PSYCHOSOCIAL AND RELATIONAL EFFECTS OF SEXUAL ASSAULT

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To Tyler, mom, and dad, thank you for your unconditional love and support as I have pursued my passions.

To Kami, Matt, Glade, Brandt, and Courtney, thank you for helping me grow personally and as a therapist.

To all survivors, thank you for your strength and inspiration which motivates me in this work.

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Abstract: The current study aimed to examine the effects of sexual assault on female survivors' levels of psychosocial and relational distress, including more specific subscales of relational distress (cohesion, consensus, and satisfaction). Retrospective analyses were conducted on clinical data for 154 female clients who presented for couples therapy at a Marriage and Family Therapy university training program. Half of the women (n = 77) reported a history of at least one rape experience, while the other half of participants did not. Participants completed assessments measuring their levels of psychosocial and relational distress before starting services. Between group analyses found the sexual assault group reported significantly more cumulative traumas, $t(152) = -9.38$, $p = .000$, more suicide attempts, $\chi^2(1, N = 154) = 6.29$, $p = .010$, and greater psychosocial distress at the time of treatment, $t(152) = -4.30$, $p = .000$. No differences in relational distress were discovered between groups. Multiple regression analyses were conducted examining the levels of psychosocial and relational distress within the sexual assault group based on six factors (ethnicity, cumulative trauma, age at the time of perpetration, time elapsed since perpetration, relationship to the perpetrator, and marital status). The regression model yielded no significant findings overall for the outcome measures of interest. However, the model approached significance in predicting reported consensus scores. Several factors within the model were found to be significant or approaching significance as well. Unmarried survivors reported lower rates of relational distress than married survivors, higher rates of consensus, and greater agreement in sex relations with current partner. Younger age at time of perpetration was associated with lower rates of consensus, higher rates of overall relationship distress, and higher rates of disagreement in sex relations with their current partner. Greater time elapsed since perpetration was associated with higher rates of consensus and lower rates of relational distress. Survivors perpetrated by a stranger/acquaintance reported lower rates of consensus and cohesion, and higher rates of relational distress compared to other perpetrator groups. Results suggest that sexual assault, certain individual characteristics, and trauma variables have an impact on psychosocial and relational outcomes for females.

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INTRODUCTION

Gender based violence and sexual assault continue to be pervasive issues in today's society. It is estimated that globally, 35% of women have experienced intimate partner violence or sexual violence from a non-partner during their lifetime (García-Moreno et al., 2013). Within the United States, approximately half (44.6%) of women report an experience of "sexual violence victimization other than rape at some point in their lives" (Black et al., 2011, pp. 19). Nearly 20% of American women report at least one lifetime rape experience, with the majority of these assaults (37.4%) occurring between the ages of 18 and 24 years (Black et al., 2011). These statistics emphasize the need for research on outcomes for survivors of sexual violence across all domains of functioning.

Many studies have responded to this need by examining the lasting effects of sexual assault on female survivors' psychological functioning. Women who experience

sexual assault are often left to cope with an enduring myriad of mental health issues including depression, posttraumatic stress disorder (PTSD), dissociative disorders, anxiety, psychosomatic disturbances, substance abuse, difficulties with sexual functioning, self-harm, and suicidality (Au, Dickstein, Comer, Salters-Pedneault, & Litz, 2013; Elklit & Christiansen, 2013; Herman, 1997; Mason & Lodrick, 2013). Research suggests that sexual assault places survivors at a higher risk for PTSD and major depressive episodes than survivors of other types of violent trauma, including veterans of war (Herman, 1997; Kaukinen & Demaris, 2005). Previous research has determined that certain survivor characteristics pre-dating a sexual assault (e.g., ethnicity and cumulative trauma) can place women at a heightened risk for adverse psychological outcomes (Álvarez et al., 2015; Bryant-Davis, Chung & Tillman, 2009; Krupnick et al., 2004; Lefley, Scott, Llabre, & Hicks, 1993). Similarly, specific variables relating to the sexual assault (e.g., age at the time of perpetration and relationship to the perpetrator) have been found to place survivors at a higher risk for negative outcomes as well (Culbertson & Dehle, 2001; Herman, 1997; Kaltman, Krupnick, Stockton, Hooper, & Green, 2005; Masho & Ahmed, 2007).

An area of sexual assault literature requiring further exploration is how a history of such traumas impact relational outcomes for couples. Thus far, the research in this area has focused primarily on the sexual relationship between partners. Previous studies have determined that couple sexual relationships may be greatly impacted by a history of sexual assault due to the development of negative beliefs surrounding sex, as well as sexual dysfunction and frequent lack of desire (Katz & Tirone, 2008; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Reissing, Binik, Khalif, Cohen, & Amsel, 2003; van

Berlo & Ensink, 2000). This has the potential to negatively impact each partner's level of satisfaction in the relationship, as well as the level of intimacy and trust experienced.

While the sexual relationship between partners is an important topic of study, many other variables that contribute to overall levels of relational distress have yet to be examined in the literature. Three such variables that could assist in the conceptualization of relationship distress following a sexual assault are perceived levels of cohesion, consensus, and satisfaction. Together, these variables have been found to reliably measure dyadic adjustment and distinguish between distressed and non-distressed couple relationships (Busby, Christensen, Crane, & Larson, 1995). Further research on these dimensions of relationship functioning could help identify what couple processes look like when the female partner reports a history of sexual assault.

Though research has indicated that females with a history of sexual assault generally recover faster from the impact of the trauma through receiving social support, treatment is generally provided through individual therapy services rather than relational (Herman, 1997; Mason & Lodrick, 2013). This constitutes a missed opportunity for treating not only the survivor, but their romantic partners who are affected by the trauma as well. Partners of sexual assault survivors may be at risk for developing secondary traumatic stress (the experiencing of traumatic symptoms in the absence of a personal trauma) due to their extended exposure to the symptoms and reactions of the traumatized individual (Figley, 1998). In these ways, failing to include romantic partners in the trauma treatment leaves the assault survivor, non-traumatized partner, and the relationship as a system at a disadvantage.

This study aims to provide mental health providers with a clearer picture of potential differences in level of functioning between female clients with and without a history of sexual assault. Additionally, this study aims to provide more information on how specific survivor and assault variables correlate with psychological and relational distress among females with a history of sexual assault. The overall goal of this study is to inform clinicians of potential trends in functioning characteristic of female survivors of sexual assault, as well as take an initial step towards delineating what relationship dynamics could be most effective to focus on in treatment when working with a couple in this context. The present study works towards this goal by focusing on two overarching research questions:

1. Among females seeking couples therapy, do differences exist between women with and without a history of sexual assault in self-reported psychosocial and relational distress?

2. Which survivor characteristics (i.e., ethnicity, cumulative traumas, marital status) and assault variables (i.e., age at time of perpetration, relationship to perpetrator, time elapsed since perpetration) are most influential in predicting psychosocial and relational distress among females with a history of sexual assault?

CHAPTER II

REVIEW OF LITERATURE

The following literature review will be comprised of five sections. First, a summary will be provided on how sexual assault has been defined, conceptualized and operationalized in the present study. Next, there will be a review of literature examining the impact of survivor characteristics on psychological responses to sexual assault. In the third section, research on sexual assault variables linked to psychological outcomes for survivors will be reviewed. In the following section, there will be a summary of the limited research examining relational effects of sexual assault. Next, theoretical evidence for exploring relational impacts of sexual assault will be presented. Finally, the research questions and hypotheses for the present study will be stated.

Sexual Assault

The terms sexual assault and rape are often used interchangeably within society as well as research literature. Sexual assault by definition is an umbrella term encompassing any form of sexual contact or behavior that is engaged in without the

consent of one of the parties involved (Department of Justice, 2016). Such behaviors include, but are not limited to, childhood sex abuse, sexual harassment, molestation, fondling, and rape. Rape is more specifically defined as any form of penetration occurring without the victim's consent (Federal Bureau of Investigation, 2013). While these terms technically encompass different experiences, a movement away from the usage of "rape" towards the usage of "sexual assault" has been encouraged in order to be more inclusive and less stigmatizing towards survivors of all backgrounds. Rape has traditionally referenced only male perpetration against a female (Rymel, 2004). This fails to recognize the full prevalence of the issue including male to male perpetration, female to male perpetration, as well as perpetration against individuals in the LGBTQ community.

Initially, the current study hoped to integrate outcome data for male partners with a reported history of sexual assault as well. Unfortunately, the clinical data used in the study yielded too small of a sample of males reporting sexual assault for any analyses to be performed. This is perhaps a result of the systematic underreporting of male victimization that occurs within our society, thought to be driven by negative social stigma men believe they will face for disclosing abuse (Choudhary, Gunzler, Tu, & Bossarte, 2012). Occurrence and effects of sexual assault perpetrated against men is a topic greatly understudied in the literature which deserves further exploration in future studies.

As a result of these limitations, the current study is specifically interested in the outcomes of women who have experienced rape: unwanted, forced oral, anal, or vaginal penetration. Though this study has a specific and narrow framework for the type of

trauma to be studied, the term sexual assault will be used throughout the study, referring to forced penetration without the participants' consent. In addition to being potentially exclusive in its usage, it is the author's opinion that the term "rape" generally carries a highly charged and negative stigma within society, suggesting that the term "sexual assault" may be less abrasive to readers.

Survivor Characteristics

Previous studies have examined the moderating effects of various survivor characteristics on psychological outcomes following sexual assault. The present review summarizes the findings for the variables of ethnicity and cumulative traumas.

Ethnicity. Studies have found variations in psychological responses to sexual assault among women in differing ethnic groups. In one of the seminal studies on this topic, Lefley et al. (1993) found that reported psychological distress was most severe in Hispanic survivors, followed by African American survivors, and least severe among Caucasian survivors. In line with these findings, women within minority groups report PTSD, depression, lower self-esteem, substance use, suicidality and distressing somatic symptoms more frequently than Caucasian women (Bryant-Davis et al., 2009). Hispanic women are more likely to experience depression and Asian American women are more likely to report suicidal ideation after childhood sexual assault than their counterparts in other ethnic groups (Bryant-Davis et al., 2009; Kaukinen & Demaris, 2005). Additionally, female assault survivors within minority ethnic groups (specifically Hispanic and African American) are more likely to respond to the trauma by using heavy drinking and illicit substance use as coping mechanisms (Kaukinen & Demaris, 2005).

