FEMALE CHILD SEXUAL ABUSE SURVIVORS AND NONVICTIMS: A COMPARISON OF SEXUAL BEHAVIOR AND SEXUAL FUNCTIONING

By

TRACY FEHRENBACH

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CHAPTER I

INTRODUCTION

It is now widely acknowledged that sexual abuse of children is associated with a vast array of negative life problems. Such experiences include impediments in normal development, adjustment difficulties, and both physical and mental complaints and disorders (Polusney & Follette, 1995). Difficulties experienced by survivors of childhood sexual abuse (CSA) may occur immediately following abuse, may be either transient or pervasive, or may not surface until years following abuse (Browne & Finkelhor, 1986).

One particular area characterized by many difficulties for survivors of abuse is sexuality (Finkelhor & Browne, 1985). It has been hypothesized, and limited research has been conducted, which suggests that survivors and nonvictims differ in initiation and frequency of sexual behavior, sexual dysfunction, conceptualization of sexuality, number of negative outcomes related to sexual interactions, and adult victimization. Because the adolescent and early adult years are a time during which individuals are introduced to sexuality (via puberty, sexual attention toward and from peers, sexual peer pressure, and certain societal influences and expectations), it seems rational to explore the effects of CSA on sexuality within this age group. Unfortunately, data on adolescent and young adult survivors is relatively limited, especially when looking at literature regarding sexuality issues.

It was the purpose of this study to examine a population of older adolescents/young adults to determine if those with a history of CSA differ significantly from those without a history of victimization with regard to several dimensions of sexuality. Specifically, this study assessed for CSA and compared young females with a history of CSA to those without such a history on measures of sexual behavior (type and frequency), sexual functioning (beliefs and adjustment), and comfort in dating/romantic relationships. This study was particularly advantageous given the low numbers of, and absence of clarity in, previous studies examining the sexuality of victimized adolescents and young adults. Before adolescent sexuality as related to CSA is discussed, the general literature on CSA as well as the literature regarding sexuality in a normal adolescent and young adult population will be reviewed.

CHAPTER II

REVIEW OF LITERATURE

Characteristics of Child Sexual Abuse

Prevalence

A number of studies within the area of childhood sexual abuse (CSA) have been concerned with identifying the prevalence of this social ailment. During the 1980s, a number of studies were conducted employing large sample sizes and slightly different, yet reliable, research designs and yielded vastly different rates of CSA (Salter, 1992). Reported rates of childhood victimization have ranged between 2% and 62% (Peters, Wyatt & Finkelhor, 1986; Vogeltanz et al., 1999). Within this vast range, the majority of studies examining the general female population have found rates between 15% and 33% (Polusny & Follette, 1995).

In a national survey of adults, Finkelhor, Hotaling, Lewis, and Smith (1990) found that 27% of women and 16% of men disclosed experiences of victimization. Similar reports were obtained in a study of Canadian women and men that revealed that 34% of women and 13% of men had experienced unwanted sexual contact prior to age 18 (Bagley et al., 1984). In a more recent study of Oregon high school students, Nelson, Higginson, Grant, and Grant-Worley (1994) report overall prevalence rates of CSA at

20.9%, with female victimization rates of 33.1% and male victimization rates of 8.1%. A 1991 national survey of women's drinking and life experiences revealed that 15% to 32% (depending on the inclusiveness of CSA definition) of women experienced sexual abuse as a child (Vogeltanz et al., 1999). Wynkoop, Capps, and Priest (1995) review these inconsistent findings and posit an explanation based on inconsistent data collection procedures and other confounding variables.

Numerous factors have been suggested to account for variance within prevalence studies. Methodological differences such as sampling procedures, operational definitions of abuse, response rates, and research protocols designed to detect CSA status are speculated to account for much of the variation in reported rates of abuse. Peters, et al., (1986) reviewed studies investigating the effect of each of these variables and found that each did influence prevalence. Overall, higher prevalence rates were associated with more carefully designed and controlled studies. Variation, however, existed between even the most meticulous studies. Each of these factors will be examined more carefully.

Sampling. Response rates of CSA have been found to vary by the type of population sampled in each study. Generally, CSA studies conducted with patient populations have yielded higher rates of victimization than have research projects with non-clinical samples (Polusny & Follette, 1995). Lower rates of victimization are identified with the use of a college population in CSA research. Finally, there is some speculation that survivors are less likely than nonabused peers to pursue an advanced degree, thus college samples may be distinct and under-representative samples.

Definition of Abuse. The operational definition of CSA used in each study varies in multiple ways. The upper-age limit chosen as a cut-off for "childhood" abuse, the type of act considered abusive, and the identity of the perpetrator are all such examples. Many studies refer to CSA as an abusive experience occurring prior to 18 years of age with an individual at least 5 years older than the victim (e.g., Seidner & Calhoun, 1984; Wyatt, 1985). Other studies examine experiences occurring prior to puberty only (e.g., Fritz, Stoll, & Wagner, 1981; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Inconsistencies in prevalence rates of CSA may also be a result of the types of experiences deemed abusive (Vogeltanz et al., 1999). Specifically, many studies include non-contact, exposure experiences (e.g., Finkelhor, 1984; Fromuth, 1986) where as others require that abusive experiences involve physical contact or force (e.g., Messman & Long, 1996). Lastly, at times definitions of abuse are contingent upon the survivor's relationship with the perpetrator of the abuse, such as extrafamilial versus intrafamilial abuse.

Response Rates. Response rates are thought to affect prevalence rates in studies of CSA for two opposing reasons (Peters et al., 1986). Survivors of abuse may be more likely to select themselves as participants in studies of childhood victimization. On the other hand, survivors may be more likely to avoid participating in such studies. Either way, a conscious effort to participate or avoid CSA research may affect prevalence rates of abuse experiences.

Research Protocol. Research protocol or instrumentation used to prompt abuse disclosure has also been found to be related to the prevalence of reported CSA. Specifically, those studies employing face-to-face interviews have a higher percentage of

participants who disclose victimization than do studies using telephone interviewing or self-report questionnaires (Peters, Wyatt, & Finkelhor, 1986). Reasons for this include an opportunity for the interviewer to build rapport with the participant, to ascertain the participant's understanding, and to probe for information not spontaneously offered by the participant.

Abuse Characteristics

Sexual abuse during childhood is reported by a wide array of people, occurs under a variety of different circumstances, and takes many forms. Studies reveal, however, that certain patterns or characteristics of abuse are most commonly reported. For instance, several studies document the mean age of onset of abuse for females between 7 and 9 years of age (Polusny & Follette, 1995; Trickett & Putnam, 1993). Another peak, occurring just prior to the early teenage years, has also been suggested (Finkelhor, 1979). CSA is not an act usually committed by strangers (Finkelhor, Hotaling, Lewis, & Smith,1990). Rather, most studies reveal that a high percentage of abuse occurs between a minor and a father figure, another relative, a friend, or an acquaintance. Faller (1989) conducted a study employing a clinical sample of 313 sexually abused children; all of these children reported abuse inflicted by an individual previously known to them.

Abuse Effects

A number of negative consequences have been found to be associated with CSA. Survivors experience a variety of psychological, physiological, and social difficulties both immediately and many years following CSA (Kendall-Tackett, Williams, & Finkelhor,

1993; Lipovsky & Kilpatrick, 1992). Although individuals without a history of abuse sometimes experience similar problems, CSA survivors are overwhelmingly more likely to be candidates for such difficulties. These effects will be reviewed in more detail.

Initial Effects

Immediate, or short-term effects, are referred to as those which occur during childhood or adolescence, are either evident immediately subsequent to or shortly following abuse, and may or may not subside with time. A large portion of CSA symptomatology can be broken down into two categories: internalizing and externalizing behaviors. Some of the most common internalizing effects of CSA displayed by child survivors are fear (Browne & Finkelhor, 1986), anxiety (Mannarino & Cohen, 1996), and depression (Mannarino & Cohen, 1996). Stern et al., (1995) concluded that victimized children and adolescents were twice as likely to experience sadness or depressive symptoms when compared to nonabused counterparts. Prevalent externalizing problem behaviors include school problems and aggressive or anti-social behaviors (Kendall-Tackett et al., 1993), with one study reporting that sexually victimized children are almost five times more likely to exhibit clinically relevant behavior problems than are non-victimized children (Stern et al., 1995). Dysfunction is also evident in other areas such as sexuality, self-esteem, and somatization (Sauzier, Salt, & Calhoun, 1990).

Research suggests that child survivors often experience different types of symptoms, or levels thereof, dependent upon their age or developmental level (Dubowitz, Black, Harrington, & Verschoore, 1993). Kendall-Tackett and colleagues (1993) provide support for this idea in their review of 45 CSA studies. They found that

each age group (e.g., preschool, grade school, and adolescence) of child survivors exhibit certain hallmark effects, independent of the age at which their abuse occurred.

One review paper (Sauzier et al., 1990) indicates that regression, hyperactivity, impaired trust, lying, and difficulty separating have all been identified as developmentally common expressions of abuse among preschoolers. Many school age children and adolescents experience difficulties with depression, school problems, running away, drug abuse, suicide attempts, tics, borderline states, aggression, and delinquency. Obsessions and psychosis are also problems most likely to appear during either middle childhood or preadolescence, although these symptoms are considered rare.

On the other hand, Sauzier et al. (1990) note some symptoms may be experienced by all age groups and some may, but do not necessarily, continue into adulthood. Several symptoms of CSA were experienced by children of every age group. Anxiety, withdrawal, guilt, somatic complaints, sleep problems/nightmares, and sexualized behaviors were present in preschoolers, school-aged children, and adolescents. Longitudinal CSA studies reviewed by Kendall-Tackett and colleagues (1993) show that most childhood problems subside over time, while approximately one-fourth of survivors fail to improve or worsen. Yet, it is not clear whether this improvement was a function of intervention or time alone. Certain behaviors have been found more likely to abate than others. Anxiety symptoms were found by Gomes-Schwartz, Horowitz, and Sauzier (1990) to recede over time, while aggressive and sexualized behavior problems remained or even multiplied. Finally, for some children, symptoms change over time such that while some dissipate, others originate (Friedrich & Reams, 1987).

Long-Term Effects

Long-term effects are those which are manifested throughout childhood and persist into adulthood or appear for the first time in adulthood. Long-term effects include a vast array of mental disorders as well as emotional and social difficulties including, but not limited to, the following: depression, anxiety, sexual problems, suicidal behaviors, self-harm, alcohol and drug abuse, poor social adjustment, poor self-esteem, dissociation, sleep disturbance, and revictimization (Finkelhor & Browne, 1988; Polusney & Follette, 1995). Some of these symptoms will be reviewed in more detail.

Depression. Depression is a construct which has been thoroughly studied in relationship to CSA. Burnman et al., (1988) identified depression twice as often in a sample of community women five years following abuse than in a closely matched control group of nonvictims. The relationship between these constructs is increasingly complex, as the authors note that depression was one of four factors related to CSA as both a precursor and a consequence. Sedney and Brooks (1984) obtained results supporting a relationship between depression and CSA, finding a significantly greater prevalence among college students with a history of victimization than in those without such a history. While studies of both community and college women support such a relationship, Lundberg-Love, Marmion, Ford, Geffner, and Peacock (1992) found that incest survivors seeking treatment experienced no more depression than a clinical sample of women without an abusive history.

Brown and Finkelhor (1986) cite depression as the most pervasive symptom identified in clinical literature. Lipovsky and Kilpatrick (1992), however, in their review

of the empirical research on abuse effects, caution that the relationship between depression and victimization is not clearly understood. Specifically, discrepant research findings have led scholars to speculate that certain abuse characteristics, or a collection thereof, may lead to depressive symptomology. Another review of the literature indicates that studies unable to identify a significant relationship between depression and abuse often employ participants who have experienced less severe abuse or whose time since abuse was unusually long (Beichman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992). Thus, while adequate support has been obtained identifying depression as a consequence of abuse, some studies have failed to find a relationship.

Anxiety. Anxiety is another often identified consequence of CSA. Overall, many studies find that CSA survivors have an increased likelihood of experiencing anxious symptomatology or anxiety disorders. Examination of over 3000 community women and men revealed that survivors of sexual assault experience three types of anxiety disorders significantly more often than their non-abused counterparts (Burnam et al., 1988). Closer examination of this sample revealed that panic disorder was evident twice as often in survivors, and phobias and obsessive compulsive disorder were evident approximately three times as often five years following sexual assault. A study of a clinical sample of incest survivors also lends support to a relationship between these two constructs. Specifically, female survivors of incestuous abuse scored higher on general anxiety measures and were significantly more likely than three non-abused control groups to manifest obsessive compulsive behavior (Lundberg-Love et al., 1992). In a survey of college women, chronic anxiety was present to a significantly greater extent in survivors

of CSA who experienced abuse prior to age fifteen than in nonabused students. The authors of this study feel that this finding is particularly noteworthy in light of their assumption that survivors pursuing a college degree are generally higher functioning than are survivors without advanced schooling (Briere & Runtz, 1988). In a study of general psychopathology among CSA survivors, Saunders, Villeponteaux, Lipovsky, Kilpatrick, and Veronen (1992) found increased rates of agoraphobia, panic disorder, obsessive compulsive disorder, and social phobia among women who experienced contact abuse as compared to those who experienced either non-contact abuse or no abuse at all.

Two reviews of the literature report that the relationship between sexual abuse and subsequent anxiety disorders or symptomatology is puzzling (Beitchman et al., 1992; Lipovsky & Kilpatrick, 1992). Some studies fail to find a significant relationship between generalized anxiety and experiences of childhood sexual victimization. Lipovsky and colleagues (1992) point out that demographic variables (such as race and gender) may be partially responsible for the discrepancies in research findings.

Self-Harming Behaviors. Studies show that survivors of sexual abuse are at heightened risk for exhibiting a variety of self-harming behaviors (Lipovsky & Kilpatrick, 1992). A paper written on the adverse effects of violence against women posits that "abuse may be the most important precipitating factor" in female suicide attempts (Goodman, Koss, & Russo, 1993, p. 80). Briere (1988) examined the current and past occurrence of self-destructive and suicidal behaviors in a sample of out-patient, female CSA survivors. Survivors self-reported more incidents of both behaviors than did a comparison sample of outpatient women with no history of abuse. Additional analyses

revealed that abuse experiences involving intercourse may result in markedly elevated rates of suicidality. Likewise, Saunders et al. (1992) report that 17.9% of women in their community sample reporting childhood rape and 15.8% reporting childhood molestation had attempted suicide in the past, while only 5.8% of nonvictims reported one or more suicide attempts.

Adjustment Problems. Psychopathology does not encompass all long-term effects of CSA, rather many effects are expressed as difficulties in social and interpersonal functioning. The relationship between CSA and impairment in social adjustment has been investigated and supported (Polusny & Follette, 1995). Brayden, Dectrich-MacLean, Dietrich, Sherrod and Altemeier (1995) found that CSA was a significant predictor of poor physical self-concept and that overall well-being was substantially lower in a sample of survivors participating in a prenatal care program as compared to women in the program who had not experienced abuse, even when specific childhood family constructs were controlled. Increased interpersonal sensitivity symptom are also sometimes exhibited by survivors of CSA (Lundberg-Love et al., 1992). A study of college women suggests that survivors exhibit poorer social adjustment than their nonabused counterparts, although neither group scored in the clinical range (Harter, Alexander, & Neimeyer, 1988). Finally, some studies report a relationship between a history of CSA and lower levels of self-esteem (Finkelhor & Browne, 1988).

Revictimization. Revictimization is most often defined as sexual (and sometimes physical) assault occurring in adulthood following a similar experience as a child or young adult. A through review of the literature by Messman and Long (1996) indicates

that revictimization is commonly noted as a long-term consequence of CSA in studies employing college, community, and clinical samples. For instance, Briere (1988) reports that outpatient survivors of CSA had higher rates of sexual assault and rape later in life than did nonvictims also seeking psychological services. Likewise, Wind and Silvern (1992) suggest that adults who experienced a combination of physical and sexual assault as a minor were at an increased likelihood of experiencing both types of abuse in adulthood.

Effects as Manifested in Adolescent Survivors

It is necessary to note that the effects of abuse present in adolescence and young adults may not be easily categorized as either initial or long-term effects. The period of time since the teen last experienced abuse, as well as the developmental changes specific to adolescence and young adulthood, make the delineation of initial or short-term effects from long-term outcomes difficult to make. Although theory exists which suggests that the sequela of abuse manifested in adolescence may be both qualitatively and quantitatively different from that of childhood and adult effects (Kendall-Tackett et al., 1993), relatively little empirical examination has been conducted with this population.

Limited research, however, suggests several problems which appear to be most prominent in adolescent and young adult survivors. These include: lowered self-esteem, homosexuality, hostility, disrupted peer relations, promiscuity, illegal acts, and self-injurious behavior (Kendall-Tackett et al., 1993; Sauzier et al., 1990). In addition, many symptoms have been found to be more prevalent in teens with a history of abuse when compared to those without such a history.

One large scale community study (Garnefski & Diekstra, 1997) conducted with sexually abused Dutch adolescents (age 12 - 19) and matched controls found that, across gender, adolescent survivors had significantly more symptomatology on measures of emotional adjustment, behavioral problems, and suicidality. Males with an abuse history appeared to possess a greater level of distress across these areas than both nonabused boys and abused girls. Female adolescent survivors were two to four times more likely to experience emotional and behavior problems, as well as suicidal ideation and/or suicide attempts, than were nonabused female controls. Silverman, Rienherz, and Giaconia (1996) also conducted a study employing community participants. This longitudinal study followed a group of young people over a period of 18 years with measures of adjustment taken at ages 15 and 21. Female survivors of CSA scored significantly higher on measures of somatic complaints, anxious/depressed symptomatology, social problems, thought and attention problems, and aggressiveness as compared to their nonabused counterparts. These young women were two times more likely to report depression and over three times more likely to have a history of suicidal ideation or attempts than were nonabused peers. One additional study, conducted in New Zealand, employed a sample of community adolescents and obtained results which support the previous findings. Specifically, young adult survivors in this study, when contrasted with nonabused peers, had higher rates of major depression, anxiety and conduct disorders, alcohol abuse/dependence, other drug use, attempted suicide, and post sexual abuse trauma (Lynskey & Fergusson, 1997).

When investigating the symptomatology of inpatient adolescents, differences between abused and nonabused participants appear less distinct. A number of these

studies have failed to find expected differences in major depression, anxiety, suicidal ideation, social competence, and self-esteem (e.g., Brand, King, Olson, Ghaziuddin, Naylor, 1996; Hussey & Singer, 1992; Pantle & Oegema, 1990). Significant differences have been found with regards to PTSD symptomatology (Brand et al., 1996), substance abuse (Hussey & Singer, 1992), depressive and psychotic symptoms (Sanonnet-Hayden, Haley, Marriage, & Fine, 1987), and suicide attempts (Sanonnet-Hayden et al., 1987) with the abused adolescent functioning more poorly on each measure as compared to nonabused counterparts. When levels of severity are used to compare groups of inpatient survivors, those with more extensive abuse display more cognitive difficulties, lower self-esteem, more social introversion, and depressed mood (Pantle & Omega, 1990).

Also noteworthy are effects of abuse manifested in adolescents that appear to be rather stable over time and somewhat resistant to intervention. A study conducted in 1997 (Tebutt, Swanston, Oates, & O'Toole, 1997) followed child and adolescent survivors (age 5 - 15 years) over a period of 5 years, assessing for levels of self-esteem, depression, and behavior problems. Assessment at 18 months and 5 years following abuse reflected no significant change on any level of symptomatology. When the sample was examined more closely, however, it appeared that the percentage of young people who had experienced a decrease in symptoms was no greater than the percentage for whom symptomatology increased.

Moderators of Abuse Effects

A number of different variables have been identified as possible moderators of the relationship between sexual abuse and later adjustment problems. In most cases,

literature examines and identifies characteristics of abuse which are believed to be associated with greater symptomatology or increased negative effects of abuse. Quite often, the findings are inconclusive and an interaction between several abuse characteristics are hypothesized to be more deterministic of outcome than any single characteristic. This literature will be reviewed.

Age of Onset. While it is understood that sexual abuse occurring at any age can result in a variety of negative consequences, the relationship between the age at which the abuse begins and subsequent symptomatology has been subject to some investigation. Unfortunately, no clear conclusions can be made due to inconsistent, and sometimes contradicting, results.

Brown and Finkelhor (1986) cite seven studies investigating the relationship between the age at initial abuse and later adjustment; two supported and five failed to support a relationship. The authors of this review article note trends in the research that support a relationship between younger age of onset and more severe sequela. It does appear, however, that the most rigorous research tends to find no relationship. In their 1992 review, Beitchman et al. concluded that such inconsistencies may be the result of an overlap between the age of onset of abuse with other characteristics of abuse such as frequency and duration, perpetrator of abuse, and type of abuse.

Frequency and Duration. Surprisingly, results of research on frequency or duration of CSA and subsequent pathology are dissenting. One study found a significant difference in self-reported trauma symptoms when comparing groups of adult women who were abused one time only, women abused multiple times over a period less than

five years, and women abused in excess of five years (Russell,1986). Those women enduring more instances of abuse reported greater levels of trauma supporting a positive relationship between the two factors. A comparison of survivors from clinical and non-clinical settings found that women who sought treatment for CSA reported abuse experiences of greater frequency and duration than did the non-clinical survivors (Tsai, Feldman-Summers, & Edgar, 1979). In contrast, Brown and Finkelhor (1986) reviewed two studies that supported better adjustment in women with histories of long-lasting abuse experiences and four studies which found no relationship between well-being and frequency and duration at all. Therefore, despite some support that duration or frequency of abuse may have some influence on symptomatology, research fails to provide consistent support. It is possible that frequency and duration of abuse may not each be powerful enough to determine outcome. For instance, Beitchman and colleagues (1992) speculate that long-term abuse may be more likely to involve penetration or to be perpetrated by a family member, a combination which may together account for increased symptomology.

Type of Abuse. One rather consistent finding is the association between more intrusive CSA and greater trauma or distress (Kendall-Tackett et al., 1993). Severity of abuse is often determined by the degree of sexual contact between the survivor and the perpetrator, with vaginal, anal, or oral intercourse considered more severe than fondling-only or non-contact experiences. In a review of the research, Brown and Finkelhor (1986) reported six studies confirming this finding. For instance, penetration was the variable most accountable for mental health impairment in a study of community women

by Bagley and Ramsey (1986). Likewise, in her study of long-term effects of CSA, Russell (1986) found a significant difference in the degree of trauma experienced between groups of women with histories of various degrees of abuse. Specifically, three-fifths of women who experienced direct genital-genital or oral-genital contact reported feelings of extreme trauma; in contrast, only one-third of women experiencing fondling of unclothed genitals and breasts, and one-fifth of those reporting unwanted kissing or touching over clothing felt extremely traumatized.

