SEXUAL DECISION-MAKING IN YOUNG ADULT CHILD SEXUAL ABUSE SURVIVORS AND NONVICTIMS

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CHAPTER I

Introduction

An association between sexual abuse of children and a vast array of negative life problems is now widely acknowledged. Specifically, child sexual abuse (CSA) is thought to disrupt normal development and my result in adjustment difficulties and both psychological and physical problems (Polusney & Follette, 1995). Difficulties experienced by survivors of childhood sexual abuse (CSA) can occur immediately following the abuse, but sometimes do not surface until years after the abuse. Additionally, the symptomatology may be either transient or pervasive (Browne & Finkelhor, 1986).

One particular area characterized as problematic for survivors of CSA is sexuality (Finkelhor & Browne, 1985). For instance, research demonstrates that survivors and nonvictims differ in rates of childhood sexual behavior problems, initiation and frequency of sexual behavior, sexual dysfunction, and adult victimization (Kendall-Tackett, Williams, & Finkelhor, 1993; Davis & Petretic-Jackson, 2000). Empirical investigation of sexual adjustment specific to adolescent and young adult survivors concludes that teens with a sexual abuse history are more likely than nonabused peers to engage in a variety of risky sexual behaviors including early initiation of voluntary sexual intercourse, multiple sexual partners, teen pregnancy, and inconsistent contraceptive use (Evanston, Fiscella, Kitzman, Cole, Sidora, & Olds, 1998; Fergusson, Horwood, &

Lynskey, 1997; Krahe, Scheinberger-Olwig, Waizenhoper, & Kolpin, 1998; Luster & Small, 1997; Miller, Monson, & Norton, 1995; Stock, Bell, Boyer, & Connell, 1997).

Literature on normal sexual development suggests that an adolescent's perceptions or conceptualization of sexuality influence the young person's sexual decision-making and subsequent sexual behavior (Holmbeck, Crossman, Wandrei, & Gasiewski, 1994; Walen & Roth, 1987). It has been theorized that differences in survivors' sexual behavior reflect differences in the way they think about or conceptualize sexuality. Several theories of CSA hypothesize that survivors develop a sexual repertoire of attitudes, feelings, and behaviors (e.g., sexual script) that is different from that of young people with no abuse history as a result of reinforcement and punishment in the context of sexual abuse (Browning & Laumann 1987; Finkelhor & Browne 1985). Thus, understanding the sexual belief system of adolescent CSA survivors and the way it differs from nonabused adolescents may be especially important given their high rates of participation in sexual risk-taking behavior.

To date, only three studies have examined sexual decision-making in adolescent sexual abuse survivors, and no study has investigated similarities and differences in the sexual perceptions of abused and nonabused youth. Several theories of sexual development and theories of CSA symptomatology directly suggest that cognitive factors influence sexual behavior, yet to date, no study has broadly examined the impact of cognitive style (e.g, attributional style) on sexual decision-making and subsequent sexual behavior. In other words, attributions in general, and those particular to sexuality, are likely factors that influence sexual decision-making and behavior; however, the sexual

decision-making literature has not addressed the likely contribution of attributional style on sexual decision-making or subsequent sexual behavior.

The purpose of the current study was to broaden what is known about the factors that influence the sexual decision-making of late adolescent/young adult survivors of sexual abuse. The goals of this study were three fold. First, this study attempted to replicate findings of previous studies by comparing the sexual activity of survivors and nonvictims. Secondly, this study attempted to determine whether survivors make causal meaning of sexuality in a way different from their nonabused peers and whether this influences participation in sexual behavior by examining the relationship of victimization status to sexual behavior and attributional variables. Finally, this study attempted to replicate and extend the findings of previous sexual decision-making studies with a sample of CSA surviviors by examining three factors that have been supported as predictors of sexual decision-making in studies of nonvictimized samples. These included level of parental supervision, positive consequences (benefits) associated with sexual behavior, and negative consequences (costs) associated with sexual behavior. In sum, the present study was intended to evaluate the relative contribution general attributional style and sexual-specific attributional style on sexual behavior for survivors and nonvictims, above and beyond level of parental supervision, benefits, and costs.

CHAPTER II

REVIEW OF THE LITERATURE

Child Sexual Abuse

Prevalence

During the 1980s, a number of studies were conducted employing large sample sizes and slightly different, yet reliable, research designs. Collectively, they yielded vastly different rates of CSA (Salter, 1992). Reported rates of childhood victimization ranged between 2% and 62% (Peters, Wyatt, & Finkelhor, 1986) with the majority of studies between 15% and 33% in the general female population (Polusny & Follette, 1995). Studies conducted in the 1990s have continued to assess prevalence and rates do not appear to have increased or decreased significantly over the past ten years (Wyatt, Burns, Loeb, Solis, Carmona, & Romero, 1999; Vogeltanz, Wilsnack, Harris, & Kristjanson, 1999).

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 1116 Swiss children and youth, revealing that 33.8% of girls and 10.9% of boys had experienced unwanted sexual contact (Bouvier et al., 1999). In a 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).

Numerous factors have been suggested to account for the variance within prevalence studies (Wynkoop, Capps, & Priest, 1995). 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. For example, Peters, Wyatt, and Finkelhor (1986) reviewed studies investigating the effect of each of these variables, documenting that each influenced measured prevalence rates. Overall, they found that higher prevalence rates were associated with more carefully designed and controlled studies. Variation, however, existed between even the most meticulous studies. To better understand the influence of these variables, the effects of sampling, abuse definition, response rates, and research protocol will be examined in brief below.

Sampling

Response rates of CSA have been found to vary by the type of population sampled. Generally, CSA studies conducted with psychiatric patient populations have yielded higher rates of victimization than have research projects with non-clinical samples (Polusny & Follette, 1995). In CSA research, lower rates of victimization have been identified in college populations as compared to a clinical or general community sample. This finding may reflect that survivors are less likely than nonabused peers to pursue an advanced degree. Overall, these studies suggest that clinical samples have the greatest proportion of CSA survivors relative to community samples, and the lowest rates

of CSA survivors are found in samples of high-functioning populations such as college students.

Definition of Abuse

The operational definition of CSA used by researchers in each study has varied substantially. For example, the upper-age limit chosen as a cut-off for "childhood" abuse, the type of act considered abusive, and the identity of the perpetrator differ across studies. 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), whereas others require that abusive experiences involve physical contact or force (e.g., Messman & Long, 1996). Some studies have only assessed the occurrence of childhood rape (e.g., Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999). Lastly, definitions of abuse are contingent upon the survivor's relationship with the perpetrator, classifying abuse as either extrafamilial or intrafamilial abuse. Thus, the reported prevalence in each study is likely to be related to the definition of abuse, with more broad definitions yielding higher rates of CSA and more stringent definitions yielding lower rates.

Response Rates

Survivors of abuse may be more or less likely than their non abused peers to participate in CSA studies thereby affecting prevalence rates. Specifically, survivors may

be more likely to participate in studies of childhood victimization because they feel they have valuable information to share. Conversely, they may not want to talk or think about their abusive history and thereby avoid participation in such studies (Peters, Wyatt, & Finkelhor, 1986). 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 et al., 1986). Reasons for this reporting difference may 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. It is also possible, however, that a greater number of participants in interview studies disclose abuse out of a desire to be helpful and please the interviewer. Regardless of the reason, research suggests that study methodology alone is enough to effect reported rates of childhood sexual victimization, with one-on-one methods reflecting rates higher than telephone surveys or group administered self-report questionnaires.

In conclusion, many factors can affect the reported prevalence rates of CSA across studies. It is not uncommon for studies employing clinical samples, broader definitions of abuse, and more personal research instrumentation to report higher rates of CSA. Likewise, lower rates are oftentimes reported in studies employing college samples, more stringent definitions of abuse, and self-report questionnaires. Just as these factors

moderate the reported prevalence rates of CSA, other factors, specific to the abusive experience itself, are hypothesized to mediate the consequences of the abuse for the survivor.

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). Despite popular perception, 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. As an example, Faller (1989) conducted a study employing a clinical sample of 313 sexually abused children in which all of the children reported abuse inflicted by an individual previously known to them.

While studies reveal some patterns specific to CSA, abuse experiences from survivor to survivor are quite heterogeneous. It has been hypothesized that effects of abuse on the survivor are related to the characteristics of the abusive situation. Many studies have investigated the role of such variables, but research methodology and findings have been overwhelming inconsistent, making it difficult to establish a clear relationship between moderating characteristics and abuse symptomatology (Brown & Finkelhor, 1986; Kendall-Tackett, Williams, & Finkelhor, 1993). Suspected moderators

include: age of onset of abuse, intrusiveness of abuse, whether or not force was used, and the identity of the perpetrator. Each of these moderators is reviewed below.

Age of Onset

Although 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 abuse begins and survivor outcome is not clear. Brown and Finkelhor (1986) cite seven studies that investigated this relationship. Findings of the studies were somewhat inconsistent, but there appears to be some support for an association between early age of onset and more severe negative outcome. There has been some speculation that poor methodology prevents the identification of an existing relationship between age-of-onset and subsequent symptomatology. It is important to note, however, that some of the most well conducted research tends to find no relationship. Beitchman et al. (1992) conclude that a combination of the age at abuse onset and other characteristics (e.g., frequency, duration, force) may impact adjustment more than age at abuse onset alone.

Frequency and Duration

Studies investigating the role of frequency and duration in CSA also reveal dissenting results. Russell (1986) examined trauma symptoms in groups of adult women who were abused one time only, women abused multiple times over a 5-year period, and women abused for duration of over 5 years. Women with longer-lasting abuse experiences reported a greater amount of traumatic symptomatology, supporting a positive relationship between duration and trauma. Tsai, Feldman-Summers, and Edgar (1979) compared clinical and non-clinical samples of CSA survivors. Their findings revealed that women seeking therapy reported both a greater number of abuse

experiences and a longer duration of abuse than did survivors not seeking services. In contrast, Brown and Finkelhor (1986) review two studies that report better adjustment of women with histories of long-lasting abuse, and four studies that revealed no relationship. Unfortunately frequency and duration of abuse are rarely examined separately, which may confuse findings. It is also possible that neither frequency nor duration are powerful enough to consistently impact abuse outcome, either separately or in combination.

Severity of Abuse

A relationship is commonly found between more intrusive CSA (e.g., vaginal, anal, or oral intercourse) and greater trauma or distress (Kendall-Tackett, Williams, & Finkelhor, 1993). In a review by Browne & Finkelhor (1986), six studies support this finding. For instance, whether or not penetration occurred was the variable most accountable for mental health impairment in a study of community women by Bagley and Ramsey (1985). Likewise, in her study of long-term effects of CSA, Russell (1986) found that three-fifths of women who experienced direct genital-genital or oral-genital contact reported feelings of extreme trauma. In contrast, while only one-third of women who experienced fondling of unclothed genitals and breasts, and one-fifth of women reporting unwanted kissing or touching over clothing felt extremely traumatized.