When examining these findings, it is important to consider the sociocultural differences that exist within each ethnic group. Differences in rates of sexual trauma, gender expectations, religious beliefs, acceptability of violence, and sex education among other factors all contribute to how sexual assault victims are perceived and treated. Native American women have been found to experience sexual victimization at rates (39% lifetime prevalence) exceeding other ethnic groups in the United States Studies (Bryant-Davis et al., 2009). In a national survey assessing for the prevalence of sexual violence across groups in the United States, 22% of African American women, 18.8% of Caucasian women, and 14.6% of Hispanic women reported experiencing rape (Black et al., 2011). No reports on the prevalence of sexual violence among Asian American women were provided by this survey. Studies have determined that African American and Latin American women are more likely than Caucasian Americans to experience sexual assault by an intimate partner; however, minority women are less likely to believe that sexual assault can occur between romantic partners, which may indicate power structures that culturally place men above women, and/or a lack of education surrounding consensual sex (Bryant-Davis et al., 2009; Kaukinen & Demaris, 2005). Similarly, Asian American women are more likely to express beliefs that women are responsible in preventing sexual assault, not men (Bryant-Davis et al., 2009).

Another cultural factor that may impact the development of higher rates psychological distress among survivors is the type of social reaction they receive upon disclosure. Ullman and Filipas (2001) discovered that when dichotomously coded, women within ethnic minority groups reported higher rates of negative social reactions following a sexual assault compared to Caucasian women. The same study determined

negative social reactions to be highly correlated to severity of PTSD symptomology (Ullman & Filipas, 2001).

These cultural differences coupled with societal risk factors minority groups are more commonly subject to such as systematic oppression, poverty, racism, and lack of access to adequate resources are likely to impact the adverse psychological outcomes many minority women face.

Cumulative trauma. Cumulative trauma (a history of more than one trauma experience) has been linked to increased risk for development of mental health diagnoses across the lifetime. Studies have indicated that multiple trauma experiences in childhood increase victims' chances of developing anger issues, depression, and schizophrenia (Álvarez et al., 2015). Incidence of multiple trauma experiences in adulthood have been correlated to an increased risk for PTSD, chronic depression, and psychosis as well (Álvarez et al., 2015). In examining differential outcomes for survivors of chronic abuse and multiple incidences of trauma versus survivors of single trauma events, Krupnick et al. (2004) similarly discovered that individuals with more than one cumulative trauma across the lifetime were significantly more likely to develop PTSD, major depressive disorder, anxiety disorders, and eating disorders. In the same study, individuals with a history of multiple traumas were more likely to report poor functioning in social adjustment and family relationships compared to those with only one traumatic experience (Krupnick et al., 2004). The likelihood of problematic alcohol use has been observed to increase in conjunction with an increase in cumulative traumas as well (Hunt, 2013; Krupnick et al., 2004).

Suicidal ideation and suicide attempts have both been reported at greater rates among women with higher cumulative trauma histories (Ullman & Brecklin, 2002; Ullman & Najdowski, 2009). Research indicates that survivors of both childhood and adult sexual assault are more likely to report suicide attempts than survivors of adult sexual assault alone (Ullman & Brecklin, 2002). This suggests that chronicity of sexual assaults as well as general trauma history both have an effect on the suicidality of female survivors of sexual assault.

Data indicating that survivors of multiple traumatic events tend to function more poorly than survivors of single trauma incidences is unfortunate given the fact that women who are sexually assaulted as children or adults have high rates of re-victimization (Najdowski & Ullman, 2011). In fact, a history of sexual victimization has been found to be the strongest predictor of re-victimization across many studies (Nishith, Mechanic, & Resick, 2000). In a study examining women sexually abused as children, approximately two-thirds reported being sexually assaulted as adults, a rate double to that of the rest of the female population (Herman, 1997). Similarly, Spinazzola, Blaustein, van der Kolk, Walsh, and Knight (2007) found that 75% of female victims of childhood sexual assault reported re-victimization in adulthood, compared to only 11% of women who were victimized only as adults. Of survivors surveyed in a study about a previous lifetime experience of sexual assault, 45% of the sample reported being re-victimized during the one year follow up period (Najdowski & Ullman, 2011).

A couple of notable hypotheses have been put forward as to why cumulative trauma may have an increasingly adverse effect on psychological outcomes. The dose-response relationship hypothesis posits that individuals who endure repeated traumas

become conditioned to feel unsafe and untrusting (Basile, Arias, Desai, & Thompson, 2004). This theory would help explain the higher rates of PTSD among individuals with repeated trauma exposure, particularly when considering symptoms of hyperarousal. Najdowski and Ullman (2011) proposed that cumulative traumas result in greater psychological symptomology because individuals develop maladaptive coping such as disengagement and avoidance. In line with the dose-response theory, these maladaptive coping skills may develop out of a sense of learned helplessness in the face of repeated traumatization.

Assault Variables

Previous studies have also examined the moderating effects of assault variables on survivor outcomes following sexual assault. The present review summarizes the findings for the variables of age at the time of assault and the survivor's relationship to the perpetrator.

Age at time of assault. Despite the age at which a sexual assault occurs, survivors may become vulnerable to an array of physical and mental health issues, including substance use, major depression, and other internalizing problems (Kaukinen & Demaris, 2005). Research has indicated, however, that perpetration of a sexual assault before the age of 18 years increases the risk of developing PTSD among survivors (Masho & Ahmed, 2007). Sexual trauma that occurs during adolescence specifically may have a particularly negative impact on psychological outcomes (Herman, 1997). Kaltman et al. (2005) found that survivors of adolescent sexual assault reported significantly higher rates of psychiatric diagnoses and PTSD compared to survivors of childhood

sexual abuse. These findings are significant given the fact that approximately 30% of initial rape experiences occur before the age of 18 (Black et al., 2011).

Relationship to perpetrator. Though society often views sexual assaults committed by strangers to be more common and legitimate than assaults perpetrated by people known to the victim, the majority of rapes are committed by individuals known to the survivor (Larsen, Hilden, & Lindegaard, 2015; Mason & Lodrick, 2013). In fact, in a national study in the United States, only 13.8% of female rape survivors reported perpetration by a stranger (Black et al., 2011). Boykins and Mynatt (2007) found that 51% of their sample of American women presenting to a hospital for treatment following a sexual assault knew their perpetrator. Two studies in Denmark discovered 69-75% of sexual assault survivors reported knowing their perpetrator prior to the assault (Ingemann-Hansen, Sabroe, Brink, Knudsen, & Charles, 2009; Larsen et al., 2014). Black et al. (2011) found more specifically that over half of rape victims (51.1%) had experienced assaults by a current or former intimate partner, 40.8% reported assaults by acquaintances, while 12.5% reported a history of assault by a family member. These figures account for the fact that 16.4% of female rape survivors report two lifetime perpetrators, while 12.4% of female survivors report three or more (Black et al., 2011).

The extent to which the survivor knew their perpetrator has the potential to greatly impact how they are able to cope with the trauma. Women who are assaulted by husbands or romantic partners are tasked not only with processing the trauma, but determining what they want to happen with the relationship as well. Some survivors assaulted by partners are unable to distance themselves from the abusive relationship due to many barriers, including lack of resources or social stigma against leaving the

relationship, thus compounding the trauma and leaving them in a vulnerable position for further victimization. Additionally, many societies fail to recognize sexual assault as a legitimate phenomenon in adult couples because there exists an internalized belief that men are entitled to sex in romantic relationships; therefore, any sexual encounter between partners is viewed as justified in context (Culbertson & Dehle, 2001). This may limit survivors' willingness to come forward and address the trauma, and may have an effect on the responses they receive from others if they do choose to disclose. Women assaulted by family members are often forced into continued contact with their perpetrator as well due to the nature of their relationship. Survivors in this situation may be hesitant to disclose abuse for fear of retribution from the perpetrator or other family members.

The closer a woman is relationally to her perpetrator before the assault increases the likelihood that her primary support system will be shared with the perpetrator, often making them less available to her as a resource (Culbertson & Dehle, 2001). Survivor relationships to their perpetrator may also have differing effects on attachment styles and sense of safety following an assault (Herman, 1997). When perpetration occurs from someone the survivor has previously trusted, they must wrestle with re-evaluating what they believe about intimate relationships (Mason & Lodrick, 2013). This has the potential to impact their level of relational distress, both with the perpetrator and in subsequent intimate relationships.

Women assaulted by strangers or acquaintances may be hesitant to go out in public or meet new people, as every person they encounter may be perceived as a potential threat (Mason & Lodrick, 2013). This is supported by the finding that sexual assaults by strangers produce higher levels of fear and anxiety in survivors compared to

assaults perpetrated by known offenders (Ullman & Siegel, 1993). A potential difference for survivors without a previous relationship with their perpetrator is that they may have greater, continued access to a support system through romantic partners or family members. Though not all survivors receive positive support after a sexual assault experience perpetrated by a stranger, they are not forced to cope with the betrayal of a pre-existing relationship.

Research examining differences in psychological outcomes based on survivor relationships to their perpetrator has yielded mixed findings. Lawyer, Ruggiero, Resnick, Kilpatrick, and Saunders (2006) found that adolescents who were sexually assaulted by people they knew were more likely to develop PTSD symptoms than adolescents assaulted by strangers. Similarly, Culbertson and Dehle (2001) determined that survivors assaulted by spouses, cohabitating partners, or acquaintances reported higher levels of hyperarousal than survivors assaulted by casual dating partners. Within this sample, women married to or cohabitating with their perpetrator also reported significantly higher rates of intrusive symptoms compared to women not living with their perpetrator (Culbertson & Dehle, 2001). These findings are consistent with Culbertson, Vik, and Kooiman's (2001) study which indicated that women living with their perpetrator reported feeling lower levels of safety at home, requiring them to be "on edge" at all times. One limitation to the findings from Culbertson and Dehle's (2001) study is that assaults perpetrated by strangers were excluded from analyses due to a small sample size.

