevented the abuse, but did not, may have led to anger, frustration, and a sense of helplessness. The literature has linked these emotions to the occurrence of depression (Briere, 1989; Browne & Finkelhor,1986; Abramson et.al., 1978; Seligman, 1975). Attributions of stability were associated with greater PTSD. The literature indicates that perceptions of stability for a negative event will lead to feelings of hopelessness and distress (Weiner, 1985; Proulx et. al., 1991; Abramson et. al., 1978; Seligman et. al., 1979; Gold, 1986; Seligman, 1975). Attributions of external locus of causality were associated with a higher incidence of PTSD. Unlike the other symptoms measured, PTSD has a physiological basis. Cognitive processes may be differentially related to PTSD than to depression, anxiety, somatization, and general distress, which are predominantly psychological in nature. Further, locus of causality only accounted for a very small proportion of the PTSD variance. Personal control, stability, and locus of causality together

accounted for only 5% of the PTSD variance. Therefore these results maybe spurious and should be interpreted with caution.

It is important to note that overall, attributions did not account for a very large amount of the variance of distress symptomatology in child sexual abuse survivors. Although the results in general are consistent with predictions, they may be spurious and should be interpreted with caution. It is only the personal control dimension that appears to be a constant, albeit minimal, predictor of distress in child sexual abuse survivors.

Peer Sexual Abuse. For peer sexual abuse survivors perceptions of internal locus of causality and high external control were associated with greater distress across most measures. Both the attribution and abuse literature suggest that internal locus of causality for a negative event such as abuse leads to greater distress. Individuals who perceive themselves as responsible for their abuse will experience low self esteem and an increase in distress symptoms such as depression and anxiety (Briere, 1989; Browne & Finkelhor, 1986; Janoff-Bulman, 1979; Wiehe, 1990; Gold, 1986; Morrow, 1991). According to Weiner (1986) anger results from attributions of external control to a negative event. This anger may be channelled into distress symptoms such as depression, anxiety, and somatization (Briere, 1989; Browne & Finkelhor, 1986).

Although personal control and stability dimensions play a small role in predicting distress, they do appear in the expected direction. Attributions of high personal control were associated with greater depression and anxiety. As forementioned, the literature has linked perceptions of personal control to feelings of guilt and shame and to distress such as depression and anxiety. Attributions of stability were associated with greater incidence of PTSD. The attribution literature has found that attributions of stability for a negative event are associated with hopelessness and greater distress.

Again it is important to remember that attributions did not account for a large amount of the variance of distress symptomatology in peer sexual abuse survivors. Therefore the results may be spurious and should be interpreted with caution. It is the locus of causality and external control dimensions that are the most consistent, albeit minimal, predictors of distress in peer sexual abuse survivors.

Adult Sexual Assault. For adult sexual assault survivors, perceptions of internal locus of causality and stability were associated with greater distress symptomatology. These results are in the predicted direction and corroborate attribution and sexual abuse literature findings. Individuals who assume responsibility for a negative event such as abuse will feel guilt and shame (Weiner, 1985). These emotions lead to lowered self-esteem,

negative self-perceptions, and greater distress (Briere, 1989; Browne & Finkelhor, 1986; Janoff-Bulman, 1979; Wiehe, 1990: Gold, 1986; Morrow, 1991). Individuals who perceive the cause of negative events as stable acquire a sense of hopelessness (Weiner, 1985). Hopelessness leads to greater levels of distress such as depression and anxiety (Abramson et. al., 1978; Seligman et. al., 1979).

Attributions of personal control were associated with a greater degree of depression. This finding corroborates both attributions and sexual abuse literature (Weiner, 1985; Briere, 1989; Browne & Finkelhor, 1986; Janoff-Bulman, 1979; Wiehe, 1990: Gold, 1986; Morrow, 1991; Abramson et. al., 1978; Seligman et. al., 1979).

General Observations. In general, examination of the results indicated that attributions were not strong predictors of distress symptoms in sexual abuse survivors. These findings may have ensued from the nature of attributions. Attributions address one aspect of cognitive functioning. Other aspects of cognitive functioning such as coping strategies, or other areas of functioning such as the interpersonal realm may exert more influence over adjustment to abuse.

Results also indicated that attributions were more predictive of recent sexual trauma such as adult sexual assault than of past sexual trauma such as child and peer sexual abuse. Many factors may have contributed to these

findings. First, the scale used to measure attributions may be more sensitive to attributions about recent events than to attributions about past events. Second, subjects may have had difficulty analyzing personal cognitions about traumatic events retrospectively. More recent abuse incidents may be more salient and therefore more amenable to personal assessment and analysis. Third, cognitive processes such as attributions may occur within a limited time span preceding an event. Hence, these cognitive processes would affect adjustment directly preceding the event and would be less involved in adjustment to past events. Finally, it is possible that past abuses have been resolved and therefore play a more minimal role in current distress symptoms, whereas recent incidents would be more strongly associated with current distress symptoms.

Further, measures of the same symptom did not always yield similar results. Some measures are more stringent than others. For example the SCL-90-R subscale for PTSD has been found to be much more inclusive than the Trauma Sequelae (Hanna, Koverola, & Proulx, 1992). The Beck Depression Inventory and the Taylor Manifest Anxiety Scale are much broader in response range than their SCL-90-R counterparts, and therefore may be measuring a wider range of symptom aspects. Finally, the variance accounted for was minimal for child and peer sexual abuse survivors, creating the possibility that results were spurious.

Distress symptomatology was predicted by different dimensions for the three different abuse groups. In child sexual abuse groups personal control was the predominant predictor. Perhaps those individuals who retrospectively view themselves as having been able to stop the abuse and not having done so feel a greater degree of guilt and consequently display greater levels of symptomatology. In the peer sexual abuse group internal locus of causality and external control were the predominant predictors. Those individuals who see a shared responsibility in causing and terminating the abuse may view the abuse as having several points of potential termination. The frustration that the abuse still occurred might then lead to higher distress symptomatology. In adult sexual assault groups internal locus of causality and stability were the predominant predictors. More recent abuse may still be emotionally charged. Characterological self-blame may result from the emotional and irrational thoughts characteristic of recent abuse. These group differences support the notion that attributions are situation specific. Different situations accentuate different attributional dimensions. The implication is that therapists must take into account the recency of the abuse when assessing and treating abused clients.

The general trend across the three groups is that internal locus of causality, stability, and high personal

and external control were associated with greater distress symptomatology. These results are in the predicted direction, corroborate the literature, and replicate the pilot study conducted in the previous year.

Hypothesis 3

The third hypothesis predicted that sexual abuse survivors who perceived their family, community, and society as attributing the abuse to internal, stable, and personally controllable causes would display greater symptomatology, while sexual abuse survivors who perceived their family, community, and society as attributing the abuse to external, unstable, and personally uncontrollable causes would display lower symptomatology. The number of subjects responding to questions about family, community, and society attributions was reduced, thereby necessitating a reduction in analytical focus. This depletion of responses may reflect a fatigue effect. Subjects may have experienced frustration and boredom at having to repeatedly respond to the same questions about the same event. Further, interpreting and ascertaining the attributions of others may be more difficult than ascertaining one's own attributions. For some individuals family, community, and society attributions may not have been relevant to their experience or to their adjustment to the abuse. Task difficulty and a lack of perceived relevance may have led subjects to decline a response to the questionnaires on family, community, and

society attributions. Further, it is possible that for nonresponding subjects, family, friends, and community groups may not have been aware of the abuse, thereby rendering the questionnaires on family and community abuse-related attributions inapplicable. Finally, survivors of child sexual abuse and peer sexual abuse may have been too young to either remember, notice, or be aware of other's reactions towards them and/or their abuse. For these individuals the information requested was not available for them to provide.

Family Attributions. Results indicated that family attributions of high external control were associated with greater global distress. Family attributions of external control may have led to anger and frustration at others' failure to terminate or prevent the abuse. Perceptions that others caused a negative event to occur has been found to result in anger (Weiner, 1985). Anger in sexual abuse survivors has been associated with various distress symptoms (Finkelhor & Browne, 1985; Briere, 1989; Russell, 1990). Family perceptions of external control may have been imparted through assurances of blamelessness. Stressing the individuals' blamelessness may inculcate a sense of powerlessness, helplessness, and frustration (Lamb, 1986; Janoff-Bulman, 1979). According to the literature, helplessness is likely to lead to greater distress (Abramson et.al., 1980; Anderson et.al., 1983; Anderson & Arnoult,

1985; Briere, 1989; Browne & Finkelhor, 1986; Janoff-Bulman, 1979; Kelley, 1986).

Results of analyses of personal assault-related attributions and distress for adult sexual assault survivors indicated that individuals who had attributions of internal locus of causality and stability reported greater distress. These individuals blamed themselves for their assault. Their family on the other hand, believed they were blameless and/or helpless. These individuals may feel they are deceiving their family. This perceived deception may lead to feelings of guilt and shame. Feelings of guilt and shame have been associated with greater distress in sexual abuse victims (Finkelhor & Browne, 1985; Janoff-Bulman, 1979; Briere, 1989; Wiehe, 1990).

Community Attributions. Results indicate that community attributions of stability were associated with greater global distress. Other's perceptions that the cause of the event was unchanging may have incurred the fear of its reoccurrence in assault victims. Attributions of stability lead to feelings of hopelessness and learned helplessness (Weiner, 1985; Abramson et. al., 1978). Hopelessness and helplessness have been associated with greater distress (Weiner, 1985; Proulx, et. al., 1991; Abramson et. al., 1978; Seligman et. al., 1979; Gold, 1986).

Community attributions of internal locus of causality and stability were associated with greater anxiety. This

attribution pattern parallels the characterological self-blame outlined by Janoff-Bulman (1979). Characterological self-blame has been associated with feelings of guilt and shame. Characterological self-blame, guilt, and shame have been linked to greater anxiety and distress (Lamb, 1986; Janoff-Bulman, 1979; Weiner, 1985; Abramson et. al., 1980; Kelley, 1986; Briere, 1989; Wiehe, 1990; Russell, 1990; Finkelhor & Browne, 1985).

Results of analysis of personal assault-related attributions and distress for adult sexual assault survivors indicated that individuals who had internal and stable attributions reported greater distress. The similarity between personal attributions and community attributions may be indicative of a transfer of attitudes from friends and social groups to the individuals, or a validation of personal attitudes by friends and social groups. Confirmation of negative attributions may exacerbate anxiety and distress.

