ATTACHMENT AND MORAL ORIENTATION IN ADULT WOMEN SURVIVORS OF CHILDHOOD MALTREATMENT

BY

CINDY HANNA

A Dissertation
Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of

DOCTOR OF PHILOSOPHY

Department of Psychology
University of Manitoba
Winnipeg, Manitoba

(c) June 2002

National Library of Canada
Acquisitions and Bibliographic Services
395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque nationale du Canada
Acquisitions et services bibliographiques
395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-79849-6

Canada

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION

Attachment and Moral Orientation in Adult Women Survivors of Childhood Maltreatment

BY

Cindy Hanna

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirement of the degree

of

DOCTOR OF PHILOSOPHY

Cindy Hanna © 2002

Permission has been granted to the Library of the University of Manitoba to lend or sell copies of this thesis/practicum, to the National Library of Canada to microfilm this thesis and to lend or sell copies of the film, and to University Microfilms Inc. to publish an abstract of this thesis/practicum.

This reproduction or copy of this thesis has been made available by authority of the copyright owner solely for the purpose of private study and research, and may only be reproduced and copied as permitted by copyright laws or with express written authorization from the copyright owner.

The Road goes ever on and on
Out from the door where it began.
Now far ahead the Road has gone,
Let others follow it who can!
Let them a journey new begin,
But I at last with weary feet
Will turn towards the lighted inn,
My evening-rest and sleep to meet.

J. R. R. Tolkein, The Return of the King, (Volume 3 of the Lord of the Rings trilogy). Houghton Mifflin, 1987.

Dedication

This work is the culmination of a long journey, and some who were with me at the beginning did not live to see the end. I dedicate this work to their memories, which sustain me.

For my sister, Shirley (Hanna) Seitz; my aunt, Florence Noble; my brother, Robert Hanna; and my friend Don Noble.

Acknowledgments

Dr. Catherine Koverola (Director of Research, Center for Families, University of Maryland at Baltimore) served as my advisor during the years that it took me to complete this project. I am extremely grateful for her keen insight, support, and guidance. Dr. Linda Rhodes and Dr. Josette Durup (Department of Psychology, University of Manitoba) and Dr. Karen Grant (Department of Sociology, U of M) served as members of my committee. Throughout this process they were encouraging and provided me with excellent critical feedback. I very much appreciate the insightful comments of Dr. Judith Jordan (Co-director, Jean Baker Miller Training Institute, Wellesley Centers for Women), who served as my external examiner. I am grateful to Dr. Joe Pear for attending my defense and making it possible. Dr. Barry Ferguson, Department of History, served as the Chair for the final oral examination and helped me to feel very comfortable.

A number of people also provided me with consultation and administrative support, and without their help this would have been a much more difficult road. I appreciate the assistance of:

- Dr. Don Sharpe (Department of Psychology, University of Regina, SK) for his statistical wizardry (any errors are mine and mine alone);
- Dr. Candice Schachter (Dept. of Physical Therapy, University of Saskatchewan, Saskatoon) who consulted with me about qualitative analyses and interpretation;
- Dr. David Green (Saskatoon, SK) for editorial support and the generous loan of his laptop computer;
- my friend and neighbor Ola Ogunleye, who was so helpful with my Powerpoint presentation;
- Dr. Murray Stein, (Professor of Psychiatry, University of California at San Diego) who generously provided the honoraria for the quantitative part of the study;
- Linda Inglis (Graduate Office Assistant) and Shirley Christie (Assistant to the Department Head) of the Department of Psychology, U of M, for their emails and endless patience;
- and to Gina Neufeld and Mark from Classroom and Media Services (U of M) for your help arranging the room and equipment for my defense.

This research was supported in part by a grant from the Manitoba Health Research Council, and I very much appreciate their assistance.

The women who participated in this research project were very generous with their time and emotional energy. I remain in awe of their openness and strength, and I am very thankful to have had the opportunity to spend time with them.

Without the support of my family and friends, I could not have completed this dissertation. My mother, Marion Hanna, is a constant source of strength and inspiration to me. My brother, Brian Hanna, knows what it means to complete a dissertation and he and his partner Ricki Zinman helped me to believe in myself. My brother Ken Hanna and sister-in-law Sigrun and their children, Tara and Kenny, were unfailingly encouraging. My friends in the Saskatoon Jewish Community fed me, prodded me, and made me laugh when I most needed to. I am lucky to have friendships with Julie Mackrow (Lantzville, B.C.), Maggie Hanna (Calgary, AB), Karen White (Montreal, PQ) and many others that transcend time and distance. My friends and colleagues at the Alvin Buckwold Child Development Program, Kinsmen Children's Centre, Saskatoon have been unfailing in their support.

Abstract

Questionnaires were used to investigate adult attachment and moral orientation in 86 women: 30 child sexual abuse (CSA) survivors, 28 child physical abuse (CPA) survivors, and 28 nonabused (NA) women. Attachment was measured using the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) and the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994). The CSA and CPA groups were rated significantly higher on insecure attachment (in particular fearful attachment) and significantly lower on secure attachment than the NA group. Results support the findings of previous research indicating that CSA is associated with insecure attachment in adulthood, and further suggest that CPA is associated with insecure attachment. Interviews conducted with 23 women were analyzed using a thematic qualitative approach. Results suggest that most women believed that their attachment styles had developed in childhood as a result of their family life. Many CSA and CPA women attributed the development of their insecure attachment styles to abuse. Many NA women attributed the development of their secure attachment to a warm, supportive upbringing that provided them with a strong sense of self. Several women described changes in their attachment styles over the years. Some abused women were able to achieve healthy intimate relationships, and credited supportive partners, friends, and/or therapists. Results point to the importance of adressing attachment issues of CSA and CPA survivors in therapy.

Kohlberg's (1969, 1981) theory of moral development is justice or rule-based. Gilligan (1982) proposed that moral development includes care-oriented reasoning, associated with attachment to primary caregivers. It was hypothesized that abuse may affect the development of both orientations. This was investigated with interviews and The Moral Orientation Scale Using Childhood Dilemmas (MOS; Yacker & Weinberg, 1990). Results indicate no significant difference in response on the MOS according to attachment style or abuse group. In interviews, most women used care-oriented reasoning in deciding what to do in real-life moral dilemmas, and included themselves in moral decision making.

CONTENTS

List of Appendices

List of Tables

List of Tables, Cont'd

List of Figures

1. INTRODUCTION

Child sexual and physical abuse are associated with a wide range of negative outcomes, both in childhood and later in adult life (Briere, 1989; Briere & Runtz, 1988; Browne & Finkelhor, 1986; Cicchetti, 1987; Finkelhor, 1990; Kendall-Tackett, Williams, & Finkelhor, 1993; McLaren, 1989). These outcomes are commonly referred to in the literature as "effects", but are more accurately described as correlations between abuse and such variables as self-esteem, symptomatology, and interpersonal functioning. Attachment theory provides a useful framework for understanding the development of these outcomes. Both theory and research suggest that child maltreatment may have a negative impact on the child's capacity to form attachments to significant others. Although research supports an association between child sexual abuse and insecure attachment in adulthood, there is as yet, no published research on the association between child physical abuse and adult attachment.

According to Gilligan's moral orientation theory (Gilligan, 1982), attachment may act as a mediator of moral development. Historically, theories of the development of morality have focused primarily on a justice or rule-based orientation (e.g. Kohlberg, 1969, 1981). Gilligan proposes that moral development embodies two orientations - one of justice and one of care (Gilligan, 1982, 1987; Gilligan & Attanucci, 1988; Gilligan & Wiggins, 1987). According

to Gilligan, the child's moral sense develops not only through the experience of inequality (which highlights concerns of justice), but also in the context of attachment to primary caregivers (which highlights concerns of care).

In theory, the experience of child sexual or physical abuse may impact moral development both in terms of justice and of care. Gilligan (1982) proposes that the experience of attachment profoundly affects both the child's understanding of how one should act toward other people and the child's knowledge of human feelings. For example, many survivors of childhood abuse report chaotic family environments characterised by the capricious enforcement of rules (Herman, 1992); this may affect the development of the justice orientation. Further, child physical abuse and neglect has been demonstrated to be associated with disruptions in primary attachment relationships. Gilligan proposes that the experience of attachment profoundly affects both the child's understanding of how one should act toward other people and the child's knowledge of human feelings. Therefore, disrupted attachments associated with child abuse may have a negative impact on the development of the care orientation.

The tasks involved in normative development are outlined briefly in order to provide a context for the impact of child abuse on attachment and moral orientation. Attachment theory as it pertains to infants, children, and adults is

reviewed. The justice and care moral orientations are described and critiqued. The associations between child sexual and physical abuse, attachment, and moral orientation are delineated. Clinical and research evidence supporting the deleterious effects of child abuse on attachment and moral orientation are presented.

2. LITERATURE REVIEW

A Developmental Perspective

Cicchetti (1987) has highlighted the importance of viewing the effects of child maltreatment in a developmental context. Research in the area of child development indicates that infants are part of a complex system of social interaction from their earliest months (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). For example, as early as two months of age infants can distinguish a voice directed at them from one talking to someone else (Trevarthen, 1977). By nine months, infants can accurately perceive discrepancies between their own emotional states and those reflected by someone else's face (Stern, 1985). Between the ages of six and 12 months the infant's fundamental task is the development of a secure attachment relationship to the primary caretaker (Bowlby, 1969/1982, 1973, 1979, 1980; Sroufe, 1979; Sroufe & Rutter, 1984).

With the advent of increased cognitive and motor development between 12 and 36 months of age, the infant begins to develop an autonomous self (Sroufe, 1979). Self-recognition emerges; by about 18 months, most toddlers show evidence of being able to recognise their mirror images (Lewis & Brooks-Gunn, 1979). Socially significant emotions such as pride, shame, and guilt begin to emerge between 24 and 30 months (Lewis, 1990, 1992). During this time children begin to realise that their actions have an impact on others; this is

indicated by the emergence of empathic acts (Zahn-Waxler, Radke-Yarrow, & King, 1979). In childhood, the developmental tasks involve establishing friendships outside the family and developing a sense of self-competence in the social world. The developmental tasks of adolescence include integrating aspects of self into a more consolidated whole (Damon & Hart, 1982) and developing a sexual identity. The outcomes of child maltreatment may vary depending on the child's developmental level (e.g. Crittenden & Ainsworth, 1989). Thus, it is important to consider not only the effects of child maltreatment on the child's current functioning, but also its effects on future development.

Overview of Attachment Theory

Attachment theory as conceptualised by Bowlby (1969/1982, 1973, 1979, 1980) concerns close affectional bonds throughout the lifespan. Bowlby (1979) stated:

> attachment behaviour is conceived as any form of behaviour that results in a person attempting or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser. Although it is most frequently and intensely displayed by infants and young children, it continues to be manifested throughout life, especially when distressed, ill, or afraid. (p. 129)

According to attachment theory, stability of attachment patterns is maintained through processing information that confirms internal models of self and others (e.g. Main, Kaplan, & Cassidy, 1985). These internal working models of

attachment are believed to include both cognitive and affective components; they "consist of accumulated knowledge about the self, attachment figures, and attachment relationships" (Rothbard & Shaver, p. 33). The association between self-concept and attachment is thought to be reciprocal; the quality of attachments influences self-concepts as well as expectations and beliefs about future relationships (Goldberg, 1991).

Attachment - State or Trait?

There is considerable debate in the literature about whether attachment is a state or trait variable (Sroufe & Waters, 1977). Proponents of the state position view attachment behaviour as "a universal emotional reaction to separations and losses" (Berman & Sperling, 1994, p. 11). Conversely, the trait position emphasises "stable individual differences in emotional experience" (Berman & Sperling, p. 11). There is some research support for the stability of attachment patterns through infancy; concordance rates in these studies varied from 60% to 77% (Bolen, 2000). Further, several longitudinal studies have established the concordance of attachment patterns from infancy through adolescence; rates vary from 70% to 77% (Bolen, 2000).

The controversy between the state and trait views of attachment has generated a concept of attachment as an organisational construct (Ainsworth, 1972; Bowlby, 1969/1982; Sroufe & Waters, 1977; Yarrow, 1972). From this

perspective, attachment is neither a static trait nor a constantly changing state. Rather, "attachment refers to an affective tie between infant and caregiver and to a behavioral system, flexibly operating in terms of set goals, mediated by feeling, and in interaction with other behavioral systems" (Sroufe & Waters, p. 1185). Internal working models of attachment are thought to be able to change in response to new information; therefore, it makes sense that they can be modified by life experiences.

Infant and Child Attachment

Attachment in infancy and childhood pertains to how infants and children organize their behaviour to maintain proximity to a particular caregiver (e.g., Ainsworth, 1982). Ainsworth's development of the Strange Situation paradigm (Ainsworth, Blehar, Waters, & Wall, 1978) enabled researchers to investigate empirically attachment in infants. This laboratory based procedure involves observing the infant, the caregiver, and a friendly but unfamiliar adult in a series of semi-structured interactions in a laboratory playroom (Goldberg, 1991). The episodes involve a series of separations and reunions "which serve to activate the child's attachment behavioral system" (Carlson, Cicchetti, Barnett, & Braunwald, 1989, p. 525). The sessions are videotaped to facilitate coding of the infant's behaviour toward the caregiver, including "seeking contact, maintaining contact, distance interaction, avoidance, and resistance to contact" (Goldberg, 1991, p.

394).

Early research with this paradigm (Ainsworth et al., 1978; Sroufe & Waters, 1977) yielded three attachment classifications: Type A (anxious/avoidant), B (secure), and C (anxious/ambivalent). The securely attached infant often engages in affective displays with the caregiver and is able to seek comfort and be calmed by the caregiver when upset. Observational studies by Ainsworth et al. noted that secure infants tend to have primary caregivers who are usually sensitive and responsive to their infants' signals. The caregiver is believed to act as a secure base for such infants, enabling them to explore the environment. Through their interactions with primary caregivers, securely attached infants have built up a working model of caregivers as responsive and accessible (Ainsworth, 1985).

Infants classified as anxious/avoidant display minimal affect and distress when the caregiver is present, and tend to avoid the caregiver under conditions that usually evoke interaction and proximity seeking (Ainsworth et al., 1978; Sroufe & Waters, 1977). Their avoidance is understood as a defensive manoeuvre; it results from an intense approach-avoidance conflict (Ainsworth, 1985). Observational studies indicate that caregivers of anxious/avoidant infants tend to avoid close bodily contact and rebuff their infants when they seek proximity (Ainsworth et al., 1978). Ainsworth has posited that as a result, such

infants have built up a working model of their caregivers as rejecting.

Infants with anxious/ambivalent attachment tend to alternate between seeking and resisting proximity; they may appear passive and inactive. When in distress, they are unable to be comforted and calmed by the caregiver (Carlson et al., 1989). Although these infants are distressed by separation episodes, upon reunion they simultaneously desire contact and are angry with the caregiver. Caregivers of anxious/ambivalent infants respond inconsistently to their infants; they alternate between being unresponsive and intrusive (Ainsworth et al., 1978). Ainsworth (1985) has theorised that anxious/ambivalent infants have come to expect their caregivers to be inconsistently accessible and responsive.

The proportion of attachment styles among infants in the general population has been demonstrated to range from 57% to 73% for secure attachment, 15% to 32% for anxious/avoidant attachment, and 4% to 22% for anxious/ambivalent attachment (Spieker & Booth, 1988). These results have received support from a meta-analysis of 39 studies that showed almost exactly the same distribution, with some cultural variations (Van Ijzendoorn & Kroonenberg, 1988). Researchers using the Strange Situation noted that 10% to 15% of infants were unclassifiable, and that the classifications of others did not appear to correspond to home observations (e.g. Crittenden, 1985, 1988; Lyons-Ruth, Connell, Zoll, & Stahl, 1987; Main & Weston, 1981; Radke-Yarrow,

Cummings, Kuczynski, & Chapman, 1985). Consequently a fourth attachment style has been identified, labelled Type D (disorganized/disoriented) by Main and colleagues (e.g., Main & Hesse, 1990; Main & Solomon, 1990; Main et al., 1985) and A/C (avoidant/ambivalent) by Crittenden. Type D attachment is assigned along with a best-fitting alternate attachment category.

Infants labelled Type D behave in a contradictory fashion in the Strange Situation. They may cry for their caregivers during separation but move away from them upon reunion, or approach their caregivers and then fall to the floor or suddenly freeze in mid-approach (Rothbard & Shaver, 1994). Such infants appear to lack a consistent way of coping with separations and reunions (Goldberg, 1991). Their unusual behaviours have been "interpreted to reflect confusion or fear of the caregiver" (Goldberg, p. 396).

Adult Attachment

In contrast to the more behaviourally based work on infant and child attachment, the field of adult attachment has been defined either in terms of internal working models that govern interpersonal behaviour or in terms of particular strategies that individuals use to feel secure (Hazan & Shaver, 1994). Adult attachment also differs from infant and child attachment in that adult relationships are typically reciprocal in nature (Hazan & Shaver). Assessments of adult attachment do not attempt to determine objectively the quality of close

relationships; rather, they appraise the individual's current working model of attachment (Goldberg, 1991).

The study of adult attachment has generated numerous models and approaches to measurement. Three models of adult attachment will be presented. The first is based on studies of attachment between parents and their children. The next two are based on studies of attachment in close relationships.

Parent-Child Attachment

Several studies of parent-child attachment have been conducted using the Adult Attachment Interview ([AAI]; George, Kaplan, & Main, 1987; cited in Griffin & Bartholomew, 1994a). The AAI is a semi-structured interview that explores adults' conceptions of their childhood attachments. The interviews are transcribed and rated for factors related to security and insecurity of attachment. The scoring of the interview focuses "on the manner in which one makes sense of, can reflect on, and has come to terms with early attachment experiences [rather] than merely on the occurrence of problematic experiences" (Fishler, Sperling, & Carr, 1990, p. 510).

Three primary patterns of adult attachment are identified with the AAI: secure, detached, and enmeshed. These patterns parallel those of secure, avoidant, and resistant for childhood attachment. Adults who are rated secure not only value attachment in the abstract, but also consider attachment an important

influence on their personalities. They find it easy to remember early relationships and do not speak of them in an idealised manner.

In contrast, detached adults tend to deny the importance of attachment relationships in their lives. They find it difficult to remember early experiences, and are more likely to generalise and idealise their memories (Fishler et al., 1990). Fishler and colleagues note that adults characterised as enmeshed appear to feel dependent on their own parents and continue to actively try to please them. Like members of the detached group, dismissing adults have difficulty assimilating their early memories; their memories tend to be diffuse and idealised.

In addition, the AAI yields an unresolved category that may parallel the disoriented/disorganized attachment category identified by Main and Solomon (1990). The unresolved category is assigned to people who have unresolved mourning due to the death of someone close, abuse experiences, or recent traumatic experiences. This attachment category is analogous to Type D attachment in infants in that it reflects disorganisation and disorientation in the individual's working model of attachment. Like the Type D category, unresolved attachment is assigned in conjunction with a best-fitting alternative adult category.

Bakermans-Kranenburg and van Ijzendoorn (1993) have investigated the psychometric properties of the AAI. They report inter-rater reliabilities ranging

from 75% (kappa = .66) for the four-category classification, and 81% (kappa = .72) without the unresolved category. Test-retest reliability over a 2-month interval for the three-category classification was 78% (kappa = .63). The AAI classifications were found to be independent of autobiographical memory unrelated to attachment, verbal and performance intelligence, and social desirability.

Research with the AAI offers some support for the intergenerational transmission of attachment patterns. Early research demonstrated a strong relationship between mother's attachment patterns and those of their infants ($r = .62$, $p<.001$); the relationship between attachment patterns of infants and fathers is less strong ($r = .37$, $p<.05$; Main et al., 1985). In a recent review of research with nonclinical populations, Van Ijzendoorn (1992) found that infant attachment to mothers could be predicted on the basis of mother's internal working model of attachment in 80% of cases.

Attachment in Close Relationships

Two models of adult attachment in close relationships will be considered: a three-category typology proposed by Hazan and Shaver (1987, 1990, 1994), and a four-category typology proposed by Bartholomew (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994a, 1994b).

Hazan and Shaver's Three-Category Model. Hazan and Shaver (1987) have conceptualised romantic love as an attachment process; they argue that romantic love is similar to child-caretaker attachment in some important respects. Their self-report procedure asks adults to rate themselves on a number of Likert-scale items with reference to their most important romantic relationship, and to answer a number of questions regarding relationship and attachment histories. Finally, adults were presented with descriptions of secure, avoidant, or ambivalent types and asked to classify themselves into the most appropriate category. These categories were designed to correspond to those derived by Ainsworth (1985).

Results of this study indicated that "attachment style is related in theoretically meaningful ways to mental models of self and social relationships and to relationship experiences with parents" (Hazan & Shaver, 1987, p. 511). The proportions of the three attachment types were similar to those obtained in infant research (i.e., secure= 56%, avoidant= 25%, anxious-ambivalent= 19%). Further, results indicated that compared with the two insecure groups, the secure group had longer lasting romantic relationships, reported more positive experiences and beliefs about romantic relationships, and had more positive perceptions about their childhood relationships with parents.

Hazan and Shaver (1987) found no significant differences between attachment styles on the likelihood or duration of separation from parents.

Contrary to this finding, in Feeney and Noller's (1990) study of 374 undergraduate students, participants who classified themselves as avoidant were significantly more likely to report being separated from their mothers in childhood.

There are several limitations to Hazan and Shaver's (1987) discrete measure (Collins & Read, 1990; Simpson, 1990). First, each description includes statements about more than one facet of relationships (i.e., the "avoidant" style contains references to being uncomfortable with closeness and having difficulty depending on others). Second, this method does not enable the researcher to assess the extent to which a style typifies an individual. Simpson notes that consequently, it is not possible to assess the variability associated with individual differences within each category. Third, this measure asks participants to classify themselves on only one of three mutually exclusive styles of attachment, despite the fact that the attachment styles of some adults may best be represented by a blend of styles. Fourth, there are limits to the types of statistical analysis that can be conducted using this method. Finally, Simpson points out that this method does not enable the researcher to determine the internal reliability of each style.

In an attempt to address some of these limitations, Collins and Read (1990) developed an 18-item scale to measure adult attachment styles based on Hazan and Shaver's (1987) categorical measure. Participants are asked to rate

each item on a five-point Likert scale. Factor analysis of the results yielded three underlying dimensions. These dimensions were termed: Close (reflecting the individual's level of comfort with closeness), Depend (denoting a willingness to depend on others), and Anxiety (indicating anxiety or fear of abandonment and/or unlovability). Internal consistency of the Close, Depend, and Anxiety dimension items as measured by Cronbach's alpha were found to be .69, .75, and .72, respectively. Test-retest reliability over a two-month interval for the Close, Depend, and Anxiety dimensions were .68, .71, and .52, respectively.

Simpson has also developed a continuous self-report measure using Hazan and Shaver's (1987) categorical measure (Simpson, 1990; Simpson, Rholes, & Nelligan, 1992). This measure consists of 13 items, each rated on a seven-point Likert scale. Internal consistency for the secure, avoidant, and anxious attachment indices as measured by Cronbach's alpha were .51, .79, and .59, respectively. No test-retest data are reported. Factor analysis performed on the items indicated two underlying dimensions: secure-avoidant and anxious-nonanxious. Simpson presents correlational evidence indicating that securely attached individuals had more interdependent relationships, and a higher degree of commitment, trust, and satisfaction than insecurely attached individuals. Further, less securely attached individuals reported experiencing fewer positive and more negative emotions in their relationships.

Bartholomew's Four-Category Model. In an effort to anchor the measurement of attachment more closely to its theoretical foundations, Bartholomew developed a four-category model of adult attachment styles (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994a, 1994b). The model was derived from Bowlby's (1973) attachment theory, with particular reference to internal working models of attachment.

Underlying the model are two dimensions consisting of the person's conception of the self and the person's conception of hypothetical others (Griffin & Bartholomew, 1994a). According to Griffin and Bartholomew,

> The positivity of the self model indicates the degree to which individuals have internalized a sense of their own self-worth and therefore expect others to respond to them positively; thus, the self model is associated with the degree of anxiety and dependency experienced in close relationships. The positivity of the other model indicates the degree to which others are generally expected to be available and supportive; thus, the other model is associated with the tendency to seek out or avoid closeness in relationships. (p. 431)

As shown in Figure 1, the four attachment patterns are defined in terms of the convergence of the two dimensions; these are: Secure, Preoccupied, Dismissing, and Fearful (Griffin & Bartholomew, 1994a). Each pattern is expressed in terms of "a theoretical ideal or prototype with which individuals may correspond to varying degrees" (Griffin & Bartholomew, 1994b, p. 25). Research indicates that most individuals have elements of two or more attachment patterns; it is rare for one pattern to exemplify an individual (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994b). It is also possible to express the

attachment patterns categorically. Although a great deal of individual variability is lost using this method of measurement, Bartholomew and Horowitz found that the two measurement approaches showed nearly identical patterns of results across dependent measures.

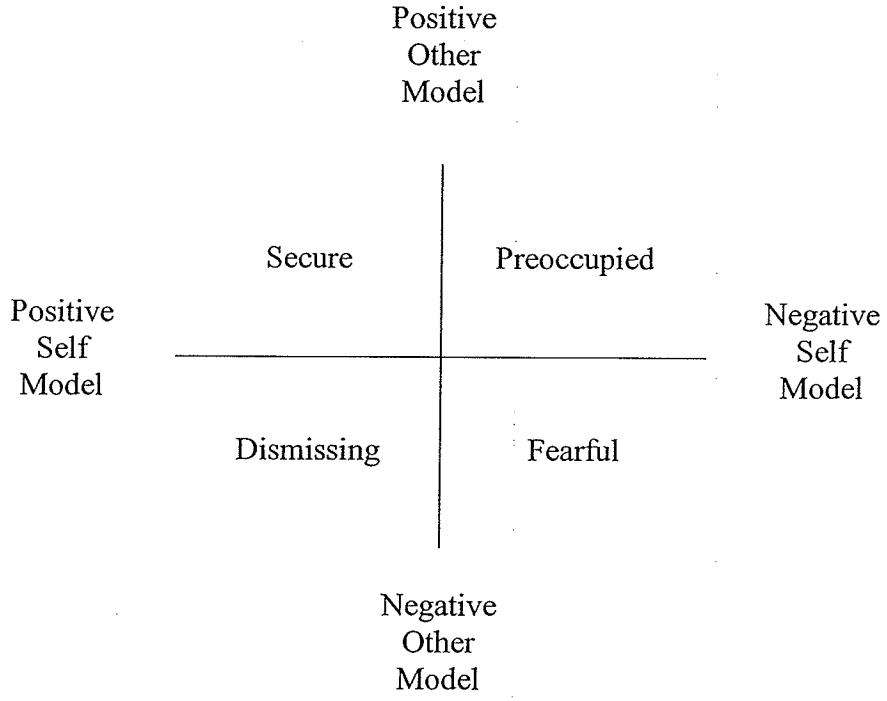


Figure 1: Bartholomew's four-category model of adult attachment, showing combinations of models of self and other. Note. From: D. Griffin and K. Bartholomew (1994), *Journal of Personality and Social Psychology, 67*(3), p. 2. Copyright 1994 by the American Psychological Association Inc. Adapted with permission.

The person in the Secure category has a sense of self-worth or lovability as well as an expectation that other people are usually welcoming and responsive

(Bartholomew & Horowitz, 1991). In contrast, the Preoccupied person has a sense of unworthiness or unlovability combined with a positive view of others. Bartholomew and Horowitz note that "this combination of characteristics would lead the person to strive for self-acceptance by gaining the acceptance of valued others" (p. 227). The Preoccupied pattern is conceptually similar to Hazan and Shaver's (1987) ambivalent group and to Main's enmeshed or preoccupied with attachment pattern (Main et al., 1985).

People who correspond to the Dismissing pattern of attachment have a strong sense of self-worth or lovability combined with negative expectations of others. These people tend to "protect themselves against disappointment by avoiding close relationships and maintaining a sense of independence and invulnerability" (Bartholomew & Horowitz, 1991, p.227). This pattern corresponds conceptually to Main's detached or dismissing of attachment style (Main et al., 1985). The Fearful pattern of attachment is found in those who have a sense of unworthiness or unlovability combined with negative expectations of others. They expect people to be untrustworthy and rejecting; they cope with their fear of rejection by avoiding close involvement with others (Bartholomew & Horowitz). Bartholomew and Horowitz posit that this pattern may correspond in part to the avoidant style described by Hazan and Shaver (1987) and to disorganized attachment as described by Main and Solomon (1990).

Initial research on this model used interview and questionnaire measures to assess attachment styles in a sample of 77 male and female undergraduate students (Bartholomew & Horowitz, 1991). The following proportions of attachment styles were obtained: 47% secure, 18% dismissing, 14% preoccupied, and 21% fearful. In a subsequent study of 144 young adults, Scharfe and Bartholomew (1994) report the following proportions: 68% secure, 8% dismissing, 13% preoccupied, and 11% fearful.

There is evidence of good test-retest reliability of the attachment styles over an eight-month interval (Scharfe & Bartholomew, 1994). As assessed by interviews, 75% of females (kappa = .60) and 80% of males (kappa = .69) were classified in the same attachment style at both testing periods. As assessed by self-report, 63% of females (kappa = .42) and 56% of males (kappa = .26) demonstrated the same attachment pattern. Interview ratings were consistently more stable than those obtained by self-report. As would be expected, Scharfe and Bartholomew report that categories with higher base rates showed greater stability over time than those with lower base rates.

Further, Bartholomew and Horowitz (1991) present evidence on convergent and discriminant validity of underlying dimensions. The two groups postulated as having a positive self-model differed significantly on measures of self-concept from the two groups postulated as having a negative self-model.

Bartholomew and Horowitz state that "the two groups theoretically described as having a positive model of others differed on a measure of sociability from the two groups described as having a negative model of others" (p. 234). Each insecure attachment style was found to be associated with a unique pattern of interpersonal problems. Fearful participants were most likely to describe problems with being overly passive. Dismissing participants experienced problems with interpersonal warmth. Preoccupied participants tended to attempt to maintain contact with others through a controlling interpersonal style.

Bartholomew's four-category model of attachment offers a distinct advantage over the three-category models (Bartholomew & Horowitz, 1991). Bartholomew's model makes a distinction between avoidant adults who deny their need for attachment (Dismissing) and those who admit to such a need (Fearful). Bartholomew and Horowitz point to the danger of subsuming all avoidant adults in a single category. They state that

> Whereas the interview method identified avoidant adults as people who denied experiencing subjective distress and downplayed the importance of attachment needs, the self-report method identified people who reported feeling subjective distress and discomfort when they become close to others. Thus, a single avoidant-detached category may obscure conceptually separable patterns of avoidance in adulthood. (p. 227)

Brennan, Shaver, and Tobey (1991) compared Bartholomew's four-category model with Hazan & Shaver's (1987) three-category model in a study of 840 male

and female undergraduate students. Their results provide support for Bartholomew's distinction between Dismissing and Fearful styles of attachment. Individuals categorised as fearful by Bartholomew's model tended to endorse both the avoidant and ambivalent options on Hazan and Shaver's measure. Further, "the same two dimensions were found to underlie both typologies" (Brennan et al., p. 451).

There is some indication that self-report attachment ratings may be confounded with relationship functioning (e.g. Senchak & Leonard, 1992). Research indicates that "subjects in steady romantic relationships are disproportionately likely to categorize themselves as secure on self-report attachment measures" (Bartholomew, 1994, p. 25). This bias is not apparent in interview studies (e.g. Fonagy, Steele, & Steele, 1991). In a study of attachment in established couples, Bartholomew and Scharfe (1993; cited in Bartholomew, 1994) found that over 80% of participants rated themselves as primarily secure on self-report, whereas only approximately 50% were rated secure on the basis of a semi-structured interview.

Many researchers are of the opinion that interviews are the most sensitive means of measuring attachment (e.g. Griffin & Bartholomew, 1994b; Main et al., 1985); nevertheless, interviews have the disadvantage of being extremely time-consuming to conduct, code, and analyse. Further, extensive training of

interviewers and raters is necessary to obtain adequate reliability and validity. For the present study, some questions were added to the moral dilemma interview in order to explore the relationship between attachment development and abuse. Questionnaire measures of attachment were also employed in the present study because they offer ease of administration and coding with adequate reliability and validity. The primary disadvantage of these measures is participants' tendency to bias their responses. The present study attempted to account for such biases by administering a measure of social desirability.

Critique of Attachment Theory

One of the primary criticisms of attachment theory is that it is culturally specific. There has been relatively little cross-cultural attachment research; a review by van Ijzendoorn and Sagi (1999) cites only 14 studies. Rothbaum, Weisz, Pott, Miyake, & Morelli (2000) identified three core hypotheses central to attachment theory that they deem to be particularly problematic in cross-cultural research. They involve maternal sensitivity, infant competence, and the concept of the secure base.

Rothbaum et al. (2000) have raised concerns about cross-cultural differences in the association between maternal sensitivity and security of attachment. This refers to the primary caregiver accurately interpreting and appropriately responding to the infant's distress signals (Ainsworth et al., 1978).

Central to the definition of sensitivity is the belief that "it is a good thing for a baby to gain some feeling of efficacy" (Ainsworth, 1976, pp. 3-4). Cultural variations in the way maternal sensitivity is manifested have been found (Rothbaum et al., 2000; van Ijzendoorn and Sagi, 1999).

The second concern involves the prediction that securely attached children become more socially and emotionally competent than those who are insecure. Social competence includes the concepts of autonomy, independence, ability to regulate negative affect, low incidence of behaviour problems, and ability to form close, stable peer relationships (Cassidy & Shaver, 1999). Children who are insecurely attached score higher on measures of dependency, which is regarded as a failure to successfully individuate (Weinfield, Sroufe, Egeland, & Carlson, 1999). Accommodating to the needs of others and depending on them as a way of meeting one's needs is valued in some cultures. Although the appropriate expression of negative affect is encouraged in Western cultures, in Asian cultures it is considered more appropriate to suppress these feelings or to "express them indirectly to preserve social harmony" (Rothbaum et al., 2000, p. 1098).

The third concern involves the concept that infants are more likely to explore their environments from a secure base, when they feel protected and comforted (Ainsworth, 1978; Bowlby, 1982). Several studies have noted cultural differences in the extent to which exploration occurs (e.g., Bornstein, Haynes,

Pascual, Painter, & Galperin, 1999; Gaskins, 1996, cited in Rothbaum et al., 2000). The conception of what constitutes a secure base also vary across cultures, making assessment more complicated (Rothbaum et al., 2000). Finally, infants who have more experience with separation will likely respond differently to the strange situation (Eyer, 1996).

Rothbaum, Weisz, Pott, Miyake, and Morelli (2001) encouraged researchers to "identify the ways in which sensitivity, competence, and the secure base are conceptualized and manifested in different cultures" (p. 828).