Force

Research suggests that force in an abusive situation predicts adjustment of the survivor. Force in studies of CSA most often refers to actual or threatened physical force or verbal coercion. Banyard and Williams (1996) found a significant relationsip between the use of physical force and increased mental health problems. Similarly, a 1987 National Survey of 441 young women, revealed lower internal locus of control, higher

rates of depression and more need for psychological intervention in individuals that experienced forced sexual intercourse than did women without a coercive sexual experience (Miller, Monson, & Norton, 1995). Thus, it would appear that force is a major predicting factor of adjustment problems.

Perpetrator Identity

Many studies have investigated whether abuse inflicted by a family member produces more harmful consequences than extra-familial abuse. Seven of nine studies reviewed by Kendall-Tackett, Williams, and Finkelhor (1993) reported increased symptomatology when the offender and child had a "close relationship" prior to the abuse. In this study, a close relationship did not necessarily indicate a familial relationship but could involve any type of close linkage, e.g., family friend, neighbor, minister. Brown and Finkelhor (1986) concluded from their review that abuse by a father or father-figure is likely to have a greater negative impact than abuse perpetrated by other individuals.

Some studies, however, have failed to find a relationship between adjustment 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 have close relationship with family perpetrators, while some may have had an extremely close relationship with an abusive neighbor or family friend.

In summary, variations in abuse experiences do exist with certain characteristics hypothesized as predictors of better or worse outcomes. Research findings, however, have been overwhelmingly inconsistent, making it difficult to establish a clear

relationship between some characteristics and symptomatology. Although only limited empirical support has been found for age of onset, frequency, duration, and relationship to perpetrator, intrusiveness of abuse and the use of force appear to be consistently predictive of poorer adjustment following abuse.

Certain aspects of CSA have been well investigated, yet there has been little to no examination of the processes leading to the formation of and underlying the presence of immediate and long-term abuse effects. Several scholars have attempted to account for the presence of symptomatology among survivors of abuse, despite little to no empirical support. Distorted cognitions associated with the abuse, the amount of trauma experienced during the abuse, and the survivor's conceptualization of sexuality based on the nature of the abuse have all been theorized as responsible for a variety of abuse symptomatology. This paper will first review select theories of CSA symptomatology, including cognitive-behavioral approaches, a post-traumatic stress disorder framework, and Finkelhor's Traumagenic Dynamic Model, and then review the immediate and long-term abuse effects.

Theories of Childhood Sexual Abuse

Cognitive-Behavioral Approaches

A theoretical elucidation of abuse effects via a general cognitive-behavioral orientation involves a combination of cognitive appraisals and beliefs paired with behaviors learned via classical conditioning, reinforcement and punishment, and social learning mechanisms. Wheeler and Berliner (1988) have explained how such a cognitive-behavioral model may account for the symptomatology following victimization. According to this model, trauma experienced during and following an

abusive episode is thought to provoke anxious emotional reactions in the survivor. Attempts to cope with anxiety lead the survivor to adopt certain behaviors or cognitions meant to make sense of the abuse or avoid the subsequent emotional responses. Unfortunately, attempts to cope are sometimes detrimental to the mental/physical health of the survivor (e.g., self-blame, substance abuse).

Classical conditioning is one way anxiety is maintained beyond the abusive interaction itself. To illustrate, anxiety is paired with contextual variables of the abuse experience (e.g., the male voice of the perpetrator) and result in a conditioned response that is then generalized to other, previously neutral, stimuli (e.g., all male voices, or men). Social learning theory, unlike classical conditioning, stresses the importance of cognitive expectations in the maintenance of symptoms over time (Hogben & Bryne, 1998). It suggests that survivors adopt inaccurate, inappropriate, dysfunctional, and/or negative beliefs /expectations about sexuality (e.g., sex is painful). Operant conditioning takes place via abuse-specific feedback in the form of instruction, reinforcement, punishment, and instruction from the offender. Survivors may learn to use sex as a means of acquiring a variety of needs (e.g., popularity, emotional intimacy). These distorted cognitions are theorized to affect the way in which survivors perceive and respond to sexual situations later in their lives.

Hoier et al. (1992) discuss how a cognitive-behavioral model can address both the "initiation" and "maintenance" of problems resulting from CSA. The 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. According to these authors, CSA experiences can be divided into "types" (according to contextual characteristics and

severity of abuse). The authors propose a "Challenge-Stress-Trauma-Continuum" of sexual abuse along which the different types of CSA fall according to their severity. Severity is determined by the characteristics of abuse, such as frequency, duration, amount of control perceived by the survivor, and pain or threatened harm. Abusive situations falling along the severe end of the continuum are associated with greater amounts of unhealthy learning contingencies and likewise, greater symptomatology. Feedback in the form of punishment evoked from the survivor's attempts to change or control his/her environment shapes his/her future cognitive and behavioral responses. Environmental cues are conditioned from the survivor's specific abusive situation and are responsible for eliciting physiological, psychological, or emotional responses. Survivors may adopt cognitions or behaviors such as alcohol use to numb themselves and avoid cues and/or anxiety associated with abuse. Additionally, symptoms may differ in the clusters, or patterns, in which they are manifested.

Polusney and Follette (1995) have offered an emotional avoidance theory, another cognitive-behavioral model. This model accounts for long-term sequalae of CSA as a survivor attempts 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). Once the survivor begins to employ unhealthy coping mechanisms, they are maintained by negative reinforcement, namely the avoidance of abuse-evoked emotional states. Some survivors experience numbing or dissociation,

which not only prevents negative emotional responses, but also inadvertently prevents the experience of all extreme emotions, including pleasant ones.

Like the model of emotional-aviodance, a more recent model, Acceptance and Committment Theory (ACT), focuses on the harm resulting from an avoidance of abuse-related feelings and thoughts. This theory asserts that efforts to control or avoid abuse-related thoughts and emotion actually lead to an increase in CSA symptomatology. ACT therapy strives to change the survivor's pattern of avoidance, and to teach the survivor to accept and experience their emotional reactions, rather than avoid them (Wilson, Follette, Hayes, & Batten, 1996).

Sigmon, Greene, Rohan, and Nichols (1996) provide mixed support for the emotional avoidance theory. They 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 better adjustment in adulthood, despite the possibility that a tendency to cope by avoidance can hypothetically be unhealthy to the extent that it prevents the survivor from dealing with their abuse and experiencing negative and positive emotions all together. Long and Jackson (1993) also found emotion-focused coping strategies, including those in which the experience of negative emotion is avoided, to be the most common type of coping utilized in a sample of female college survivors. This study, however, found emotion-focused strategies to be predictive of poorer adult adjustment.

Another cognitive behavioral explanation of CSA effects emphasizes the influence of "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. He suggested that survivors most often make internal, stable, and global attributions for negative events. A propensity to make internal attributions taxes an individual's ability to cope, and thereby results in feelings of helplessness. Results of Gold's study offer empirical support for this model. First, the attributional style of survivors was found to significantly differ from attributions of nonvictims. Survivors were also more likely to make external attributions for positive events. Secondly, within a group of survivors, those who experienced the most severe abuse effects were most likely to hold internal, stable, and global attributions for negative life events.

Application of Folkman and Lazarus's Stress and Coping Theory (1979) emphasizes the importance of the survivor's initial appraisal of the abuse situation, appraisal of his/her ability to cope with the situation, and the availability of resources. Inherent characteristics of the individual are not thought to 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 influences coping outcome. One's perception theoretically will vary across situations; therefore, one's method of coping will vary as well. This model focuses on the importance of "goodness of fit" between the demands of a particular situation and one's method of coping. The better the fit between one's method of coping and the demands of the situation, the less likely one is to experience aversive side effects or distress. Long-term abuse effects are then accounted for by a lack of fit between the survivor's coping mechanisms and the demands of 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. She found that the survivor's method of coping was the only significant predictor of adjustment, with greater amounts of emotion focused coping 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. 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 within the field of CSA have recognized PTSD symptomatology in survivors of CSA (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. However, she feels that a diagnosis of PTSD alone does not sufficiently account for the additional symptoms commonly exhibited by survivors of long-term abuse, i.e., somatization, dissociation, affective changes, and pathological changes in relationships 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. 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. Briere concludes that the composite may be viewed as a complex form of PTSD specific to severe and chronic CSA survivors. He further states that the inability to adjust to post-abuse trauma leads many survivors to experience maladjustment or dysfunction later in life.

Traumagenic Dynamics Model

Finkelhor and Browne (1985) suggested an alternate model to explain the effects of CSA. This model describes four factors, which they refer to as "traumagenic dynamics," to explain symptomatology. The first dynamic is Traumatic Sexualization referring to "conditions in sexual abuse under which a child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways" (Finkelhor, 1988, 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 generalized 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. Secondly, powerlessness occurrs 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. For example, Traumatic Sexualization accounts for sexual behavior problems, or repertoires of inappropriate sexual behavior, in childhood as a result of a developmentally inappropriate emphasis put on sexuality and the genitals during abuse. This dynamic may also account for indiscriminate sexual activity seen in adolescence or adulthood. The dynamic of Betrayal may prevent adult abuse survivors from initiating and maintaining close, intimate relationships with others because of their lack of trust. On the other hand, betrayal may lead survivors to become overly dependent and inhibit them from accurately judging the trustworthiness of others. Adult victimization, more common in sexual abuse survivors than the general population, may result from a lack of self-efficacy or a sense of powerlessness to decline unwanted sexual experiences. Fear and anxiety, manifested in nightmares, school problems, or aggressive behavior, are also theorized to result from a sense of powerlessness. The dynamic of Stigmatization is likely to account for the self-blame and self-degradation sometimes exhibited by survivors, resulting in poor self-esteem, feelings of guilt, and possibly suicidal ideation.

Thus, the dynamics, or combination thereof, particular to each individual's abuse experience, are thought to account for their particular constellation of symptoms.

Effects of Child Sexual Abuse

A number of negative consequences have been found to be associated with CSA. Survivors can 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. Initial effects seen shortly following abuse, adult or long-term effects, and abuse effects specific to the adolescent survivor are reviewed.

Initial Effects

Immediate, or short-term effects, are referred to as those which occur during childhood or are either evident immediately subsequent to or shortly following abuse. These effects may or may not decrease 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, Lynch, Oates, O'Toole and Cooney (1995) concluded that victimized children and adolescents were twice as likely to experience sadness or depressive symptoms when compared to a nonabused group. 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 within a particular stage of development or age bracket often experience similar types or degree of symptoms (Dubowitz, Black, Harrington, & Verschoore, 1993). Adoelscents, for example, regardless of whether they were abused at age 3 or age 9, are more likely than their nonabused peers to engage in a variety of high risk behaviors. 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 began or ended.