Society Attributions. Results indicated that societal attributions of external control were associated with greater distress. As mentioned, perceptions that others could have exerted some control over the occurrence of the assault, but did not, could lead to anger and heightened distress (Weiner, 1985; Finkelhor & Browne, 1985; Briere, 1989; Russell, 1990). Perceptions that the assault was within the control of another person may also fuel

blamelessness and possibly instill a sense of powerlessness, helplessness, and frustration. These cognitions and emotions have been associated with greater distress (Abramson et.al., 1980; Anderson et.al., 1983; Anderson & Arnoult, 1985; Briere, 1989; Browne & Finkelhor, 1986; Janoff-Bulman, 1979; Kelley, 1986). As in the case of family attributions, individuals may feel that others see them as blameless, while they themselves believe they were responsible for their assault. The guilt and shame associated with this perceived deception may lead to greater distress.

Societal attributions of high personal control were associated with greater depression. The perception that society endorses victim culpability in not terminating or acting against the assault may lead to depression. Guilt and shame may result if societal attributions are incorporated into personal attributions. Guilt and shame has been associated with depression (Weiner, 1985; Finkelhor & Browne, 1986; Janoff-Bulman, 1979; Abramson et. al., 1980; Kelley, 1986).

Societal attributions of stability were associated with greater anxiety. Perceived societal beliefs in the permanence of the cause of the abuse may be incorporated into personal attributions. Indeed, analysis of personal attributions and distress on adult sexual assault survivors indicated that individuals with attributions of stability

reported greater distress. Attributions of stability to a negative event create feelings of hopelessness (Weiner, 1985). Hopelessness has been associated with greater distress including anxiety (Proulx et. al., 1991; Abramson et. al., 1978; Seligman et. al., 1979; Gold, 1986).

General Observations. In all cases, the statistic for overall significance of the model was nonsignificant while some individual regressions were significant. Multivariate regression tested the relationship between the entire set of attributional dimensions and the entire set of symptoms. Individual multiple regressions revealed that not all attributional dimensions were predictive of all symptom measures. Only one or two attributional dimensions were predictive of each distress measure, and in some instances distress measures were not predicted by attributional dimensions. Therefore all of the attributional dimensions were not predictive of all the distress measures.

Another general observation is the comparative influence of family, community, and society on individual distress. Community attributions were the most powerful predictors of individual distress. Subjects were 17-24 years of age; the average age being 18.69 years. These individuals can be conceptualized as being in the late adolescent stage of life. For individuals at this stage of life peers and reference groups represent the most significant source of social influence (Goff, 1980; Hewitt,

1984; Charon, 1989). Community includes friends and social groups.

Family maintained some influence over individuals' distress. As late adolescents, these individuals may be in the process of separating from their families. Family influence is waning, but has not completely disappeared. Reduced family influence may also reflect the family's lack of awareness of the assault. Adult sexual assault is defined as occurring after 17 years of age. Assaulted individuals may not have informed family members about the assault. Friends and social groups may have been the preferred consultants and sources of support.

Society had very little influence over individuals' distress. As mentioned, these individuals may be in transition between being a family dependent child and an independent adult. Their concern may not yet be focused on social structures and generalized others. Individuals may be still self and peer oriented rather than society oriented. This potential self and peer orientation may have diminished family and society influence and emphasized community influence.

The general trend across family, community, and society is that high external control, high personal control, stability, and internal locus of causality were associated with greater distress symptomatology in survivors of adult sexual assault. These results are in the predicted

direction, and concur with the attribution, symbolic interactionism, and sexual abuse literature. Results of the first exploratory analysis indicated that personal attributions did not differ from perceptions of family, community, and societal attributions. Results of the second hypothesis indicated that personal attributions of internal locus of causality, stability, personal control, and external control were associated with greater distress symptomatology. Therefore the expectation would be that family, community, and societal attributions of internal locus of causality, stability, personal control, and external control would also be associated with greater distress symptomatology. These results encourage further explorations into the effects of social sources on individual adjustment to trauma.

Exploratory Analysis 1

Exploratory analysis found that subjects' abuse related attributions did not differ from perceived family, community, and societal attributions. Symbolic interactionism proposes that through the role taking process judgments made by significant others, reference groups, and generalized others are internalized and incorporated into the self. These judgments help to define one's social reality, one's self-perceptions, and the acceptability of one's behavior (Charon, 1989; Celano, 1992). Individuals are active agents in interpreting and acting upon the

perceptions of significant others, reference groups, and generalized others. Through interactions the individual and these three social sources share information and exert mutual influence. Ultimately these interactions result in a shared perspective of reality (Hewitt, 1984; Jones & Day, 1977; Stryker, 1980).

Another consideration is that difficulty in distinguishing between self and others' attributions may have biased subjects' interpretation of family, community, and society attributions. Subjects may have assumed others shared their view of the abuse.

Exploratory Analysis 2

The incidence of child sexual abuse was lower than the 33% reported by the literature (Bagley & Ramsey, 1986; Finkelhor, Hotaling, Lewis, & Smith, 1990; Herman, Russell, & Trocki, 1986; Koverola, 1992; Painter, 1986) but comparable to previous studies conducted at the University of Manitoba (Proulx et. al., 1991; Runtz, 1990; Briere & Runtz, 1988). Peer sexual abuse has not been as clearly outlined in the literature. However, the findings of this study are similar to the pilot study. Adult sexual assault was reported by 11% of the sample. The reported incidents of rape is approximately 33% (Russell & Howell, 1983). Rape is generally defined as forced oral sex, or anal or vaginal penetration. Adult sexual assault, defined as unwanted sexual contact occurring after the age of 17, was a more

inclusive category than rape. The incidence rates of sexual assault would be expectedly higher than for rape. However, the cited incidents of rape refer to the entire adult female population. The current study only examined females 17-24 years of age. The sampling of such a young and narrowly defined cohort undoubtedly accounted for this study's lower incidents of adult sexual assault.

Physical abuse was reported by 40% of the sample. In 1991 Runtz found an incidence rate of 66% on a similar University of Manitoba population. Runtz's (1991) physical abuse criteria was slightly more lenient than the criteria used in this study. The physical abuse criteria for this study included incidents in which a parent or guardian engaged in hitting or slapping the individual hard enough to cause injury, beating or kicking the individual, pushing or throwing the individual, hitting the individual with an object, pulling the individual's hair, burning or scratching the individual or twisting the individual's arm or leg. These incidents must have occurred before the individual was 17 years of age. The physical abuse criteria for Runtz's study included incidents where a parent or guardian engaged in hitting or slapping the individual, beating or kicking the individual, pushing or throwing the individual, hitting the individual with an object, pulling the individual's hair, burning or scratching the individual or twisting the individual's arm or leg. These incidents must have occurred

before the individual was 18 years of age. The greater leniency of Runtz's (1991) criteria would account for some of the discrepancy in reported incidents of physical abuse. Further, Runtz's (1991) sample consisted of both males and females, while this study only utilized female subjects. Males are more likely than females to be abused and injured by a parent or guardian (Runtz, 1991). The gender composition of these two studies likely accounts for some of the discrepancy in reported physical abuse rates. The reported incidents of physical abuse for more general populations range from 9% (Berger, Knutson, Mehm, & Perkins, 1988) to 97% (Straus, 1983). The definitional criteria also range from experiencing repeated incidence of severe physical assault (Berger, et. al., 1988) to ever hitting or spanking a child (Strauss, 1981). In comparison, the results of this study fall midrange both in criteria and incidents rates.

A high rate of concurrent sexual and physical abuse was reported by subjects. Physical and sexual abuse may occur as two manifestations of the same family dysfunction, or one form of abuse may predispose the individual to revictimization through another form of abuse (Briere, 1989; Browne & Finkelhor, 1986; Russell, 1986; Vargo et. al., 1988; Wiehe, 1090).

Exploratory Analysis 3

The third area of exploratory analysis examined the

difference in reported distress symptomatology between childhood sexual abuse, physical abuse, concurrent child abuse, revictimization, and nonabuse groups. Physical abuse, concurrent child abuse, and revictimization groups reported significantly greater distress than the nonabuse group. The literature indicates that abuse leads to the occurrence of distress symptomatology. The results of this study corroborate the existing literature.

The childhood sexual abuse group, although consistently higher in reported distress symptomatology than the nonabuse group, was not statistically higher in reported distress symptomatology than the nonabuse group. This distress pattern is likely due to the severity of the abuse within each group.

The nonabuse group reported the lowest level of distress. The childhood sexual abuse group reported only slightly higher levels of distress. Within this particular sample, child sexual abuse survivors and peer sexual abuse survivors reported low levels of severity of abuse. For these individuals incidence of abuse were typically singular (56%), extrafamilial (58%), with one perpetrator (69%), and mild in severity (52%). Singular or infrequent incidence of abuse, extrafamilial abuse, single perpetrator abuse, and low severity of abuse have been associated with less distress symptomatology than frequent abuse, intrafamilial abuse, abuse by numerous perpetrators, and

severe abuse (Friedrich, 1990; Koverola, 1992; Wolfe & Wolfe, 1989; Browne & Finkelhor, 1986). It is important to note that this low severity pattern is not typical of individuals experiencing child sexual abuse and peer sexual abuse. The low severity of abuse may be an artifact of the type of sample obtained. Individuals who function at a level required to attend university may be representative of the lower end of the severity spectrum for child sexual abuse. It is expected that individuals experiencing more severe abuse would report distress symptomatology comparable to that of physical abuse, concurrent child abuse, and revictimization groups. It is not possible to empirically examine this issue in this sample because of low sample size for this group.

The physical abuse, concurrent child abuse, and revictimization groups were representative of a group experiencing more severe abuse. For those individuals fitting the physical abuse criterion 63% reported three or more incidence of abuse, and 56% sustained physical injury from their abuse. Further, physical abuse was defined as having occurred at the hands of parents and/or guardians in comparison to the child sexual abuse and peer sexual abuse groups where abuse was inflicted largely by extrafamilial persons. Further, both concurrent child abuse and revictimization represent compounded abuse. This speculated difference in severity between the abuse groups provides one

possible explanation for the differential degree of distress symptomatology reported by the individuals within these groups.

Finally, the Beck Depression Inventory showed greater depression only for the concurrent child abuse group. This measure is the most stringent of the distress measures used. Abuse may have to be severe and compounded before differences can be detected in symptomatology.

Exploratory Analysis 4

The fourth exploratory analysis compared the attributions of individuals in the childhood sexual abuse, physical abuse, concurrent child abuse, revictimization, and nonabuse groups. In general, no attributional differences between these abuse groups were found. The attributions analyzed were nonabuse-related attributions. Similarity in attributions may reflect a similarity in general problems and trauma for these abuse groups. These results corroborate the research of the pilot study completed in 1991. For the pilot study, abused and nonabused individuals did not differ in their nonabuse-related attributions.