A second criticism that has been leveled against attachment theory concerns biological determinism. Lamb, Thompson, Gardner, Charnov, and Estes (1984) have stated that "secure infant behavior is considered species-appropriate and the consequence of rearing by a caretaker behaving in a species-appropriate pattern" (p. 128). Most attachment research has been conducted with mothers and infants (Eyer, 1992, 1996; Field, 1996). It is only relatively recently that fathers and other attachment figures (e.g., extended family, daycare workers) have been included in attachment research. Research on attachment between mothers and infants has not only shaped attachment theory, but also public policy (Eyer, 1992, 1996). It has led to criticism of mothers working outside the home and of placing children in daycare. Eyer (1996) cautions that

Contemporary interpretations of biological bases of behavior provide the

> comfortable message that injustices and inequalities are natural and inevitable accomplices of human evolution, providing confirmation for those who find comfort in the status quo and its legitimation [sic] by science. The research on attachment serves a similar function. By interpreting it to mean that women are best suited to take care of their own children alone, it helps rationalize the lack of support for our impoverished mothers and children by suggesting that women's only necessary reward in caring for their children is satisfaction of their instinctual nature. (p. 99)

Eyer makes some valid points in her criticism of attachment theory, including cautioning researchers against making overly broad conclusions. It is also important for future research to include multiple caregivers, most particularly fathers (Field, 1996).

In summary, it is apparent from this review of the literature that there is support for the thesis that attachment patterns are formed in infancy as a result of interactions with primary caregivers. Further, there is some evidence that such patterns are enduring. Research on parent-child attachment indicates that there is considerable convergence between the attachment patterns of parents and children. Research on close relationships has found that the proportions of attachment patterns in adulthood are remarkably similar to those in infancy. The clinical and research evidence of the attachment outcomes associated with child physical and sexual abuse will now be reviewed.

Child Abuse and Attachment

Estimates of Type D or A/C attachment in nonclinical middle- to lower-class samples range from 10 to 15% (Cicchetti, 1987). The incidence of disorganised attachment among infants and children in clinical samples, however, ranges from 70% to 100% (Carlson et al., 1989; Lyons-Ruth et al., 1987; Schneider-Rosen, Braunwald, Carlson, & Cicchetti, 1985). Research indicates that this attachment style is associated with caregivers who are physically abusive, extremely neglectful, depressed, or otherwise emotionally unavailable to their infants. George (1996) describes these caregivers as "helpless" and as feeling out of control. Disorganised/disoriented attachment has been shown to be associated with failure to thrive (Ward, Kessler, & Altman, 1993) and with maternal alcohol consumption (O'Connor, Sigman, & Brill, 1987). Maternal depression has been demonstrated to be associated with both Type D attachment (Lyons-Ruth, Connell, & Grunebaum, 1990) and Type A/C attachment (Radke-Yarrow et al., 1985). Main and Hesse (1990) have found an association between Type D infants and their mothers' unresolved grief about attachment-related traumas and losses.

To date, there is no published research investigating the relationship between child sexual abuse and attachment in childhood. There is, however, a substantial amount of research indicating that child physical abuse is associated with insecure attachment in childhood. Further, research suggests associations

between child maltreatment and later socioemotional problems in childhood, including low self-esteem, decreased empathy, increased aggression, antisocial behaviour, and impaired peer relationships (see Crouch & Milner, 1993; Salzinger, Feldman, Hammer, & Rosario, 1991; and Kendall-Tackett, 2001 for reviews). The findings from these areas of research are briefly reviewed.

Child Physical Abuse

A longitudinal study conducted by Erickson, Egeland, and Pianta (1989) provides a profile of the socioemotional development of physically abused infants. This research found significantly higher rates of insecure attachment at 18 months for abused infants in comparison to nonabused infants. At 24 months, the abused children demonstrated more anger, noncompliance, and frustration with their mothers than nonabused children. At 42 months, abused children were rated more hyperactive and distractible, and lower in self-esteem, self-control, and assertiveness than nonabused children. Further, they demonstrated a lack of affection and avoidance of their mothers. By 54 months, these children continued to lack self-control, showed more negative affect, and were more impulsive and dependent than their nonabused peers. There is also evidence to suggest that avoidant attachment persists beyond infancy in physically abused children. Finzi, Cohen, Sapir, and Weizman (2000) found that their sample of six to 12 year old physically abused children had predominantly avoidant attachment styles.

Research suggests that the disorganised/disoriented attachment behaviour observed in infancy may evolve into controlling behaviour later in childhood (Main & Cassidy, 1988). Such children behave in either a punitive or a caregiving manner toward their parents, "controlling the behaviour of the parent in a manner that could be described as a partial reversal of roles" (Main & Cassidy, p. 423). Main and Cassidy suggest that these children may have developed a controlling stance toward their parents as a way of organising the attachment relationship.

This finding is consistent with clinical reports of abused children becoming "parentified" (e.g. James, 1989); the relationships of such children with their parents are characterised by role reversal (DeLozier, 1982; Polansky, 1981). Parentified children report feeling responsible for their parents' welfare, and may see their parents as vulnerable and in need of protection. According to attachment theory, this pattern may develop because children must work harder to maintain emotional connections to unresponsive parents. Bowlby (1980) theorised that inadequate care in early childhood results in "compulsive caretaking", a syndrome in which the child is excessively concerned for the welfare of significant others. Retrospective research conducted by DeLozier (1982) indicates that women who were maltreated in childhood are significantly more likely to have felt responsible for their parents than nonmaltreated women.

Self-Esteem

There is a body of research indicating that physically abused children have more negative images of themselves than nonabused children (e.g. Kazdin, Moser, Colbus, & Bell, 1985). The empirical evidence of low self-esteem in sexually abused children is equivocal, perhaps due to the way that researchers have attempted to measure this construct (Browne & Finkelor, 1986; Damon & Hart, 1982). There is also some research evidence that the capacity for self-reflection is more well-developed in children who have a history of secure attachments (Main, 1991). Main demonstrated secure attachment at 12 months to be associated with spontaneous self-reflective remarks and spontaneous monitoring of thinking and memory in six-year-old children. Further, research with adult female survivors of child sexual abuse provides support for an association between child sexual abuse and impairment in self-concept, for example, low self-esteem (Bagley & Ramsay, 1986; Courtois, 1979; Herman, 1981); feelings of isolation (Briere & Runtz, 1986; Courtois; Herman); and deliberate attempts at self-harm (Bagley & Ramsay; Briere & Runtz; Bryer, Nelson, J. B. Miller, & Krol, 1987; Herman).

Empathy

The association between child physical abuse and lack of empathy is well documented (e.g. Lamphear, 1985). Main and George (1985) found that the

distress of peers evoked markedly less concern from abused toddlers than from their nonabused agemates. Both groups were from disadvantaged families. Nonabused toddlers responded to distress with simple interest or with concern, empathy, or sadness. In contrast, although the abused toddlers noticed that their peers were distressed, none responded with empathy or sadness. Rather, the abused toddlers often reacted to an agemate's distress with disturbing behaviour, for example, physical attacks, fear, or anger. Three of the abused toddlers alternated between trying to comfort and attacking their distressed peers. The latter behaviour is reminiscent of the behaviour exhibited by infants with disorganized/disoriented attachment in the Strange Situation.

Straker and Jacobson (1981) compared a group of physically abused 5- to 10-year-old children with a group of nonabused children on measures of empathy, fantasy aggression, and emotional maladjustment. Children in the physical abuse group were significantly less empathic and more emotionally maladjusted than the nonabused children. There was no difference between the two groups on the measure of fantasy aggression. Barahal, Waterman, and Martin (1981) found that 6- to 8-year-old physically abused children were less able to identify appropriate feelings in others than nonabused children. A meta-analysis of studies on empathy and aggression conducted by P. A. Miller and Eisenberg (1988) indicated that empathic responding is negatively related to aggression and

antisocial behaviour. This finding provides support for the hypothesis that empathic reactions may play an important role in reducing or inhibiting aggressive behaviour (e.g. Feshbach & Feshbach, 1982).

Aggression

Research also suggests that children who have been sexually or physically abused and/or neglected are more aggressive than nonabused children. Type D attachment in infants has been demonstrated to be associated with deviant levels of hostile behaviour toward peers at age five (Lyons-Ruth, Alpern, & Repacholi, 1993). All three types of child maltreatment are associated with higher levels of aggression toward peers (Burgess & Conger, 1978; George & Main 1979; Lamphear, 1985; Reidy, 1977).

Antisocial Behaviour

Child physical abuse is associated with the development of conduct disorder (Friedrich & Luecke, 1988), antisocial behaviour (Christozov & Toteva, 1989; Oliver, 1988), delinquency, criminality, and violent behaviour (Cavaiola & Schiff, 1988; Lewis, Mallouh, & Webb, 1989; Oliver, 1988; Rivera & Widom, 1992; Widom, 1989). Research indicates that experiencing physical abuse and/or neglect in childhood is one risk factor for becoming an abusive parent (Kaufman & Zigler, 1989). Luntz and Widom (1994) conducted a prospective longitudinal study to investigate whether child physical abuse and neglect are associated with

antisocial personality disorder in adulthood. Results indicated that significantly more abused than nonabused adults met the criteria for antisocial personality disorder, even when demographic factors and criminal history were controlled.

Peer Relationships

Given that maltreated children are less empathic, more aggressive, and engage in more antisocial behaviour than nonmaltreated children, it is not surprising that research indicates that they have impaired peer relationships. Physically abused toddlers have been observed to initiate fewer social interactions with peers and show less positive emotion than their nonabused agemates; these differences increase with development (Howes & Espinosa, 1985). In a review of a number of studies of the psychosocial correlates of physical maltreatment, Lamphear (1985) reported that physically abused children tend to have poorer relationships with peers and are less socially involved than nonabused children. As compared to nonabused children, physically abused children have been demonstrated to have lower peer status (Coie, Dodge, & Coppotelli, 1982; Salzinger et al., 1993) and are rated by peers as more aggressive and less cooperative by Salzinger and colleagues.

Similar findings have been noted for sexually abused children. In comparison to their nonabused peers, sexually abused children have fewer friends in childhood (Oates, Forrest, & Peacock, 1985), lack social competence, and are

more socially withdrawn (Friedrich, Urquiza, & Beilke, 1986).

Child Abuse and Adult Attachment

Although there is considerable overlap between the long-term sequelae of child physical abuse and child sexual abuse, the effects are not identical (Briere & Runtz, 1990). It is thus important to consider the differential impact of various types of abuse. There is a limited amount of published research investigating the relationship between child physical abuse and adult attachment. Gauthier, Stollak, Messe, and Aronoff (1996) studied physical abuse and emotional neglect in 512 undergraduates. They found a significant relationship between physical abuse and avoidant attachment. Emotional neglect was significantly related to general psychological problems, avoidant attachment, and resistant attachment. Emotional neglect was negatively related to secure attachment. Escudero (1997) investigated the relationship between childhood physical, sexual, and emotional abuse and adult attachment and symptomatology in 96 women. Results indicated that physical and/or emotional abuse were related to adult symptomatology, and that this relationship was mediated through attachment development. In contrast, sexual abuse was not correlated with attachment.

There is supporting evidence that child physical abuse is associated with impairment in interpersonal functioning in adulthood. Specifically, child physical abuse has been demonstrated to be associated with increased aggression in

adolescents (Zeiller, 1982), and college students (Graybill, MacKie & House, 1985). Further, such abuse is associated with later delinquency, criminality, and violent behaviour (Cavaiola & Schiff, 1988; Oliver, 1988; Rivera & Widom, 1992; Widom, 1989). A prospective longitudinal study conducted by Luntz and Widom (1994) indicated associations between child physical abuse, neglect, and antisocial personality disorder in adulthood. Research also indicates that experiencing physical abuse and/or neglect in childhood is one risk factor for becoming an abusive parent (Kaufman & Zigler, 1989). Notwithstanding, it must be emphasised that not all people who were physically abused as children have impaired interpersonal functioning as adults.

It is well documented that women who were sexually abused in childhood experience impairment in interpersonal functioning as adults. Specifically, women with a history of incest report more difficulty trusting others and experiencing psychological intimacy than nonabused women (Briere & Runtz, 1988; Courtois, 1979; Herman, 1981). They also feel less confident, less organized, and less in control as parents in comparison with nonabused women (Cole & Woolger, 1989). Further, women with histories of child sexual abuse report higher rates of becoming involved in abusive relationships in adulthood (e.g. Browne & Finkelhor, 1986; Koverola, Proulx, Battle, & Hanna, 1996; Kutil, 1999; West, Williams, & Siegel, 2000).

Research on personality disorders indicates that a disproportionate number of individuals diagnosed with these disorders suffered severe physical and/or sexual abuse in childhood (Brown & Anderson, 1991; Herman, Perry, & van der Kolk, 1989; Ogata, Silk, Goodrich, Lohr, Westen, & Hill, 1990; Westen, Ludolph, Misle, Ruffins, & Block, 1990). In particular, severe childhood abuse may be associated with the development of borderline personality disorder (BPD). One of the core features of BPD is "a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation" (American Psychiatric Association [APA], 1994, p. 654). People with BPD have "chronic feelings of emptiness" and often engage in "frantic efforts to avoid real or imagined abandonment" (APA, p. 1990). Further, BPD is associated with the lack of development of a stable sense of self.

Some research has been conducted on adult attachment patterns of women who experienced sexual abuse as children (Alexander, 1993; Roche, 1994; Roche, Runtz, & Hunter, 1999). Alexander (1993) used the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) to study attachment in 112 female sexual abuse survivors of intrafamilial child sexual abuse. Alexander did not collect a comparison sample; nevertheless, results indicated that the attachment patterns of the sexually abused sample differed significantly from that of the normative sample collected by Bartholomew and Horowitz (1991). The mean score on each

of the RQ scales was as follows: Secure = 2.9 (*SD* = 1.84), Preoccupied = 3.3 (*SD* = 1.94), Dismissing = 3.7 (*SD* = 2.06), and Fearful = 5.5 (*SD* = 1.56). When participants were asked to choose one category which best categorised their attachment style, 14% of the participants classified themselves as Secure, 13% as Preoccupied, 16% as Dismissing, and 58% as Fearful. In contrast, participants in the normative sample were categorised as 47% Secure, 14% Preoccupied, 18% Dismissing, and 21% Fearful. These results suggest that the experience of incest is associated with a higher occurrence of insecure attachment (particularly of Fearful attachment) in adulthood.

Further, using regression analysis Alexander (1993) found attachment styles to be significant predictors of personality disorders in this sample. In particular, Preoccupied attachment was related to dependent, self-defeating, and borderline personality disorders; Fearful attachment was related to avoidant and self-defeating personality disorders, and individuals who rated higher on Dismissing attachment denied feelings of dependency.

Roche used the RQ to investigate the relationships between child sexual abuse, adult attachment, and current psychological functioning in a sample of 307 female undergraduate university students (Roche, 1994; Roche, Runtz, & Hunter, 1999). Of these women, 31 (10.1 %) reported intrafamilial child sexual abuse, 54 (17.5 %) reported extrafamilial child sexual abuse, and 222 (72.3 %) reported no

history of sexual abuse. Results indicated that the intrafamilial abuse group was less secure, more fearful, and less dismissing than the extrafamilial abuse group. Further, participants in both the intrafamilial and extrafamilial abuse groups rated themselves lower on Secure attachment and higher on Fearful attachment than the nonabused participants. The nonabused group had a significantly more positive model-of-self and model-of-other than the combined abuse groups. Intrafamilial abuse was associated with a less positive model-of-self than extrafamilial abuse. Analyses also suggest that attachment style acts as a mediator of the effects of child sexual abuse on current psychological functioning.

Research suggests that outcomes differ for survivors of intrafamilial vs. extrafamilial abuse (e.g., Alexander,1993; Banyard & Williams, 1996; Roche, 1994; Roche, Runtz, & Hunter, 1999). Partly for this reason, participants in the present study were limited to those who had experienced intrafamilial abuse.

Overview of Moral Orientation Theory

The justice and care moral orientations are briefly reviewed in order to provide a context for discussing the potential effects of child abuse on moral development.

Justice Orientation

The justice model of moral development generated by Kohlberg (1969, 1981, 1984) and based on earlier work by Piaget (1932/1966) has long been

considered the dominant model of moral psychology (Lyons, 1983). Piaget acknowledged that "apart from our relations to other people, there can be no moral necessity" (p. 196). Nevertheless, Kohlberg's conceptualisation of the justice model holds as its ideal an attitude of objectivity and impartiality; it abstracts moral problems from their interpersonal situations (Gilligan, 1982).

The justice orientation is an ethic of rights; its primary focus is on fulfilling obligations, duty, or commitments. Within this context, moral decisions are made with reference either to standards, rules or principles for self or society, or to considerations of fairness. For example, one might consider how one would like to be treated if in the other person's place. Consequently, an underlying assumption of the justice orientation is that others are the same as oneself (Lyons, 1983). A second assumption of the justice orientation is that the self is "capable of detached objectivity in situations of human choice" (Lyons, p. 126). Considerations of principle are valued above situational factors. Within this perspective, moral decisions are evaluated by considering how decisions were justified or whether values, principles, or standards were maintained.

Kohlberg's (1969, 1981) model consists of six hierarchically ordered stages of moral judgement-making. The stages are organised within three levels, representing preconventional, conventional, and postconventional morality. Peters (1973) summarises the six stages:

> Children start by seeing rules as dependent upon power and external compulsion; then they see them as instrumental to rewards and to the satisfaction of their needs; then as ways of obtaining social approval and esteem; then as upholding some ideal order, and finally as articulations of social principles necessary to living together with others - especially that of justice. (p. 24)

Moral reasoning at each level is assessed by determining the person's reasons for observing certain rules or norms (Vreeke, 1991).

The first two stages in Kohlberg's (1969, 1981) model embody preconventional morality. In stage one, the person's view of morality is egocentric. The person bows to the superior power of authorities and acts morally in order to avoid punishment. The morality of an act during this stage is defined in terms of its physical consequences. Stage two is marked by an increasing awareness of the interests of others. Although there is some evidence of reciprocity and sharing during this stage, moral acts are performed primarily in order to gain rewards.

The next two stages represent the conventional moral level (Kohlberg, 1969, 1981). Stage three joins the need for approval with the wish to care for and help others. The person behaves morally in order to maintain the approval of others. In stage four, the emphasis is on the blind acceptance of social conventions and rules. Social regulations are accepted without questioning, and behaviour is judged as good in terms of its conformity to a rigid set of rules.

The final two stages mark the level of postconventional morality (Kohlberg, 1969, 1981). Stage five is marked by a flexibility of moral beliefs that was not evident in earlier stages. The person accepts that morality is based upon an agreement among individuals to conform to norms that are necessary to maintain the social order and the rights of others. Further, the person recognises that sometimes morality and law conflict, but has difficulty integrating the two. Finally, in stage six the person acts according to self-chosen ethical principles regardless of whether they conflict with the law. The emphasis at this level is on conforming not only to social standards but also to internalised ideals. The person acts morally in order to avoid self-condemnation rather than to avoid criticism by others. Moral decisions are based upon abstract principles involving justice, compassion, and equality.

Although Kohlberg (1969, 1981) envisioned these six stages as invariant, he demonstrated that cognitive development is a necessary but not sufficient condition for progression through the stages. As such, Kohlberg did not make predictions about when in the life cycle people would attain each stage. In general, research indicates that the moral reasoning of young children is characterised more by preconventional (stage one and two) responses. Stage one reasoning constitutes the majority (70%) of moral statements of 7-year-old children (Kohlberg, 1969). As the child matures, the balance shifts toward

conventional responses. Kohlberg has demonstrated that conventional responses to moral dilemmas predominate by early adolescence. Very few people attain postconventional moral reasoning; stage five reasoning characterises only 5% of adults, and stage six reasoning is very rare.

It is apparent from an examination of Kohlberg's (1969, 1981) theory of moral development that although moral decisions are not completely abstracted from interpersonal concerns, consideration of such concerns is limited in scope (J. G. Miller & Bersoff, 1992). Kohlberg delineates these limits in the following passage:

> Judgments which consider the needs and welfare of the other as an individual, where the other's welfare seems to be a matter of a right or claim the other has or where it is a matter of not harming the other's welfare, are justice judgments. Judgments which consider fulfilling the other's need when it is not based on a right or claim or where it is a matter of preventing harm are responsibility judgments. (Kohlberg, Levine, & Hewer, 1983, p. 26)

Kohlberg considered responsibility judgements to be interpersonal matters outside the realm of the justice orientation.

Critique of Kohlberg's Research and Theory

Kohlberg's research and theory has been critiqued both in terms of its underlying philosophy and on methodology. Kohlberg's model has been critiqued on several grounds. These include the stage basis of the model, its claim to universality, and sex bias.

Kohlberg viewed the stages of moral development as structural wholes that represent "unified and differentiated patterns of thought" (Locke, 1980, p. 168). Locke (1980) argues that the research evidence and methodology imply a developmental continuum rather than a discrete stage structure. Research has demonstrated that most participants' responses are distributed in a normal curve over a number of stages, rather than being characterised by one predominant stage (Kohlberg, 1969, p. 387).

Further, Kohlberg viewed the stages of moral development as occurring in an invariant sequence. Kohlberg (1971) claims that moral reasoning develops in the particular order he has set out because of "a universal inner logical order of moral concepts ... the order or differentiations could not logically be other than it is" (p. 187). This is a strong claim that has some supporting evidence in cross-sectional studies. Locke (1980) argues that longitudinal studies show that people skip stages and regress from higher to lower stages (e.g., Blatt & Kohlberg, 1975; Kohlberg & Kramer, 1969; Modgil & Modgil, 1976), and that Kohlberg has adjusted his model to account for these findings.

Third, Kohlberg maintained that his theory of moral development was universal. In particular, he claimed that cross-cultural research showed that the same sequence of moral development occurs in different cultures. In fact, however, stage five reasoning is rarely found, and stage six reasoning is absent

outside of Western (North American and Western European) cultural samples (Sullivan, 1977). Other cultures often place the good of community above that of the individual, and such responses are scored at stages three or four (Locke, 1980). Thus, Kohlberg's theory appears culturally biased.

In contrast, the communitarian perspective asserts that morality is always dependent on the social context (e.g., Etzioni, 1998). Haste (1996) states that

> people "are deeply social, embedded in culture and in social practices. It is meaningless to talk of people 'stepping outside' or 'transcending' their culture and time, however 'rational' they try to be. Therefore it is pointless to make autonomy an ideal either as a personal quality, or as a form of reasoning. Morality cannot be understood unless we take full account of the social, cultural and historical context" (p. 36).

Carol Gilligan (1982) has criticised Kohlberg's theory extensively based on the concern that all of Kohlberg's original research participants were male. Her research with both female and male participants gave rise to the development of the care orientation.

Care Orientation

In contrast to the justice orientation, the care orientation is based not on an ethic of rights and responsibilities but on an ethic of care and response. The central consideration within this perspective is how moral decisions will effect the relationships between those involved. Gilligan (1982) states

> In this conception, the moral problem arises from conflicting responsibilities rather than from competing rights and requires for its

> resolution a mode of thinking that is contextual and narrative rather than formal and abstract. This conception of morality as concerned with the activity of care centers moral development around the understanding of responsibility and relationships, just as the conception of morality as fairness ties moral development to the understanding of rights and rules. (p. 19)

Thus, the "right" moral decision is one that avoids conflict, promotes the welfare of another, or alleviates hurt or suffering. Within the care orientation, moral judgements are contextually relative rather than categorical. According to Lyons (1983), this orientation "involves considering others in their specific contexts and not always invoking strict equality" (p. 135). Thus, the care orientation embodies a sense of respect for individual differences. Moral decisions are evaluated by considering their consequences as well as whether relationships were maintained or restored.

Gilligan (1982) conceives of development within this model as consisting of

> A sequence of three perspectives, each perspective representing a more complex understanding of the relationship between self and other and each transition involving a critical reinterpretation of the conflict between selfishness and responsibility ... The sequence ... proceeds from an initial concern with survival to a focus on goodness and finally to a reflective understanding of care as the most adequate guide to the resolution of conflicts in human relationships. (p. 105)

At the first level of moral reasoning, the person's focus is on caring for the self in order to ensure survival. Nevertheless, "the self, which is the sole object of

concern, is constrained by a lack of power that stems from feeling disconnected and thus, in effect, all alone" (Gilligan, p. 75). Gilligan contends that at this level morality is imposed by society.

At the second level, the person sees it as selfish to care for the self; rather, the emphasis is on responsibility to others. Exclusion of the self in the moral equation, however, causes problems in relating to others. Gilligan (1982) contends that in order to care for another, one must first be able to care responsibly for oneself. When the person becomes aware of this conflict a transition phase is entered.

The essence of this transition involves moving toward social participation and adopting societal values. Survival is now perceived to depend on the acceptance of others. Thus, the emphasis is on consensual judgement about goodness (Gilligan, 1982). Although the person now feels more connected to others, self-expression is constrained by this need for acceptance. Gilligan describes the way this conflict is expressed in interviews with women:

> The image of drifting along or riding it out recurs throughout the interviews to denote the experience of women caught in the opposition between selfishness and responsibility. Describing a life lived in repose, guided by the perception of others' needs, they can see no way of exercising control without risking an assertion that seems selfish and hence morally dangerous. (p. 143)

This tension between self-sacrifice and care gives rise to the third level, which is marked by a new understanding of the interconnection between self and other. In order to be able to reach this level, the person must be able to "see in oneself the potential for being good and therefore worthy of social inclusion" (Gilligan, p. 78). Thus, at the highest level of moral development it is important to consider the repercussions of moral decisions for all involved, including oneself.

It is apparent that within Gilligan's (1982, 1986a, 1987, 1988) model of moral orientation, conceptions of self and morality are inextricably linked. Within the justice orientation, the self is defined through autonomy and separation from others, whereas within the care orientation the self is delineated through connections with others. One of the challenges of development is thus to find a way to remain connected with others and at the same time develop a sense of self.

Support for the link between conceptions of self and moral orientation is provided by a number of interview studies (Gilligan, 1982; Lyons, 1983, 1987; Pratt, Diessner, Hunsberger, Pancer, & Savoy, 1991; Pratt, Golding, Hunter, & Sampson, 1988). Results indicate that individuals who characterise themselves predominantly in connected terms more frequently use the care orientation in constructing and resolving real-life moral conflicts. Conversely, individuals who characterise themselves predominantly in separate or objective terms more

frequently use the justice orientation. Further, Pratt and colleagues (1991) found that for women, greater connectedness of self-concept was associated with a higher stage score for justice reasoning. A longitudinal study conducted by Lifton (1985) also provides support for the importance of self in moral development. Results indicated that for young women, moral judgement is related to the sense of a social self. The social self is characteristic of level two in Gilligan's (1982) developmental model. In contrast, as the women matured their moral development was related not only to social identity but also to an integrated sense of self. The integrated sense of self is characteristic of level three in Gilligan's model.

Critique of Gilligan's Research and Theory

There have been numerous critiques of Gilligan's research on moral orientation. Some critics take issue with her methodology, others with what they perceive to be her findings and their implication for women, and still others claim that her research is essentialist.

Luria (1986) has taken issue with Gilligan's methodology, saying that her sample sizes were insufficient to be able to draw conclusions about all males and all females. Gilligan (1986b) states that her argument was not based on being able to generalise the findings, but rather " was interpretive and hinged on the

demonstration that the examples presented illustrated a different way of seeing" (p. 208). She further states that

> To claim that there is a voice different from those which psychologists have represented, I need only one example - one voice whose coherence is not recognized within existing interpretive schemes. To claim that common themes recur in women's conceptions of self and morality, I need a series of illustrations (Gilligan, 1986b, p. 210).

Further, critics have argued that Gilligan's work is biologically determinist (see, e.g., Kerber, 1986). Gilligan's work has been criticized by several researchers and theorists who take issue with what they perceive to be her assertion that there are sex differences in moral reasoning (e.g., Greeno & Maccoby, 1986; Walker, 1984, 1986a). Walker (1986a) reviewed 61 studies in which Kohlberg dilemmas were used and scored using Kohlberg's justice-oriented scheme. He found no trend in childhood or adolescence for males to score at higher levels than females. Some studies showed sex differences in adults; Walker maintained that these differences were accounted for by education rather than gender. In reply, Gilligan (1986b) has stated that her interest was in the way people frame moral problems, rather than on whether there are sex differences on Kohlberg's measure. She also emphasises that the association of care-oriented moral reasoning with women "is not absolute, and the contrasts between male and female voices are presented ... to highlight a distinction between two modes of

thought and to focus a problem of interpretation rather than to represent a generalization about either sex" (Gilligan, 1982, p. 2).

Gilligan's research has also been criticized by feminist scholars as essentialist (see, e.g., Kerber, 1986; Larrabee, 1993; Stack, 1986). Essentialism, as defined by Spelman (1988; cited in Heyes, 1997) is the contention that presenting the experiences of white, middle class women as representative of all women fails to recognize the diversity among women. Failure to recognize diversity of race, socioeconomic class, and sexual orientation has both political and philosophical ramifications. Although Gilligan's original sample included black middle-class women and white working-class women, she did not make this diversity explicit (Martin, 1994). These are valid criticisms, but it is also important to emphasize that Gilligan conducted groundbreaking research in her study of moral reasoning in women (Heyes, 1997). Previous research on moral reasoning (e.g., Kohlberg, 1969) had used exclusively male participants and had generalised the results to all people. In Gilligan's later work (Taylor, Gilligan, & Sullivan, 1995), she has taken essentialist criticism to heart and has responded by openly including women and girls of colour as well as those from different socio-economic backgrounds. Unfortunately, we do not have the benefit of knowing

how a more inclusive research design would have affected her original research on moral orientation.

Heyes (1997) cautions against the indiscriminate use of anti-essentialism, because at its extreme it makes doing research difficult, if not impossible. She states:

The most effective method for reading work like Gilligan's requires feminists to examine how generalisations are used; not to reject the use of generality altogether, but to ask what is enabled and what excluded in the context in question. Without Gilligan's generalisations, we would be left to depend on psychological theories that ignore girls' narratives or rate them as second-class (p. 149).

Martin (1994) makes this case even more strongly:

> My vision of a collective enterprise is of a research community governed by an open welcoming spirit, one that is as inclusionary on the methodological level as on the personal. It is of people who hold up high standards for themselves and each other but do not demand perfection. And it is of scholars from different backgrounds and with quite different kinds of training who are expert enough to see the mistaken assumptions and the gaps in other women's research, generous enough to give constructive criticism and to recognize the positive contributions contained in the work of others, and wise enough to know that their way of doing research is not the only right way - indeed, that there probably is no single right way or even a short list thereof (p. 654).

In summary, the justice orientation is based on a presumption of equality

and fairness, whereas the care orientation relies on the recognition of individual differences in need (Gilligan, 1982). It is important to emphasise that these two modes of moral thinking are not unitary; people generally "use both kinds of considerations in the construction, resolution, and evaluation of real-life moral conflicts, but usually one mode predominantly" (Lyons, 1983, p. 140). Johnston (1988) demonstrated that children as young as 11 years of age could spontaneously switch orientations if they were asked if there was another way to think about a dilemma. Research indicates that the type of moral judgement used often depends on the way the dilemma is framed (Gilligan, Murphy, & Tappan, 1990; Rothbart, Hanley, & Alber, 1986; Walker, 1989). Gilligan notes that the construction of the hypothetical dilemmas used by Kohlberg (1969, 1984) may be more likely to elicit justice-oriented moral reasoning. These dilemmas ask respondents to choose between one of two alternatives, thus precluding the possibility of an inclusive solution (Gilligan, 1986a; Johnston). In contrast, real-life dilemmas are more likely to elicit care-oriented reasoning (Pratt, Golding, Hunter, & Sampson, 1988; Walker, 1989).

Moral development in adults has also been demonstrated to be associated with educational level and parental status. Several researchers have demonstrated that cognitive development is a necessary but not sufficient condition for justice-

oriented moral development (Kuhn, Langer, Kohlberg, & Haan, 1977; Walker, 1980). Research also indicates higher education level to be associated with more advanced moral reasoning (Boldizar, Wilson, & Deemer, 1989; Pratt et al., 1984; Pratt et al., 1991; Walker, 1986b). This finding is not merely a reflection of the relationship between education level and IQ; the relationship between education level and moral development holds even when IQ is used as a covariate (Colby, Kohlberg, Gibbs, & Lieberman, 1983). A study conducted by Haan, Langer, and Kohlberg (1976) suggests that the relationship between education level and moral development may not apply at the highest levels of education. There is also some research suggesting that parental status is related to moral orientation. Specifically, Pratt and colleagues (1988) found that women were more likely to use care-oriented moral reasoning if they were parents; there was no relationship between parental status and type of moral reasoning for men.

Clinical and research evidence of the relationship between child abuse and moral orientation will now be presented.

Child Abuse and Moral Orientation

Although no research on the relationship between child abuse and the development of moral orientation has yet been published, several related areas of research suggest that child abuse has an impact on moral development. First,

research germane to the development of the justice orientation will be considered, with particular attention to social cognition. Next, the research that has already been presented on the relationship between child abuse and attachment will be considered in the light of its relationship to the development of the care orientation.

Justice Orientation

Research indicates that in comparison with nonabused children, children with a history of physical abuse and/or neglect have deficits in a number of areas of social cognition. As compared to nonabused children, physically abused children have been demonstrated to perform more poorly on perspective-taking tasks both in the preschool years (Howes & Espinosa, 1985) and in later childhood (Barahal et al., 1981). Dean, Malik, Richards, and Stringer (1986) found that abused children's descriptions of child-adult and child-child reciprocal behaviour differed from those of nonabused children. Specifically, abused children in the 6- to 8-year-old group told more stories in which children reciprocated an adult's kind act than did nonabused children. Further, abused children told more stories in which children deserved to be punished than nonabused children, suggesting that abused children may attribute their abuse to internal factors. In contrast, Barahal and colleagues (1981) found that 6- to 8-

year-old physically abused children were more likely to have an external locus of control than nonabused children, indicating that they believed that outcomes were primarily determined by factors outside themselves. Thus, the evidence for the association between abuse and a particular locus is equivocal.

Further evidence for the relationship between maltreatment and social cognition is provided by a study that investigated attitudes toward moral and social transgressions in three groups of preschoolers: physically abused, neglected, and nonabused (Smetana, Kelly, & Twentyman, 1984). Results indicated that type of maltreatment differentially impacts moral judgment. Children appear to be more sensitive to moral transgressions that parallel the type of maltreatment they have experienced. Specifically, physically abused children considered transgressions of others that caused psychological distress to be more universally wrong than did the neglected children. Conversely, neglected children considered the unfair distribution of resources to be more universally wrong for themselves than did the abused children.

A study conducted by Kelly (1986, described in Smetana & Kelly, 1989) indicates that "abused children are more likely than other children to view trangressions that violate others' rights or welfare to be permissable" (p. 639-640). This was particularly true when the acts were described as causing high levels of

harm. There are several possible explanations for this finding. Kelly speculates that abused children may be less able than nonabused children to inhibit their egocentrism in actual behaviour. It is also possible that maltreatment may lead children to develop higher thresholds for pain. Alternately, physically abused children may identify with the aggressor in an attempt to feel more powerful (A. Freud, 1966).