Regression, hyperactivity, impaired trust, lying, and difficulties separating have all been identified as developmentally common expressions of abuse among preschoolers (Sauzier et al., 1990; Kendall-Tackett et al., 1993). Many school age children and adolescents experience depression, school problems, running away, drug abuse, suicide attempts, tics, borderline states, aggression, and delinquency. Although these symptoms are considered to be rare, obsessions and psychosis are also problems most likely to appear during either middle childhood or preadolescence,.

Although some symptoms are age group specific, some symptoms may be experienced by all age groups and some may, but do not necessarily, continue into adulthood. Several symptoms of CSA appear to be experienced by children of every age group (Kendall-Tackett et al., 1993). These include anxiety, withdrawal, guilt, somatic

complaints, sleep problems/nightmares, and sexualized behaviors, which were found in all age groups. Longitudinal CSA studies reviewed by Kendall-Tackett and colleagues (1993) show that most childhood problems subside over time, while approximately 25% of survivors fail to improve or got worse. It is not clear whether this improvement was a function of intervention or time alone. Specifically, certain behaviors have been found more likely to abate than others. For example, anxiety symptoms were found by Gomes-Schwartz, Horowitz, and Sauzier (1990) to decrease over time, while aggressive and sexualized behavior problems remained constant or even increased.

Long-Term Effects

Long-term effects are those that 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 subclinical levels of emotional and social difficulties. Such problem states include, but are 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). These adjustment difficulties are reviewed in brief below.

Depression.

Depression is a construct that has been extensively studied in relationship to CSA. Burnman and Stein (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 depression and CSA 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. Although studies of both community and college women support such a relationship, Lundberg-Love, Marmion, Ford, Geffner, & 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 CSA 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 to speculation 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 et al., 1992). Thus, while adequate support has been obtained identifying depression as a consequence of abuse, some studies have failed to find such a relationship.

Anxiety.

Anxiety is another frequently identified consequence of CSA. Overall, many studies find that CSA survivors have an increased likelihood of experiencing anxiety 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 anxiety and CSA. 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 (Briere & Runtz, 1988). This finding is particularly noteworthy in light of the 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 et al. (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.

Although much of the literature supports a positive relationship between sexual abuse and subsequent anxiety, two reviews of the literature report that the relationship is complex (Beichman et al., 1992; Lipovsky & Kilpatrick, 1992). Some studies fail to find a significant relationship between generalized anxiety and experiences of childhood sexual victimization (i.e., Carmen, Rieker, & Mills, 1984; Meiselman, 1978). The population sample and their particular demographic variables (such as race and gender)

may be partially responsible for the discrepancies in research findings. Studies that focus exclusively on anxiety may fail to find differences due to the fact that general anxiety is relatively common and sometimes considered a normal response to particular situations, whereas many of the specific anxiety disorders (e.g., panic disorder, agoraphobia) are not. In summary, survivors of abuse appear more likely than nonabused individuals to manifest anxiety disorders. Meanwhile a handful of studies have failed to differentiate survivors from nonvictims on the basis of generalized anxiety.

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). Goodman, Koss, and Russo (1993) examined the adverse effects of violence against women and posit that "abuse may be the most important precipitating factor" in female suicide attempts (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 types of 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 characterize all long-term effects of CSA as some effects are expressed as subclinical difficulties in social and interpersonal functioning

(Polusny & Follette, 1995). For example, 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. This finding held even when specific childhood family constructs (e.g., nurturance) were controlled. Increased interpersonal sensitivity is also sometimes exhibited by survivors of CSA (Lundberg-Love et al., 1992). Further, Harter et al. (1988) found that among college women, survivors exhibited poorer social adjustment than their nonabused counterparts, although neither group scored in the clinical range. Finally, some studies report a relationship between a history of CSA and lower levels of self-esteem (Finkelhor & Browne, 1988). Overall, studies consistently find that survivors of CSA exhibit a variety of subclinical problems in the areas of self-esteem, self-concept, and social adjustment.

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 thorough review of the literature by Messman-Moore 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) reported 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. College student samples also suggest CSA survivors are more likely to be raped than are their nonabused peers. Stevenson and Gajarsky (1991) found that 72% of the college women in their study who reported a history of CSA also reported being sexually victimized as an adult. Mayall and Gold (1995) investigated the mediating variables in the sexual revictimization of women with a history of CSA and found that CSA was correlated with higher rates of adult sexual assault but was also correlated with higher voluntary sexual activity in adulthood. None of the factors suspected to mediate revictimization was supported. The authors suggest that adult women with a history of CSA might engage in more sexual activity due to reduced sexual disinhibition, reinforcement of sexual behavior by the perpetrator, attempts to gain control over past abusive experiences, learned helplessness for sexual advances, or feeling valued only for sexuality. In general, high rates of revictimization for survivors of abuse have been supported. What is less clear are the variables mediating this relationship and further investigation of these constructs is needed.

Effects in Adolescent Survivors

Adolescents and young adults may also experience the effects of CSA. However, these effects are not easily categorized as either initial or long-term. For instance, they may not appear until adolescence and may or may not continue into adulthood. The normal developmental changes specific to adolescence and young adulthood also make the CSA effects experienced in adolescence different from childhood/short-term effects and adulthood/long-term effects. Lastly, theory 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), although relatively little empirical research has been conducted with this population.

The limited research that does exist suggests that several problems are most prominent in adolescent and young adult survivors. These include lowered self-esteem, hostility, disrupted peer relations, indiscriminate sexual activity, illegal acts, and self-injurious behavior (Kendall-Tacket et al., 1993; Sauzier et al., 1990). Many additional symptoms have been found to be more prevalent in teens with a history of abuse when compared to those without such a history. Several studies are presented below.

Garnefski and Diekstra (1997) conducted a large scale community study with sexually abused Dutch adolescents (age 12 - 19) and matched controls. They found that, across gender, adolescent survivors had significantly more symptomatology on measures of emotional adjustment, behavioral problems, and suicidality. Adolescent boys with an abuse history appeared to possess a greater level of distress across these areas than both nonabused males and abused females. Further, 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) followed a group of young people over a period of 18 years. Measures of adjustment taken at ages 15 and 21 revealed that female survivors of CSA scored significantly higher on levels of somatic complaints, anxious/depressed symptomatology, social problems, thought and attention problems, and aggressiveness as compared to their nonabused counterparts. The young women with a CSA history 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. Lynskey and

Fergusson (1997) found similar results. Specifically, young adult survivors, 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.

When investigating the symptomatology of adolescents receiving inpatient psychiatric care, 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). However, significant differences have been found with regards to PTSD symptomatology (Brand et al., 1996), substance abuse (Hussey & Singer, 1992), depressive and psychotic symptoms, and suicide attempts (Sanonnet-Hayden, Haley, Marriage, & Fine, 1987), with the abused adolescents functioning more poorly on each measure as compared to nonabused counterparts. When levels of severity of abuse 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 those effects of abuse manifested in adolescents that appear to be rather stable over time and somewhat resistant to intervention. Tebutt, Swanston, Oates, and O'Toole, (1997) followed child and adolescent survivors (age 5 - 15 years) over a period of five years, assessing their levels of self-esteem, depression, and behavior problems. Assessment at 18 months and 5 years following abuse reflected no overall significant changes in symptomatology. Further, it appeared that the percentage of young

people who had experienced a decrease in symptoms was similar to the percentage for whom symptomatology increased. The authors suggest that the severity of the abuse in this sample of child survivors was greater than other recent empirical investigations, and that a high number of participants experienced recent negative life events other than abuse. Both sets of factors may account for a lack of significant improvement and continued dysfunction.

Sexuality

As noted previously, numerous theories have been posited to account for the effects of CSA on survivors of abuse and empirical investigation has documented that survivors of CSA experience a diverse set of problems. Sexuality is one area which seems to be problematic for survivors of CSA across the lifespan (Davis & Petretic-Jackson, 2000; Kendall-Tackett et al., 1993). This is likely due to the impact CSA has on the development of sexuality of survivors. Notably, little empirical research has been conducted in this area. This paper will next 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 and continues through the time at which a young person is able to accept responsibility for him/herself in several different areas (Downs, 1993). 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 on the development of sexuality (Irwin & Shafer, 1992; Peterson, Leffert, & Grahm, 1995). The "timing and tempo" of such changes, however, fluctuate within and between individuals (Peterson et al., 1995). Several models have been proposed to explain the process of sexual development in normal, nonabused adolescents. Three of the most prominent theories are reviewed here.

Developmental Approach

A developmental model of sexual development examines maturation across a number of domains (e.g., physiological, cognitive, emotional). The thesis of the developmental approach is that children and adolescents progress through a series of stages. During each stage a young person is faced with and resolves relevant issues. Graber and Brooks-Gunn (1995) review developmental models as they apply to sexuality. Such models explain that changes in adolescence often occur simultaneously, and that too many changes occurring at once or changes paired with other, unrelated stressors can exhaust resources and the ability to cope, as well as activate predispositions for problem behaviors 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 the 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). Such factors are likely to 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 in 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 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 themselves 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).

The media can also strongly impact the decisions made by adolescents (Frith & Frith, 1993). Popular music and television programs, for example, portray scenarios of teenage angst and shape adolescents' perceptions by differentiating cool or desirable

behavior from behavior that will make one unpopular with their peers. Likewise, teens form ideas about what their peers are doing sexually and otherwise. Thus, from a developmental perspective, a teen's sexual decision-making and subsequent behavior is likely to be affected by their perception of what is socially acceptable taken in combination with an increased desire for social status, a greater understanding of moral behavior, and an ability to critically think (Peterson & Boxer, 1982; Tharinger, 1987).

A Cognitive Approach

Cognitive models examine the cognitive development and thought patterns or sexual belief system of the child or adolescent (Walen & Roth, 1987). According to this model, a young person's conceptualization of sexuality is a result of interaction between cognitive maturity and the messages received from her or his environment. For instance, a child unable to think abstractly has little ability to critique information. Thus, when s/he receives limited or incorrect information about sex s/he is likely to draw immediate, inflexible, and invalid conclusions about sexuality. Therefore, successful sexual development, to some degree, is dependent upon receiving accurate information about sexuality, but the child's interpretation and understanding of the material play a key role in sexual development. When a child is sexually abused s/he is exposed to sexual information and experiences s/he is not cognitively mature enough to understand. This may result in a variety of negative consequences, i.e., inappropriate sexual behavior with peers or self-blame for the abusive experience.

During adolescence, one's ability to think abstractly and hypothetically increases and allows for more rational, critical thought. However, there are still limitations on the cognitive ability of the developing adolescent. The concept of "personal fable" refers to

the adolescent's propensity to view his or her own feelings and behaviors as unlike those of other peoples', leading to a self-perception that s/he is unique, special, and not easily understood (Walen & Roth, 1987). Adolescents also sometimes report a sense of invulnerability to negative consequences usually associated with specific behavior (e.g., pregnancy from unprotected sex) (Elkind, 1967). Egocentrism is also often present during adolescent development (Walen & Roth, 1987). A combination of these three, a tendency to view one's self as "special," feelings of invulnerability, and a belief that one's perception is the correct or privileged perception, can be particularly harmful in sexual situations, especially when the adolescent holds distorted or incorrect beliefs about risky sexual behavior.