An examination of the attribution literature reveals that attributions have both a state dependent component and a trait component. Like all traits, attributions have a certain degree of cross-situation consistency and are therefore predictive of general behavior patterns over time and across contexts. Fluctuations occur, but there is an

average or tendency towards a particular attributional pattern.

Because there are natural fluctuations in attributions to events, differences from the general tendency will occur. One specific case may differ quite broadly from another case and/or from the general pattern. It is for this reason that Russell (1982) recommends examining attributions for a specific situation to predict the behavioral outcome for that situation. It is possible that the degree of fluctuation may reflect the nature of the situation. There may be more consistency in attributions across similar situations, while dissimilar situations may be cognitively apprehended in very different ways.

The results of the fourth exploratory analysis revealed a significant difference between abuse groups with regard to nonabuse-related attributions. This difference only occurred for the stability dimension. The concurrent child abuse group perceived the cause of their nonabuse-related event as more stable than did the childhood sexual abuse group. It may be that individuals who have experienced concurrent abuse have acquired a more consistently negative view of life. They may be more likely to perceive negative events as persistent. Physical abuse at the hands of a guardian or parent may have been prevalent throughout their lives. This physical abuse combined with previous sexual abuse may have predisposed these individuals to perceive

negative events of any kind as stable. Individuals who were sexually abused but not physically abused in childhood may have experienced a termination of their abuse earlier in life. The childhood sexual abuse group may therefore be more likely to perceive negative events as evanescent. The effect of past experience on current and future attributions reflect the consistent trait component of attributions.

Further, the results of the third exploratory analysis revealed that individuals experiencing concurrent abuse reported greater symptomatology than sexually abused individuals. The tendency of individuals experiencing concurrent abuse to attribute negative events to stable causes may be a contributing factor in their distress. Further investigations are needed to clarify and confirm these findings.

Other attributional dimensions were similar across the five abuse categories. Subjects experienced similar nonabuse-related trauma or problems. Different groups of individuals tend to view similar events in similar ways. Certain social or cultural factors allow similar events to be cognitively appraised in similar ways, even by different people.

A comparison can be made between these findings and the results of the first hypothesis which indicated that abuse-related and nonabuse-related attributions do differ. Very different events were cognitively appraised in different

ways. The nature of the situation appears to be a contributing factor in the attributional pattern. This finding may reflect the unstable component of attributions.

Directions for Future Research

The results of this study indicated that attributions were more predictive of distress symptomatology for recent sexual trauma than for past sexual trauma. Based on these findings it would appear that attributions impact within a limited time span directly preceding the event. Attributions are best assessed directly following the termination of the abuse and before therapeutic intervention. At this time abuse-related attributions would be most salient. In order to assess the impact of child sexual abuse and peer sexual abuse immediately following the abuse, age appropriate measures would need to be developed. Interviews would likely be the most appropriate method of assessment.

One of the limitations of this study was the sampling of university students. This type of sample was collected for it's expediency, accessability, and affordability. However this sample could only provide a retrospective analysis of child sexual abuse and peer sexual abuse attributions. This analysis did not prove as fruitful as expected. Examination of a cross section of ages immediately after the abuse would yield more conclusive results.

A sampling of different ages may enable investigations of developmental issues. Attributions could be assessed for quality and effects at different developmental stages. For example, research could possibly assess and compare attributions originating from a concrete operations stage of cognitive development versus a formal stage of cognitive development. Knowledge of different developmental stages and the nature and quality of attributions derived from these stages could provide therapists with useful information in the treatment of child sexual abuse survivors.

Another limitation of the study was the reduced number of responses to questions on family, community, and society attributions. This reduction precluded analysis of family, community, and society attributions for child sexual abuse and peer sexual abuse groups, and led to a reduction in analyses for the adult sexual assault group. These attributions and their impact on the individual deserve more thorough examination.

Towards this end future research should endeavor to increase the number of subjects responding to questions about perceived family, community, and society attributions. One reason for the decreased number of respondents to these questionnaires may have been the ambiguity and length of the questionnaires. Clarification and simplification of questionnaires would encourage subjects to respond carefully

and completely. Additionally, the sampling of different cohorts at a time more immediate to their sexual trauma may yield more satisfactory results.

For the analyses conducted in this study, attributional dimensions appeared in the predicted direction in relation to symptomatology. This finding supports the argument that attributions are one component of the adjustment process for victims of sexual trauma. Further, it points to the need for further investigations of this issue.

In addition to the primary findings discussed, this study indicates a need for an expansion of focus in ascertaining mediators of adjustment to sexual trauma. The CMTI outlines several areas of exploration. Moral, sexual, physical, affective, and interpersonal mediators need to be explored. Initial investigations suggest that interpersonal variables such as social support and family functioning are significant predictors of symptomatology (Koverola, Proulx, & Kral, 1992). Cognitive mediators other than attributions also need to be considered. Preliminary explorations suggest that coping strategies may yield more significant results than attributions (Proulx, Koverola, & Kral, 1992). Locus of control is another viable area of investigation as control is often an issue for victims of sexual abuse. Further, personality factors such as extraversion and neuroticism may provide information on individuals' adjustment to sexual trauma.

Finally, research can be directed to ascertaining whether or not and to what extent sexual trauma shares mediators and mediation patterns with other types of trauma. Different types of trauma can differentially impact upon the individuals. They may also impact in similar ways. Different types of trauma can be mediated by different functional processes, but they may also have common mediators. These differences and similarities between types of trauma require further investigation.

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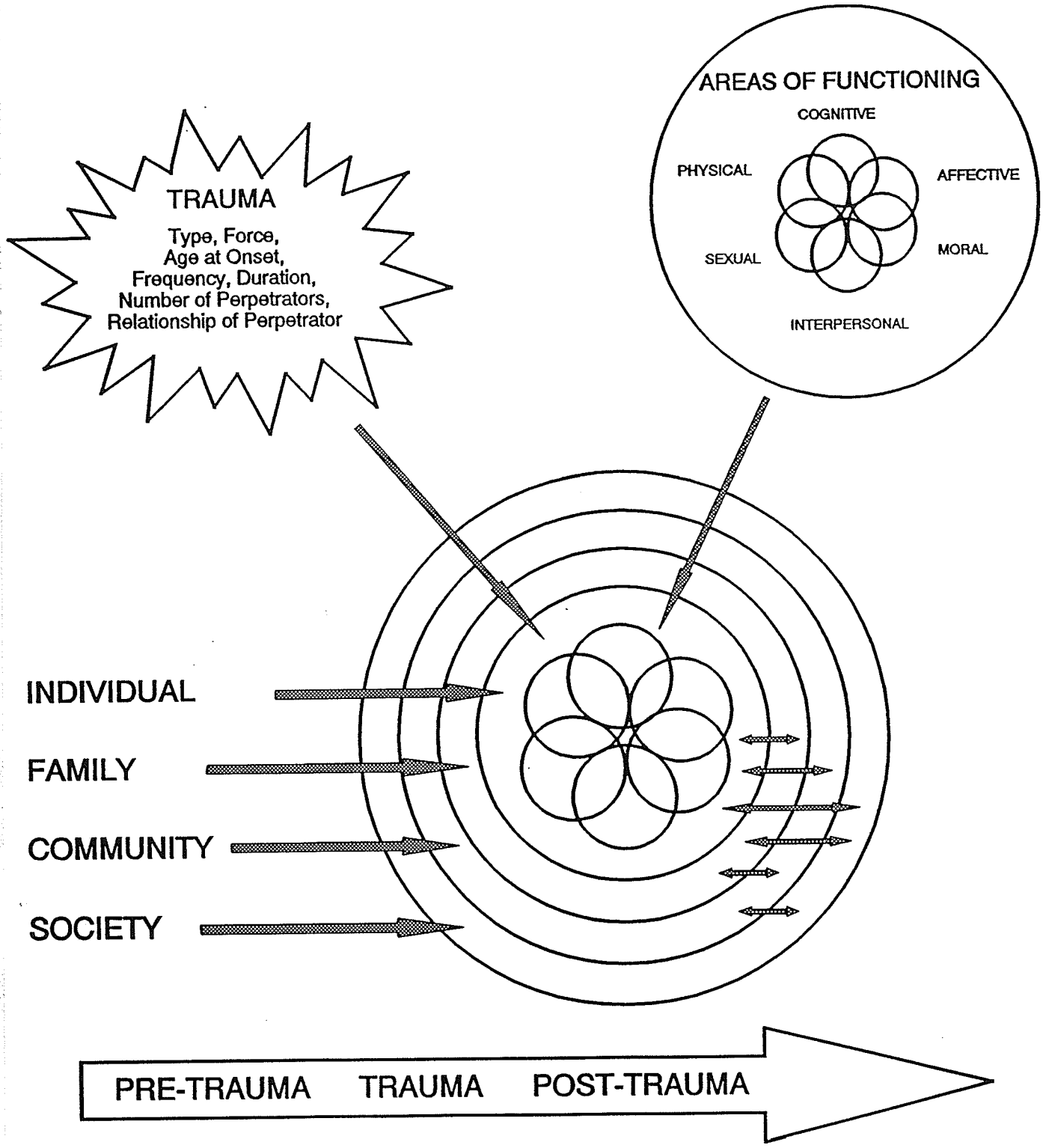
Appendix A

COMPREHENSIVE MODEL OF TRAUMA IMPACT



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Appendix B

This is a study examining university students' feelings, values, ideas, and attitudes about self, health problems, friends, family, community, society, and life events such as sexual and physical assault. Should you agree to participate in this study you will be asked to complete a series of questionnaires pertaining to the topics previously mentioned. The completion of these questionnaires will take approximately 3 hours, for which you will receive three experimental credits. Should you consent to participate in this study, you may withdraw your consent at anytime without penalty. All responses will be kept strictly confidential.

Appendix C

Consent Form

This is a study examining university students' feelings, values, ideas, and attitudes about self, health problems, friends, family, community, society, and life events such as sexual and physical assault. Should you agree to participate in this study, you will be asked to complete a series of questionnaires pertaining to the topics mentioned above. The completion of these questionnaires will take approximately 3 hours, for which you will receive three experimental credits. Should you consent to participate in this study, you may withdraw your consent at anytime without penalty. All responses will be anonymous and confidential.

Your signature below indicates your consent to participate in this study.