It is possible that children's moral judgement may become impaired as a result of parents' rules being arbitrary or inconsistent. Many survivors of childhood abuse report chaotic family environments characterised by the capricious enforcement of rules. Other survivors "describe a highly organized pattern of punishment and coercion" (Herman, 1992, p. 99). Bowlby (1980) theorised that the experience of abuse or neglect may alter children's sense of fairness in parent-child interactions by encouraging a working model of relationships in which parents are always above criticism and the child is always to blame. Such parents may insist that children view them as perfect in order to compensate for their own feelings of inadequacy. Support for this hypothesis is found in clinical observations that neglected children see themselves as worthless (Polansky, 1981), and that physically and sexually abused children often blame themselves for their parent's behaviour (Amsterdam, Brill, Bell, & Edwards,

1979; Kempe & Kempe, 1978).

Further, Dean and colleagues (1986) study on reciprocal interactions provides empirical support of the tendency of abused children to blame themselves. A "perfect parent-worthless child model" predominated in stories told by 9- to 11-year-old and 12- to 14-year-old children (p. 624). Children in the 6- to 8-year-old group told stories involving two competing schemas. The first schema involved children attempting to be kind and helpful towards their parents and the parents failing to reciprocate. The second schema involved children being constantly at fault and parents being above criticism.

Care Orientation

Several areas of research presented earlier support the hypothesis that child abuse affects the development of the care orientation. Research has demonstrated an association between child maltreatment and insecure attachment in infants, children, and adults. Further, research findings indicate that child abuse is associated with low self-esteem, decreased empathy, increased aggression and antisocial behaviour, and impaired peer relationships. These findings will now be considered with regard to their bearing on the development of the care orientation.

Attachment is theorised to be integral to the development of the care

orientation. There is a body of clinical and research evidence that indicates that abused children often develop impaired attachment relationships with their primary caregivers. Child abuse damages relationships with primary caregivers because it violates the child's basic sense of trust. Herman (1992) notes that abused children must find ways "to develop primary attachments to caretakers who are either dangerous or ... negligent" (p. 101).

Abused children often develop pathological attachments to those who abuse and neglect them, and will strive to maintain these attachments even at risk to their own welfare. These pathological attachments have been explained using the concept of "traumatic bonding" (e.g. deYoung & Lowery, 1992; Herman, 1992). Traumatic bonding has been defined as "the evolution of emotional dependency between two persons of unequal power ... The nature of this bond is distinguished by feelings of intense attachment, cognitive distortions, and behavioral strategies of both individuals that paradoxically strengthen and maintain the bond" (deYoung & Lowery, p. 167). In order to maintain attachments to abusive caretakers, the child often minimises, rationalises and excuses the abuse. Traumatic bonds become particularly strong when the abuse is intermittent and is alternated with periods of nonabusive or even loving interaction, as is often the case with child sexual abuse (Berliner & Conte, 1990).

Research also indicates that child abuse is associated with low self-esteem. According to Gilligan's (1982, 1986a) conceptualisation of the care orientation, the child's sense of self is integral to moral thinking. By the time children attain the level of conventional moral judgement according to Kohlberg's (1969, 1981) model of moral development, they have developed sufficient self-control to be able to "inhibit impulsive or selfish acts for the sake of social relations" (Cole & Putnam, 1992, p. 178). Cole and Putnam note that by this stage, "the moral sense and attendant guilt is integrated into how one views oneself, whereas earlier the moral sense was more defined by the concrete consequences of wrongful actions (e.g., punishment)" (p. 178). Thus, it appears likely that child abuse occurring at this stage of cognitive development would have a negative impact on the child's sense of self, particularly if the child takes responsibility for the abuse.

Miller and Stiver (1993) suggest a mechanism by which abusive relationships affect self-esteem. They state that

> If a person cannot find ways to have an impact on the available relationships, she will take the only possible step, which is to attempt to change herself. Specifically, she tries to alter her internal image of herself and others and her image of the nature of the connections between herself and others. (p. 428)

It is apparent from the earlier discussion of the development of moral reasoning within the care orientation that a person with low self-esteem will be unable to

attain the highest level of moral development.

Further, research has documented associations between child abuse and decreased empathy, increased aggression and antisocial behaviour, and impaired peer relationships. Each of these constructs are theoretically related to the care orientation. According to Gilligan (1982), the construct of empathy is central to care-oriented moral reasoning. Thus, if the development of empathy is impaired as a result of child maltreatment it seems reasonable to assume a concomitant effect on the development of the care orientation.

In summary, child abuse is associated with a number of areas which impact upon interpersonal functioning. The sequelae of child abuse include insecure attachment, low self-esteem, decreased empathy, increased aggression and antisocial behaviour, impaired peer relationships, and deficits in social cognition. Each of these constructs is theoretically related to moral development. Thus it appears that child abuse may have a negative impact upon moral development.

3. RESEARCH RATIONALE AND HYPOTHESES

It is apparent from this review of the literature that child physical and sexual abuse are associated with a wide range of deleterious effects on the self and interpersonal functioning. There is considerable research evidence of an association between child maltreatment and insecure attachment in infants and children. Research on child abuse and adult attachment is more limited. Although there is preliminary evidence of a relationship between child sexual abuse and insecure attachment in adulthood, the relationship between child physical abuse and adult attachment has yet to be investigated. Research suggests that child physical abuse and child sexual abuse frequently co-occur (e.g., Briere & Runtz, 1986, 1989; Styron & Janoff-Bulman, 1997), particularly in cases of severe sexual abuse (e.g., Koverola, Hanna, & Stein, 1995). Further, although there is some overlap in the sequelae of these two forms of abuse, they are not identical (Briere & Runtz, 1990). Researchers in the area of child maltreatment have emphasised the importance of accounting for the unique influences of different types of maltreatment (e.g. Briere, 1992).

Research also indicates that child physical and sexual abuse are associated with deficits in a number of areas of functioning related to moral development. The sequelae of child abuse include insecure attachment, decreased empathy,

increased aggression and antisocial behaviour, impaired peer relationships, and deficits in social cognition. On a theoretical level these constructs are related to care- and justice-oriented reasoning. Thus, child abuse survivors may have deficits in moral reasoning within both moral orientations.

According to Gilligan's (1982, 1986a) theory of moral orientation, the development of care-oriented moral reasoning is mediated through attachment. It is possible that the damaged attachment relationships associated with child maltreatment may affect the development of the care orientation. Further, Gilligan proposes that the person's concept of self is linked to moral development within the care orientation. Thus if the development of the self is arrested the person will be unable to progress to the highest level of moral development. Child abuse has been demonstrated to be associated with low-self esteem in adult survivors. Consequently, it may be expected that survivors of child abuse would have concomitant deficits in care-oriented moral reasoning.

The present study had two primary objectives. The first was to compare adult attachment patterns in three groups of women: (1) survivors of intrafamilial child sexual abuse (CSA group), (2) survivors of intrafamilial child physical abuse (CPA group), and (3) women who were neither physically nor sexually abused as children (nonabused or NA group).

Initial data on attachment were collected using the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) and the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994a, 1994b). The RQ and RSQ were compared to determine whether they classified groups differently in terms of attachment. Semi-structured interviews were conducted with a subgroup of women in order to augment the quantitative data, in particular, to investigate how participants viewed their attachment development.

The second objective was to investigate the relationship between moral orientation and attachment in the three groups. The Moral Orientation Scale Using Childhood Dilemmas (MOS; Yacker & Weinberg, 1990) was used to gather initial data on moral orientation.

In order to augment and help explain the information collected by questionnaires, semi-structured interviews were administered to a subgroup of the sample. These interviews were used to investigate attachment, moral orientation, and the tendency of participants to include themselves in moral reasoning.

The hypotheses of the study were as follows:

1. That women in the CSA and CPA groups would rate significantly higher on insecure styles of attachment (Preoccupied, Dismissing, and Fearful) and significantly lower on Secure attachment than those in the NA group.

2. In particular, that women in the CSA group would rate significantly higher on Fearful attachment than those in either the CPA or NA group.
3. That women with Secure or Preoccupied attachment styles would use care-oriented moral reasoning (as measured by the MOS) with greater frequency than would women with Dismissing or Fearful attachment styles.

In addition, the following research questions were investigated:

1. Exploratory analyses were conducted to investigate whether the degree to which participants endorsed the care orientation (as measured by the MOS) differed according to abuse group.
2. Exploratory analyses were conducted to investigate whether the number of important attachment figures and number of separations from attachment figures (as assessed by the Caretaker History Questionnaire) differed significantly according to abuse group.
3. Exploratory analyses were conducted to investigate whether the number of important attachment figures and number of separations from attachment figures (as assessed by the Caretaker History Questionnaire) differed significantly according to primary attachment style (as assessed by the RQ), respectively.
4. Thematic qualitative analysis (see, e.g., Boyatzis, 1998) was used to analyse

the interview data, with a few specific questions in mind. (a) To what factors do participants relate the development of their attachment style? In particular, do they attribute part or all of their style of relating to childhood experiences, including abuse? (b) Did participants use primarily care-oriented or primarily justice-oriented moral reasoning in their moral dilemmas? (c) To what extent do participants include themselves in moral decision-making?, and (d) Does the extent to which participants included themselves in moral deliberations appear to be related to abuse history?

5. METHOD

Participants

Participants comprised 86 adult women: 30 survivors of severe intrafamilial child sexual abuse (CSA), 28 survivors of severe intrafamilial child physical abuse (CPA), and 28 nonabused women (NA). Child sexual abuse was defined as oral sex, digital or object penetration, and/or attempted or completed vaginal or anal intercourse occurring before age 17 by a family member at least five years older than the child. Concurrent child physical abuse was not an exclusionary criterion for this group. Child physical abuse was defined as having been deliberately physically injured by a caretaker within the family before age 17. The NA group comprised women with no history of child sexual or physical abuse or adult sexual assault.

A total of 104 telephone screening interviews were conducted in order to determine whether participants met criteria for the study; five women in the NA group were not given the telephone screening interview. This yielded a potential sample of 109 participants. Twenty women were not admitted to the study for the following reasons. Nine women did not meet the criteria for the CPA group because they had experienced concurrent peer sexual abuse or extrafamilial child sexual abuse. Four women did not meet the criteria for the NA group; two had

experienced peer sexual abuse and two had experienced adult sexual assault. Two women did not meet the criteria for the CSA group as defined. One woman met the criteria for the CSA group, but was too busy to schedule an appointment. An additional four women met the criteria for the CSA group, but were not admitted to the study because by the time they were interviewed, this group had the required number of participants.

The data of three participants who appeared to meet the criteria during the telephone screening interview had to be eliminated from the study once their data were reviewed. The data of one participant in the CPA group were not included in the analyses because she experienced extrafamilial abuse. Two participants in the NA group who did not report adult sexual assault during the telephone interview reported it in the questionnaires, and their data was therefore excluded from the study. The final sample used in the analyses comprised 86 participants: 30 CSA, 28 CPA, and 28 NA.

There were no significant between-group differences on demographic variables, including age, socioeconomic status, number of years of education, ethnicity, parental status, and being in a close romantic relationship. Participants ranged in age from 19 to 54 years ($X=34.9$, $S.D.= 8.4$) and had a mean education level of 13.8 years ($S.D.=2.19$). They were predominantly Caucasian ($N=64$,

71.1%). Nine women (10%) identified themselves as Aboriginal, and two (2.2%) as Asian. Thirteen women (14.6%) identified their ethnicity as "other," and one woman (1.1%) did not report her ethnicity. Their average socio-economic level as measured by Hollingshead's (1957) two-factor index of social position (cited in Miller, 1991) was 37 (skilled clerical/sales). Just over half of the women (57%) had one or more children, and 64% of them were in a romantic relationship.

Initially, efforts were made to restrict participant selection to women who were in psychotherapy at the time of data collection or had been in psychotherapy in the past, in order to hold this variable constant. It proved to be extremely difficult to recruit participants with this restriction, and so it was dropped. The three groups did differ significantly on whether they were currently in therapy or had been in the past ($X^2 = 11.39$, $p = .003$). A majority of CSA and CPA survivors were or had been in therapy (30 [100%] and 22 [79%], respectively), whereas approximately half (16 [57%]) of the NA participants had never been in therapy. In order to determine whether the variable indicating whether participants had ever been in therapy (ANYTHER) should be included in further analyses as a covariate, the correlations between ANYTHER and other dependent variables were examined. As can be seen in Table 1, the highest correlation was between ANYTHER and PRERSQ (Preoccupied attachment as measured by the

RSQ). At r=.2757, approximately 8% of the variance in PRERSQ is accounted for by ANYTHER. It was therefore decided that it was not necessary to include ANYTHER in further analyses as a covariate.

Procedure

Participants were recruited via therapist referrals (see Appendix A), counselling centres and university classes. Posters were placed in bookstores and mental health clinics (see Appendix B). Advertisements were placed in newspapers, newsletters, and on cable television (see Appendix C). Interviews were given to CBC radio as well as to a commercial talk radio program. Some participants for the CSA group were recruited from a pool of 28 abused participants who participated in an earlier study on psychological, neuropsychological, and neurophysiological sequelae of child sexual abuse (Koverola, Hanna, & Stein, 1995; Stein, Hanna, Koverola, Torchia, & McClarty, 1997; Stein, Koverola, Hanna, Torchia, & McClarty, 1997; Stein, Yehuda, Koverola, & Hanna, 1997). These participants were contacted by telephone and asked if they would be interested in participating in a further study on close relationships and moral issues. Participants were informed that participation in the study was completely voluntary and that they were under no obligation to participate. Further, participants were informed that all of the data to be collected

would be identified by number rather than by name, and that all of their responses would be kept strictly confidential.

The purpose and nature of the study was explained to potential participants. If they were interested in participating, a telephone screening interview was conducted in order to ensure that they met the criteria for the study (see Appendix D). Participants were informed that the study would be conducted in two parts, and that not all participants would be asked to participate in the second part. Part one involved completing a series of questionnaires on close relationships and moral orientation. This took approximately 1-1/2 to 2 hours. Questionnaire data were collected between September 14, 1995 and August 26, 1996. Part two involved an interview on attachment, moral dilemmas and self-concept; this took approximately 1-1/2 hours.

Data collection took place in an office at the Psychological Service Centre at the University of Manitoba, in a therapy room at the Elizabeth Hill Counselling Centre, or at times in participants' homes. Participants were asked to sign a consent form prior to commencement of data collection (see Appendix E). They were informed that they were free to discontinue participation in the study at any time.

Following each session the participant was given a feedback sheet (see

Appendix F) informing her more fully of the purpose of the study. This sheet included telephone numbers of mental health resources in the event that procedures or the content of the study caused the participant any emotional distress. Each participant was paid a $10 honorarium for participating in each part of the study. Participants recruited from university classes also received experimental credits for their participation. Upon completion of the study, a summary of the general results was mailed to each participant.

Qualitative Interview Procedure

A subgroup of 24 participants was selected on the basis of their primary attachment style as indicated by the RQ as well as by abuse group status. Attempts were made to select eight participants from each abuse group (CSA, CPA, and NA) with representation from each of the four attachment categories (Secure, Dismissing, Preoccupied, and Fearful). Many of the women had a blend of two or three attachment styles. Unfortunately, following data collection it became apparent that one CPA participant had experienced extrafamilial rather than intrafamilial child physical abuse, and so her interview data was deleted from the analysis.

The interviews were conducted over approximately a one-month period from July 25 to August 26, 1996. They ranged in length from just under one hour

to two and a half hours, with most interviews taking approximately one to one and a half hours.

One-way analysis of variance was conducted to determine whether the age, years of education, and socioeconomic status of interview participants differed significantly from the rest of the participants. They did not. The mean age of interview participants was 36, and participants ranged in age from 22 to 52. Participants in the interview group had an average education level of 14.1 years, with a range from 10 to 21 years. The average socio-economic level of interview participants as measured by Hollingshead's (1957) two-factor index of social position (cited in Miller, 1991) was 39 (skilled clerical/sales). Thirteen interview participants (56.5%) identified their ethnicity as Caucasian, 5 (21.7%) as Aboriginal, and 5 (21.7%) as "other". Fifteen (65.2%) of the interview participants were currently in a relationship, whereas 40 (63.5%) of the rest of the participants were currently in a relationship. Twenty-one (91.3%) of the interview participants had children, as compared with 28 (44.4%) of the rest of the participants. Fifteen interview participants (65.2%) had been in therapy at some time in their lives. A Mann-Whitney U test found that this rate did not differ from the rest of the participants ($Z = -1.58$, $p = .11$).

The experience that I brought to this study included training and

experience in clinical interviewing, including interviewing women sexual abuse survivors for a previous research study (Koverola et al., 1995; Stein, Hanna, et al., 1997, Stein, Koverola, et al., 1997, Stein, Yehuda, et al., 1997). A large part of this training involved client-centered therapy; this includes active listening and included empathic responding (see, e.g., Martin, 1983; Rogers, 1951, 1980). I also used prompting questions such as "Tell me more about that". I was familiar with the literature on the effects of and treatment of child sexual and physical abuse and attachment disorders, and I think that this helped me to be sensitive to participants' emotional needs during the interview process.

A brief description of my theoretical orientation as a therapist may help to illuminate my perspective in this study. I conceptualise psychological development within a psychodynamic framework. Several aspects of this framework appeal to me. First, I have always considered early childhood experience to be formative for both normative personality development and psychopathology. Second, I appreciate the emphasis of psychodynamic theory on unconscious processes. Finally, I find the developmental focus of the psychodynamic framework appealing. However, the relative inattention paid to the unique features of women's development by classical psychoanalytic theory has always disturbed me. Further, classical psychoanalytic theory developed out

of the study of psychopathology. As such, I feel that it de-emphasizes the process of normative development. In my opinion a theoretical framework should enable the clinician to conceptualise not only clients' areas of dysfunction but also their strengths.

As I continued to develop as a therapist my interest turned to object relations theory. (e.g. Guntrip, 1971; Fairbairn, 1952/1978; Kernberg, 1976; Scharff, 1992.) In contrast to the emphasis of classical psychoanalytic theory on drives (e.g. Freud, 1905/1961, 1915/1962), object relations theory conceptualizes the human need for relationships as the prime motivator of development (eg. Fairbairn 1952/1978). In accordance with object relations theory, I view the therapeutic relationship as a primary agent of change in psychotherapy.

As a result of my experience working on this study, I have incorporated more features of relational therapy into my work with clients (see, e.g., Jordan, 1995a, 1995b, 1997a, 1997b; Stiver, 1997; & Stiver & Miller, 1997).

One of the biases that I brought to the study is that I tend, more often than not, to put a lot of credit in women's accounts of their abuse experiences. By this I do not mean that I accept such accounts uncritically, as I realize that they may have been altered by intervening experience. Rather, I am accepting of their perceptions of their experience.

I came to this study with a background in quantitative approaches, but with a curiosity and interest in qualitative research. My involvement in previous research with sexual abuse survivors (Koverola et al., 1995; Stein, Hanna, et al., 1997, Stein, Koverola, et al., 1997, Stein, Yehuda, et al., 1997) had left me with a desire to hear more about the women's stories, and in particular, how they saw their development of close relationships. Many things appealed to me about qualitative research, including the richness of the data in contrast to that collected with quantitative methods. Stiles (1993), captured this by saying that qualitative research "encompasses the study of meanings, including the purposes and significance that people attach to what they do" (p. 595).

Validity in Qualitative Research

Lincoln and Guba (1985) describe the process of achieving validity in qualitative research as establishing 'trustworthiness'. They recommend considering four factors when designing and implementing a qualitative study: credibility, transferability, dependability, and confirmability. These factors may be thought of as parallel criteria to internal validity, external validity or generalisability, reliability, and objectivity in quantitative research.

1. Credibility in the findings is sought by attempting to establish some agreement between the "constructed realities of respondents and the

reconstructions attributed to them" (Guba & Lincoln, 1989, p. 237). It is not possible to seek the "truth" of findings because multiple constructed realities are assumed in qualitative research. Several techniques are recommended for seeking this agreement. They include:

a. Prolonged engagement with respondents, in order to establish rapport and build trust. This was not achieved in the present study; I met with participants twice. During the first meeting participants completed the questionnaires, and the interview was conducted during the second meeting. Four of the women in the CSA group had participated in a study on the neuroanatomy and neurophysiology of post-traumatic stress disorder in women survivors of CSA (Koverola et al., 1995; Stein, Hanna, et al., 1997, Stein, Koverola, et al., 1997, Stein, Yehuda, et al., 1997). I had interviewed these women using structured interviews on post-traumatic stress disorder and dissociative symptoms, and had accompanied many of them while they underwent bloodwork and CT scans of their brains. Over the course of this study many of the women grew to trust me and were likely more willing as a result to participate in the present study. It is possible that their interview data was more personally revealing as a result of our prior

relationship.

b. Peer debriefing, involving discussing findings, conclusions, and tentative analyses with a disinterested peer. I was fortunate to have the opportunity to consult with several colleagues who had, or were in the process of, conducting qualitative research. This consultation was carried out in an informal way at several points during the data analysis.

c. Negative case analysis, involving revising working hypotheses until they account for all known cases. This was employed and is discussed briefly in the section on qualitative analysis.

d. Progressive subjectivity, involving recording expected findings prior to beginning data collection and several times during the process. This procedure was followed and is discussed in the section on qualitative analysis.

e. Member checks, involving testing hypotheses, data, preliminary categories, and interpretations with respondents (Guba & Lincoln, 1989, pp. 237-238). These were not employed, because immediately after data collection I moved to another province for a pre-doctoral internship program. Considerable time elapsed between data

collection and analysis. This combination of factors made it much less feasible to conduct member checks. Upon the completion of the study, a summary of the results was mailed to all participants as well as to the organizations that supported the study by helping to recruit participants.

2. Transferability involves providing enough information about the hypotheses and methods of the study to enable other researchers to apply these conditions.
3. Dependability is concerned with the stability of the data over time. One way that Lincoln and Guba (1985) recommend for demonstrating dependability is to use "overlap methods" (p. 317). This was done to some extent in the present study by administering questionnaires as well as conducting interviews. The two methods converged to a degree, but frequently the questionnaire data provided much more detailed information.
4. Confirmability refers to the integrity of the findings. The use of overlap methods (Lincoln & Guba, 1985) and a reflexive journal contribute to achieving confirmability. Qualitative and quantitative results were compared within this study. Further, qualitative results were compared with the findings of other researchers when available. Memos were used throughout data analysis to track changes in working hypotheses, codes, and to assist in theory

building.

Measures

(1) Background Questionnaire. This measure was developed for this study in order to gather information about participants' age, ethnic origin, marital status, parental status, educational level, and occupation (see Appendix G).

(2) Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991, see Appendix H). The RQ is an adaptation of an attachment measure developed by Hazan and Shaver (1987). The measure consists of four short paragraphs describing the four attachment styles: Secure, Dismissing, Preoccupied, and Fearful, respectively. Respondents are asked to rate (on a seven-point Likert scale) the degree to which they resemble each of the four styles, and to pick the one style that best characterises them. Results of a factor analysis indicated that participants' self-ratings converged with ratings of the participants by interviews and friends' ratings (Bartholomew & Horowitz, 1991). Correlations between the RQ prototype ratings and interview ratings of each of the four patterns range from .22 for secure to .50 for fearful. The RQ yields two indices of attachment: an attachment profile that consists of ratings of each of the four styles, and the one attachment style that best characterises the participant.

(3) The Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew,

1994a, 1994b, see Appendix I). The RSQ is a 30-item self-report measure that yields a number of attachment subscales. Items are drawn from three sources: Hazan and Shaver's (1987) three-category attachment measure, Bartholomew and Horowitz's (1991) four-category attachment measure, and Collins and Read's (1990) measure. Each item is scored on a five-point scale. Computing the mean of the items representing each prototype derives scores reflecting the secure, fearful, preoccupied, and dismissing attachment styles.

Griffin and Bartholomew (1994a) report that the internal consistencies of the RSQ prototype scores are variable; in one sample they ranged from alpha = .41 for the secure pattern to alpha = .70 for the dismissing pattern. They contend that the internal consistencies of the RSQ are low because the two orthogonal dimensions for the self- and other-models are being combined.

The RSQ pattern scores demonstrate limited convergent validity. Griffin and Bartholomew cite correlations between the RSQ pattern scores and interview ratings of the prototypes ranging from .25 for secure to .47 for dismissing. Griffin and Bartholomew (1994a) suggest that the relatively low convergence between self-report and interview ratings for the secure pattern may result from self-report biases. The RSQ yields mean scores for each of the four attachment styles.

(4) Caretaker History Questionnaire. This measure was adapted from the Attachment History Questionnaire (AHQ; Kessler & Pottharst, 1983, see Appendix J). The AHQ is a self-report measure designed to assess disruptions in attachment in childhood and family interactions that impact on attachment. The version of the questionnaire used in the present study consisted of six descriptive items on attachment history. Four items provided background information on the participant's caretaker(s) in childhood and adolescence. One item provided information on the attachment figures the participant considered supportive at various ages. This information was summed to provide an index of the number of supportive people in each participant's life between birth and age 20. One item assessed whether the participant had significant separations from attachment figures during childhood and adolescence.

(5) History of Unwanted Sexual Contact Questionnaire (Koverola, Proulx, Hanna, & Battle, 1992; see Appendix K). This self-report measure assessed descriptive characteristics of child sexual abuse, peer sexual abuse, and adult sexual assault. Participants were asked to indicate their age at the onset of the sexual abuse, how long the abuse continued, their relationship to the perpetrator, the perpetrator's age and gender, and the use of force by the perpetrator. The questionnaire is divided into three sections in order to differentiate between child

sexual abuse, peer sexual abuse, and adult sexual assault. This measure was used to provide descriptive information about participants' sexual abuse experiences.

(6) Family Conflict Questionnaire (adapted from Runtz, 1991; Briere & Runtz, 1988; see Appendix L). This scale assessed the frequency of child physical abuse, psychological or emotional maltreatment, and neglect occurring before age 17 at the hands of caretakers. Eight questions assessed frequency of physically abusive behaviours, four questions assessed frequency of psychologically or emotionally abusive behaviours, and one question assessed frequency of neglectful behaviours. The response range is from 0-20 times per year. The measure was primarily used to categorise participants on the basis of whether they experienced physical abuse. Severity of physical abuse was measured through 'yes' or 'no' responses to a list of possible injuries resulting from the abuse. Only participants who have been subjected to deliberate (i.e., not accidental) maltreatment by a caretaker that was severe enough to cause injury met the criteria for child physical abuse. Runtz (1991) reports a Cronbach's alpha of .85 for the scale. This measure was also used to provide descriptive information about participants' child maltreatment experiences.

(7) The Moral Orientation Scale Using Childhood Dilemmas (MOS; Yacker & Weinberg, 1990, see Appendix M). The MOS consists of a set of 12

moral dilemmas commonly encountered by eight to ten-year old children. Respondents are asked to imagine that they have an eight to ten-year old child. Each dilemma has four response alternatives (two care-oriented and two justice-oriented), and participants are asked to rank these according to which one they would most want their child to consider. Only the participant's first choice was used in scoring each dilemma. The number of care responses was summed to yield a total score reflecting the strength of the participant's care orientation. The total score for the justice orientation is obtained in a like manner. Item analysis indicated that all alternative responses appeared to be plausible and to have appeal in Yacker and Weinberg's (1992) sample. Test-retest reliability with an interval of 2-3 weeks produced a coefficient of .71, $p < .001$.

(8) The Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960; see Appendix N). Strahan and Gerbasi (1972) developed a shortened form of this scale, which was used in the present study. This 10-item True-False self-report measure yields a total score that reflects the participant's tendency to respond in socially desirable ways. In order to control for positive response bias, half of the items are keyed false. An advantage of this scale is that it was designed to be independent of psychopathology. Strahan and Gerbasi (1972) cite reliability coefficients for this short form ranging from .59 to .70 using the Kuder-

Richardson formula 20. Fischer and Fick (1993) compared 6 short forms of the original scale, and recommend this form as the scale of choice.

(9) Real-Life Moral Conflict and Choice Interview (Brown, Argyris, Attanucci, Bardige, Gilligan, Johnston, Miller, Osborne, Ward, Wiggins, & Wilcox, 1988; see Appendix O). This is an open-ended, semi-structured interview on moral orientation and the self as a moral agent. Participants were asked to describe an important moral conflict that they had experienced. After relating the conflict, participants were asked a series of questions to clarify what moral considerations they used in coming to a decision. Following transcription, thematic qualitative analysis (see, e.g., Boyatzis, 1998) was used to code and analyse the interview data.

(10) The researcher developed a set of questions designed to obtain information about the participants' perceptions of their attachment development and included these in the interviews (see Appendix P).

5. RESULTS

Quantitative Results

Statistical Procedures

SPSS (1996) was used to calculate all statistics for this study. Several procedures were conducted prior to data analysis to determine if the data violated assumptions of normality. These included procedures designed to identify missing data, skewness, linearity and homoscedasticity, outliers, homogeneity of variance, multicollinearity, and singularity. First, the data were checked for missing data points. One participant in the CSA group did not state her ethnicity. One participant did not state her number of years of education, but indicated that she had attended university and was employed as a professional. It was decided to assign a value of 16 years, representing the equivalent of a Bachelor's degree. Information on whether women were currently in therapy or had ever been in therapy in the past was collected by telephone interview. Five women in the NA group were not given the telephone screening interview, and so these data were missing. Some data were missing in the descriptive statistics on abuse; these are reflected in the summary tables. Generally, only one or two data points were missing for most variables.

Second, univariate statistics were used to determine if the distributions of

any of the variables were skewed. Tabachnik and Fidell (1989) recommend that the data be divided into groups for these analyses if univariate or multivariate analyses are to be undertaken. Therefore, the distributions were examined for each variable for each of the three abuse groups. For all three groups, the variable indicating the number of separations from caregivers early in life (NUMSEP) was positively skewed and showed kurtosis. These results were skewed toward having few separations. The Mahalanobis distance statistic was examined for all values of the variable and was not significant for any of them. Examinations of the means and standard deviations for the three groups revealed that the CSA (X=2.60, S.D.=3.06) and CPA (X=1.57, S.D.= 2.81) groups appeared to have significantly more separations than the NA group (X=.21, S.D.=.49). With means this different, it is logical that it cannot be assumed that the groups are from the same population. It was therefore decided to conduct a nonparametric test of the data.

For the CSA and CPA groups, the total number of supportive attachment figures (SIGTOT) was positively skewed, indicating that the majority of these respondents endorsed having fewer supportive people in their lives between birth and age 20. Further examination of the data revealed the presence of three multivariate outliers on this variable for the CSA and CPA groups. The range for

most of the sample was 0 to 31, and the three outliers were 38, 42, and 46. The Mahalanobis distance statistic was calculated for the three values, and was X^2=7.69 ($p<.01$), X^2=10.2 ($p<.005$), and X^2=13.06 ($p<.001$), respectively. Tabachnik and Fidell (1989, p. 70) offer the option of changing the scores on the variables as an alternative to deletion of cases or variables. It was decided to assign to the outlying scores a score of 32, one greater than the next most extreme score in the distribution. After transformation, skewness in the distribution was found to be reduced, although it was still significant for the CSA group ($Z=3.08$ $p<.01$). The Mahalanobis distance statistic was re-calculated, and no values were significant at the $p<.01$ level. It was decided not to transform the variable to further reduce skewness, to maintain ease of interpretation.

For the CPA group, FEARQ (Fearful attachment as measured by the RQ) was negatively skewed ($Z=3.48$, $p<.001$), because most of these respondents endorsed Fearful attachment. Pairwise linearity was checked using within-group scatterplots and found to be satisfactory. Multiple regression was conducted to look for multivariate outliers on all RQ and RSQ subscales, and none were found. It was therefore decided not to transform these variables, to maintain ease of interpretation.

Homogeneity of variance was examined for all variables using the Levene

statistic. There was a slight inequality of variance for the age variable ($F=14.431$, $p<.001$), likely caused by a higher range of values for the CPA group. Because the data were normally distributed and the group sizes were fairly equal, no correction was made to this variable.

Spearman's bivariate correlation coefficients were calculated for all combinations of independent and dependent variables. Tabachnik and Fidell (1989, p. 87) recommend not including variables with a bivariate correlation higher than .70 in the same analysis. As noted in Table 1, none of the correlation coefficients reached this level.

Table 1
Spearman bivariate correlation coefficients, frequency counts, and significance levels of all dependent and independent variables

	.2854							
2	N(86)							
	.008							
	-.2199	-.0924						
3	N(86)	N(86)						
	.042	.397						
	-.1143	-.1692	-.1967					
4	N(86)	N(86)	N(86)					
	.294	.119	.070					
	-.2774	-.4427	.0599	.2165				
5	N(86)	N(86)	N(86)	N(86)				
	.010	.000	.584	.045				
	.1922	.5962	-.1576	-.1252	-.5215			
6	N(86)	N(86)	N(86)	N(86)	N(86)			
	.076	.000	.147	.251	.000			
	-.2681	-.1963	.5820	-.3657	.1665	.3031		
7	N(86)	N(86)	N(86)	N(86)	N(86)	N(86)		
	.013	.070	.000	.001	.125	.005		
	-.1777	-.1950	-.1622	.5276	.2496	-.1615	-.4090	
8	N(86)	N(86)	N(86)	N(86)	N(86)	N(86)	N(86)	
	.102	.072	.136	.000	.020	.137	.000	
	-.3375	-.5840	.1660	.2983	.6829	-.5998	.1636	.3907
9	N(86)	N(86)	N(86)	N(86)	N(86)	N(86)	N(86)	N(86)
	.001	.000	.127	.005	.000	.000	.132	.000
	1	2	3	4	5	6	7	8
	Group	Secrq	Prerq	Disrq	Fearq	Secrsq	Prersq	Disrsq

1. Group= Abuse group; 2. Secrq=Secure; 3. Prerq=Preoccupied;
4. Disrq=Dismissing; 5. Fearq=Fearful (attachment as measured by RQ);
6. Secrsq=Secure; 7. Prersq=Preoccupied; 8. Disrsq=Dismissing;
9. Fearrsq=Fearful (attachment as measured by RSQ).

Table 1 cont'd
Spearman bivariate correlation coefficients, frequency counts, and significance levels of all dependent and independent variables

10	-.5882 N(86) .000	-.3077 N(86) .004	-.0701 N(86) .522	.1619 N(86) .136	.3056 N(86) .004	-.1961 N(86) .070	.0377 N(86) .730	.2597 N(86) .016
11	.1489 N(86) .171	.3206 N(86) .003	.1420 N(86) .192	-.0422 N(86) .700	-.1594 N(86) .143	.1879 N(86) .083	.1001 N(86) .359	-.1374 N(86) .207
12	-.4825 N(75) .000	-.0975 N(75) .406	-.0965 N(75) .410	.1348 N(75) .249	.2518 N(75) .029	-.0471 N(75) .688	.0667 N(75) .570	.1909 N(75) .101
13	-.8791 N(49) .000	-.2536 N(49) .079	.2484 N(49) .085	-.0439 N(49) .765	.1823 N(49) .210	.0418 N(49) .775	.2878 N(49) .045	.0123 N(49) .933
14	-.0120 N(86) .913	-.0160 N(86) .883	.0534 N(86) .626	-.0997 N(86) .361	-.0504 N(86) .645	.1292 N(86) .236	.0232 N(86) .832	.0053 N(86) .961
15	-.3755 N(81) .001	-.1847 N(81) .099	.2004 N(81) .073	.0142 N(81) .900	.1835 N(81) .101	-.2322 N(81) .037	.2757 N(81) .013	.0602 N(81) .593
	1 Group	2 Secrq	3 Prerq	4 Disrq	5 Fearq	6 Secrsq	7 Prersq	8 Disrsq

1. Group= Abuse group; 2. Secrq=Secure; 3. Prerq=Preoccupied;
4. Disrq=Dismissing; 5. Fearq=Fearful (attachment as measured by RQ);
6. Secrsq=Secure; 7. Prersq=Preoccupied; 8. Disrsq=Dismissing;
9. Fearrsq=Fearful (attachment as measured by RSQ); 10. #sep=Number of separations from caregivers during childhood; 11. Sigtot=Number of supportive attachment figures during childhood; 12. Endcpa=Endorsed having been physically abused during childhood; 13. Endcsa=Endorsed having been sexually abused during childhood; 14. Care=Total # of care-oriented responses on the MOS; 15. Anyther=Currrent and/or Past therapy.