A cognitive approach emphasizes the impact that inaccurate cognitions can have on sexual development. It posits that sexual misattributions and misperceptions can result in emotional arousal and disruption of sexual development, possibly leading to risky sexual behavior and sexual dysfunction. As previously reviewed, sexual misattributions oftentimes result from CSA experiences.

A Learning Approach

Learning models emphasize the role of conditioning, reward, punishment, and observation in the development of sexuality in adolescence. Conditioning, for instance, occurs when previously neutral stimuli are paired with stimuli that are naturally arousing. In normal sexual development, teens begin to make associations between types of music, style of dress, and body type and sexuality (e.g., via the media). In the case of child sexual abuse, the development of sexuality becomes skewed when associations are made between previously neutral stimuli (e.g., sexual body parts) and negative sexual

experiences early in life (e.g., abuse). As a result, survivors can experience anxiety and aberrant thoughts, beliefs, or feelings about sexual interactions. Operant learning is also involved in the development of sexuality. In this case, rewarded behaviors become part of an individual's sexual repertoire, while those punished should decrease in frequency or disappear all together. For instance, in a cultural context that says what is right and what is wrong, youth are taught to discriminate appropriate from inappropriate sexual behavior via reinforcement and punishment. In the context of abuse, reward and punishment provided by the perpetrator may teach the survivor an inappropriate repertoire of sexual behavior and/or inaccurate beliefs about sexuality. Social learning theory highlights the importance of observation, instruction, and modeling in sexual development and also emphasizes the role of cognitive expectations (Hogben & Byrne, 1998). In normal development, it is expected that youth will acquire expectations about the rewards associated with sexual behavior prior to engaging in sexual activities. Children without an abuse history learn by observing peers, parents, and popular media icons and adopt expectations of social or physical reward (e.g., popularity, physical gratification). Children with an abuse history observe the behavior of the offender and other members of the family who do not acknowledge ongoing sexual abuse and may acquire negative expectations about future sexual interactions based on their abuse history.

Summary

Developmental, cognitive, and learning models all suggest that sexual development is a result of an interaction between: (a) maturation across a number of domains, (b) messages received from both personal experience and society at large, and (c) formation of sexual rules, norms, and expectations. These models support a

relationship between a youth's sexual development and their subsequent sexual behavior. This paper will next review sexual behavior and functioning in nonabused adolescents followed by models of disrupted sexual development in survivors of CSA, including a review of the available literature on sexual behavior and functioning in adolescent survivors.

Adolescent Sexual Behavior and Functioning

Many scholars have examined the typical sexual development of adolescents. Results of investigations suggest that adolescent sexual behavior 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 teens' sexual interactions (for review see Brooks-Gunn & Furstenberg, 1989; Sandler et al., 1992; Small & Kern 1993).

Examination of adolescent sexual activity, other than participation in intercourse, is rare (Brooks-Gunn & Furstenberg, 1989; Irwin & Shafer, 1992), but some research suggests that sexual activity generally follows a progression from kissing to more intimate behaviors such as touching/petting, oral sex, and sexual intercourse (Rosenthal & Smith, 1997). Studies also suggest that recent generations of adolescents are engaging in sexual intercourse at younger ages than past generations (Brooks-Gunn & Paikoff, 1993, Susheela & Darroch, 1999). In the 1970s, studies revealed that 33% of 16-year-old girls had participated in sexual intercourse, while 1980 and 1990 figures are around 50% (Breakwell, 1996). Specifically, a 1990 national survey conducted in the United States revealed that 37% of 15-year-old girls had participated in sexual intercourse, and by age

16 this figure increased to almost 50% (Leigh, Morrison, Trocki, & Temple, 1994). One recent study examining trends in adolescent sexual behavior over the past 20 years supports an increase during the 1980s, but suggests that rates in the 1990s appear to be leveling off with approximately 50% of 15 - 19-year-olds reporting participation in sexual intercourse (Susheela & Darroch, 1999). Continued examination of these trends are certainly needed.

Many studies have failed to compare rates of sexual behavior across gender, but those that have report few significant differences. Teenage boys generally report engaging in intercourse more frequently than teenage girls. When questioned about instances of intercourse in the past year, however, adolescent girls and boys reported similar numbers of experiences (N = 11 and 10, respectively) (Leigh et al., 1994). Devine, Long, and Forehand (1993) found that adolescent girls experience the greatest frequency of sexual activity from 15 through 18 years of age, and that adolescent males appear to be most active between the ages of 16 and 18. Finally, 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).

Conversely, safe-sex seems to be an issue for teens with almost 50% of both male and female teens reporting condom use "sometimes," and over one-third reporting condom use "every time" they have intercourse (Leigh et al., 1994). 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 about and use of contraceptives.

Likewise, a recent study reports that adolescents have substantial knowledge about and hold positive attitudes about condom use (Langer & Girard, 1999).

Finally, studies of adolescent sexual activity often fail to differentiate voluntary forms of sexual activity from involuntary interactions. This is particularly noteworthy because some research suggests that a significant proportion of early sexual interactions occur against the will of the adolescent (Abma, Driscoll, & Moore, 1998). For instance, Zimmerman and colleagues (1995) examined teen's perceived ability to say no to sexual pressure from a partner. They assessed the role of personality factors, educational goals, sexual worries, permissiveness and level of experience, family background, and perceived peer influence. They found that only 19% of 10th grade girls believed that they were definitely unable, probably unable, or possibly unable to say "no" to an unwanted sexual advance by a partner. A recent study of 7,699 high school students found that of the 59% reporting past sexual activity, almost 20% felt forced into having sex via either emotional or physical control by their partner (Downey & Landry, 1997).

Similar findings come from an Australian study using a sample of high school students (Buzwall & Rosenthal,1996). Separate "sexual styles" were hypothesized to represent a teen's sexual self and predict adolescent sexual behavior. Five styles emerged with each group characterized by specific levels of the aforementioned variables. Adolescents within each group were similar with regard to sexual experience. Of the five groups, only one group rated their ability to say no as "high" and two of the five groups, despite high reported levels of self-esteem and competence, rated their ability to decline unwanted sexual interactions as "low."

In summary, the sexual behavior of adolescents is varied and influenced by both intrapersonal and interpersonal factors. The recent generations of adolescents appear to become sexually active younger than past generations, although sexual activity in adolescence appears to be episodic. Teens are knowledgable about HIV/AIDS and other sexually transmitted diseases and report moderately high rates of contraceptive use (Bailey & Piercy, 1997; Breakwell, 1996).

Models of Sexual Development of Survivors

Most theories that have been posited to explain the negative consequences often experienced by survivors of CSA are general in their explication, although a few attempt to account directly for particular symptomatology. As a specific example, several theories have been set forth to explain frequency of sexual dysfunction found in survivors. Unfortunately, little empirical research of the underpinnings of sexual sequlae of CSA has been conducted to investigate these theories and, hence, many of the following explanations are based on little specific data and sometimes speculation alone (Tharinger, 1990).

Most theories explain problematic sexual behaviors and attitudes as a result of CSA interfering with normal sexual development. Thus, the sexual development of survivors is viewed as different from that of nonvictims (Tharinger, 1990). In her review, 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, and Finkelhor's Traumagenic Dynamics Model. These and two additional theories, a cognitive approach and a life course perspective, will now be reviewed.

Developmental Approaches

Child sexual abuse is thought to disrupt the survivor's normal progression of development by introducing the child to information s/he is not mature enough to process. Disruption takes place at the time the abuse begins and leads to problems in subsequent stages of development, resulting in both immediate and persistent problems in sexual functioning (e.g., Tricket & Putman, 1993). According to this framework, the experience of sexual behavior with an older person during childhood interferes with cognitive, emotional, and moral development, all of which impact the development of sexuality. This can result in a variety of symptoms found in survivors, such as fear and anxiety (Tharinger, 1990). Unfortunately, this theory does not specifically indicate how this interference takes place. Likewise, there is no empirical evidence to date to support this theory.

Psychodynamic Theories

Psychodynamic theories account for survivors' problematic development of sexuality by focusing upon the confusion that results from the presence of physiological pleasure or arousal, despite an 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). The anxiety resulting from failure to meet these tasks specific to psychosexual development leads to symptomatology in general, and specifically to problems associated with sexuality. Although most studies support increased levels of anxiety in survivors of CSA, the tenets of this particular theory have not been examined or supported in empirical research.

Learning Perspectives

Learning paradigms can also account for sexual problems experienced by survivors. Classical conditioning can potentially result in problems for the survivors of CSA. This occurs when specific stimuli, initially 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 particular behaviors that may continue to persist beyond the abusive experience. For example, if a child's most basic needs are withheld until s/he performs a sexual act, then s/he may learn that sexual behavior is useful and necessary across a variety of situations, thereby leading the child to use sexuality in inappropriate and harmful ways that can continue into adolescence and adulthood (Gil & Cavanagh-Johnson, 1993).

Social learning approaches focus on the teaching (direct or indirect) role of the perpetrator. As compared to nonvictimized children who learn about sexuality progressively and through various mediums, the knowledge and understanding of sexuality by survivors is often based on the information they receive from the offending adult (Maltz & Holman, 1987; Tharinger, 1990). This 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 use sexuality as a means to acquire love or affection and may lead to self-exploitation (Gil & Cavanagh-Johnson, 1993; Maltz & Holman, 1987). The concepts of classical, operant, and observational learning are empirically well-supported, and literature examining the consequences of CSA is often

consistent with what would be expected from a learning perspective. Learning theory based studies have not, however, employed samples of CSA survivors to directly apply and test this model.

Finkelhor's Traumagenic Dynamics Model

The model of Traumatic Dynamics was 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. Consistent with many of the other theories, it concludes that appropriate development of sexuality is hindered by (a) rewards provided to the child for inappropriate sexual behavior at the time of abuse, (b) realization, on the part of the child survivor, that sexuality can be used to obtain unrelated desires or needs, (c) increased attention a child receives based on the use of certain body parts such as genitalia, (d) distorted beliefs about sexual behavior and morals based on information provided by the perpetrator, and (e) the association of painful memories of abuse with subsequent sexual interaction (Finkelhor, 1988). The Traumagenic Dynamics model incorporates many facets of the learning perspective, but attempts to more clearly categorize the types of symptoms that can result from learned behaviors. This model, like a general learning approach, is consistent with the results of literature that examine symptomatology in CSA survivors but has not been directly applied in research investigations.