Appendix D

Feedback

The purpose of the study you have just completed was to explore the nature of attributions made about traumatic life events and coping strategies used in dealing with traumatic life events. We are particularly interested in the consequences that individuals' attributions about traumatic events and the coping strategies used to deal with these events have upon future expectations and distress symptoms. Variables which play a mediating role in attributional and coping processes, including personality factors, family, friends, community services, and other support systems, will also be examined. A general summary of the results of the study will be made available through the offices of Dr. Koverola and Jocelyn Proulx upon completion of the study.

Please be assured that your responses will be anonymous and confidential. If any of the issues brought up in the study have caused you distress and you wish to seek counselling, we encourage you to contact Student Counselling Services at 474-8592 or the Psychological Services Center at 474-9222. These services are free of charge.

Your participation in this study was greatly appreciated. Thank-you.

Appendix E

Background Sheet

1. AGE: _____ yrs.

2. ETHNICITY:

Caucasian ___
Black ___
Asian ___
Hispanic ___
Native ___
Other ___

3. SOCIO-ECONOMIC STATUS OF YOUR FAMILY:

< $15,000 ___
$15-25,000 ___
$25-35,000 ___
$35-45,000 ___
$45-55,000 ___
$55-65,000 ___
> $65,000 ___

4. FAMILY:

a. Are you still living with your parents? (Check one)

Yes ___ No ___

b. How many siblings in your family? ___
Any natural siblings? ___
Any step-siblings? ___

c. Are your parents: Living together ___
Separated ___
Divorced ___

d. If your parents are separated or divorced, how old were you at the time? ___ yrs.

e. Please check one if applicable:

i. One parent remarried? ___
Both parents remarried? ___
ii. How old were you at the time of remarriage(s)? ___ yrs
___ yrs

5. Have you ever had any major physical illnesses?

Yes ___ No ___

If yes, please specify, and give age of onset:

_____

_____

6. When you need emotional support, who do you go to first? (Please rank order all applicable, eg: 1, 2, 3, etc.)

Immediate family ___
Extended family ___
Friend ___
Teacher ___
Health Professional ___
Clergy ___
Other (please specify) _____
_____

7. Have you ever sought the following types of help in dealing with emotional/psychological problems? (Check all applicable)

Peer Counselling ___
Group therapy/Support group ___
Psychologist ___
Psychiatrist ___
Social Worker ___
Counselling by clergy ___
Other (please specify) _____
_____

8. Have you ever been prescribed any medication to deal with emotional/psychological problems?

Yes ___ No ___

If yes, please specify _____

9. Have you ever been hospitalized for psychological problems?

Yes ___ No ___

10. Are you currently involved in an intimate relationship (i.e. do you have a partner, lover, husband)?

Yes ___ No ___

If you answered "No", have you been involved in an intimate relationship in the past?

Yes ___ No ___

11. Have you ever experienced physical assault in an intimate relationship?

Yes ___ No ___

12. Have you ever experienced forced sexual assault in an intimate relationship?

Yes ___ No ___

Appendix F

Family Conflict

Almost everyone gets into conflicts with other people in their family and sometimes these lead to physical blows or violent behavior. Answer the following questions about your experiences **BEFORE YOU WERE AGE 17,** with your parents, stepparents, or guardians.

Please use the following scale to indicate how often each of the listed behaviors occurred.

1 = never
2 = once or twice
3 = 3-10 times
4 = 11-20 times
5 = more than 20 times

1. How often did your parents or guardians:

a) Hit or slap you really hard _____
b) Beat or kick you _____
c) Push, throw, or knock you down _____
d) Hit you with an object _____
e) Pull your hair _____
f) Burn or scald you _____
g) Scratch or dig fingernails into you _____
h) Twist or pull your leg or arm _____

If you answered "**never**" to all of the above please go on to the **next** questionnaire.

2. If you answered "**yes**" to any of the above please indicate if the following people were involved at any point in time:

a) mother yes____ no____
b) father yes____ no____
c) stepmother yes____ no____
d) stepfather yes____ no____
e) other adult relative or guardian yes____ no____

3. If you experienced any of the above behaviors, by any of the above individuals, did they ever result in the following?

a) bruises or scratches yes____ no____
b) cuts yes____ no____
c) injuries requiring medical treatment yes____ no____
d) other injury yes____ no____

4. Did any of the following people ever hit you or beat you before you were 17?

a) brother or sister yes____ no____
b) other children or adolescent yes____ no____
c) other adult non-family member yes____ no____

5. Do you feel that you were physically abused as a child?

yes____ no____

Appendix G

History of Unwanted Sexual Contact

It is now generally realized that most people have sexual experiences as children and while they are still growing up. Some of these are with friends and playmates, and some with relatives and family members. Some are very upsetting and painful, and some are not. Some influence people's later lives and sexual experiences, and some are practically forgotten. Although these may be important events, very little is actually known about them. We are interested in gathering information on any unwanted sexual experiences you had while growing up.

1. Please use the following scale to indicate how often each of these sexual experiences occurred when you were **AGE 16 OR YOUNGER** with someone **at least 5 YEARS OLDER** than yourself.

1 = never
2 = once or twice
3 = 3-10 times
4 = 11-20 times
5 = more than 20 times

a) Sexual kissing _____
b) Fondling of buttocks, thighs, breasts, or genitals _____
c) Insertion of fingers or any objects in the vagina or anus _____
d) Oral sex _____
e) Anal intercourse _____
f) Attempted vaginal intercourse _____
g) Completed vaginal intercourse _____

If you answered **"never"** to all of the above please go on to **page 3.**

If you answered **"yes"** to any of the above, then **please continue to answer the following questions.**

2. Was the other person: (check all that apply)

a) a stranger	_____	male___	female___
b) an acquaintance	_____	male___	female___
c) a friend of yours	_____	male___	female___
d) a friend of your parents	_____	male___	female___
e) father	_____		
f) mother	_____		
g) grandfather	_____		
h) grandmother	_____		
i) stepfather	_____		
j) stepmother	_____		
k) boyfriend	_____		
l) uncle	_____		
m) aunt	_____		
n) brother	_____		
o) sister	_____		
p) cousin	_____	male___	female___
q) neighbor	_____	male___	female___

r) teacher _____ male___ female___
s) babysitter _____ male___ female___
t) clergy _____ male___ female___
u) other (specify) _____ male___ female___

3. Please answer the following: (fill in as many incidences as applicable).

Type of Experience (Identify using corresponding letters a-g in #1)	Your Age	Other Person's Age	The Other Person was: (Identify using corresponding letters a-u in #2)	Duration of the Experiences	Was Force Used?
1. _____	____	_____	_____	_____	_____
2. _____	____	_____	_____	_____	_____
3. _____	____	_____	_____	_____	_____
4. _____	____	_____	_____	_____	_____
5. _____	____	_____	_____	_____	_____

4. Were you ever: (check all that apply).

a) threatened _____
b) physically forced _____
c) physically hurt _____
d) convinced to participate _____

5. Looking back at it now, would you say these experiences were: (please circle a number)

positive 1...2...3...4...5...6...7 negative

6. How confident do you feel about your memory of these experiences? (please circle a number)

not very confident 1...2...3...4...5...6...7 very confident

7. Of the experiences which you have indicated in question 3, which was the **single most** traumatic experience 1, 2, 3, 4, or 5? _____

8. Do you feel that you were sexually abused as a child? yes___ no___

1. Please use the following scale to indicate how often each of these sexual experiences occurred when you were **AGE 16 OR YOUNGER with someone less than 5 YEARS OLDER** than yourself.

1 = never
2 = once or twice
3 = 3-10 times
4 = 11-20 times
5 = more than 20 times

a) Sexual kissing _____
b) Fondling of buttocks, thighs, breasts, or genitals _____
c) Insertion of fingers or any objects in the vagina or anus _____
d) Oral sex _____
e) Anal intercourse _____
f) Attempted vaginal intercourse _____
g) Completed vaginal intercourse _____

If you answered **"never"** to all of the above please go on to **page 5.**

If you answered **"yes"** to any of the above, then **please continue to answer the following questions.**

2. Was the other person: (check all that apply)

a) a stranger	_____	male___	female___
b) an acquaintance	_____	male___	female___
c) a friend of yours	_____	male___	female___
d) a friend of your parents	_____	male___	female___
e) father	_____		
f) mother	_____		
g) grandfather	_____		
h) grandmother	_____		
i) stepfather	_____		
j) stepmother	_____		
k) boyfriend	_____		
l) uncle	_____		
m) aunt	_____		
n) brother	_____		
o) sister	_____		
p) cousin	_____	male___	female___
q) neighbor	_____	male___	female___
r) teacher	_____	male___	female___
s) babysitter	_____	male___	female___
t) clergy	_____	male___	female___
u) other (specify)	_____	male___	female___

3. Please answer the following: (fill in as many incidences as applicable).

Type of Experience (Identify using corresponding letters a-g in #1)	Your Age	Other Person's Age	The Other Person was: (Identify using corresponding letters a-u in #2)	Duration of the Experience	Was Force Used?
1. _____	____	_____	_____	_____	_____
2. _____	____	_____	_____	_____	_____
3. _____	____	_____	_____	_____	_____
4. _____	____	_____	_____	_____	_____
5. _____	____	_____	_____	_____	_____

4. Were you ever: (check all that apply).

a) threatened _____
b) physically forced _____
c) physically hurt _____
d) convinced to participate _____

5. Looking back at it now, would you say these experiences were: (please circle a number)

positive 1...2...3...4...5...6...7 negative

6. How confident do you feel about your memory of these experiences? (please circle a number)

not very confident 1...2...3...4...5...6...7 very confident

7. Of the experiences which you have indicated in question 3, which was the **single most** traumatic experience 1, 2, 3, 4, or 5? _____

3. Please answer the following: (fill in as many incidences as applicable).

	Type of Experience (Identify using corresponding letters a-g in #1)	Your Age	Other Person's Age	The Other Person was: (Identify using corresponding letters a-v in #2)	Duration of the Experience	Was Force Used?
1.	_____	____	_____	_____	_____	_____
2.	_____	____	_____	_____	_____	_____
3.	_____	____	_____	_____	_____	_____
4.	_____	____	_____	_____	_____	_____
5.	_____	____	_____	_____	_____	_____

4. Were you ever: (check all that apply).

a) threatened _____
b) physically forced _____
c) physically hurt _____
d) convinced to participate _____

5. Looking back at it now, would you say these experiences were: (please circle a number)

positive 1...2...3...4...5...6...7 negative

6. How confident do you feel about your memory of these experiences? (please circle a number)

not very confident 1...2...3...4...5...6...7 very confident

7. Of all of the experiences which you have indicated happened to you, which was the **single most** traumatic experience 1, 2, 3, 4, 5?