Somewhat conversely to the aforementioned studies, Ullman and Filipas (2001) found that victim relationships to their perpetrator did not have a significant correlation to PTSD symptomology. However, this study only used a dichotomous variable to define

the victim/perpetrator relationship (i.e., known to victim, unknown to victim), which could account for some of the differences between studies. Ullman, Filipas, Townsend, and Starzynski (2006) later found that survivors sexually assaulted by relatives demonstrated the highest rates of PTSD symptoms across perpetrator groups. However, stranger perpetrated sexual assault yielded higher rates of PTSD than acquaintance or romantic partner assaults (Ullman et al., 2006).

It is clear that many questions remain to be answered to gain clarity into psychological outcomes based on the survivor's relationship to the perpetrator. This is a crucial area of study as survivors could greatly benefit from clinicians being better informed about trends associated with specific survivor-perpetrator relationship dynamics.

Relational Effects of Sexual Assault

While research findings have been able to establish correlations between survivor and assault factors and psychological outcomes, less is known about how these factors correlate to subsequent relational distress among female survivors. Sexual assault experiences are especially difficult to integrate due to the interpersonal nature of the trauma and the damage to survivors' connection to others which often occurs (Herman, 1997). Treatment for survivors is generally provided on an individual basis using trauma focused approaches such as cognitive-behavioral therapy or Eye Movement Desensitization and Reprocessing (EMDR; Shapiro & Maxfield, 2002; Mason & Lodrick, 2013). This constitutes a missed clinical opportunity in utilizing pre-existing relationships as a resource in therapy. Given the interpersonal nature of these traumas, the health of the

survivor's interpersonal relationships following a sexual assault has the potential to mitigate the psychological effects of the trauma (Herman, 1997).

Previous studies have demonstrated that social support can have a positive impact on female survivors of sexual assault's ability to cope with trauma they endured, while negative reactions can increase the risk of developing PTSD (Ullman & Brecklin, 2002; Ullman & Filipas, 2001). In fact, the recovery rate of survivors has been correlated with the stability and quality of their intimate relationships (Herman, 1997). Herman (1997) posits that recovery from trauma must take place in the context of a safe relationship in order to reform the basic human tenants of trust, autonomy, intimacy, and identity which the trauma inherently stripped the survivor of.

Unfortunately, in the aftermath of trauma, positive interactions can be difficult to sustain even for the most supportive partners. Survivors of sexual assault often struggle with regulating their emotions and reactions to day to day stimuli as they are trying to cope with the daunting task of integrating their trauma experience and re-establishing meaning and trust in their world (Ehring & Quack, 2010; Herman, 1997). Partners of survivors may also be susceptible to secondary traumatic stress caused by caring for and being exposed to the symptoms of the traumatized person (Figley, 1998). This theory of secondary trauma posits that trauma symptoms are capable of spreading between family members to the extent that non-traumatized individuals begin to experience distress similar to the survivor (Figley, 1998). These factors may contribute to the significantly lower rates of marital quality reported by partners of individuals displaying trauma related symptomology stemming from a past event (Oseland, Gallus, & Nelson Goff, 2016). Thus, further research is needed on what challenges romantic relationships face in

the aftermath of a sexual assault in order to foster positive interactions, decrease negative interactions, and better understand how they may be used as a resource in the healing process.

One of the dimensions of romantic relationships that may be most affected by a history of sexual assault is the sexual relationship between partners. Previous research tracking the sexual activity of female survivors found that of the 78% who were sexually active at the time of the assault, 38% reported giving up sex for at least 6 months (Mason & Lodrick, 2013). The entire sample of survivors included in this study also reported lower levels of sexual satisfaction after the assault occurred (Mason & Lodrick, 2013). It is not clarified in the data how much of this sample of women were in a romantic relationship at the time of the assault.

These effects on sexual functioning and satisfaction have been found to vary based on certain survivor and assault characteristics. The age at which a sexual assault occurs has been shown to variably affect survivors' sexuality in adulthood. Previous studies have found childhood sexual abuse to place survivors at a higher risk for poorer sexual functioning, as well as lower levels of desire and satisfaction as adults (Katz & Tirone, 2008; Najman et al., 2005; Reissing et al., 2003; van Berlo & Ensink, 2000). Easton, Coohey, O'Leary, Zhang, and Hua (2011) found more specifically that victims over the age of six years at the time of the assault had an increased likelihood of experiencing fear, guilt, and dissatisfaction when engaging in sex as adults when compared to children who were victimized between birth and age five. This may indicate that children with more developmentally advanced cognitive abilities have greater

difficulties understanding and effectively processing their abuse experience, leading to more negative relational outcomes later in life.

The relationship between the survivor and the perpetrator of childhood sexual abuse has been shown to have long term effects on sexual outcomes as well. Easton et al. (2010) discovered that survivors of incestuous cases of sexual abuse were three times more likely to have problems being touched as adults, which they hypothesize as a product of the added betrayal that comes with a family member perpetrating as opposed to a non-relative.

Theoretical Foundation

There are a number of possible reasons for why sexual assault may be linked to partner relational outcomes. According to systems theory, all individuals exist within the context of a greater network of relationships (Laszlo & Clark, 1972). These relationships are interrelated in a circular, recursive manner such that the actions and influences of one member of a system cannot help but effect other members as well. In this way, while an incidence of sexual assault may only be perpetrated against one partner, is it inevitable that the other partner and relationship as a whole will be affected. The manner in which each partner responds will in turn affect how the trauma negatively or positively influences relational outcomes long term. Similarly, relational functions between partners will affect how well the traumatized partner is able to cope with the sexual assault.

Systems theory eschews the traditional, reductionistic scientific model which relies on a linear explanation for causation of psychopathology or relational distress to focus on the interactionalist approach, which recognizes the combined influence of multiple factors on any given phenomenon (Steinglass, 1987). When applying this

perspective to an individual who has experienced sexual assault, it becomes evident that it is not solely the sexual assault that will determine long term outcomes. Contextual and environmental factors in the survivor's life, the belief systems they subscribe to, their family background, and aspects of a current romantic relationship (among other things) cannot help but impact the way in which the trauma is processed, integrated, and coped with. In the same way, the functioning of a romantic relationship is not solely determined by the presence or absence of a sexual trauma. Instead, many factors of the relationship (such as communication styles, conflict management, roles and rules, etc.) come together with the trauma history, creating an interactional effect that cannot be treated effectively by singling one of the factors out.

Systems theory posits that systems adjust and reorganize themselves in an effort to maintain homeostasis as a way to ensure continuity of functioning (Becvar & Becvar, 1999; Steinglass, 1987). Positive feedback occurs within systems when a change has occurred, signaling members that action must be taken in order to re-establish the status quo (Becvar & Becvar, 1999). Members typically respond to positive feedback by altering their own behaviors in an effort to alter the behaviors of others and restore balance in the relationship. When trauma occurs for one member of a couple system, the resulting symptoms cause positive feedback within the relationship and force the non-traumatized partner to respond differently in an effort to maintain functioning. The way in which the non-traumatized partner responds has the potential to promote healing and begin integrating the trauma such that a new state of homeostasis within the relationship is able to be reached. However, the way in which the non-traumatized partner responds

also has the potential to escalate the positive feedback in the relationship and increase the level of distress experienced by both partners.

A key challenge to this process is that neither person has a manual explaining how to cope with trauma and respond to their partner in a way that minimizes distress. Given the new demands on the couple relationship, the system engages in what systems theory labels structural determinism (Becvar & Becvar, 1999). The couple begins to rely on behaviors and interactions that make sense within their context to maintain the integrity of the system. This could look like avoidance of certain situations or activities (such as sex) or introducing substances (such as alcohol or drugs) into the system in an effort to lessen the severity of certain symptoms. While these behaviors are functional and serve their purpose, they may not be the optimal way to respond to trauma and may in fact perpetuate negative symptomology and processes within the couple relationship.

One factor to consider when looking at how couples are interacting after a trauma is that pre-existing couple dynamics may have a varying impact on the way couples respond to such events. Systems theory proposes that interpersonal processes (between people) are either symmetrical or complementary depending upon the intrapersonal processes (within individuals) of each member of the system (Becvar & Becvar, 1999). Symmetrical relationships exist when partners frequently display similar forms of behavior (e.g., how they communicate, how they respond to stress, how they express emotions). Complementary relationships, in contrast, exist when partners typically display different, opposite forms of behavior. Non-traumatized partners in a symmetrical relationship may respond by mirroring and escalating the symptoms displayed by the traumatized partner. In example, if a traumatized partner copes by withdrawing and

internalizing their distress, the non-traumatized partner may act in a similar way. By perpetuating each other's behaviors, the symmetrical couple may withdraw to the point that no effective communication or problem solving exists within the relationship, inhibiting their ability to incorporate the trauma in a functional way. In a complementary relationship, the non-traumatized partner might respond to the withdrawal of the traumatized partner by pursuing and pressuring them to externalize their distress. Within this context, the traumatized partner may become increasingly distressed and choose to withdraw more, while the non-traumatized partner becomes increasingly anxious and continues to pursue without avail. This type of interaction also has the potential to inhibit trauma processing within the relationship as each partner becomes increasingly polarized in their approach to the relationship.

When conceptualizing the effects of sexual assault using a systems theory lens, it brings to question why sexual assault is not more frequently treated using a relational approach. For a woman with a history of sexual assault currently in a relationship with someone who is not the perpetrator, it may be less effective to treat her without the collaboration of her partner based on the principle that all contextual factors in an individual's life are inextricably linked to one another. Information received in therapy has the potential to create positive feedback within the system, which the non-traumatized partner may naturally attempt to counteract in an effort to maintain homeostasis unless they are simultaneously included in treatment. Additionally, research has demonstrated that survivors of sexual assault recover more quickly and effectively with the positive support of others, including romantic partners, family, or friends (Herman, 1997; Ullman & Brecklin, 2002; Ullman & Filipas, 2001).

Summary, Research Goals, and Hypotheses

In summary, the existing literature supports the idea that survivors of sexual assault experience higher rates of psychosocial and relational distress, and can benefit from a relational approach to trauma treatment in therapy. What is currently missing within the literature is more specific delineation of what areas of romantic relationships (aside from sexual relations) are correlated with history of sexual assault in the female partner. To address the gap in the literature, the current study aims to address two primary research goals.