Force. Another factor examined in relation to abuse effects is whether force or coercion was employed by the perpetrator. Banyard and Williams (1996) found a significant relationship between the use of physical force and increased mental health problems. Similarly, information collected by the 1987 National Survey of Children, a study of 441 young women, revealed that individuals forced to have sexual intercourse had lower internal locus of control, higher rates of depression and needed and received more psychological assistance than did women without history of coercive sexual experience (Miller, Monson, & Norton, 1995). Thus, research indicates that the greater the amount of force employed in a CSA experience, the less well-off the survivor.

Identity of the Perpetrator. Many studies have investigated whether abuse inflicted by a family member produces more harmful consequences than extra-familial abuse. Findings are somewhat inconsistent but suggest that children who are abused by a close family are often worse of than those abused by strangers or acquaintances. Seven of nine studies reviewed by Kendall-Tackett et al. (1993) reported an increase in symptomatology when the offender and child had a "close relationship" prior to the abuse

(a close relationship did not necessarily indicate a familial relationship). Similarly, a review by Brown and Finkelhor (1986) found that abuse by a father or father-figure is likely to have a greater negative impact than abuse perpetrated by other individuals. It cannot be concluded that abuse by a relative is sufficient to increase the amount of consequent trauma. Brown and Finkelhor (1986) reviewed some studies that have failed to find support for a relationship between outcome and perpetrator identity (e.g., Finkelhor, 1979; Seidner & Calhoun, 1984). Discrepant findings may be partially accounted for by a mistaken assumption that a familial relationship is indicative of a close relationship. Realistically, it is likely that some survivors did not feel particularly close to family perpetrators while some may have had an extremely close relationship with an abusive neighbor or friend of the family.

Summary. In summary, variations in abuse experiences do exist with certain characteristics hypothesized as predicting better or worse outcome. Research, however, has been overwhelmingly inconsistent, making it difficult to establish a clear relationship between many characteristics of abuse and later effects. The effects of age of onset, frequency, duration, and identity of perpetrator have been only minimally supported in their roles as moderating variables. The impact of intrusiveness of abuse and the use of force on adjustment following abuse has been more clearly supported.

Theory of Childhood Sexual Abuse

While significant attention has been given to factors that may moderate the extent of symptomatology and overall adjustment in survivors, less focus has been placed on

determining the processes directly responsible for the presence of immediate and long-term effects. Some scholars have attempted to theoretically account for the presence of symptomatology among survivors of abuse based on the survivor's thoughts about the abuse, the amount of trauma experienced during the abuse, and/or the survivor's conceptualization of sexuality based on the nature of the abuse. This paper will review select theories including cognitive-behavioral approaches, Finkelhor's Traumagenic Dynamic Model, and a post-traumatic stress disorder framework.

Cognitive-Behavioral Approaches. An elucidation of abuse effects via a general cognitive-behavioral orientation involves a combination of cognitive appraisals and beliefs paired with learned behavioral coping mechanisms, classical conditioning, and social learning mechanisms. Wheeler and Berliner (1988) have explained how such a cognitive-behavioral model may account for the consequences of victimization. According to this model, trauma experienced during and following the abusive episode is thought to provoke anxious emotional reactions in the survivor. Attempts to cope with this anxiety lead the survivor to adopt certain behaviors or cognitions meant to make sense of or avoid further abuse and the subsequent emotional responses.

It is via classical conditioning that anxiety is experienced beyond the abusive interaction itself. To illustrate, anxiety is paired with contextual variables of the abuse experience and result in a conditioned response which is then generalized to other, previously neutral, stimuli. Further explanation for the maintenance of symptoms involves application of social learning theory. Specifically, survivors are thought to adopt inaccurate, inappropriate, dysfunctional, and/or negative beliefs and behaviors as a result

of abuse-specific feedback such as reinforcement, punishment, and instruction from the offender. These distorted cognitions are theorized to affect the way in which survivors perceive and respond later in their lives.

Hoier et al. (1992) also discuss how the cognitive-behavioral model can address both the "initiation" and "maintenance" of problems resulting from CSA. According to these authors, CSA experiences are divided into "types" according to contextual characteristics and severity of abuse and are then placed somewhere along the authors' proposed "Challenge-Stress-Trauma-Continuum" of sexual abuse. Characteristics of abuse such as frequency, duration, amount of control perceived by the survivor, and pain or threatened harm are used to determine severity. An underlying premise of this model is that the greater the severity/trauma of one's abuse, the more dramatic the emotional, psychological and/or behavioral effects. In this model, responses to abuse are accounted for by learning contingencies such as classical conditioning, reinforcement, and punishment. Environmental feedback evoked from the survivor's attempts to change or control his/her environment shapes his/her cognitive and behavioral responses regarding abuse. Variation in symptomatology across survivors is recognized by this model and is viewed to be a result of several factors. Environmental cues are sometimes responsible for eliciting physiological, psychological, or emotional responses from survivors. Cues are conditioned from the survivor's specific abusive situation and, therefore, vary from person to person. The authors note that cognitions or behaviors which are similar across survivors sometimes exist to fulfill differential functions. For example, alcohol use may serve the purpose of numbing and avoiding cues associated with abuse or may be used in efforts to reduce anxiety symptomatology associated with abuse. Additionally, symptoms

may differ in the clusters, or patterns, in which they are manifested. Overall, those abusive situations falling toward the more severe end of the continuum are associated with greater amounts of unhealthy learning contingencies and likewise, greater symptomatology.

Application of the emotional avoidance theory, as explained by Polusney and Follette (1995), accounts for long-term sequela of CSA as a survivor's attempt to avoid experiencing negative emotional or psychological states elicited by abuse. Symptoms may themselves be an act of avoidance (e.g., substance abuse) or symptoms may be more indirectly related such that a preoccupation with efforts to avoid experiencing a certain symptom results in exacerbation of that very symptom (e.g., when an anxious individual attempts to ignore anxiety and as a result becomes increasingly anxious). Further, once the survivor begins to employ such unhealthy coping mechanisms they are maintained by negative reinforcement, namely the alleviation of abuse-evoked emotional states. The numbing or dissociation some survivors experience not only prevents negative emotional responses but also is inadvertently used to avoid experiencing all extreme emotions, including pleasant emotions. This model, like those previously mentioned, also adheres to the belief that conditioned emotional responses play a significant role in CSA symptomatology. A study conducted by Sigmon, Greene, Rohan, and Nichols (1996) provides mixed support for the role that avoidance may play for survivors of CSA. Specifically, this study found that avoidance coping was the strategy most often employed by both male and female survivors during the childhood abusive experience. This type of coping was also found to predict adjustment in adulthood. One study which examined the coping strategies of female college survivors (Long & Jackson, 1993) found that

emotion focused strategies, including those in which the experience of negative emotion is avoided, are the most common type of coping utilized by adult survivors. This study, however, found emotion-focused strategies of coping to be predictive of poorer adult adjustment.

An alternate explanation of long-term CSA effects involves "attributions" or beliefs held by survivors. Guided by the learned helplessness model of depression (Abramson, Seligman, & Teasdale, 1978), Gold (1986) hypothesized that survivors have a particular pattern or style of making attributions. She suggested that they most often made internal, stable, and global attributions for negative events. A taxed ability to cope and feelings of helplessness result from a propensity to make internal attributions. Results of Gold's study offer empirical support for this model. The attributional style of survivors was found to differ significantly from attributions of nonvictims. Additionally, survivors who experienced the most severe abuse effects were most likely to hold internal, stable, and global attributions for negative life events. Survivors were also more likely to make external attributions for positive events.

In applying Folkman and Lazarus's Stress and Coping Theory (1979), another cognitive-behavioral model, one would posit that an individual's response to childhood victimization is dependent upon his/her initial appraisal of the situation, his/her ability, and the availability of resources to cope with the encounter. This theory states that inherent characteristics of the individual experiencing trauma do not solely determine one's ability to cope. Rather, an individual's perception of the demands of a particular situation in ratio to the available internal and external resources does. One's situation and perception will vary across contexts; therefore, one's method of coping will do so as well.

This model refers to a desirable "goodness of fit" between the demands of a particular situation and one's method of coping. Specifically, the better the fit, the less likely one is to experience aversive side-effects or distress associated with the event. When using this model to examine CSA symptomatology, long-term abuse effects are accounted for as a lack of fit between the coping mechanisms available to the victim and the stress created by the abusive experience. Distress would result when the demands of the abusive situation out-weigh the survivor's available resources. An empirical examination of coping methods as applied to CSA, failed to provide support for this model. Long (1990), in a study of 600 college women, failed to find support for the goodness of fit hypothesis when examining the relationship between the type of coping mechanism employed, women's appraisal of the abuse, and the level of subsequent symptomatology of CSA survivors. It was found that survivor's coping alone was predictive of adjustment (greater amounts of emotional focused coping were associated with greater symptomatology). Appraisal of control was not associated with symptomatology either alone or in combination with coping.

Complex Post Traumatic Stress Disorder. Some scholars have come to identify the effects of CSA as very similar to the pattern of effects displayed by individuals with post traumatic stress disorder (PTSD). PTSD results from of a variety of traumatic life experiences and this disorder is characterized by mental or emotional reexperiencing of the event, extreme avoidance, numbing, and heightened arousal (American Psychological Association, 1994). Many clinicians and scholars with in the field of CSA have recognized PTSD symptomatology in survivors (Herman, 1992).

Herman (1992) posits that CSA symptomatology is deserving of its own DSM diagnosis as a "complex form of PTSD." In her opinion, characteristics of abuse are comparable to contextual characteristics of other situations known to evoke long-term trauma, such as being a prisoner of war. She, however, feels that a diagnosis of PTSD alone does not sufficiently account for the additional symptoms commonly exhibited by survivors of long-term abuse such as somatization, dissociation, affective changes, and pathological changes in relationship and identity. Specifically, her model suggests that CSA often results in feelings of extreme trauma over an extended period of time evoked by a situation over which the victim has little if any control and is unable to escape from. It is the resulting experience of "prolonged trauma" which leads to illness and maladjustment.

In a recent book chapter, Briere (1996) used a similar classification. He divided long-term abuse effects into cognitive, emotional, interpersonal, and finally PTSD-type symptomatology. Briere posits that the most traumatic cases of CSA lead to dysfunction which is characteristic of PTSD as well as maladjustment in the areas of cognition, emotion, and interpersonal relations. The composite of which, Briere concludes, may be viewed as a complex form of PTSD specific to severe and chronic CSA survivors. Briere further clarifies that the inability to adjust to post-abuse trauma leads many survivors to experience maladjustment or dysfunction later in life.

Traumagenic Dynamic Model. Finkelhor and Browne (1985) have an alternate model to explain the effects of CSA. This model relies on four factors or traumagenics to explain symptomatology. The first dynamic is Traumatic Sexualization and "refers to the

conditions in sexual abuse under which a child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways" (p. 355). Betrayal is the second dynamic and is thought to describe a child's reaction to being abused by an individual whose presence the child depends upon for survival. Feelings of betrayal may be a reaction to the perpetrator or to a non-offending close family member viewed as responsible for protecting the child from such abuse. Finkelhor's third proposed dynamic, Stigmatization, "refers to the negative messages about the self - evilness, worthlessness, shamefulness, guilt - that are communicated to the child around the experience" (p. 357) This stigma may be received from the offender of the abuse, skeptical friends or family, or societal messages in general. Powerlessness, the last dynamic, is divided into two different parts. A child may experience a sense of powerlessness initially when his/her personal boundaries and attempts to control the abusive situation are recurrently disregarded and result in no change and secondly, when fear or threat of physical harm or death are experienced during the abuse. Each dynamic is responsible for the expression of a specific range of initial and long-term effects and therefore the combination of dynamics particular to each individual's experience provides an explanation for variation in symptomatology.

Adolescent Sexuality

As reviewed, numerous theories have been posited which account for the effects of CSA on survivors of abuse. It has also been documented that survivors of CSA may experience a diverse set of problems related to sexuality (this literature will be reviewed below), thus it is important to examine how sexuality may develop in general, how the

sexual development of survivors may deviate, and specific ways in which CSA may impact this realm of development.

Models of Sexual Development

The developmental period of "adolescence" has been characterized as the time at which one enters puberty through the time at which the young person is able to accept responsibility for him/herself in several different areas (Downs, 1993). Additionally, the development of sexuality is often associated with adolescence. Adolescence is generally broken down into three stages: early adolescence (10 - 14 years), middle adolescence (15 - 17 years), and late adolescence (17 - 18 or 18 - 20 years). Within each stage are a collection of hallmark changes (Feldman & Elliot, 1990; Stevens-Simon & Reichet, 1994). The developmental changes occurring in adolescence span a variety of intrapersonal and interpersonal domains and may or may not occur concurrently.

Adolescents experience biological, emotional, cognitive, moral, and social growth, all of which exert an influence upon the development of sexuality (Irwin & Shafer, 1992; Peterson, Leffert, & Grahm, 1995). The "timing and tempo" of such changes, however, fluctuate within and between individuals (Petersen et al., 1995). A number of models propose how sexuality develops in normal, nonabused adolescents. three will be reviewed here.

Developmental Approach. A developmental approach to sexual development concentrates on maturation across a number of domains (e.g., physiological, cognitive, emotional). Graber and Brooks-Gunn (1995) review developmental models as they apply

to sexuality. Such models explain that changes in adolescence occur simultaneously. Too many changes occurring at once can exhaust resources and ability to cope as well as activate existing predispositions for problem behavior that sometimes last into adulthood.

The domain of change most easily detected and monitored is physiological or biological development. Puberty, considered the marker of early adolescence, results in both increased levels of estrogen and testosterone and the development and growth of primary and secondary sex characteristics (Miller, Christopherson, & King, 1993). The biological development of an adolescent influences sexual activity by increasing sex drive and leading to physical maturation, both which may attract potential sexual partners (Smith, 1989). Cognitive changes also occur in adolescence. Research reveals that cognitive growth enables adolescents to think more hypothetically and coherently, weigh costs and benefits, and to anticipate consequences of behavior (Bartsch, 1993; Harter, 1990). These factors may influence knowledge and decision making about dating and sexual experimentation, partner choice, contraceptive use, and reproduction (Brooks-Gunn & Furstenburg, 1989; Sandler, Watson, & Levine, 1992; Serbin & Sprafkin, 1987). Social development is another area of significant growth for the adolescent, with peers taking priority and exerting greater influence upon a young person's life (Brown, Doleini, & Leventhal, 1997). Increase in social interaction is likely to expose the adolescent to heightened opportunity for talking, joking, and learning about sex, forming intimate relationships with opposite sex peers, and experimenting sexually (Belle, 1989; Billy & Udry, 1985; Furman, 1989). Psychological and emotional changes also take place during these critical years as young people begin to pay greater attention to intrapersonal/psychological characteristics in selves and others (Harter, 1990). The

development of morals and an increase in ethically guided behavior is linked with adolescent development as well. Moral and psychological growth experienced by the adolescent provide additional ground from which the adolescent makes decisions (Bear, 1987). A developmental approach posits that a combination of these changes and other influences, such as the media (Frith & Frith, 1993), are key in predicting and explaining sexuality during adolescence are likely to be deterministic of immediate and later sexual behaviors (Peterson & Boxer, 1982; Tharinger, 1987).

A Cognitive Approach. Cognitive models concentrated on the child's or adolescent's thought patterns or understanding of sexuality (Walen & Roth, 1987). According to this model, a young person's conceptualization of sexuality is a result of an interaction between an individual's cognitive maturity and the messages received from her or his environment. For instance, a child unable to think abstractly who receives limited or incorrect information from his or her environment is likely to draw immediate, inflexible, and invalid conclusions about sexuality. Thus, successful sexual development, to some degree, is dependent upon exposure to accurate information about sexuality. Even when supplied with correct information, the child's interpretation and understanding of the material is limited by his or her developmentally determined ability to engage in higher levels of reasoning. During adolescence, one's ability to think abstractly and hypothetically increases and allows for more rational, critical thought. There are still limitations on the cognitive ability of the developing adolescent. The concept of "personal fable" refers to the adolescent propensity to view one's own sexual feelings and behaviors as unique paired with the belief that negative consequences usually

associated with specific sexual behavior will not apply to their own behavior (Walen & Roth, 1987). A second concept, "imaginary audience," refers to the adolescent assumption that the world at large holds the same opinions as does the adolescent him/herself (Walen & Roth, 1987). A combination of personal fables and imaginary audiences can be particularly harmful when beliefs about sexuality are distorted. A cognitive approach to the development of sexuality, emphasizes the impact of inaccurate cognitions, namely misattributions and misperceptions, which are theorized to result in emotional arousal and disruption of sexual development, possibly leading to deviant sexual behavior and sexual dysfunction.

A Learning Approach. The importance of learning in the acquisition of sexuality in adolescence is mentioned in several different theories. Theories differ in the ways they believe learning takes place (McConaghy, 1987). Conditioning, for instance, occurs when previously neutral (now conditioned) stimuli are paired with unconditioned stimuli (those that naturally provide the response without training). With repeated exposure, new neural connections are created in the cortex of the brain and the previously neutral then elicits a conditioned response. Child sexual abuse affects the development of sexuality when previously neutral stimuli (e.g., sexual behaviors) are paired with negative sexual experiences early in life. As a result, survivors may come to experience anxiety and aberrant thoughts, beliefs, or feelings about sexual interactions. These problematic sexual associations sometimes persist into the survivor's adult life. Operant learning may also be involved in the development of sexuality. In this case, rewarded behaviors become part of an individual's sexual repertoire, while those punished will decrease in frequency

or disappear all together. Social learning theory, when applied to the development of sexuality, indicates that learning can occur as a result of observation, instruction, or modeling. Therefore, as a child is exposed to sexual information via peers, media, or society, information is gathered and conclusions are based on what is viewed.

Adolescent Sexual Behavior

Many scholars have examined the typical sexual development of adolescents. Results of investigations suggest that sexual behavior of the adolescent is varied and that factors such as alcohol use, parental monitoring, communication with parents, parenting style, peer influences, academic success, body changes, opinions regarding pregnancy and contraception, religious values, and social and cognitive status all exert influence upon teen's sexual interactions (for review see Brooks-Gunn & Furstenberg, 1989; Sandler et al., 1992; Small & Kerns 1993). Although the examination of adolescent sexual activity other than participation in intercourse are rare (Brooks-Gunn & Furstenberg, 1989; Irwin & Shafer, 1992), one recent study asked adolescents' at what age they felt various levels of sexual behavior to be appropriate (Rosenthal & Smith, 1997). Findings suggest that teens generally expect sexual activities to follow a progression from kissing to more intimate behaviors such as touching/petting, oral sex, and sexual intercourse.

The timing and effects of sexual intercourse on a teen's life have been well investigated. A 1990 national survey conducted in the United States revealed that 37% of 15-year-old women have participated in sexual intercourse; by age 16 this figure increased to almost 50% (Leigh, Morrison, Trocki, & Temple, 1994). This survey did not differentiate voluntary forms of sexual activity from involuntary interactions. This is

noteworthy because a significant proportion of early sexual interactions may occur against the will of the adolescent (Abma, Driscoll, & Moore, 1998). A recent study of 7,699 high school students found that of the 58.9% reporting past sexual activity, almost one-fifth felt forced into having sex via either emotional or physical control by their partner (Downey & Landry, 1997).

Males generally report engaging in intercourse more frequently than females. However, when questioned about instances of intercourse in the past year, young women and young men reported similar numbers of experiences, eleven and ten instances respectively, on average (Leigh et al., 1994). A study conducted by Devine, Long, and Forehand (1993) found that adolescent females experience the greatest frequency of sexual activity from 15 through 18 years of age, and that males appear to be most active between the ages of 16 and 18. Teen sexual intercourse appears to be episodic among sexually active teens, with large spans of time occurring between periods of sexual activity (Downey & Landry, 1997).

Studies also suggest that recent generations of adolescents are engaging in sexual intercourse at younger ages than past generations (Brooks-Gunn & Paikoff, 1993). In the 1970s, studies revealed that one-third of 16-year-old girls had participated in sexual intercourse, while 1980 and 1990 figures are around 50%.

Safe-sex seems to be an issue for teens with almost 50% of both male and female teens report using condoms "sometimes" and over one-third reporting condom use "every time" they have intercourse (Leigh et al., 1994). In a study examining knowledge, attitudes, and behavior related to contraceptive use, Holmbeck, Crossman, Wandrei, and Gasiewski (1994) found that high-school and college students who scored high on

measures of cognitive development and self-esteem reported greater sexual knowledge as well as greater knowledge and use of contraceptives.

Studies find that adolescents who participate in early sexual intercourse experience a number of negative effects including, but not limited to, school problems, pregnancy, poor job prospects, sexually transmitted diseases, lower occupational status, a greater number of sexual partners, participation in unsafe sexual interactions, and increased likelihood of participating in other high-risk behaviors (Brooks-Gunn & Furstenburg, 1989; Devine, et al., 1993; Graber & Brooks-Gunn, 1995).

In order to fully understand adolescent sexuality it is necessary to look beyond participation in and frequency of sexual intercourse. As cognitive and developmental models suggest, an adolescent's perceptions or conceptualization of sexuality are likely to play a significant role in the young person's sexual decision making and sexual interactions (Holmbeck, Crossman, Wandrei, & Gasiewski, 1994; Walen & Roth, 1987). Unfortunately, no large-scale study exploring adolescents' general attitudes or perception of sexuality has been conducted in the United States since the 1970s. Some work has attempted to gather information regarding adolescents' opinions or understanding of one particular aspect or outcome of sexuality such as contraception, HIV/AIDS, or pregnancy (e.g., Van der Plight & Richard, 1994). Likewise, researchers have attempted to examine how particular traits or intrapersonal characteristics such as self-esteem, self-efficacy, and assertiveness, are related to an adolescent's sexual relations or attitudes (e.g., Zimmerman, Sprecher, Langer, & Holloway, 1995).