Cognitive Perspective

Distorted beliefs or cognitions a survivor has about the abuse itself or her or his role in the abuse are theorized to account for CSA symptoms. Cognitive distortions may lead to self-blame for the initiation or continuation of the abuse (e.g., a belief that the

survivor actually seduced the perpetrator or encouraged him or her by not reporting the experience) and more general negative self-attributions (e.g., feeling stupid, dirty, or worthless) (Downs, 1993; Finkelhor & Brown, 1988; Maltz & Holman, 1987). Beliefs often persist following the termination of the abuse and lead to self-stigmatization and negative or distorted conceptualization of sexual interactions. Fromuth (1986) provides support for this theory as she found 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. While a cognitive approach receives support from clinicians who work with survivors of CSA (Herman, 1981), little empirical work has examined the attributions that survivors may hold in general or specific to their history of abuse.

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 indiscriminate sexual behavior (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. This model posits that CSA causes children to have a hightened awareness of and preoccupation with sexuality, leading to an increase in frequency of sexual interactions for survivors. This theory only addresses the impact of adult-child sexual interaction on later sexual functioning and only recognizes other effects of abuse (e.g., emotional, psychological, and other interpersonal responses) to the extent that they are a result of indiscriminate and/or unhealthy sexual practices in adolescence and adulthood.

Browning and Laumann (1987) discuss the concept of "sexual scripts," which are hypothetically 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 is thought to erotocize the child by introducing a "sexual trajectory" that leads to sexual activity in adolescence, teen pregnancy, multiple sexual partners throughout adulthood, and harmful events associated with sexually risky behavior, including sexually transmitted infections and forced sexual experiences. The survivor's early initiation to sexuality is hypothesized to cause many problems for survivors of abuse as compared to nonabused counterparts. These include 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 hypothetically related to the amount of reinforcement received for the initially acquired sexual script. Unfortunately, this model does not explicitly account for those survivors who have generalized negative feelings toward sexuality and thus avoid sexual interaction all together.

Sexual Behavior and Functioning of Survivors Across the Lifespan

As all of the aforementioned theories suggest, CSA can have adverse effects upon sexuality across the lifespan. It is not uncommon for child survivors of sexual abuse to engage in inappropriate sexual behavior or to have information about sex beyond what would be developmentally expected (Bonner, Walker, & Berliner, 1999; Fredrich, Grambsch, Broghton, Kuiper, & Beilke, 1991). Young children with a sexual abuse history may become preoccupied with sexual behavior to the extent that it hinders the formation of normal friendships with peers. This is largely because young sexually

abused children have learned inappropriate rules about sexual behavior and have not yet developed the capacity to inhibit impulses that may lead them to engage other children into sexual behavior.

Child sexual abuse can also exert adverse effects in adult sexual adjustment. Some empirically validated sexual difficulties experienced by survivors are clinical disorders such as vaginismus, arousal and orgasmic disorders, and dyspareunia. Saunders et al. (1992) examined the prevalence of psychopathology in community women, finding that women who had experienced sexual abuse prior to the age of 18 met diagnostic criteria for sexual dysfunction significantly more often than did women who had experienced CSA. In a community study, Jackson, Calhoun, Amick, Maddever, and Habif (1990) found 65% 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 also 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," defined as lower sexual responsiveness to positive sexual interactions as well as lower sexual satisfaction in general, significantly more often in adult female sexual abuse survivors than in nonvictimized women. A large telephone survey 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 especially significant for groups of older adult women (age 40-49 and over 60). Sexual abuse involving intercourse was most predictive of dissatisfaction.

Studies using clinical samples yield similar results. Tsai, Feldman-Summers, and Edgar (1979) compared the symptomatology of three groups of adult women: (a) survivors seeking clinical treatment for CSA, (b) survivors of CSA who had never sought professional help, and (c) 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 reported relatively less enjoyment and fulfillment in sexual interactions, they engaged in sexual intercourse at a significantly higher frequency rate than the groups of survivors who had not sought treatment and nonvictims.

However, Fromuth (1986) investigated sexual adjustment, sexual self-esteem, sexual adjustment, and sexual desire revealed no differences between a college sample of survivors and nonvictims. In this study, however, sexual desire was examined 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), which could have resulted in a more sensitive measure.

Some studies investigating survivors' perceptions of their own sexuality found that CSA survivors harbor cognitive and emotional distortions regarding sexuality resulting in sexual guilt, sexual anxiety, and low sexual self-esteem. Mackey, Hacker, Weissfeld, Ambrose, Fisher, and Zobel (1991) investigated sexual functioning in women with and without a history of sexual abuse. Only those women with a history of CSA reported orgasmic dysfunction and guilt. Women with a history of CSA also 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.

Likewise, Herman (1981) reported that incest survivors expect disappointment and sexual abuse in intimate relationships and sexual interactions with men, and as a result experience a lack of sexual enjoyment. Jackson et al. (1990) examined interpersonal and sexual functioning in a small number of adult incest survivors and matched controls. Findings from a general measure of social adjustment revealed that women with a history of incestual CSA had poorer social adjustment in dating situations than did matched controls.

Sexual Behavior and Functioning of Adolescent Survivors

Empirical investigation of sexual adjustment in adolescent and young adult survivors lends support to theories that posit abuse has deleterious effects on sexuality throughout development. The overwhelming conclusion reached across studies is that teens with a sexual abuse history are more likely than nonabused peers to engage in a variety of risky sexual behaviors. The majority of available research supports a relationship between a CSA history and early initiation of voluntary sexual intercourse, multiple partners, teen pregnancy, and inconsistent contraceptive use (Evanston, Fiscella,

Kitzman, Cole, Sidora, & Olds, 1998, Fergusson, Horwood, Lynskey, 1997; Krahe, Scheinberger-Olwig, Waizenhoper, & Kolpin, 1998; Luster & Small, 1997; Miller, Monson, & Norton, 1995; Stock, Bell, Boyer, & Connell, 1997). Unfortunately, the examination of adolescent CSA survivors is a relatively recent area of research, and thus, few studies are available.

Five of six empirical studies reviewed found that adolescent/young adult survivors engage in sexual intercourse at an earlier age than nonabused peers. The first of these studies was longitudinal in nature and tracked a non-clinical cohort of 520 New Zealand girls 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 in this study were comprehensively interviewed for a history of mental disorders and CSA and classified into one of four groups: (a) no history of CSA, (b) a history of noncontact CSA only, (c) a history of CSA involving contact but not attempted or completed intercourse, and (d) a history of CSA including attempted or completed intercourse. Fergusson found that girls 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.

Additional studies support such findings. A US study determined abuse status in a group of over 3000 female high school students using a questionnaire format. Students were asked whether or not they had been touched in a sexual way when they did not want to be touched, or had something done to them sexually which should not have been done (Stock et al., 1997). With this definition, ten percent of the sample reported a history of sexual abuse. Survivors were 3.5 times more likely than their nonabused peers to endorse

having engaged in intercourse at the time of the study. Unfortunately, this study failed to differentiate voluntary intercourse from intercourse that may have been occurred within the context of abuse.

Another study surveyed young adult women and determined abuse status by responses to the question: "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) employed a large sample of college undergraduate women to examine the effects of father-daughter incest versus extrafamilial CSA. A history of abuse, regardless of relationship between perpetrator and victim, was related to an earlier initiation and increased frequency of voluntary intercourse. However, this study failed to reveal differences in sexual functioning or satisfaction between the two abused groups of women and between 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 (Fiscella, Kitzman, Cole, Sidora, & Olds, 1998).

Discrepant findings do exist however, but these discrepancies may be related to differences in methodology rather than actual differences. 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 related to voluntary sexual intercourse only when parental supportiveness was not controlled, suggesting that a young adult's relationship with her parents may be more predictive of consensual sexual

activity than a history of CSA. It is necessary to note, however, that physical abuse and neglect items were included on the measure of parental supportiveness used in this study. Thus, low parental support as indicated by this measure may actually reflect physical abuse or neglect by parents. Therefore, participation in voluntary sexual intercourse may be related to an abusive or neglectful relationship with parents rather than just a lack of support. This study differs from the others in the amount of information gathered about consensual sex. In this study, participants did not report the precise age at which voluntary intercourse first occurred, but rather simply reported whether or not they had *ever* engaged in voluntary sexual intercourse. It is possible that this study failed to find a difference between survivors and nonvictims with regard to history of voluntary sexual intercourse because most women have engaged in intercourse by the time they are college age, despite their victimization status.

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, decreased use of contraceptives, sexually transmitted diseases, lower occupational status, a greater number of sexual partners, participation in unsafe sexual interactions, revictimization, substance use, and increased likelihood of participating in other high-risk behaviors (Abma, Driscoll, Moore, 1998; Brooks-Gunn & Furstenburg, 1989; Devine et al., 1993; Graber & Brooks-Gunn, 1995; Jessor, 1992). These associated negative outcomes of risky sexual behavior make a survivor's life even more difficult and challenging. Teen pregnancy, for example, often results in school drop out, decreased ability to find stable employment, and poverty. Teen mothers are less likely to marry than are their older counterparts, are more likely to abuse substances, and

are at increased risk of abusing their own children (Garrett & Tidwell, 1999; Kissman, 1998).

Research also suggests that adolescent abuse survivors engage in sexual behavior with a greater number of partners than nonabused teens. Five studies employing adolescent community samples examined this issue (Fergusson, et al., 1997; Fromuth, 1986; Luster & Small, 1997; Krahe, Scheinberger-Olwig, Waizenhoper, & Kolpin, 1998; Stock et al., 1997). In two studies, survivors clearly reported having significantly more sexual partners than non-abused counterparts (Fergusson, 1997; Krahe et al.,1998), while another study failed to replicate this finding with a college sample (Fromuth, 1986). Fergusson (1997) followed adolescent girls over time and asked participants to report their exact number of sexual partners once per year at ages 14, 15, and 16. Girls who had six or more sexual partners by the age of 16 were classified as "having multiple sexual partners" and 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 also found that young women with a sexual abuse history reported a greater number of partners in a variety of voluntary sexual behaviors 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 the number of partners than a CSA history alone.

In the one study that did not report a difference in number of sexual partners, participants were asked if they (a) had sexual intercourse with one or two partners or (b) had sexual intercourse with more than 10 partners (Fromuth, 1986). Participants in this study who had more than 2 sexual partners but less than 10 were unable to report their

exact number, and may have been unable to complete this item altogether. Thus, this study may have failed to find a difference due to a lack of specificity in measurement. Survivors did, however, report more noncoital sexual activity in the past month.

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). However, when sexually active survivors were compared only to sexually active nonabused peers, no differences were found in rates of pregnancy (Stock et al., 1997). The authors suggest that a history of CSA may be more of a risk factor for early intercourse and thereby lead to an increased risk of pregnancy.

Similar findings emerged 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 who experienced intercourse in the context of abuse were more likely to have been pregnant than young women without a history of abuse (in no case was pregnancy a result of the sexual abuse) (Fergusson et al., 1997). Another study found that mothers aged 12- to 42-years with a history of sexual abuse had significantly more children than nonabused mothers (Herman-Giddens, Kotch, Browne, Ruina, Winsor, Jung, & Stewart, 1998). The increased birth rate was accounted for by the earlier age at which these women began to engage in intercourse and lower rates of contraceptive use (Stock et al., 1997).