Table 1 cont'd
Spearman bivariate correlation coefficients, frequency counts, and significance levels of all dependent and independent variables

10	.4055 N(86) .000					
11	-.3089 N(86) .004	-.1099 N(86) .314				
12	.1891 N(75) .104	.2966 N(75) .010	-.0976 N(75) .405			
13	.0387 N(49) .792	.2509 N(49) .082	.0077 N(49) .958	.0024 N(47) .987		
14	.0658 N(86) .547	.0680 N(86) .530	-.1606 N(86) .140	-.1143 N(75) .329	-.0109 N(49) .941	
15	.2212 N(81) .047	.1748 N(81) .119	-.0301 N(81) .790	.1630 N(72) .171	.4037 N(49) .004	-.0071 N(81) .950
	9 Fearsq	10 #sep	11 Sigtot	12 Endcpa	13 Endcsa	14 Care

9. Fearsq=Fearful attachment as measured by the RSQ; 10. #sep=Number of separations from caregivers during childhood; 11. Sigtot=Number of supportive attachment figures during childhood; 12. Endcpa=Endorsed having been physically abused during childhood; 13. Endcsa=Endorsed having been sexually abused during childhood; 14. Care=Total # of care-oriented responses on the MOS; 15. Anyther=Current and/or past therapy.

Descriptive Statistics

The one-way analysis of variance procedure was used to test for significant differences between the groups on continuous demographic variables (age, SES, and number of years of education) and on social desirability. No significant differences were found between continuous demographic variables. Results are reported in Table 2.

Table 2

Tests of group differences on continuous demographic variables and social desirability

Variable	Mean	S.D.	F	p
Age (years)	34.581	8.336	2.629	0.078
SES (Hollingshead, 1975)	37.361 (Skilled Clerical/Sales)	10.697	2.534	0.086
Education (years)	13.878	2.161	0.999	0.373
Social Desirability (Marlowe-Crowne)	4.291	2.125	0.455	0.636

The Kruskal-Wallis 1-Way Anova procedure was used to test for group differences on categorical demographic variables (ethnicity, parental status, and being in a close romantic relationship) and on whether participants were currently, or had ever been, in therapy. Results are reported in Table 3.

Table 3
Tests of group differences on categorical demographic variables and therapy status

Variable	Totals and Percentages	X^2	p-value
Ethnicity	Caucasian = 62 (72.1%) Aboriginal = 8 (9.3%) Asian = 2 (2.3%) Other = 13 (15.1%) Not reported = 1 (1.2%)	11.287	0.079
Relationship Status	Yes = 55 (64%) No = 31 (36%)	2.222	0.329
Parental Status	Children = 49 (57%) No children = 37 (43%)	3.439	0.179
Any Therapy (Current/Past)	CSA = 30 (100%) CPA = 22 (78.6%) NA = 15 (53.6%)	11.388	0.003

CSA=Child Sexual Abuse; CPA=Child Physical Abuse; NA=Nonabused

Child Sexual Abuse

Child sexual abuse characteristics are reported in Table 4. Within the CSA group, the average age of onset of sexual abuse reported was 4.7 (S.D.=3.04) and the range was 1-15 years. It is apparent from examination of the data that a significant number of women in the CSA group (70%) experienced severe abuse by more than one perpetrator. Perpetrators of intrafamilial abuse were parents (77%), siblings (20%), and/or extended family members (57%). Participants in

the CSA group also reported being abused by strangers (37%) and by acquaintances (50%). All of the women in the CSA group answered "yes" to a question asking them if they believed they had been sexually abused in childhood.

Data were also collected on peer sexual abuse, defined as sexual abuse by someone less than five years older than the participant. Sixteen women (53%) in the CSA group reported peer sexual abuse. Age at onset ranged from two to 16 years (X=10, S.D.=4.72).

Thirteen women in the CPA group (46%) and four women in the NA group (14%) also reported experiencing some unwanted sexual experiences as children, either by adults or peers. These experiences did not meet the criteria for child sexual abuse set for this study. Three women in the CPA group (11%) believed they were sexually abused in childhood. No women in the NA group believed they were sexually abused in childhood.

Women in the CSA and CPA groups reported a high level of adult sexual assault (ASA). ASA was reported by 27 women (90%) in the CSA group and by 15 women in the CPA group (54%). None of the women in the NA group met the criteria for adult sexual assault. This was considered a potential confound and was further investigated in the qualitative component of the study.

Table 4

Child sexual abuse characteristics for CSA, CPA, and NA participants

		Group		
Type of Abuse	Frequency	CSA	CPA	NA
Unwanted sexual kissing	Never	5 (17%)	23 (82%)	27 (96%)
	1-2 times	7 (23%)	5 (18%)	1 (4%)
	> 2 times	18 (60%)	0 (0%)	0 (0%)
Fondling	Never	1 (3%)	17 (61%)	27 (96%)
	1-2 times	1 (3%)	8 (29%)	1 (4%)
	> 2 times	28 (93%)	3 (11%)	0 (0%)
Digital or object penetration	Never	1 (3%)	28 (100%)	28 (100%)
	1-2 times	3 (10%)	0 (0%)	0 (0%)
	> 2 times	26 (87%)	0 (0%)	0 (0%)
Oral sex	Never	5 (17%)	28 (100%)	28 (100%)
	1-2 times	6 (20%)	0 (0%)	0 (0%)
	> 2 times	19 (63%)	0 (0%)	0 (0%)
Attempted vaginal intercourse	Never	9 (31%)	27 (96%)	28 (100%)
	1-2 times	5 (17%)	1 (4%)	0 (0%)
	> 2 times	15 (52%)	0 (0%)	0 (0%)

CSA = Child Sexual Abuse; CPA = Child Physical Abuse; NA = Nonabused

Table 4, cont'd
Child sexual abuse characteristics for CSA, CPA, and NA participants

		Group		
Type of Abuse	Frequency	CSA	CPA	NA
Completed vaginal intercourse	Never	11 (39%)	28 (100%)	28 (100%)
	1-2 times	4 (14%)	0 (0%)	0 (0%)
	> 2 times	13 (46%)	0 (0%)	0 (0%)
Anal sex	Never	18 (60%)	28 (100%)	28 (100%)
	1-2 times	1 (3%)	0 (0%)	0 (0%)
	> 2 times	9 (30%)	0 (0%)	0 (0%)
Other	Never	1 (3%)	2 (8%)	0 (0%)
	> 2 times	1 (3%)	0 (0%)	0 (0%)
	No Response*	28 (94%)	26 (92%)	28 (100%)
Meets criteria for CSA		30 (100%)	0 (0%)	0 (0%)
Identified self as CSA		30 (100%)	3 (11%)	0 (0%)
Perpetrators	Parent(s)	23 (77%)	1 (4%)	0 (0%)
	Sibling	6 (20%)	0 (0%)	0 (0%)
	Extended family	17 (57%)	1 (4%)	0 (0%)
	Acquaintance	15 (50%)	10 (36%)	1 (4%)
	Stranger	11 (37%)	3 (11%)	0 (0%)

CSA = Child Sexual Abuse; CPA = Child Physical Abuse; NA = Nonabused
* No Response = assumed to mean that participant did not experience

Child Physical Abuse

Child physical abuse characteristics for the CSA, CPA, and NA groups are summarised in Table 5. Examination of the data revealed that women in the CPA group were severely physically abused and that 22 (78%) of them endorsed the question asking whether they believed they had been physically abused in childhood. A preponderance of women in the CSA group (25, or 83%) also met the criteria for physical abuse. Twenty-three women in the CSA group (77%) indicated that they believed they had been physically abused in childhood. No women in the NA group met the criteria for child physical abuse, but one woman (4%) indicated that she had experienced injury. This woman reported that she had been hit, scratched, and had her hair pulled once or twice, resulting in bruising. She reported no other injury and the injury was not severe enough to require medical treatment. It was therefore decided not to eliminate this participant's data from further analyses.

Table 5
Child physical abuse characteristics for CSA, CPA, and NA participants

		Group		
Type of Abuse	Frequency	CSA	CPA	NA
Hit	Never	0 (0%)	0 (0%)	21 (75%)
	1-2 times	2 (7%)	0 (0%)	5 (18%)
	> 2 times	28 (93%)	28 (100%)	1 (4%)
Beaten	Never	8 (27%)	3 (11%)	27 (96%)
	1-2 times	6 (20%)	7 (25%)	0 (0%)
	> 2 times	16 (53%)	16 (57%)	1 (4%)
Pushed	Never	6 (20%)	3 (11%)	26 (93%)
	1-2 times	4 (13%)	6 (21%)	2 (7%)
	> 2 times	20 (67%)	19 (68%)	0 (0%)
Hit with an object	Never	8 (27%)	2 (7%)	21 (75%)
	1-2 times	3 (10%)	4 (14%)	5 (18%)
	> 2 times	19 (63%)	22 (79%)	2 (7%)
Hair pulled	Never	9 (30%)	8 (29%)	26 (93%)
	1-2 times	6 (20%)	5 (18%)	2 (7%)
	> 2 times	15 (50%)	15 (54%)	0 (0%)
Burned	Never	24 (87%)	25 (89%)	28 (100%)
	1-2 times	1 (3%)	2 (7%)	0 (0%)
	> 2 times	3 (10%)	1 (4%)	0 (0%)

CSA = Child Sexual Abuse; CPA = Child Physical Abuse; NA = Nonabused

Table 5, cont'd
Child physical abuse characteristics for CSA, CPA, and NA participants

		Group		
Type of Abuse	Frequency	CSA	CPA	NA
Scratched	Never	20 (67%)	18 (64%)	27 (96%)
	1-2 times	2 (7%)	2 (7%)	1 (4%)
	> 2 times	7 (24%)	8 (29%)	0 (0%)
Arm or leg twisted or pulled	Never	5 (17%)	6 (21%)	24 (86%)
	1-2 times	6 (20%)	7 (25%)	2 (7%)
	> 2 times	19 (63%)	15 (54%)	1 (4%)
Other physical abuse	Never	2 (7%)	2 (7%)	1 (4%)
	> 2 times	2 (7%)	0 (0%)	3 (11%)
	No response*	26 (86%)	26 (93%)	24 (85%)
Injured	Yes	25 (83%)	28 (100%)	1 (4%)
	No	5 (17%)	0 (0%)	17 (61%)
	No response*	0 (0%)	0 (0%)	10 (35%)
Meets criteria for physical abuse	Not abused	5 (17%)	0 (0%)	28 (100%)
	Abused	25 (83%)	28 (100%)	0 (0%)
Identified self as physically abused	Yes	7 (23%)	5 (18%)	17 (61 %)
	No	23 (77%)	22 (78%)	1 (4%)
	No response*	0 (0%)	1 (4%)	10 (35%)

CSA = Child Sexual Abuse; CPA = Child Physical Abuse; NA = Nonabused
*No response = assumed to mean that participant did not experience

Table 5, cont'd
Child physical abuse characteristics for CSA, CPA, and NA participants

		Group		
		CSA	CPA	NA
Perpetrators	Mother	23 (77%)	20 (71%)	15 (54%)
	Father	25 (83%)	22 (79%)	11 (39%)
	Stepmother	2 (7%)	1 (4%)	0 (0%)
	Stepfather	2 (7%)	2 (7%)	1 (4%)
	Other adult relative	9 (30%)	7 (25%)	1 (4%)
Perpetrators of concurrent abuse	Sibling	14 (47%)	18 (64%)	11 (39%)
	Peer	9 (30%)	3 (11%)	1 (4%)
	Nonrelated adult	12 (40%)	1 (4%)	0 (0%)

CSA = Child Sexual Abuse; CPA = Child Physical Abuse; NA = Nonabused

Emotional Abuse and Neglect

A summary of emotional abuse and neglect characteristics are reported in Table 6. Participants met criteria for emotional abuse if they reported any of: having been verbally abused (called names, insulted, humiliated), threatened with physical harm, had an object thrown at them with intent to harm, or had property damaged in front of them more than twice. Results indicated that 27 participants in the CSA group (90%) and 28 participants in the CPA group (100%) met criteria

for emotional abuse. In contrast, 11 participants in the NA group (39%) met criteria for emotional abuse. Neglect was defined as caregivers failing to provide the participant with adequate food, medical care, or shelter at least once during childhood. Seventeen participants in the CSA group (56%) and 11 participants in the CPA group (39%) met the criteria for neglect. None of the members of the NA group met the criteria for neglect.

Post hoc analyses were conducted in order to determine whether there were associations between the summary measures of emotional abuse and attachment style and neglect and attachment style. The Kolmogorov-Smirnov two-sample test was used; this is a nonparametric test of whether two samples come from the same distribution. The results were non-significant for both emotional abuse and attachment (K-S $Z = .78$, $p=.58$) and neglect and attachment (K-S $Z = .56$, $p = .92$).

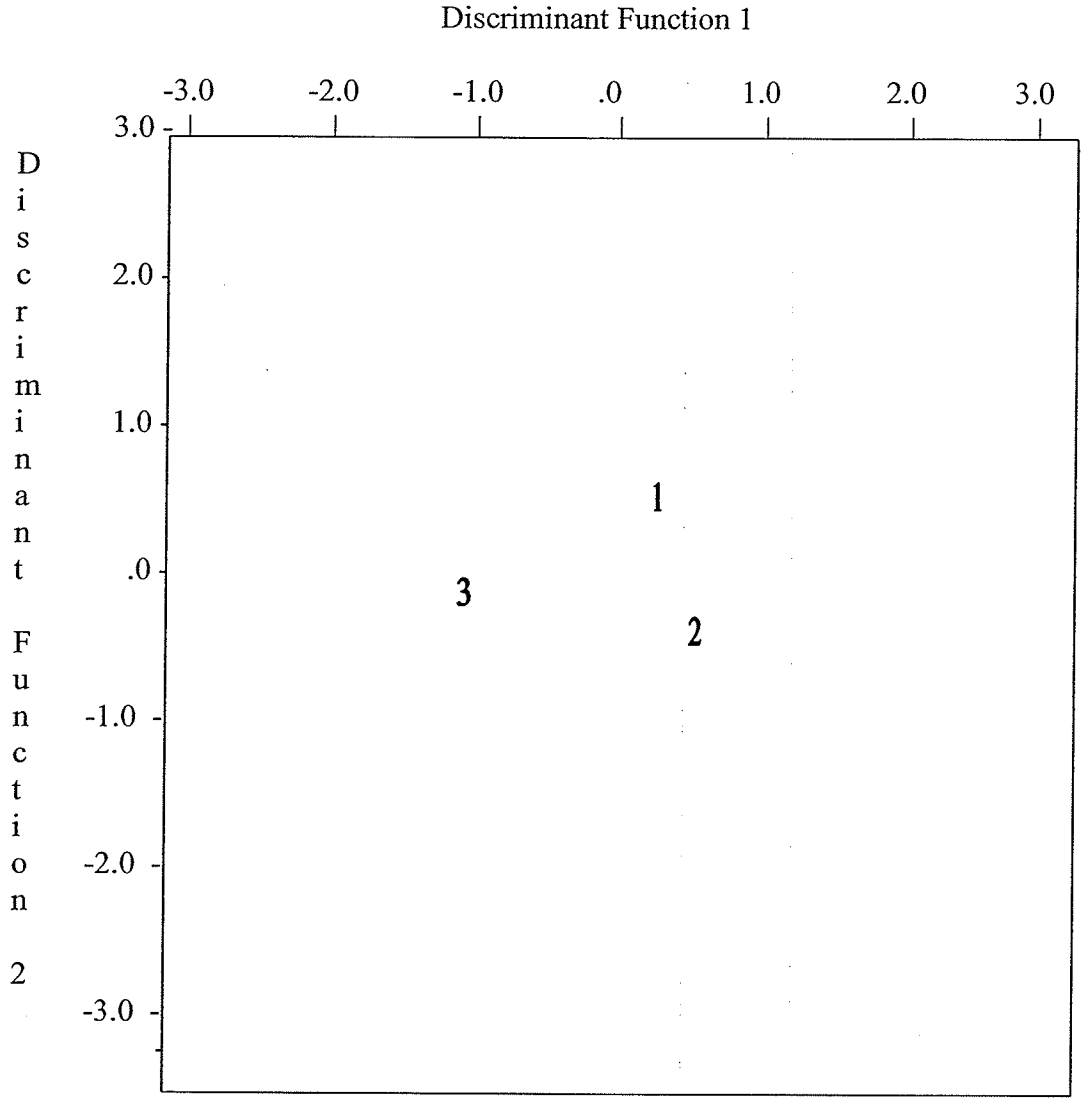
Table 6
Emotional abuse and neglect characteristics for CSA, CPA, and NA participants

		Group		
		CSA	CPA	NA
Verbally Abused	Never	2 (7%)	1 (4%)	16 (57%)
	1-2 times	1 (3%)	0 (0%)	5 (18%)
	> 2 times	27 (90%)	27 (96%)	7 (25%)
Threatened with physical harm	Never	4 (13%)	1 (4%)	22 (79%)
	1-2 times	2 (7%)	0 (0%)	2 (7%)
	> 2 times	24 (80%)	27 (96%)	4 (14%)
Object thrown	Never	12 (41%)	6 (21%)	26 (93%)
	1-2 times	5 (17%)	3 (11%)	2 (7%)
	> 2 times	12 (41%)	19 (68%)	0 (0%)
Damaged property	Never	10 (33%)	9 (32%)	23 (82%)
	1-2 times	5 (17%)	9 (32%)	2 (7%)
	> 2 times	15 (50%)	10 (36%)	3 (11%)
Emotionally Abused	Not abused	3 (10%)	0 (0%)	17 (61%)
	Abused	27 (90%)	28 (100%)	11 (39%)
Neglected	Never	13 (43%)	17 (61%)	28 (100%)
	At least once	17 (56%)	11 (39%)	0 (0%)

CSA=Child Sexual Abuse; CPA=Child Physical Abuse; NA=Nonabused; Verbally Abused = e.g., called names, insulted, humiliated; Object thrown (at participant with intent to harm); Damaged property (in front of participant); Emotionally Abused (endorsed any category > 2 times; Neglected (failed to provide adequate food, medical care, or shelter).

Hypothesis Testing

First, an exploratory analysis was conducted to investigate whether the RQ and the RSQ placed participants in the same attachment categories. Discriminant function analysis was used to investigate which attachment variables best discriminated between the three abuse groups. According to Tabachnick and Fidell (1989), "The major purpose of discriminant function analysis is to predict group membership from a set of predictors" (p. 505). Direct discriminant function analysis was used for this analysis. This means that all predictors enter the equations at once. Eight attachment variables (four each from the RQ and RSQ) were used as predictors of membership in the three abuse groups (CSA, CPA, and NA). Classification was made on the basis of a modified equation in which unequal prior probabilities were set to reflect unequal group sizes. Two discriminant functions were calculated, with a combined X^2=37.46 (16), p<.01. After removal of the first function, no significant association between groups and predictors remained (X^2=8.14 (7), p=.32). This indicates that only the first function was a significant predictor. It accounted for 80.5% of the between-group variability. As shown in Figure 2, the first discriminant function maximally separates the CSA and CPA groups from the NA group.



Group centroids: 1 = CSA group 2 = CPA group 3 = NA group

Figure 2: Territorial map of canonical discriminant functions, from SPSS discriminant function analysis of RQ, RSQ by Group.

Results of the discriminant function analysis are found in Table 7. The tests of equality of group means reveal that all attachment variables except for Dismissing attachment as measured by the RQ were significant predictors. The standardized canonical discriminant function coefficients indicate the relative importance of each attachment variable in predicting group membership. They are used to assess each variable's unique contribution. Based on these results, it was decided to use the RSQ rather than the RQ in further analyses because it appeared to be a better predictor for distinguishing between the three groups.

The pooled within-groups correlations between discriminating variables and standardized canonical discriminant functions can shed light on what the functions represent. Loadings less than .30 are not interpreted. The highest correlations are associated with Fearful attachment as measured by the RQ and RSQ, Secure attachment as measured by the RQ, and Dismissing attachment as measured by the RSQ. It is possible that function 1 corresponds to Bartholomew's (Griffin & Bartholomew, 1994a) underlying dimension of "other" because Fearful and Dismissing attachment styles are associated with negative views of others, whereas Secure attachment is associated with positive views of others.

Table 7
Results of discriminant function analysis of attachment variables

	Standardized canonical discriminant function coefficients		Pooled within-groups correlations between discriminating variables and functions		Tests of equality of group means	
Predictor variable	Function 1	Function 2	Function 1	Function 2	Univariate F (2, 83)	p
Fearsq	.398	.233	.779*	.121	11.289	.000
Fearq	.103	.049	.553*	.095	5.698	.005
Secrq	-.187	-.216	-.521*	-.198	5.199	.007
Disrsq	.466	-.069	.495*	-.336	5.033	.009
Secrsq	.095	.594	-.451*	.050	3.774	.027
Prerq	.497	-.754	.424*	-.029	3.332	.041
Prersq	.195	1.220	.248*	.695	3.300	.042
Disrq	.246	-.006	.360	-.265*	2.717	.072
Canonical R	.56	.31				
Eigen-value	.45	.11				

Disrq=Dismissing; Secrq=Secure; Prerq=Preoccupied; Fearq=Fearful (attachment as measured by RQ); Disrsq=Dismissing; Secrsq=Secure; Prersq=Preoccupied; Fearsq=Fearful (attachment as measured by RSQ).

* Largest absolute correlation between each variable and any discriminant function

Pooled within-group correlations among the eight predictors are shown in Table 8. The highest positive correlations are between corresponding attachment styles on the RQ and RSQ. The highest negative correlations are between opposing attachment styles on the RQ and RSQ, which may provide support for Bartholomew's (Griffin & Bartholomew, 1994a) underlying dimensions of self and other. The negative correlations between the Secure and Fearful attachment styles may be due to the underlying dimension of self. The high negative correlations between the Preoccupied and Dismissing attachment styles may be due to the dimension of other.

Table 8
Pooled within-group correlations among predictor variables

	Pooled within-group correlations among predictors						
Predictor variable	Prerq	Disrq	Fearq	Secrsq	Prersq	Disrsq	Fearsq
Secrq	-.021	-.149	-.435	.550	-.152	-.104	-.541
Prerq		-.312	.002	-.110	.606	-.317	.100
Disrq			.166	-.057	-.419	.504	.192
Fearq				-.493	.085	.195	.669
Secrsq					-.290	-.077	-.579
Prersq						-.458	.147
Disrsq							.300

Classification results indicated that overall, 62.8% of the cases were correctly classified into groups. A summary of actual vs. predicted group membership is presented in Table 9.

Table 9

Actual vs. predicted group membership from discriminant function analysis of attachment

Actual Group	No. of cases	Predicted group membership		
		CSA	CPA	NA
CSA	30	17 (56.7%)	8 (26.7%)	5 (16.7%)
CPA	28	6 (21.4%)	19 (67.9%)	3 (10.7%)
NA	28	6 (21.4%)	4 (14.3%)	18 (64.3%)

CSA=Child Sexual Abuse; CPA=Child Physical Abuse; NA=Nonabused

Hypotheses 1 predicted that women in the CSA and CPA groups would rate significantly higher on insecure styles of attachment (Preoccupied, Dismissing, and Fearful) and significantly lower on Secure attachment than those in the NA group. Results indicated that women in the CSA and CPA groups had higher mean scores on insecure attachment styles and lower mean scores on secure attachment as compared with the NA group (summarised in Table 10).

Multivariate analysis of variance (MANOVA) revealed that, as predicted, women in the CSA and CPA groups were significantly higher on insecure styles of attachment and significantly lower on secure attachment (as measured by the RQ) than those in the NA group ($F=3.91$, Wilks' Lambda=.70, $p<.001$). Examination of pairwise comparisons revealed no significant differences between the CSA and CPA groups on attachment styles. Results further indicated that the CSA group was significantly higher on Preoccupied and Fearful attachment than the NA group. The CPA group was significantly higher on Secure attachment and significantly lower on Dismissing and Fearful attachment than the NA group. Results are summarised in Table 10.

Table 10
Results of multivariate analysis of variance of group by attachment style as measured by the RSQ

Attachment (RSQ)	F(2, 83)	Mean (Standard Deviation)		
		CSA N=30	CPA N=28	NA N=28
Secure	3.77*	2.89 (.74)	2.77 (.58)	3.25 (.71)
Preoccupied	3.30*	3.20 (.78)	2.82 (.85)	2.67 (.80)
Dismissing	5.03**	3.50 (.83)	3.80 (.68)	3.16 (.75)
Fearful	11.29**	3.66 (.98)	3.79 (.65)	2.71 (1.11)

* = $p<.05$
** = $p<.01$
CSA = child sexual abuse; CPA = child physical abuse; NA = nonabused.

These results support the findings of previous research (Alexander, 1993; Roche, Runtz, & Hunter, 1999) indicating that child sexual abuse is associated with insecure attachment, in particular Fearful attachment, in adulthood.

Hypothesis 2 stated that women in the CSA group would rate significantly higher on Fearful attachment than those in either the CPA or NA group. MANOVA revealed that there were no significant differences between the CSA and CPA groups on the proportions of the respective attachment styles. More specifically, the CSA group was not significantly higher on Fearful attachment than the CPA group. Results are summarised in Table 10.

Hypothesis 3 stated that that women with Secure or Preoccupied attachment styles would choose care-oriented responses with greater frequency than would women with Dismissing or Fearful attachment styles on the Moral Orientation Scale for Childhood Dilemmas (MOS). The predominant attachment style as reported on the RSQ was used as the dependent variable for a one-way ANOVA. Results indicated no significant between-group differences ($F=.200$, $p=.90$). The mean number of care responses was 4.91 (S.D.=1.71), suggesting that participants were no more likely to choose care-oriented than justice-oriented responses.

An exploratory analysis was conducted to investigate whether the degree

to which participants endorsed the care orientation (as measured by the MOS) differed according to group. One-way analysis of variance indicated no significant between-group differences (F=.393, p=.68).

An exploratory analysis was conducted to investigate whether the number of important attachment figures and number of separations from attachment figures (as assessed by the Caretaker History Questionnaire) differed significantly according to group. One-way analyses of variance indicated that there were no significant differences in the number of important attachment figures between the three groups (F=.886, p=.416). It seems plausible that the quality of support, rather than the number of supportive figures, may be associated with attachment. A review of the raw data indicated that a majority (74/86 or 86.5%) of participants reported having support from one or more close family members before age 10. The remainder (12/86 or 13.5%) reported having little or no support from close family members before age 10.

There were significant between-group differences on number of separations from attachment figures. This was tested using a nonparametric test, a Kruskal-Wallis one-way ANOVA, because the variable was not normally distributed. Results indicated significant differences between the mean ranks of the three groups (X^2= 29.42, p<.001). Examination of the means of the three

groups (CSA=2.60, CPA=1.57, NA=.21) suggests that the difference is due to the CSA (and possibly also the CPA) participants having significantly more separations than the NA participants.

An exploratory analysis was conducted to investigate whether the number of important attachment figures and number of separations from attachment figures (as assessed by the Caretaker History Questionnaire) differed significantly according to primary attachment style (as assessed by the RSQ). One-way analyses of variance indicated that there were no significant between-group differences for number of important attachment figures ($F=.975$, $p=.41$). Kruskal-Wallis one-way Anova indicated no significant differences for number of separations from attachment figures based on attachment style ($X^2= 4.35$, $p=.23$).

Several research studies in the area of resiliency (e.g., Cowen, Work, & Wyman, 1997; Werner, 1989) have suggested that separations from caregivers during infancy differentiate resilient from stress-affected children. It may be that separations from caregivers in infancy and early childhood have a particular impact on attachment development. The data were examined to see how many participants reported separation for more than three weeks from one or both parents before age five. Results indicated that five women in the CSA group reported early childhood separation; four had Fearful attachment and one had

Preoccupied attachment. Reasons for separation included the participants' own illness or the illness of a parent, being placed in foster care or sent away to boarding school, and being cared for by grandparents. Length of separations ranged from six weeks to several years. One participant in the CPA group reported being separated from a parent at age three due to divorce; she developed Fearful attachment. No participants in the NA group reported early childhood separation.

Qualitative Results

Thematic Qualitative Analysis

The researcher transcribed the interviews verbatim. Transcription yielded an initial sense of the 'stories' within each interview. Data were then coded and analysed using thematic qualitative analysis (see, e.g., Boyatzis, 1998) as well as some of the techniques from grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

Data analysis was conducted using Atlas/ti, a qualitative data analysis and management program (Muhr, 1997). Atlas/ti is based on the principles of grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990). The program enables the researcher to work with the data on two levels. The textual level facilitates coding passages of data and writing comments and memos. The

conceptual level enables the researcher to connect passages, memos, and codes visually by creating diagrams. This ability to outline relationships graphically facilitates theory building.

Data analysis began with open coding. Strauss and Corbin (1990) liken open coding to "beginning to work on a puzzle" (p. 204). It is necessary to start to identify pieces of the data and sort them by common attributes. Most of these initial codes were fairly descriptive. For example, an early code was "Self esteem – lack," defined as "Indications of a lack of self-esteem or self-assuredness." As the data were further examined, a more conceptual code evolved: "Suppressing sense of self," defined as "Participant shows evidence of suppressing her usual way of being because of what others think of her or because of a situation." As more and more conceptual codes emerge, they were developed into categories whose properties and dimensions were defined.

Throughout coding and theory building, the constant comparative method (Glaser & Strauss, 1967) was employed. Charmaz (2000) summarises the constant comparative method as;

> (a) comparing different people (such as their views, situations, actions, accounts, and experiences), (b) comparing data from the same individuals with themselves at different points in time, (c) comparing incident with incident, (d) comparing data with category, and (e) comparing a category with other categories. (p. 515)

An example of how this method worked with coding follows. Each time a passage of text was coded, it was compared with other passages that had been assigned the same code. As a given code was assigned to an increasing number of passages, it became necessary to define the code, or to give it a description. At times during coding, it became apparent that two codes overlapped. Then a decision was made about whether to merge them into a new code. At other times, it became apparent that the code category was too broad and diffuse; it was then necessary to split and define two (or more) codes. Writing memos during this process helped to define and describe the properties of a category and was an important tool to facilitate theory building.

The next step involved axial coding, which Strauss and Corbin (1990) describe as beginning "to fit the pieces of the puzzle together" (p. 211). This phase involved moving back and forth between coding and looking for relationships in the data. Ryan and Bernard (2000) describe this process as answering the questions "When, why, and under what conditions do these themes occur in the text?" (p. 783) Atlas/ti also enables the researcher to create links between passages of text using the hypertext function. Linking text in this way sometimes formed the basis for creating a network view, or concept map. This is a graphical representation of the data that can include codes, quotations, memos

or comments, and entire documents (in this case, icons that represent interviews) and allows the researcher to show relationships between them. It is also important to ensure that the data support the developing theory. This involved a process of continually defining and redefining the relationships between these elements (Charmaz, 2000; Strauss & Corbin, 1990). In the present study, this was accomplished by going back and forth between interview texts and network views or concept maps. Negative case analysis, or looking for examples that do not fit the theory, was used to identify problems and revise the theory.

Although the interviews were transcribed verbatim, the quotations included here were edited to increase readability. For example, expressions such as "uh", "um", and "you know" and word repetitions were deleted.

It is important to preface the presentation of these results by emphasising that they represent a small sample (23/86) of the participants. These analyses are exploratory. Although they have lead to some interesting hypotheses, it is not appropriate to attempt to draw generalisable conclusions from them.

Attachment Analysis

The first focus of data coding and theory development involved investigating the following questions:

a) To what factors do participants relate the development of their attachment style?

b) In particular, do they attribute part or all of their style of relating to childhood experiences, including abuse?

Attachment Development and Abuse

A preponderance of women in all three groups in this sample believed that their attachment styles had developed in childhood as a result of their family lives. This pattern held across attachment styles. Not all of the participants had one predominant attachment style; some had combinations of two or three styles. Further, some women changed attachment styles over time.

Several women in the CSA and CPA groups linked the development of their insecure attachment styles to the abuse they suffered during childhood. Two sexual abuse survivors described how it is for them to try to be in relationships.

> Well, for me I'm sure it probably came from abuse, ... episodes, and that. And so I became more, leery I guess at times it's like I'm in there, you know, and then other times I'm very, stay away from me [chuckle]. (Participant 100)

> The people that I was closest to were the ones that betrayed me. .... which made me I guess leery of all people. .... And, so part of me knew that there were sort of authentic kinds of relationships and that's sort of what I always aspired to achieve, a real, relationship where it wouldn't be betrayed. (Participant 108)

A physical abuse survivor attributed the problems she experiences with

attachment to her emotional abuse experiences.

> I think a lot of the way my moth, my mom treated me helped create this, problem with trusting other people, and trusting myself, too .... I think what happened was a lot of the boundaries between mother and child got blended, and she was expecting, she would talk to me about a lot of her problems ... almost making me feel like I am at fault for why she's feeling the way she is ... and [pause] putting me down, criticizing me, being overall negative. (Participant 222)

This participant's reference to having difficulty trusting others was a recurrent theme in the interviews of abuse survivors. It was particularly significant in those classified as having Fearful and Dismissing attachment, the two attachment styles in which the person has negative expectations of others.

Attachment Development and Family Life

Many other women did not make direct links between their abuse experiences and insecure attachment development. Rather, they attributed the development of their insecure attachment styles to their family lives. Several themes emerged, including a lack of nurturing relationships in their families, not feeling valued within the family, and the effect of being separated from caregivers in early childhood.

In the following passage, a child sexual abuse survivor connected the development of her Preoccupied attachment style to a lack of nurturing.

> Seeing as I grew up without cl, very little close emotional relationships there's a I'm, needy's the right word or have a, I have a large emotional

> close deficit. [chuckle] .... I, may be hard to balance that because I have, that strong need to be emotionally in sync or connecting with people. (Participant 112)

A child physical abuse survivor who developed a Dismissing attachment style described her family life as follows:

> My mother was always working like a slave because my Dad was an alcoholic, and drank all the money, she had to pay all the bills, so I was always alone, so I guess that's why I sort of like my space. (Participant 201)

A nonabused woman talked about developing a primarily Fearful attachment style. She attributed this to her family life and acknowledged that it was reinforced by her adult relationships.