_____

1. Please use the following scale to indicate how often each of these sexual experiences occurred when you were **AGE 17 OR OLDER.**

1 = never
2 = once or twice
3 = 3-10 times
4 = 11-20 times
5 = more than 20 times

a) Sexual kissinng _____
b) Fondling of buttocks, thighs, breasts, or genitals _____
c) Insertion of fingers or any objects in the vagina or anus _____
d) Oral sex _____
e) Anal intercourse _____
f) Attempted vaginal intercourse _____
g) Completed vaginal intercourse _____

If you answered **"never"** to all of the above please go on to **page 7**

If you have not experienced any unwanted sexual contact of any kind please go on to the **next** questionnaire.

If you answered **"yes"** to any of the above, then **please continue to answer the following questions.**

2. Was the other person: (check all that apply)

a) a stranger	_____	male___	female___
b) an acquaintance	_____	male___	female___
c) a friend of yours	_____	male___	female___
d) a friend of your parents	_____	male___	female___
e) father	_____		
f) mother	_____		
g) grandfather	_____		
h) grandmother	_____		
i) stepfather	_____		
j) stepmother	_____		
k) boyfriend	_____		
l) uncle	_____		
m) aunt	_____		
n) brother	_____		
o) sister	_____		
p) cousin	_____	male___	female___
q) neighbor	_____	male___	female___
r) high school teacher	_____	male___	female___
s) professor/university instructor	_____	male___	female___
t) clergy	_____	male___	female___
u) employer	_____	male___	female___
v) other (specify)	_____	male___	female___

Appendix H

CAUSAL DIMENSION SCALE

REFLECT ON THE ABUSE AND THINK OF ITS MAIN CAUSE. NOTE: We realize that there may be many causes. Please list the one that contributed **most** to the abuse.

_____

THINK ABOUT THE CAUSE YOU HAVE LISTED ABOVE. THE ITEMS BELOW CONCERN YOUR IMPRESSIONS OR OPINIONS OF THIS CAUSE OF YOUR ABUSE. CIRCLE **ONE** NUMBER FOR EACH OF THE FOLLOWING SCALES.

1. Is the cause something that:										
Reflects an aspect of yourself	9	8	7	6	5	4	3	2	1	Reflects an aspect of the situation
2. Is the cause:										
Manageable by you	9	8	7	6	5	4	3	2	1	Not manageable by you
3. Is the cause something that is:										
Permanent	9	8	7	6	5	4	3	2	1	Temporary
4. Is the cause something:										
You can regulate	9	8	7	6	5	4	3	2	1	You cannot regulate
5. Is the cause something:										
Over which others have control	9	8	7	6	5	4	3	2	1	Over which others have no control

6. Is the cause something that is:										
Inside of you	9	8	7	6	5	4	3	2	1	Outside of you
7. Is the cause:										
Stable over time	9	8	7	6	5	4	3	2	1	Variable over time
8. Is the cause something that is:										
Under the power of other people	9	8	7	6	5	4	3	2	1	Not under the power of other people
9. Is the cause:										
Something About you	9	8	7	6	5	4	3	2	1	Something about others
10. Is the cause something:										
Over which you have power	9	8	7	6	5	4	3	2	1	Over which you have no power
11. Is the cause:										
Unchangeable	9	8	7	6	5	4	3	2	1	Changeable
12. Is the cause something:										
Other people can regulate	9	8	7	6	5	4	3	2	1	Other people cannot regulate

CAUSAL DIMENSION SCALE

PLEASE RESPOND TO THE FOLLOWING SET OF QUESTIONS ABOUT THE ABUSE INCIDENT WHICH OCCURRED WHEN YOU WERE **16 YEARS OF AGE OR YOUNGER** AND THE OTHER PERSON WAS **AT LEAST 5 YEARS OLDER.**
IF YOU ARE RESPONDING TO THESE QUESTIONS, PLACE A CHECK MARK HERE _____.
IF THERE WAS MORE THAN ONE ABUSE INCIDENT, PLEASE CHOOSE THE ONE YOU FOUND MOST TRAUMATIC.

IF YOU HAVE **NOT** EXPERIENCED SUCH AN INCIDENT, PLEASE RESPOND TO THE FOLLOWING SET OF QUESTIONS ABOUT THE ABUSE INCIDENT WHICH OCCURRED WHEN YOU WERE **16 YEARS OF AGE OR YOUNGER** AND THE OTHER PERSON WAS **LESS THAN 5 YEARS** OLDER THAN YOU.
IF YOU ARE RESPONDING TO THESE QUESTIONS, PLACE A CHECK MARK HERE _____.
IF THERE WAS MORE THAN ONE ABUSE INCIDENT, PLEASE CHOOSE THE ONE YOU FOUND MOST TRAUMATIC.

IF YOU HAVE **NOT** EXPERIENCED SUCH AN INCIDENT, PLEASE RESPOND TO THE FOLLOWING SET OF QUESTIONS ABOUT THE ABUSE INCIDENT WHICH OCCURRED WHEN YOU WERE **17 YEARS OF AGE OR OLDER.**
IF YOU ARE RESPONDING TO THESE QUESTIONS, PLACE A CHECK MARK HERE _____.
IF THERE WAS MORE THAN ONE ABUSE INCIDENT, PLEASE CHOOSE THE ONE YOU FOUND MOST TRAUMATIC.

WHAT DO YOU THINK WAS THE MAIN CAUSE OF THE ABUSE? NOTE: We realize that there may be many causes. Please list the one that contributed **most** to the abuse.

_____

THINK ABOUT THE CAUSE YOU HAVE LISTED ABOVE. THE ITEMS BELOW CONCERN YOUR IMPRESSIONS OR OPINIONS OF THIS CAUSE OF YOUR OUTCOME. CIRCLE ONE NUMBER FOR EACH OF THE FOLLOWING SCALES.

1. Is the cause something that:										
Reflects an aspect of yourself	9	8	7	6	5	4	3	2	1	Reflects an aspect of the situation
2. Is the cause:										
Manageable by you	9	8	7	6	5	4	3	2	1	Not manageable by you
3. Is the cause something that is:										
Permanent	9	8	7	6	5	4	3	2	1	Temporary
4. Is the cause something:										
You can regulate	9	8	7	6	5	4	3	2	1	You cannot regulate
5. Is the cause something:										
Over which others have control	9	8	7	6	5	4	3	2	1	Over which others have no control
6. Is the cause something that is:										
Inside of you	9	8	7	6	5	4	3	2	1	Outside of you
7. Is the cause:										
Stable over time	9	8	7	6	5	4	3	2	1	Variable over time

8. Is the cause something that is:										
Under the power of other people	9	8	7	6	5	4	3	2	1	Not under the power of other people
9. Is the cause:										
Something about you	9	8	7	6	5	4	3	2	1	Something about others
10. Is the cause something:										
Over which you have power	9	8	7	6	5	4	3	2	1	Over which you have no power
11. Is the cause:										
Unchangeable	9	8	7	6	5	4	3	2	1	Changeable
12. Is the cause something:										
Other people can regulate	9	8	7	6	5	4	3	2	1	Other people cannot regulate

CAUSAL DIMENSION SCALE

REFLECT ON WHAT YOUR **FAMILY** (eg. parents, siblings, grandparents) PERCEIVED AS THE MAIN CAUSE OF THE ABUSE.

NOTE: We realize that various family members may have had different perceptions of the abuse. Please list the person or persons whose views were the **most** influential to you at the time of the abuse. We realize that this person(s) may have perceived many causes of the abuse, but please indicate the **main cause.**

PERSON(S) _____

CAUSE _____

THINK ABOUT THE CAUSE YOU HAVE LISTED ABOVE. THE ITEMS BELOW CONCERN YOUR FAMILY MEMBER'S PERCEPTIONS OF THE CAUSE OF YOUR ABUSE. CIRCLE **ONE** NUMBER FOR EACH OF THE FOLLOWING SCALES.

1. Is the cause something that:										
Reflects an aspect of yourself	9	8	7	6	5	4	3	2	1	Reflects an aspect of the situation
2. Is the cause:										
Manageable by you	9	8	7	6	5	4	3	2	1	Not manageable by you
3. Is the cause something that is:										
Permanent	9	8	7	6	5	4	3	2	1	Temporary
4. Is the cause something:										
You can regulate	9	8	7	6	5	4	3	2	1	You cannot regulate
5. Is the cause something:										
Over which others have control	9	8	7	6	5	4	3	2	1	Over which others have no control

6. Is the cause something that is:										
Inside of you	9	8	7	6	5	4	3	2	1	Outside of you
7. Is the cause:										
Stable over time	9	8	7	6	5	4	3	2	1	Variable over time
8. Is the cause something that is:										
Under the power of other people	9	8	7	6	5	4	3	2	1	Not under the power of other people
9. Is the cause:										
Something about you	9	8	7	6	5	4	3	2	1	Something about others
10. Is the cause something:										
Over which you have power	9	8	7	6	5	4	3	2	1	Over which you have no power
11. Is the cause:										
Unchangeable	9	8	7	6	5	4	3	2	1	Changeable
12. Is the cause something:										
Other people can regulate	9	8	7	6	5	4	3	2	1	Other people cannot regulate

If there is anything you feel needs to be clarified about your family's perceptions of the abuse, please express these issues in the space provided below.

CAUSAL DIMENSION SCALE

REFLECT ON WHAT YOUR **COMMUNITY** (eg. ethnic group, religious group, school friends, social group) PERCEIVED AS THE MAIN CAUSE OF THE ABUSE OR OF ABUSE IN GENERAL.

NOTE: We realize that various community groups may have had different perceptions of the abuse. Please choose the group or groups whose views were the **most** influential to you at the time of the abuse. We realize that this group(s) may have perceived many causes, but please indicate the **main cause.**

GROUP(S) _____

CAUSE _____

THINK ABOUT THE CAUSE YOU HAVE LISTED ABOVE. THE ITEMS BELOW CONCERN YOUR COMMUNITY'S PERCEPTIONS OF THE CAUSE OF YOUR ABUSE. CIRCLE **ONE** NUMBER FOR EACH OF THE FOLLOWING SCALES.