A longitudinal, Australian study by Buzwall and Rosenthal (1996), examined a sample of 470 high school students and identified separate "sexual styles" believed to be

representative of a teen's sexual self and predictive of adolescent sexual behavior. Each style was constructed from responses to self-report measures of self-esteem, self-efficacy, and sexual self-image. Current sexual interactions were also examined. Five styles emerged and were grouped as: sexually naïve, sexually unassured, sexually competent, sexually adventurous, and sexually driven. Each group was characterized by specific levels of the aforementioned variables and adolescents within were similar with regard to sexual experience. The first cluster, Sexually Naïve (N = 120), consists of students with a low sexual self-esteem, very low sexual self-efficacy, high ability to say "no" to unwanted sex, high sexual commitment, high sexual anxiety, and the lowest levels of arousal and sexual exploration. Sexually Unassured (N = 81), the second style, is characterized by particularly low sexual self-esteem and self-efficacy scores, little ability to state their sexual desires, and little ability to say "no" to unwanted interaction. This group reports moderate levels of sexual commitment, arousal, and exploration and much sexual anxiety. The majority of youth in these two groups were virgins. The third cluster was named Sexually Competent (N = 131) and included teens with high sexual self-esteem and self-efficacy scores, high sexual competence and control, and moderate commitment and sexual anxiety. The Sexually Adventurous group (N = 74) consisted of teens with high sexual self-esteem and sexual self-efficacy, low commitment and low sexual anxiety. The majority of students in the Sexually Competent and Sexually Adventurous group had at least some sexual experience. The smallest group, Sexually Driven (N = 39), represented a collection of youth with the highest sexual self-esteem, moderate levels of self-efficacy (despite markedly low perceived ability to say no), and the lowest scores on sexual commitment and sexual anxiety. This group was also

characterized by the highest amount of sexual arousal and level of sexual experience. Sexual risk-taking was examined for each style and the Sexually Naïve cluster was found to engage in significantly less sexually risky behavior than the Competent, Adventurous, and Driven groups. Further, significantly more regular risk-taking activity was found in the Sexually Competent and Sexually Driven group as compared to the Sexually Unassured group. These results suggest that adolescents' sexual perceptions, competencies, and behavior are related. Whether perceptions predict behavior or vice versa remains to be determined, although these authors speculate that the former can estimate the latter.

Taris and Semin (1995) conducted a longitudinal study in hopes of clarifying the direction of the relationship between adolescents' sexual behavior and attitudes. This study collected data regarding sexual permissiveness, dating habits, knowledge of partners' sexual history, and assertiveness scores of 15 - 18-year-old participants on two different occasions over a period of one year. The participants in this study were divided into three groups: virgins, non-virgins, and teens who experienced sexual intercourse for the first time between data collection one and collection two. Results show that all three groups experienced a significant change in attitude over time, with an increase in both permissive attitudes and assertiveness, but that the sexually inexperienced group of adolescents changed the most. These authors thus speculate that the passage of time and accompanying change in attitudes maybe predictive of future sexual behavior, rather than behavior leading to a change in sexual attitudes. Another study, examining the precursors of "casual sex" revealed that positive attitudes about sex (e.g., perceived physical pleasure and physical relaxation) were predictive of greater activity. A perceived sense of

deprivation when not engaging in sex also led to greater sexual activity in young women (Levinson, Jaccard, & Beamer, 1995).

Another study (Zimmerman, et al., 1995) attempted to identify variables affecting an adolescent's ability to say no to sexual pressure from a partner. Personality factors, educational goals, sexual worries, permissiveness and level of experience, family background, and perceived peer influence were examined. Self-efficacy and worry regarding negative outcomes of sexual intercourse were the only two significant predictors of sexual activity identified for females. Disturbingly, this study found that 19% of 10th grade students ($\underline{N}$ = 2,472) believed that they were definitely, probably, or possibly unable to say "no" to an unwanted sexual advance by a partner.

A recent study (Rosenthal, Burklow, Lewis, Succop, & Biro, 1997) examined romantic adolescent dating relationships and found that girls who had engaged in sexual intercourse were more likely to share intimate information with their boyfriends, spend significantly more time outside of school with their boyfriends, and believe that they would remain in their current relationships longer than did a comparable group of sexually inexperienced girls. Interestingly, no difference in relationship satisfaction was found between the two groups. This study also noted that of those sexually experienced girls, over 80% reported that they now felt that they were too young when they first participated in sexual intercourse. The most common reasons for participation included physical attraction, curiosity, being alone with their partner, and considerate treatment from their partner.

Distribution of a survey investigating the attitudes and beliefs of adolescents in the 1980s reveals similar reasons to participate in sexual intercourse (Juhasz, Kaufman,

& Meyer, 1986). Those reasons most often endorsed included feelings of love or attraction toward their partner, wanting to please their partner, and curiosity. Further findings show that 57% of the young women in this survey endorsed a belief that teens experience pressure to engage in sexual interactions, regardless of the respondent's attitude about sexuality (Juhasz et al., 1986).

One article explored attitudes of young people in an effort to support a hypothesized model of precursors to adolescent sexuality. Kalof (1995) hypothesized that a young person's sense of power and related sense of dependency would both directly and indirectly effect the frequency with which they had sexual intercourse. A direct effect was found for attitudes regarding gender roles with more egalitarian attitudes predicting lower rates of sexual interaction for black and white males and black females, but not significantly predicting sexual activity in white females. This study also suggests that physical desire plays a significant role in most teen's participation in unwanted sexual interactions and that a low physical self-image decreases the likelihood of coercion and actual participation in sexual intercourse. An additional interesting finding, was that less popular white, female adolescents were more likely than their popular counterparts to use sexual intercourse as a means of emotional gratification. Similarly, popular black females, when compared to unpopular peers, had lower rates of sexual intercourse due to less need for opportunity to self-disclose and closeness.

Sexuality in Survivors of Child Sexual Abuse

A number of variables have been found to affect an adolescent's sexual development and subsequent sexual attitudes and behaviors. It is likely then that an event

such as CSA impacts the development of a child in various ways and therefore exerts influence upon the sexuality of survivors. Specific sexual symptomatology will be reviewed following theories as to why such effects might be expected.

Theories of Sexuality in Survivors of Child Sexual Abuse

As previously noted in this paper, many theories have been posited which explain the negative consequences often experienced by survivors of CSA. Most theories are general in their explication, although a few attempt to account directly for particular symptomatology. Several theories have been set forth to explain sexual differences in survivors. Unfortunately, little empirical research of the sexual sequlea of CSA has been conducted to confirm these theories and, hence, many of the following explanations are based on little specific research and sometimes speculation alone (Tharinger, 1990).

Theories that strive to account for problematic sexual behaviors and attitudes often address the way in which sexuality has been effected by CSA. It is suspected that the sexual development of survivors will be deviant from the development of nonvictims and, as a result of abuse, survivors will experience more sexual difficulties (Tharinger, 1990). In her review paper, Tharinger (1990) presents four of the most common explanations for development of sexual difficulties in survivors of sexual abuse. These include a developmental approach, psychoanalytic perspective, social learning theory, including learning perspectives and cognitive perspectives and Finkelhor's Traumagenic Dynamic Model. These and one additional theory, a life course perspective, will be reviewed.

Developmental Approaches. The thesis of the developmental approach to adolescent sexuality focuses on progression through a series of developmental stages. During each stage a young person resolves relevant issues. Child sexual abuse is thought to cause immediate consequences by disrupting the survivor's current stage of development, leading to problems in subsequent stages of development, and persistent problems in functioning (e.g., Trickett & Putman, 1993). According to this framework, the experience of sexual behavior with an adult during childhood interferes with the normal progression of sexual development by skewing associated cognitions, emotions, and morals. This results in a variety of symptomatology often displayed in survivors such as fear and anxiety (Tharinger, 1990). Unfortunately, developmental approaches do not specify how it is that this interference occurs.

Psychodynamic Theories. Psychodynamic theories account for survivors' problematic development of sexuality by focusing upon the confusion which results from the presence of physiological pleasure or arousal despite the understanding that the sexual act is wrong. Some theorists further speculate that survivors fail to experience the latency stage of psychosexual development, which is the phase during which children usually learn to initiate non-sexual interactions and relationships with peers (Tharinger, 1990). It is anxiety resulting from failure to meet these tasks specific to developmental stages that leads to symptomatology in general, and specifically to problems associated with sexuality.

Life Course Perspective. Anecdotally, it has been proposed that survivors of CSA respond to sexuality later in life in one of two ways, namely by avoiding sexual

interaction or by engaging in a pattern of promiscuous sexual interaction (Tharinger, 1990). The life course perspective disregards this presumption and considers the effects of CSA on future sexual interactions to occur in a unidirectional manner. Specifically, this model posits that CSA will lead to an increase in frequency of sexual interactions for survivors. The focal point of this perspective is the impact of adult-child sexual interaction on later sexual activity. This theory recognizes other effects of abuse (e.g., emotional, psychological, and other interpersonal responses) only to the extent that they are a result of indiscriminate and/or unhealthy sexual practices in adolescence and adulthood.

The life course perspective is consistent with Browning and Laumann's (1987) description of "sexual scripts" which are adopted as a result of CSA experiences and serve as a model or representation of the child's conceptualization of sexuality in general. Childhood sexual abuse, relatedly, is thought to lead to "eroticization of the child" and to introduce a "sexual trajectory," both believed to "include the transition to coupled sexual activity in adolescence, teen childbirth, the number of sexual partners in adulthood, and the occurrence of harmful events associated with sexually active careers such as sexually transmitted infections and forced sexual experiences" (p. 543). Predictions based on this sexual transition and trajectory include many facets of problems for survivors of abuse such as earlier age for initiation of sexual intercourse, less likelihood of declining sexual invitations, and an overall greater interest in sexual interactions (for review see Wyatt, 1991). The extent of maladjustment in adulthood is positively related to the amount of reinforcement of the initially acquired sexual script by subsequent experiences. Unfortunately, this model does not explicitly account for those survivors who have

generalized negative feelings toward sexuality and thus avoid sexual interaction all together.

Learning Perspectives. Learning paradigms can also be applied to, and account for, problems survivors have related to sexuality. Social learning approaches focus on the teaching (direct or indirect) role of the perpetrator. In opposition to nonvictimized children, who learn about sexuality progressively and through various mediums, the knowledge and understanding of sexuality by survivors is often based upon the information they receive from the offending adult (Maltz & Holman, 1987; Tharinger, 1990). As noted by Maltz and Holman (1987), this teaching often results in misperceptions regarding sexual topics such as submissiveness, the male sex drive, and gender roles. These invalid beliefs may lead a survivor to be sexual when she desires love or affection and may lead to self-exploitation.

Classical conditioning can also result in problems for the survivors of CSA. This occurs when specific stimuli, once associated with the survivors' abusive experience, remain aversive to the survivor even after the abuse has ended. For instance, a survivor may have an anxious response to the intimate touch of her spouse because, via her sexual abuse experience, she associates all sexual interactions with negative feelings. Operant conditioning in the form of reward and punishment by the abuser may also serve to shape a particular behavior which continues to persist beyond the abusive experience.

Cognitive Perspective. A cognitive explanation of CSA symptoms focuses on distorted beliefs or cognitions a survivor holds concerning the abuse itself or her role in the abuse. Oftentimes, these cognitive distortions consist of self-blame for the initiation

or continuation of the abuse or more general negative self-attributions (Downs, 1993; Finkelhor & Brown, 1988; Maltz & Holman, 1987). These would include ideas that a victim of abuse actually seduced the perpetrator or encouraged them by not reporting the experience, or low self-worth characterized by feeling stupid, dirty, or worthless. If these beliefs persist following the termination of the abuse they may lead to feelings of stigmatization and negative feelings toward, or conceptualization of, sexual interactions. One study exemplifies this theory with a conclusion that survivors are likely to refer to themselves as promiscuous even when their actual level of sexual activity does not significantly differ from nonabused women (Fromuth, 1986).

Finkelhor's Traumagenic Dynamic Model. The dynamic of Traumatic Sexualization is designed to account for sexual behavior displayed at an early age, misconceptions about sexuality, sexual fetishes, the manipulative use of sex, and fearful and other aversive emotional responses linked to sexuality. It is concluded that appropriate development of sexuality is hindered by (1) rewards provided to the child for inappropriate sexual behavior at the time of abuse, (2) realization, on the part of the child survivor, that sexuality can be used to obtain unrelated desires or needs, (3) increased attention a child receives based on the use of certain body parts such as genitalia, (4) distorted beliefs about sexual behavior and morals based on information provided by the perpetrator, and (5) the association of painful memories of abuse with subsequent sexual interaction (Finkelhor, 1988).

Sexual Development of the Survivor of Child Sexual Abuse

Empirical investigation into the sexual adjustment of adolescent and young adult survivors lends credence to theories that assume abuse has deleterious effects on sexuality over time. The overwhelming conclusion reached across studies is that teens with a sexual abuse history are more likely than their nonabused peers to engage in a variety of risky sexual behaviors. For instance, the majority of research posits that teen survivors engage in voluntary intercourse at a younger age than nonabused counterparts (Fergusson, Horwood, & Lynskey, 1997; Miller, Monson, & Norton, 1995; Stock, Bell, Boyer, & Connell, 1997; Evanston, Fiscella, Kitzman, Cole, Sidora, & Olds, 1998).

Specifically, five of six empirical studies reviewed found adolescent/young adult survivors to engage in sexual intercourse at an earlier age than nonabused peers. The first of these studies was longitudinal in nature and tracked 520 New Zealand children from birth until age 18 (Fergusson, 1997). Measures of sexual behavior were repeatedly administered to this cohort from age 14 to age 18. At the age of 18, the young women were comprehensively interviewed for a history of mental disorders and CSA and classified into one of four groups: (1) no history of CSA, (2) a history of noncontact CSA only, (3) a history of CSA involving contact but not attempted or completed intercourse, and (4) a history of CSA including attempted or completed intercourse. Chi square analyses were conducted to reveal differences in sexual behaviors among the four groups. Those who experienced abuse involving intercourse were over twice as likely (72.4%) as those with no history of abuse (28.4) to have had voluntary sex at or before age 15.

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Additional studies support such findings. One study determined abuse status in a group of over 3000 female high school students via a questionnaire which asked students whether or not they had been touched in a sexual way when they did not want to be touched or had something sexually done to them which should not have been done (Stock et al., 1997). This study revealed that 10% of the sample had experienced sexual abuse and that these survivors were 3.5 times more likely to have engaged in intercourse at the time of the study. A detriment of this study, however, was failure to differentiate intercourse experienced within the context of abuse from later voluntary intercourse.

Another study surveyed 441 young adult women (age 18 - 22) and defined abuse status by a positive response to "Have you ever been forced against your will to have sex or been raped?" (Miller, 1987). Women answering this question positively were found to have experienced voluntary sexual intercourse for the first time at a significantly younger age than women who did not endorse this item. Alexander and Luper (1987) used a sample of 586 college undergraduate women (mean age of 23) to examine the effects of father-daughter incest versus CSA history with someone outside of the survivor's family. A history of abuse, regardless of relationship between perpetrator and victim, was related to an earlier initiation and increased frequency of voluntary intercourse. To the surprise of the authors, this study failed to reveal differences in sexual functioning or satisfaction between the two abused groups of women and between these abused groups and a comparison group of nonabused peers. Lastly, an examination of young, pregnant African American women found a relationship between CSA and an earlier age at first voluntary intercourse and a younger age of first pregnancy (Evanston, Fiscella, Kitzman, Cole, Sidora, & Olds, 1998).

Discrepant findings do exist however. Employing a sample of 383 young women, Fromuth (1986) failed to replicate such findings with a college sample. In her study, a history of CSA was determined by an extensive questionnaire. Abuse status was found to be related to having experienced consensual intercourse only when parental supportiveness was not controlled for. Hence, in this study, a young adult's relationship with her parents was more predictive of consensual sexual activity than was a history of CSA. Noteworthy, though, is the inclusion of items screening for physical abuse and neglect on the measure of parental supportiveness used in this study which may suggest that it is not simply a lack of support, but rather an abusive or neglectful relationship with parents that increase the likelihood of participation in consensual sexual intercourse. This study differs from the aforementioned studies in that information gathered about consensual sex did not include the precise age at which voluntary intercourse first occurred, rather it simply asked whether or not the respondent had *ever* engaged in voluntary sexual intercourse. Taking this into account, an attempt to differentiate survivors from nonvictims on the basis of ever having experienced voluntary sexual intercourse may fail due to the high percentage of college aged women who have been sexually active in the past.

Early sexual experimentation is considered noteworthy because its strong correlation with participation in other high-risk, problematic behaviors such as substance use, decreased use of contraceptives, sexually transmitted disease, pregnancy, and revictimization (Abma, Driscoll, & Moore, 1998; Jessor, 1992). Additionally, one study found, via retrospective reports of both abused and nonabused women, that the younger a

woman was at the time of her first voluntary intercourse the less desired or wanted was her experience (Abma, Driscoll, & Moore, 1998).

Consistent with theory, adolescent abuse survivors also appear to engage in more sexual behavior than other, nonabused teens. Four studies employing adolescent community samples examined this (Fergusson, et al., 1997; Luster & Small, 1997; Krahe, Scheinberger-Olwig, Waizenhoper, & Kolpin, 1999; Stock et al., 1997). Two studies found CSA survivors clearly reported having significantly more sexual partners than non-abused counterparts (Fergusson, 1997; Krahe, Scheinberger-Olwig, Waizenhoper, & Kolpin, 1999), while the another failed to replicate this finding (Fromuth, 1986). Fergusson et al., (1997) found significant differences between groups based on number of sexual partners. Participants were asked to report their exact number of partners once per year at ages 14, 15, and 16. Young women who had six or more sexual partners by the age of 16 were classified as "having multiple sexual partners" and, on this basis, survivors were found to be significantly more likely to have multiple partners than were peers with no history of abuse. A study conducted with German adolescents age 17 to 20, found that young women with a history of CSA had greater number of partners in participation in a variety of voluntary sexual behavior including vaginal intercourse (Krahe et al., 1998). Another study, conducted by Luster and Small (1997), found differences between survivors and nonvictims but also found family variables to better predict number of partners than abuse history alone.

Survivors in Fromuth's study did not report a greater number of sexual partners. They did, however, report a greater number of noncoital experiences in the past month. This study may have failed to find a difference because of the lack of specificity in

questions asked of participants in Fromuth's study. For example, in her study participants were asked if they (1) had sexual intercourse with one or two partners or (2) had sexual intercourse with more than 10 partners. Thus, respondents were unable to report any number of partners falling between 2 and 10.

Teen pregnancy is another issue commonly investigated in studies employing adolescent survivors of CSA. One study, with a sample of over 3,000 eighth through twelfth grade students, revealed that survivors were twice as likely as same aged nonabused students to have engaged in sexual intercourse and were three times as likely to have become pregnant (Stock et al., 1997). When sexually active survivors were compared only to sexually active nonabused peers, however, no differences were found in rates of pregnancy (Stock et al., 1997) suggesting that a history of abuse may be more of a risk factor for early intercourse leading to increased risk of pregnancy.

Similar findings came from a longitudinal study employing 520 girls from birth to age 18. This study also examined rates of pregnancy and revealed that survivors aged 14- to 18-years whose abuse specifically involved intercourse were especially likely to have been pregnant when compared to young women without a history of abuse (in no case were these pregnancies a result of the abusive experience) (Fergusson et al., 1997). Another study found number of births to sexually abused mothers aged 12- to 42-years to be significantly higher than the number of births to nonabused moms (Herman-Giddens et al., 1998). Once again, scholars have explained this increased birth rate as a result of the earlier age at which these women began to engage in intercourse in combination with lower rates of contraceptive use (Stock et al., 1997).

When compared to the general adolescent population, contraceptive use among CSA survivors appears to be deficient (Ferguson et al., 1997; Stock et al., 1997). Contraceptive use was investigated in two studies employing survivors of CSA both of which support a correlation between a history of CSA and less-protected sexual behavior. Specifically, Fergusson (1997) examined instances of unprotected sexual intercourse and rates of sexually transmitted disease. Results suggest that survivors experiencing contact abuse including intercourse and those experiencing contact abuse not including intercourse are most likely to have engaged in unprotected voluntary intercourse by the age of 18. Additionally, those young women who experienced intercourse during CSA were more likely than women with no history of abuse and those experiencing noncontact abuse only to have ever been diagnosed with a venereal disease. In another study, female adolescent psychiatric inpatients with a history of CSA reported less self-efficacy than did peers for condom use, and displayed more difficulty verbalizing sexual information when participating in role-play activities about sexual decision making (Brown, Kessel, Lourie, Ford, & Lipsitt, 1997).

It is not unusual for studies comparing sexual attitudes of young adult survivors and nonvictimized peers to reveal significant differences between the two groups. Inconsistencies in the type of attitude investigated, however, makes generalization or even comparison between studies difficult. Two studies will be addressed. Orr and Downs (1985) conducted a study examining the self-concept of sexually abused adolescent survivors as compared to medically ill, nonsexually abused adolescents. Scores on the Offer Self-Concept Scale, which includes a subscale of "sexual attitudes," were compared across the two groups. While the two groups did not significantly differ

on this subscale, the survivors scores fell within the clinical range. Neither a description of the sexual attitude portion of the scale nor representative items are provided by the authors. It is noted, however, that survivors' lower scores are reflective of "more negative attitudes toward sexuality and sexual behavior." Unfortunately, this conclusion is quite general. A second study, employing a large sample of college students, examined "sexual adjustment" of survivors (Fromuth, 1986). Results of this study indicated that young women with a history of abuse labeled themselves as "promiscuous" more often than did peers who had engaged in similar types/rates of sexual behavior.

Several adverse effects of CSA upon sexual experiences with adult survivors have also been empirically validated. Sometimes sexual difficulties experienced by survivors are manifested as clinical disorders such as vaginismus, arousal and orgasmic disorders, and dyspareunia. One study examining the presence of psychopathology in community women found that women who had not experienced sexual abuse prior to the age of 18 met diagnostic criteria for sexual dysfunction less often than did women who had experienced CSA (Saunders et al., 1992). In their community study, Jackson, Calhoun, Amick, Maddever, and Habif (1990) found sixty-five percent of incest survivors met criteria for at least one diagnosable sexual disorder; 50% endorsed inhibited sexual desire, 45% reported inhibited orgasm, and 35% reported inhibited sexual excitement.

Adult survivors of CSA have also been found to present with a variety of sexual difficulties that do not meet criteria for diagnosis but do have serious negative effects on their lives. Gold (1986) identified "sexual maladjustment" in adult female survivors. Maladjustment in this study was defined as lower sexual responsiveness to positive sexual interactions as well as lower sexual satisfaction in general. A large telephone

survey conducted in 1985 found that both male and female survivors over the age of 18 reported lower satisfaction in current heterosexual relations than non-abused survey respondents (Finkelhor, Hotaling, Lewis, & Smith, 1989). This finding was found to be especially significant for groups of older adult women (age 40-49 and over 60). Sexual abuse involving intercourse was found to be especially predictive of dissatisfaction.