> ... probably almost as a protective thing, I would think. Um, also I guess it's probably in the way that people are raised. I know in my own family everybody loves each other but no-one says it and ... there's not a lot of huggy kissy kind of stuff. I never really saw my Mom and Dad kiss each other or hug each other. (Participant 317)

Other statements reflected a sense of not feeling valued within the family, for example:

> They felt that a woman's place was in the home and uh a woman should be, should value everything that her husband says, and whatever she thought or did really didn't matter. .... Um, I remember when I said that I wanted to take an art course, my father said "As long as you know how to clean a chicken and change a diaper, that's all you need to know." .... So I couldn't take the art course, so, so they never valued, me in that way, in any way at all really, I was just a person to help clean up the home. (Participant 212)

An aboriginal woman who was adopted into a white family talked about how she felt set apart. The "secrets" she spoke of are her sexual abuse by her adoptive father.

> My family's white you know, my sister and brother are blonde and blue-eyed so ... I've always been, the black sheep so ... I was always treated that way, I was never ... it was quite obvious I wasn't from that family, ... afnd then having, my um, having the man, you know having these little secrets all the time I just set myself apart. (Participant 124)

Two women described being separated from their immediate families early in childhood, and related these experiences to the development of their attachment styles.

> I would have to stay it [chuckle] started way back, like I mean, I was taken from my parents, I lost people right there. Like I was two years old. .... And uh, I remember some of the stuff, like I remember standing in an office, I guess it was a CFS [Child and Family Services] office, and my Dad wanted to get me back from my aunt, and my aunt said "No way", and she's screaming at him, telling him that, you know, "Over our dead bodies", right, and so he didn't bother fighting any more for me. .... Uh, I remember not seeing him ever again until I was nine. (Participant 104)

> I was, just before my fourth birthday, and I can remember it very very clearly, I just, and I also still can't understand why. Then I had no understanding at all ... um, I couldn't figure out what I had done to be, sent away [to boarding school]. And I was the only one in my family of five kids that was sent. .... So. It was, it was tough, and that was the beginning of, [pause] not getting close to people or wanting to and then being afraid but I, in addition to that I was a military, kid. .... So there was no permanence or stability anywhere in my life. (Participant 108)

Both abused and nonabused women in this sample frequently attributed

the development of their insecure attachment styles to their family lives. Many made direct reference to the effect of the abuse. Others described a lack of nurturing relationships in their families, not feeling valued within the family, and early childhood separation.

Attachment Development and Sense of Self

Sense of self was a recurring theme throughout many of the interviews, across attachment styles and groups. Several women linked the development of their insecure attachment styles to a lack of self-esteem. For example, a physical abuse survivor stated:

> I think I have a fear of it all, I'm just not confident in myself and, I guess maybe that's true I am worried that people won't like me as much as I hope they will. I guess, I'm kinda shy and I feel kinda like maybe I'm a what do they call it, social misfit shall we say. (Participant 220)

Another participant's sexual abuse history led her to question her sense of self.

> It's very sad and it's very scary, because it's like "Oh, now you, I'm that messed up? I never realized how much it [the abuse] affected me." (Participant 100)

A physical abuse survivor started questioning her sense of self while in an abusive relationship in adulthood.

> I used to go see my hairdresser once a week all the time, because I was looking after myself better, but like the last 6 months or 8 months I've been going downhill, but, and then he [partner] started accusing me of being gay? And for years already he's accusing me of being gay, because she's [hairdresser] a little bit different, herself. I mean, she's not, but like I

> don't care what she is, but she's just nice, she listens to me, that's all, I just go to see her as a hairdresser. I don't go see in the evening, or shopping with her, or nothing. It made me start wondering, and thinking, I know I don't like to be with him sexually too much, maybe I am or something. But yeah, I knew I wasn't, but I can see how some people can get confused, how people can play on them and then they can go in different directions because they're just not so sure anymore. (Participant 201)

A physical abuse survivor who developed a combination of Fearful, Preoccupied, and Dismissing attachment linked her questioning of sense of self to not being valued in her family when she was growing up. Even in casual social situations she finds herself suppressing her usual personality, and doubting herself.

> The minute someone gets, sort of into my space where I feel that they kind of, maybe, like me a little more than just that happy person sitting at a table that they may never see or see again, or they might see again, I all of a sudden start becoming critical of myself. I all of a sudden start to think, "Oh my gosh, I shouldn't have worn this tonight" and "Oh, my hair isn't as nice as it usually is" and then I start becoming, quieter, and then people start saying "Are you okay, because you're such a bubbly person, like what's happening to you?" and, and I don't even often realise it's happening. (Participant 212)

These passages contrast with the following quotation from a woman in the nonabused group who developed Secure attachment. She describes how her behaviour is congruent with her sense of self.

> I've seen how people are who keep everything inside and the pain that they go through without, being able to share it. Like it's almost like a cleansing every day when you're an open honest person, not that everybody likes it or, some people find me even a little bit, can't understand how somebody could be like that. When I'm with somebody else I don't have to constantly be somebody else, if you've met me well if you meet somebody

> else you're not going to say "Oh, really? That's how that person was?" (Participant 323)

Many nonabused women with Secure attachment highlighted the importance of a strong sense of self as they talked about the way they relate to others. They frequently attributed the development of a healthy self-concept to growing up in a warm, supportive family. The relationship between Secure attachment, sense of self, and family life is illustrated in the following two passages.

> I had a real idyllic childhood ... totally unconditional love from my parents, always, and that definitely makes a person secure and confident and everything. (Participant 302)

> I guess from family life my Mom was always um, very outspoken and very independent and very aggressive and I guess that, she's a very confident woman and I guess, just from learning that I've always been an outgoing person. And I think with being outgoing, that's how you gain confidence and I've always been, easy to get friends and things like that. In school I was, it wasn't my problem having friends and I guess, when things come easy to you you gain more confidence and then, I guess that reflects on all your other, relationships really. I didn't have any deaths in my family and I didn't have any, divorces immediately in my family or anything taken away from me so I guess I've been lucky .... you don't really worry about losing any 'cause you haven't really lost anybody. (Participant 323)

Attachment Development and Protective Factors

Some of the women described protective relationships during childhood. This sexual abuse survivor developed a Preoccupied attachment style, but

perceives herself as having been protected by her relationship with her older sister.

> There was one person that I had a close emotional relationship as a child, my older sister ... and that's actually, why we think the two of us came out okay. … because, she essentially provided me the only emotional connection I had as a child and, and her mothering me, the best she could only being six years older, ... was what gave us, what we needed. (Participant 112)

Another woman described a friendship as an important factor that enabled her to develop more secure ways of relating.

> I had this good relationship with this, this friend, she had an equally intense kind of family, and we managed to find a way of trusting each other. And then, once we sort of had developed our little tentative, cause that's how kids are, they have to work with one person, you know, trusting each other, and I was fortunate, it was a good match. (Participant 126)

Self-protection

Another theme that emerged was that of needing to protect the self in relationships. This theme occurred across abuse groups and in all three insecure attachment styles. Women spoke in terms of putting up "boundaries" and "walls." These two sexual abuse survivors, the first with a Dismissing/Fearful attachment style and the second with a Fearful style, described the process of protecting themselves in relationships.

> I've watched it, you know you can be close with somebody, and I feel comfortable being close with people, [pause] but it's to a point [chuckle]. "Okay, this is where I stop," then that's exactly what happens, you know

> it's like, okay I feel like I'm getting too close now and it's getting uncomfortable for me, ... because of passing that, sort of safety thing that I put up, and uh, then it's like it's time to take a step back. But on the other hand, if I don't feel that closeness, then I feel that there's something wrong too. So, it's sort of a "Catch-22" thing where, yes I do want the closeness, from a relationship, but on the other hand, I guess in a way it sort of has to be on my, where my boundaries are and where they're not. (Participant 120)

> Sometimes a wall goes up right around me, and there's no trust, that's if I feel really hurt. (Participant 100)

Two women with Dismissing attachment styles, the first a physical abuse survivor and the second who was not abused, spoke in similar terms about protecting themselves.

> But, I'm cold. I'm cold. And I can be mean. I can be mean, very mean. I can turn off feelings, like you can turn off a tap. I think my best defense is my brick wall. And I've done that a lot in my first marriage, I would just, build a wall, right in front of me, and it was like as if it was an out-of-body experience, and, you could talk, but my wall was there and I was protected. (p. 209)

> I came here [to Canada] at the age of 23 all on my own again, leaving a very huge, warm family behind, so I guess that brick wall that goes around you to prevent you from hurting yourself, for no reason at all, what can you do about it, nothing. (Participant 307)

The theme of self-protection was also present for this nonabused woman with a predominantly Fearful style of relating.

> I don't usually like to make myself vulnerable. At the beginning I do probably sort of keep them [potential partners and friends], at arm's length, we're very friendly, we're very open, we have fun together but I don't like to let myself get too emotionally involved to begin with because

it can come crashing down pretty quickly. (Participant 317)

The experience of self-protection among some women with Dismissing and Fearful attachment styles was evident across groups. This may suggest that it is some characteristic of the attachment style, rather than the experience of being abused, that is associated with self-protection. Dismissing and Fearful attachment are both associated with a negative view of others, and so it makes sense that these attachment styles would be related to a tendency to protect the self.

Attachment Development and Abuse in Adulthood

Many women in this sample who had been abused as children told of experiencing repeated betrayals in adulthood, for example, by abusive partners, by those they had considered friends, by family members, and occasionally by counsellors. Some nonabused women also became involved in abusive relationships later in life. This gave rise to the following questions: What is the experience of women in this sample who become involved in abusive relationships in adulthood? Is it different for women who have been abused as children than for women who were not?

A sexual abuse survivor developed a combination of Dismissing and Fearful attachment. She was repeatedly abused during childhood and adulthood. She experienced child physical abuse by both parents, child sexual abuse by a

relative over a period of many years, and adult sexual assault by her former husband as well as by a stranger. She described experiencing emotional abuse in her marriage that caused her to question her sense of self.

> When I got married to my husband and he was always 'Oh you can't do this, you can't do that, you're doing this wrong, you're doing that wrong' and, then I started questioning, "Okay, [chuckle] I haven't been doing so good, you know, with all these things." (Participant 120)

This physical abuse survivor described the process of getting into, and out of, a physically and emotionally abusive relationship in adulthood.

> I'm a single parent, and the father was abusive, ... and that's one of the reasons why I'm not with him, I separated with him when I was about five months pregnant, cause I just, I thought I'm not gonna have a child in this situation. I give myself credit for getting myself out very early. But, once again, I look back and like, why am I attracted to guys like this, cause not, not really any of the other relationships I had where the men were abusive, but they were, typical of that, you know, somewhat aggressive. (Participant 222)

One woman whose counsellor violated her trust by making a sexual advance toward her described the experience. It is clear that despite receiving subsequent therapy, she continues to blame herself.

> I did depend, too much on this one man ... it was like he almost became like a god to me, it was like, he picked up on every feeling, every whim, everything, and he was so caring. And so I was just, I felt, sheltered, like a child, and under his wing, and it was beautiful. But even then I always had fear, I was always untrusting. (Participant 100)

She told of her struggles to achieve trust.

> Or sometimes I'll have to, almost simulate trust, I'll watch somebody else, and I'll copy, or I have to, facade it, really, but there's no trust. But the whole time I'm sort of, doing that role, it's like inside I'm wanting to say, OK, you know, I want this trust? (Participant 100)

Self-esteem sometimes appeared to act as a protective factor against abusive experiences in later life. A woman who was not abused in childhood but whose marriage became physically and emotionally abusive described the way she was able to keep her sense of security in relationships. She attributes this to the strong sense of self that she developed within her family while growing up.

> I think that I'm secure in relationships because I do have a fairly healthy self-esteem. I mean it was really shit there for a while when I was married and my husband was telling me every day how ugly I was and awful and this and this and this and, you know that gets to you after a while. But, subconsciously I think, because I had that background ... it's why I could come back to this point. Otherwise I don't know if I could have. (Participant 302)

Another nonabused participant with a Secure attachment style was in a relationship with a partner she felt was controlling. Although she perceived that her sense of self was threatened, she was determined not to let the situation continue. She took personal responsibility for figuring out how to change the situation.

> It's, come to the point like I've had some you know major, major lows, where, like I said this person is the opposite of me. You know doesn't share anything, our personal life is our personal life, and God forbid if you actually say you owe $5.00 to the telephone company that you haven't paid for twenty years you know for, or whatever ... your phone's gonna be

> cut off. So that makes it like he, he totally, it totally closes me, it doesn't let me be me. .... [I'm] trying to realise that it's me, it's not, you know everybody always says "Oh, that person makes me unhappy", so, you gotta say well it's yourself, so I'm, kind of in this, I'm determined not to let it. (Participant 323)

Women in this sample who were abused in childhood appeared to develop a vulnerability to being further abused in relationships in adulthood. They frequently continued to struggle with issues of trust and self-blame. In contrast, many of the women in the sample who were not abused as children appeared to have developed strong self-esteem. Although some of these non-abused women entered into emotionally abusive relationships, they cited their self-esteem as a factor that enabled them to end the relationships.

Change in Attachment Style

A number of women described changes in their attachment styles over the years. Some women were able to achieve healthy intimate relationships despite their traumatic histories. This was due to a number of factors, including having protective relationships with family members or friends, and working through issues in therapy. Sometimes a combination of factors came into play.

One woman described having had a Fearful style of relating during childhood and adolescence. She survived extremely severe sexual, physical, and emotional abuse as a child. She was able to develop a Secure style of relating to

her partner partly due to his support.

> But if I was on my own, Cindy, it woulda taken me a hell of a lot longer 'cause I wouldn't have had anyone there, ... to pour my heart out to or to hold me or to let me scream and cry and roll on the floor. He doesn't run away from things, he faces things head on, you know. So I'm partly where I am in our relationship because of his love and support. He helped me find that security in our relationship. (Participant 106)

Several abuse survivors described being able to develop more secure styles of relating through therapy.

> [Therapy] really helped me to get my, just all my garbage out, my insecurities, everything. You know, just to put it all on the table, and I knew she wouldn't carry it. And slowly but surely I became more and more secure (Participant 106).

> Out of a conscious choice, a conscious choice to trust. Because my trust had been so destroyed that I literally, and this was through psychotherapy. (Participant 126)

One woman described changing from a Fearful to a Dismissing style of relating by entering into a common-law relationship with a man whose work took him out of town for several weeks at a time. This arrangement enabled her to maintain her independence and allowed her sufficient emotional distance to tolerate being in a relationship.

> Just previously in the last two years since I met my boyfriend I have, like we live together and I finally started splitting bills and stupid things like that. Where I wouldn't, I had to pay everything [chuckle]. So even when he was there I wouldn't let him pick up say, the day care bill, or I wouldn't, I got offended, when he would go and buy groceries or something I got really upset. So it's taken quite a few years to get past that part. I was

> very uncomfortable, I think I'm just starting to relax a little bit now. (Participant 217)

Other women changed from being securely attached to being insecurely attached. One participant changed from a Secure to a Dismissing style of relating due to a betrayal.

> He ended up sleeping with somebody else and, [I] just lost trust and, not ever knowing if there's ever gonna be something, serious between us. We went our separate ways. And for about three years after that I was very, independent and didn't want a close relationship. I tried, but, things didn't work out, and then when I did fall into one that lasted a long time, I did lose my independence. (Participant 328)

One woman talked of how she moved to Winnipeg from another city and had a baby. This led to her becoming more socially isolated and has contributed to adding more Fearful elements to her style of relating. Another woman traced the development of her Preoccupied style of relating to her mother dying when she was 16 years old. Her childhood friendships were characterised by a more secure style of relating than those in adulthood. For a woman in the nonabused group who is securely attached, being in a relationship with a partner who is quite controlling has challenged her self-confidence. She finds that she is not as outgoing with people.

> I don't think I'm as confident [chuckle] and outgoing, maybe that was 'cause I've had a, I guess a couple, relationships that haven't worked out and right now I'm going out with somebody who's quite aggressive, and almost controlling, and I'm not used to that. So you have two people in a

> relationship that are, head to head quite a bit. And I tend to back down a bit which is unlike me. So I would say the last, four years, I've become, because of this relationship I'm not as confident and outgoing, my self-esteem has been lowered. (Participant 323)

The factors that enabled women in this study to develop more secure styles of relating were relationship based, and included developing safe, trusting relationships with partners, friends, family members, and therapists. Women who described changing to insecure attachment from secure attachment often attributed this to betrayal or to abuse in adult relationships. Social isolation due to external circumstances was also cited as a factor. Some women in the sample stated a desire to change their styles of relating.

Desire for Change in Attachment Style

Participants were also asked to explore whether they were happy with their current ways of relating to others or whether they would like these to change. They further explored what they would need in order to facilitate change in their attachment style. Some women located the ability to change within themselves; others believed that only changes in external circumstances would allow them to change their way of relating. The following passages illustrate this dichotomy. The first is from a woman with Preoccupied attachment, the second from a woman with Fearful attachment, and the third from a woman with a combination of the two styles.

> I don't necessarily want to be completely emotionally intimate, as much in a close friendship. I want it but then I don't want it [chuckle]. I mean I want it but that, it takes a long time to have a comfort level and I don't think I want to be completely, I want some space too, in a friendship. And I think actually I'm learning, that I actually want space in a romantic relationship as well. (Participant 112)

> So I don't know, I've got a lot of work to do if I do want that relationship. And I'm afraid that, even if I find someone that I'm really interested in and that might be interested in me, if I don't work through some of these things it's gonna end up disaster anyway. [sigh] So I don't know I've got a long road ahead of me, although I've come a long way. I've got ... I've still got a long way to go. (Participant 212)

> I think it depends probably on the on a couple of things, could be the type of person I meet, you know like someone who I think, who would be very friendly and, just someone who gave me a sense of safety I guess. To be myself. I think sometimes that, well, lately I've been thinking that maybe I need to talk to somebody [i.e. a counsellor]. (Participant 220)

In summary, analysis of the attachment portion of the interviews for this sample of women suggests strong links between attachment development and early family life. Many women who had been abused as children attributed the development of their insecure attachment styles to the abuse. Others attributed the development of insecure attachment to not feeling valued within their families, to lacking nurturing relationships, and to being separated from their families early in life. Women in this sample who developed a Secure attachment style frequently did so in the context of warm, supportive families. This does not mean, however, that later life experiences cannot and do not affect attachment.

Some abused women in the sample were able to become more comfortable in relationships or even to develop Secure attachment through emotionally healthy relationships. These included relationships with supportive family members, friends, and therapists. Other women went from having a Secure attachment style to an insecure style due to life events. Some women in the sample credited a strong sense of self-esteem with protecting them from a real threat to their style of relating.

Moral Dilemma Analysis

The following questions were used to guide initial coding and analysis of the moral dilemma part of the interviews:

(a) Did participants use primarily care-oriented or primarily justice-oriented moral reasoning in their moral dilemmas?

(b) To what extent do participants include themselves in moral decision-making?, and,

(c) Does the extent to which participants included themselves in moral deliberations appear related to abuse history?

Care-oriented vs. justice-oriented moral reasoning

A majority (18/23 or 78%) of participants in the interview sample used primarily care-oriented moral reasoning in their dilemmas. Five women (22%)

used a combination of care- and justice-oriented moral reasoning. No participants used primarily justice-oriented reasoning. In contrast, women were no more likely to use care- than justice-oriented reasoning on the MOS (Yacker & Weinberg, 1990). The data were examined to see if, by chance, participants with high use of care-oriented reasoning on the MOS had been chosen for the interview study. This was not the case. The type of reasoning used in the interviews was well-distributed across abuse groups and therefore did not appear to be related to whether participants had been abused or what type of abuse they had experienced.

The predominance of care-oriented reasoning may have been partly because the dilemmas were self-generated and most involved relationship issues (summarised in Table 11). Previous research has found that dilemma content can influence the type of reasoning used. Rothbart, Hanley, and Albert (1986) studied male and female participants' responses to a Kohlberg dilemma (believed to elicit justice-oriented reasoning), a dilemma that involved physical intimacy (believed to elicit care-oriented reasoning), and a self-generated moral dilemma. If the dilemmas involved personal relationships, participants were more likely to use care-oriented reasoning regardless of sex. Walker, de Vries, and Trevethan (1987) also found that dilemmas that focused on a personal relationship tended to

elicit care-oriented reasoning. A study by Pratt, Golding, Hunter, and Sampson (1988) found that women were more likely to use care-oriented reasoning in both hypothetical and self-generated moral dilemmas as their development progressed toward Kohlberg's Stage 5 of moral reasoning. It is possible, therefore, that the predominant type of reasoning used is an effect of both dilemma content and developmental stage of moral reasoning.

Table 11

Summary of types of moral dilemma

Type of dilemma	Frequency
Get married	2
Leave a romantic relationship	5
End an affair	1
Talk to friend/partner about a difficulty in their relationship	3
Being caught in the middle of a relationship between two people	1
Betrayal in counselling relationship	1
Have an abortion	2
Give up baby for adoption	2
Put child into foster care	1
Let children be alone with their grandparents (Participant had repressed memories of abuse)	1
Report a sexual assault by a family friend	1
Return to practicing religious faith	1
Give information to colleague that may help them to grow as a professional, risk damaging relationship	2
Start own business	1

The following passages illustrate a combination of care- and justice-oriented moral reasoning for a CPA participant. Her dilemma involved whether or not to go through with a marriage that her parents had arranged. At times, she used justice considerations to try to resolve the dilemma. She talks about having been raised with the expectation that she would listen to her parents.

> Well I was [brought] up to listen to my Mom and Dad like what, their wishes and that and then, his part like it wasn't, I didn't agree.

As she tried to reach a decision, she turned to care-oriented reasoning at level 3.

> Then, like, I was thinking like, it's me that's more important, not them, it's my life, 'cause it's not them that's going to be living with him for the rest of their life, what about me? So that's the way I was thinking, and I was, just maybe thinking about myself? [chuckle] (Participant 221)

Inclusion of Self in Moral Dilemmas

The entire range of care-oriented moral reasoning from Level 1 to Level 3 as well as transitional reasoning between Levels 2 and 3 was present in the interviews. Frequently, women in the sample used more than one level of reasoning to reach a decision.

Level 1 reasoning is characterised by self-care in order to ensure survival. This was present in the interviews of one CSA and three CPA participants. Two of the participants who used Level 1 reasoning classified themselves as having Dismissing attachment; the other two had Dismissing/Fearful and

Fearful/Dismissing attachment styles. The CSA participant's dilemma involved being sexually assaulted by a family friend in her home. She felt unable to report the assault out of fear that her husband would think that it was her fault. Her thinking about this dilemma was marked by a lot of blame of others as well as self-blame. She felt a keen sense of betrayal because she had always had male friends and had trusted them. The experience of betrayal influenced this participant's Dismissing attachment style. Her attachment style had, however, developed much earlier with her experience of CSA. This participant did not attribute her attachment development directly to the abuse, but rather made reference to feeling apart from the other members of the family because she was adopted and was of a different race and culture than her adoptive family.

A CPA participant who had three children deliberated about whether to leave an emotionally and physically abusive marriage. The following passage illustrates her Level 1 reasoning.

> He just wouldn't let me do anything. He wouldn't help me, he wouldn't go to the store and get me milk, I couldn't drive my car or anything. I had three little kids, you know, he wouldn't take me for groceries or nothing. When I'd go for groceries I'd have two of them in the cart and one of them would be sitting in the front, and I had no room for groceries, he was just, it was just unbelievable how UNhelpful he was, he wouldn't even take them for a walk in the summer, he would just do nothing. And so, I guess that sort of gave me the strength to let go. And then the health nurse used to come by just to visit with me because I wasn't allowed any friends, and he'd just be checking about footsteps and everything in the snow, like he

> was just really weird. Anyways, she used to come visit me, and the nutritionist, and they'd just visit with me, so at least I had somebody to talk to. Living in a housing complex, if you can figure that out! But he didn't live with me, but he was just always around - euph! (Participant 201)

Another CPA participant told of deciding whether or not to go through with a planned marriage. A significant factor in her decision was that getting married would enable her to escape her physically and emotionally abusive home.

> I had gotten to a point there, that I had decided that I wouldn't get hit anymore. So you just kinda go with the flow to keep the peace. I was also a protector of the one that was younger than me. That was really bad because nobody else would intervene. The way the blood was flowing, my Mom would call my Da[d], call these blackouts, but I can't really, I'm not gonna sit here and try to make up an excuse. I couldn't go anywhere. The doors were closed. (Participant 209)

She likened her feeling of helplessness in the dilemma to the feeling she had when being physically abused by her father as a child. Her helplessness was also evident in the way she switched from 'I' to 'you'.

> I had been at a point where, you're cornered, and it was like the time that he cornered me in the basement and he had an electrical cord. If I had been smart, I could have gone out that door, but instead I went to the right, ... and I ended up in the basement, I mean like the door, they're facing each other. Why did I do that, I don't know. We had no place to escape, right? To me, I was caught, I had no place to escape and I just ... you just, do it. (Participant 209).

Level 2 reasoning is characterised by considering others but not oneself. The person sees inclusion of self as selfish. Three CPA participants used this type

of reasoning. They had Fearful/Preoccupied/Dismissing, Fearful/Dismissing, and Preoccupied/Fearful attachment styles. Two of the women described moral dilemmas that involved affairs. The first woman became pregnant by her lover. She considered whether to leave her marriage and have the baby, whether to tell her husband and try to repair their marriage, and whether to have an abortion. Ultimately she decided to have an abortion. Her reasoning was characterised by responsibility to others.

> And then when I told this fellow that I was involved with about it, he seemed to really care, but, he also had three children in his relationship, so I could understand his not being able to just drop everything there either. So then I realised it was no future for the two of us. I really had no other alternative, I felt, at the time anyway, and I still do feel that way that I wouldn't have wanted to break up two families. You know, and I'm the only one that has to live with the guilt. (Participant 212)

Another woman's dilemma involved deciding whether to put her son in foster care. At the time, he had undiagnosed Attention Deficit Hyperactivity Disorder and she was having severe difficulties coping with his behaviour.

> Obviously for my son, if I had either chosen to kill myself, or put him in foster care, he, especially considering the problems he's having now, the only thing I could see in his future for him was like juvenile delinquency, which even is still a concern now with me. It would definitely put any little edge that he would have, over the way he is now, it would be gone. And it would be like he would be written off, too. (Participant 222)

All of the women in the sample who used Level 1 or 2 moral reasoning had histories of child sexual or physical abuse and insecure attachment styles.

Care-oriented reasoning in the transition phase reflects a tension between self-care and responsibility to others. Self-expression is constrained by a need to feel accepted by others. Transitional reasoning was present in the interviews of one CSA, three CPA, and one NA participants. Their attachment styles were Fearful, Preoccupied/Fearful, Secure/Preoccupied, Preoccupied, and Secure.

The tension between considering self and other is evident in the following quotation. The first is from an interview with the woman who was struggling with whether or not to put her son in foster care.

> You know it wasn't just what was good for him, it was also what was good for me, too. Cause the longest time I always put him first, and then I realized that if I don't put myself first sometimes, I can't look after him. I won't be able to look after him as well. So that was again, that was also another issue, like, him or me? You know, who do I, whose best interests do I look out for? (Participant 222)

The second is by the woman with a history of CPA who had an affair and became pregnant by her lover.

> I guess I felt most sorry for myself, I felt then that everybody else was okay 'cause I looked after it to make sure they'd be alright. And, they [her family] never ever knew [about the abortion]. (Participant 212)

The same sense of conflict is present for this survivor of CSA whose moral dilemma involved deciding whether to end a relationship.

> So, I think I had to for my soul and my body, and my son. Okay, that was my three reasons. But, really inside I didn't want to. I wanted to have them in my life, I wanted it to work, I want to be with D. I love D., I feel

> connected to her, we're soul-mates, that's the way it is. Like I know that. But, but I just can't, my body, my soul says, it keeps running away from it, do you know what I mean, it's like, a constant fight of two things, fighting at each other? (Participant 104)

The nonabused woman's moral dilemma involved deciding whether to leave her emotionally and physically abusive marriage. Her guilt over considering herself is apparent in the following passage.

> I mean he made me feel horribly guilty, he said to me, "You, you've ruined my life, you've ruined my career." He's threatened suicide three times. As he left my house he would say "I hope you can live with my suicide on your conscience". Women have this innate guilt in the first place and then I'm getting all these other. I'm feeling guilty because he's a mess, and I feel responsible, and I'm feeling like I look at these three beautiful kids and I think I never wanted this for you, I wanted you to have a happy wonderful family. (Participant 302)

Level 3 reasoning is the most well-developed form of care-oriented reasoning, because it involves considering both self and others in moral decisions. The majority of participants in the sample used this type of reasoning as their primary way to decide what to do in their moral dilemmas. Level 3 reasoning was present in the interviews of six CSA participants, one CPA participant, and seven NA participants. No particular attachment style was associated with this type of reasoning.

A theme of needing to look after oneself in order to survive and grow was present in several dilemmas. The following quotation is from the CSA participant

quoted earlier who eventually decided to end her romantic relationship with her partner.

> One of the things I learned is that in order for me to do anything or feel like I can emerge as a person, I need to have some things calm in my home. My home is so important, that's why I ran away all the, that's why I always moved so many times, that's why I can't say home. Because I need to have my home, it has to be fixed, it has to be clean. Clean is important to me. If there's stuff everywhere, and you don't know what's growing in the next room, like, those kind of things really affect me, and some people can live like that, that's their life. I can't, I cannot do it, there's no way. And, so I can't, I can't grow, in a house like that. If I know there's junk all over, clothes laying around, nobody's doing nothing, and you're fighting for people to try to clean up, like that's stuff is, I just can't han, that takes all my energy. (Participant 104)

A woman who was not abused in childhood, but was in an emotionally and physically abusive marriage, talked about what was at stake for her.

> I think my personal well-being, I felt like it was me there I was going nuts. Like I gotta get help or else, I either gotta leave this, situation, or, I was gonna be, roaring nuts. (Participant 313)

A nonabused woman whose moral dilemma involved deciding whether or not to return to her faith talks in terms of needing to regain her sense of self.

> I had to start to think well, "Why am I doing this, like [chuckle] do I really wanna go back to church or what is it that I'm ..." Or that's when I was crying all the time and I was, kinda depressed and everything and, I'd gone the route of being on like a medication for depression before. And well I didn't really think it did anything, and it just sort of struck me that it was 'cause I wasn't living, really, the way that I knew was right. And I wasn't happy, with myself, I think. And so I thought well, instead of going the route of the doctor and the medication, maybe I should try going back to church trying to do what you really truly believe is right even though

> you're not doing it at the moment. Because if I'm unhappy every day with how I'm living and with, myself as a person then I figured, that's what I had to do I'd try that route, instead. (Participant 319)

One of the saddest moral dilemmas was described by a woman who decided to have an abortion. She was just finishing school, her marriage was strained, and finances were limited. She agonised over what to do. After the abortion she was informed that the fetus was female; she had always wanted a girl. A few weeks later she found out that she had cervical cancer and had to have a hysterectomy. This was a terrible blow to her sense of herself as a woman. Subsequently, her youngest son became intellectually disabled. She was still trying to gain a sense of peace about her decision, as the following passages show.

> It doesn't matter now, that part doesn't matter that I didn't have a girl. Because I've got four wonderful boys. And, I've probably put a lot of energy into my youngest son, who has gone from being labeled profoundly developmentally delayed with seizure disorder and autistic tendencies and blah blah blah, to being a pretty odd, but maybe learning disabled kid. All of my energy, I put from the child that never was, the perfect child that never was, into the child that is, and isn't perfect. And I'm okay with the imperfect. And so, in a way, it's not so, I have little, sort of categories of looking at it [chuckle]. And I'm just hoping that as the years go by, I'm waiting for one of my children and I hope to have to wait a long time, but I'm waiting for one of them [chuckle] to have a kid. And I think that's sort of the marker that I've set up in my head, that will be when it's okay. (Participant 108)

It is interesting to note that all of the women who used Level 1 and 2 moral reasoning had insecure attachment styles and had experienced childhood

abuse. The tension between valuing self and other is evident in transitional reasoning. Most of the women who used transitional reasoning were insecurely attached, although one of the women had a secure attachment style. All but one of the participants who used transitional reasoning had histories of childhood abuse. This finding did not, however, occur frequently enough to speculate about an association between abuse history, attachment, and inclusion of self in care-oriented moral reasoning.

Level 3 reasoning is the most well developed form of care-oriented reasoning, because it involves considering both self and others in moral decisions. Most participants used this type of reasoning as the primary way to decide what to do in their moral dilemmas. Frequent themes that occurred in these interviews included women realising that they needed to look after themselves in order to be effective partners and parents, and needing to provide themselves with opportunities for personal growth. No particular attachment style was associated with this type of reasoning. It is notable, however, that all but one of the nonabused participants used primarily Level 3 reasoning; one used primarily transitional reasoning. Further research would be necessary to attempt to determine whether women who do not have histories of childhood abuse are, in fact, more able than abuse survivors to include themselves in moral decision

making.

Change in Moral Reasoning over Time

A further theme that emerged during data analysis involved the development or change in moral reasoning over time. The interviews of four participants (three in the CPA group and one NA participant) contained evidence of development of care-oriented reasoning from a lower level to Level 3. The following set of quotations illustrates a CPA participant's change from Level 1 (consideration of self) to Level 2 (consideration of other), and ultimately to Level 3 (consideration of self and other) moral reasoning. Her dilemma involved whether to give up her baby for adoption.

> [Level 1] I had such a hard time trying to stay still and behave myself, when I was pregnant, let alone right after. I had my sister's support and I kind of ran for about three months. I'd come home, but I wasn't doing the proper thing.
>
> [Level 2] how I was gonna be fair to her. Whether she would be better putting her up for adoption, and having that chance with a proper family, the Mom, Dad, the money, the financial. You know, give her a really good shot at everything. Instead of my world.
>
> [Level 3] I don't think of it as my loss, like my freedom or my youth or whatever you want to call it. I've never seen it like that. I see it as, for her, maybe, if she's in a proper place it wouldn't be such a struggle. Maybe she would have a better chance. I don't know if anybody could ever answer those questions. (Participant 217)

For this woman, the support of her sister appeared to be an important factor in

being able to look beyond her own needs and consider the welfare of her baby.

The following quotations illustrate a NA participant moving from transitional reasoning to Level 3. Her moral dilemma involved whether to leave her marriage. In the first quotation, it is evident that she feels guilty for considering herself. In the second quotation, it is evident that she is more comfortable including herself in the decision-making process.