1. Is the cause something that:										
Reflects an aspect of yourself	9	8	7	6	5	4	3	2	1	Reflects an aspect of the situation
2. Is the cause:										
Manageable by you	9	8	7	6	5	4	3	2	1	Not manageable by you
3. Is the cause something that is:										
Permanent	9	8	7	6	5	4	3	2	1	Temporary
4. Is the cause something:										
You can regulate	9	8	7	6	5	4	3	2	1	You cannot regulate
5. Is the cause something:										
Over which others have control	9	8	7	6	5	4	3	2	1	Over which others have no control

6. Is the cause something that is:										
Inside of you	9	8	7	6	5	4	3	2	1	Outside of you
7. Is the cause:										
Stable over time	9	8	7	6	5	4	3	2	1	Variable over time
8. Is the cause something that is:										
Under the power of other people	9	8	7	6	5	4	3	2	1	Not under the power of other people
9. Is the cause:										
Something about you	9	8	7	6	5	4	3	2	1	Something about others
10. Is the cause something:										
Over which you have power	9	8	7	6	5	4	3	2	1	Over which you have no power
11. Is the cause:										
Unchangeable	9	8	7	6	5	4	3	2	1	Changeable
12. Is the cause something:										
Other people can regulate	9	8	7	6	5	4	3	2	1	Other people cannot regulate

If there is anything you feel needs to be clarified about your community's perceptions of the abuse, or of abuse in general, please express these issues in the space provided below.

REFLECT ON WHAT **SOCIETY** (media, legal system, government) PERCEIVED AS THE MAIN CAUSE OF THE ABUSE, OR OF ABUSE IN GENERAL.

NOTE: We realize that various social systems may have had different perceptions of the abuse. Please choose the social system whose views were the **most** influential to you at the time of the abuse. We realize that this social system may have perceived many causes, but please indicate only the **main cause.**

SOCIAL SYSTEM _____

CAUSE _____

THINK ABOUT THE CAUSE YOU HAVE LISTED ABOVE. THE ITEMS BELOW CONCERN SOCIETY'S PERCEPTIONS OF THE CAUSE OF YOUR ABUSE. CIRCLE **ONE** NUMBER FOR EACH OF THE FOLLOWING SCALES.

1. Is the cause something that:										
Reflects an aspect of yourself	9	8	7	6	5	4	3	2	1	Reflects an aspect of the situation
2. Is the cause:										
Manageable by you	9	8	7	6	5	4	3	2	1	Not manageable by you
3. Is the cause something that is:										
Permanent	9	8	7	6	5	4	3	2	1	Temporary
4. Is the cause something:										
You can regulate	9	8	7	6	5	4	3	2	1	You cannot regulate
5. Is the cause something:										
Over which others have control	9	8	7	6	5	4	3	2	1	Over which others have no control

6. Is the cause something that is:										
Inside of you	9	8	7	6	5	4	3	2	1	Outside of you
7. Is the cause:										
Stable over time	9	8	7	6	5	4	3	2	1	Variable over time
8. Is the cause something that is:										
Under the power of other people	9	8	7	6	5	4	3	2	1	Not under the power of other people
9. Is the cause:										
Something about you	9	8	7	6	5	4	3	2	1	Something about others
10. Is the cause something:										
Over which you have power	9	8	7	6	5	4	3	2	1	Over which you have no power
11. Is the cause:										
Unchangeable	9	8	7	6	5	4	3	2	1	Changeable
12. Is the cause something:										
Other people can regulate	9	8	7	6	5	4	3	2	1	Other people cannot regulate

If there is anything you feel needs to be clarified about society's perceptions of the abuse or abuse in general, please express these issues in the space provided below.

CAUSAL DIMENSION SCALE

THINK OF AN EVENT **OTHER THAN SEXUAL OR PHYSICAL ABUSE** THAT YOU HAVE CONSIDERED TRAUMATIC (For example, a car accident, the death of a loved one, loss of a job, serious illness).

IN THE SPACE PROVIDED WRITE DOWN THIS EVENT.

_____

REFLECT ON THIS EVENT AND THINK OF THE MAIN CAUSE OF IT. NOTE: We realize that there may be many causes. Please list the one that contributed **most** to the event.

_____

INSTRUCTIONS: THINK ABOUT THE CAUSE YOU HAVE LISTED ABOVE. THE ITEMS BELOW CONCERN YOUR IMPRESSIONS OR OPINIONS OF THIS CAUSE OF YOUR OUTCOME. CIRCLE ONE NUMBER FOR EACH OF THE FOLLOWING SCALES.

1. Is the cause something that:										
Reflects an aspect of yourself	9	8	7	6	5	4	3	2	1	Reflects an aspect of the situation
2. Is the cause										
Manageable by you	9	8	7	6	5	4	3	2	1	Not manageable by you
3. Is the cause something that is:										
Permanent	9	8	7	6	5	4	3	2	1	Temporary
4. Is the cause something:										
You can regulate	9	8	7	6	5	4	3	2	1	You cannot regulate

5. Is the cause something:										
Over which others have control	9	8	7	6	5	4	3	2	1	Over which others have no control
6. Is the cause something that is:										
Inside of you	9	8	7	6	5	4	3	2	1	Outside of you
7. Is the cause:										
Stable over time	9	8	7	6	5	4	3	2	1	Variable over time
8. Is the cause something that is:										
Under the power of other people	9	8	7	6	5	4	3	2	1	Not under the power of other people
9. Is the cause something										
About you	9	8	7	6	5	4	3	2	1	Something about others
10. Is the cause something										
Over which you have power	9	8	7	6	5	4	3	2	1	Over which you have no power
11. Is the cause										
Unchangeable	9	8	7	6	5	4	3	2	1	Changeable
12. Is the cause something										
Other people can regulate	9	8	7	6	5	4	3	2	1	Other people cannot regulate

Appendix I

B E C K

ON THIS QUESTIONNAIRE ARE GROUPS OF STATEMENTS. PLEASE READ EACH GROUP OF STATEMENTS CAREFULLY. THEN PICK OUT THE ONE STATEMENT IN EACH GROUP WHICH BEST DESCRIBES THE WAY YOU HAVE BEEN FEELING THE PAST WEEK, INCLUDING TODAY! CIRCLE THE NUMBER BESIDE THE STATEMENT YOU PICKED. **IF SEVERAL STATEMENTS IN THE GROUP SEEM TO APPLY** EQUALLY WELL, CIRCLE EACH ONE. BE SURE TO READ ALL THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't even though I want to.

11. 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my apperance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.

    note: I am purposely trying to lose weight by eating less.
    Yes ____ No ____

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
    2 I and very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.

Appendix J

Please answer the following statements by checking off a TRUE or FALSE response.

		TRUE	FALSE
91.	I do not tire quickly.	____	____
92.	I am troubled by attacks of nausea.	____	____
93.	I believe I am no more nervous than most others.	____	____
94.	I have very few headaches.	____	____
95.	I work under a great deal of tension.	____	____
96.	I cannot keep my mind on one thing.	____	____
97.	I worry over money and business.	____	____
98.	I frequently notice my hand shakes when I try to do something.	____	____
99.	I blush no more than others.	____	____
100.	I have diarrhea once a month or more.	____	____
101.	I worry quite a bit over possible misfortunes.	____	____
102.	I practically never blush.	____	____
103.	I am often afraid that I am going to blush.	____	____
104.	I have nightmares every few nights.	____	____
105.	My hands and feet are usually warm enough.	____	____
106.	I sweat very easily even on cool days.	____	____
107.	Sometimes when embarassed I break out in sweat which annoys me greatly.	____	____
108.	I hardly ever notice my heart pounding and I am seldom short of breath.	____	____
109.	I feel hungry almost all the time.	____	____
110.	I am very seldom troubled by constipation.	____	____
111.	I have a great deal of stomach trouble.	____	____

	TRUE	FALSE
112. I have had periods in which I lost sleep over worry.	____	____
113. My sleep is fitful and disturbed.	____	____
114. I dream frequently about things that are best kept to myself.	____	____
115. I am easily embarrassed.	____	____
116. I am more sensitive than most other people.	____	____
117. I frequently find myself worrying about something.	____	____
118. I wish I could be as happy as others seem to be.	____	____
119. I am usually calm and not easily upset.	____	____
120. I cry easily.	____	____
121. I feel anxiety about someone or something almost all the time.	____	____
122. I am happy most of the time.	____	____
123. It makes me nervous to have to wait.	____	____
124. I have periods of such great restlessness that I cannot sit long in a chair.	____	____
125. Sometimes I become so excited that I find it hard to get to sleep.	____	____
126. I have sometimes felt that difficulties were pilling up so high that I could not overcome them.	____	____
127. I must admit that I have at times been worried beyond reason over something that really did not matter.	____	____
128. I have very few fears compared to my friends.	____	____
129. I have been afraid of things or people that I know could not hurt me.	____	____
130. I certainly feel useless at times.	____	____
131. I find it hard to keep my mind on a task or job.	____	____
132. I am unusually self-conscious.	____	____

	TRUE	FALSE
133. I am inclined to take things hard.	____	____
134. I am a high-strung person.	____	____
135. Life is a strain for me much of the time.	____	____
136. At times I think I am no good at all.	____	____
137. I am certainly lacking in self-confidence.	____	____
138. I sometimes feel that I am about to go to pieces.	____	____
139. I shrink from facing a crisis or difficulty.	____	____
140. I am entirely self-confident.	____	____

Appendix K

S C L R - 9 0

BELOW IS A LIST OF PROBLEMS AND COMPLAINTS THAT PEOPLE SOMETIMES HAVE. READ EACH ONE CAREFULLY, AND SELECT ONE OF THE NUMBERED DESCRIPTORS THAT BEST DESCRIBES 'HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU INCLUDING TODAY'. PLACE THAT NUMBER IN THE SPACE TO THE RIGHT OF THE PROBLEM. DO NOT SKIP ANY ITEMS, AND PRINT CLEARLY. IF YOU CHANGE YOUR MIND, ERASE YOUR FIRST NUMBER COMPLETELY. READ THE EXAMPLE BELOW BEFORE BEGINNING, AND IF YOU HAVE ANY QUESTIONS ASK THE TECHNICIAN.