One study investigating these topics with college women (Fromuth, 1986) failed to support such a relationship. Level of sexual adjustment and desire was obtained via self-report and survivors were found not to differ from nonabused individuals on levels of sexual self-esteem, sexual adjustment, and sexual desire. In this study, differences in sexual desire were determined by simply comparing women who reported "a lack of sexual desire" to those who did not. Respondents were not asked to more objectively rate their level of sexual desire (e.g., given an operationalized definition of desire or allowed to provide relative ratings on a likert scale).

Studies of clinical samples yield similar results. Tsai, Feldman-Summers, and Edgar (1979) compared the symptomatology of three groups of adult women: (1) survivors seeking clinical treatment for CSA (2) survivors of CSA who had never sought professional help, and (3) women who had not experienced CSA. They found that the survivors seeking treatment reported fewer orgasms during intercourse, more sexual partners, and less satisfaction and responsiveness in current sexual relationships than did either of the two comparison groups. It is interesting to note that although survivors seeking treatment are experiencing relatively less enjoyment and fulfillment in sexual interactions, they continue to engage in sexual intercourse at a significantly higher frequency than the groups of less distressed survivors and nonvictims.

Some studies investigating survivors' perceptions of their own sexuality reveal a tendency of CSA survivors to harbor cognitive and emotional distortions regarding sexuality resulting in sexual guilt, sexual anxiety, and low sexual self-esteem. Via newspaper advertisements, one study recruited 37 women who had been sexually assaulted in adulthood (Mackey et al., 1991). This study divided the women into 3 groups regarding prior history of sexual assault (CSA only, prior adult assault only, no prior assault) and examined current sexual functioning. Only those women with a history of CSA reported orgasmic dysfunction and guilt. These women provided a greater number of responses when asked if anything was necessary for intercourse to be pleasurable (e.g., an emotional bond with partner) and endorsed more intercourse related fears (e.g., losing/pushing away a sexual partner, inability to choose a "safe man") when compared to the other two groups. This study also conducted a qualitative analysis of commonly reported themes related to sexual dysfunction. These included mistrust/fear, decreased satisfaction/pleasure, flashbacks, decreased sexual frequency, obligatory sex, anger, decreased desire/avoidance, emotional detachment, orgasmic dysfunction, anxiety, and guilt. Herman (1981), based on clinical experience and surveys of adult incest survivors, has paid particular attention to cognitive distortions and related sexual problems resulting from a sexual relationship with a family member. She reports that incest survivors actually begin to expect sexual abuse in intimate relationships as well as disappointment in partnered sexual interactions with men. Related to these distorted expectations, she states that it is not uncommon for incest survivors to experience impairment in sexual enjoyment.

Dating interactions also appear to be effected by a history of CSA. An empirical study by Jackson et al. (1990) examined interpersonal and sexual functioning in a small number of incest survivors and matched controls. Employing a subscale from a general measure of social adjustment, women with a history of incestual CSA had poorer social adjustment in dating situations than did matched controls.

Summary. Several theories of sexual development support a relationship between a young person's thoughts, feelings, and sexual behaviors. Childhood sexual abuse is an event likely to affect this development. Survivors may thus develop a sexual repertoire of attitudes, feelings, and behaviors different from young people with no history of abuse. Recently, a few studies have begun to explore the influence of CSA on sexual development. This area of research, though, is still relatively young. The topics which have been addressed lack detail, and results are often inconsistent. Many relevant topics have not been examined at all.

Purpose of this Study

This study was designed to further what is known about the sexual behavior of young adult survivors of sexual abuse and improve upon past studies in several ways. First, a large sample of female college students ranging in age from 18-20 years was employed. Inclusion of women in this age group made the period of interest, late adolescence/early adulthood, well defined. History of CSA was assessed allowing for identification of survivors and women with no abuse history. Many previous studies investigating the effects of abuse on adolescents have studied only survivors of abuse

without appropriate comparison groups. Differences in perceptions of sexuality and specific aspects of sexual functioning of between survivors and nonvictimized peers has therefore remained unaddressed.

An additional improvement was the manner in which a history of CSA was determined. Responses to a comprehensive questionnaire, including multiple questions regarding abuse history, with known reliability was used. Many previous studies have used a single question (e.g., Has anyone ever touched you in a sexual way against your will?) or have asked participants to self-define abuse (e.g., Were you sexually abused as a child?). Screening for an abuse history in a more comprehensive manner allows for the identification specific abuse characteristics (e.g., duration and severity of abuse) and allows for identification of young women who have not yet labeled their history as abusive. Additionally, this study differentiates between forced and voluntary sexual behavior so that conclusions regarding CSA may be more clearly drawn.

Items designed to gather specific information about voluntary sexual activity subsequent to the abuse (e.g., an exact number of sexual partners) was another benefit of this study. Information about voluntary sexual behavior was obtained via multiple questions that allowed participants to supply information specific to their experiences, rather than requiring a choice from limited response options. Additionally, a variety of measures were administered to examine sexual attitudes and sexual functioning of survivors. This is an improvement over past studies that have examined a single aspect of adolescent sexuality (e.g., assertiveness) oftentimes with a small number of items designed to answer a specific question.

The aims of this study were twofold. First, this study attempted to replicate previous findings on the sexual behavior of abused adolescents (which are fairly consistent within the literature) regarding age of onset of voluntary sexual behavior, number of partners, and contraceptive use. It was hypothesized that survivors would report, on average, an earlier age of initiation of voluntary intercourse, a higher number of sexual partners, and less contraceptive use.

The second goal of this study was to examine sexual functioning across five different domains: attitudes reflecting acceptance of sexuality, sexual assertiveness, sexual self-esteem, fear of intimacy, and sexual decision making. With regards to participants' attitudes towards sexual behavior, it was hypothesized that survivors, when compared to nonvictims, would exhibit more acceptance for the participation of "others" in sexual activity and less acceptance for their own participation in the same sexual behaviors. It was additionally hypothesized that CSA survivors would report less assertion and lower sexual self-esteem as compared to nonvictims. This project also investigated adolescents' level of comfort in intimate romantic relationships. It was hypothesized that survivors would report greater anxiety with intimacy as compared to nonvictims. Finally, exploratory analyses were conducted to examine differences between survivors and nonvictims in the factors considered when making decisions about participation in sexual intercourse.

CHAPTER III

METHOD

Participants

A sample of 480 young women between the ages of 18 and 20 years were recruited from introductory psychology classes for a study examining life experiences. Class credit was provided for participation in the study. Participants reported a mean age of 18.71 years (SD = 0.72). Of these women, 98.4% had never been married, 0.2% were currently married, 1.1% were cohabitating, and 0.2% were divorced or separated. The majority of the sample described their race as Caucasian (88.1%), whereas 3.8% were Native American, 2.3% Hispanic, 2.1% African American, 1.5% Asian, and 2.1% biracial. Socioeconomic status of the sample, as determined by the two factor index of social position (Meyers & Bean, 1968), ranged from lower to upper class, with the average participant falling in the middle class. The majority of the sample, 74.6%, described their religious affiliation as Protestant; 12.4% identified as Catholic, 8.9% nonaffiliated, 0.2% Jewish, and 3.9 % other affiliations such as Jehovah's Witness, Morman, Quaker, Islamic, and agnostic.

For the purpose of this study, CSA was screened with a series of eight questions (included in the Life Experiences Questionnaire, see description below) asking participants whether or not as a child (prior to age 17) they had any sexual experience,

ranging from someone exposing themselves to the participant to having engaged in intercourse with someone. Participants were instructed to exclude any voluntary sexual activities between themselves and a dating partner and any consensual sexual play with a peer as long as the partner, in either case, was no more than five years older than the participant. Information regarding specific sexual experiences was then assessed. CSA was defined as contact abuse meeting at least one of the following criteria: (1) abuse by a family member, (2) an age difference of five or more years between the victim and the perpetrator, or (3) the use of threat or force by the perpetrator.

Of the 480 participants, 62 women (12.92 %) were identified as having had at least one experience of childhood sexual abuse. Due to incomplete questionnaire data, victimization status could not be determined for 11 participants. These women were excluded from additional analyses leaving a total sample of 469. Comparisons of survivors and nonvictims on demographic variables revealed no significant differences with regard to race $\chi 2$ (5, N=469) = 3.13, ns, marital status $\chi 2$ (1, N=447) = 1.40, ns, socioeconomic status, t (415) = 1.05, ns, or age, t (467)= 0.61, ns.

Of the 62 CSA survivors in the study, 53.2% reported abuse by a relative (intrafamilial), whereas 46.8% reported extrafamilial abuse. With regard to nature of abuse, 21.0% reported vaginal or anal intercourse, 11.3% reported penetration of vagina or anus by objects, 12.9% reported oral-genital contact, 38.7% reported genital fondling, 12.9% reported non-genital fondling, and 3.2% reported kissing. (Note. Women were classified according to the most severe level of contact experienced, so percentages add to 100). When asked to indicate the length of abuse, 36.1% of survivors reported experiences lasting over 6 months, 9.8% reported abuse lasting between 1 and 6 months,

and 54.1% reported abuse lasting less than 1 month. Just under half of survivors, 48.3%, reported that the perpetrator used threat or physical force to engage them in sexual activity, whereas 51.7% did not.

Measures

Life Experiences Questionnaire (LEQ). The LEQ is a revised version of the Past Experiences Questionnaire (PEQ; Messner et al., 1988), with demonstrated reliability (Long, 2000). It is a self-report instrument with questions regarding demographics and childhood sexual experiences (see Appendix A). Internal consistency for the eight questions used to screen for CSA in the LEQ was calculated with a sample of 648 women and is good, Chronbach's alpha is 0.89 (Messman-Moore & Long, 2000). Two-week test-retest reliability of the LEQ has been examined previously with a sample of 145 women and is good (Long, 2000). Kappas and percent agreement on items related to the identity of perpetrator (intrafamilial versus extrafamilial, 0.86, 94%), duration of abuse (less than or greater than 1 year, 1.0, 100%), the nature of the sexual abuse (penetration versus no penetration, 0.91, 97%), and presence or absence of force (0.39, 69%) all indicate a reliable scale. Similar results are seen in interclass correlation coefficients for items such as the age of onset of abuse (0.99), the age of the perpetrator (0.96), and the age difference between victim and perpetrator (0.95).

Sexual Attitudes for Self and Others (SASO). The SASO (Story, 1979) is a self-report questionnaire designed to assess an individual's feelings about different types of sexual behaviors. The scale is comprised of twelve questions, each of which is answered

twice (see Appendix B). The respondent is first asked about her own participation in the identified behaviors and then asked to indicate how she feels about others engaging in the same behavior. Items are rated on a likert scale ranging from 1 (I feel *great* about it) to 4 (I feel *repulsed* by it). (Note. Ratings used in this study were not standard. Only 4 choice options were provided as opposed to the typical 5.) Sum scores are calculated for "self" and "other" with lower scores reflecting more accepting attitudes towards the sexual behaviors. Scores could range from 12 - 48 for each scale. Examples of sexual behaviors included in this questionnaire are self-stimulation, oral-genital contact, intercourse, and participation in homosexual activities.

Pilot testing of the SASO revealed a 0.90 test/retest reliability coefficient over a period of two weeks (Story, 1979). Additional support for reliability was found employing 251 college students (Davis, Yarber, Bauserman, Schreer, & Davis, 1998). The Spearman-Brown formula reliability coefficients, which are used to determine internal consistency for scales with a small number of items, were 0.71 and 0.70 for the self and other scales, respectively. These relatively deflated coefficients are acknowledged by the author and are hypothesized to be a function of the small number of items included on each scale as well as the narrow range of possible scores. Internal consistency for the self and other subscales was also examined in the present sample (N=452) and was good, Cronbach's alpha 0.85 and 0.89, respectively. Two-week test-retest was examined with a subset of the sample (N=104) and was also good. Pearson's reliability coefficients were 0.86 for self and 0.83 for other.

The Sexual Decision Making Scale. The Sexual Decision Making Scale is a self-report instrument designed to assess the factors associated with decisions to have (or not to have) sexual intercourse. This instrument includes 20 items from the Perceived Costs and Benefits Scale (Small, Silverberg, & Kerns, 1993), which was designed to assess the costs and benefits of sexual intercourse as perceived by a young adult (see Appendix C). Additional items were generated through a literature review and consultation with others and have been included in the current instrument to reflect a wider range of reasons affecting an adolescent's decision to participate in sexual intercourse. The current measure contains a total of 31 possible reasons to engage in sexual intercourse and 25 reasons associated with a decision to not engage in sexual intercourse. Likert scale responses for each item range from 0 (did not influence) to 3 (strongly influence). Participants are asked to complete the set of 31 items twice to assess reasons that influenced their decision to engage in sexual intercourse for the first time (1) and reasons that influenced their decisions to engage in sexual intercourse most recently (2). Participants completed the set of 25 items twice to assess reasons that influenced their decision to not engage in sexual intercourse the first time they had an opportunity to do so (3) and reasons that influenced their most recent decisions to decline an opportunity to engage in sexual intercourse (4).

In order to identify the various reasons individuals choose to engage (or not engage) in sexual intercourse, participants' ratings on the various items were subjected to factor analysis using the principal components method with varimax rotation. A total of four factor analyses were conducted on participants' responses indicating the: (1) reasons participants engaged in sexual intercourse the first time (2) reasons they engaged most

recently, (3) reasons that influenced their decision not to have sexual intercourse the first time, and (4) reasons that influenced their most recent decision to not have sexual intercourse.

Inspection of eigenvalues suggested that participants' decisions to engage in sexual intercourse for the first time were best explained by seven factors. The rotated factor pattern, with each sexual-decision-making-reason's loading on the seven factors, is reported in Table D1 (see Appendix D). Items indicating that participants decided to engage in sexual intercourse to keep or improve a relationship with a partner showed substantial loadings (>.50) on the first factor. Reasons reflecting a desire to fit in or gain popularity loaded substantially on the second factor. Reasons consistent with feeling ready to engage in intercourse and having found the right partner loaded most highly on the third factor. Reasons reflecting a dislike for self and a desire to improve self-image loaded substantially on the fourth factor. Reasons that loaded substantially on the fifth factor indicated curiosity. Reasons suggesting that the respondent felt like a bad person showed substantial loadings on the sixth factor. The seventh factor indicated a desire to get pregnant. The seven factors together accounted for 19.36% of the variance after rotation.

Internal consistency for the seven factors was examined in the present sample and was good. Cronbach's alphas ranged from .75 - .92. Two week test-retest reliability was examined with a subset of the sample (n=104) and Pearson's reliability coefficients ranged from .03 - .85. Low test-retest reliability for the sixth factor is likely due to the small number of item (n=2) in that factor. See Table D1 (see Appendix D) for internal consistency coefficients and test-retest reliability coefficients for each factor.

Inspection of eigenvalues suggested that eight factors best explained the reasons that influenced participants' most recent decisions to engage in sexual intercourse. The rotated factor pattern, with each sexual-decision-making-reason's loading on the eight factors, is reported in Table D2 (see Appendix D). Reasons indicating that the respondent felt ready to have sexual intercourse and had found the right partner showed substantial loadings on the first factor. Reasons reflecting a dislike of self and a desire to improve self-esteem loaded on the second factor. Reasons indicating a desire to fit in or gain popularity loaded on the third factor. Reasons that indicated a desire to keep or improve a relationship with a partner loaded substantially on the fourth factor. Reasons suggesting the respondent felt like a bad person loaded on the fifth factor. The sixth and seventh factor reflected a desire for physical gratification and reasons of curiosity reasons, respectively. The eighth factor indicated a desire to get pregnant. The eight factors together accounted for 19.74% of the variance after rotation.

Internal consistency for the seven factors was examined in the current sample and was acceptable to excellent, with Cronbach's alphas ranging from .58 - .95. Two week test-retest reliability was examined with a subset of the sample (n=104) and Pearson's reliability coefficients ranged from .30 - 1.00. It is likely that the small number of items in some specific factors are responsible for the low test-retest reliability and alpha coefficients. See Table D2 (see Appendix D) for internal consistency coefficients and test-retest reliability coefficients for each factor.

Inspection of eigenvalues suggested that six factors best explained participants' responses for not engaging in sexual intercourse the first time they had made such a decision. The rotated factor pattern, with each sexual-decision-making-reason's loading

on the six factors, is reported in Table D3 (see Appendix D). Items naming religious or moral beliefs showed substantial loadings on the first factor. The second factor consisted of items reflecting discomfort with sex. Reasons indicating that the respondent did not feel ready for sexual intercourse or had not found the right partner loaded highly on the third factor. Items that loaded on the fourth factor indicated that the respondent felt vulnerable or had no potential partner. Having a bad experience in the past loaded substantially on the fifth factor. Not having access to birth control loaded on the sixth factor. The six factors together accounted for 13.94% of the variance after rotation.

Internal consistency for the seven factors was examined in the present sample and ranged from low to high, Cronbach's alphas .35 - .85. Two week test-retest reliability was examined with a subset of the sample (n=104) and Pearson's reliability coefficients ranged from .30 - .89. Again, the factors with a small number of items seem to have low alphas and test-retest reliability. See Table D3 (see Appendix D) for internal consistency coefficients and test-retest reliability coefficients for each factor.

Inspection of eigenvalues suggested that six factors also best explained the most recent decisions to not engage in sexual intercourse. The rotated factor pattern, with each sexual-decision-making-reason's loading on the six factors, is reported in Table D4 (see Appendix D). Very similar factor structures emerged to describe both the recent and first decisions to not engage in sexual intercourse. As with the first decision, the first factor of the recent decision solution included reasons reflecting moral or religious beliefs. Reasons reflecting discomfort with sex loaded highest on the second factor. Reasons indicating that the participant did not feel ready to have sexual intercourse or had not found the right partner loaded on the third factor. Having a bad experience in the past

loaded on the fourth factor. Items indicating the respondent had no potential or acceptable partner loaded highly on the fifth factor. Not having access to birth control loaded most highly on the sixth factor. The six factors together accounted for 14.66% of the variance after rotation.

Internal consistency for the seven factors was examined in the current sample. Cronbach's alphas ranged from .03 - .89. Two week test-retest reliability was examined with a subset of the sample (n=104) and Pearson's reliability coefficients ranged from .40 - .85. Low test-retest reliability for some factors is likely due to the small number of items in each factor. See Table D4 (see Appendix D) for internal consistency coefficients and test-retest reliability coefficients for each factor.

To calculate scores on the decision making scale, items that loaded on each of the identified factors at 0.5 or greater were identified. Responses on these items were averaged to obtain a factor score for each participant. Thus, each participant received seven mean scores indicating reasons that influenced their decision to engage in sexual intercourse the first time (improve relationship, popularity, feeling ready, to improve self-esteem, curiosity, bad person, wanting to get pregnant). Each participant received eight mean scores indicating reasons that influenced their most recent decisions to engage in sexual intercourse (improve relationship, popularity, feeling ready, to improve self-esteem, out of curiosity, bad person, wanting to get pregnant, and physical gratification). Likewise, each participant received six mean scores indicating reasons that influenced their first decision to not engage in sexual intercourse (moral/religious beliefs, discomfort with sex, not ready, no potential partner, bad experience in the past, no access to birth control) and six mean scores indicating the reasons for their most recent decisions to not

engage in sexual intercourse (moral/religious beliefs, discomfort with sex, not ready, bad experience in past, no potential partner, no access to birth control). The higher the score, the more impact the factor had on sexual decision making.

Fear of Intimacy Scale (FIS). The FIS includes 35 items designed to assess a respondent's level of anxiety about intimate interactions in dating relationships. Fear of intimacy is operationalized as "an inhibited capacity of an individual, because of anxiety, to exchange thoughts and feelings of personal significance with another individual who is highly valued." All items tap into one or more of three contributing factors: "content" or the sharing of personal information, "emotional valence" referring to the significance of the personal information communicated, and "vulnerability" defined as having high regard for the person with whom the information is shared. The 35 items are rated on a 1 (not at all characteristic of me) to 5 (extremely characteristic of me) scale (see Appendix E). For items 1 - 30, the respondent is asked to rate their current feelings and reactions. To illustrate, item 10 (reversed scored) states: "I would feel comfortable telling my experiences, even sad ones, to 0" ("0" is used to denote an intimate partner). Questions 30 - 35 ask a respondent to answer items based on past dating relationships. Responses to all items are summed to create one total score, with higher scores indicating greater fear of intimacy. The possible range of scores for this measure is 35 -175.

Multiple steps were taken to estimate the construct validity of this measure (Descutner & Thelen, 1991). First, factor analysis revealed one primary factor and two secondary factors, thus supporting the relative unidimensionality of the scale. Support for discriminate and concurrent validity were obtained by comparisons with other self-report

measures. The FIS was found to correlate negatively with measures of self-disclosure and social intimacy. A positive relationship was found between the FIS and a measure of loneliness. Finally, participants were interviewed regarding their feelings about dating and family relationships and dating behavior. Higher scores on the FIS were correlated with low dating relationship satisfaction, low comfort getting close to others, and briefer relationships. Test-retest reliability over a one month period was .89 ($p<.001$).

To measure two-week test-retest reliability in the current study, a subset of the sample ($n=104$) was examined. A Pearson's reliability coefficient of .83 was identified. Internal consistency was examined with the larger sample ($N=455$) and was also high, Cronbach's coefficient alpha = .90.

Hulbert Index of Sexual Assertiveness. This 25-item measure determines the level of sexual assertiveness an individual has in a sexual relationship and asks a respondent how comfortable she is communicating certain sexual information with a partner (Hurlbert, 1991). Items inquired about participants' ability/tendency to talk during sex, share sexual desires, initiate sexual interactions, give sexual praise, and engage in sexual behaviors that are not pleasing (see Appendix F). Responses range from 0 (All of the time) to 4 (Never) and scores of all items were summed to determine the degree of sexual assertiveness (with higher scores indicating lower levels of assertion).

This measure was administered to 129 young married women and to 65 college women to investigate the psychometrics of this scale (Hurlbert, 1991). The HISA was found to correlate .83 with the Gambrill-Richey Assertion inventory. Two-week test-retest reliability of the sexual assertiveness inventory was good (.88) when examined with

a subset of 104 participants in the current study. Internal consistency was examined with the larger sample (N=428) and was also good, Cronbach's alpha = .89.

Sexual Self-Esteem Inventory for Women - (SSEI). This 35-item self-report questionnaire (see Appendix G) is the short form of an 81-item measure designed to assess five domains of sexual self-esteem (skill/experience, attractiveness, control, moral judgment, and adaptiveness) (Zeanah & Schwarz, 1996). Each domain may be scored separately or all items may be summed to yield a total sexual self-esteem score. For the purpose of this study, a total score was employed as an indicator of overall functioning. Responses for each item fall along a likert scale from 1 (strongly disagree) to 6 (strongly agree) and the value of the total score can range from 35 to 210 with a higher score denoting higher esteem.