> [Transition] It's been really hard, and it's still hard for me. I have the guilt of feeling happier, because I'm not with him anymore. It's just guilt everywhere.
>
> [Level 3] I've learned that it's important to go with your instincts in the first place. I know that probably the best thing for me would have been to face the truth in the beginning and say "This was a mistake, and we should end it now." And we would have avoided a lot of heartache, a lot of hassle, and all that. I definitely have learned that, well I've learned a couple things, number one I've learned, that [sigh] I mean I've always been a very nurturing type of person. I think that's part of being Mennonite and just sort of the way I am. I mean I see a puppy I can't pass it by, you know, stuff like that. And, when I think back, my whole life I've always worried about how everybody else feels and am I doing the right thing for them, and I've always thought of everybody else. And I guess one thing that this has taught me, that I have to think about me, and that that's okay. That it's okay to put my needs first. (Participant 302)

One CPA participant showed a change from justice to care-oriented reasoning. She had an affair with a married man. Initially, she used justice-oriented reasoning to resolve the dilemma:

> By about the third time I really started to feel terrible. And I thought, "Well this is, this is not right, you know I wouldn't want this, if I was

married I wouldn't want this to be happening to me."

Subsequently, she got to know the man's wife. Her reasoning changed to care-oriented at Level 2 and transition oriented reasoning.

> I thought "God, you know she's a lovely woman, and she probably knows what a jerk he is and she probably puts up with a lot." I just decided, you know I must be out of my mind, she's a nice person, she doesn't deserve this, she's married to a jerk. And I must be nuts to be even thinking about this nonsense. (Participant 220)

In summary, analysis of the qualitative data for this sample suggests that moral orientation and level of care-oriented moral reasoning can change over time. It was possible for some of the women in this study to change from less well-developed to more well-developed levels of care-oriented moral reasoning. Factors related to these changes included family support and learning to trust oneself. For a woman who changed from justice-oriented to care-oriented moral reasoning, the important factor was getting to know one of the people involved in the dilemma.

Reflections on the Interview Process

Several of the participants reported after the interviews were completed that they were grateful to be able to tell their stories. Many told me that they had agreed to participate in the research in order to help others, but didn't anticipate that the process would be so helpful to them. Some of the women who had never

been in therapy expressed the desire to investigate this option. I helped them to explore this and provided them with information about community resources.

I had expected that the interviews would be emotionally difficult to conduct, and at times they were. Some of the women I interviewed were still in such raw pain. What I hadn't expected was the strong thread of hope that ran through each of the interviews. The participants were struggling to make sense of their abuse experience and to integrate it into their adult lives. Many had undergone what can only be described as self transformations; one woman changed her name as an act of claiming a self that had survived the abuse. When I responded to people's questions about what I was studying in my dissertation, they often asked me if it was a depressing topic. My answer was, and continues to be, that it was not. I had not expected to feel uplifted by these interviews, but I often was. I was awed by the strength that these women showed in being willing to explore such painful topics, by their will to survive and at times transcend the abuse, and by their spirit and love of life. That feeling of being uplifted came back to me at several times during the study – while transcribing the interviews, working with the text, and writing. It made the study worthwhile for me, and gave me the strength to complete this project.

6. DISCUSSION

Attachment Development and Abuse

Results of the quantitative analyses indicated that women in the CSA and CPA groups rated themselves significantly higher on insecure styles of attachment (Fearful, Dismissing, and Preoccupied) and significantly lower on Secure attachment than those in the NA group. Results further indicated that the CSA group was significantly higher on Preoccupied and Fearful attachment than the NA group. The CPA group was significantly higher on Secure attachment and significantly lower on Dismissing and Fearful attachment than the NA group.

It was also predicted that women in the CSA group would rate significantly higher on insecure attachment, and in particular on Fearful attachment, than those in either the CPA or NA group. There were no significant differences between the CSA and CPA groups on the proportions of the respective attachment styles. More specifically, the CSA group did not rate themselves as significantly higher on Fearful attachment than the CPA group. These findings strongly suggest that with respect to attachment styles, the two abuse groups are more similar than different.

These results support the findings of previous research suggesting that child sexual abuse is associated with insecure attachment in adulthood.

Alexander (1993) found that women who had experienced intrafamilial CSA had significantly higher proportions of Fearful attachment and significantly lower proportions of Secure attachment than the normative sample collected by Bartholomew and Horowitz (1991). Roche, Runtz, & Hunter (1999) compared women with histories of intrafamilial and extrafamilial CSA to women with no abuse histories. Participants in both abuse groups rated themselves lower on Secure attachment and higher on Fearful attachment than the nonabused participants. The intrafamilial abuse group was less secure, more fearful, and less dismissing than the extrafamilial abuse group.

There may be a number of reasons for the similarity in attachment styles between the CSA and CPA groups. Participants in the present study experienced severe, intrafamilial abuse. Women in the CSA group also experienced concurrent child physical abuse. The most likely explanation may be that child sexual and physical abuse are associated with similar outcomes with respect to attachment. Experiencing either type of abuse perpetrated by a close family member would seem to significantly impact upon trust in that relationship. It is possible, although it seems unlikely, that the experience of child physical abuse common to both the CSA and CPA groups is the important underlying factor in the development of insecure attachment. With a larger sample of participants, it

may be possible to use structural equation modelling or path analysis to determine the relative contribution of child physical abuse to attachment development.

It is also possible that another factor or combination of factors, such as emotional abuse, neglect, rejection, or chaotic family functioning, mediates the development of insecure attachment in women who have experienced child sexual and child physical abuse. The present study did not include comprehensive measures of emotional abuse or neglect. Screening questions indicated, however, that a majority of women in the CSA and CPA groups experienced emotional abuse as children. Less than half of the nonabused women reported experiencing emotional abuse in childhood. A significant number of women in the CSA and CPA groups had experienced neglect, whereas none of the nonabused participants reported neglect. No significant associations were found between emotional abuse and attachment style and neglect and attachment style. It is possible that the use of more sensitive measures of emotional abuse and neglect would be able to determine the relative contribution of each of these variables to attachment development.

There is some research evidence to suggest a significant relationship between emotional abuse and attachment. Marcy (1998) used the Relationship Scales Questionnaire (Griffin & Bartholomew, 1994a, 1994b) to study the

relationship between psychological maltreatment history and attachment, self-esteem and symptomatology in a college student sample. Results indicated that for women, psychological maltreatment was associated with Dismissing and Fearful attachment styles. Results also indicated that psychological maltreatment significantly predicted low self-esteem and symptomatology. Escudero (1997) found that emotional abuse was significantly correlated with attachment in a sample of 96 women who had experienced childhood sexual, emotional, and/or physical abuse. Results of the Minnesota Mother-Child Interaction Project, a longitudinal study begun in 1975, suggest that children of 'psychologically unavailable' mothers were more likely to have anxious avoidant attachment (Erickson, Egeland, & Pianta, 1989). Further, emotional abuse in childhood has been found to be associated with low self-esteem in adulthood (Thompson & Kaplan, 1996).

Results of the qualitative analysis of the attachment portion of the interviews suggest that both abused and nonabused women in this sample frequently attributed the development of their attachment styles to their family lives. Many of the women with abuse histories made direct reference to the effect of the abuse. They described feeling vulnerable, having difficulties trusting and setting boundaries, and lack of self-esteem. For many women, these factors acted

in combination and appeared to significantly impair their ability to form close, nurturing relationships. Several other participants who did not directly relate their attachment development to abuse made reference to such factors as chaotic family lives, a lack of nurturing relationships in their families, not feeling valued within the family, and early childhood separation.

There is some research evidence to support the influence of family functioning over and above the outcomes associated with child sexual abuse. Edwards and Alexander (1992) found that a history of parental conflict and paternal dominance made independent contributions to the social adjustment of female sexual abuse survivors. Woodruff (1999) found that female incest survivors reported more family dysfunction than women who had experienced extrafamilial sexual abuse or those in a general psychiatric outpatient population. Further, family functioning significantly contributed to the effects of sexual abuse on symptomatology.

There may be many reasons for the similarity in proportion of attachment styles in women in the CSA and CPA groups. Regardless of the reasons, this finding has important implications for treatment of abuse survivors, and in particular for therapy with survivors of child physical abuse. The importance of addressing attachment issues with child sexual abuse survivors has become

increasingly recognised over the past several years. These results point to the need to also address attachment issues with child physical abuse survivors.

Self-esteem - a Mediating Factor?

Qualitative results of the present study suggest that self-esteem may be associated with child abuse and attachment development. Several participants linked the development of their insecure attachment styles to a lack of self-esteem. They talked about having their confidence in themselves shaken, of feeling "messed up," of suppressing their personalities and of being unsure of themselves. These reports contrasted with those of women who had grown up in warm, supportive families. They attributed factors such as unconditional love and support, and lack of traumatic experiences to their ability to become secure and confident.

There is some research evidence to suggest that self-esteem is a mediating factor between child abuse and attachment development. The Roche et al. (1999) study of intra- and extra-familial child sexual abuse found that the nonabused group had a significantly more positive model-of-self and model-of-other than the combined abuse groups. Intra-familial abuse was associated with a less positive model-of-self than extra-familial abuse. This suggests that abuse perpetrated by a close family member may be more damaging to a child's sense of self than abuse

perpetrated by someone outside the family. Miller and Stiver (1993) have suggested that abusive relationships affect self-esteem when the child cannot find other ways to influence the relationship. If a relationship is unimportant or distant, there is much less of a tendency to need to influence it.

Self-protection

Another prevalent theme in the qualitative data was that of needing to protect the self in relationships. This theme occurred across groups and among women with all three insecure attachment styles. Frequently, women with insecure attachment would only let themselves become close to another person to a certain extent, and then would back away or put up boundaries or "walls". They linked their need to protect themselves to feeling vulnerable, and to having difficulty trusting others. Macnab (1997) found that incest survivors reported more difficulty trusting others in adulthood, less comfort with emotional intimacy, and more interpersonal problems than women who did not report an incest history.

Important attachment figures in childhood

No significant relationship was found between the number of important attachment figures in childhood, group, or attachment style. It seems plausible that the quality, rather than the number, of significant relationships during

childhood may influence attachment style or may make a child vulnerable to abuse. Most participants reported having support from one or more close family members before age 10. It is possible that the measure of important attachment figures was insufficiently sensitive to pick up an association with attachment style.

Research on resilience provides support for the view that close relationships can act as safeguards during childhood. The Rochester Child Resilience Project, in a cross-sectional study of stress-resilient and stress-affected 4th, 5th, and 6th grade children, found that the stress-resilient group reported receiving more support from their mothers and friends (Cowen, Work, & Wyman, 1997). In this study as well as in a longitudinal study of 2nd and 3rd grade children, the two groups were differentiated by the presence of a "sound parent-child relationship" during the preschool years (pp. 533, 539). Support was obtained for a theoretical model that predicted "that the effects of caregiver attachment history and resources on children's school adjustment and IQ are mediated by parenting attitudes and the parent-child relationship" (p. 539). In a prospective, longitudinal study of high-risk and resilient children in Kauai, Hawaii, Werner (1989) found that resilient children were more likely to have affectionate ties with family members and an external support system that

included friends and/or teachers.

The qualitative data suggests that significant relationships during childhood were important to some women. Several women described such relationships; for example, one with a sister who was nurturing and another with a close friend. They described these relationships as providing them with an emotional connection and enabling them to begin to trust another person. Participants were not specifically asked about significant childhood relationships; they volunteered this information spontaneously. This suggests that incorporating questions about supportive childhood relationships may be important in future research.

Childhood separation from caregivers

Women who were abused in childhood (and in particular, those who experienced child sexual abuse) had significantly more separations from caregivers than those who were not abused. No significant effect of number of separations on attachment style was found. This lack of a significant result may be related to the way childhood separation was measured. Examination of early childhood separations found that five women in the CSA group and one woman in the CPA group reported being separated from their caregiver(s) before age five. All of these women had insecure attachment. No participants in the NA group

reported early childhood separation. No conclusions can be drawn from this small sample, but it does suggest that early childhood separation may be an important issue to include in future research on abuse and attachment.

Analysis of the interview data suggested that early childhood separation was a salient experience in the development of insecure attachment for several participants. The feelings of loss and abandonment that participants experienced, and the sense that they made of this, appeared to have a significantly impact on their ability to make further connections and trust others. This information was offered spontaneously, and suggests that incorporating questions about early childhood separation may be important for future research.

Attachment Development and Abuse in Adulthood

Results indicated that women with histories of childhood abuse were vulnerable to further abuse in adulthood. Ninety percent of women in the CSA group and 54% of women in the CPA group reported adult sexual assault. No women in the NA group reported experiencing adult sexual assault, as this was an exclusionary criterion for the study.

The high rate of adult sexual assault (ASA) among members of the CSA group is consistent with previous research on survivors of child sexual abuse (e.g., Browne & Finkelhor, 1986; Koverola, Proulx, Battle, & Hanna, 1996; Kutil,

1999). The occurrence of ASA among women in the CPA group, however, raised the question of whether the development of insecure attachment could be attributed to childhood physical abuse, or whether it was influenced by ASA. Qualitative data were examined to further investigate this question. A total of seven women in the CPA group were interviewed. Three of these women experienced ASA; four did not. The women who experienced ASA attributed the development of their insecure attachment styles either to their abuse or to other aspects of their family life (e.g., not feeling valued within the family). This may suggest that, for these participants, childhood factors were more powerful and salient influences on attachment development. In order to further investigate this question, longitudinal research would be necessary. This would involve assessing the attachment styles of a sample of women over a period of several years to attempt to determine if these styles changed following ASA.

In the interviews, women with histories of childhood abuse told of experiencing repeated betrayals in adulthood by abusive partners, friends, family members, and counsellors. Self-blame was a frequent theme in women's analyses of these betrayals. Some women appeared not to expect anything better from their adult relationships than they had experienced in childhood.

Some nonabused women also became involved in abusive relationships

later in life. The qualitative data suggested that self-esteem may act as a protective factor against abusive experiences in later life. Women who came from families in which they felt loved and nurtured seemed better able to recognise that their relationships had become abusive and seemed to have less difficulty ending the relationships. It would be necessary to conduct further research including a measure of self-esteem in order to clarify this perceived association.

Change in Attachment Style

Many women in the interview sample described changes in their styles of relating over time. Bolen (2000) addressed the issue of whether attachment is both stable and dynamic. Although a body of research suggests that attachment styles are stable through infancy, other studies have found that life events may significantly affect attachment styles. Bolen (2000) suggests that "it would be expected that life experiences that are incongruent with one's working models of the self and others might precipitate a change in attachment status" (p. 142). It seems logical that incongruence in working models of attachment can work both to precipitate change from secure to insecure attachment, and from insecure to secure attachment. Evidence of both types of change was found in the qualitative data from the present study.

Some women who described changing from secure to insecure attachment

attributed these changes to the loss of an attachment figure due to divorce or death. Others attributed the change in their attachment styles to betrayal or to abuse in adult relationships. They often described fearing losing their independence. Social isolation was also cited as a factor for a few of the women.

The factors that enabled women in this study to develop more secure styles of relating were relationship based, and included developing safe, trusting relationships with partners, friends, family members, and therapists. Many women reported that having a partner or therapist 'stick with them' was a key factor in being able to change their attachment styles. The importance of a therapist being able to model a healthy relationship cannot be overemphasised. Support for the importance of therapy in attachment comes from a dissertation by Liker-Wolk (1998), who used the Relationship Scales Questionnaire (Griffin & Bartholomew, 1994a, 1994b) to investigate the relationship between attachment and emotional communication between women and their partners and mothers. Results indicated that psychotherapy had a positive influence on women's emotional communication with attachment figures.

A number of women stated that they wanted to change their styles of relating. Some women located the ability to change within themselves; others believed that only changes in external circumstances would allow them to change

their way of relating. Some of the external factors women cited included finding the 'right' partner: someone they could trust, who could help them feel safe, and who would be supportive. Sometimes women realised that a combination of these factors might help to facilitate change. For example, some women stated that they wanted to seek therapy to help them to change their ways of relating. It is also important to note, however, that some women with insecure attachment styles did not want to change their styles of relating. It is possible, given their histories, that these styles were adaptive.

In summary, the questionnaires on attachment provided information that described individual participant's attachment styles and enabled them to be compared across groups. This revealed the important finding that CSA and CPA survivors in this study were much more likely to have insecure attachment (in particular, Fearful attachment) than women who had not been abused in childhood. The interviews were a rich source of data about participants' beliefs about how their attachment styles developed. Most participants across all groups attributed the development of their attachment styles to their family lives as they were growing up. Several participants in the CSA and CPA groups linked the development of their insecure attachment styles to the abuse they experienced as children. Several themes emerged in the data that would be interesting to

investigate further in future research. These include the potential for change in attachment styles, differences in ways of relating between partners in intimate relationships and friends, self-esteem, and self-protection.

Psychotherapy and Attachment

Cicchetti and Toth (1995) note that therapy with abuse survivors is likely to be challenging because the influence of working models of attachment may be very strong. They suggest that "attachment organization may serve to inform the therapist as to which therapeutic modalities are likely to be effective" (p. 301). Women whose central issue concerns attachment may benefit from therapy that specifically addresses and supports relationships. Relational therapy was developed by a group of therapists at the Stone Centre at Wellesley College (see, e.g., Jordan, 1995a, 1995b, 1997a, 1997b; Stiver, 1997; & Stiver & Miller, 1997).

Relational psychotherapy has its roots in feminist theories of women's development (Belenky, Clinchy, Goldberger, & Tarule, 1986; Gilligan, 1982; Goldberger, 1996; Miller, 1976), which emphasize the importance of connection and relationship to women's self-development. This model holds that:

1. We grow in, through, and towards relationship.
2. For women, especially, connection with others is central to psychological well-being.
3. Movement towards relational mutuality can occur throughout life, through

> mutual empathy, responsiveness, and contribution to the growth of each individual and to the relationship. (Jordan, 1997a, p. 139)

There is an appreciation in relational psychotherapy of the ongoing need for connection to others. The therapy honours the needs for intimacy, nurturance, and involvement in relationships. Jordan (1997b) states that: "Empathy is central to the process of relational psychotherapy. It diminishes the client's sense of isolation and enhances the experience of interpersonal effectiveness; being responded with increases one's sense of connectedness and relational competence" (p. 345). Being responded to with empathy enables the client to develop empathy for herself.

Not surprisingly, the relationship between therapist and client is central to relational psychotherapy. The therapist is not a distant figure or a blank slate, but rather is integrally involved in the process of change. Clinical reports of therapists working with sexual abuse survivors indicate that a warm and respectful therapeutic relationship is of primary importance (e.g.. Cahill, Llewelyn, & Pearson, 1991; Lebowitz, Harvey, & Herman, 1993). Psychotherapy research supports the fundamental importance of the therapist-client relationship over and above any particular method or technique (Bergin & Lampert, 1978; Najavits and Strupp,1994; Orlinsky & Howard, 1978). The therapist in relational psychotherapy engages in "mutual emotional responsiveness", meaning that they

are "emotionally open to change and to being affected by each other" (Jordan, 1997b, p. 347). In order for the relationship to remain therapeutic and healing, however, it is important for the therapist to keep focused on the client's well-being.

Alexander and Anderson (1994) have developed hypotheses about the challenges that clients with various attachment styles may encounter in therapy. Based on this analysis, it is likely that clients with Secure attachment would do very well in relational psychotherapy. Because they have a positive sense of self and other, these clients would likely approach the therapist with a sense of self-confidence and trust. They usually have good social support and attachment relationships and would likely be able to make use of them. Relational therapy would likely pose more difficulty for clients with insecure attachment. Clients with Preoccupied attachment have a negative sense of self and a positive sense of others. When seeking support in therapy they are likely to idealize the therapist and risk becoming emotionally dependent, which then feels threatening. It is therefore very important for the therapist to be clear about the purpose of the therapeutic relationship when working with a client with Preoccupied attachment.

The client with Fearful attachment is likely to be more difficult to engage in therapy. This style is characterized by a negative perception of self and others

and by considerable fear around engaging in and maintaining relationships. Acknowledging the legitimacy of this fear early in the therapeutic relationship, it may help the client to feel supported. It is particularly important for clients with Fearful attachment to feel empowered, and so the issue of informed consent is central. While the therapeutic relationship is in the process of becoming established, it is necessary for the therapist to ensure that the client has other sources of support (Alexander & Anderson, 1994).

Relational psychotherapy is likely to be most difficult and potentially unsuccessful with those with Dismissing attachment. Clients with this style have a positive self-image, but a negative image of others. They tend to be uncomfortable with intimacy and prefer to rely on themselves. They are probably less likely to seek therapy. Alexander and Anderson (1994) suggest that a stance of curiosity about the client's perspectives and ideas may create a nurturing environment that enables her to experience and gradually tolerate her pain.

Moral Orientation and Abuse

It had been expected that women with Secure or Preoccupied attachment styles would be more likely to choose care-oriented moral responses than women with Dismissing or Fearful styles. There were no significant differences on care-oriented responses on the Moral Orientation Scale (MOS; Yacker & Weinberg,

1990) according to attachment style or group. The mean number of care responses was close to half. This suggested that women were no more likely to choose care responses than justice responses in response to the questions on the MOS. It is possible that this is due to a characteristic of the instrument. Some research evidence suggests that dilemma content can significantly affect choice of type of moral reasoning (e.g., Rothbart, Hanley, & Albert, 1986). Kohlbergian dilemmas seem to elicit justice-oriented reasoning, whereas dilemmas involving interpersonal situations seem to elicit care-oriented reasoning. It is also important to emphasize, however, that few people use a single moral orientation on a consistent basis, and that most use a combination of care- and justice-oriented reasoning (Johnston, 1988; Lyons, 1983; Walker, de Vries, & Trevethan, 1987).

Results of the qualitative analyses indicated that most (78%) participants used primarily care-oriented moral reasoning to resolve their dilemmas. This would be expected, given that the content of most of the dilemmas was relationship oriented (see Table 11). Previous research has indicated that dilemmas involving interpersonal situations are associated with care-oriented reasoning (e.g., Rothbart, Hanley, & Albert, 1986). Pratt, Golding, Hunter, & Sampson (1988) found that women were more likely to use care-oriented reasoning in both hypothetical and personal moral dilemmas as their development

progressed toward Stage 5 of Kohlberg's model of moral reasoning. It is possible, therefore, that choice of moral reasoning is influenced both by dilemma content and by level of moral development. Further research would be necessary to investigate the relative contributions of dilemma content and level of moral development to choice of moral reasoning. One way to attempt to accomplish this might be to design a study with both hypothetical and personal moral dilemmas and to code the interview data using both Kohlberg's and Gilligan's models.

Fewer participants (22%) in the present study used a combination of care- and justice-oriented moral reasoning, and no participants used primarily justice-oriented reasoning. Choice of type of reasoning was well-distributed across abuse groups and therefore did not appear to be related to whether participants had been abused or what type of abuse they had experienced.

Moral Orientation, Abuse, and Attachment

The entire range of care-oriented moral reasoning from Level 1 to Level 3 as well as transitional reasoning between Levels 2 and 3 was present in the interviews. Frequently, women used more than one level of reasoning to reach a decision.

All of the women who used Level 1 and 2 moral reasoning had insecure attachment styles and had experienced childhood abuse. Most of the women who

used transitional reasoning were insecurely attached, although one of the women had a secure attachment style. All but one of the participants who used transitional reasoning had histories of childhood abuse. This finding did not, however, occur frequently enough to speculate about an association between.

Level 3 reasoning is the most well developed form of care-oriented reasoning, because it involves considering both self and others in moral decisions. Most participants used this type of reasoning as the primary way to decide what to do in their moral dilemmas. Some women with abuse histories and insecure attachment used Level 3 reasoning; therefore it cannot be concluded that abuse and/or insecure attachment is necessarily associated with having difficulty considering the self in moral decision-making. It is notable, however, that all but one of the nonabused participants used primarily Level 3 reasoning; one used primarily transitional reasoning. Further research would be necessary to attempt to determine whether women who do not have histories of childhood abuse are, in fact, more able than abuse survivors to include themselves in moral decision making.

Like attachment development, moral reasoning showed evidence of change over time. Participants sometimes changed from using primarily justice-oriented reasoning to primarily care-oriented reasoning as they struggled with

resolving a dilemma. In several interviews, participants' reasoning evolved from Level 2 or transitional reasoning to Level 3 reasoning. This suggests that there is hope for women to learn to include themselves in moral decision making if they become able to value themselves. Jordan (1991) states that "For many women, attention to their own inner experience often feels incompatible with attention to other (it is 'selfish,' 'egocentric,' 'hurtful'); an ethic of caring for others carries the connotation of self-sacrifice or putting oneself last). This experience corresponds to Stage 2 of Gilligan's moral reasoning. When the validity of womens' experience is acknowledged in therapy, they begin to be able to become aware of and honour their own needs. Jordan (1991) states that "In some sense, this involves a growth of compassion – for self and other" (p. 289).

In summary, quantitative results of the moral orientation analyses indicated that women were no more likely to choose care responses than justice responses in response to the questions on the MOS. This may have been due to a characteristic of the instrument. In contrast, results of the qualitative analyses with a smaller sample indicated that most participants used primarily care-oriented moral reasoning to resolve their dilemmas. This is consistent with previous research that has found associations between care-oriented reasoning and interpersonal themes in real-life dilemmas (e.g., Rothbart, Hanley, & Albert,

1986). The interviews were a rich source of data about how women construed their moral dilemmas and reasoned their way to decisions. Although results from this small sample must be interpreted with caution, the data suggested several interesting directions for future research. One area for further research involves investigating the relative contributions of dilemma content and level of moral development to choice of moral reasoning. A second involves further investigating the association between abuse history, attachment, and inclusion of self in care-oriented moral reasoning

Study Limitations

The findings on attachment need to be interpreted with a degree of caution because of the retrospective nature of the data. Participants in the interview study were asked to speculate on how their current attachment styles had developed. Results of the qualitative part of the study suggested that many participants attributed the development of their attachment styles to their family lives in childhood. It is possible that participants' attachment styles were different in childhood. In order to demonstrate a direct link between childhood abuse and adult attachment styles we must await the results of ongoing longitudinal research. Nevertheless, the quantitative findings of this study support the results of previous research (Alexander, Roche, Runtz, & Hunter, 1999). Results suggest

an association between sexual and physical abuse sustained in childhood and insecure attachment, in particular Fearful attachment, in adulthood.

A further complicating factor in interpreting the data was that almost all of the women in the CSA group, and slightly more than half of the women in the CPA group had experienced adult sexual assault. In addition, some participants in the interview study reported becoming involved in emotionally and physically abusive relationships in adulthood. If we accept that life experiences can alter internal working models of attachment, it is quite possible that these experiences changed participants' attachment styles. Longitudinal research would be one way to attempt to account for the relative influence of adult sexual assault and abusive relationships on attachment.

When considering severe childhood abuse, it is very difficult to obtain a sample of participants who have experienced child sexual abuse but not child physical abuse. This makes it difficult to determine the relative contribution of child physical abuse to development of insecure attachment. Many other factors characterise families in which abuse takes place. These include emotional abuse, chaotic family environments, and neglect. These factors may also contribute to the development of insecure attachment, and with a larger sample size it may be possible to conduct analyses to determine the relative contributions of each of

these factors.

An effort was made in this study to recruit participants who were currently in therapy, but this was not possible. A suggestion for future research is to attempt to hold this variable constant, particularly as results indicated that psychotherapy may affect attachment style.

This study did not include a measure of self-esteem. It would be interesting to include this in future research in order to further clarify the relationship between abuse, attachment, and self-esteem that was suggested by the qualitative results.

Because this study included only adult women, it has limited generalisability. Further research needs to be conducted to determine whether these results also hold true for men.

Most of the women in the study reported moral dilemmas that involved relationships and resolved them using primarily care-oriented moral reasoning. Further research would be necessary to investigate whether there are associations between abuse history, attachment, and inclusion of self in care-oriented moral reasoning.

Results of the moral orientation analyses indicated that women were no more likely to choose care- than justice-oriented responses on the MOS. This

may have been due to characteristics of the instrument. In contrast, qualitative results indicated that most participants used primarily care-oriented moral reasoning to resolve their dilemmas. It was not possible to draw conclusions from the qualitative analyses on the relationship between moral orientation, abuse, and attachment. This part of the study did, however, generate several ideas for future research. These included investigating the relative contributions of dilemma content and level of moral development to choice of moral reasoning. A second area of research involves further investigating the association between abuse history, attachment, and inclusion of self in care-oriented moral reasoning.

The qualitative component of the study contained a relatively small sample of data. It was therefore not possible to make generalisations about the information presented in this part of the study. The interviews were, however, a source of rich descriptive data and generated some interesting ideas for future research. These include investigating the influence of early childhood separation and close, supportive relationships in childhood on attachment development. The qualitative findings would have been more trustworthy if member checks had been conducted. These were not feasible because I moved to another province immediately after data collection, and the process of analysis was lengthy.

Summary and Conclusions

An important finding of this study is that women who have been physically abused in childhood exhibit very similar attachment styles to those who have experienced child sexual abuse. Women in both abuse groups tend to have higher proportions of insecure attachment, in particular of Fearful attachment, than women who were not abused in childhood. Participants in the study experienced severe intrafamilial abuse as children. It is likely that attachment development is determined by many factors. Results of both quantitative and qualitative data suggest that factors such as emotional abuse and neglect may be associated with insecure attachment. In addition, qualitative findings suggest that such factors as self-esteem, chaotic family functioning, and perceived rejection may impact the development of insecure attachment.

Results indicated that women with histories of childhood abuse were vulnerable to further abuse in adulthood. Many of the women who were interviewed also reported that intrafamilial abuse negatively affected their ability to trust in close relationships, their willingness to enter into further relationships, and their expectations of others in relationships.

The results of this study have important clinical implications for the treatment of survivors of childhood sexual and physical abuse. The similarity in

attachment styles between the CSA and CPA groups strongly suggests that addressing the attachment issues of both groups needs to be a fundamental step in therapy. Many women in the interview part of the study identified the desire to change their ways of relating to others. The interview data also suggest that some women succeed in developing more secure ways of relating to others through therapy. Relational therapy addresses attachment issues by enabling the client to work through these issues in a relationship with the therapist, and may be a good choice of therapy for abuse survivors with insecure attachment.

Most of the women in the interview part of the study reported moral dilemmas that involved relationships and resolved them using primarily care-oriented moral reasoning. The qualitative data suggested that moral reasoning, like attachment development, may be capable of change over time. This finding suggests that as women learn to increasingly value themselves, they may be able to include themselves in moral decision making. Further research would be necessary to investigate whether there are associations between abuse history, attachment, and inclusion of self in care-oriented moral reasoning.

REFERENCES

Ainsworth, M. D. S. (1972). Attachment and dependency: A comparison. In J. Gewirtz (Ed.), *Attachment and dependency* (pp. 97-137). Washington, D.C.: Winston.

Ainsworth, M. D. S. (1982). Attachment: Restrospect and prospect. In C. M. Parkes & J. Stevenson-Hinde (Eds.), *The place of attachment in human behavior* (pp. 3-30). NY: Basic.

Ainsworth, M. D. S. (1985). Patterns of infant-mother attachments: Antecedents and effects on development. *Bulletin of the New York Academy of Medicine, 61*, 771-791.

Ainsworth, M. D. S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

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

Alexander, P. C. & Anderson, C. L. (1994). An attachment approach to psychotherapy with the incest survivor. *Psychotherapy, 31*, 665-675.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Amsterdam, B., Brill, M., Bell, N. W., & Edwards, D. (1979). Coping with abuse: Adolescent's views. *Victimology, 4*, 278-284.

Bagley, C., & Ramsay, R. (1986). Sexual abuse in childhood: Psychosocial outcomes and implications for social work practice. *Journal of Social Work and Human Sexuality, 4*, 33-47.

Bakermans-Kranenburg, M. J., & van Ijzendoorn, M. H. (1993). A psychometric study of the Adult Attachment Interview: Reliability and discriminant validity. *Developmental Psychology, 29*, 870-879.

Banyard, V. L. & Williams, L. M. (1996). Characteristics of child sexual abuse as correlates of women's adjustment: A prospective study. *Journal of Marriage and the Family*, *58*, 853-865.

Barahal, R. M., Waterman, J., & Martin, H. P. (1981). The social cognitive development of abused children. *Journal of Consulting and Clinical Psychology*, *49*, 508-516.

Bartholomew, K. (1994). Assessment of individual differences in adult attachment. *Psychological Inquiry*, *5*, 23-67.

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

Baumrind, D. (1986). Sex differences in moral reasoning: Response to Walker's (1984) conclusion that there are none. *Child Development*, *57*, 511-521.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). *Women's ways of knowing: The development of self, voice, and mind.* NY: Basic Books.

Bergin, A. E., & Lambert, M. J. (1978). The evaluation of therapeutic outcomes. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed.). NY: Wiley.

Berliner, L., & Conte, J. R. (1990). The process of victimization: The victims' perspective. *Child Abuse and Neglect*, *14*, 29-40.

Berman, W. H., & Sperling, M. B. (1994). The structure and function of adult attachment. In M. B. Sperling & W. H. Berman (Eds.), *Attachment in adults: Clinical and developmental perspectives* (pp. 1-28). NY: Guilford.

Blatt, M. & Kohlberg, L. (1975). The effects of classroom discussion upon children's level of moral judgment. *Journal of Moral Education*, *4*, 129-161.

Boldizar, J. P., Wilson, K. L., & Deemer, D. K. (1989). Gender, life experiences, and moral judgment development: A process-oriented approach. *Journal of Personality and Social Psychology, 57*, 229-238.

Bolen, R. M. (2000). Validity of attachment theory. *Trauma, Violence, and Abuse, 1*, 128-153.

Bornstein, M. H., Haynes, O. M., Pascual, L., Painter, K. M., & Galperin, C. (1999). Play in two societies: Evasiveness of process, specificity of structure. *Child Development, 70*, 317-331.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: anxiety and anger.* NY: Basic.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock.

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

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment.* NY: Basic. (Original work published 1969)

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development.* Thousand Oaks, CA: Sage.

Brennan, K. A., Shaver, P. R., & Tobey, A. E. (1991). Attachment styles, gender and parental problem drinking. *Journal of Social and Personal Relationships, 8*, 451-466.

Briere, J. (1989). *Therapy for adults molested as children.* NY: Springer Publishing Company.

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

Briere, J., & Runtz, M. (1986). Suicidal thoughts and behaviours in former sexual abuse victims. *Canadian Journal of Behavioural Science, 18*, 413-423.

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

Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4*, 151-163.

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

Brown, G. R., & Anderson, B. (1991). Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *American Journal of Psychiatry, 148*, 55-61.

Brown, L., Argyris, D., Attanucci, J., Bardige, B., Gilligan, C., Johnston, K., Miller, B., Osborne, D., Ward, J., Wiggins, G., & Wilcox, D. (1988). *A guide to reading narratives of conflict and choice for self and moral voice.* Unpublished Manuscript, Center for the Study of Gender, Education and Human Development, Harvard University, Boston, MA.

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

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

Burgess, R. L., & Conger, R. D. (1978). Family interactions in abusive, neglectful, and normal families. *Child Development, 49*, 1163-1173.

Cahill, C., Llewelyn, S. P., & Pearson, C. (1991). Treatment of sexual abuse which occurred in childhood: A review. *British Journal of Clinical Psychology, 30*, 1-12.

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

Cassidy, J., & Shaver, P. R. (1999). *Handbook of attachment: Theory, research, and clinical applications*. NY: Guilford Press.