EXAMPLE

How much were you distressed by:

	Answer
Ex. Body Aches	Ex. 3

Descriptors

0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

****

HOW MUCH WERE YOU DISTRESSED BY:

0 Not at all

1 A little bit

2 Moderately

3 Quite a bit

4 Extremely

1. Headaches ..... _____
2. Nervousness or shakiness inside ..... _____
3. Repeated unpleasent thought that won't leave your mind ..... _____
4. Faintness or dizziness ..... _____
5. Loss of sexual interest or pleasure ..... _____
6. Feeling critical of others ..... _____
7. The idea that someone else can control your thoughts ..... _____
8. Feeling others are to blame for most of your troubles ..... _____
9. Trouble remembering things ..... _____
10. Worried about sloppiness or carelessness ..... _____

HOW MUCH WERE YOU DISTRESSED BY:

0 Not at all 1 A little bit

2 Moderately 3 Quite a bit

4 Extremely

11. Feeling easily annoyed or irrritated ..... ____
12. Pains in heart or chest ..... ____
13. Feeling afraid of open space ..... ____
14. Feelings oflow energy or slowed down ..... ____
15. Thoughts of ending your life ..... ____
16. Heaing voices that other people do not hear ..... ____
17. Tembling ..... ____
18. Feeling that most people do not hear ..... ____
19. Poor appetite ..... ____
20. Crying easily ..... ____
21. Feeling shy or uneasy with the opposite sex ..... ____
22. Feelings of being trapped or caught ..... ____
23. Suddenly scared for no reason ..... ____
24. Temper outbursts that you could not control ..... ____
25. Feeling afraid to go out of your house alone ..... ____
26. Blaming yourself for things ..... ____
27. Pains in lower back ..... ____
28. Feeling blocked in getting things done ..... ____
29. Feeling lonely ..... ____
30. Feeling blue ..... ____
31. Worrying too much about things ..... ____
32. Feeling no interest in things ..... ____

HOW MUCH WERE YOU DISTESSED BY:

0 Not at all 1 A little bit

2 Moderately 3 Quite a bit

4 Extremely

33. Feeling fearful ..... _____

34. Your feelings being easily hurt ..... _____

35. Other people being aware of your private thoughts ..... _____

36. Feeling others do not understand you or are unsympathetic ..... _____

37. Feeling that people are unfriendly or dislike you ..... _____

38. Having to do things very slowly to insure correctness ..... _____

39. Heart pounding or racing ..... _____

40. Nausea or upset stomach ..... _____

41. Feeling inferior to others ..... _____

42. Soreness or your muscles ..... _____

43. Feeling that you are watched or talked about by others ..... _____

44. Trouble falling asleep ..... _____

45. Having to check and doublecheck what you do ..... _____

46. Difficulty making decisions ..... _____

47. Feeling afraid to travel on buses ..... _____

48. Trouble getting your breath ..... _____

49. Hot or cold spells ..... _____

50. Having to avoid certain things, places, or activities because they frighten you ..... _____

51. Your mind going blank ..... _____

52. Numbness or tingling in parts of your body ..... _____

HOW MUCH HAVE YOU BEEN DISTRESSED BY:

0 Not at all 1 A little bit

2 Moderately 3 Quite a bit

4 Extremely

53. A lump in your throat ..... _____

54. Feeling hopeless about the future ..... _____

55. Trouble concentrating ..... _____

56. Feeling weak in parts of your body ..... _____

57. Feeling tense orr keyed up ..... _____

58. Heavy feelings in your arms or legs ..... _____

59. Thought of death or dying ..... _____

60. Overeating ..... _____

61. Feeling uneasy when people are watching or talking about you ..... _____

62. Having thoughts that are not your own ..... _____

63. Having urges to beat, injure, or harm someone ..... _____

64. Awakening in the early morning ..... _____

65. Having to repeat the same actions such as touching, counting, washing ..... _____

66. Sleep that is restless or disturbed ..... _____

67. Having urges to break or smash things ..... _____

68. Having ideas or beliefs that others do not share ..... _____

69. Feeling very self conscious with others ..... _____

70. Feeling uneasy in crowds, such as shopping or at a movie ..... _____

71. Feeling everything is an effort ..... _____

HOW MUCH WERE YOU DISTRESSED BY:

0 Not at all 1 A little bit

2 Moderately 3 Quite a bit

4 Extremely

72. Spells of terror or panic ..... _____

73. Feeling uncomfortable about eating or drinking in public ..... _____

74. Getting into frequent arguments ..... _____

75. Feeling nervous when you are left alone ..... _____

76. Others not giving you proper credit for your achievements ..... _____

77. Feeling lonely even when you are with people ..... _____

78. Feeling so restless you couldn't sit still ..... _____

79. Feelings of worthlessness ..... _____

80. The feeling that something bad is going to happen to you ..... _____

81. Shouting or throwing things ..... _____

82. Feeling afraid you will faint in public ..... _____

83. Feeling that people will take advantage of you if you let them ..... _____

84. Having thoughts about sex that bother you a lot ..... _____

85. The idea that you shoukd be punished for your sins ..... _____

86. Thoughts and images of a frightening nature ..... _____

87. The idea that something serious is wrong with your body ..... _____

88. Never feeling close to another person ..... _____

89. Feelings of guilt ..... _____

90. The idea that something is wrong with your mind ..... _____

Appendix L

TRAUMA SEQUELAE

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH REGARD TO THE PHYSICAL ABUSE EXPERIENCE WHICH YOU FOUND **MOST** TRAUMATIC.

1. Do you have any memories of the experience?

Yes ___ No ___

If you answered yes, please answer the following:

(a) Do you have recurring memories of the experience?

Yes ___ No ___

(b) Do these memories intrude on your life?

Yes ___ No ___

(c) Do these memories distress you?

Yes ___ No ___

2. Do you have recurrent dreams about the experience?

Yes ___ No ___

If yes, are these dreams upsetting?

Yes ___ No ___

3. Have you experienced a sense of reliving the experience? (For example, have you acted or felt as though the experience were recurring? Include any experiences that happened upon awakening or when intoxicated)

Yes ___ No ___

(a) Have you experienced flashbacks (i.e. replaying of vivid memories of the experience)?

Yes ___ No ___

(b) Have you experienced perceptual illusions (i.e. mistaken perceptions; for example, you thought you saw your abuser on the street but it couldn't have been him/her)?

Yes ___ No ___

(c) Have you experienced hallucinations (i.e. hearing or seeing things that aren't there)?

Yes ___ No ___

4. Do you feel distressed or upset when you are reminded of the experience? (For example, does the anniversary of the experience upset you?)

Yes ___ No ___

5. Do you have any other symbolic reminders of the experience? (eg: objects, music, words or phrases which trigger memories of the experience?)

Yes ___ No ___

In reference to questions 1 to 5, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the experience did they begin to occur?

less than 6 months ___ more than 6 months ___

6. Do you deliberately avoid activities or situations that remind you of the experience?

Yes ___ No ___

7. Do you find that you have trouble remembering certain aspects of the experience?

Yes ___ No ___

8. Are you much less interested in things that used to be important to you (eg: sports, hobbies, social activities)?

Yes ___ No ___

9. Do you feel distant or cut off from others?

Yes ___ No ___

10. Do you feel emotionally numb? (For example, are you no longer to feel strongly about things or have loving feelings for people?)

Yes ___ No ___

In reference to questions 6 to 10, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the experience did they begin to occur?

less than 6 months ___ more than 6 months ___

11. Do you feel pessimistic about your future?

Yes ___ No ___

12. Do you have trouble sleeping?

Yes ___ No ___

13. Are you often irritable, or do you often have outbursts of anger?

Yes ___ No ___

14. Do you have trouble concentrating?

Yes ___ No ___

15. Are you watchful or on guard even when there is no reason to be?

Yes ___ No ___

16. Do you find yourself reacting physically to things that remind you of the experience?

Yes ___ No ___

17. Do you startle easily?

Yes ___ No ___

TRAUMA SEQUELAE

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH REGARD TO THE SEXUAL ABUSE EXPERIENCE(S) WHICH YOU FOUND **MOST** TRAUMATIC.

1. Do you have any memories of the experience?

Yes ___ No ___

If you answered yes, please answer the following:

(a) Do you have recurring memories of the experience?

Yes ___ No ___

(b) Do these memories intrude on your life?

Yes ___ No ___

(c) Do these memories distress you?

Yes ___ No ___

2. Do you have recurrent dreams about the experience?

Yes ___ No ___

If yes, are these dreams upsetting?

Yes ___ No ___

3. Have you had a sense of reliving the experience? (For example, have you acted or felt as though the experience were recurring? Include any experiences that happened upon awakening or when intoxicated)

Yes ___ No ___

(a) Have you experienced flashbacks (eg: replaying of vivid memories of the experience)?

Yes ___ No ___

(b) Have you experienced perceptual illusions (i.e. mistaken perceptions; for example, you thought you saw your abuser on the street, but it couldn't have been him/her)?

Yes ___ No ___

(c) Have you experienced hallucinations (i.e. hearing or seeing things that aren't there)?

Yes ___ No ___

4. Do you feel distressed or upset when you are reminded of the experience? (For example, does the anniversary of the experience upset you?)

Yes ___ No ___

5. Do you have any other symbolic reminders of the experience? (eg: objects, music, words or phrases which trigger memories of the experience?)

Yes ___ No ___

In reference to questions 1 to 5, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the experience did they begin to occur?

less than 6 months ___ more than 6 months ___

6. Do you deliberately avoid activities or situations that remind you of the experience?

Yes ___ No ___

7. Do you find that you have trouble remembering certain aspects of the experience?

Yes ___ No ___

8. Are you much less interested in things that used to be important to you (eg: sports, hobbies, social activities)?

Yes ___ No ___

9. Do you feel distant or cut off from others?

Yes ___ No ___

10. Do you feel emotionally numb? (For example, are you no longer to feel strongly about things or have loving feelings for people?)

Yes ___ No ___

In reference to questions 6 to 10, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the experience did they begin to occur?

less than 6 months ___ more than 6 months ___

11. Do you feel pessimistic about your future?

Yes ___ No ___

12. Do you have trouble sleeping?

Yes ___ No ___

13. Are you often irritable, or do you often have outbursts of anger?

Yes ___ No ___

14. Do you have trouble concentrating?

Yes ___ No ___

15. Are you watchful or on guard even when there is no reason to be?

Yes ___ No ___

16. Do you find yourself reacting physically to things that remind you of the experience?

Yes ___ No ___

17. Do you startle easily?

Yes ___ No ___

TRAUMA SEQUELAE

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH REGARD TO THE TRAUMATIC EXPERIENCE WHICH YOU LISTED IN THE PREVIOUS QUESTIONNAIRE.

1. Do you have any memories of the experience?

Yes ___ No ___

If you answered yes, please answer the following:

(a) Do you have recurring memories of the experience?

Yes ___ No ___

(b) Do these memories intrude on your life?

Yes ___ No ___

(c) Do these memories distress you?

Yes ___ No ___

2. Do you have recurrent dreams about the experience?

Yes ___ No ___

If yes, are these dreams upsetting?

Yes ___ No ___

3. Have you experienced a sense of reliving the experience? (For example, have you acted or felt as though the experience were recurring? Include any experiences that happened upon awakening or when intoxicated)

Yes ___ No ___

(a) Have you experienced flashbacks (i.e. replaying of vivid memories of the experience)?