Fergusson et al. (1997) also found that contraceptive use among adolescent CSA survivors may be deficient. More specifically, examination of instances of unprotected sexual intercourse and rates of sexually transmitted diseases suggest that survivors with a history of contact abuse (with and without intercourse) were more likely to have engaged in unprotected voluntary intercourse by the age of 18 than nonabused peers. Additionally, those young women who experienced intercourse during CSA were more likely than young women with a history of noncontact abuse and young women with no abuse history to have ever been diagnosed with a sexually transmitted disease. In another study, female adolescent psychiatric inpatients with a history of CSA reported less self-efficacy for condom use than did nonvictimized residents, and displayed more difficulty verbalizing sexual information when participating in role-play activities about sexual decision-making (Brown, Kessel, Lourie, Ford, & Lipsitt, 1997).

Summary

As reviewed, theories of sexual development support a relationship between a young person's thoughts, feelings, behavior and their sexual development. Childhood sexual abuse is an event likely to adversely affect this development. As a result of CSA, many survivors develop a repertoire of sexual attitudes, feelings, and behaviors different from young people with no history of abuse. Recently, studies have begun to explore the influence of CSA on sexual development. This area of research is still relatively young and the topics that have been addressed lack detail, at times resulting in inconsistent findings. Although most studies that examine sexual behavior in adolescent survivors raise concerns about rates of risky sexual behavior (e.g., early age of onset, multiple partners, and inconsistent contraceptive use), many relevant topics have not been

examined to date, i.e., survivors conceptualization of sexuality and the amount of control survivors feel in voluntary sexual situations.

High rates of risky sexual behavior and the associated negative consequences have resulted in the implementation of education and intervention programs, with the goal of encouraging safer sexual behaviors (e.g., postponing sex, sex only in committed relationships, use of contraceptives). These programs, however, have had limited success and have led researchers to recommend looking more closely at the decision- making process influencing sexual behavior (Bailey & Piercy, 1997). Additionally, research is needed to examine factors that influence the sexual decision-making of adolescents with a sexual abuse history, given their greater participation in risky sexual behavior.

Sexual Decision-Making

Researchers have voiced a need to learn more about the factors that influence adolescents' decisions to engage in (or avoid) sexual behavior (e.g., Furby, Ochs, & Thomas, 1997; Juhasz & Sonnenshein-Schneider, 1987; Pete & Desantis, 1990; Schensul, 1998-1999). There is a growing consensus that examination of adolescent sexuality should go beyond sexual behavior per se (e.g., participation in and frequency of sexual intercourse) and consider the contribution of adolescent thought processes (e.g., belief systems, attitudes toward sexuality) (e.g., Furby, Ochs, & Thomas, 1997; Juhasz & Sonnenshein-Schneider, 1987; Pete & Desantis, 1990; Schensul, 1998-1999). Such a focus is consistent with cognitive and developmental theories suggesting that adolescents' perceptions or conceptualization of sexuality play a significant role in the young person's sexual decision-making and subsequent sexual behavior (Holmbeck, Crossman, Wandrei, & Gasiewski, 1994; Walen & Roth, 1987).

Notably, findings from recent studies have demonstrated that factors previously thought to strongly influence adolescent's sexual behavior (e.g., knowledge about sex or HIV) may have only limited impact. For instance, Langer and Giraud (1999) and Levinson, Jaccard, and Beamer (1995) found that adolescents engaged in risky sexual behavior despite accurate information about the risk of HIV/AIDS. Additionally, Schensul (1998) concluded that youth understand the relationship between behavior and disease, but that other factors (e.g., peer pressure, stress) continue to influence the decisions they make about sexual behavior. Likewise, Green, Johnson, and Kaplan (1992) did not find support for their predicted relationship between past contraception use and future decisions to use contraception. In sum, it does not appear that knowledge about sex or disease nor, to some extent, past contraception use consistently predicts future sexual behavior, contradicting what was previously thought. Thus, considerably more research is needed to elucidate those factors that reliably predict sexual behavior. In the section to follow, both cognitive and situational variables that have been associated with sexual decision-making will be reviewed.

Suspected Influential Factors

The above noted findings have prompted researchers to examine different variables in an attempt to clarify the assumed relationship between adolescents' cognitions and their sexual decision-making. Prior to reviewing the relevant literature, it is important to note a trend in sexual decision-making research, specifically, the method by which sexual decision-making has been examined. Across studies, indices of sexual behavior, rather than indices of decision-making itself, have been employed to identify variables that influence the sexual decision-making process. In this case, sexual activity

is viewed as an indication that a sexual decision has been made to participate or not. While this could potentially be viewed as a methodological flaw across studies, it is important to note that there appears to be a shortage of psychometrically sound measures of sexual decision-making per se. Thus, the investigation of sexual behavior may allow for more precise, objective, and consistent research at this time.

For instance, Juhasz, Kaufman, and Meyer (1986) distributed a sexual attitude survey to a large sample of high school boys and girls. Fear of pregnancy was the factor identified as most influential upon both boys and girls decisions to not engage in sexual intercourse. Three of every four girls who completed the survey reported that "being in love" influenced their decision to participate in sexual intercourse. A "desire to save or maintain a relationship" and "curiosity" were other factors that related to participation in sexual behavior.

Juhasz and Sonnenshein-Schneider (1987) asked adolescents to rate to what degree 14 different factors influenced their sexual decision-making. These authors found that desire/need for intimacy, consideration of "family establishment," external morality, and self-enhancement/physical gratification were all deemed important. The researchers also identified several "personality factors" which were found to influence sexual decision-making, including level of intelligence and degree of excitability. Unfortunately, the factors such as "family establishment" and "external morality" were identified by name only; no description or sample items were included and the direction of the influence was not indicated.

Other researchers have also attempted to identify situational and cognitive variables that influence an adolescent's sexual behavior. For example, Pete and Desantis

(1990) examined the relationship between sexual expectations and sexual decision-making. As hypothesized, adolescents who associated sexual intercourse with a greater number of negative consequences (e.g., pregnancy) engaged in sexual intercourse less often than those with fewer negative expectations. Six additional factors were identified that substantially impacted adolescent sexual decisions. These were: (a) unsupervised free time, (b) inconsistent parental rules/expectations, (c) ineffective authority figures, (d) lack of communication about sex with parents or peers, (e) a desire to first establish a relationship based on trust and love, and (f) an inability to obtain birth control.

Levinson, Jaccard, and Beamer (1995) also examined cognitions in the form of sexual expectations as precursors of "casual sex." They found a positive relationship between expectations of physical pleasure/physical relaxation and greater casual sexual activity in young women. Young women who reported a perceived sense of deprivation when not engaging in sex also had higher rates of sexual behavior. Likewise, Kalof (1995) explored sexual attitudes of young people in an effort to support a hypothesized model of precursors to adolescent sexual behavior. A direct effect was found for gender role attitudes, with more egalitarian attitudes predicting lower rates of sexual interaction for black and white male adolescents and black female adolescents, but not significantly predicting sexual activity in white female adolescents. Finally, it was noted that less popular female adolescents, both black and white, were more likely than their popular counterparts to use sexual intercourse as a means of emotional gratification. This study also found that physical desire alone substantially increased the likelihood that teens would be sexually active. Consistent with previous literature, Kalof's study supports a

relationship between attitudes and sexual activity. In contrast to other studies, Kalof suggests that cognitive factors may be differentially important across race and gender.

Taris and Semin (1995) attempted to investigate the direction of the relationship between an adolescent's sexual attitudes and behavior. This longitudinal study collected data regarding sexual permissiveness, dating habits, knowledge of partner's sexual history, and assertiveness scores of 15 - 18-year-old participants on two different occasions over a period of one year. At the conclusion of the study, the participants 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, reporting more permissive attitudes and greater assertiveness. It was hypothesized that teens who experienced sexual intercourse for the first time between data collection one and two would endorse the most change in sexual attitudes. On the contrary, all groups endorsed more permissive attitudes without significant between group differences. From these findings, the authors speculated that sexual attitudes change with passage of time alone, and that change in attitude is predictive of sexual behavior, rather than sexual behavior leading to a change in sexual attitudes. However, the methodology of this study could entirely not rule out the latter proposition.

Buzwall and Rosenthal (1996) examined sexual self-esteem, sexual self-efficacy, sexual attitudes, and sexual risk-taking in a sample of 470 high school boys and girls. A significant relationship between adolescents' sexual perceptions, competencies, and behaviors was identified. Across three indexes of sexual risk-taking, namely number of sexual partners, sex without a condom, and number of one-night stands, adolescents with

high levels of sexual self-esteem and sexual assertiveness endorsed greater participation in high-risk behavior. The direction of the relationship between sexual behavior and sexual self-esteem and sexual assertivness, however, is indeterminate given the correlational design of the study.

Rosenthal, Lewis, and Cohen (1996) used qualitative methods to gather information about adolescents' views of sexuality and concluded that adolescents engage in sex primarily to either enhance an emotionally intimate relationship or for physical gratification. The amount of control an adolescent felt in a sexual situation also emerged as an influential factor. Other factors identified as important in sexual decision-making included a desire to fit in with friends, curiosity, use of alcohol and drugs, and time spent alone with a potential partner.

Rosenthal, Burklow, Lewis, Succop, and Biro, (1997) recently examined four factors related to sexual behavior in intimate relationships. Factors identified as increasing participation in sexual behavior were physical attraction, curiosity, being alone with their partner, and considerate treatment from their partner. Miller, Norton, Fan, and Christopherson (1998) also attempted to identify situational, or noncognitive, factors that influence adolescent sexual decision-making. Specifically, parent/adolescent communication was also found to be an important variable. Female adolescents who reported higher quality communication with parents endorsed fewer risky sexual behaviors than those with poorer communication. The age at which a girl reached puberty also affected the likelihood that she would make decisions to participate in sexual behavior, such that girls who reached puberty early were more likely than their peers who experienced puberty later to have engaged in sexual behavior at the time of the study.

Finally, Langer and Girard (1999) examined the relationship between sexual decision-making risky sexual behavior, identifying several factors that were predictive of high-risk sexual behavior. The cognitive variables identified as influential included poor attitudes about condom use, perceptions that peers are not using condoms, and less rational decision-making (e.g., not considering multiple options or weighing positive and negative outcomes). The use of drugs and alcohol were also identified as influential. Specifically, their findings suggest that adolescents who held negative opinions about condoms, who were under the impression that their peers did not use condoms, who were less able engage in higher level decision-making, and those who engaged in alcohol or drug use were more likely to engage in high-risk sexual behavior. The cross-sectional design of this study does not allow for conclusions regarding the direction of the relationship between predictor variables and sexual behavior. Additionally, this study employed a sample of adolescents from a substance abuse treatment program; thus, the generalizability of this study is somewhat limited.