Reliability and validity of this measure were examined using a group of over 300 college women (Zeanah & Schwarz, 1996). Factor analysis of subscale items confirms five coherent and different dimensional constructs of sexual self-esteem. Internal consistency for the short form was good and ranged from .80 to .92 for each subscale. Support is also found for the use of the total score in that the alpha coefficient for the total score was .92. The SSEI was found to correlate with, but provide more powerful and specific information than, the Rosenberg Self-Esteem Inventory. When compared to measures of social desirability, the SSEI was very poorly correlated, indicating good validity.

Internal consistency for the SSEI was examined in the current sample (N=406) and is good, Cronbach's alpha = .91. Two-week test-retest reliability was also examined with a subset of the current sample (n=104) and is good, Pearson's reliability coefficient = .88.

The Sexual Behavior Inventory. The Sexual Behavior Inventory is an 8-item self-report questionnaire created for this study for the purpose of gathering descriptive information about sexual activity (see Appendix H). Items address age at first voluntary intercourse, number and type of partners, and contraceptive use. Several published sexual behavior subscales were used as guidelines in the creation of this measure. Two-week test-retest reliability of the items of interest here was examined with a subset of the current sample(n=104) and ranged from good to excellent. Pearson's reliability coefficients for items examining age of first intercourse, number of sexual partners, and frequency of birth control use were .98, .99, .77 respectively. Pearson's reliability coefficients were .81 for frequency of condom use and .98 for whether or not the participant had ever engaged in voluntary sexual intercourse.

Procedures

This study was reviewed and approved by the Institutional Review Board at Oklahoma State University (see Appendix I). Following informed consent, all questionnaires were administered in a group setting supervised by either clinical psychology graduate students or a licensed clinical psychologist. Questionnaires were randomized in packets and respondents' answers were kept anonymous. Upon completion of questionnaire packets, participants were debriefed regarding the purpose of this study.

CHAPTER IV

RESULTS

Sexual Behavior of Participants

Of the overall sample of 469 participants, 263 young women (56.3%) had engaged in voluntary sexual intercourse at the time of this study. The average age of first intercourse for these women was 16.58 years (SD=1.53) with a range of 12 to 20 years. The number of sexual partners reported ranged from 1 to 38 (M= 3.41, SD=4.04), with the majority of young women reporting between 1 and 3 partners (69.5%).

Comparisons of Sexuality Across Survivors and Nonvictims

Given the overall large number of planned comparisons, attempts were made to control for the error rate across the study. Six families of analyses were identified: examination of sexual behaviors, sexual attitudes, sexual self-esteem, sexual assertiveness, fear of intimacy, and sexual decision making. Alpha was controlled across each of the families using Bonferonni corrections and Multivariate Analyses of Variance procedures.

The first family of analyses examined sexual behaviors and tested the hypotheses that survivors are more likely to engage in voluntary sexual intercourse at a younger age, have a greater number of sexual partners, and use birth control less often when compared

to their peers without a history of victimization. A Bonferonni corrected alpha of $p<.02$ (.05/3 comparisons) was used for the family of analyses examining sexual behavior. Analyses failed to support the hypothesis that (for those women who had engaged in voluntary sexual intercourse) the first experience of voluntary sexual intercourse occurs at a younger age for survivors ($M=16.10$, $SD=1.89$) than nonvictims ($M=16.66$, $SD=1.44$), $t(47.5)=1.79$, $p < .08$. The hypothesis that survivors ($M=4.88$, $SD=4.73$) have a greater number of sexual partners when compared to nonvictims ($M=3.15$, $SD=3.86$) was supported, $t(260)= 2.51$, $p<.02$. However, survivors ($M=2.38$, $SD=0.84$) were not found to use birth control less often than their nonvictimized peers ($M=2.39$, $SD=0.89$), $t(261)=0.10$, ns. Given the nonsignificant finding with general use of birth control, an exploratory follow-up analysis was conducted to test for differences specific to condom use. Use of condoms may be different from birth control use in general because, unlike most other contraceptive methods (e.g., birth control pill, diaphragm, depo provera), it requires the cooperation of the male partner. Thus, it seemed likely that survivors would struggle more than their nonabused counterparts in their efforts to either persuade their partner to use a condom or refuse participation in sex without condom, leading them to have lower rates of condom use overall. No difference was found for condom use and thus, this rationale was not supported, $t(261)=0.03$, ns.

Given that the expected differences for age of onset and use of birth control were not supported, a follow-up chi-square analysis was conducted to examine if survivors differed from nonvictims with regard to whether or not they had ever engaged in voluntary intercourse. A chi-square analysis revealed no difference between survivors of

CSA (64.52%) and nonvictims (55.06%) with regard to whether they had ever engaged in voluntary sexual intercourse $\chi^2(1, N=467)=1.95$, ns.

The second family of analyses examined the sexual attitudes of survivors and nonvictims and employed a Bonferroni corrected alpha level of $p < .025$ (.05/2 comparisons). It was hypothesized that survivors would be more accepting than nonvictims of the sexual behavior of others but less accepting of their own sexual behavior. As predicted, survivors reported more acceptance for the sexual behavior of others (M=36.47, SD=8.50) than did nonvictims (M=39.10, SD=6.99), $t(74.3) = 2.32$, $p<.02$. Surprisingly, survivors also described their own sexual behavior as more acceptable (M=39.29, SD=7.64) than did nonvictims (M=41.62, SD=5.72), $t(71.9)=2.30$, $p<.02$.

Independent sample t-tests were conducted to examine three additional families of analyses (sexual assertiveness, sexual self-esteem, and fear of intimacy). With one analysis per family, alpha remained at $p<.05$ for each test. It was hypothesized that survivors of CSA would report less sexual assertiveness than their nonabused peers; however, no significant differences were found between survivors (M=55.30, SD=19.76) and nonvictims (M=57.09, SD=17.72), $t(454) = 0.70$, ns. Survivors (M=133.36, SD=28.42) were found to report significantly less self-esteem in sexual situations than young women without an abuse history (M=145.90, SD=27.88), $t(459) = 3.26$, $p < .001$. Survivors also reported experiencing more anxiety about intimacy (M=76.34, SD=21.81) than nonvictims (M=71.17, SD=18.67), $t(460) = 1.97$, $p < .05$.

Finally, Multivariate Analysis of Variance (MANOVA) was used to examine differences between CSA survivors and nonvictims with regard to sexual decision

making. Four MANOVAs were conducted to examine the reasons that influenced respondent's decisions to engage in voluntary sexual intercourse (for the first and most recent time) and decisions to not engage in voluntary sexual intercourse (for the first and most recent time).

In the first MANOVA, examining the reasons for first voluntary intercourse, dependent variables included scores on the seven identified factors: wanting to improve a relationship with a partner, wanting to fit in or feel popular, feeling ready, disliking self and wanting to improve self-esteem, curiosity, viewing one's self as a bad person, and wanting to become pregnant. A significant effect was found for victimization status, Pillai's Trace $\underline{F}$ (7, 254) = 2.08, $\underline{p}$<.05. Individual analyses of variance (ANOVA) produced significant results across two decision making indices: to improve relationship with a partner ($\underline{p}$< .02) and to improve self-esteem ($\underline{p}$< .007, see Table D5, Appendix D, for information on all univariate ANOVAs and for means and standard deviations for survivors and nonvictims on each dependent variable). Survivors were more likely than nonvictims to engage in intercourse to improve their relationship with a partner and to improve their own self-esteem.

The second MANOVA examined the reasons participants gave for engaging in sexual intercourse most recently. Dependent variables included mean scores across the eight factors (feeling ready, to improve self-esteem, popularity, improve relationship, bad person, physical gratification, curiosity, wanting to get pregnant). Although not significant at conventional levels, a trend for significance was found for victimization status, Pillai's Trace $\underline{F}$ (8, 250) = 1.72, $\underline{p}$<.093. To insure that important differences were not overlooked, univariate analyses were examined and three of the eight factors appeared

to differentiate nonvictims from survivors of abuse. These were to improve a relationship with a partner, to improve self-esteem, and wanting to get pregnant. Because the overall MANOVA was not significant, these findings should be interpreted with caution. Information on univariates are presented in Table D6 (see Appendix D).

The third MANOVA, examining the first time an adolescent decided to decline an opportunity to engage in sexual intercourse, included six dependent variables (moral/religious beliefs, discomfort with sex, not ready, bad experience in past, no potential partner, no access to birth control). No significant effect was found for victimization status, Pillai's Trace $\underline{F}$ (6, 424) = 1.01, ns. Information on univariate ANOVAs are presented in Table D7 (see Appendix D).

The fourth MANOVA examined reasons the participants decided to decline an opportunity to engage in sexual intercourse most recently. Dependent variables included scores on the six identified factors: moral/religious beliefs, discomfort with sex, not ready for sex, no potential partner, having had a bad experience in past, and no access to birth control. Results revealed a significant effect for victim status, Pillai's Trace $\underline{F}$ (6, 406) = 7.10, $\underline{p}<.0001$. Individual ANOVAs (see Table D8, Appendix D) revealed significant differences between survivors and nonvictims on one dimension of decision making, having a bad experience in the past ($\underline{p}<.0001$). Having had a past negative experience was more influential in survivors' decisions to decline sexual intercourse than it was for nonvictims.

CHAPTER V

DISCUSSION

The purpose of this study was to investigate the sexual behavior and sexual functioning of a sample of late adolescent sexual abuse survivors and to compare these to that seen in same-aged, nonabused peers. Age at first voluntary intercourse, number of sexual partners, contraception use, sexual attitudes, sexual self-esteem, fear of intimacy, sexual assertiveness, and sexual decision making were examined. Results revealed several important differences between survivors of CSA and nonvictimized young adults whereas other findings suggested that some areas may be unaffected by a history of sexual abuse.

Of the total sample, only 263 of the 469 participants (56.3%) reported having engaged in voluntary sexual intercourse. This finding is inconsistent with and lower than findings from other studies that suggest at least 50% of high school students (aged 16 and older) have engaged in voluntary sexual intercourse (Downey & Landry, 1997; Leigh et al., 1994). Thus, the percentage of young women reporting sexual experience in the current study is less than what would have been expected for a college-aged sample. The relatively large percentage of participants who have never engaged in voluntary sexual intercourse may have impacted the findings of this study. Important differences in sexual

behavior or sexual functioning may have been overlooked because of the relatively low number of young women overall who have engaged in sexual intercourse.

Examination of sexual behavior variables revealed differences between CSAS and their peers in the number of sexual partners each reported, but not in age of first intercourse or the frequency with which they use birth control. Survivors reported engaging in sexual intercourse with a greater number of partners than did their peers with no abuse history. This finding is consistent with previous literature and could be a result of survivors using sexual behavior in different ways than nonvictimized adolescents (e.g., to fulfill a greater number of purposes). It may also reflect a tendency for survivors to engage in sexual intercourse sooner in a relationship than would their nonabused peers. Intercourse with multiple partners not only puts survivors at greater risk of contracting a sexually transmitted infection, but may also increase their possibility of being revictimized.

Given that the expected difference in age of first intercourse was not found, a follow-up analysis to examine whether a greater number of survivors, as compared to nonvictims, had ever engaged in voluntary intercourse was conducted. No difference was found between survivors of CSA (64.52%) and nonvictims (55.06%) with regard to whether they had ever engaged in voluntary sexual intercourse. Thus, findings of the current study suggest that survivors do not begin to engage in sexual intercourse at a younger age than their nonvictimized peers, nor are they more likely to have engaged in intercourse by the time they attend college.

Inconsistent with most previous findings, survivors were not found to be significantly younger than nonvictims at the time of first voluntary intercourse. This may

be due to the fact that this study asked participants to report their first experience of *voluntary* sexual intercourse, whereas most previous studies have failed to differentiate voluntary intercourse from intercourse in the context of abuse. If CSA survivors are not specifically asked to report their age at first voluntary intercourse, they may report experiences that occurred during childhood sexual abuse scenarios. In the majority of cases, this would make them younger at age of first intercourse than their nonabused peers and may account for the differences found in past studies. Failure to replicate past findings may also be partially due to the sample employed. College students, in general, are assumed to be high in overall functioning. Individuals who have engaged in and experienced adverse side effects associated with early intercourse (e.g., teen pregnancy) may not be represented in a college population.

It is interesting that survivors begin to have sexual intercourse at the same age as their nonabused peers, yet report a greater number of sexual partners. Previous literature has not addressed this contradiction but several explanations are possible. For instance, anxiety about sexual relations or intimacy may inhibit a survivor's ability to maintain a long-lasting relationship. As a result, a survivor may have a series of brief dating relationships and, thus, a greater number of sexual partners. Likewise, survivors may be more likely than their nonabused peers to date and have sexual relationships with multiple people at the same time. Another possibility is that survivors engage in sexual one-night stands more often than do their nonabused peers. It is also possible that adolescents without an abuse history engage in sexual intercourse for the first time (e.g., out of curiosity, because they are in love) and then decide not to have sexual intercourse

in the contexts of future relationships, whereas survivors may view sex as a required part of every dating relationship.

The failure to find differences in age of first voluntary intercourse may also, however, reflect problems with study methodology. Previous studies that have found significant differences in the age of onset of sexual behavior have measured age in months. Unlike these studies, the current study asked respondents to report their age of first voluntary intercourse in years, rather than in months, which may not have been sensitive enough to detect differences. Furthermore, the fact that a large percentage of participants in the study had never engaged in sexual intercourse may have reduced the likelihood of finding differences. Later examination of all participants (after all have had sexual intercourse) may reveal such differences.

Results also failed to support the hypothesis that survivors of sexual abuse use contraception less often than their nonabused counterparts. Rather, survivors and nonvictims reported similar rates of birth control use. One follow-up analysis was conducted to test the possibility that survivors differ in their use of one specific method of birth control, namely the use of condoms (which require the cooperation of their male partners). It was thought that this method of birth control might be particularly difficult for the survivor because of the possibility that she would have to persuade her partner to use a condom or refuse to engage in sex without a condom, both of which would require self-esteem and assertiveness. Follow-up analysis, however, revealed no differences in reported rates of condom use. Examination of means for both groups revealed that adolescents' use of birth control in general falls somewhere between "most of the time" and "always," whereas they reported using condoms somewhere between "some of the

time" and "most of the time." Thus, while it is positive that the average participant in both groups reported using birth control at such high rates, it is concerning that condom use is relatively lower for each group. This is especially important considering that condom use is the only form of birth control that will provide protection against sexually transmitted infections, including HIV/AIDS. It is important to again note that this study asked participants to report contraceptive use for voluntary sexual intercourse, whereas past studies may have found differences because they did not ask survivors to differentiate voluntary from involuntary sexual activity (e.g., it is not likely that contraception was used during instances of abuse).

Failure to find a difference between survivors and nonvictims regarding use of birth control may suggest that survivors in this sample are using protection more consistently than survivors participating in previous research. This finding is particularly important given that survivors are also engaging in sexual intercourse with a greater number of partners relative to their peers. Research with nonabused adolescent populations suggests that a substantial number of teens are regularly practicing safe sex (Leigh et al., 1994). Thus, it may be that the use of contraceptives has become an expected part of sexual interactions for recent generations. Perhaps, this is now less influenced by a victimization history. It is also possible, however, that the response pattern of both groups was influenced by a desire to present themselves in a socially acceptable way (i.e., reporting the use of birth control more frequently than is actually the case, resulting in an inability to find true differences between groups).

Methodological issues may also account for a failure to find differences in contraceptive use. While this study asked participants to identify the types of birth

control they have used and the frequency of their use of birth control in general, it did not ask participants to report their use of each type of birth control. Unfortunately, past studies have not specifically indicated how contraceptive use was measured, but it is possible that the measures they employed were more specific than the measure employed in the current study.

The sexual attitudes of survivors were next investigated. It was expected that survivors would endorse more accepting attitudes for others' participation, and less accepting attitudes for their own participation, in sexual behavior. Interestingly, survivors, as compared to nonvictims, endorsed more accepting attitudes about both their own and others' participation in a variety of sexual behaviors (e.g., oral-genital sex, heterosexual intercourse, homosexual intercourse). It is possible that survivors are less critical of others' participation in sexual interactions because they feel stigmatized by their CSA history and different from (e.g., less valuable than) their nonvictimized peers; they therefore may be less likely to critically judge the sexual behavior of others.

The finding that survivors are more accepting of their own participation in a variety of sexual behaviors than are their peers without an abuse history was unexpected, however. This finding does not support the theory that suggests survivors view themselves as dirty or sex as repulsive. Rather, it may suggest that CSA survivors view sex between two consenting adults as natural and acceptable. The importance a survivor places on sexual activity between two consenting adults may override any negative perception of particular types of sexual behavior (as long as it is consensual). Therefore, if this study had not made the distinction between voluntary and nonvoluntary sexual activity, survivors might have endorsed less accepting attitudes. Likewise, less

conservative sexual behaviors (e.g., sex in the presence of others, homosexual sex, maintenance of more than one sexual relationship at a given time) may be more familiar and less shocking and offensive to survivors given their heightened awareness of and greater exposure to sexuality. Relatedly, a survivor may think of a variety of sexual activities as "normal" whereas these activities may be viewed as deviant by adolescents with limited sexual experience and no history of sexual abuse. Also possible is that survivors maintain more accepting attitudes in an effort to normalize either their past or current sexual experiences. It is also important to note that the traditional, 5-item response scale of the sexual attitudes questionnaire was not employed in this study. Rather, the version used in this study provided a 4-item response scale that may have made differences between groups appear more extreme than they actually are.

The third set of analyses examined sexual functioning across the domains of sexual self-esteem, fear of intimacy, and sexual assertiveness. Mixed support was found for the hypotheses. As hypothesized, survivors reported lower levels of overall sexual self-esteem as compared to nonvictims. This finding is consistent both with previous research and with CSA theory that suggests survivors have lower self-esteem in general. It is suspected that low sexual self-esteem in adolescent survivors is a direct result of having had negative sexual experiences as a child. Unfortunately, a lack of confidence in sexual situations, resulting from low self-esteem, could put the survivor at greater risk for being coerced into unwanted sexual behavior. Additionally, a lack of positive feelings about one's self in sexual situations may lead survivors to continually look for sexual partners with whom they are comfortable. This explanation would account for the

finding that survivors participate in sexual behavior with more partners than nonabused adolescents.

Findings also suggested that survivors experience a greater amount of anxiety or fear in emotionally intimate relationships. This was expected given the previous literature that suggests survivors experience a greater amount of anxiety across a number of domains. Again, cognitive theory and Finkelhor's traumagenic dynamics theory also suggest that survivors' distorted expectations about sexuality and intimacy (e.g., lack of trust) may account for their inflated fear of intimacy.

A review paper on sexuality in adult survivors suggests that fear of intimacy may actually lead survivors to engage in more sexual intercourse, with a greater number of partners, in an effort to make their relationships physical and not emotional (Davis & Petretic-Jackson, 2000). It has also been hypothesized that survivors end romantic relationships with partners as there becomes the potential for emotional intimacy. This idea is consistent with the suggestion that survivors engage in sex with a greater number of sexual partners because they have a greater number of brief relationships. This idea would be consistent with the results found here regarding greater fears of intimacy and higher numbers sexual partners in CSA survivors relative to nonvictims. Likewise, the combination of multiple sexual partners, low sexual self-esteem, and high fear of intimacy might prevent survivors from developing and maintaining healthy sexual relationships.

The hypothesized difference in sexual assertiveness was not supported. Rather, survivors reported rates of assertiveness in sexual situations similar to their nonabused peers. Given their lower levels of esteem, it is surprising that adolescents do not report

lower levels of sexual assertiveness. Additionally, assertiveness is thought to reflect comfort in sexual situations and survivors are theorized to lack comfort due to their abuse histories. On the contrary, it is possible that survivors have learned to use sex as a tool to get their unrelated needs met. It may be that adolescent survivors discover their potential to negotiate sex for other valued commodities such as popularity (e.g., "I'll have sex with you if you say you're my boyfriend") and may learn to be assertive with sexual partners in order to clearly define their own needs. Furthermore, a certain degree of assertiveness may be necessary to enable survivors to set limits on the amount of intimacy a survivor is willing to experience in her dating relationships.

Alternatively, it is possible that adolescents in general, as compared to adults, may be less able to assert themselves sexually due to less experience or comfort with sexuality overall. An examination of group means reveals that neither group reported high levels of assertiveness. This is consistent with research that reveals that large proportions of adolescents feel unable to decline unwanted sexual advances by a partner (e.g., Buzwall & Rosenthal, 1996; Zimmerman, Sprecher, Langer, & Holloway, 1995). Thus, existing differences in sexual assertiveness of adolescent survivors and nonabused peers may not be detected when using a measure designed to tap sexual assertiveness in adult populations.

Finally, the concept of sexual decision making was explored. Factors that influenced sexual decision making across four time frames were examined. As hypothesized, survivors differed from nonvictimized adolescents in their sexual decision making the first time they engaged in voluntary sexual intercourse and in their most recent decisions to decline participation. Survivors were more likely to engage in

intercourse for the first time in an effort to improve their self-esteem and to improve a relationship with a partner. Thus, while survivors in this study are beginning to have sexual intercourse at approximately the same age as nonvictims they appear to be motivated to participate in sexual intercourse for different reasons. This finding provides support for the premise that survivors conceptualize sexuality different than their peers. This in turn may be responsible for their different emotional responses, different expectations, and different sexual behavior. This is also consistent with the premise that CSA disrupts normal sexual development. Through CSA, survivors may have been taught to use sex to get needs unrelated to sexuality met by engaging in sexual behavior.

Surprisingly, a difference was not found for the factor of viewing one's self as a bad person. It is possible that the low number of participants who endorsed this factor overall did not allow differences to be statistically significant. Likewise, it was somewhat surprising that there was no difference for the factor of curiosity in decisions to have sexual intercourse for the first time. It was assumed that curiosity would be less influential for survivors, given their past sexual experience in the context of their abuse. Perhaps, though, survivors' are curious about what sexual relations would be like with a peer or how voluntary sexual intercourse would differ from their past experiences.

Survivors also differed in sexual decision making the most recent times they decided to not engage in sexual intercourse. Survivors, as compared to nonvictims, were more likely to report that a bad experience in the past influenced their decision not to have sexual intercourse in the present. One likely assumption is that the bad experience in the past is their experience of childhood sexual abuse, although it is possible that survivors of CSA had a greater number of additional bad experiences during their lifetime

than their peers without an abuse history. For instance, the bad experience reported by survivors might include an acquaintance rape or other late adolescent sexual assault given the rates of revictimization for survivors.