Research Goal #1:

The first research goal is exploring potential differences between women with and without a history of sexual assault in terms of psychological and relational outcomes. It is hypothesized that:

- Females with a history of sexual assault will report higher levels of psychosocial distress than females without a history of sexual assault.
- Females in the sexual assault group will report higher levels of relational distress and lower levels of satisfaction, cohesion, and consensus within their partner relationship.

Research Goal #2:

The second research goal examines within group data among sexual assault survivors to determine whether certain factors (i.e., survivor characteristics, assault variables) impact psychosocial and relational outcomes. Survivor characteristics, including survivors' ethnicity, marital status, and cumulative trauma scores, are analyzed

to determine whether these variables have differing effects on psychosocial and relational outcomes. It is hypothesized that:

- Members of ethnic minority groups (i.e., non-Caucasian) will report higher levels of psychosocial and relational distress due to additional social challenges that often are present for these individuals.
- Survivors with higher incidences of cumulative trauma will experience higher levels of psychosocial and relational distress.
- Survivors who are married will report lower levels of psychosocial and relational distress.

Assault variables, including age at the time of perpetration, time elapsed since the assault, and the survivor's relationship to the perpetrator are also be examined. It is hypothesized that:

- Survivors reporting perpetration at a younger age will report higher rates of psychosocial and relational distress.
- Those assaulted by an older male family member will report the highest rates of psychosocial and relational distress.
- Survivors with greater time elapsed since the assault will report lower levels of psychosocial and relational distress.

CHAPTER III

METHODOLOGY

The current study conducted retroactive analyses on clinical data collected at a Marriage and Family Therapy (MFT) university training program in the Midwest. The MFT program is COAMFTE-accredited and provides therapy services for the university and surrounding community. Therapists in the clinic are Master's level graduate students who are supervised by core faculty who are Licensed Marriage and Family Therapists (LMFTs) in Oklahoma and American Association of Marriage and Family Therapy (AAMFT) approved supervisors.

Therapy services are offered by the clinic for individuals, couples, and families. Fees per session are determined using a sliding fee scale that accounts for the family's total income as well as the number of people in the household. Fees range from $5 to $75.

Participants

Prior to beginning secondary analyses on the data collected at the training clinic, IRB approval was received through the university (for IRB approval document, see Appendix A). The current study examined retrospective data of female clients who presented for couples therapy at the MFT training clinic between the years of 2008 to 2015 and consented for their data to be used for research purposes (n = 358). Inclusion criteria for the study required participants to currently be in a heterosexual relationship. From this sample, 271 women reported no history of sexual assault, while 87 women (24.3%) reported experiencing at least one sexual assault. From the sexual assault group, five women were removed prior to analysis because they were attending couples therapy with their perpetrator, and as such could be experiencing different levels of relational distress from the rest of the subsample. The sexual assault subsample was further reduced to 77 participants, as five of the participants were missing data on at least one of the outcome variables of interest. To ensure equal group sizes prior to analysis, a random sample of 77 participants was drawn from the subsample of women without a history of sexual assault who had complete data for the dependent variables of interest.

Procedures

Prior to meeting with a therapist for the intake therapy session, clients were instructed to fill out paperwork and assessments as part of standard clinical procedures. Required paperwork included basic background information such as client's race/ethnicity, history of suicide attempts, presenting concern for treatment, and current relationship status, among other things (see Appendix B for full packet). At this time, clients also completed the Stressful Life Events Screening Questionnaire (SLESQ;

Goodman, Corcoran, Turner, Yuan, & Green, 1998), Outcome Questionnaire (OQ-30.2; Lambert et al., 1996), and the Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995).

Measures

Independent Variable

Sexual assault history. Participants' trauma history was measured using the Stressful Life Events Screening Questionnaire (SLESQ; Goodman et al., 1998), a 13-item self-report screening measure assessing lifetime exposure to a variety of traumatic events. For the purpose of the current study, the SLESQ was used to identify participants' sexual assault history based on responses to the item "*At any time, has anyone (parent, other family member, romantic partner, stranger, or someone else) ever physically forced you to have intercourse, or to have oral or anal sex against your wishes, or when you were helpless, such as being asleep or intoxicated?*" Responses were coded as 0 = *No* and 1 = *Yes*. Participants were divided into two groups (i.e., sexual assault history, no sexual assault history) based on their responses. The SLESQ has good test-retest reliability with a median kappa of .73 and acceptable convergent validity with a median kappa of .64 when compared to the Trauma History Questionnaire (Goodman et al., 1998).

Outcome Measures

Psychosocial functioning. Participants' levels of psychosocial functioning were assessed using the Outcomes Questionnaire 30.2 (OQ-30.2) self-report measure (Lambert et al., 1996). The OQ 30.2 consists of 30 statements designed to be responded to using a 5-point Likert scale ranging from "*never*" to "*almost always*" (see Appendix C for full assessment). Statements within the measure pertain to participants' symptoms, moods,

and negative thoughts (e.g., *I have an upset stomach, I am a happy person, I blame myself for things*). Participant responses were entered into the OQ 30.2 scoring database online through the clinic's registered account for scoring. Scores obtained through the database were used for analysis. Higher scores on the OQ 30.2 are indicative of higher levels of distress. The measure uses normative data from adults in the community, out-patient mental health services, as well as in-patient mental health services to determine clinical cut-offs. Previous research has supported test-retest reliability over a three week span (r = .84) as well as the internal consistency (α = .93) for the total measure (Lambert et al.,1996). Concurrent and construct validities have been supported by previous research as well (Lambert et al., 1996). The OQ 30.2 in the current study was found to be highly reliable (α = .94).

Relational distress. Participants' levels of relational distress were assessed using the Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995). The RDAS consists of 14 questions and is designed to assess for relational distress across three subscales: couple cohesion, consensus, and satisfaction (see Appendix D for full assessment). Scores for each subscale can range from 0 to 19 for cohesion, 0 to 30 for consensus, and 0 to 20 for satisfaction. The scores calculated for each subscale are summed to provide a total score for each client. Higher subscale and total scores are indicative of lower levels of distress within the relationship. Clients with a total score of 48 or higher are considered to be "non-distressed" within their romantic relationship, while clients scoring a total of 47 or lower fall below the clinical cut-off for "distressed" couples.

Questions on the RDAS assessment are answered on a 5 or 6 point scale and ask about the frequency in which specific events happen in the couple relationship (e.g., *How*

often do you and your partner quarrel?; Do you ever regret getting married/living together?), as well as how much agreement couples have on certain topics (e.g., *religious matters, sex relations*). The present study used participants' total scores, subscale scores, as well as the responses from Question 4 assessing the couples' level of agreement on sex relations for analyses.

Cronbach's Alpha (α = .90) has been calculated to determine the internal validity of the measure using clinical and community samples of couples (Busby et al., 1995). Busby et al. (1995) demonstrated construct validity for the RDAS through correlation to the original measure which the revised version was based on, the Dyadic Adjustment Scale (r = .97). Discriminant validity between the subscales has also been analyzed in previous studies (Consensus, r = .34; Satisfaction, r = .55; Cohesion, r = .32) and purports that the subscales do indeed provide information about distinctive areas in couples' relationships (Busby et al., 1995). The RDAS in the current study was found to be highly reliable (α = .89).

Control Factors

Survivor characteristics.

Ethnicity. Participants selected their self-identified race/ethnicity from a list of fixed responses on the background information paperwork. Response options in the paperwork include: *Asian American, African American, Caucasian, Native American, Hispanic/Latino, Middle Eastern,* and *Other*. Ethnicity outcomes were coded as "*non-Caucasian*" with each participant who selected a minority race/ethnicity coded as "1" and each participant who selected "*Caucasian*" coded as "0" to control for influences of minority races/ethnicities.

Cumulative traumas. The SLESQ contains 13 true-false response questions asking participants whether they have an experience with a series of different traumas (e.g., sexual assault, life threatening illness, physical abuse). Cumulative trauma counts for each survivor were calculated by summing the number of traumas each participant indicated experiencing throughout their lifetime. The possible range for participants' cumulative trauma counts was 0 to 13 unique trauma types.

Suicide attempts. Participants were prompted to confirm or deny a history of suicide attempt(s) within the background information by answering a fixed true/false question. Responses to the question "*Have you ever attempted suicide?*" were coded dichotomously as *Yes* = 1 and *No* = 0.

Relationship status. Upon initiating therapy services, clients are assigned a "family identification" number tied to their case file to allow collected research data to be archived anonymously. Females seeking couples therapy services with their husbands were coded as wife (Family ID = 2), while females seeking couples therapy with a male partner were coded as female partner (Family ID = 4). Only females with a family ID of 2 or 4 were considered for inclusion in the study. For analysis, relationship statuses will be re-coded dichotomously as *married* = 0 or *unmarried* = 1.

Assault variables.

Age at time of assault. Participants with a history of sexual assault indicated their age at the time of the assault in a free response question included in the SLESQ. Age responses were treated as a continuous variable for analyses.

Time elapsed since assault. Participant ages at the time of seeking therapy were indicated on the background forms completed prior to their first session. For individuals

who indicate a history of sexual assault, their age at the time of assault will subtracted from their age at the time of seeking therapy to provide the time elapsed since assault.

Survivor's relationship to perpetrator. Participants who confirmed a history of sexual assault on the SLESQ were prompted to indicate their relationship to the perpetrator in a free response format within the same assessment. Participant responses were grouped and coded prior to analysis in an effort to illuminate potential differences in psychosocial and relational functioning based on different relationships to the perpetrator. Perpetrators were coded according to the following designations: *former spouse/partner* (e.g., ex-husband, ex-boyfriend), *older male relative* (e.g., dad, step-dad, uncle, grandpa), *peer* (e.g., sibling, cousin, friend, school boys), and *no relationship* (e.g., stranger, acquaintance, date). The perpetrator categories were dummy coded for each participant, such that each sexual assault survivor who provided perpetrator information would have a "1" in the category they indicated as their relationship to the perpetrator, and "0" in each of the other three categories. Only one perpetrator code was given to each participant, including those who reported multiple perpetrators from different relationship categories. Perpetrator codes were assigned in this way to simplify analyses conducted. For participants with multiple reported perpetrators, the code selected for analyses was based on the researchers' conceptualizations of which of the perpetrators' proximity in relationship was closest to the survivor in terms of time spent together and expectations from roles. Former romantic partners were conceptualized as closest to the participants, followed by older male relatives, peers, and finally strangers/acquaintances.