Cavaiola, A. A., & Schiff, M. (1988). Behavioral sequelae of physical and/or sexual abuse in adolescents. *Child Abuse and Neglect, 12*, 181-188.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (2nd ed.) (pp. 509-535). Thousand Oaks, CA: Sage.

Christozov, C., & Toteva, S. (1989). Abuse and neglect of children brought up in families with an alcoholic father in Bulgaria. *Child Abuse and Neglect, 13*, 153-155.

Cicchetti, D. (1987). Developmental psychopathology in infancy: Illustration from the study of maltreated youngsters. *Journal of Consulting and Clinical Psychology, 55*, 837-845.

Cicchetti, D., & Toth, S. L. (1995). Child maltreatment and attachment organization: Implications for intervention. In S. Goldberg, R. Muir, & J. Kerr (Eds.) *Attachment theory: Social, developmental, and clinical perspectives* (pp. 279-308). Hillsdale, NJ: The Analytic Press.

Coie, J. D., Dodge, K. A., & Coppotelli, H. (1982). Dimensions and types of social status: A cross-age perspective. *Developmental Psychology, 18*, 557-570.

Colby, A., Kohlberg, L., Gibbs, J., & Lieberman, M. (1983). A longitudinal study of moral judgment. *Monographs of the Society for Research in Child Development, 48*.

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

Cole, P. M., & Woolger, C. (1989). Incest survivors: The relation of their perceptions of their parents and their own parenting attitudes. *Child Abuse and Neglect, 13*, 409-416.

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

Courtois, C. (1979). The incest experience and its aftermath. *Victimology, 4*, 337-347.

Cowen, E. L., Work, W. C., & Wyman, P. A., The Rochester child rsilience project (RCRP): Facts found, lessons learned, future directions divined. In S. S. Luthar, J. A. Burack, D. Cicchetti, & J. R. Weisz (Eds.), *Developmental psychopathology: Perspectives on adjustment, risk, and disorder* (pp. 527-547). Cambridge: Cambridge University Press.

Crittenden, P. M. (1985). Maltreated infants: Vulnerability and resilience. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 26*, 85-96.

Crittenden, P. M. (1988). Relationships at risk. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment theory* (pp. 136-174). Hillsdale, NJ: Erlbaum.

Crittenden, P. M., & Ainsworth, M. D. S. (1989). Child maltreatment and attachment theory. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 432-463). Cambridge, MA: Cambridge University Press.

Crouch, J. L., & Milner, J. S. (1993). Effects of child neglect on children. *Criminal Justice and Behavior, 20*, 49-65.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24*, 349-354.

Damon, W., & Hart, D. (1982). The development of self-understanding from infancy through adolescence. *Child Development, 52*, 831-857.

Dean, A. L., Malik, M. M., Richards, W., & Stringer, S. A. (1986). Effects of parental maltreatment on children's conceptions of interpersonal relationships. *Developmental Psychology, 22*, 617-626.

DeLozier, P. P. (1982). Attachment theory and child abuse. In C. M. Parkes and J. Stevenson-Hinde (Eds.), *The place of attachment in human behaviour* (pp. 95-117). NY: Basic Books.

deYoung, M., & Lowery, J. A. (1992). Traumatic bonding: Clinical implications in incest. *Child Welfare, 71*, 165-175.

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

Erickson, M. F., Egeland, B., & Pianta, R. (1989). The effects of maltreatment on the development of young children. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 647-684). Cambridge, MA: Cambridge University Press.

Escudero, D. M. (1997). Childhood trauma: Its impact on attachment, psychosocial development, and symptomatology in women. *Dissertation Abstracts International, 58* (4-B): 2117. Abstract from: WebSPIRS File: PsychInfo.

Etzioni, A. (Ed.) (1998). *The essential communitarian reader*. Lanham, MD: Rowman & Littlefield.

Eyer, D. E. (1992). *Mother-infant bonding: A scientific fiction*. New Haven, CT: Yale University Press.

Eyer, D. (1996). *Motherguilt: How our culture blames mothers for what's wrong in society*. NY: Times Books.

Fairbairn, W. R. D. (1978). *Psychoanalytic studies of the personality*. London: Routledge & Kegan Paul.

Feeney, J. A., & Noller, P. (1990). Attachment styles as a predictor of adult romantic relationships. *Journal of Personality and Social Psychology, 58*, 281-291.

Feshbach, N. D., & Feshbach, S. (1982). Empathy training and the regulation of aggression: Potentialities and limitations. *Academic Psychology Bulletin, 4*, 399-413.

Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional Psychology: Research and Practice, 21*(5), 325-330.

Fischer, D. G., & Fick, C. (1993). Measuring social desirability: Short forms of the Marlowe-Crowne Social Desirability Scale. *Educational and Psychological Measurement, 53*, 417-424.

Fishler, P. H., Sperling, M. B., & Carr, A. C. (1990). Assessment of adult relatedness: A review of empirical findings from object relations and attachment theories. *Journal of Personality, 55*, 499-520.

Finzi, R., Cohen, O., Sapir, Y., & Weizman, A. (2000). Attachment styles in maltreated children: A comparative study. *Child Psychiatry and Human Development, 31*, 113-128.

Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year. *Child Development, 62*, 891-905.

Freud, A. (1966). *The ego and the mechanisms of defense* (Rev. Ed.). NY: International Universities Press.

Freud, S. (1961). Three essays on the theory of sexuality. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, p. 125-243). London: Hogarth Press. (Original work published 1905).

Freud, S. (1962). Instincts and their vicissitudes. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, p. 1-66). London: Hogarth Press. (Original work published 1915).

Friedrich, W. N., Luecke, W. J. (1988). Young school-age sexually aggressive children. *Professional Psychology: Research and Practice, 19*, 155-164.

Friedrich, W. N., Urquiza, A., & Beilke, R. (1986). Behavior problems in sexually abused young children. *Journal of Pediatric Psychology, 11*, 47-57.

Gauthier, L., Stollak, G., Messe, L., & Aronoff, J. (1996). Recall of childhood neglect and physical abuse as differential predictors of current psychological functioning. *Child Abuse & Neglect, 20*, 549-559.

George, C. (1996). A representational perspective of child abuse and prevention: Internal working models of attachment and caregiving. *Child Abuse & Neglect, 20,* 411-424.

George, C., & Main, M. (1979). Social interactions of young abused children: Approach, avoidance, and aggression. *Child Development, 50*, 306-318.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Gilligan, C. (1986a). Remapping the moral domain: New images of the self in relationship. In T. C. Heller, M. Sosna, & D. E. Wellbery (Eds.), *Reconstructing individualism* (pp. 237-252). Stanford, CA: Stanford University Press.

Gilligan, C. (1986b). Reply to critics. *Signs, 11*, 324-333.

Gilligan, C. (1987). Moral orientation and moral development. In E. F. Kittay & D. T. Meyers (Eds), *Women and moral theory* (pp. 19-33). Totowa, NJ: Rowman & Littlefield.

Gilligan, C. (1988). Adolescent development reconsidered. In C. Gilligan, J. V. Ward, & J. M. Taylor (Eds), *Mapping the moral domain: A contribution of women's thinking to psychological theory and education* (pp. vii-xxxix). Cambridge, MA: Harvard University Press.

Gilligan, C., & Attanucci, J. (1988). Two moral orientations: Gender differences and similarities. *Merrill-Palmer Quarterly, 34*, 223-237.

Gilligan, C., Murphy, J. M., & Tappan, M. B. (1990). Moral development beyond adolescence. In C. N. Alexander & E. J. Langer (Eds.), *Higher stages of human development* (pp. 208-225). NY: Oxford University Press.

Gilligan, C., & Wiggins, G. (1987) The origins of morality in early childhood relationships. In J. Kagan & S. Lamb (Eds.) *The emergence of morality in young children*, (pp. 277-305). Chicago: University of Chicago Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Goldberg, S. (1991). Recent developments in attachment theory and research. *Canadian Journal of Psychiatry, 36*, 393-400.

Goldberger, N. (1996). Looking backward, looking forward. In N. Goldberger, J. Tarule, B. Clinchy, & M. Belenky, (Eds.), *Knowledge, difference, and power: Essays inspired by Women's Ways of Knowing*. (pp. 1-21). NY: Basic Books.

Graybill, D., MacKie, D. J., & House, A. E. (1985). Aggression in college students who were abused as children. *Journal of College Student Personnel, 26*, 492-495.

Greeno, C. G., & Maccoby, E. E. (1986). *Signs, 11*, 310-316.

Griffin, D., & Bartholomew, K. (1994a). Models of the self and other: Fundamental dimensions underlying measures of adult attachment. *Journal of Personality and Social Psychology, 67*, 430-445.

Griffin, D., & Bartholomew, K. (1994b). The metaphysics of measurement: The case of adult attachment. In K. Bartholomew & D. Perlman (Eds.). *Advances in personal relationships: Vol. 5. Attachment processes in adulthood.* (pp. 17-52). London: Jessica Kingsley.

Guba, E. G. & Lincoln, Y. S. (1989). *Fourth generation evaluation.* Newbury Park, CA: Sage.

Guntrip, H. J. S. (1971). *Psychoanalytic theory, therapy and the self.* NY: Basic Books.

Haan, N., Langer, J., & Kohlberg, (1976). Family patterns of moral reasoning. *Child Development, 47*, 1204-1206.

Haste, H. (1996). Communitarianism and the social construction of morality. *Journal of Moral Education, 25*, 33-41.

Hazan, C., & Shaver, P. R. (1987). Love and work: An attachment-theoretical perspective. *Journal of Personality and Social Psychology, 59*, 270-280.

Hazan, C., & Shaver, P. R. (1990). Love and work: An attachment-theoretical perspective. *Journal of Personality and Social Psychology, 59*, 270-280.

Hazan, C., & Shaver, P. R. (1994). Attachment as an organizational framework for research on close relationships. *Psychological Inquiry, 5*, 1-22.

Herman, J. L. (1981). *Father-daughter incest.* Cambridge, MA: Harvard University Press.

Herman, J. L. (1992). *Trauma and recovery.* NY: Basic Books.

Herman, J. L., Perry, J. C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry, 146*, 490-495.

Heyes, C. J. (1997). Anti-essentialism in practice: Carol Gilligan and feminist philosophy. *Hypatia, 12*, 142-163.

Howes, C., & Espinosa, M. P. (1985). The consequences of child abuse for the formation of relationships with peers. *Child Abuse and Neglect, 9*, 397-404.

James, B. (1989). *Treating traumatized children: New insights and creative interventions*. Toronto: Lexington.

Johnston, D. K. (1988). Adolescents' solutions to dilemmas in fables: two moral orientations -- two problem-solving strategies. In C. Gilligan, J. V. Ward, & J. M. Taylor (Eds.), *Mapping the moral domain: A contribution of women's thinking to psychological theory and education* (pp. 49-71). Cambridge, MA: Harvard University Press.

Jordan, J. V. (1991). Empathy, mutuality, and therapeutic change: Clinical implications of a relational model. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver, & J. L. Surrey (Eds.), *Women's growth in connection: Writings from the Stone Center* (pp. 283-289). NY: Guilford.

Jordan, J. V. (1995a). A relational approach to psychotherapy. *Women and Therapy, 16*, 51-61.

Jordan, J. V. (1995b). Female therapists and the search for a new paradigm. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 259-272). NY: John Wiley & Sons.

Jordan, J. V. (1997a). Relational Development: Therapeutic implications of empathy and shame. In J. V. Jordan (Ed.), *Women's growth in diversity: More writings from the Stone Center* (pp. 138-161). NY: Guilford.

Jordan, J. V. (1997b). Relational development through mutual empathy. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 343-351). Washington, DC: American Psychological Association.

Kaufman, J., & Zigler, E. (1989). The intergenerational transmission of child abuse. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 129-150). Cambridge, MA: Cambridge University Press.

Kazdin, A. E., Moser, J., Colbus, D., & Bell, R. (1985). Depressive symptoms among physically abused and psychiatrically disturbed children. *Journal of Abnormal Psychology, 94*, 298-307.

Kempe, R. S., & Kempe, C. H. (1978). *Child abuse.* Cambridge, MA: Harvard University Press.

Kendall-Tackett, K. A. (2001). Victimization of female children. In C. M. Renzetti, J. L. Edleson, & R. K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 101-113). Thousand Oaks, CA: Sage.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin. 113*, 164-180.

Kerber, L. (1986). Some cautionary words for historians. *Signs, 11*, 304-310.

Kernberg, O. F. (1976). *Object-relations theory and clinical psychoanalysis.* NY: Jason Aronson.

Kessler, R., & Pottharst, K. E. (1983). *An instrument for measuring affectional bonding: The attachment history questionnaire.* Unpublished manuscript, California School of Professional Psychology, Los Angeles.

Kohlberg, L. (1969). Stage and sequence: The cognitive developmental approach to socialization. In D. Goslin (Ed.), *The handbook of socialization theory and research* (pp. 347-480). Chicago, IL: Rand McNally.

Kohlberg, L. (1971). From is to ought: How to commit the Naturalistic Fallacy and get away with it in the study of moral development. In T. Mischel (Ed.), *Cognitive development and epistemology* (pp. 151-235). NY: Academic Press.

Kohlberg, L. (1981). *The philosophy of moral development: Moral stages and the idea of justice.* San Francisco: Harper & Row.

Kohlberg, L. & Kramer, R. (1969). Continuities and discontinuities in childhood and adult moral development. *Human Development, 12*, 93-120.

Kohlberg, L., Levine, C., & Hewer, A. (1983). Moral stages: A current formulation and a response to critics. In J. A. Meacham (Ed.), *Contributions to human development* (Vol. 10). Basel, Switzerland: Karger.

Koverola, C., Hanna, C., & Stein, M. (Aug., 1995). Clinical sequelae in multiply traumatized child sexual abuse survivors: A controlled comparison study. Paper presented at the 103rd Annual convention of the American Psychological Association, New York, NY.

Koverola, C., Proulx, J., Battle, P., & Hanna, C. (1996). Family functioning as predictors of distress in revictimized sexual abuse survivors. *Journal of Interpersonal Violence, 11*, 263-280.

Koverola, C., Proulx, J., Hanna, C., & Battle, P. (1992). *History of unwanted sexual contact questionnaire.* Unpublished manuscript, University of Manitoba.

Kuhn, D., Langer, J., Kohlberg, L., & Haan, N. S. (1977). The development of formal operations in logical and moral judgment. *Genetic Psychology Monographs, 95*, 97-188.

Kutil, R. M. (1999). Attachment theory and childhood sexual abuse. *Dissertation Abstracts International, 59* (7-B): 3348. Abstract from: WebSPIRS File: PsychInfo.

Lamb, M. E., Thompson, R. A., Gardner, W. P., Charnov, E. L, & Estes, D. (1984). Security of infantile attachment as assessed in the "strange situation": Its study and biological interpretation. *The Behavioral and Brain Sciences, 7*, 127-171.

Lamphear, V. S. (1985). The impact of maltreatment on children's psychosocial adjustment: A review of the research. *Child Abuse and Neglect, 9*, 251-263.

Larrabee, M. J. (1993) *An ethic of care: Feminist and interdisciplinary perspectives*. NY: Routledge.

Lebowitz, L., Harvey, M. R., & Herman, J. L. (1993). A stage-by-dimension model of recovery from sexual trauma. *Journal of Interpersonal Violence, 8*, 378-391.

Lewis, D. O., Mallouh, C., & Webb, V. (1989). Child abuse, delinquency, and violent criminality. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 707-721). Cambridge, MA: Cambridge University Press.

Lewis, M. (1990). Self knowledge and social development in early life. In L. Pervin (Ed.), *Handbook of social psychology*. (NY: Guilford).

Lewis, M. (1992). *Shame: The exposed self*. NY: The Free Press.

Lewis, M., & Brooks-Gunn, J. (1979). *Social cognition and the acquisition of self*. NY: Plenum.

Lifton, P. D. (1985). Individual differences in moral development: The relation of sex, gender, and personality to morality. *Journal of Personality, 53*, 306-334.

Liker-Wolk, R. (1998). Emotional communication: Relationships with attachment figures, life experiences, and psychotherapy. *Dissertation Abstracts International, 58* (12-B): 6846. Abstract from: WebSPIRS File: PsychInfo.

Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. In Y. S. Lincoln & E. G. Guba (Eds.), *Naturalistic inquiry* (pp. 289-331). Beverly Hills, CA: Sage Publications.

Locke, D. (1980). Cognitive stages or developmental phases? A critique of Kohlberg's stage-structural theory of moral reasoning. *Journal of Moral Education, 8*, 168-181.

Luntz, B. K., & Widom, C. S. (1994). Antisocial personality disorder in abused and neglected children grown up. *American Journal of Psychiatry, 151*, 670-674.

Luria, Z. (1986). A methodological critique. *Signs, 11*, 316-321.

Lyons, N. P. (1983). Two perspectives: On self, relationships, and morality. *Harvard Educational Review, 53*, 125-145.

Lyons, N. P. (1987). Ways of knowing, learning and making moral choices. *Journal of Moral Education, 16*, 226-239.

Lyons-Ruth, K., Alpern, L., & Repacholi, B. (1993). Disorganized infant attachment classification and maternal psychosocial problems as predictors of hostile-aggressive behavior in the preschool classroom. *Child Development, 64*, 572-585.

Lyons-Ruth, K., Connell, D. B., & Grunebaum, H. U. (1990). Infants at social risk: Maternal depression and family support services as mediators of infant development and security of attachment. *Child Development, 61*, 85-98.

Lyons-Ruth, K., Connell, D. B., Zoll, D., & Stahl, J. (1987). Infants at social risk: Relations among infant maltreatment, maternal behavior, and infant attachment behavior. *Developmental Psychology, 23*, 223-232.

Macnab, C. L. (1997). Incenst history and adult psychosocial functioning: the role of parental bonding, family environment, and adult attachment. *Dissertation Abstracts International, 57*(8B):5334. Abstract from: WebSPIRS File: PsychInfo.

Main, M. (1991). Metacognitive knowledge, metacognitive monitoring, and singular (coherent) vs. multiple (incoherent) models of attachment: Findings and directions for future research. In C.M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the life cycle* (pp. 127-159). London: Routledge.

Main, M., & Cassidy, J. (1988). Categories of response to reunion with the parent at age 6: Predictable from infant attachment classifications and stable over a 1-month period. *Developmental Psychology, 24*, 415-426.

Main, M., & George, C. (1985). Responses of abused and disadvantaged toddlers to distress in agemates: A study in the day care setting. *Developmental Psychology, 21*, 407-412.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 161-182). Chicago, IL: University of Chicago Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), *Growing points in attachment theory and research. Monographs of the Society for Research in Child Development, 50*, 55-104.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings, (Eds.), *Attachment in the preschool years*. Chicago, IL: University of Chicago Press.

Main, M., & Weston, D. (1981). The quality of the toddler's relationship to mother and to father: Related to conflict behavior and the readiness to establish new relationships. *Child Development, 52*, 932-940.

Marcy, S. N. (1998). Childhood maltreatment and negative sequelae in young adults: A comparison between outcomes of psychological, physical, and sexual maltreatment. *Dissertation Abstracts International, 59* (2-B): 0878. Abstract from: WebSPIRS File: PsychInfo.

Martin, D. G. (1983). *Counseling and Therapy Skills*. Prospect Heights, IL: Waveland Press.

Martin, J. R. (1994). Methodological Essentialism, false difference, and other dangerous traps. *Signs, 19*, 630-657.

McLaren, J. (1989). Childhood problems associated with abuse and neglect. *Canada's Mental Health, 37(1),* 1-6.

Miller, D. C. (1991). *Handbook of research design and social measurement* (5th Ed.). Newbury Park, CA: Sage.

Miller, J. B. (1976). *Toward a new psychology of women.* Boston: Beacon Press.

Miller, J. B., & Stiver, I. P. (1993). A relational approach to understanding women's lives and problems. *Psychiatric Annals, 23*, 424-431.

Miller, J. G., & Bersoff, D. M. (1992). Culture and moral judgment: How are conflicts between justice and interpersonal responsibilities resolved? *Journal of Personality and Social Psychology, 62*, 541-554.

Miller, P. A., & Eisenberg, N. (1988). The relation of empathy to aggressive and externalizing/antisocial behaviour. *Psychological Bulletin, 103*, 324-344.

Modgil, S. & Modgil, C. (1976). *Piagetian research: Compilation and commentary, Vol. 6.* Windsor: NFER Publishing Co.

Muhr, T. (1997). *Atlas/ti for Windows, Version (WIN 4.1).* Berlin: Scientific Software.

Najavits, L. M., & Strupp, H. H. (1994). Differences in the effectiveness of psychodynamic therapists: A process-outcome study. *Psychotherapy, 31*, 114-123.

Oates, R., Forrest, D., & Peacock, A. (1985). Self-esteem of abused children. *Child Abuse and Neglect, 9*, 159-163.

O'Connor, M. J., Sigman, M., & Brill, N. (1987). Disorganization of attachment in relation to maternal alcohol consumption. *Journal of Consulting and Clinical Psychology, 55*, 831-836.

Ogata, S. N., Silk, K. R., Goodrich, S., Lohr, N. E., Westen, D., & Hill, E. M. (1990). Childhood sexual and physical abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry, 147*, 1008-1013.

Oliver, J. E. (1988). Successive generations of child maltreatment: The children. *British Journal of Psychiatry, 153*, 543-553.

Orlinsky, D. E., & Howard, K. I. (1978). The relation of process to outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed.). NY: Wiley.

Peters, R. S. (1973). *Reason and compassion.* London: Routledge & Kegan Paul.

Piaget, J. (1966). *The moral judgment of the child.* NY: Free Press. (Originally published, 1932).

Polansky, N. A. (1981). *Damaged parents: An anatomy of child neglect.* Chicago: University of Chicago Press.

Pratt, M., Diessner, R., Hunsberger, B., Pancer, S. M., & Savoy, K. (1991). Four pathways in the analysis of adult development and aging: Comparing analyses of reasoning about personal-life dilemmas. *Psychology and Aging, 6*, 666-675.

Pratt, M., Golding, G., & Hunter, M. (1984). Does morality have a gender? Sex, sex role, and moral judgment relationships across the adult lifespan. *Merrill Palmer Quarterly, 30*, 321-340.

Pratt, M., Golding, G., Hunter, M., & Sampson, B. (1988). Sex differences in adult moral orientations. *Journal of Personality, 56*(2), 373-391.

Rabinowitz, V. C., & Weseen, S. (1997). Elu(ci)d(at)ing epistemological impasses: Re-viewing the qualitative/quantitative debates in psychology. *Journal of Social Issues, 53*, 605-626.

Radke-Yarrow, M., Cummings, E. M., Kuczynski, L., & Chapman, M. (1985). Patterns of attachment in two- and three-year-olds in normal families and families with parental depression. *Child Development, 56*, 884-893.

Reidy, T. J. (1977). The aggressive characteristics of abused and neglected children. *Journal of Clinical Psychology, 33*, 1140-1145.

Rivera, B., & Widom, C. S. (1992). Childhood victimization and violent offending. *Violence and Victims, 5*, 19-35.

Roche, D. N. (1994). *The nature of the relationship between childhood sexual abuse, adult attachment style, and current psychological functioning in women*. Unpublished M.A. thesis, University of Victoria, Victoria, British Columbia.

Roche, D. N., Runtz, M. G., & Hunter, M. A., (1999). Adult attachment: A mediator between child sexual abuse and later psychological adjustment. *Journal of Interpersonal Violence, 14*, 184-207.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Rogers, C. R. (1980). Client centered therapy. In H. I. Kaplan, G. J. Sadock, & A. M. Freedman (Eds.), *Comprehensive textbook of psychiatry, Vol. 3*. Baltimore, Williams & Wilkins.

Rothbard, J. C., & Shaver, P. R. (1994). Continuity of attachment across the life span. In M. B. Sperling & W. H. Berman (Eds.), *Attachment in adults: Clinical and developmental perspectives* (pp. 31-71). NY: Guilford.

Rothbart, M. K., Hanley, D., & Albert, M. (1986). Gender differences in moral reasoning. *Sex Roles, 15*, 645-653.

Rothbaum, F., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2000). Attachment and culture: Security in the United States and Japan. *American Psychologist, 55*, 1093-1104.

Rothbaum, F., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2001). Deeper into attachment and culture. *American Psychologist, 56*, 827-829.

Runtz, M. (1991). *Coping strategies, social support, and recovery from physical and sexual maltreatment during childhood.* Unpublished doctoral dissertation, University of Manitoba.

Ryan, G. W., & Bernard, H. R. (2000). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (2nd ed.) (pp. 769-802). Thousand Oaks, CA: Sage.

Salzinger, S., Feldman, R. S., Hammer, M., & Rosario, M. (1991). Risk for physical child abuse and the personal consequences for its victims. *Criminal Justice and Behavior, 18*, 64-81.

Scharfe, E., & Bartholomew, K. (1994). Reliability and stability of adult attachment patterns. *Personal Relationships, 1*, 23-43.

Scharff, D. E. (1992). *Refinding the object and reclaiming the self.* Northvale, NJ: Jason Aronson.

Schneider-Rosen, K., Braunwald, K., Carlson, V., & Cicchetti, D. (1985). Current perspectives in attachment theory: Illustration from the study of maltreated infants. In I. Bretherton & E. Waters (Eds.), *Growing points in attachment theory and research. Monographs of the Society for Research in Child Development, 50*, 194-210.

Senchak, M., & Leonard, K. E. (1992). Attachment styles and marital adjustment among newlywed couples. *Journal of Social and Personal Relationships, 9*, 51-64.

Simpson, J. A. (1990). Influence of attachment styles on romantic relationships. *Journal of Personality and Social Psychology, 59*, 971-980.

Simpson, J. A., Rholes, W. S., & Nelligan, J. S. (1992). Support seeking and support giving within couples in an anxiety-provoking situation: The roles of attachment styles. *Journal of Personality and Social Psychology, 62*, 434-446.

Smetana, J. G., & Kelly, M. (1989). Social cognition in maltreated children. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 620-646). Cambridge, MA: Cambridge University Press.

Smetana, J. G., Kelly, M., & Twentyman, C. (1984). Abused, neglected and nonmaltreated children's conceptions of moral and social-conventional transgressions. *Child Development, 55*, 277-287.

Spieker, S. J., & Booth, C. L. (1988). Maternal antecedents of attachment quality. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 95-135). Hillsdale, NJ: Lawrence Erlbaum.

SPSS for Windows, Rel 6.1.4. 1996. Chicago: SPSS Inc.

Sroufe, L. A. (1979). The coherence of individual development: Early care, attachment, and subsequent developmental issues. *American Psychologist, 34*, 834-841.

Sroufe, L. A., & Rutter, M. (1984). The domain of developmental psychopathology. *Child Development, 55*, 17-29.

Sroufe, L. A., & Waters, E. (1977). Attachment as an organizational construct. *Child Development, 48*, 1184-1199.

Stack, C. B. (1986). The culture of gender: Women and men of color. *Signs, 11*, 321-324.

Steckler, A., McLeroy, K. R., Goodman, R. M., Bird, S. T., & McCormick, L. (1992). Toward integrating qualitative and quantitative methods: An introduction. *Health Education Quarterly, 19*, 1-8.

Stein, M. B., Hanna, C., Koverola, C., Torchia, M. G., & McClarty, B. (1997). Structural brain changes in PTSD: Does trauma alter neuroanatomy? *Proceedings of the New York Academy of Science, 821*, 76-82.

Stein, M. B., Koverola, C., Hanna, C., Torchia, M. G., & McClarty, B. (1997). Hippocampal volume in women victimized by childhood sexual abuse. *Psychological Medicine, 27*, 951-960.

Stein, M. B., Yehuda, R., Koverola, C., Hanna, C. (1997). Enhanced dexamethasone suppression of plasma cortisol in adult women traumatized by childhood sexual abuse. *Biological Psychiatry, 42*, 680-686.

Stern, D. N. (1985). *The interpersonal world of the infant.* NY: Basic Books.

Stiver, I. P. (1997). A relational approach to therapeutic impasse. In J. V. Jordan (Ed.), *Women's growth in diversity: More writings from the Stone Center* (pp. 288-310). NY: Guilford.

Stiver, I. P. & Miller, J. B. (1997). From depression to sadness in women's psychotherapy. In J. V. Jordan (Ed.), *Women's growth in diversity: More writings from the Stone Center* (pp. 217-238). NY: Guilford.

Strahan, R., & Gerbasi, K. C. (1972). Short, homogeneous versions of the Marlowe-Crowne Social Desirability Scale. *Journal of Clinical Psychology, 28*, 191-193.

Straker, G., & Jacobson, R. S. (1981). Aggression, emotional maladjustment and empathy in the abused child. *Developmental Psychology, 17*, 762-765.

Strauss, A. L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13*, 593-618.

Styron, T., & Janoff-Bulman, R. (1997). Childhood attachment and abuse: Long-term effects on adult attachment, depression, and conflict resolution. *Child Abuse & Neglect, 21*, 1015-1027.

Sullivan, E. V. (1977). A study of Kohlberg's structural theory of moral development: A critique of liberal social science ideology. *Human Development, 20*, 352-376.

Tabachnick, B. G., & Fidell, L. S. (1989). *Using multivariate statistics* (2nd Ed.). NY: Harper & Row.

Taylor, J. M., Gilligan, C., & Sullivan, A. M. (1995). *Between voice and silence: Women and girls, race and relationship*. Cambridge: Harvard University Press.

Thompson, A. E., & Kaplan, C. A. (1996). Childhood emotional abuse. *British Journal of Psychiatry, 168*, 143-148.

Trevarthen, C. (1977). Preschool children's intraconversational narratives. *Journal of Child Language, 6*, 91-109.

Van Ijzendoorn, M. H. (1992). Intergenerational transmission of parenting: A review of studies in nonclinical populations. *Developmental Review, 12*, 76-99.

van IJzendoorn, M. H., & Kroonenberg, P. M. (1988). Cross cultural patterns of attachment: A meta-analysis of the strange situation. *Child Development, 59*, 147-156.

van IJzendoorn, M. H., & Sagi, A. (1999). Cross-cultural patterns of attachment: Universal and contextual dimensions. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 713-734). NY: Guilford Press.

Vreeke, G. J. (1991). Gilligan on justice and care: Two interpretations. *Journal of Moral Education, 20*, 33-46.

Walker, L. J. (1980). Cognitive and perspective-taking prerequisites for moral development. *Child Development, 53*, 1330-1336.

Walker, L. J. (1984). Sex differences in the development of moral reasoning: A critical review. *Child Development, 55*, 667-691.

Walker, L. J. (1986a). Sex differences in the development of moral reasoning: A rejoinder to Baumrind. *Child Development, 57*, 522-526.

Walker, L. J. (1986b). Experiential and cognitive sources of moral development in adulthood. *Human Development, 29*, 113-124.

Walker, L. J. (1989). A longitudinal study of moral reasoning. *Child Development, 60*, 157-166.

Walker, L. J., de Vries, B., & Trevethan, S. D. (1987). Moral stages and moral orientations in real-life and hypothetical dilemmas. *Child Development, 58*, 842-858.

Ward, M. J., Kessler, D. B., & Altman, S. C. (1993). Infant-mother attachment in children with failure to thrive. *Infant Mental Health Journal, 14*, 208-220.

Weinfield, N. S., Sroufe, L. A., Egeland, B., & Carlson, E. A. (1999). The nature of individual differences in infant-caregiver attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 68-88). NY: Guilford Press.

Werner, E. E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry, 59*, 72-81.

West, C. M., Williams, L. M., & Siegel, J. A. (2000). Adult sexual revictimization among Black women sexually abused in childhood: A prospective examination of serious consequences of abuse. *Child Maltreatment, 1*, 49-57.

Westen, D., Ludolph, P., Misle, B., Ruffins, S., & Block, J. (1990). Physical and sexual abuse in adolescent girls with borderline personality disorder. *American Journal of Orthopsychiatry, 60*, 55-66.

Widom, C. S. (1989). Child abuse, neglect and adult behavior: Research design and findings on criminality, violence, and child abuse. *American Journal of Orthopsychiatry, 59*, 355-367.

Woodruff, D. L. (1999). General family functioning, parental bonding, and attachment style: Familial factors influencing the severity and type of symptomatology in adult women who report childhood sexual abuse and nonabused psychatric outpatients. *Dissertation Abstracts International, 59* (7-B): 3720. Abstract from: WebSPIRS File: PsychInfo.

Yacker, N., & Weinberg, S. L. (1990). Care and justice moral orientation: A scale for its assessment. *Journal of Personality Assessment, 55*, 18-27.

Yarrow, L. (1972). Attachment and dependency: A developmental perspective. In J. Gewirtz (Ed.), *Attachment and dependency* (pp. 81-95). Washington, D.C.: Winston.

Zahn-Waxler, C., Radke-Yarrow, M., & King, R. A. (1979). Child rearing and children's prosocial initiations toward victims of distress. *Child Development, 50*, 319-330.

Zeiller, B. (1982). Physical and psychological abuse: A follow-up of abused delinquent adolescents. *Child Abuse and Neglect, 6*, 207-210.

Appendix A

Recruitment Letter to Clinicians

Dear

I am a doctoral candidate in the clinical psychology program at the University of Manitoba. I am conducting a study on the impact of severe child maltreatment on adult women survivors. The focus of the study is to investigate the effect of child maltreatment on adult attachment. A brief description of the project is attached. I have had considerable experience interviewing child sexual abuse survivors as a clinical research assistant for a previous study conducted by Dr. Catherine Koverola of the University of Manitoba and Dr. Murray Stein at St. Boniface Hospital (now at UCSD, San Diego, CA).

I would like to extend an invitation to Winnipeg clinicians to assist in the study. I am seeking three groups of female clients age 20-55 who are either involved in ongoing therapy or are completing a course of therapy. The first group are women who experienced severe intrafamilial child sexual abuse before age 17. The second group are women who experienced severe child physical abuse before age 17, but have no history of child sexual abuse. The third group comprises women with no history of child sexual or physical abuse or adult sexual assault, and who are in therapy for other issues.

If you have clients who would be potential candidates for this study I would appreciate your mentioning this study to them and giving them a copy of the enclosed "Summary for Potential Participants."

If you would like further information about the study, please do not hesitate to telephone me at I will gladly send you a copy of the results upon completion of the study. Thank you for your time.

Sincerely,

Cindy Hanna, M. A.

Summary for Clinicians

Effects of Child Maltreatment on Attachment

The child abuse literature presents a wide range of effects of early maltreatment on adult functioning. Findings point to differential psychological adjustment in individuals. The purpose of this study is to investigate the differential effects of child sexual and physical abuse on adult attachment.

Prior to being accepted into the study, potential participants will be asked to take part in a brief telephone screening interview in order to ensure that they meet criteria for the study. Participants will be asked to complete a questionnaire package requiring approximately 2 hours of time. Data collection will be conducted at an office at the Fort Garry campus of the University of Manitoba. The assessment will be conducted by a graduate student who is trained and experienced in clinical interviewing and questionnaire administration.

Participants must be females age 20-55 who are either involved in ongoing therapy or are completing a course of therapy. Three groups of women are being sought for this study.