Yes ___ No ___

(b) Have you experienced perceptual illusions (i.e. mistaken perceptions connected with the experience)?

Yes ___ No ___

(c) Have you experienced hallucinations (i.e. hearing or seeing things that aren't there)?

Yes ___ No ___

4. Do you feel distressed or upset when you are reminded of the experience? (For example, does the anniversary of the experience upset you?)

Yes ___ No ___

5. Do you have any other symbolic reminders of the experience? (eg: objects, music, words or phrases which trigger memories of the experience?)

Yes ___ No ___

In reference to questions 1 to 5, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the traumatic experience did they begin to occur?

less than 6 months ___ more than 6 months ___

6. Do you deliberately avoid activities or situations that remind you of the experience?

Yes ___ No ___

7. Do you find that you have trouble remembering certain aspects of the experience?

Yes ___ No ___

8. Are you much less interested in things that used to be important to you (eg: sports, hobbies, social activities)?

Yes ___ No ___

9. Do you feel distant or cut off from others?

Yes ___ No ___

10. Do you feel emotionally numb? (For example, are you no longer to feel strongly about things or have loving feelings for people?)

Yes ___ No ___

In reference to questions 6 to 10, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the traumatic experience did these begin to occur?

less than 6 months ___ more than 6 months ___

11. Do you feel pessimistic about your future?

Yes ___ No ___

12. Do you have trouble sleeping?

Yes ___ No ___

13. Are you often irritable, or do you often have outbursts of anger?

Yes ___ No ___

14. Do you have trouble concentrating?

Yes ___ No ___

15. Are you watchful or on guard even when there is no reason to be?

Yes ___ No ___

16. Do you find yourself reacting physically to things that remind you of the traumatic experience?

Yes ___ No ___

17. Do you startle easily?

Yes ___ No ___

Appendix M

Table 1: Differences Between Abuse Related and Nonabuse Related Attributions in Sexual Abuse Survivors.

Abuse Group	Attributional Dimensions	Nonabuse Mean	Abuse Mean	T	p<
Child Sexual Abuse	locus of causality	9.24	10.96	1.45	.15
	stability	16.69	12.39	-5.54	.0001*
	personal control	7.97	10.69	2.67	.009 *
	external control	11.94	15.92	3.83	.0002*
Peer Sexual Abuse	locus of causality	10.30	12.19	1.71	.09
	stability	15.86	12.17	-4.14	.0001*
	personal control	9.39	12.86	2.71	.008 *
	external control	11.57	13.72	1.99	.05
Adult Sexual Assault	locus of causality	10.63	12.51	1.56	.12
	stability	16.07	10.93	-4.51	.0001*
	personal control	9.64	13.87	2.73	.008 *
	external control	12.11	16.77	2.96	.004 *

x = .01

Table 2a: Attributional Dimensions as Predictors of Distress Symptomatology for Child Sexual Abuse Survivors

Symptom Measure	Attributional Dimensions	B	Model R^2	p<
SCL90-R Global Distress Scale	personal control	.01	.02	.13
Beck Depression Inventory	personal control	.17	.02	.16
Taylor Manifest Anxiety Scale	_____	—	—	—
SCL90-R Depression Scale	personal control external control	.02 .01	.03	.21
SCL90-R Anxiety Scale	personal control	.02	.04	.05
SCL90-R Somatization Scale	personal control	.02	.03	.09
SCL90-R PTSD Scale	personal control locus of causality stability	.03 -.02 .01	.05	.21
Trauma Sequelae	_____	—	—	—

Table 2b: Attributional Dimensions as Predictors of Distress Symptomatology in Peer Sexual Abuse Survivors

Symptom Measure	Attributional Dimensions	B	Model R^2	p<
SCL90-R Global Distress Scale	personal control external control	.01 .01	.04	.23
Beck Depression Inventory	locus of causality	.26	.03	.10
Taylor Manifest Anxiety Scale	external control locus of causality	.29 .16	.05	.11
SCL90-R Depression Scale	external control locus of causality	.03 .02	.07	.06
SCL90-R Anxiety Scale	personal control external control	.01 .02	.04	.24
SCL90-R Somatization Scale	locus of causality	.02	.03	.11
SCL90-R PTSD Scale	———	—	—	—
Trauma Sequelae	locus of causality stability	.02 .02	.05	.14

Table 2c: Attributional Dimensions as Predictors of Distress Symptomatology in Adult Sexual Abuse Survivors

Symptom Measure	Attributional Dimensions	B	Model R^2	p<
SCL90-R Global Distress Scale	locus of causality stability	.01 .02	.12	.01
Beck Depression Inventory	locus of causality personal control	.29 -.15	.06	.12
Taylor Manifest Anxiety Scale	stability	.54	.05	.07
SCL90-R Depression Scale	stability	.03	.08	.01
SCL90-R Anxiety Scale	locus of causality stability	.01 .03	.12	.01
SCL90-R Somatization Scale	locus of causality stability	.02 .01	.07	.08
SCL90-R PTSD Scale	locus of causality stability	.01 .02	.10	.03
Trauma Sequelae	stability	.04	.10	.008

Table 3: Perceived Family, Community, and Society Attributions as Predictors of Distress Symptomatology in Adult Sexual Assault Survivors.

Attribution Source	Symptom Measure	Attributional Dimensions	B	Model R^2	p<
Family	SCL-90-R Global Distress	external control	.02	.11	.10
	Beck Depression Inventory	_____	___	___	_
	Manifest Anxiety Scale	_____	___	___	_
Community	SCL-90-R Global Distress	stability	.01	.05	.16
	Beck Depression Inventory	_____	___	___	_
	Manifest Anxiety Scale	locus of causality stability	.51 .70	.23	.005
Society	Scl-90-R Global Distress	external control	.01	.05	.22
	Beck Depression Inventory	personal control	.17	.05	.22
	Manifest Anxiety Scale	stability	.40	.06	.18

Table 4a: Differences Between Subjects' Abuse Related Attributions and Perceived Family Abuse Related Attributions

Abuse Group	Attributional Dimensions	Subject Mean	Family Mean	T	p<
Child Sexual Abuse	locus of causality	9.24	9.15	.52	.61
	stability	16.69	14.18	-.16	.87
	personal control	7.97	9.85	-.95	.35
	external control	11.94	14.67	1.63	.11
Peer Sexual Abuse	locus of causality	10.30	11.54	.08	.94
	stability	15.86	12.62	-.73	.47
	personal control	9.39	11.92	-.24	.81
	external control	11.57	14.65	-.26	.80
Adult Sexual Assault	locus of causality	10.63	12.15	.24	.81
	stability	16.07	16.22	.00	1.0
	personal control	9.64	13.89	-.61	.54
	external control	12.11	15.07	.70	.48

x = .01

Table 4b: Differences Between Subjects' Abuse Related Attributions and Perceived Community Abuse Related Attributions

Abuse Group	Attributional Dimensions	Subject Mean	Community Mean	T	p<
Child Sexual Abuse	locus of causality	9.24	10.73	.51	.62
	stability	16.69	13.42	-.71	.48
	personal control	7.97	11.04	-1.15	.25
	external control	11.94	14.78	1.10	.28
Peer Sexual Abuse	locus of causality	10.30	14.49	-2.0	.05
	stability	15.86	13.62	-.66	.52
	personal control	9.39	14.78	-2.33	.02
	external control	11.57	14.27	.17	.87
Adult Sexual Assault	locus of causality	10.63	11.81	-.28	.78
	stability	16.07	11.26	1.05	.30
	personal control	9.64	13.30	-.42	.67
	external control	12.11	16.67	.53	.60

x = .01

Table 4c: Differences Between Subjects' Abuse Related Attributions and Perceived Society Abuse Related Attributions

Abuse Group	Attributional Dimensions	Subject Mean	Society Mean	T	p<
Child Sexual Abuse	locus of causality	9.24	10.34	.13	.89
	stability	16.69	13.18	-1.29	.20
	personal control	7.97	12.05	-1.26	.22
	external control	11.94	17.31	.24	.81
Peer Sexual Abuse	locus of causality	10.30	12.76	-.24	.81
	stability	15.86	13.79	-.25	.81
	personal control	9.39	14.95	-2.08	.04
	external control	11.57	17.18	-1.37	.18
Adult Sexual Assault	locus of causality	10.63	11.61	-.02	.98
	stability	16.07	13.15	-1.58	.12
	personal control	9.64	14.52	-1.53	.14
	external control	12.11	15.24	1.56	.13

x = .01

Table 5: Incidence of Sexual and Physical Abuse.

Abuse Category	N	%
Child Sexual Abuse	131	15.7
Peer Sexual Abuse	127	15.2
Adult Sexual Assault	92	11.0
Physical Abuse	331	39.7
Concurrent Child and Physical Abuse	79	9.5
Concurrent Peer and Physical Abuse	61	7.3
Concurrent Adult Assault and Physical Abuse	54	6.5

Table 6: MANOVA for Comparison of Sexual Abuse Categories on Distress Symptoms

symptom measure	childhood sexual abuse X (N=64)	physical abuse X (N=135)	concurrent child abuse X (N=76)	revictim-ization X (N=53)	non abused X (N=202)	F
Global Distress	1.02	1.11	1.28	1.16	.80	12.71**
Beck Depres-sion Inventory	9.80	10.47	12.28	10.53	7.65	5.19*
Manifest Anxiety Scale	22.27	26.57	25.70	26.26	19.88	8.52**
SCL-90-R Depres-sion Subscale	1.25	1.34	1.51	1.49	.97	11.54**
SCL-90-R Anxiety Subscale	.93	1.04	1.30	1.12	.72	12.90**
SCL-90-R Somatiza-tion Subscale	.97	.98	1.22	1.06	.71	10.58**
SCL-90-R PTSD Subscale	.96	1.04	1.23	1.07	.73	12.47**

* p< .0004
** p< .0001

Table 7: MANOVA for Comparison of Sexual Abuse Categories on Attributional Dimensions

symptom measure	childhood sexual abuse X (N=64)	physical abuse X (N=136)	concurrent child abuse X (N=75)	revictim-ization X (N=68)	non abused X (N=203)	F
Locus of Causality	9.07	10.31	9.42	11.32	9.98	.97
Stability	14.16	15.62	18.31	15.81	16.94	4.02*
Personal Control	7.91	10.08	8.03	10.34	9.58	1.85
External Control	12.48	11.68	11.64	12.46	11.32	.40

* P< .003

Graph 1: Abuse Category Demographics