CHAPTER IV

RESULTS

In order to assess for potential demographic differences between women seeking couples therapy with and without a history of sexual assault, a series of *t*-test analyses and chi-square tests were conducted. Demographic information for each group is included in *Table 1*. Analyses indicated no significant differences between women with and without a history of sexual assault in terms of age at the time of therapy, income, or education level attained. There was a significant difference in cumulative trauma scores, with women in the sexual assault group reporting significantly more traumatic events, $t(152) = -9.38$, $p = .000$. Chi-square analyses indicated no significant group differences in marital status or ethnicity. A significant difference in history of suicide attempts was discovered, with women in the sexual assault group reporting higher rates, $\chi^2(1, N = 154) = 6.29$, $p = .010$.

In order to assess further for potential unique characteristics of the women in the sexual assault group regarding suicidality, a *t*-test was performed examining the average

age at the time of perpetration between survivors with and without previous suicide attempts. A significant difference was found between groups, indicating that survivors with a history of suicide attempts were younger at the time of perpetration (M = 11.28) than survivors without a history of suicidality (M = 15.00), $t(71) = 2.25$, $p = .028$.

Table 1. Means and Standard Deviations of Study Variables by Sexual Assault Group

	Non-Sexual Assault Group (n = 77)		Sexual Assault Group (n = 77)	
Variables	*M or %*	*SD*	*M or %*	*SD*
Marital Status				
Married	61%		64%	
Unmarried	39%		36%	
Ethnicity				
Caucasian	88%		89%	
Non-Caucasian	12%		11%	
Suicide Attempts				
Yes	10%		26%	
No	90%		74%	
Age	29.79	7.42	29.75	8.16
Income	4.24	2.02	3.93	1.98
Education Level	4.56	1.71	4.05	1.61
Cumulative Trauma	1.71	1.62	4.69	2.26
OQ-30	42.43	19.36	55.47	18.24
RDAS Total	42.01	12.77	40.13	10.79
RDAS Consensus	20.07	5.64	18.91	4.87
RDAS Satisfaction	12.22	4.45	11.42	4.27
RDAS Cohesion	9.73	4.51	9.79	4.18
RDAS Question 4	3.23	1.37	3.26	1.42
Relationship to Perpetrator (n = 66)				
Former spouse/partner			30%	
Older male relative			21%	
Peer			33%	
No relationship			15%	
Age at time of assault			14.08	6.26
Time since assault			15.89	10.34

Research Goal #1:

A series of *t*-tests were conducted to address the first research goal, which aimed to explore potential differences between women with and without a history of sexual assault in terms of psychological and relational distress. No significant differences were found between groups on scores for the RDAS Total, RDAS Consensus, RDAS Satisfaction, RDAS Cohesion, or RDAS Question 4. Comparison of the OQ scores between groups indicated that women with a history of sexual assault reported significantly higher levels of psychosocial distress at initiation of couples focused therapy services, $t(152) = -4.30$, $p = .000$.

Research Goal #2:

In order to address the second research goal of determining what independent factors significantly impact sexual assault survivors' psychosocial and relational distress levels, a series of 18 multiple regression analyses were conducted. Six factors loaded into each regression equation included ethnicity (coded dichotomously as "*Caucasian*" or "*not-Caucasian"*), cumulative trauma scores, the age at the time of perpetration, the amount of time elapsed since the perpetration, the marriage status of the individual (coded dichotomously as "*married*" or "*unmarried*"), and finally the individual's relationship to their perpetrator. Each of the four perpetrator categories (i.e., *former spouse/romantic partner, older male relative, peers,* and *strangers/acquaintances*) were recoded as dummy variables prior to being entered into the regression equations. Before running the final regression analyses, correlations between each of the six independent variables were calculated to identify any possible multicollinearity between factors. No significant correlations were discovered between any of the six factors, indicating that the

regression model could include each factor of interest. For each of the six outcome variables of interest (i.e., OQ-30.2 scores, RDAS total scores, RDAS cohesion scores, RDAS satisfaction scores, RDAS consensus scores, and RDAS Question 4 responses), three separate regression analyses were conducted in order to allow for comparison between each of the four perpetrator categories.

The amount of participant information included in the regressions was less than the total sample of females with a history of sexual assault (n = 77). Two individuals did not report information on their ethnicity, four individuals did not report information on their age at the time of perpetration, and 11 individuals did not provide information on their relationship to the perpetrator of their assault. Any individual missing one or more pieces of data for the six factors in the regression equations were dropped from the sample. Therefore, the final sample of sexual assault survivors included in the regression analyses was reduced (n = 62). Of the 18 multiple regression equations calculated, none yielded significant results as predictive models for the outcome variables of interest. While the overall regression model did not significantly predict any of the outcome variables of interest, the model for RDAS consensus as well as several individual factors loaded into the model were found significant or approaching significance. Only the model and factors found to be significant or approaching significance will be discussed below. The results discussed will be organized by outcome variable.

RDAS Consensus. While no models yielded significant results for any outcome variable, regression results indicated that the overall model approached significance in predicting scores on the RDAS Consensus subscale, $R^2 = .22$, $R^2_{adj} = .11$, $F(8, 53) = 1.91$, $p = .078$. Although merely approaching significance, results suggest that the present model accounted for roughly 22.3% of the variance in RDAS Consensus scores for females with a history of sexual assault. Within the regression for RDAS Consensus, the marriage status of participants was a significant predictor of reported scores, such that unmarried females with a history of sexual assault reported higher

levels of consensus with their partners, $t(61) = 2.39$, $p = .020$. The age at the time of perpetration, $t(61) = 1.92$, $p = .059$, and time elapsed since the sexual assault, $t(61) = 1.83$, $p = .073$, each approached significance within the model such that survivors who were older at the time of the assault and those with greater elapsed time since reported higher levels of consensus in their relationships. Differences approaching significance were found between perpetrator codes as well. Females with a history of sexual assault perpetrated by a stranger or acquaintance reported lower scores for RDAS Consensus compared to females assaulted by former romantic partners, $t(61) = -1.82$, $p = .074$, or peers, $t(61) = -1.98$, $p = .053$.

RDAS Cohesion. Similar differences approaching significance between perpetrator codes were found in RDAS Cohesion scores as RDAS Consensus scores. Females with a history of sexual assault perpetrated by a stranger or acquaintance reported lower scores for RDAS Cohesion compared to females assaulted by peers, $t(61) = -1.94$, $p = .058$.

RDAS Satisfaction. No notable findings were discovered in the regression analysis of RDAS Satisfaction scores among females with a history of sexual assault. However, separate correlation analyses examining the factors of interest found a significant correlation between RDAS Satisfaction scores and cumulative trauma scores among females with a history of sexual assault, $r(75) = -.25$, $p = .030$. This indicates that female survivors reporting more traumatic experiences also reported significantly lower rates of satisfaction in their relationships.

RDAS Total. Marriage status of females with a history of sexual assault had a significant effect on participants' RDAS Total scores, such that unmarried women reported lower levels of relational distress, $t(61) = 2.05$, $p = .046$. Other factors approaching significance in relation to participants' RDAS Total scores, included the age at time or perpetration, $t(61) = 1.83$, $p = .073$ and the time elapsed since the assault, $t(61) = 1.84$, $p = .073$. These results indicated that women who were older at the time of the assault or more time had elapsed since their assault reported lower levels of relational distress. Additionally, women reporting a sexual assault perpetrated by a stranger or acquaintance were approaching significance in reporting greater levels of

relationship distress compared to females assaulted by peers, $t(61) = -1.92$, $p = .06$, or former romantic partners, $t(61) = -1.71$, $p = .094$.

RDAS Question 4. The regression model did not significantly predict participant responses to Question 4 of the RDAS, which asks about couples' level of agreement on sex relations. However, within the model, the marital status of participants was found to be significantly related to responses to the question such that unmarried females with a history of sexual assault reported significantly more agreement with their partner regarding sex relations, $t(61) = 2.08$, $p = .042$. Additionally, the age at the time of perpetration was approaching significance in predicting participant responses to the question. This suggests that the younger a participant was at the time of a sexual assault, the more likely they are to report disagreement in sex relations with their romantic partner, $t(61) = 1.83$, $p = .073$.

CHAPTER V

DISCUSSION

The purpose of the current study was to determine whether differences exist between women presenting for couples therapy with a history of sexual assault compared to women without a history of sexual assault. Further, this study aimed to determine what individual and assault factors had the greatest impact on psychosocial and relational outcomes for women reporting a history of sexual assault.

Research Goal #1:

Results from between group analyses comparing demographics, psychosocial and relational distress found both similarities and differences between women with and without a history of sexual assault. Participants in each group were similar in terms of marital status, ethnicity, age at the time of therapy, income, and achieved education level. Women from each group reported similar levels of relational distress, both overall and within each of the RDAS subscales (i.e., cohesion, consensus, satisfaction). Similarly, no significant differences were discovered between groups in terms of level of agreement in

sex relations with their current partner.

Significant differences were discovered between groups in participants' reported levels of psychosocial distress (as assessed by the OQ 30.2) at the onset of therapy services, with women reporting a history of sexual assault being more distressed. This is consistent with previous research showing that sexual traumatization in women results in higher rates of PTSD symptomology and expression of other mental health issues compared to women with non-sexual or no trauma experiences (Elklit & Christiansen, 2013). Higher rates of psychosocial distress could also be associated with the finding that the sexual assault group reported significantly higher cumulative trauma scores compared to women without a history of sexual assault. Greater rates of cumulative trauma across the lifetime have been found to increase the likelihood of developing mental health disorders (Álvarez et al., 2015; Krupnick et al., 2004). Additionally, the sexual assault group reported significantly higher rates of previous suicide attempts. This is consistent with previous research findings which discovered higher rates of suicidal contemplation as well as attempts among sexual assault survivors compared to women without a history of sexual assault (Mason & Lodrick, 2013).