Differences were not found with regard to sexual decision making for the first time participants decided to decline an invitation to engage in voluntary sexual intercourse nor for their most recent decisions to engage in sexual intercourse. Examination of means reveals that moral or religious beliefs and not feeling ready were most influential in the first decision to decline sexual intercourse for both survivors and nonvictims. While the overall MANOVA examining reasons participants gave for engaging in sexual intercourse most recently was not significant, it is important to note that follow-up univariate analyses did suggest significant differences for three factors. These factors were: to improve a relationship, to improve self-esteem, and wanting to get pregnant. While these differences can not be considered significant, they do suggest that these are factors in need of further examination.

Overall, results point to the impact of CSA on the developing sexuality of young women. Childhood sexual abuse survivors reported participation in less healthy sexual behavior and reported poorer functioning across several areas of sexuality. Survivors' participation in sexual intercourse with a greater number of partners relative to their peers puts them at greater risk for contracting a sexually transmitted disease or being revictimized. Other domains affected by a sexual abuse history were sexual self-esteem, fear of intimacy, and sexual decision making. All of these findings taken together suggest that survivors are not functioning as well in sexual situations as are nonvictims. Unfortunately, these results also suggests that survivors may use participation in sexual

intercourse as an opportunity to feel better about themselves (e.g., raise their self-esteem) or to avoid emotional intimacy in an ongoing romantic relationship.

On a positive note, a CSA history was not associated with problems in all areas of sexuality examined. Survivors were not younger at age of first intercourse, which is critical given the many negative risk factors associated with young age of intercourse (e.g., increased risk of pregnancy). Likewise, survivors reported use of birth control at rates similar to their peers. Investigation of sexual functioning revealed that survivors are accepting in their attitudes about participation in a wide range of sexual behaviors. Survivors were not found to be any less assertive in sexual situations than were their peers. Thus, it appears that adolescent survivors may be resilient to some, but not all, of the possible negative influences of CSA on sexual development.

This study improved upon past studies given that it examined both sexual behavior and sexual functioning across a number of domains. Likewise, this study clearly differentiated voluntary from nonvoluntary sexual intercourse, allowing more clear conclusions to be drawn from participants' responses. Unlike past studies, this study employed a sample of adolescent survivors of sexual abuse and an appropriate control group of nonvictimized peers. This is the first study to examine survivors' motivation to engage in and to avoid sexual intercourse subsequent to abuse. Also advantageous was the use of standardized instruments with good reliability and validity to assess victimization status and sexual functioning.

Despite these strengths, limitations of the current investigation should be addressed. For instance, while the majority of measures used in this study have good psychometric properties, the Sexual Decision Making Scale revealed quite low reliability

coefficients for a number of factors. This low reliability may lower the confidence with which the findings can be interpreted. Likewise, important differences may have been overlooked. Secondly, although this study employed a group of adolescents/young adults, it is retrospective in design and dependent upon participants' recall of the first time they engaged in sexual intercourse. Given their history of CSA, and the possibility that they hold cognitive distortions about sex, survivors may recall past voluntary sexual experiences differently than nonvictims. An additional limitation of this study is the correlational design of this study which prevents conclusions regarding causality from being drawn. For instance, it is possible that the differences in sexual behaviors seen here could be caused by other, unidentified factors that are also related to a history of CSA (e.g., lack of parental supervision). Additionally, generalization of the current findings may be limited by the fact that the sample studied is predominately Caucasian, college women.

This study was also limited in that it did not investigate the role of several factors thought to influence sexual behavior in adolescence, such as media, parental attitudes, relationship with parents, pressure to engage in sexual intercourse, access to contraception, or physical, cognitive, or emotional maturity. Further, this study assessed for childhood sexual abuse experiences (those occurring prior to age 17), but did not screen for any sexual assault experiences occurring after age 17. Sexual assault experiences occurring in young adulthood may also affect the participants' sexual development or sexual adjustment and may have limited the ability of this study to detect differences between young women with and without a CSA history.

Despite some limitations, findings of this study have important implications for therapeutic intervention with child, adolescent, and young adult survivors of CSA. Young adult/adolescent sexual abuse survivors, even those attending a 4-year university, report having had a greater number of sexual partners than nonvictimized adolescents. This significantly increases risk for pregnancy and contraction of sexually transmitted diseases including HIV/AIDS. Thus, therapists should treat a history of CSA as a possible red flag to assess for high-risk sexual behavior in adolescent clients. Sex education may also be important for survivors of CSA to address and challenge distorted or incorrect beliefs about sexuality.

Findings of this study also suggest that teens with a history of abuse may be able to assert themselves sexually, although they have significantly lower levels of self-esteem than their nonabused peers. Thus, the assumption that teens who can talk openly about sex are more sexually well adjusted than those who are less able to discuss sex may be incorrect. This study suggests that teens with a CSA history are not functioning well despite normal levels of sexual assertiveness. Therapists might consider the possibility that sexual assertiveness may mask a lack of comfort and confidence in sexual situations. Likewise, it may also be the case that survivors of abuse are engaging in greater amounts of sexual behavior in order to hide their own sexual insecurity or in an attempt to replace negative perceptions of sexuality. If this is the case, therapeutic intervention could teach adolescents alternative methods to feel better about themselves.

Also revealed in this study were the factors that influence sexual decision making of sexually abused adolescents. Therapists should become familiar with the reasons sexually abused adolescents have for choosing to engage in or avoid sexual contact.

Knowledge of what makes sense for adolescents should increase the effectiveness of prevention and intervention programs designed to reduce risky sexual behavior, teenage pregnancy, and the spread of sexually transmitted diseases.

Additionally, survivors in this study reported a significant fear of intimacy that may prevent them from acquiring or maintaining close interpersonal relationships. Thus, survivors would likely benefit from therapeutic interventions designed to increase survivors' trust and ability to openly communicate in intimate relationships. It may also be beneficial to teach survivors how a relationship can be intimate without being sexual.

Although not examined in this study, research suggests that adolescent survivors experience sexual assault (revictimization) to a greater degree than peers without a CSA history (Krahe, Scheinberger-Olwig, Waizenhofer, & Kolpin, 1999). This finding may be in part due to differences in the way abused teens conceptualize sexuality, their lack of self-esteem in sexual situations, or their greater number of partners. Addressing the sexual functioning problems identified here would be beneficial for revictimization prevention programs. Group treatment programs for sexually abused adolescents may be especially helpful in normalizing the adolescent survivor's current perceptions of and discomfort in sexual situations.

Findings of this study suggest that survivors engage in sexual behavior because they conceptualize, or think about, sexuality in ways different from their nonabused peers. Future research designed to clearly define the sexual schemas of adolescents, both survivors and nonvictims, would further our understanding of adolescent sexual behavior. It seems, as well, that studies of sexual decision making would benefit from qualitative analysis of adolescents' open-ended responses to why they engage in or avoid sexual

intercourse. The use of focus groups with abused and nonabused adolescents would allow researchers to examine factors that influence sexual decision making that are not currently represented on quantitative measures.

Future research should also consider employing a sample of younger adolescents in order to examine developmental differences in sexual behavior and functioning. The examination of sexual decision making with a sample of younger adolescents may reveal different findings because participants are closer in age to the time when they first decide to engage in sexual intercourse. Such studies should continue to explicitly distinguish voluntary from involuntary sexual experiences and should consider the impact of unwanted childhood, adolescent, and adult sexual experiences. It may also be beneficial for future studies to look at the sexual functioning of survivors with different histories of abuse (i.e., to consider the potential impact of abuse characteristics including force and intrusiveness of abuse). Lastly, to allow for generalization of findings, studies should strive to examine the sexual behavior of both male and female adolescents from a community setting. This will allow for a broader understanding of the impact of CSA on sexual behavior, sexual functioning, and sexual decision making.

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APPENDIXES

APPENDIX A

LIFE EXPERIENCES QUESTIONNAIRE

Code # _____

LIFE EXPERIENCES QUESTIONNAIRE

Please circle the number before the most appropriate answer and/or write in the information requested.

1. Sex:
   (1) Female
   (2) Male

2. Age ____ _____

3. Race
   (1) Caucasian
   (2) African American
   (3) Hispanic
   (4) Native American
   (5) Asian/Asian American
   (6) Other (please specify)
   _____

4. Marital status:
   (1) Never married
   (2) Married
   (3) Cohabitating
   (4) Divorced or separated
   (5) Widowed
   (6) Other (please specify)
   _____

5. What is your religious affiliation/preference ?
   (1) Protestant (e.g., Baptist, Lutheran, Methodist, Christian, etc.)
   (2) Catholic
   (3) Jewish
   (4) Nonaffiliated
   (5) Other (please specify) _____

For items 6 and 7, write a description of your parent's occupation when you were a child. Category descriptions provided below may be used, or exact job titles (e.g., high school teacher, owns small farm) may be provided. If parent was retired or deceased when you were a child, please indicate this.

6. Father's occupation _____
7. Mother's occupation _____

   (1) Executive, major professional
   (2) Manager, minor professional
   (3) Administrator, owner of a small business, semi-professional
   (4) Clerical and sales worker
   (5) Skilled worker
   (6) Semi-skilled worker
   (7) Unskilled worker
   (8) Unemployed
   (9) Homemaker

Using the numbers from the list below, indicate how far each of your parents went to school.

8. Father _____
9. Mother _____

   (1) Graduate of professional training (degree obtained)
   (2) Partial graduate or professional training
   (3) College graduate (degree obtained)
   (4) Partial college training (include technical schooling beyond high school)
   (5) High school graduate (graduate of technical or trade school)
   (6) Partial high school (10^{th} grade through partial 12^{th} grade)
   (7) Partial junior high school (7^{th} grade through 9^{th} grade)
   (8) Elementary school (6^{th} grade or less)

10. a. Are you currently involved in an exclusive romantic/dating relationship or marriage?
    (1) Yes
    (2) No

    b. If yes, how long have you been involved with the person? _____ months

11. Did anyone in your family have a chronic physical illness or handicap (at least one year in duration)?
    (1) No
    (2) Mother
    (3) Father
    (4) Brother or sister
    (5) You
    (6) Other (please specify) _____

12. a. Did anyone in your family have a psychiatric illness? _____
    (1) No
    (2) Father
    (3) Mother
    (4) Brother or sister
    (5) You
    (6) Other (please specify) _____

    b. If someone in your family had a psychiatric illness, was that person hospitalized?
    (1) NA - no one had a psychiatric illness
    (2) No
    (3) Yes, once
    (4) Yes, two to five times
    (5) Yes, six to nine times
    (6) Yes, more than 10 times

    c. What was the longest period of hospitalization?
    (1) NA - no one hospitalized
    (2) No hospitalization
    (3) Less than 2 weeks
    (4) 2 to 4 weeks
    (5) 1 to 6 months
    (6) 7 to 12 months
    (7) More than one year

13. Did any member of your family have a drug abuse problem (including alcohol abuse)?
    (1) No
    (2) Mother
    (3) Father
    (4) Brother or sister
    (5) You
    (6) Other (please specify)

14. Have you ever been robbed on the street or at home?
    (1) No
    (2) Yes, once
    (3) Yes, more than once

15. a. Were you ever beaten as a child to the extent that you suffered visible physical injuries?
    (1) No
    (2) Yes, once
    (3) Yes, 2 to 3 times
    (4) Yes, repeatedly
    (5) Yes, and to the point of needing medical care.

    b. By whom were you beater as a child?
    (1) NA - never beaten
    (2) Father
    (3) Mother
    (4) Father and mother
    (5) Stepfather and stepmother
    (6) Other family members or relatives
    (7) Other (please identify) _____

16. a. Have you been beaten as an adult (since age 18)?
    (1) No
    (2) Yes, once
    (3) Yes, 2 to 3 times
    (4) Yes, repeatedly
    (5) Yes, and to the point of needing medical care

    b. By whom were you beaten as an adult?
    (1) NA - never beaten
    (2) Husband/wife
    (3) Boyfriend/girlfriend
    (4) Date or acquaintance
    (5) Several of the above
    (6) Other (please identify) _____

17. Have you ever been to see a professional for an emotional problem (i.e., social worker, psychologist, psychiatrist, counselor, clergy, etc.)?
    (1) No
    (2) Yes, once for 6 months or less
    (3) Yes, 2 or 3 times for 6 months or less; one time for a year or more
    (4) Yes, more than 3 times for 7 months or less; 2 or 3 times for a year or more
    (5) Yes more than 3 times for a year or more each time

18. Have you ever taken medications for your nerves?
    (1) No
    (2) Mild tranquilizer, less than 1 month
    (3) Mild tranquilizer, over 1 month
    (4) Sleeping pill or antidepressant, less than 3 months
    (5) Sleeping pill or antidepressant, more than 3 months
    (6) Major tranquilizer, less than 3 months
    (7) Major tranquilizer, more than 3 months

19. a. Have you ever been hospitalized for emotional problems? for a nervous breakdown? For drug addiction? For a drinking problem? For a suicide attempt?
    (1) No
    (2) Yes, once for 6 weeks or less
    (3) Yes, 2 or 3 times for 6 weeks or less; one time for 3 months or more (up to 12 months)
    (4) Yes, more than three times for 6 weeks or less; 2 or 3 times for 3 months or more (up to 12 months)
    (5) More than three times for 3 to 12 months; one time for 18 months or longer

    b. When were your hospitalized for this emotional problem most recently?
    (1) Never hospitalized
    (2) Within the past 6 months
    (3) 6 months to 1 year ago
    (4) 1 to 4 years ago
    (5) 5 to 10 years ago
    (6) More than 10 years ago

Childhood Sexual Experiences. It is now generally realized that many women and men, while they were child or adolescents, have had a sexual experience with an adult or someone older than they were. By sexual, I mean behaviors ranging from someone exposing themselves (their genitals) to you to someone having intercourse with you. These experiences may have involved a relative, a friend of the family, an acquaintance, a stranger or another individual. Some experiences are very upsetting and painful while others are not, and some may have occurred without your consent.

Now I'd like you to think back to your childhood and adolescence (before your 17th birthday), remember if you had any sexual experiences, and answer the following questions.

EXCLUDE:

- Voluntary sexual activities with a dating partner no more than 5 tears older than you were.
- Consensual sexual play with a peer no more than 5 years older than you were.

Report below activities that occurred without your consent or were unwanted or that happened with a partner more than 5 years older than you or that happened with a family member.

20. During childhood and adolescence, did anyone ever expose themselves (their sexual organs) to you?
    (1) Yes (2) No

21. During childhood and adolescence, did anyone masturbate in front of you?
    (1) Yes (2) No

22. During childhood and adolescence, did anyone ever touch or fondle your body, including your breasts or genitals, or attempt to arouse you sexually?
    (1) Yes (2) No

23. During childhood and adolescence, did anyone try to have you arouse them or touch their body in a sexual way?
    (1) Yes (2) No

24. During childhood and adolescence, did anyone rub their genitals against your body in a sexual way?
    (1) Yes (2) No

25. During childhood and adolescence, did anyone attempt to have intercourse with you?
    (1) Yes (2) No

26. During childhood and adolescence, did anyone have intercourse with you?
    (1) Yes (2) No

27. During childhood and adolescence, did you have any other sexual experiences involving another person not included above?
    (1) Yes (2) No

If you answered "yes" to any of the questions (21 through 28), please go to the next page.
If you answered "no" to questions 21 through 28 (all must be answered "no"), you are finished with this questionnaire and may go to the next questionnaire in your packet.

If you were involved with more than one person, please answer all of the questions for the first person in Column #1. Answer each question for that person and then return to question 29 and answer the questions again for the second person in Column #2. Repeat if you were involved with a third person in Column #3.

28. With what person were you sexually involved as a child (before your 17th birthday)?

	Column #1 First Person	Column #2 Second Person	Column #3 Third Person
Mother	(1)	(1)	(1)
Father	(2)	(2)	(2)
Stepmother	(3)	(3)	(3)
Stepfather	(4)	(4)	(4)
Brother	(5)	(5)	(5)
Sister	(6)	(6)	(6)
Stepbrother	(7)	(7)	(7)
Stepsister	(8)	(8)	(8)
Half brother	(9)	(9)	(9)
Half sister	(10)	(10)	(10)
Grandfather	(11)	(11)	(11)
Grandmother	(12)	(12)	(12)
Uncle	(13)	(13)	(13)
Aunt	(14)	(14)	(14)
Male cousin	(15)	(15)	(15)
Female cousin	(16)	(16)	(16)
Other male relative	(17)	(17)	(17)
Other female relative	(18)	(18)	(18)
Male friend of yours	(19)	(19)	(19)
Female friend of yours	(20)	(20)	(20)
Male acquaintance	(21)	(21)	(21)
Female acquaintance	(22)	(22)	(22)
Male stranger	(23)	(23)	(23)
Female stranger	(24)	(24)	(24)
Male friend of the family	(25)	(25)	(25)
Female friend of the family	(26)	(26)	(26)
Male babysitter	(27)	(27)	(27)
Female babysitter	(28)	(28)	(28)
Male neighbor	(29)	(29)	(29)
Female neighbor	(30)	(30)	(30)
Other male nonfamily member	(31)	(31)	(31)
Other female nonfamily member	(32)	(32)	(32)

IF "OTHER" IS MARKED, PLEASE SPECIFY WHO ON THE LINE PROVIDED.

29. How old are you when these activities began? Please specify exact age.

Age _____ Age _____ Age _____

30. How old was the other person when these activities began? Please specify exact age if possible.

Age _____ Age _____ Age _____

	Column #1 First Person	Column #2 Second Person	Column #3 Third Person

31. What was the length of time from the first to the last of the activities?

Only one incident	(1)	(1)	(1)
0 to 1 months	(2)	(2)	(2)
1 to 6 months	(3)	(3)	(3)
6 months to 1 year	(4)	(4)	(4)
13 months to 2 years	(5)	(5)	(5)
2 to 5 years	(6)	(6)	(6)
5 to 10 years	(7)	(7)	(7)
More than 10 years	(8)	(8)	(8)

32. How often did these activities occur?

Daily	(1)	(1)	(1)
Once per week	(2)	(2)	(2)
Twice per week	(3)	(3)	(3)
Once per month	(4)	(4)	(4)
Once per year	(5)	(5)	(5)
Once per 5 years	(6)	(6)	(6)
NA - only one incident occurred	(7)	(7)	(7)

33. When did these activities occur most recently?

Less than 6 months ago	(1)	(1)	(1)
6 months to a year ago	(2)	(2)	(2)
1 to 3 years ago	(3)	(3)	(3)
3 to 5 years ago	(4)	(4)	(4)
5 to 10 years ago	(5)	(5)	(5)
More than 10 years ago	(6)	(6)	(6)

34. How old were you when these activities ended? Please specify exact age, or circle NA if the activities have not ended.

Age _____ (NA) Age _____ (NA) Age _____ (NA)

35. How were these activities terminated?

NA - activities have not been terminated	(0)	(0)	(0)
You left the household	(1)	(1)	(1)
The other person left the household	(2)	(2)	(2)
The other person stopped the activities voluntarily	(3)	(3)	(3)
The activities became known to a third party	(4)	(4)	(4)
You confronted/resisted the other person	(5)	(5)	(5)
The other person became involved with someone else.	(6)	(6)	(6)
You became involved with someone else.	(7)	(7)	(7)
It was brought to the attention of the authorities	(8)	(8)	(8)
Other (please specify how)	(9) _____	(9) _____	(9) _____

	Column #1 First Person	Column #2 Second Person	Column #3 Third Person
36. What was the nature of the sexual activity? Circle all that occurred.			
Kissing	(1)	(1)	(1)
Fondling of your breasts	(2)	(2)	(2)
Other fondling or rubbing of your body	(3)	(3)	(3)
The other person exposed his/her genitals to you	(4)	(4)	(4)
The other person watched you undress or engage in some sexual activity	(5)	(5)	(5)
Fondling of your genitals	(6)	(6)	(6)
The other person forced you to fondle/stimulate his/her genitals	(7)	(7)	(7)
The other person put his/her mouth on your genitals	(8)	(8)	(8)
You put your mouth on the other person's genitals	(9)	(9)	(9)
Intercourse	(10)	(10)	(10)
Anal intercourse	(11)	(11)	(11)
Penetration of your vagina or anus by objects	(12)	(12)	(12)
Other (please specify act)	(13)_____	(13)_____	(13)_____

37. Please indicate the extent to which you viewed the experience as having either a positive or negative impact on you life at the time the experience occurred.

Involvement with first person:

extremely negative (-3)	moderately negative (-2)	somewhat negative (-1)	no impact (0)	slightly positive (1)	moderately positive (2)	extremely positive (3)

Involvement with second person:

extremely negative (-3)	moderately negative (-2)	somewhat negative (-1)	no impact (0)	slightly positive (1)	moderately positive (2)	extremely positive (3)

Involvement with third person:

extremely negative (-3)	moderately negative (-2)	somewhat negative (-1)	no impact (0)	slightly positive (1)	moderately positive (2)	extremely positive (3)

38. Please indicate how much control you believed you had over the experience at the time the experience occurred.

Involvement with first person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

Involvement with second person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

Involvement with third person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

39. Looking back on the experience, how much control do you now perceive you had at the time the experience occurred?

Involvement with first person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

Involvement with second person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

Involvement with third person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

40. At the time the experience occurred, how much control did you feel you had over your life in general?

Involvement with first person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

Involvement with second person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

Involvement with third person:

very little control (1)	(2)	(3)	(4)	great deal of control (5)

41. Currently, how much control do you feel you have over your life in general?

very little control (1)	(2)	(3)	(4)	great deal of control (5)

42. All the things that happened to me during the experiences had absolutely nothing at all to do with my actions.

strongly agree (1)	(2)	(3)	(4)	strongly disagree (5)

43. I can definitely control whether or not I will ever experience this type of event again in the future.

strongly agree (1)	(2)	(3)	(4)	strongly disagree (5)

44. I always control whether or not bad things happen to me.

strongly agree (1)	(2)	(3)	(4)	strongly disagree (5)

45. During the sexual activities, how did you feel emotionally? Rate each emotion according to the following scale.

I didn't feel this way at all (1)	(2)	I felt this way occasionally/somewhat (3)	(4)	(5)	(6)	I felt this way often/strongly (7)

	Column #1 First Person	*Column #2 Second Person*	*Column #3 Third Person*
a. Guilty	a. _____	a. _____	a. _____
b. Afraid	b. _____	b. _____	b. _____
c. Repulsed	c. _____	c. _____	c. _____
d. Angry	d. _____	d. _____	d. _____
e. Ashamed	e. _____	e. _____	e. _____
f. Anxious	f. _____	f. _____	f. _____
g. Disgusted	g. _____	g. _____	g. _____
h. Detached	h. _____	h. _____	h. _____
i. Numb	i. _____	i. _____	i. _____
j. Content	j. _____	j. _____	j. _____
k. Peaceful	k. _____	k. _____	k. _____
l. Loved	l. _____	l. _____	l. _____
m. Cared for	m. _____	m. _____	m. _____
n. Aroused	n. _____	n. _____	n. _____
o. Enjoyed the physical sensation	o. _____	o. _____	o. _____

p. Interested	p. _____	p. _____	p. _____
q. Curious	q. _____	q. _____	q. _____
r. Special	r. _____	r. _____	r. _____
s. Important	s. _____	s. _____	s. _____
t. Other (please specify feeling below and rate _____	t. _____	t. _____	t. _____

46. 1. In general, how much did you blame these activities on the <u>things you did</u>?