In sum, these studies suggest a relationship between several cognitive variables in sexual decision-making and subsequent sexual behavior. More specifically, support has been found for the impact of attitudes about condom use, perception of peer condom use, decision-making ability, egalitarian gender attitudes, perceived amount of control in sexual situations, and other sexual expectations about sex (e.g., perceived physical pleasure, physical relaxation, and negative consequences) on sexual behavior. A handful of studies have not examined the impact of specific cognitive variables but have identified important situational factors that influence sexual decision-making. As

theorized, sexual cognitions, attitudes, expectations, perceptions, as well as situational variables, appear to impact sexual behavior.

Unfortunately, none of the above studies have differentially evaluated how adolescents with a sexual abuse history make sexual decisions. The following three studies are the only known studies to date that have attempted to investigate the sexual belief system of adolescents with a history of CSA. Huerta-Franco & Malacara (1999) examined the sexual attitudes, sexual knowledge, and sexual experiences of underprivileged Mexican adolescents. Of the sample of sexually active adolescents, 14 young men and women endorsed histories of CSA. This study did not compare survivors and nonvictims on any of the outcome variables. Rather, the authors examined the relationship of sexual attitudes and sexual decision-making for the sample as a whole (survivors and nonvictims together) and for CSA survivors alone. Variables identified as most influential for the small sample of CSA survivors were age, number of persons in the family, knowledge about contraceptives, and attitudes toward sexuality. Examination of the entire sample revealed that female adolescents engage in sexual activity primarily out of love. Other factors identified as influential for the entire sample were age, knowledge about sexually transmitted disease, and attitudes toward sexuality. These factors were all positively correlated with participation in sexual behavior, whereas father's years of schooling and family functioning were negatively related. These findings suggest that age and attitudes toward sexuality are influential for both survivors and nonvictims, although the extent to which they are differentially influential was not determined.

Orr and Downs (1985) compared the self-image of sexually abused adolescent survivors to medically ill, nonsexually abused adolescents. The two groups did not significantly differ from one another, although the survivor sample scored in the poorly adjusted range on the subscales of sexual attitudes, mastery of environment, and overall adjustment. These findings suggest that survivors of sexual abuse hold negative attitudes about sexuality, do not perceive themselves as having control over their environment, and overall are more poorly adjusted than nonclinical sample. Similar to other studies, the generalizability of these findings are limited due to a small sample size (n=20 for each group) and the composition of the comparison group (medically ill adolescents).

Fromuth (1986) examined psychological and sexual adjustment in a large sample of college students. The sexual adjustment measure assessed whether or not young women considered themselves sexually promiscuous. Participants with a history of abuse labeled themselves as "promiscuous" more often than did their nonabused peers who had engaged in similar types/rates of sexual behavior. These findings suggest that survivors view participation in sexual behavior differently from their nonabused counterparts, and that they may be more negative when judging their own sexual behavior. Measures of depression, self-esteem, and locus of control were also administered but no important differences were identified between the two groups.

Summary

Although the sexual decision-making of adolescents has begun to receive empirical attention over the past decade, much work is left to be done. Studies to date have examined a wide range of decision-making variables but the studies have relatively little in common with regard to the particular variables investigated, making it difficult to

draw strong conclusions. Rarely have any of these investigations been theory-driven. Additionally, the majority of decision-making of studies have employed community samples or samples of convenience, few have compared decision-making across samples, and even fewer have examined the sexual decision-making of sexually abused adolescents.

Studies of abused and nonabused adolescent samples demonstrate that both situational and cognitive factors indeed affect adolescent sexual behavior. In total, 38 factors that potentially influence the sexual behavior of adolescents have been identified and are reviewed here (see Table 1).

Despite the common goal of these studies, only 12 of the 38 factors identified were investigated and supported in more than one study (see Table 2). Likewise, only 6 of the 38 factors were cognitive in nature (see Table 3). Although the exploratory nature of this field warrants investigation of a wide variety of factors, it is unfortunate that studies have been so varied with regard to the factors examined. This has, for the most part, prevented replication of findings and limited the confidence with which conclusions can be drawn. For instance, of the 12 factors that were included and supported in more than one study, 6 were examined in only 2 studies (sexual attitudes, love for partner, decision-making ability, communication with parents, age, and religiosity); 4 factors were included in 3 studies (curiosity, consequences of sexual behavior, emotional gratification, substance/drug use); parental supervision, was included in 4 separate studies and the final factor, physical gratification, was examined in 6 studies.

Importantly, some potentially influential cognitive factors have been overlooked altogether in this literature. Attributional style, for example, has not ever been

investigated in relation to sexual decision-making, despite an abundance of theoretical and empirical support suggesting it would be an important variable to examine (Browning & Laumann 1987; Downs, 1993; Finkelhor & Brown, 1988; Maltz & Holman, 1987; Mayall & Gold, 1995). A brief overview of the attributional style literature follows, particularly as it relates to sexual decision-making in survivors of CSA.

Attributional Style as a Predictor of Sexual Decision-Making

Attributional theory proposes that individuals have a particular style of ascribing causality to future or past events. One's attributional style is the way an individual interprets the cause of situations across three separate, dichotomized dimensions, namely, locus (internal/external), globality (global/specific), and stability (stable/unstable) (Abramson, Seligman, & Teasdale, 1978; Peterson & Seligman, 1984). Locus refers to the amount that one feels the cause of an event is due to something they have done or something particular to their character. Globality refers to the pervasiveness of a particular cause across situations. Stability refers to the likelihood of a particular cause being present over time.

To elaborate, the internal/external range of locus is the degree to which one attributes the outcomes of events as within their own control. Internal attributions reflect one's perception that outcome is contingent upon something about them (e.g., a personal characteristic, ability, or behavior). External attributions are those that ascribe the cause of an event to an external cause, something that was not the responsibility of the individual, some cause outside of their control.

The domain of globality refers to the degree that one generalizes the outcome of a situational specific event to other events in different situations. Thus, one who makes a

global attribution believes that the outcome of a specific event will predict a similar outcome in other situations or events. Conversely, a specific attribution would reflect a belief that the cause attributed to the outcome of an event is particular to that situation or event.

Lastly, the stability dimension is divided into stable/unstable, and refers to the consistency of causality across time. For instance, a stable attribution is one that predicts outcome of future tasks based on outcome of past events, no matter the length of time that has passed. An unstable attribution is one that predicts outcome as time-specific; whereas, outcomes of similar, future events are not seen as related to past events.

From these dichotomous dimensions, several combinations of general attributional style can result. When an individual's attributions for negative events are internal, global, and stable s/he is said to have a depressive, pessimistic, or negative attributional style. On the other hand, when one makes external, specific, and unstable attributions for negative events, s/he is regarded as having a positive attributional style. Particular combinations are generally considered most predictive of functioning or behavior. For instance, attributional style has been investigated as a mediator of functioning in a variety of studies and in many cases, a negative attributional style for negative events is predictive of worse functioning (Seligman, Abramson, Semmel, & von Baeyer, 1979; Nolen-Hoeksema, Seligman, & Girgus, 1986; Sweeney, Anderson, & Bailey, 1986). Conversely, a postive attributional style is hypothetically associated with better functioning because it allows for externalization of causality for negative events and provides hope that outcomes will be different in later, similar situations.

As previously stated, the impact of negative attributional style and to a lesser degree positive attributional style on functioning has been empirically investigated and supported. For example, an internal, stable, and global attributional style for negative events has predicted depression in a variety of samples including elementary school children, college students, inpatients, and community samples (e.g., Pecuch, 1998; Porter, 1999; Seligman, Kaslow, Alloy, Peterson, Tanenbaum, & Abramson, 1984; Sweeny et al., 1986). Positive attributional style, while theoretically viewed as related to better functioning, has undergone significantly less empirical investigation. Some qualitative studies, however, consider a positive attributional style a "protective" factor that allows for resiliency in the face of negative life events (e.g., Valentine & Feinauer, 1993).

Simply put, an attribution is the causal explanation one makes for an event across persons, time, and situations. Theoretically, attributions mediate the relationship between stimulus and response. For instance, if one perceives oneself as having little or no control over the outcome of an event, s/he is less likely to behave in a ways that would disrupt an expected outcome or facilitate a desired outcome (Abramson, Seligman, & Teasdale, 1978). Empirically, this relationship has been well supported across a number of studies, employing a number of different samples.

Researchers in the field of CSA have begun to examine attributional style in an attempt to clarify the relationship between the attributions survivors make about their abuse history or general negative events and their later adult functioning. Four of five studies have found that CSAS are more likely than nonabused counterparts to endorse negative attributional styles (e.g., Arata 1999; Gold, 1986; Mannarino & Cohen, 1996; Porter, 1999; Wenninger & Ehlers, 1998). Further, the relationship of attributional style

and functioning in survivor samples is similar to the relationship in nonvictimized samples, such that a negative attributional style for bad events is related to poorer functioning across several domains. These studies will be reviewed in more detail below.

Employing an adult sample of female CSA survivors, Wenniger and Ehlers (1998) found that CSAS reported more internal, stable, and global attributions for negative events as compared to nonvictims and that a negative attributional style predicted more symptoms of post-traumatic stress disorder (PTSD). In a study of long-term functioning, Gold (1986) also found that CSAS were more likely than nonvictimized women to endorse general negative attributions and that attributional style was the strongest predictor of women's overall psychological distress and low self-esteem.

In a study employing grade school children with histories of CSA, Feiring and colleagues found that higher abuse severity predicted a more negative or pessimistic general attributional style (Feiring, Coates, & Taska, 2001), and in a subsequent study, the interaction of abuse severity and general attributional style significantly predicted depressive symptoms and problems with self-esteem (Feiring, Taska, & Lewis, 2002).

Mannarino and Cohen (1996) examined attributional style in sexually abused and nonvictimized adolescents and children. They found that children with a history of CSA were more likely to have negative attributional styles, and that negative attributional styles, across both groups, predicted more depressive and anxious symptomatology as well as lower self-esteem. Notably, in this study abuse-specific attributional style was identified as a better predictor of symptomatology than was a general attributional style

for the CSA survivors. For the nonvictimized sample in this study, general attributional style was most predictive of psychological functioning.

Wolfe, Gentile, and Wolfe (1989) also utilized a measure of attributional style specific to traumatic events in their study of sexually abused children. Results implied that both attributional style in general and attributions specific to sexual abuse were related to higher levels of PTSD symptomatology. Likewise, Arata (1999) employed the sexual assault rating scale in an investigation of adult female rape victims with and without a history of CSA. She found that CSA survivors were more likely to engage in self-blame (part of a negative attributional style) for the sexual assault than were rape survivors without a CSA history.

Porter (1999), in a study examining the relationship of attributional style, negative life events, and depression in young adult college women, failed to identify a difference in the negative attributional styles of CSAS and nonvictims. Although differences in attributional style were not found, a negative attributional style was supported as a predictor of more depressive symptoms and overall general distress for both CSAS and nonvicims.