Given previous research indicating that females with a history of sexual assault are significantly more distressed and on average experience more adverse life experiences, it is interesting that their level of reported relational distress in the current study was not significantly different from women without a history of sexual assault. This could, in part, be due to the fact that the current study utilized a clinical sample of women seeking couples therapy with their partners, rather than a community sample. Regardless of trauma history or level of personal distress, women in the clinical sample both with

and without a history of sexual assault may have reached a similar level of relational distress before deciding to seek therapy services for their relationship. Future research examining the average levels of distress couples reach before self-referring to therapy in a community clinic setting could be helpful in identifying the validity of this hypothesis. An additional hypothesis for explaining this phenomenon is that a social desirability bias could contribute to women being more honest about their levels of intrapersonal distress than the levels of interpersonal distress being experienced with their partner. Further research examining potential differences in social desirability bias across the assessments used in the present study could be helpful as well.

It is important to note from the current findings the significantly higher rates of psychosocial distress and suicidality reported among women with a history of sexual assault. Clinicians should be aware of the increased risk among this population and assess for potential safety concerns regardless of what type of therapy the woman may be presenting for. When safety exists within the couple relationship, the clinician may utilize the partner as a resource and involve them in safety planning when necessary.

Research Goal #2:

Within group regression analyses were conducted looking at six individual and assault factors (i.e., ethnicity, cumulative trauma scores, age at time of perpetration, amount of time elapsed since perpetration, marital status, individual's relationship to their perpetrator) in terms of their impact on psychosocial and relational distress for women with a history of sexual assault. This model applied to each of our six outcome variables of interest (i.e., OQ 30.2 scores, RDAS Total scores, RDAS Cohesion scores, RDAS Satisfaction scores, RDAS Consensus scores, and RDAS Question 4 responses) did not

yield any significant results. However, the model for RDAS Consensus and several other individual factors within the models were found to be significant or approaching significance.

Outcome Variables

The regression model approached significance in being able to predict the level of relationship consensus reported by women with a history of sexual assault. This may indicate that the factors included in our model have an impact on couples' abilities to come to agreement on important areas of their relationship when a history of sexual trauma is present. As delineated in the Couple Adaptation to Traumatic Stress (CATS) model, relationships are systemically influenced by the functioning of each partner in response to a trauma, predisposing factors from each partners' past, and the resources available to the couple (Nelson Goff & Smith, 2005). Given this framework, it makes sense that the individual and assault factors loaded into our regression could have an impact on the couples' abilities to communicate effectively about their relationship, and thereby inhibit their abilities to reach consensus. Further examination into this dimension of relationship functioning could be helpful in determining if this lack of perceived consensus stems from the traumatized women feeling unable to voice their needs or opinions, from conflict/lack of problem solving skills in the relationship, or something else entirely.

No notable findings were discovered in the regression analysis of RDAS Satisfaction scores in the sexual assault group. However, a correlation analysis examining the interaction between reported levels of satisfaction and cumulative trauma scores indicated that participants with more traumatic experiences reported significantly lower

rates of satisfaction in their current relationship. This is in line with the study from Krupnick et al. (2004) which established that individuals with a history of multiple traumatic events reported poorer functioning in social adjustment and family relationships compared to individuals with only one traumatic experience. This finding could benefit clinicians in their conceptualization of couple relationship dynamics when trauma history of each partner is thoroughly assessed.

Marital Status

The marital status of participants with a history of sexual assault was found to be significant in predicting outcome variables within several of the regression models. Unmarried females with a history of sexual assault reported higher levels of consensus, lower levels of relational distress, and more agreement with their current partner in terms of sex relations.

This finding could be influenced by the fact that unmarried couples who have not engaged in a legal commitment to one another may be less likely to remain together when issues of consensus, relational distress, or disagreement in sex relations arise, implying that those who present for couples therapy may not be as distressed as married couples who present for services. In terms of sex relations, previous research determined that survivors of child sex abuse who were married or cohabitating with their partner displayed higher rates of avoidance in sex relations compared to survivors who were single (Vaillancourt-Morel et al., 2016). At the same time, survivors of child sex abuse who were single or cohabitating also displayed significantly higher rates of compulsivity in sexual relations (Vaillancourt-Morel et al., 2016). With these results, Vaillancourt-Morel and colleages (2016) found relationship status to be a moderating factor in sexual

behavior among survivors of child sex abuse, such that individuals with higher levels of "official" commitment to their partner are more likely to be avoidant and reserved in their sexual behaviors.

These findings could be helpful for clinicians to consider while treatment planning for couples who are married or unmarried when the female partner reports a history of sexual assault. As suggested in our results, clinicians should not assume that a higher level of legal commitment between partners is equated to higher levels of contentment in the relationship. When addressing trauma, it is important that the clinician assess for each partner's level of personal commitment to the relationship at the outset of services, regardless of marital status. This is crucial in establishing safety and stability in the therapeutic context for the traumatized partner, which Herman (1997) identifies as the first step in assisting with trauma recovery. When a low level of commitment is expressed from either partner, the clinician should devise a treatment plan that does not place the traumatized partner in a vulnerable position until greater commitment is established by both members of the couple.

Relationship to Perpetrator

Within the model for RDAS Consensus, participants perpetrated by a stranger or acquaintance reported lower scores compared to women assaulted by former romantic partners at a rate approaching significance. This finding is interesting as one might expect someone assaulted by a former romantic partner to experience difficulty in coming to a consensus regarding important issues with subsequent romantic partners due to resulting attachment injuries. Attachment injuries are defined as betrayals that "call into question basic beliefs about relationships, the other, and the self" (Johnson, Makinen, & Millikin,

2001, pp. 150). When one's basic understanding of themselves and how romantic relationships work are violated, it could be expected that a traumatized individual would be less likely to trust future partners enough to come to an agreement on important issues.

On the other hand, the violation of expectations in how romantic relationships function stemming from the attachment injury could result in the traumatized individual having a skewed construct for how partners interact with one another in a healthy way. This could lead to higher levels of reported consensus as a result of the traumatized partner simply acquiescing to the requests of her partner rather than engaging in negotiations which require higher levels of assertiveness and communication. Attachment injuries from a sexual assault impacting the way survivors perceive relationships and establish consensus could be tied to the finding that a history of sexual victimization is the strongest predictor of re-victimization (Nishith, Mechanic, & Resick, 2000). Further investigation into why survivors perpetrated by former romantic partners report higher rates of consensus in subsequent relationships could be helpful in elucidating the interaction of these findings.

Similar differences approaching significance between perpetrator codes were found in RDAS Cohesion and RDAS Total scores as well. Females with a history of sexual assault perpetrated by a stranger or acquaintance reported lower scores for RDAS Cohesion compared to females assaulted by peers. Additionally, participants perpetrated by a stranger or acquaintance reported greater levels of overall relationship distress compared to women assaulted by peers or romantic partners, at a rate approaching significance.

Taken together, these findings may indicate that women assaulted by strangers or acquaintances experience greater levels of distress which impact their romantic relationships in a variety of ways. While the existing literature on this topic has yielded mixed results, the findings in the current study may support previous research which found that survivors perpetrated by strangers demonstrated higher levels of fear and anxiety as well as higher rates of PTSD compared to women assaulted by known perpetrators (Ullman et al., 2006; Ullman & Siegel, 1993). As suggested in the CATS model, higher rates of trauma related symptomology may impact the survivors' ability to interact effectively with their partner, and vice versa (Nelson Goff & Smith, 2005).

While further research is needed to delineate why this phenomenon is occurring, this could be important information for clinicians to be aware of when treatment planning for couples when the female partner has a history of sexual assault perpetrated by a stranger or acquaintance. Assessing the survivor's level of traumatization and symptomology could be beneficial in the beginning to establish safety and stability prior to moving onto higher levels of processing and relational work (Herman, 1997). The clinician should also be cognizant of the potential differences in types and locations of triggers for survivors dependent upon their relationship to the perpetrator. Identifying triggers and providing education to the partner could be helpful in decreasing the survivor's level of distress and symptomology as well, thereby improving the relationship potential as well.

Age at the Time of Perpetration

The age at the time of initial perpetration for women with a history of sexual assault approached significance within several of the regression analyses. Women who

were younger at the time of perpetration reported lower levels of consensus, higher levels of relational distress, and higher rates of disagreement in sex relations with their current partners. These findings align with previous research indicating that sexual perpetration before age 18 may place survivors at an increased risk for adverse psychological outcomes compared to survivors of sexual assault as adults (Masho & Ahmed, 2007). Additionally, previous studies have found that survivors of childhood sexual abuse are at a higher risk for poor sexual functioning, and may experience lower levels of desire and satisfaction (Katz & Tirone, 2008; Najman et al., 2005; Reissing et al., 2003; van Berlo & Ensink, 2000). This may indicate that women who are sexually victimized at a younger age have greater difficulty maintaining healthy relationship interactions and sexual relations later in life. This has important implications for clinicians treating couples with a history of sexual assault reported by the female partner. Clinicians may want to assess for the age at which the sexual assault occurred to determine whether that could be a factor impacting the couples' reported areas of greatest relational distress.

Another important finding relating to age at the time of perpetration is how this may impact survivor risk for suicidality. Within group analyses indicated that women with reported suicide attempts were significantly younger at the time of perpetration compared to those who did not report past suicidality. This is a critical finding for clinicians to be cognizant of when working with children, adolescents, or adults who were sexually victimized at a young age. Proper assessment and safety planning for self-harm should be conducted with women who fit these criteria.

Time Elapsed Since Assault

The amount of time elapsed between the participants' sexual assaults and their presentation for therapy had an impact that approached significance in two of the regression models. Women with greater elapsed time since their assault reported higher levels of consensus and lower levels of relational distress overall. This may indicate that more recent assaults have a greater adverse impact on couple relationships than assaults that happened in the more distant past. This finding is interesting given the findings associated with participants' age at the time of perpetration. Adults presenting for therapy who experienced a sexual assault in childhood would have a greater time elapsed since the trauma than other adults who were victimized in adulthood. However, perpetration at a younger age appears to be a risk factor for more adverse outcomes in some areas of relational functioning. This may indicate the presence of a moderating factor on outcome variables for individuals sexually assaulted as children or adolescents compared to individuals assaulted only as adults. These results could be associated with previous research findings that children perpetrated over age six are more adversely affected in their sexuality in adulthood than children under age six (Easton et al., 2011). These differing outcomes may be tied to developmental differences in children based upon their age at the time of perpetration, which may in turn impact the outcomes for individuals with greater time elapsed since the assault. Further research should be conducted to determine how these two variables (i.e., age at the time of perpetration, time elapsed since assault) interact.