1 2 3 4 5 6 7
did not blame at all blamed completely

47. 2. In general, how much did you blame these activities on things <u>about your personality</u>?

1 2 3 4 5 6 7
did not blame at all blamed completely

48. 3. Think back to when these activities occurred. Rate the following statements according to how you felt then.

1 2 3 4 5 6 7
completely false completely true

a. I was too gullible a person.	1	2	3	4	5	6	7
b. I should have resisted the abuser.	1	2	3	4	5	6	7
c. I put myself in a bad situation.	1	2	3	4	5	6	7
d. I was the kind of person who attracted trouble.	1	2	3	4	5	6	7
e. There was something about me that led to the abuse.	1	2	3	4	5	6	7
f. I should have asked for help.	1	2	3	4	5	6	7
g. I should have known how to say no.	1	2	3	4	5	6	7
h. I was a bad person.	1	2	3	4	5	6	7
i. I was too flirtatious a person.	1	2	3	4	5	6	7
j. I had bad luck.	1	2	3	4	5	6	7
k. I should have done something to stop the abuse.	1	2	3	4	5	6	7
l. I deserved to be abused because of something I did.	1	2	3	4	5	6	7
m. I encouraged my abuser by my words. actions, dress, etc.	1	2	3	4	5	6	7
n. I was in the wrong place at the wrong time.	1	2	3	4	5	6	7
o. I was stupid.	1	2	3	4	5	6	7
p. I was the type of person who got what I deserved.	1	2	3	4	5	6	7
q. I wasn't self-confident enough to stop the abuse.	1	2	3	4	5	6	7

r. I should have tried harder to avoid the abuse.	1	2	3	4	5	6	7
s. I should have known it was wrong.	1	2	3	4	5	6	7
t. I trusted people too much.	1	2	3	4	5	6	7
u. I should not have trusted my abuser.	1	2	3	4	5	6	7
v. I was a careless person.	1	2	3	4	5	6	7
w. I should have been more cautious.	1	2	3	4	5	6	7

	Column #1 First Person	*Column #2 Second Person*	*Column #3 Third Person*
49. Were any of the following used to get you engaged in sexual activities? Circle all that apply.			
Offers of rewards (e.g., gifts, money, privileges)	(1)	(1)	(1)
Threats of telling another person about the activities	(2)	(2)	(2)
Verbal threats of violence	(3)	(3)	(3)
Physical force	(4)	(4)	(4)
Experience was described as "educational" or "good for you"	(5)	(5)	(5)
Threats of suspended privileges	(6)	(6)	(6)
Overwhelmed by continual arguments and pressure.	(7)	(7)	(7)
Person used position of authority (boss, teacher, camp counselor, supervisor) to make you	(8)	(8)	(8)
Incapable of giving consent or resisting due to alcohol or drugs	(9)	(9)	(9)
None of the above was used	(10)	(10)	(10)
Other (please specify)	(11)	(11)	(11)
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

50. Did you feel pressured in any way to participate in these activities?

No	(0) _____	(0)_____	(0)_____
Yes	(1) _____	(1) _____	(1) _____

51. Would you describe these sexual activities as "sexual abuses"?

No	(0)	(0)	(0)
Yes	(1)	(1)	(1)
Not sure	(2)	(2)	(2)

52. During the sexual activities, was the other person under the influence of alcohol or drugs?

No	(0)	(0)	(0)
Yes	(1)	(1)	(1)
Not sure	(2)	(2)	(2)

	Column #1 First Person	*Column #2 Second Person*	*Column #3 Third Person*

53. During the sexual activities, were you under the influence of alcohol or drugs?

No	(0)	(0)	(0)
Yes	(1)	(1)	(1)
Not sure	(2)	(2)	(2)

54. How would you describe your relationship with the other person involved before the sexual activities began?

NA - did not know the other person	(0)	(0)	(0)
Close, warm	(1)	(1)	(1)
Friendly	(2)	(2)	(2)
Dislike	(3)	(3)	(3)
Extreme dislike, disgust	(4)	(4)	(4)
Fearful of him/her	(5)	(5)	(5)

55. How many people have you told about these sexual activities?

None	(1)	(2)	(3)
One	(1)	(2)	(3)
Two	(1)	(2)	(3)
Three to five	(1)	(2)	(3)
Six to nine	(1)	(2)	(3)
10 or more	(1)	(2)	(3)

	Column #1 First Person	*Column #2 Second Person*	*Column #3 Third Person*

56. Circle all of those whom you have told about these experiences.

I have never told	(0)	(0)	(0)
Mother	(1)	(1)	(1)
Father	(2)	(2)	(2)
Stepmother	(3)	(3)	(3)
Stepfather	(4)	(4)	(4)
Grandmother	(5)	(5)	(5)
Grandfather	(6)	(6)	(6)
Brother	(7)	(7)	(7)
Sister	(8)	(8)	(8)
Other relative (please specify)	(9) _____	(9)_____	(9) _____
Male friend	(10)	(10)	(10)
Female friend	(11)	(11)	(11)
Boyfriend (dating partner)	(12)	(12)	(12)
Girlfriend (dating partner)	(13)	(13)	(13)
Male teacher	(14)	(14)	(14)

Female teacher	(15)	(15)	(15)
Male physician	(16)	(16)	(16)
Female physician	(17)	(17)	(17)
Wife	(18)	(18)	(18)
Husband	(19)	(19)	(19)
Minister, rabbi, priest	(20)	(20)	(20)
Social service agency	(21)	(21)	(21)
Police	(22)	(22)	(22)
Male psychologist/psychiatrist	(23)	(23)	(23)
Female psychologist/pshicatrist	(24)	(24)	(24)
Your children	(25)	(25)	(25)
Other (please specify)	(26) _____	(26)	(26) _____

57. How long was it after the sexual activities began that you told?

Never told	(0)	(0)	(0)
Immediately - within a day	(1)	(1)	(1)
Within a month	(2)	(2)	(2)
Within 6 months	(3)	(3)	(3)
Within a year	(4)	(4)	(4)
2 to 5 years	(5)	(5)	(5)
5 to 10 years	(6)	(6)	(6)
More than 10 years	(7)	(7)	(7)

	Column #1 First Person	*Column #2 Second Person*	*Column #3 Third Person*
58. When you told about your sexual experience for the first time, how did the person you told respond?			
Never told	(0)	(0)	(0)
The person was sympathetic to you	(1)	(1)	(1)
The person encouraged you to talk about it	(2)	(2)	(2)
The person doubted or questioned the truthfulness of what you said	(3)	(3)	(3)
The person expressed anger at you	(4)	(4)	(4)
The person expressed anger to the other person involved in the sexual activities	(5)	(5)	(5)
The person was sympathetic to the other person involved in the sexual activities	(6)	(6)	(6)
The person blamed you	(7)	(7)	(7)
The person blamed the other person	(8)	(8)	(8)
The person said nothing	(9)	(9)	(9)
Other (please specify)	(10) _____	(10) _____	(10) _____

59. a. If you are currently involved in an exclusive romantic/dating relationship or marriage, have you ever told this person about any of these sexual activities?

Not currently involved in an exclusive romantic/dating relationship or marriage	(0)	(0)	(0)
No	(1)	(1)	(1)
yes	(2)	(2)	(2)

b. If yes, how long ago did you tell him/her? _____ months

a. If yes, how would you describe his/her reaction toward you?

very supportive of you		neutral		very unsupportive of you
(1)	(2)	(3)	(4)	(5)

60. Looking back, how would you describe the impact of these sexual activities on your life?

Involvement with first person:

very positive		neutral		very negative
(1)	(2)	(3)	(4)	(5)

Involvement with second person:

very positive		neutral		very negative
(1)	(2)	(3)	(4)	(5)

Involvement with third person:

very positive		neutral		very negative
(1)	(2)	(3)	(4)	(5)

APPENDIX B

SEXUAL ATTITUDE FOR SELF AND OTHERS

Sexual Attitude for Self and Others

Please indicate your feelings about these specific activities, using the following alternative responses.

1 = I feel great about it
2 = I feel comfortable about it
3 = I feel neutral about it
4 = I feel repulsed by it

1. Using masturbation as a form of sexual outlet:
   for myself: 1 2 3 4
   for others: 1 2 3 4

2. Mutual masturbation with someone of the opposite sex (An affectionate and tender relationship between partners is assumed. It is also assumed that there is no danger of venereal disease.):
   for myself: 1 2 3 4
   for others: 1 2 3 4

3. Mutual masturbation with someone of the same sex (An affectionate and tender relationship between partners is assumed. It is also assumed that there is no danger of venereal disease.):
   for myself: 1 2 3 4
   for others: 1 2 3 4

4. Sexual intercourse with someone of the opposite sex (An affectionate and tender relationship between partners is assumed. It is also assumed that there is no danger of venereal disease.):
   for myself: 1 2 3 4
   for others: 1 2 3 4

5. Sexual intercourse with someone of the same sex (An affectionate and tender relationship between partners is assumed. It is also assumed that there is no danger of venereal disease.):
   for myself: 1 2 3 4
   for others: 1 2 3 4

6. Oral-genital stimulation with someone of the opposite sex (An affectionate and tender relationship between partners is assumed. It is also assumed that there is no danger of venereal disease.):
   for myself: 1 2 3 4
   for others: 1 2 3 4

1 = I feel great about it
2 = I feel comfortable about it
3 = I feel neutral about it
4 = I feel repulsed by it

7. Oral-genital stimulation with someone of the same sex (An affectionate and tender relationship between partners is assumed. It is also assumed that there is no danger of venereal disease.):
   for myself: 1 2 3 4
   for others: 1 2 3 4

8. Engaging in sex with a partner in the presence of others:
   for myself: 1 2 3 4
   for others: 1 2 3 4

9. Three or more people engaging in intercourse and other sexual activity together:
   for myself: 1 2 3 4
   for others: 1 2 3 4

10. Maintaining more than one sexual relationship at a given time:
    for myself: 1 2 3 4
    for others: 1 2 3 4

11. The woman in a heterosexual relationship being the more aggressive partner at times:
    for myself: 1 2 3 4
    for others: 1 2 3 4

12. Using erotica (erotic literature, pictures, films, live sex shows) to stimulate sexual arousal:
    for myself: 1 2 3 4
    for others: 1 2 3 4

13. Intercourse during the menstrual flow:
    for myself: 1 2 3 4
    for others: 1 2 3 4

APPENDIX C

ADOLESCENT SEXUAL DECISION MAKING SCALE

Why People Have Sexual Intercourse

_____ Please check here if you have NOT had voluntary sexual intercourse and continue on to page 3 of this questionnaire.

Below are some reasons that may have influenced your decision to participate in voluntary sexual intercourse at one time or another. Indicate how much each individual reason influenced your decision to have voluntary sexual intercourse the first time and how much it influenced your most recent decisions to have voluntary sexual intercourse using the rating scale below. If you're not sure, give your best guess.

Did not Influence	Slightly Influenced	Moderately Influenced	Strongly Influenced
0	1	2	3

Decision to Have First Voluntary Sexual Intercourse	Most Recent Decisions to Have Sexual Intercourse	
1. _____	_____	I thought it would help me forget my problems.
2. _____	_____	I thought it would make me feel grown up.
3. _____	_____	I wanted to get pregnant or become a parent.
4. _____	_____	It was a way to get or keep a boyfriend.
5. _____	_____	I thought it would make me feel good.
6. _____	_____	I thought it would make me feel loved.
7. _____	_____	I wanted to fit in with my friends.
8. _____	_____	I wanted to see what it's like.
9. _____	_____	I thought it would make me feel more confident and sure of myself.
10. _____	_____	People I admired or looked up to made it seem like a "cool" thing to do.
11. _____	_____	I wanted to gain popularity with a group.
12. _____	_____	I wanted respect from my partner.
13. _____	_____	I wanted love from my partner.
14. _____	_____	I wanted to show love to my partner.
15. _____	_____	I wanted physical gratification.

Did not Influence	Slightly Influenced	Moderately Influenced	Strongly Influenced
0	1	2	3

Decision to Have First Voluntary Sexual Intercourse	Most Recent Decisions to Have Sexual Intercourse	
16. _____	_____	Out of curiosity.
17. _____	_____	My friends had.
18. _____	_____	My partner wanted to.
19. _____	_____	I wanted to gain attention.
20. _____	_____	I wanted to feel better about myself.
21. _____	_____	I didn't like myself.
21. _____	_____	I loved my partner.
22. _____	_____	I was in a marriage or committed relationship.
23. _____	_____	I felt ready.
24. _____	_____	I had found the right partner.
25. _____	_____	I didn't like my body.
26. _____	_____	I was drunk or high.
27. _____	_____	I felt bad about myself.
28. _____	_____	I thought of myself as a dirty, loose, or immoral person.
29. _____	_____	I thought of myself as an irresponsible person.
30. _____	_____	Other, please specify:

_____ _____

Why People Choose Not to Have Sexual Intercourse

Below are some of the reasons that you might give, or have given in the pas *NOT* having voluntary sexual intercourse. Please indicate how much each reason influenced your decision NOT to have voluntary sexual intercourse the first time yo strongly considered having sexual intercourse and how much it influenced your dec in the most recent times that you have chosen NOT to participate in sexual intercou using the rating scale below. If you're not sure, give your best guess.

Did not Influence	Slightly Influenced	Moderately Influenced	Strongly Influe
0	1	2	3

	First Time Considered Sexual Intercourse But Didn't	Most Recent Times Considered Sexual Intercourse But Didn't	
1.	_____	_____	I thought it was morally wrong.
2.	_____	_____	I was embarrassed.
3.	_____	_____	I didn't want to get a sexually transmitted dise (STD) or a disease like AIDS
4.	_____	_____	My parent(s) didn't approve.
5.	_____	_____	I didn't feel old enough to handle it.
6.	_____	_____	My friends didn't approve.
7.	_____	_____	I might have gotten pregnant.
8.	_____	_____	I wasn't in love.
9.	_____	_____	I didn't need it to make me happy.
10.	_____	_____	I would have felt guilty.
11.	_____	_____	I didn't want to.
12.	_____	_____	Religious beliefs.
13.	_____	_____	I felt vulnerable.
14.	_____	_____	Nobody wanted to have sex with me.
15.	_____	_____	I was not ready.
16.	_____	_____	I couldn't get birth control.

Did not Influence	Slightly Influenced	Moderately Influenced	Strongly Influenced
0	1	2	3

	First Time Considered Sexual Intercourse But Didn't	Most Recent Times Considered Sexual Intercourse But Didn't	
17.	_____	_____	I wasn't married.
18.	_____	_____	I had a bad experience in the past.
19.	_____	_____	I hadn't found the right partner.
20.	_____	_____	I wasn't comfortable with sex.
21.	_____	_____	I had a difficult time trusting people.
22.	_____	_____	It was scary.
23.	_____	_____	It made me very uncomfortable.
24.	_____	_____	My partner might have thought something was wrong with me.
25.	_____	_____	Other, please specify: _____

APPENDIX D

TABLES

Table D1

Factor Loadings for Reasons to Engage in Sexual Intercourse for the First Time

	Factor						
Item	1[a]	2	3	4	5	6	7
To forget my problems	0.38	-0.07	-0.31	0.18	0.01	0.08	0.21
To make me feel grown up	0.29	0.57	-0.10	0.03	0.31	-0.05	0.38
To get pregnant	-0.04	-0.01	-0.01	-0.07	0.07	0.11	0.76
To get or keep boyfriend	0.63	0.23	-0.30	-0.06	0.17	0.27	-0.11
To make me feel good	0.46	0.04	0.10	0.18	0.51	-0.06	0.28
To make me feel loved	0.78	0.10	0.03	0.21	0.17	-0.01	-0.01
To fit in with friends	0.03	0.83	-0.10	0.06	0.06	0.01	-0.05
To see what it's like	0.16	0.21	-0.03	0.03	0.85	0.03	-0.01
To feel more confident	0.41	0.42	-0.06	0.38	0.19	- 0.02	0.16
Seemed like a "cool" thing	0.23	0.73	-0.04	0.17	0.12	0.01	0.24
To gain popularity	0.04	0.71	-0.18	0.02	- 0.03	0.03	-0.13
Wanted respect from partner	0.69	0.22	-0.05	0.26	0.07	0.08	-0.01
Wanted love from partner	0.80	0.09	0.16	0.16	0.03	0.02	-0.10
To show love to partner	0.56	-0.08	0.58	0.03	0.08	-0.01	-0.10
Wanted physical gratification	0.14	0.08	0.27	0.32	0.49	- 0.09	0.04
Out of curiosity	0.05	0.19	0.00	-0.02	0.86	0.04	-0.03
My friends had	-0.07	0.76	-0.12	0.06	0.25	0.03	-0.05
My partner wanted to	0.37	0.14	-0.22	0.05	0.30	0.13	-0.45
To gain attention	0.27	0.54	-0.10	0.22	0.11	-0.01	-0.12
To feel better about myself	0.33	0.17	-0.05	0.60	0.25	0.02	0.11
Didn't like myself	0.11	0.13	-0.06	0.81	0.09	0.25	-0.07
I loved my partner	0.17	-0.26	0.78	-0.13	-0.12	-0.00	-0.08
In marriage/committed	0.03	-0.10	0.76	-0.15	0.02	0.02	0.10
I felt ready	-0.21	-0.05	0.70	0.06	0.21	-0.21	0.04
Found the right partner	-0.10	-0.16	0.87	-0.04	-0.03	0.04	0.02

Continued

Table D1 - Continued

Item	Factor 1[a]	2	3	4	5	6	7
Didn't like my body	0.18	0.14	0.00	0.77	-0.02	-0.07	-0.02
Was drunk or high	-0.02	0.10	-0.31	0.39	-0.06	-0.11	-0.05
Felt bad about myself	0.19	-0.04	-0.12	0.79	0.07	0.34	-0.07
Thought of self as dirty, immoral	0.07	0.01	-0.05	0.14	-0.03	0.94	-0.02
Thought of self as irresponsible	0.07	0.02	-0.01	0.08	0.02	0.93	0.12
Eigenvalue	6.98	3.61	2.66	1.76	1.71	1.46	1.17
Variance accounted for by the factor after rotation	3.66%	3.51%	3.31%	3.00%	2.51%	2.12%	1.25%
Cronbach's alpha	0.80	0.83	0.83	0.83	0.75	0.92	[c]
Two week test-retest reliability [b]	0.81	0.84	0.75	0.72	0.85	0.03	[c]

Note. Item phrasing is not exact; [a] Factor 1 = Improve relationship, Factor 2 = Popularity, Factor 3 = Feeling ready, Factor 4 = To improve self-esteem, Factor 5 = Curiosity, Factor 6 = Bad person, Factor 7 = Wanting to get pregnant; [b] Test-retest reliability reflects Pearson correlation coefficients; [c] Cronbach's alpha coefficient for single item scale was not calculated.

Table D2

Factor Loadings for Reasons to Engage in Sexual Intercourse for the Most Recent Times

Item	Factor							
	1[a]	2	3	4	5	6	7	
To forget my problems	-0.30	0.53	-0.09	0.35	-0.17	0.17	-0.13	0.04
To make me feel grown up	-0.03	0.09	0.13	0.20	-0.02	0.09	-0.01	0.77
To get pregnant	0.14	0.36	-0.03	-0.15	0.33	-0.06	0.10	0.57
To get or keep boyfriend	-0.19	0.30	0.06	0.60	0.06	-0.03	0.06	0.14
To make me feel good	0.04	0.13	-0.01	0.40	0.03	0.63	0.17	0.18
To make me feel loved	0.12	0.11	0.11	0.70	0.09	0.31	-0.01	0.26
To fit in with friends	-0.04	-0.15	0.57	0.17	0.03	- 0.09	0.10	0.37
To see what it's like	0.07	-0.02	0.09	0.06	0.05	0.00	0.90	0.15
To feel more confident	-0.08	0.34	0.50	0.18	-0.09	0.27	0.13	-0.17
Seemed like a "cool" thing	0.03	0.17	0.75	0.01	0.04	0.13	0.12	0.09
To gain popularity	-0.02	0.10	0.83	0.05	-0.03	-0.03	-0.04	-0.09
Wanted respect from partner	0.04	0.12	0.31	0.65	0.18	0.13	0.06	-0.10
Wanted love from partner	0.28	0.11	0.08	0.73	0.05	-0.05	0.00	0.05
To show love to partner	0.66	-0.05	0.01	0.48	0.04	0.02	-0.04	-0.05
Wanted physical gratification	0.01	0.07	0.06	0.03	0.05	0.83	0.02	-0.01
Out of curiosity	-0.09	0.08	0.17	0.07	0.06	0.15	0.86	-0.12
My friends had	-0.03	-0.08	0.78	0.17	0.05	-0.04	0.13	0.13
My partner wanted to	0.01	-0.02	0.13	0.45	0.03	0.33	0.16	-0.10
To gain attention	-0.10	0.45	0.45	0.12	0.01	0.27	-0.10	-0.06
To feel better about myself	-0.10	0.65	0.32	0.21	-0.02	0.26	0.13	-0.23
Didn't like myself	-0.01	0.75	0.03	0.17	0.34	-0.09	0.08	0.14
I loved my partner	0.82	-0.08	-0.15	0.21	-0.01	- 0.19	0.00	-0.06
In marriage/committed relationship	0.75	-0.07	-0.08	-0.02	0.06	0.11	-0.14	-0.01
I felt ready	0.69	0.06	0.06	0.02	-0.23	0.09	0.11	0.13
Found the right partner	0.85	0.00	0.04	-0.04	-0.09	0.04	0.04	0.02
Didn't like my body	0.05	0.65	0.11	-0.03	0.14	0.08	-0.08	0.34

Continued

Table D2 – Continued

Item	Factor 1	2	3	4	5	6	7	
Was drunk or high	-0.47	0.16	0.03	0.09	0.00	0.37	-0.02	-0.01
Felt bad about myself	-0.07	0.83	-0.00	0.13	0.26	0.04	0.07	0.05
Thought of self as dirty, immoral	-0.11	0.16	0.02	0.22	0.89	0.05	0.05	0.02
Thought of self as irresponsible	-0.11	0.28	0.02	0.08	0.89	0.07	0.06	0.11
Eigenvalue	5.99	3.65	2.67	1.94	1.68	1.49	1.24	1.07
Variance accounted for by the factor after rotation	3.41%	3.22%	3.00%	2.89%	2.07%	1.84%	1.78%	1.53%
Cronbach's alpha	0.84	0.84	0.77	0.75	0.95	0.58	0.79	[c]
Two week test-retest reliability [b]	0.80	0.67	0.42	0.77	0.30	0.68	0.40 1.00	

Note. Item phrasing is not exact; [a] Factor 1 = Feeling ready, Factor 2 = To improve self-esteem, Factor 3 = Popularity, Factor 4 = Improve relationship, Factor 5 = Bad person, Factor 6 = Physical gratification, Factor 7 = Curiosity, Factor 8 = Wanting to get Pregnant; [b] Test-retest reliability reflects Pearson correlation coefficients; [c] Cronbach's alpha coefficient for single item scale was not calculated.