(1) Women who experienced severe intrafamilial child sexual abuse before age 17. Severe sexual abuse is defined as oral sex, digital or object penetration, and/or attempted or completed vaginal or anal intercourse occurring before age 17 by someone at least 5 years older than the child. The perpetrator must have been a close family member residing within the home at the time of the abuse. Other forms of abuse are not exclusionary criteria.
(2) Women who experienced severe child physical abuse before the age of 17, but have no history of child sexual abuse. The abuse must have been severe enough to cause physical injury (e.g., bruising).
(3) Women with no history of child sexual or physical abuse or adult sexual assault, and who are in therapy for other reasons.

All information collected is identified by number coding, and all responses will be strictly confidential. If you have clients that you think may be interested in participating in this research, please give them a copy of the attached "Summary of Study for Potential Participants." Thank you very much.

Summary of Study for Potential Participants

It is well known that childhood experiences can affect how we function later in life. I am conducting a research project to investigate the effects of childhood experiences and adjustment to these experiences. In particular, I am interested in learning more about how childhood experiences can affect our relationships later in life. I am a doctoral level graduate student in the Clinical Psychology program at the University of Manitoba. I have had extensive experience in clinical interviewing, particularly with child sexual abuse survivors.

To take part in this study you must be a woman age 20-55. Participation in the project will involve a short telephone screening interview to determine whether you meet the criteria for the study. Taking part in this study is completely voluntary. If you decide you don't want to take part in the study any more you can quit at any time. If you meet the criteria for the study and you are interested in participating, you will be asked to come to an office at the University of Manitoba to complete a number of questionnaires on past and current relationships. This will require approximately 2 hours of your time.

All of your data will be identified by number so your results cannot be identified with you personally. Only the researchers will be looking at your test results, and your test results will be kept completely confidential. If you are interested in taking part in this study or if you would like more information, please call Leave a message and I will call you back.

Thank you,

Cindy Hanna

Appendix B

Participant Recruitment Poster

UNIVERSITY OF MANITOBA RESEARCH STUDY

WOMEN age 20-55 are being sought to participate in a University of Manitoba research study on the effects of child physical and sexual abuse on close relationships. You are eligible to participate if you:

a) Were physically punished, mistreated, or abused by a family member before age 17, or
b) Were sexually abused before age 17 by someone within your family who was at least 5 years older than you, or
c) Have no history of child physical or sexual abuse or adult sexual assault.

Participation involves a brief telephone interview to ensure that you meet the criteria for the study. You would then meet with the researcher to complete several questionnaires; this will take 1 to 1-1/2 hours. All information collected is completely confidential. There is a $10 honorarium to cover transportation costs. For more information please call Cindy at Thank you very much.

Appendix C

Advertisements

WOMEN age 20-50 are needed for a Dept. of Psychology research project on the effects of child maltreatment on close relationships in adulthood. Participants must have been physically punished, mistreated, or abused by a family member before age 17, **OR** have **NO** history of child physical or sexual abuse or adult sexual assault. All information collected is completely confidential, and participants will be paid $10 to cover transportation costs. For more information please call Cindy at

Winnipeg Free Press, Winnipeg Sun, Manitoban, & Lance/Metro Ad:

WOMEN age 20-50 needed for a U of M Dept. of Psychology research study on the effects of child maltreatment on adult relationships. If you were: (1) physically punished, mistreated or abused before age 17 but **not** sexually abused, or (2) have **no** history of child physical or sexual abuse or adult sexual assault, you may be eligible to participate. Confidentiality guaranteed, $10 to cover transportation costs. Call Cindy at

Videon Ad:

Women age 20-50 needed for U of M research on child maltreatment and adult relationships. If you were physically punished or abused but **not** sexually abused as a child, **OR** have no history of child sexual or physical abuse, you may be eligible. Call Cindy,

Women Healing for Change Ad:

WOMEN age 20-50 are being sought to participate in a University of Manitoba research project on the effects of child physical and sexual abuse on close relationships. You are eligible to participate if you:

- Were physically punished, mistreated, or abused by a family member **before age 17, or**
- Were sexually abused **before age 17** by someone within your family who was **at least 5 years older** than you, **or**
- Have **no** history of child physical or sexual abuse or adult sexual assault.

Participation involves a brief telephone interview to ensure that you meet the criteria for the study. You would then meet with the researcher to complete several questionnaires; this will take 1 to 1-1/2 hours. All information collected is completely confidential. There is a $10 honorarium to cover transportation costs. For more information please call Cindy at

Appendix D

Telephone Screening Interview

Before we begin, could you tell me where you heard about this study?

In this study, we are looking at ways that different types of childhood experiences affect people. In order to determine whether you qualify for the study, I'll need to ask you some questions that will take about 20 minutes. Do you have time now, or would you like me to call you back another time?

Some of these questions deal with the possibility of you having been physically or sexually abused as a child. Some of the questions are explicit and may feel intrusive, but your answers are completely confidential. Do you wish to continue?

If NO, terminate ___. Thank you for your time.

If YES, continue ___. Please tell me if you become upset by the questions at any time, and we can take a break or stop the interview. I also need to tell you that participating in this screening interview does not guarantee acceptance into the study, but I'll be able to tell you at the end of the interview whether or not you qualify.

1) (a) Are you in therapy at present? Yes ___ No ___

If YES, How long have you been in therapy with your current therapist? _____

If NO, Have you been in therapy in the past? Yes ___ No ___

If YES, How long were you in therapy? _____

How many different therapists have you seen? _____

I'm going to ask you now about any physical maltreatment you may have experienced as a child. Is that o.k.? If **yes**, continue. If **no**, terminate.

2) (a) Before you were 17 years old, were you ever slapped, kicked, or punched by a caregiver?

_____

_____

(b) Did a caregiver ever push you, throw you, or knock you down?

_____

_____

(c) What about pulling your hair, burning or scalding you?

_____

_____

If NO, proceed to 3. **If YES,** inquire about:

age _____

injury _____

medical treatment _____

_____

(d) Did you always have memories of these experiences, or was there a time in your life when you didn't remember what had happened?

_____

3) Now I'm going to ask you about any unwanted sexual experiences that happened to you before you were 17 years old. Is that o.k.? If **yes**, continue. If **no**, terminate.

4) **(a)** Before you were 17 years old, did anyone try to kiss you in a sexual way when you didn't want them to? Yes ___ No ___ **If YES, inquire about:**

age ____ perpetrator _____

effects _____

(b) Before you were 17 years old, did anyone try to fondle any part of your body when you didn't want them to? Yes ___ No ___ **If YES, inquire about:**

age ____ perpetrator _____

effects _____

_____

(c) Before you were 17 years old, did anyone try to insert their fingers or any other object in your vagina or anus when you didn't want them to? Yes ___ No ____**If YES, inquire about:**

age ____ perpetrator _____

effects _____

_____

(d) Before you were 17 years old, did anyone try to perform oral sex on you or try to force you to perform oral sex on them when you didn't want them to? Yes ___ No **If YES, inquire about:**

age ____ perpetrator _____

effects _____

_____

(e) Before you were 17 years old, did anyone try to have vaginal intercourse with you when you didn't want them to? Yes __ No __ **If YES, inquire about:**

age ____ perpetrator _____

effects _____

_____

(f) Before you were 17 years old, did anyone try to have anal intercourse with you when you didn't want them to? Yes __ No __ **If YES, inquire about:**

age ____ perpetrator _____

effects _____

_____

(g) Did you always have memories of these experiences, or was there a time in your life when you didn't remember what had happened?

_____

(h) Have you even been physically assaulted as an adult? _____

_____

(i) Have you even been sexually assaulted as an adult? _____

_____

If NO to all abuse experiences --> Nonabuse Group ____

If meets criteria for sexual abuse --> CSA Group ____

If physically but not sexually abused --> CPA Group ____

Name _____ Phone _____

Appointment _____

Appendix E

Consent Form

Research suggests that our early life experiences may have an affect on our close relationships later in life. I am interested in learning more about this area, in particular how early traumatic experiences affect our ability to form close relationships.

This study will be conducted in two parts. Participating in the first part of the study requires approximately 1 to 1-1/2 hours of your time. You will be asked to complete several questionnaires on past and current relationships as well as a questionnaire about moral issues. All of your answers will be number coded and will be kept completely confidential. You may also be invited to participate in the second part of the study. This involves an in-person interview with the researcher about moral issues. The interview will take approximately 1 to 1-1/2 hours, and will be tape-recorded for the purposes of transcription and coding. I will transcribe the tapes and will remove all identifying information in the process.

Taking part in this study is completely voluntary. If there are particular questions that you do not wish to answer, you may leave them blank. Also, if you decide you don't want to take part in the study any more you can quit at any time. I am offering a $10 honorarium as a token of appreciation for your participation in each part of the study. A cheque will be mailed to you once you have completed the study. At the conclusion of the study, I will send you a summary of the overall results by mail.

If you understand what you will be expected to do in this study and you agree to take part, please sign your full name and the date below.

_____ _____

Participant signature Date

_____ _____

Investigator signature Date

Appendix F

Feedback Sheet

Research has shown that traumatic experiences can have a number of effects on people's mental and emotional functioning. In particular, studies have shown that child sexual and physical abuse can lead to psychological problems. We were interested in investigating the effects of child sexual and physical abuse on attachment, or how people feel about close relationships. We were also interested in learning about whether women who have been abused in childhood think any differently about moral dilemmas than women with no history of abuse. In order to learn more about this area we compared the responses of women survivors of child sexual abuse and child physical abuse to those of women with no histories of abuse. Very little research has been done on this issue with abuse survivors, and we believe that our results will contribute to the general knowledge about the effects of child abuse. Further, the findings may also help to improve the treatment of people who have experienced abuse.

Your participation in this study was greatly appreciated. If any part of the study and your participation in it has created issues of concern or caused you distress, please discuss these issues with your therapist or physician, or make use of the telephone numbers of mental health resources listed below. We remind you that all of your responses are completely confidential. No one can see your results except the researcher and all the information you gave us was number coded so you cannot be identified with your results once all the data is collected. A copy of the general results of the study will be mailed to you upon completion of the study. Thank you very much for your participation.

Klinic Crisis Line: 786-8686

Womyn's Counselling Services: 772-2504

Appendix G

Background Questionnaire

Age: ____ yrs

Ethnic Origin:

Caucasian	___	Asian	___
Aboriginal	___	West Indian	___
African-Canadian	___	Other	___
Hispanic	___		

Relationship Status: Are you currently in a relationship? Yes ___ No ___

If **Yes,** are you (check one):

Married	___
Living in a common-law relationship	___
Living with same-sex partner	___

If **No,** are you (check one):

Single	___
Separated	___
Divorced	___

Education: (Write in the **highest** level completed. For example, 8th grade, 1st year B.A.)

Elementary	___	Community college	___
Junior high	___	Technical school	___
Senior high	___	University	___

Other (please specify) _____

If you are a parent or stepparent, please list the age and gender of each child:

Age	Gender
___	___
___	___
___	___
___	___
___	___

Current Occupation (including homemaker): _____

Usual Occupation (if different from current occupation): _____

_____

Appendix H

Relationship Questionnaire

PLEASE READ DIRECTIONS!!!

1) Following are descriptions of four general relationship styles that people often report. Please read each description and **CIRCLE** the letter corresponding to the style that **best** describes you or is **closest** to the way you generally are in your close relationships. If there is a difference between the way you are in close **friendships** as opposed to **romantic** relationships, please think of **romantic relationships** as you complete this and the following questionnaire.

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

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

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

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

2) Please **rate** each of the following relationship styles according to the **extent** to which you think each description corresponds to your general relationship style.

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

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

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

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

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

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

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

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

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

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

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

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

Appendix I

Relationship Scales Questionnaire

Please read each of the following statements and rate the extent to which it describes your feelings about close relationships. Think about all of your close relationships, past and present, and respond in terms of how you generally feel in these relationships. Use the scale below, and put the number that best corresponds to the description of how you feel in the blank beside the question.

1.....2.....3.....4.....5

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

1. I find it difficult to depend on other people. ___
2. It is very important to me to feel independent. ___
3. I find it easy to get emotionally close to others. ___
4. I want to merge completely with another person. ___
5. I worry that I will be hurt if I allow myself to become too close to others. ___
6. I am comfortable without close emotional relationships. ___
7. I am not sure that I can always depend on others to be there when I need them. ___
8. I want to be completely emotionally intimate with others. ___
9. I worry about being alone. ___
10. I am comfortable depending on other people. ___
11. I often worry that romantic partners don't really love me. ___

1.....2.....3.....4.....5

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

12. I find it difficult to trust others completely. ___
13. I worry about others getting too close to me. ___
14. I want emotionally close relationships. ___
15. I am comfortable having other people depend on me. ___
16. I worry that others don't value me as much as I value them. ___
17. People are never there when you need them. ___
18. My desire to merge completely sometimes scares people away. ___
19. It is very important to me to feel self-sufficient. ___
20. I am nervous when anyone gets too close to me. ___
21. I often worry that romantic partners won't want to stay with me. ___
22. I prefer not to have other people depend on me. ___
23. I worry about being abandoned. ___
24. I am somewhat uncomfortable being close to others. ___
25. I find that others are reluctant to get as close as I would like. ___
26. I prefer not to depend on others. ___
27. I know that others will be there when I need them. ___
28. I worry about having others not accept me. ___

1.....2.....3.....4.....5

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

29. Romantic partners often want me to be closer than I feel comfortable being. ___

30. I find it relatively easy to get close to others. ___

Appendix J

Caretaker History Questionnaire

The following questions are designed to increase our understanding of the effects on children of separations from their caretakers. Some of the questions will ask you about your parents. If you are adopted, please answer the questions in relation to your adopted parents or guardian.

Please check one of the following statements:

1. I am answering the questions with my birth parents in mind. ___

2. I am adopted and I am answering the questions with my parents/guardians in mind. ___

3. My situation is special. Please explain. _____

   _____

4. Do you have step-parents?

   Step-mother: Yes ___ No ___

   If "Yes", how old were you when she became your step-mother? ___

   Step-father: Yes ___ No ___

   If "Yes", how old were you when he became your step-father? ___

FAMILY INFORMATION

5. For the following time periods, please list the people who you feel were the most important or significant people in your life. List persons who you remember as being supportive, helpful, encouraging, caring, etc.

Your Age

0-3 yrs _____

3-5 yrs _____

5-10 yrs _____

10-15 yrs _____

15-20 yrs _____

6. Before the age of 17, was there ever a period of time when you were separated from either of your parents for a period of time?

Yes ___ No ___

If you answered "yes", please answer the following questions and explain the circumstances of the separation.

How long was the separation? _____

How old were you at the time? ____

Please explain the circumstances (e.g., the separation was due to illness or death, I was placed in foster care, etc.) _____

_____

Appendix K

History of Unwanted Sexual Contact

A) Please answer the following questions about any **UNWANTED** sexual experiences that occurred **BEFORE AGE 17** with someone **AT LEAST 5 YEARS OLDER** than yourself.

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

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

1) How often did you experience:

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

If you answered "**never**" to the above questions, please go on to the next questionnaire. If some of these experiences did occur, please answer the questions below.

2) How old were you when the unwanted sexual contact first started? _____

3) How many individuals were involved? _____

4) Please indicate who these individuals were (check all that apply):

a) stranger ___
b) unrelated acquaintance (neighbor, babysitter, teacher) ___
c) extended family (cousin, uncle/aunt, grandparent) ___
d) sibling ___
e) parent/stepparent/guardian ___

5) Were you ever (check all that apply):

a) forced into participating ___
b) threatened ___
c) physically forced ___
d) physically hurt ___

6) Do you believe that you were sexually abused as a child? yes ___ no ___

B) Please answer the questions on the following pages about any **UNWANTED** sexual experiences that occurred **BEFORE AGE 17** with someone **LESS THAN 5 YEARS OLDER** than yourself.

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

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

1) How often did you experience:

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

If you answered "**never**" to the above questions, please go on to the next questionnaire. If some of these experiences did occur, please answer the questions below.

2) How old were you when the unwanted sexual contact first started? _____

3) How many individuals were involved? _____

4) Please indicate who these individuals were (check all that apply):

a) stranger ___
b) unrelated acquaintance (neighbor, babysitter, teacher) ___
c) extended family (cousin, uncle/aunt, grandparent) ___
d) sibling ___
e) parent/stepparent/guardian ___

5) Were you ever (check all that apply):

a) forced into participating ___
b) threatened ___
c) physically forced ___
d) physically hurt ___

6) Do you believe that you were sexually abused as a child? yes ___ no ___

C) Please answer the following questions about any **UNWANTED** sexual experiences that occurred when you were **AGE 17 OR OLDER.**

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

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

1) How often did you experience:

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

If you answered "**never**" to the above questions, please go on to the next questionnaire. If some of these experiences did occur, please answer the questions below.

2) How old were you when the unwanted sexual contact first started? _____

3) How many individuals were involved? _____

4) Please indicate who these individuals were (check all that apply):

a) stranger ___
b) unrelated acquaintance (neighbor, babysitter, teacher) ___
c) extended family (cousin, uncle/aunt, grandparent) ___
d) sibling ___
e) parent/stepparent/guardian ___
f) partner/spouse/date ___

5) Were you ever (check all that apply):

a) forced into participating ___
b) threatened ___
c) physically forced ___
d) physically hurt ___

Appendix L

Family Conflict Questionnaire

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

Please use the following scale to indicate how often each of the listed behaviours 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, stepparents or guardians deliberately (i.e. not accidentally):

a) Verbally abuse you (call you names, insult you, humiliate you, say that you were worthless) ___
b) Threaten you with physical harm/assault ___
c) Throw something at you with intent to harm ___
d) Damage walls, doors, furniture, or any other household items in your home in front of you ___
e) Fail to provide you with adequate food, medical care, or shelter ___
f) Hit or slap you really hard ___
g) Beat or kick you ___
h) Push, throw, or knock you down ___
i) Hit you with an object ___
j) Pull your hair ___
k) Burn or scald you ___
l) Scratch or dig fingernails into you ___
m) 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 (check all that apply):

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

3) If you experienced any of the above behaviours, did they ever result in the following (check all that apply):

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

4) Did any of the following people ever hit you or beat you before you were 17? (Check all that apply)

a) brother or sister ___
b) other child or adolescent ___
c) other adult non-family member ___

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

Yes ___ No ___

Appendix M

Moral Orientation Scale

This scale is a measure of moral reasoning style for adults using 12 dilemmas encountered by children between the ages of 8 and 10 years. In completing the scale it is important that you imagine yourself to be the parent of an 8 to 10-year-old child. As you respond to each dilemma, think about how you would help "your child" decide what to do. That is, **what would you most want your child to consider when deciding what to do**. After each dilemma, there are four issues you might consider when helping your child decide what to do. Please rank them from 1 to 4 in order of your preference.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

Please place the ranking directly on the scale on the line to the left of each issue. Even if none of the issues matches **exactly** what you would say or do, please rank them to match your thinking as closely as possible. Be sure to rank each issue. Of course, there are no right or wrong answers for any question.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

1. Your child is having a birthday party and wants to invite most of the children in the class. One classmate, who lives down the street, is not popular with your child or the other children in the class. Your child does not want to invite the neighbour child.

___ Since the other child lives on the block, I would explore how my child would feel when she/he saw the child in the future if the child were not invited to the party and how the other child would feel after being left out.

___ I would explain to my child that if most of the class is invited, the unpopular child must be as well. It is not fair to leave out one or two.

___ I would remind my child that there are times when neighbours help each other. Especially because the child is unpopular, it would be best to be friendly with the neighbour child and invite him/her to the party.

___ I would want my child to consider the reasons why the child is not popular. If the child is just shy, she/he should be invited. If the child is out of control or abusive, it would be unfair to the other children to include the child.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

2. Your child accidentally broke a toy that belonged to another child. No one saw your child do this and your child does not wish to confess.

___ I would explain to my child that honesty is the best policy and that the thing to do is admit having broken the toy.

___ I would want my child to consider that by not confessing, someone else might get blamed and punished for breaking the toy.

___ I would discuss how difficult it might be for my child to play with the other child in the future, having to live with the guilt about the toy.

___ I would want my child to know that in this case there are no questions. If you break it, you offer to replace it.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

3. **Your child and another child were misbehaving in school while the teacher was out of the room. When the teacher returned, your child was caught misbehaving, but the other child was not. Your child wonders what to do.**

___ I would want my child to be concerned about his/her own behaviour only and to understand that this wouldn't have happened if my child had behaved properly in the first place.

___ I would expect my child not to tattle. As for the other child, it is a matter between that child and the teacher.

___ I would help my child understand that it would be unkind to get the other child in trouble and that the upset and anger at the other child for not being caught will not last long.

___ I would explore with my child what would happen to their relationship if my child told on the classmate.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

4. Your child agreed to participate in an extra-curricular event which requires after-school preparation. As the day of the event nears, the weather becomes more conducive to outdoor play. Your child no longer wishes to participate in the event or to help in its preparation.

___ I would want my child to consider the potential disappointment of others, as they are depending on her/his participation in the event.

___ I would help my child understand that a commitment is a commitment and that one must honour responsibilities that one agrees to.

___ My child made a promise. I would want my child to consider how he/she would feel if someone broke his/her word to my child.

___ I would want my child to be concerned with the selfishness of her/his wishes and I would point out that acting this way can make a person feel bad about herself/himself later.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

5. **Your child often plays with two other children and all three are close friends. For some reason, one of the friends becomes unhappy with the other and wishes your child to break off relations with that friend also. Your child feels caught in the middle and wonders what to do.**

___ I would encourage my child to remain friends with both children, even if all three do not play together at the same time.

___ I would want my child to consider whether the two children could become friends again by helping my child understand what went wrong.

___ I would want my child to consider whether it is fair for someone else to determine who his/her friends should be.

___ I would want my child to consider how she/he would feel if she/he were in the position of the third friend. I would want my child to treat others the way she/he wants to be treated.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

6. **Your child agrees to pay for a relatively inexpensive household item that she/he broke despite warnings "not to touch". Your child is saving a portion of her/his allowance to do this. As the savings increase, your child wishes very much to spend the money on something she/he has wanted for a long time.**

___ I would explain to my child that life is like this sometimes; we often have to do things we don't want to do. It's not always easy to play by the rules.

___ I would want my child to know that we can accommodate each other. I would allow a small portion of the saved money for his/her own purchase, even though it will take a little longer to pay back the broken item.

___ I would want my child to consider the importance of priorities and to understand that the prior obligation must be satisfied before her/his wishes.

___ I would impress upon my child that even though the item was small, it was important to me and that for the sake of my feelings, I would like him/her to replace it before making his/her own purchase.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

7. **Your child admires a toy that belongs to a friend. The friend accidentally leaves the toy at your house. Because the friend does not seem to miss the toy or ask for its return, your child wants to keep the toy.**

___ I would want my child to consider how the child who owns the toy feels about not having it. I would point out that just because the other child doesn't seem to care about the toy, this may not be the case.

___ I would want my child to consider how she/he would feel if someone kept a toy that was hers/his. The principle of not doing to others what you would not want them to do to you is key in this case.

___ I would want my child to consider who owns the toy. Regardless of the circumstances, the toy still belongs to someone else and the important thing is to return it.

___ I would want my child to consider the good feeling he/she would get from returning the toy and the problems that might occur between the children if the friend remembers the toy later and it wasn't returned.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

8. **An afternoon has been set aside for the whole family to give the home a thorough cleaning. On the appointed day, your child wishes to watch a special program on television. (There is no VCR in the household.)**

___ My child should consider that watching the T.V. show would not be very considerate to the other members of the family, and should imagine how they might feel.

___ My child would have to understand that she/he is no more privileged than any other member of the family and therefore has to participate in the family chores.

___ I would stress all the important aspects of responsibility, togetherness and belonging that go with "family", as well as the need to be able to depend on one another.

___ My child should consider that a commitment has been made to the family in an almost contractual way. It would not be fair to change her/his mind at the last minute.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

9. **Your child finds on the street a pocketbook containing some small items that intrigue your child. Your child wishes to keep some or all of the contents of the bag.**

___ I would want my child to understand that ownership is an important concept. People have a right to their belongings, even though kids often say, "finders keepers, losers weepers."

___ I would remind my child of the "Golden Rule" (Do unto others as you would have them do unto you.)

___ I would want my child to consider that if she/he kept the pocketbook without trying to locate the owner, she/he might feel guilty about keeping something that somebody else might need.

___ I would remind my child that these items are probably considered special to the person they belong to and that person would want them back.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

10. **Your child promises another child to help him/her with a school project due the next day. When your child tells you this, you remind your child that this was the day the family had planned to visit with friends who live in a town an hour away. Your child does not know what to do.**

___ I would want my child to consider that promises made are promises kept unless good reasons prevent you from keeping your word. Since the commitment to the other family was made first, it takes precedence.

___ I would want my child to consider that membership in the family is important and that when the parents make plans, I would like for us all to be together.

___ I would discuss the problem of an individual's freedom within the group and that when the family makes plans, one family member doesn't have the right to make separate plans.

___ I would want my child to consider the predicament of the other child. If the friend really needs the help, I could see where my child might have to stay home and help the friend.

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

11. **Your child has made long standing overnight plans with a good friend who moved out of town and who your child sees infrequently. On the afternoon of the appointed evening, a neighbour calls to say that there is an extra ticket to the Ice Capades (or other special event) and invites your child to attend. Your child does not know what to do.**

___ I would want my child to consider that not only is the friend looking forward to the visit, the adults in the families had to make special plans for the overnight.

___ I would want my child to consider the friend's feelings and find out if it might be possible to change the overnight plans without upsetting the friend.

___ I would want my child to understand that the first commitment takes precedence.

___ I would want my child to consider her/his priorities. Which is more important - friend or event?

1 = the issue I would most want my child to consider
2 = the issue I would next want my child to consider
3 = the issue I would next want my child to consider
4 = the issue I would least want my child to consider

12. **Your child was scolded by one of the teachers in the school for a perceived misdemeanor that your child really did not commit. Your child wishes to explain, but fears being further scolded for "talking back".**

___ I would want my child to understand that justice is justice and that taking blame unnecessarily need not be tolerated.

___ I would want my child to consider how important it is to communicate with the teacher, not only to clear himself/herself, but to maintain integrity and self esteem.

___ I would want my child to consider that teachers are human beings and they sometimes make mistakes. Unless my child were very upset, I would advise her/him to leave things alone this time.

___ I would want my child to consider the importance of having the truth be known even when you think people don't want to hear it.

Appendix N

Personal Reaction Inventory

Please respond to the following statements by indicating whether each statement is **True (T)** or **False (F).**

1. I like to gossip at times. ___
2. There have been occasions when I took advantage of someone. ___
3. I'm always willing to admit it when I make a mistake. ___
4. I always try to practice what I preach. ___
5. I sometimes try to get even rather than forgive and forget. ___
6. At times I have really insisted on having things my own way. ___
7. There have been occasions when I felt like smashing things. ___
8. I never resent being asked to return a favour. ___
9. I have never been irked when people expressed ideas very different from my own. ___
10. I have never deliberately said something that hurt someone's feelings. ___

Appendix O

Real-Life Moral Conflict and Choice Interview

All people have had the experience of being in a situation where they had to make a decision, but weren't sure of what they should do. Would you describe a situation when you faced a moral conflict and you had to make a decision, but weren't sure what you should do?

If necessary, one or more of the following questions are asked in order to clarify/elaborate the dilemma.

1. What was the situation? (Be sure you get a full elaboration of the story).

2. What was the conflict for you in that situation? Why was it a conflict?

3. In thinking about what to do, what did you consider? Why? Anything else you considered?

4. What did you decide to do? What happened?

5. Do you think it was the right thing to do? Why/why not?

6. What was at stake for you in this dilemma? What was at stake for others? In general, what was at stake?

7. How did you feel about it? How did you feel about it for the other(s) involved?

8. Is there another way to see the problem? (other than the way you described it?)

9. When you think back over the conflict you described, do you think you learned anything from it?

10. Do you consider the situation you described a moral problem? Why/why not?

11. What does morality mean to you? What makes something a moral problem for you?

Appendix P

Attachment Questions

Your responses on the questionnaires indicated that in close romantic relationships you (description of attachment style).

I'm wondering how you think this way of interacting developed?

When do you think this started?

Has it changed at all over the years?

Is this style of relating different for close friendships than it is for romantic relationships?

Are you happy with this style of interacting?

Do you see this as something that could change [further]? If so, what would change it?

Appendix Q

Codes for Qualitative Data Analysis

Abuse – CPA: Child Physical Abuse; deliberate physical injury by a caretaker before age 17.

Abuse – CSA: Child Sexual Abuse; experiencing one or more of the following: oral sex, digital or object penetration and/or attempted or completed vaginal or anal intercourse occurring before age 17 by a family member at least 5 years older than the child.

Abuse – Emotional: Reported more than two emotionally abusive experiences in childhood (e.g., witnessing family violence, being threatened, demeaned, harshly criticized, and/or called names).

Abusive relationship(s): Refers to emotionally, physically, or sexually abusive relationships.

Action: Action taken to attempt to resolve moral dilemma. This includes action not taken; e.g., choosing not to talk to someone about the issue.

Action considered: Action considered in an attempt to resolve the moral dilemma.

Anger: Examples of the participant feeling or becoming angry.

ASA: Adult sexual assault.

Att-Abuse: Linking development of attachment style to childhood abuse.

Att: Adult relationship: Linking development of attachment style to a relationship in adulthood.

Attachment Development: Refers to what factors influenced development of participant's attachment style(s); when and how style(s) developed, and what relationships influenced development. Also refers to change in attachment style over time.

Attitudes to relationships: Refers to the participant's attitudes to relationships of any kind, with friends, family, partner, or in general.

Betrayal: Refers to instances of betrayal or the participant feeling betrayed.

Blame - other(s): Refers to blame of others, not to blame by others of participant.

Blame – self: Examples of self-blame by the participant. Taking responsibility for an action or lack of action; assuming blame or fault; self-censure.

Boundaries: References to boundaries, including boundary violations.

Care-based considerations: Refers to the use of care-based moral reasoning in the dilemma or in moral decisions in general.

Care - Level 1: Indicates Level 1 of care-based moral reasoning; self-care in order to ensure survival.

Care - Level 2: Care-based reasoning at Level 2 - responsibility to others but self not considered.

Care - Level 3: Indicates Level 3 of Care-based moral decision-making; considering both self and others in moral decisions.

Care – transition: Care-based reasoning in the transition phase; reflecting a tension between self-sacrifice and care for others.

Confusion: Refers to the participant feeling confused.

Current relationship: Refers to relationship with current partner.

Dealing with abuse: All of the things that participant did to deal with her CPA or CSA abuse history.

Discomfort: Refers to the participant feeling discomfort.

Dismissing attachment: Positive model of self, negative model of others. An expectation of rejection leads these people to protect themselves by adopting a posture of invulnerability. (Relationship Questionnaire (RQ) defines as: "I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or to have others depend on me.")

Dissociation: Reference to feelings of dissociation.

Early childhood separation: Refers to separation from caregivers in childhood, before age 5.

Effect on self: Effect on self of moral dilemma.

Emotional distress: Refers to evidence of emotional distress, including talking about feeling distressed or evidence of distress during the interview.

Emotional pain: Refers to feelings of emotional pain; more intense than emotional distress.

Family & attachment: Qualities within the family that affected the way the person developed attachment relationships.

Family & morality: Effect of upbringing on moral development or moral decision making.

Fear: Refers to the participant's feelings of fear.

Fear-lack of: Refers to the participant's feelings of fearlessness.

Fearful Attachment: A negative model of self and others. (RQ defines as: "I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.")

Friendship & attachment: Refers to attachment in friendships, incl. differences in attitudes to attachment in friendships vs. those in romantic relationships

Frustration: Refers to participant's feelings of frustration.

Guilt: Feelings of personal guilt for action(s) or the situation. Feeling responsible or culpable.

Guilt-lack of: Refers to the participant's lack of feelings of guilt.

Insecurity: Indications of a lack of security and/or lack of self-esteem in self or others.

Justice-based considerations: Refers to the use of justice-based reasoning in the dilemma or in considering moral decisions in general.

Learning: Things learned as a result of the moral dilemma.

Loving feelings: Feelings of love felt by participant toward other, or felt by other toward participant

Mixed emotions: Evidence of mixed emotions within the participant; also an indication of internal conflict.

Moral dilemma: Self-definition of the participant's moral dilemma.

Moral question: Answers to the question(s), "In general, what makes something a moral dilemma?:, or, "What about the particular moral dilemma described makes it a moral dilemma?"

Moral reasoning: This delineates the person's thinking about their particular moral dilemma. Used to code passages where moral reasoning is not clearly care-based or justice-based.

NA: Nonabused - No history of child sexual or physical abuse or adult sexual assault.

Notes: Notes about the interview itself; incl. setting, anything notable about the recording.

Other(s) considered: Evidence that the participant considered others in the moral dilemma, including others' opinions of self.

Other(s) not considered: Evidence that others were not considered in the moral dilemma.

Potential for change: Potential for change in the participant's attitudes toward attachment.

Preoccupied attachment: A negative model of self and positive model of others. A tendency to try to bolster self-esteem by seeking the approval of others. (RQ defines as: "I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I worry that others don't value me as much as I value them.")

Regret: Refers to the participant's sense of regret, i.e., expression of sorrow, repentance, or distress over an action, lack of action, or loss.

Religion/Spirituality: Referring to religious faith or matters of religiosity or spirituality.

Repression: Indications that the participant repressed memory of an experience.

Rightness of decision: Whether participant felt she took the right steps to try to resolve the moral dilemma.

Sadness/loss: Indications of sadness, loss, and/or depression.

Satisfaction: Level of satisfaction with type of attachment/attitudes toward attachment.

Secure attachment: A positive model of self and others. Characterized by a sense of self-worth and the expectation that others will be responsive. (RQ defines as: "It is easy for me to become emotionally close to others. I am comfortable depending on others and having them depend on me. I don't worry about being alone or having others not accept me.")

Self – attachment: Considerations of self in attachment relationship(s); incl. personal qualities that influenced attachment development.

Self – moral: Includes any other mention of self in the moral dilemma or in moral dilemmas in general (not coded Self considered or Self not considered).

Self considered: This involves the participant considering herself in the moral dilemma or including herself in moral decision making.

Self deprecation: Self-deprecating comments, possibly suggestive of low self-esteem.

Self doubt: Self-doubt about action taken or not taken in moral dilemma.

Self esteem: Evidence of self-esteem, self-assuredness.

Self esteem – lack: Indications of a lack of self-esteem or self-assuredness.

Self growth: Indications of or references to self-growth or self-development.

Self not considered: Indications that the participant did not consider herself in the moral dilemma or include herself in moral decision making.

Suppressing sense of self: Participant shows evidence of suppressing her usual way of being because of what others think of her or because of a situation.

Surprise/shock: Indications of surprise or shock on the part of the participant.

Therapy: Having to do with the relationship between client and therapist/counsellor, or any mention of seeing a therapist or counsellor.

Trust: The participant's references to her ability to trust.

Trust – lack: Refers to the participant's difficulty with trust or inability to trust.

Vulnerability: Refers to the participant's feelings of vulnerability.