Limitations and Future Directions

Several notable limitations are present for the current study. Firstly, the participants for the study were drawn from a clinical population. As with any study that uses clinical data, it is questionable whether or not the findings would be generalizable to non-clinical samples. The average RDAS Total scores in the present study for both the sexual assault (M = 40.13, SD = 10.79) and non-sexual assault (M = 42.01, SD = 12.77) groups were similar to the scores reported in previous research on couples seeking therapy (M = 40.58, SD = 9.84) (Anderson, Tambling, Heafner, Johnson, & Ketring, 2014). In the same study, Anderson et al. (2014) found the average RDAS scores for a community sample (M = 52.95, SD = 8.26) to be significantly higher than the sample seeking couples therapy, indicating notably lower levels of distress among couples in the community. Future research examining the impact of sexual assault history on relational functioning done in a community setting could be beneficial in gaining a greater understanding of these variables.

This study was also limited by the sample size of women with a history of sexual assault included in the multiple regression analyses. Given the fact that 15 women from the sexual assault subsample were missing at least one piece of information from the six factors included in the regression model, the sample included in the analyses was reduced to 62 individuals. This smaller sample size had an adverse effect on the statistical power of the regression analyses, especially given the large number of factors loaded into the model. Future research with larger sample sizes and more complete data sets could increase the statistical power and yield more significant results, especially for the many regression models and factors found to be approaching significance in the present study.

Another potential limitation is the way in which perpetrator information was coded. The perpetrator information was coded into four groups that were organized based on the researchers' conceptualizations of the nature of the survivor's relationship with each subgroup. For example, fathers, step-fathers, uncles, and grandfathers were all included in a group for "*older male relatives*." Additionally, siblings, cousins, schoolmates, and friends were all included in a "*peer*" group. Several of the women reporting a history of sexual assault reported having more than one perpetrator during their lifetime. In order to simplify analyses, researchers selected only one perpetrator code for each participant to be included in the study. For participants with multiple reported perpetrators, the code selected for analyses was based on the researchers' conceptualizations of which of the perpetrators' proximity in relationship was closest to the survivor in terms of time spent together and expectations from roles. Former romantic partners were conceptualized as closest to the participants, followed by older male relatives, peers, and finally strangers/acquaintances. The method in which perpetrator information was coded and the fact that only one perpetrator type could be included in the study may have impacted the results from the regression analyses. Future studies examining the effect of perpetrator relationships on survivor outcomes could benefit from having a large enough sample size to warrant including more perpetrator codes that could yield more specific information for clinicians.

Only outcome scores for the female partner in the couples presenting for therapy were included in analyses for the present study. This greatly limits the insight clinicians are able to gain in how to systemically treat couples when a history of sexual assault is present for the female partner. Much helpful information could be gleaned from including

the male partner's point of view when conceptualizing how past sexual trauma in the female partner may be impacting current relationship functioning. Future research looking at dyadic analyses of each partner could help better illuminate ways to effectively treat couples in this population.

A final limitation to the current study was the fact that all sexual assault data reported by participants was included for analyses, regardless of whether the abuse occurred during childhood or adulthood. Existing literature suggests that notable differences may exist in the effects of sexual assault dependent upon what time of life individuals are victimized (Herman, 1997; Kaltman et al., 2005; Masho & Ahmed, 2007). By lumping these distinct experiences together as one phenomenon, the current study may have missed variations in outcome with the participants based on these age differences. It is difficult to delineate the differential effects of childhood versus adulthood sexual assault due to the fact that 75% of child abuse victims report re-victimization in adulthood (Spinazzola et al., 2007). Future research using samples of individuals reporting only one type (i.e., adult or childhood) of sexual assault to analyze relational outcomes could be helpful in identifying possible differences between these two subgroups.

In future research, accounting for the trauma history of the male partner as well could be beneficial in examining differences in relational outcomes for females with a history of sexual assault. Given that survivors of multiple traumatic events have been found to have more adverse outcomes in psychological and relational functioning, future studies should control for the trauma history of the male partner to help illuminate

potential interaction effects on relational outcomes for female sexual assault survivors (Krupnick et al., 2004).

Conclusion

The present study acts as a first step towards increasing the effectiveness of couples therapy when a history of sexual assault is reported by the female partner by providing insight to the unique influence of individual and assault characteristics on relational functioning. While no significant differences were found between groups in terms of relational functioning, the significantly higher rates of psychosocial distress discovered in the sexual assault group suggest that additional challenges may be present for couples in this context. Within group differences discovered among the sexual assault survivors highlight the varying impact individual and assault variables can have on relational outcomes for these individuals. These findings emphasize the importance of clinicians being well-informed in the systemic effects of trauma, as well as ensuring that a thorough assessment of historical and contextual factors is conducted at the onset of therapy services.

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APPENDICES

Appendix A

Oklahoma State University Institutional Review Board

Date:	Tuesday, February 23, 2016
IRB Application No	HE1611
Proposal Title:	Psychosocial and relational distress following sexual assault
Reviewed and Processed as:	Exempt

Status Recommended by Reviewer(s): Approved Protocol Expires: 2/22/2019

Principal Investigator(s):

Morgan PettyJohn
Stillwater, OK 74078

Kami L. (Schwerdtfeger) Gallus
233 HES
Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

☐ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1.Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval. Protocol modifications requiring approval may include changes to the title, PI advisor, funding status or sponsor, subject population composition or size, recruitment, inclusion/exclusion criteria, research site, research procedures and consent/assent process or forms
2.Submit a request for continuation if the study extends beyond the approval period. This continuation must receive IRB review and approval before the research can continue.
3.Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of the research; and
4.Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Dawnett Watkins 219 Scott Hall (phone: 405-744-5700, dawnett.watkins@okstate.edu).

Sincerely,

Hugh Crethar, Chair
Institutional Review Board

Appendix B

For Office Use Only

ID # _____

Family Member _____

Today's Date _____

Center for Family Services – Background Form

101 Human Sciences West

Stillwater, Oklahoma 74078

This information is part of your **confidential** file and will be available to CFS staff for reference / research purposes.

Name: Age: Gender:

Address :

Street City, State Zip Code

Home #: Cell #: Work #:

1. Religious Preference: 1. ☐ Protestant (e.g. Baptist, Lutheran, etc.) 4. ☐ None
   2. ☐ Catholic 5. ☐ Non-Denominational
   3. ☐ Jewish 6. ☐ Other (Please Specify) _____

2. Ethnicity: 1. ☐ White or Caucasian 5. ☐ Asian or Pacific Islander
   2. ☐ Black or African American 6. ☐ Middle Eastern
   3. ☐ Spanish/Hispanic/ or Latino 7. ☐ Other_____
   4. ☐ American Indian or Alaska Native → My tribe is:_____

3. Primary Occupation:

→Are you presently: (Check all that apply) 1. ☐ Employed full-time 5. ☐ Retired
2. ☐ Employed part-time 6. ☐ Full-time student
3. ☐ Unemployed 7. ☐ Part-time student
4. ☐ Full-time homemaker 8. ☐ Other (Please specify)__

4. In what range was your total household income before taxes last year?
   1. ☐ Under $5,000 per year 2. ☐ Less than $10,000, but more than $5,000
   3. ☐ Less than $15,000, but more than $10,000 4. ☐ At least $15,000, but less than $25,000
   5. ☐ At least 25,000, but less than $35,000 6. ☐ At least $35,000, but less than $45,000
   7. ☐ More than $45,000 per year

5. Highest Level of Education Completed:
   1. ☐ Less than 9th grade 2. ☐ 9th to 12th grade, no diploma
   3. ☐ High school graduate (includes equivalency) 4. ☐ Some college, no degree
   5. ☐ Associates degree (2 years) 6. ☐ Bachelor's degree (4 years)
   7. ☐ Some graduate school 8. ☐ Graduate or Professional Degree

6. What is your marital status?

1. ☐ Single, never married
2. ☐ Single, widowed
3. ☐ Living with partner who is not the parent of your child(ren)
4. ☐ Living with partner who is the parent of your child(ren)
5. ☐ Single, previously married
6. ☐Married, but separated
7. ☐ Married, 1st marriage
8. ☐Remarried

7. Are you a military veteran? ☐ No ☐ Yes →If yes, years of service _____to_____

Immediate Family

(Spouse, children, and step-children) Please list name, gender, age, relationship to you, and current residence (same as you or different).

Name	**Gender**	**Age**	**Relationship to you**	**Residence**	**(City, State if different)**
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____

How many children under the age of 18 are you the primary parent/caregiver for? _____

The items listed below refer to events that may have taken place at <u>any point in your entire life</u>, including early childhood. **If an event or ongoing situation occurred more than once, please record all pertinent information about additional events on the last page of this questionnaire. (**<u>Please print or write neatly</u>).