Table D3

Factor Loadings for Reasons NOT to Engage in Sexual Intercourse for the First Time

	Factor					
Item	1[a]	2	3	4	5	6
I thought it was morally wrong	0.82	0.04	0.01	0.07	-0.00	-0.10
I was embarrassed	0.06	0.65	-0.01	0.23	-0.04	0.17
I didn't want an STD or AIDS	0.33	0.01	0.45	0.01	0.29	0.47
My parents didn't approve	0.62	0.20	0.11	0.03	-0.01	0.20
I didn't feel old enough	0.27	0.41	0.50	0.16	-0.20	0.10
My friends didn't approve	0.33	0.12	0.19	0.40	-0.12	0.08
I might have gotten pregnant	0.36	0.12	0.36	-0.19	-0.03	0.45
I wasn't in love	-0.03	-0.00	0.77	0.25	0.12	0.01
I didn't need it to make me happy	0.32	0.12	0.51	0.09	-0.16	0.12
I would have felt guilty	0.67	0.30	0.18	0.09	-0.08	0.10
I didn't want to	0.06	0.25	0.53	-0.04	-0.01	-0.18
Religious beliefs	0.87	-0.03	0.02	0.04	0.04	-0.05
I felt vulnerable	0.13	0.39	0.06	0.51	0.14	0.07
Nobody wanted to have sex with me	0.04	0.05	0.12	0.82	0.02	-0.02
I was not ready	0.20	0.41	0.58	-0.02	-0.18	0.09
I couldn't get birth control	-0.05	0.12	-0.06	0.11	-0.06	0.79
I wasn't married	0.83	0.06	0.10	0.08	0.04	0.02
I had a bad experience in the past	-0.00	0.07	0.01	-0.00	0.77	-0.13
I hadn't found the right partner	-0.02	0.07	0.72	0.06	0.27	0.10
I wasn't comfortable with sex	0.17	0.67	0.36	-0.02	0.05	-0.02
I had a difficult time trusting people	-0.05	0.40	0.23	0.04	0.51	0.24
It was scary	0.08	0.78	0.21	-0.00	0.09	0.01
It made me very uncomfortable	0.13	0.79	0.16	0.09	0.17	-0.00
My partner would have thought	0.05	0.51	-0.09	0.32	0.42	0.20
Eigenvalue	6.16	2.61	1.73	1.20	1.14	1.13
Variance accounted for by the factor	3.60%	3.27%	2.93%	1.42%	1.38%	1.34%
Cronbach's alpha	0.85	0.80	0.76	0.37	0.35	[c]
Two-week test-retest reliability	0.89	0.84	0.73	0.65	0.73	0.30

Note. Item phrasing is not exact; [a] Factor 1 = Moral/religious beliefs, Factor 2 = Discomfort with sex, Factor 3 = Not ready, Factor 4 = No potential partner, Factor 5 = Bad experience in past, Factor 6 = No access to birth control; [b] Test-retest reliability reflects Pearson correlation coefficients; [c] Cronbach's alpha coefficient for single item scale was not calculated.

Table D4

Factor Loadings for Reasons NOT to Engage in Sexual Intercourse for the Most Recent Times

	Factor					
Item	1[a]	2	3	4	5	6
I thought it was morally wrong	0.83	0.11	0.10	0.07	0.04	-0.10
I was embarrassed	0.14	0.31	0.02	0.54	0.24	0.08
I didn't want an STD or AIDS	0.31	0.19	0.57	0.23	-0.01	0.16
My parents didn't approve	0.78	0.14	0.12	0.03	0.08	0.07
I didn't feel old enough	0.37	0.62	0.20	-0.17	0.17	0.01
My friends didn't approve	0.35	0.21	0.15	-0.11	0.53	0.08
I might have gotten pregnant	0.40	0.27	0.40	0.05	-0.17	0.21
I wasn't in love	0.01	0.12	0.79	0.14	0.19	0.00
I didn't need it to make me happy	0.26	0.08	0.58	0.01	0.09	-0.25
I would have felt guilty	0.68	0.17	0.30	0.17	0.09	-0.01
I didn't want to	-0.04	0.27	0.34	0.09	-0.07	-0.53
Religious beliefs	0.87	0.11	0.08	0.06	0.06	-0.11
I felt vulnerable	0.16	0.15	0.17	0.46	0.46	0.09
Nobody wanted to have sex with me	0.02	0.01	0.10	0.12	0.80	-0.08
I was not ready	0.26	0.65	0.41	-0.09	0.06	-0.01
I couldn't get birth control	-0.08	0.06	0.14	0.08	-0.03	0.76
I wasn't married	0.76	0.35	0.06	-0.02	0.13	0.02
I had a bad experience in the past	0.04	-0.13	0.13	0.70	-0.15	-0.13
I hadn't found the right partner	0.14	0.23	0.70	0.16	0.12	0.03
I wasn't comfortable with sex	0.22	0.75	0.17	0.24	0.03	-0.09
I had a difficult time trusting people	0.01	0.11	0.37	0.68	-0.08	0.11
It was scary	0.20	0.76	0.15	0.26	0.09	0.01
It made me very uncomfortable	0.12	0.65	0.09	0.47	0.08	-0.06
My partner would have thought something	-0.03	0.24	-0.02	0.66	0.29	0.03
Eigenvalue	7.16	2.47	1.46	1.34	1.18	1.08
Variance Accounted for by the factor after	3.91%	3.07%	2.68%	2.45%	1.49%	1.09%
Cronbach's alpha	0.89	0.84	0.73	0.67	0.37	0.03
Two-week test-retest reliability	0.85	0.79	0.72	0.78	0.53	0.40

Note. Item phrasing is not exact; [a] Factor 1 = Moral/religious beliefs, Factor 2 = Discomfort with sex, Factor 3 = Not ready, Factor 4 = Bad experience in past, Factor 5 = No potential partner, Factor 6 = No access to birth control; [b] Test-retest reliability reflects Pearson correlation coefficients.

Table D5

Group Means, Standard Deviations, and F Statistics for Reasons to Engage in Voluntary Sexual Intercourse for the First Time.

Factor name	Nonvictims (n = 223)	Survivors (n = 39)	F(df)	p
Improve relationship	M = 0.84 SD = 0.76	M = 1.17 SD = 0.92	6.31 (1, 260)	.01
Popularity	M = 0.33 SD = 0.56	M = 0.36 SD = 0.49	0.18 (1, 260)	ns
Feeling ready	M = 1.70 SD = 1.00	M = 1.61 SD = 0.97	0.29 (1, 260)	ns
To improve self-esteem	M = 0.16 SD = 0.44	M = 0.37 SD = 0.65	7.34 (1, 260)	.01
Out of curiosity	M = 1.62 SD = 0.87	M = 1.54 SD = 1.05	0.27 (1, 260)	ns
Bad person	M = 0.06 SD = 0.33	M = 0.14 SD = 0.57	1.54 (1, 260)	ns
Wanting to get pregnant	M = 0.01 SD = 0.13	M = 0 SD = 0	0.17 (1, 260)	ns

Note. Higher scores reflect greater influence upon decision to engage in sexual intercourse for the first time.

Table D6

Group Means, Standard Deviations, and F Statistics for Most Recent Decisions to Engage in Voluntary Sexual Intercourse.

Factor name	Nonvictims (n =221)	Survivors (n = 38)	F(df)	p
Improve relationship	M = 0.56 SD =0 .69	M= 0.89 SD = 0.87	6.86 (1, 257)	.01
Popularity	M = 0.10 SD = 0.29	M = 0.14 SD = 0.27	0.46 (1, 257)	ns
Feeling ready	M = 1.93 SD = 1.00	M = 1.96 SD = 0.94	0.04 (1, 257)	ns
To improve self-esteem	M = 0.12 SD = 0.37	M = 0.30 SD = 0.68	5.60 (1, 257)	.02
Out of curiosity	M = 0.54 SD = 0.87	M = 0.63 SD = 0.94	0.35 (1, 257)	ns
Bad person	M = 0.10 SD = 0.40	M = 0.25 SD = 0.72	3.61 (1, 257)	.06
Wanting to get pregnant	M = 0.00 SD = 0.00	M = 0.08 SD = 0.49	5.93 (1, 257)	.02
Physical gratification	M = 1.36 SD = 1.03	M = 1.41 SD = 1.14	0.09 (1, 257)	ns

Note. Higher scores reflect greater influence upon most recent decisions to engage in sexual intercourse.

Table D7

Group Means, Standard Deviations, and F Statistics for Reasons to NOT Engage in Voluntary Sexual Intercourse the First Time.

Factor name	Nonvictims (n =375)	Survivors (n =56)	F(df)	p
Moral/religious beliefs	M = 1.93 SD = 1.00	M =1.96 SD = 0.94	0.54 (1, 429)	ns
Discomfort with sex	M = 0.12 SD =0.37	M = 0.30 SD =0.68	3.38 (1, 429)	.07
Not ready	M = 0.10 SD =0.29	M = 0.14 SD =0.27	0.00 (1, 429)	ns
Bad experience in past	M = 0.10 SD =0.40	M = 0.25 SD =0.72	0.03 (1, 429)	ns
No potential partner	M = 0.56 SD =0.69	M = 0.89 SD =0.87	0.71 (1, 429)	ns
No access to birth control	M = 1.36 SD =1.03	M = 1.41 SD =1.14	0.69 (1, 429)	ns

Note. Higher scores reflect greater influence upon decision to not engage in sexual intercourse the first time.

Table D8

Group Means, Standard Deviations, and F Statistics for Most Recent Decision to NOT Engage in Voluntary Sexual Intercourse.

Factor name	Nonvictims (n = 361)	Survivors (n = 52)	F(df)	p
Moral/religious beliefs	M = 1.75 SD = 1.09	M = 1.65 SD = 1.05	0.33 (1, 411)	ns
Discomfort with sex	M = 0.97 SD = 0.90	M = 1.18 SD = 0.85	2.50 (1, 411)	.12
Not ready	M = 1.67 SD = 1.00	M = 1.88 SD = 0.87	2.14 (1, 411)	.14
Bad experience in past	M = 0.53 SD = 0.64	M = 1.13 SD = 0.90	36.39 (1, 411)	0.0001
No potential partner	M = 0.28 SD = 0.58	M = 0.18 SD = 0.49	1.38 (1, 411)	ns
No access to birth control	M = 0.64 SD = 0.76	M = 0.60 SD = 0.73	0.19 (1, 411)	ns

Note. Higher scores reflect greater influence upon decision to not engage in sexual intercourse most recently.

APPENDIX E

FEAR OF INTIMACY SCALE

FIS

Part A: Imagine you are in a *close, dating relationship.* Respond to the following statements as you would *if you were in that close relationship.*

1	2	3	4	5
Not at all characteristic of me	*Slightly characteristic of me*	*Moderately characteristic of me*	*Very characteristic of me*	*Extremely characteristic of me*

Note: In each state "0" refers to the person who would be in the close relationship with you.

1. _____ I would feel uncomfortable telling 0 about things in the past that I have been ashamed of.
2. _____ I would feel uneasy talking with 0 about something that has hurt me deeply.
3. _____ I would feel comfortable expressing my true feeling to 0.
4. _____ If 0 were upset, I would sometimes be afraid of showing that I care.
5. _____ I might be afraid to confide my innermost feelings to 0.
6. _____ I would feel at ease telling 0 that I care about him/her.
7. _____ I would have a feeling of complete togetherness with 0.
8. _____ I would have problems discussing significant problems with 0.
9. _____ A part of me would be afraid to make a long-term commitment to 0.
10. _____ I would feel comfortable telling my experiences, even sad ones, to 0.
11. _____ I would probably feel nervous showing 0 strong feelings of affection.
12. _____ I would find it difficult being open with 0 about my personal thoughts.
13. _____ I would feel uneasy with 0 depending on me for emotional support.
14. _____ I would not be afraid to share with 0 what I dislike about myself.
15. _____ I would be afraid to take the risk of being hurt in order to establish a closer relationship with 0.
16. _____ I would feel comfortable keeping very personal information to myself.

1	2	3	4	5
Not at all characteristic of me	*Slightly characteristic of me*	*Moderately characteristic of me*	*Very characteristic of me*	*Extremely characteristic of me*

17. _____ I would not be nervous about being spontaneous with 0.

18. _____ I would feel comfortable telling 0 things that I do not tell other people.

19. _____ I would feel comfortable trusting 0 with my deepest thoughts and feelings.

20. _____ I would sometimes feel uneasy if 0 told me about very personal matters.

21. _____ I would be comfortable revealing to 0 what I feel are my shortcomings and handicaps.

22. _____ I would be comfortable with having a close emotional tie between us.

23. _____ I would be afraid of sharing my private thoughts with 0.

24. _____ I would be afraid that I might not always feel close to 0.

25. _____ I would be comfortable telling 0 what my needs are.

26. _____ I would be afraid that 0 would be more invested in the relationship than I would be.

27. _____ I would feel comfortable about having open and honest communication with 0.

28. _____ I would sometimes feel uncomfortable listening to 0's personal problems.

28. _____ I would feel at ease to completely be myself around 0.

29. _____ I would feel relaxed being together and talking about our personal goals.

Part B: Respond to the following statements as they apply to your past relationships. Rate how characteristic each statement is of you on a scale of 1 to 5 as listed above.

30. _____ I have shied away from opportunities to be close to someone.

31. _____ I have held back my feelings in previous relationships.

32. _____ There are people who think that I am not an easy person to get to know.

33. _____ I have done things in previous relationships to keep me from developing closeness.

APPENDIX F

HURLBERT INDEX OF SEXUAL ASSERTIVENESS

Hurlbert

Please complete this questionnaire regardless of your sexual history or c
relationship status. Answer each item as accurately as you can by placing a nu
each question as follows. There are no right or wrong answers.

0 = All of the time
1 = Most of the time
2 = Some of the time
3 = Rarely
4 = Never

Note: The term "sex" in this questionnaire may refer to a variety of sexual beh
necessarily
sexual intercourse alone.

1. _____ I feel uncomfortable talking during sex.
2. _____ I feel that I am shy when it comes to sex.
3. _____ I approach my partner for sex when I desire it.
4. _____ I think I am open with my partner about my sexual needs.
5. _____ I enjoy sharing my sexual fantasies with my partner.
6. _____ I feel uncomfortable talking to my friends about sex.
7. _____ I communicate my sexual desires to my partner.
8. _____ It is difficult for me to touch myself during sex.
9. _____ It is hard for me to say no even when I do not want sex.
10. _____ I feel reluctant to describe myself as a sexual person.
11. _____ I feel uncomfortable telling my partner what feels good.
12. _____ I speak up for my sexual feeling.
13. _____ I am reluctant to insist that my partner satisfy me.
14. _____ I find myself having sex when I do not really want it.
15. _____ When a technique does not feel good, I tell my partner.
16. _____ I feel comfortable giving sexual praise to my partner.
17. _____ It is easy for me to discuss sex with my partner.
18. _____ I feel comfortable in initiating sex with my partner.
19. _____ I find myself doing sexual things that I do not like.
20. _____ Pleasing my partner is more important that my pleasure.
21. _____ I feel comfortable telling my partner how to touch me.

22. _____ I enjoy masturbating myself to orgasm.
23. _____ If something feels good, I insist on doing it again.
24. _____ It is hard for me to be honest about my sexual feelings.
25. _____ I try to avoid discussing the subject of sex.

APPENDIX G

SEXUAL SELF-ESTEEM INVENTORY

FOR WOMEN

SSEI

Instructions: This inventory asks you to rate your feelings about several aspects of sexuality. There are no right or wrong answers; feelings about sexuality normally vary. From the rating scale near the top of each page, select the response which most closely corresponds to the way you feel about each statement. Write the number for that response in the space before the statement.

Disagree Strongly	Disagree Moderately	Disagree Mildly	Agree Mildly	Agree Moderately	Agree Strongly
1	2	3	4	5	6

_____ 1. I wish I could relax in sexual situations.

_____ 2. I am pleased with my physical appearance.

_____ 3. I feel emotionally vulnerable in a sexual encounter.

_____ 4. I feel good about the place of sex in my life.

_____ 5. I feel guilty about my sexual thoughts and feelings.

_____ 6. I feel I am pretty good at sex.

_____ 7. I hate my body.

_____ 8. I am afraid of losing control sexually.

_____ 9. I like what I have learned about myself from my sexual experiences.

_____ 10. My sexual behaviors are in line with my moral values.

_____ 11. I feel that "sexual techniques" come easily to me.

_____ 12. I am pleased with the way my body had developed.

_____ 13. I feel I can usually judge how my partner will regard my wishes about how far to go sexually.

_____ 14. I don't feel ready for some of the things that I am doing sexually.

_____ 15. Some of the things I do in sexual situations are morally wrong.

_____ 16. Sexually, I feel like a failure.

Disagree Strongly	Disagree Moderately	Disagree Mildly	Agree Mildly	Agree Moderately	Agree Strongly
1	2	3	4	5	6

_____ 17. I would like to trade bodies with someone else.

_____ 18. I feel physically vulnerable in a sexual encounter.

_____ 19. Sometimes I wish I could forget about sex.

_____ 20. I have punished myself for my sexual thoughts, feelings, and/or behaviors.

_____ 21. I do pretty well at expressing myself sexually.

_____ 22. I worry that some parts of my body would be disgusting to a sexual partner.

_____ 23. I worry that I won't be able to stop something I don't want to do in a sexual situation.

_____ 24. I wish sex were less a part of my life.

_____ 25. I never feel bad about my sexual behavior.

_____ 26. I feel embarrassed about my lack of sexual experience.

_____ 27. I would be happier if I looked better.

_____ 28. I worry that things will get out of hand because I can't always tell what my partner wants in a sexual situation.

_____ 29. I am glad that feelings about sex have become a part of my life.

_____ 30. I never feel guilty about my sexual feelings.

_____ 31. I feel good about my ability to satisfy my sexual partner.

_____ 32. I am proud of my body.

_____ 33. I worry that I will be taken advantage of sexually.

_____ 34. In general, I feel my sexual experiences have given me a more positive view of myself.

_____ 35. From a moral point of view, my sexual feelings are acceptable to me.

APPENDIX H

SEXUAL BEHAVIOR INVENTORY

Questionnaire A

1. Have you ever had voluntary sexual intercourse?
_____ Yes
_____ No

2. If you have ever had voluntary sexual intercourse, how old were you when you had voluntary intercourse for the first time?
_____ Years old _____ I have never had voluntary sexual intercourse.

3. With how many people have you had voluntary sexual intercourse?
_____ Number of people _____ I have never had voluntary sexual intercourse.

4. With how many people have you participated in sexual intercourse with when you would ***not*** have considered that person to be your "partner" (boyfriend/girlfriend) at that time?
_____ Number of people _____ I have never had voluntary sexual intercourse.

5. When you have voluntary sexual intercourse, how often do you use some kind of birth control?
_____ Never _____ I have never had voluntary sexual intercourse.
_____ Sometimes
_____ Most of the time
_____ Always

6. Which types of the sexual protection listed below have you used in the past: (check all that apply)
_____ abstinence
_____ withdrawal
_____ the rhythm method
_____ a daily birth control pill
_____ condom, rubbers
_____ Depo Provera (a medical injection for birth control)
_____ I.U.D.
_____ sponge
_____ diaphragm
_____ spermacide, foam, jelly
_____ Norplant
_____ other, please specify: _____

7. When you have voluntary sexual intercourse, how often does your partner wear a condom?
_____ Never _____ I have never had voluntary sexual intercourse.
_____ Sometimes _____ Always
_____ Most of the time

8. How many times have you had voluntary sexual intercourse in the past with a partner who you know was having sex with other people?
   _____ Number of people _____ I have never had voluntary sexual intercourse.

9. How does your voluntary sexual experience compare to the sexual experiences of most people your age?
   _____ I am less experienced
   _____ I have the same amount of experience.
   _____ I am more experienced.

APPENDIX I

INSTITUTIONAL REVIEW BOARD

APPROVAL FORM

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Date: April 27, 1999 IRB #: AS-95-015A

Proposal Title: "LIFE EXPERIENCES AND CURRENT ADJUSTMENT"

Principal Investigator(s): Trish Long

Reviewed and Processed as: Modification and Continuation

Approval Status Recommended by Reviewer(s): Approved

Signature:

Carol Olson, Director of University Research Compliance

April 27, 1999
Date

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA

Tracy Fehrenbach

Candidate for the Degree of

Master of Science

Thesis: FEMALE CHILD SEXUAL ABUSE SURVIVORS AND NONVICTIMS: A COMPARISON OF SEXUAL BEHAVIOR AND SEXUAL FUNCTIONING

Major Field: Psychology

Biographical:

Education: Graduated from Mehlville Senior High School, St. Louis, Missouri in May of 1993; received Bachelor of Arts degree with honors in Psychology from the University of Missouri, Columbia, Missouri in May of 1997. Completed requirements for the Master of Science degree with a major in Psychology at Oklahoma State University, Stillwater, Oklahoma in December, 2000.

Experience: Graduate research assistant in the Life Experiences research lab at Oklahoma State University, September 1997 – October 2000. Duties include participation in research design, administration of assessment materials, and scoring, entry, and presentation of data with community and college populations. Responsibilities also include supervision of undergraduate research assistants, statistical analyses, and writing of research papers. Practicum student research assistant for a treatment outcome program for children with sexual behavior problems at Center for Child Abuse and Neglect, Oklahoma Health Sciences Center, July 1998 – July 2000.

Professional Memberships: American Professional Society for the Abuse of Children, International Society for Prevention of Child Abuse and Neglect, American Psychological Association, Psychology of Women, Section on Child Maltreatment, Psychology Graduate Student Association, Oklahoma State University; Southwestern Psychological Association.