1. **Have you ever had a life-threatening illness?**
   ☐ No ☐ Yes → if yes, at what age? _____
   - Duration of Illness _____
   - Describe specific illness _____

2. **Were you ever in a life-threatening accident?**
   ☐ No ☐ Yes → if yes, at what age? _____
   - Describe accident_____ _____
   - Did anyone die? ☐ No ☐ Yes → if yes, who? (relationship to you)_____

- What physical injuries did you receive?
  _____
- Were you hospitalized overnight? ☐ No ☐ Yes

3. **Was physical force or a weapon ever used against you in a robbery or mugging?**
   ☐ No ☐ Yes → if yes, at what age? _____
   - How many perpetrators?_____
   - Describe physical force (e.g., restrained, shoved) or weapon used against you.
     _____
     ___
   - Did anyone die? ☐ No ☐ Yes → if yes, who?
     _____
   - What injuries did you receive?_____
   - Was your life in danger? ☐ No ☐ Yes

4. **Has an immediate family member, romantic partner, or <u>very</u> close friend died because of accident, homicide, or suicide?**
   ☐ No ☐ Yes → if yes, at what age? _____
   - How did this person die?_____
   - Relationship to person lost_____
   - In the year before this person died, how often did you see/have contact with him/her? _____

5. **At any time, has anyone (parent, other family member, romantic partner, stranger or someone else) ever <u>physically forced</u> you to have intercourse, or to have oral or anal sex against your wishes, or when you were helpless, such as being asleep or intoxicated?**
   ☐ No ☐ Yes → if yes, at what age? _____
   - If yes, how many times? ☐ 1 ☐ 2-4 ☐ 5-10 ☐ more than 10
   - If repeated, over what period? ☐ < 6 months ☐ 7 months-2 years ☐ 2-5 years ☐ 5+ years
   - Who did this? (specify sibling, date, etc.)
     _____
   - Has anyone **else** ever done this to you? ☐ No ☐ Yes

6. **Other than experiences mentioned in earlier questions, has anyone ever touched private parts of your body, made you touch their body, or tried to make you to have sex against your wishes?**
   ☐ No ☐ Yes → if yes, at what age? _____
   - If yes, how many times? ☐ 1 ☐ 2-4 ☐ 5-10 ☐ more than 10
   - If repeated, over what period? ☐ < 6 months ☐ 7 months-2 years ☐ 2-5 years ☐ 5+ years
   - Who did this? (Specify sibling, date, etc.)
     _____
   - What age was this person? _____
   - Has anyone **else** ever done this to you? ☐ No ☐ Yes

7. **When you were a child, did a parent, caregiver or other person ever slap you repeatedly, beat you, or otherwise attack or harm you?**

☐ No ☐ Yes → if yes, at what age? _____

- If yes, how many times? ☐ 1 ☐ 2-4 ☐ 5-10 ☐ more than 10
- If repeated, over what period? ☐ < 6 months ☐ 7 months-2 years ☐ 2-5 years ☐ 5+ years
- Describe force used against you (e.g., fist, belt)_____
- Were you ever injured? ☐ No ☐ Yes → if yes, describe_____
- Who did this? (Relationship to you)_____
- Has anyone **else** ever done this to you? ☐ No ☐ Yes

8. **As an adult, have you ever been kicked, beaten, slapped around or otherwise physically harmed by a romantic partner, date, family member, stranger, or someone else?**

☐ No ☐ Yes → if yes, at what age? _____

- If yes, how many times? ☐ 1 ☐ 2-4 ☐ 5-10 ☐ more than 10
- If repeated, over what period? ☐ < 6 months ☐ 7 months-2 years ☐ 2-5 years ☐ 5+ years
- Describe force used against you (e.g., fist, belt) _____
- Were you ever injured? ☐ No ☐ Yes → If yes, describe_____
- Who did this? (Relationship to you) _____
- If sibling, what age was he/she_____
- Has anyone **else** ever done this to you? ☐ No ☐ Yes

9. **Has a parent, romantic partner, or family member repeatedly ridiculed you, put you down, ignored you, or told you were no good?**

☐ No ☐ Yes → if yes, at what age? _____

- If yes, how many times? ☐ 1 ☐ 2-4 ☐ 5-10 ☐ more than 10
- If repeated, over what period? ☐ < 6 months ☐ 7 months-2 years ☐ 2-5 years ☐ 5+ years
- Who did this? (Relationship to you) _____
- If sibling, what age was he/she_____
- Has anyone **else** ever done this to you? ☐ No ☐ Yes

10. **Other than the experiences already covered, has anyone ever <u>threatened</u> you with a weapon like a knife or gun?**

☐ No ☐ Yes → if yes, at what age? _____

- If yes, how many times? ☐ 1 ☐ 2-4 ☐ 5-10 ☐ more than 10
- If repeated, over what period? ☐ < 6 months ☐ 7 months-2 years ☐ 2-5 years ☐ 5+ years
- Describe nature of threat_____

- Who did this? (Relationship to you)_____
- Has anyone **else** ever done this to you? ☐ No ☐ Yes

11. Have you ever been present when another person was killed? Seriously injured? Sexually or physically assaulted?

☐ No ☐ Yes → if yes, at what age? _____

- Please describe what you witnessed_____
- Was your own life in danger? _____

12. Have you ever been in any other situation where you were seriously injured or your life was in danger (e.g., involved in military combat or living in a war zone)?

☐ No ☐ Yes → if yes, at what age? _____

- Please describe. _____

13. Have you ever been in any other situation that was extremely frightening or horrifying, or one in which you felt extremely helpless, that you haven't reported?

☐ No ☐ Yes → if yes, at what age? _____

- Please describe. _____

Medical History

List all medications taken within the last 6 months, both prescription and non-prescription.

Name of medication	**Reason Taken**	**Check if taking now**

Do you drink alcohol? ☐ No ☐ Yes → if yes, how much?

☐ Less than once a week ☐ 1-3 times per week ☐ 4-6 times per week ☐ 7 or more per week

Has anyone expressed concern for how much you drink? ☐ No ☐ Yes → if yes, who?

Do you think another family member drinks too much? ☐ No ☐ Yes → if yes, who and please explain.

Have you taken or are you currently taking any non-medical/illicit drugs (e.g., meth, marijuana, etc.)?
☐ No ☐ Yes please list below.

Name of drug	**Frequency of use**	**Dates of use**

Have you ever had a miscarriage or an abortion? ☐ No ☐ Yes → if yes, give date(s) and details.

Have you ever attempted suicide? ☐ No ☐ Yes → if yes, give date(s) and details.

Has anyone in your family ever attempted suicide? ☐ No ☐ Yes → if yes, give name(s), relationship to you, and details.

Are you currently receiving services from another therapist/counselor? ☐ No ☐ Yes → if yes, who and for what?

Have you ever been treated by another therapist/counselor? ☐ No ☐ Yes → if yes, when, where, and for what?

From the following list, please check the reasons that you are seeking services at this time:

1. ☐ Personal Enrichment
2. ☐ Relationship Enrichment
3. ☐ Marital Enrichment
4. ☐ Family Enrichment
5. ☐ Marital Conflict
6. ☐ Family Conflict
7. ☐ Sexual Problems
14. ☐ Single Parenting
15. ☐ Parenting- Two parent family
16. ☐ Step-Parenting
17. ☐ Child Behavior Problems
18. ☐ Adolescent Behavior Problems
19. ☐ Alcohol Abuse- Child/Adolescent
20. ☐ Drug Abuse- Child/Adolescent

8. ☐ Physical Abuse
9. ☐ Sexual Abuse
10. ☐ Divorce Adjustment
11. ☐ Adjustment to Loss
12. ☐ Financial Loss
13. ☐ Loss due to death
21. ☐ Alcohol Abuse- Adult
22. ☐ Drug Abuse- Adult
23. ☐ Family Stress
24. ☐ Loss due to break up of relationship
25. ☐ Health Problems
26. ☐ Other (Specify) _____

Please describe in your own words the major reason for seeking our services at this time.

_____

_____

_____

How serious would you say this problem is right now? (Please circle one)

NOT AT ALL SERIOUS	SLIGHTLY SERIOUS	MODERATELY SERIOUS	VERY SERIOUS

How likely do you think the problem is to change? (Please circle one)

NOT AT ALL LIKELY	SLIGHTLY LIKELY	MODERATELY LIKELY	VERY LIKELY

Appendix C

OQ-30

Looking back over the last week, including today, help us understand how you have been feeling. Circle the number that best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

	Never	***Rarely***	***Sometimes***	***Frequently***	***Almost Always***
1) I have trouble falling asleep or staying asleep	0	1	2	3	4
2) I feel no interest in things	0	1	2	3	4
3) I feel stressed at work, school, or other daily activities	0	1	2	3	4
4) I blame myself for things	0	1	2	3	4
5) I am satisfied with my life	0	1	2	3	4
6) I feel irritated	0	1	2	3	4
7) I have thoughts of ending my life	0	1	2	3	4
8) I feel weak	0	1	2	3	4
9) I find my work/school or other daily activities satisfying	0	1	2	3	4
10) I feel fearful	0	1	2	3	4
11) I use alcohol or a drug to get going in the morning	0	1	2	3	4
12) I feel worthless	0	1	2	3	4
13) I am concerned about family troubles	0	1	2	3	4
14) I feel lonely	0	1	2	3	4
15) I have frequent arguments	0	1	2	3	4
16) I have difficulty concentrating	0	1	2	3	4
17) I feel hopeless about the future	0	1	2	3	4

	Never	*Rarely*	*Sometimes*	*Frequently*	*Almost Always*
18) I am a happy person	0	1	2	3	4
19) Disturbing thoughts come into my mind that I cannot get rid of	0	1	2	3	4
20) People criticize my drinking (or drug use) (If not applicable, mark "never")	0	1	2	3	4
21) I have an upset stomach	0	1	2	3	4
22) I am not working/studying as well as I used to	0	1	2	3	4
23) I have trouble getting along with friends and close acquaintances	0	1	2	3	4
24) I have trouble at work/school or other daily activities because of drinking or drug use (If not applicable, mark "never")	0	1	2	3	4
25) I feel that something bad is going to happen	0	1	2	3	4
26) I feel nervous	0	1	2	3	4
27) I feel that I am not doing well at work/school or in other daily activities	0	1	2	3	4
28) I feel something is wrong with my mind	0	1	2	3	4
29) I feel blue	0	1	2	3	4
30) I am satisfied with my relationships with others	0	1	2	3	4

Appendix D

RDAS

Most persons have disagreements in their relationships. Please indicate below, by checking the appropriate box, the extent of agreement or disagreement ***between you and your partner****.*

	Always Agree	***Almost Always Agree***	***Occasionally Disagree***	***Frequently Disagree***	***Almost Always Disagree***	***Always Disagree***
1) Religious matters						
2) Demonstrations of affection						
3) Making major decisions						
4) Sex relations						
5) Conventionality (correct or proper behavior)						
6) Career decisions						

	All the time	***Most of the time***	***More often than not***	***Occasion-ally***	***Rarely***	***Never***
7) How often do you discuss or have you considered divorce, separation, or terminating your relationship?						
8) How often do you and your partner quarrel (or argue)?						
9) Do you ever regret that you married (or lived together)?						
10) How often do you and your partner "get on each other's nerves"?						

	Every day	***Almost every day***	***Occasionally***	***Rarely***	***Never***
11) Do you and your partner engage in outside interests together?					

How often would you say the following events occur between you and your partner?

	Never	***Less than once a month***	***Once or twice a month***	***Once or twice a week***	***Once a day***	***More often***
12) Have a stimulating exchange of ideas						
13) Work together on a project						
14) Calmly discuss something						

VITA

Morgan E. PettyJohn

Candidate for the Degree of

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