In conclusion, a small body of research suggests that CSAS as compared to nonvictimized samples and adult rape survivors without a CSA history may be more likely to endorse a negative attributional style for negative events than are nonvictims; only one study has failed to support this finding. Further, negative attributional style has consistently predicted worse functioning in samples of CSAS and nonvictims with regard to PTSD, depression, low self-esteem, and general distress. Abuse specific attributions

have also been examined and appear related to outcome, sometimes to a greater degree than general negative attributional style.

Although these studies suggest a relationship between attributional style and survivor status, they are limited in that very few have investigated the impact of attributional style for a particular domain of interpersonal functioning (e.g., interpersonal relations, academic performance, sexual relationships).

One exception was a study that investigated the role of attributional style as a mediating variable of sexual revictimization in women with and without histories of CSA (Mayall & Gold, 1995). In this study, survivors of CSA were more likely to be victimized as adults than were women with no CSA history. Women with a CSA history also had higher levels of voluntary sexual behavior than participants without a CSA history. Attributional style not supported as a mediator of the relationship between sexual abuse and revictimization, but the participants' frequency of voluntary sexual behavior was. In other words, having a negative attributional style did not appear to make survivors of CSA more likely to be revictimized in adulthood. Rather, their greater participation in later, presumably voluntary, sexual activity appeared to make them more susceptible to revictimization. Authors of this study emphasized the need to investigate factors that lead CSA survivors to be more sexually active in adulthood, suggesting that attributional style may still play a significant role.

Two other studies have examined constructs similar to attributional style in relation to sexual functioning. Hazzard (1993) used the Sexual Symptom Checklist to examine maladaptive sexual feelings or dysfunctions in survivors of CSA. Working within the framework of Finkelhor's Traumagenic Dynamics model, she found that

"betrayal" beliefs predicted sexual problems and "traumatic sexualization beliefs" predicted sexual avoidance. Feiring et al. (1998) examined shame, self-blaming attributions, and traumatic events sequaelae in a sample of child and adolescent CSA survivors. Shame and attributional style mediated the relationship between number of abuse events and depression, self-esteem, and children's sexualized behavior, but not symptoms of PTSD.

In conclusion, the relationship between attributional style and child sexual behavior, sexual avoidance, sexual problems, and sexual revictimization has been investigated in samples of CSA survivors and have received mixed support. Although several theories of sexual development and theories of CSA directly suggest that cognitive factors influence adolescent sexual behavior, no study to date has specifically examined the contribution of attributional style on sexual decision-making or subsequent sexual behavior. Nor, has any study examined CSA survivors attributions specific to sexuality.

It is particularly relevant to examine the attributional style of CSA survivors because they are at increased risk of having distorted belief systems and attributions about sexuality for several reasons. First, a survivor's childhood sexual experience is theoretically the basis from which s/he comes to understand sexuality, shaping her/his expectations for assumptions about "normal" sexual behavior. Second, CSA is hypothesized to lessen the amount of control a survivor feels she has in sexual situations. Third, based on survivors sexual experience in the context of abuse, she may hold expectations that all future sexual interactions during childhood or adulthood voluntary or not, will be abusive. The need to investigate attributional style as a predictor of sexual

decision-making and voluntary sexual behavior is clear. Literature and theory suggest that is especially relevant to examine the relationship of sexual decision-making and attributional style in survivors of CSA.

Purpose of the Current Study

The current study examined factors that potentially impact the sexual behavior of young adult survivors of child sexual abuse, specifically, factors that influence sexual decision-making. Consistent with the sexual decision-making literature, the present study investigated participant's reported rates of participation in voluntary sexual behavior. In other words, the objective of the current study was not to examine the actual decision-making process that occurred in sexual situations, but to identify variables, cognitive and situational, that are related to and predictive of participation in voluntary sexual behavior. Therefore, if a participant reported engaging in voluntary sexual intercourse, it was assumed here that a volitional decision to have sexual intercourse had been made.

The specific goals of this study were threefold. First, this study attempted to replicate findings of previous studies suggesting that survivors of CSA engage in a greater amount of sexual behavior than nonvictimized samples. Survivors and nonvictims were compared with regard to their participation in typical sexual behavior other than sexual intercourse over the past year (e.g., kissing and petting), the age at which they first engaged in voluntary sexual intercourse, and their participation in high-risk, or risky, sexual behavior over the past year. Survivors and nonvictims were also compared with regard to their predicted participation in future risky sexual behavior over the subsequent twelve months. Secondly, this study examined the relationship between victimization status (survivor versus nonvictim) and attributional variables. More

specifically, survivors and nonvictims were compared on general attributional style for negative events and sexual-specific attributional style for negative sexual events. The third goal of the present study was to replicate previous sexual decision-making studies by identifying factors related to participation in sexual behavior and to extend these findings to a sample of CSA survivors. Three factors previously supported as predictors of sexual decision-making in studies employing nonvictimized samples were included in the present study. These included level of parental supervision, costs (negative consequences) associated with sexual behavior, and benefits (positive consequences) associated with sexual behavior. The present study evaluated the relative contribution of each of these variables, as well as the contribution of general attributional style and sexual-specific attributional style to participation in sexual behavior, for both survivors and nonvictims. Parental supervision, perceived costs, and perceived benefits were expected to directly predict participation in risky sexual behavior for both survivors and nonvictims. However, attributional style was expected to account for variance above and beyond that accounted for by these variables.

Research Questions and Hypotheses

1. a. Are survivors more likely than nonvictims to endorse participation in "typical" sexual behavior over the past twelve months?

1. b. Are survivors more likely than nonvictims to endorse participation in "high-risk" sexual behavior over the past twelve months?

1. c. Are survivors more likely than nonvicims to predict more or less participation in future risky sexual behavior?

Hypothesis 1 a. It was hypothesized that participants with a history of CSA would endorse greater participation in typical sexual behavior by reporting a total greater frequency of participation across a number of sexual behavior items, including kissing and degrees of petting.

Hypothesis 1 b. It was also hypothesized that participants with a history of CSA would endorse greater participation in risky sexual behavior by reporting a) a younger age at first sexual intercourse, and b) a higher composite score on the measure of sexual risk-taking.

Hypothesis 1c. No directional difference was hypothesized for participation in future sexual behavior, as this research question was exploratory in nature.

2 a. Are survivors more likely than nonvictims to endorse a general negative attributional style for negative events?

2. b. Are survivors more likely than nonvictims to endorse sexual-specific, negative attributional style for negative sexual events?

Hypothesis 2 a. It was hypothesized that survivors would be more likely than nonvictims to report a negative general attributional style for negative events.

Hypothesis 2 b. It was also hypothesized that survivors would be more likely than nonvictims to report a negative sexual-specific attributional style for negative sexual events.

3 a. Is general negative attributional style associated with participation in high-risk sexual behavior above and beyond the influence of parental supervision, perceived costs, and perceived benefits?

3 b. Is sexual-specific negative attributional style associated with risky sexual behavior

above and beyond the influence of parent supervision, and perceived costs and benefits?

Hypothesis 3 a. It was hypothesized that general attributional style would account for significant variability in high-risk sexual behavior above and beyond parental supervision, perceived consequences (costs) of sexual intercourse, and perceived benefits of sexual intercourse. Parental supervision and perceived consequences (costs) of sexual behavior were predicted to be inversely related to participation in risky sexual behavior for both survivors and nonvictims. Perceived benefits of participating in sexual behavior were hypothesized to be positively associated with high-risk sexual behavior for both survivors and nonvictims.

Hypothesis 3 b. It was hypothesized that sexual-specific attributional style would also predict sexual behavior above and beyond that accounted for by parental supervision and perceived costs and benefits.

CHAPTER III

Method

Participants

A sample of 486 young women between the ages of 18 and 21 was recruited from psychology classes for participation in a study examining sexual decision-making. Class credit was provided for participation in the study. Of the 486 participants, 310 were recruited from a non-urban state university located in the southwest and 176 were recruited from a private urban university located in the northeast. Due to incomplete questionnaire data, 29 of the 486 young women were excluded from further analyses leaving a total sample of 457, 290 in the non-urban sample and 166 in the urban.

Demographic variables for each of these samples follow.

Participants in the non-urban sample reported a mean age of 18.97 years (SD = .86). Of these, 92.6% were not married, 2.1% were currently married, 2.1% were cohabitating, and 0.4% were divorced or separated. Approximately half (56%) of the young women in this sample were reportedly in a romantic relationship at the time of the study. The majority of this sample described their ethnicity as Caucasian (80%), whereas 4.5% identified themselves as African American, 3.1% as Latino, 7.9% as Native American, 1.4% as Asian American, and 2.4% as biracial or other. With regard to

religious affiliation, 75.6% of sample identified themselves as Protestant, 14.1% as Catholic, 6.2% as nonaffiliated, and 4.1% as other.

Participants in the urban sample reported a mean age of 18.82 years (SD = .86). Of these, 93.3% were not married, 4.0% were cohabitating, and 0.7% were divorced or separated; none were married at the time of the study. Similar to the non-urban sample, approximately half (54.9%) of the urban young women were in a romantic relationship at the time of the study. With regard to racial identity, 45.5% described their ethnicity as Caucasian, whereas 29.4% identified themselves as African American, 1.8% as Latino, 12.9% as Asian American, and 10.4% as biracial or other. Approximately one-third of the sample (37.3%) reported a Protestant religious affiliation, whereas 34.8% identified themselves as Catholic, 1.9% as Jewish, 9.3% as nonaffiliated, and 16.8% as other.

Multiple chi square analyses were conducted to compare the two sites on demographic variables. Several significant group differences were identified; hence data regarding demographics were presented separately for each group (also presented in Table 5). With regard to categorical demographic variables no significant differences were found for marital status, $\chi^2(4, N = 433) = 4.9$, ns or whether or not participants were involved in a current romantic relationship status, $\chi^2(1, N = 453) = .75$, ns. Further, no significant differences were found with regard to whether or not participants had ever pursued counseling, $\chi^2(1) = .52$, ns. The two geographical sites did significantly differ from one another with regards to race, $\chi^2(5) = 119.07$, $p = .00$, with the non-urban sample having higher percentages of Caucasian, Native American, and Hispanic participants and the urban sample having higher percentages of African American and Asian American participants. There were also significant differences in participants'

reported religious affiliation status, χ^2 (4) = 71.30, p = .00, with the nonurban sample reporting higher rates of participants identifying as Protestant and the urban sample reflecting higher rates of Catholic, Jewish, and religiously nonaffiliated participants.

Next, a set of seven independent sample t-tests were conducted to compare the two samples on all dependent and independent variables of interest (see Table 6 for means and standard deviations). No significant differences were found between the two sites with regard to parental supervision t(459) = -.78, ns, rates of participation in typical sexual behavior, t(272) = .73, ns, or rates of participation in risky sexual behavior, t(431) = -1.48, ns. However, site differences between costs and benefits of sexual intercourse were found, with the nonurban sample reporting less perceived costs, t(458) = -4.67, p = .00, and greater perceived benefits, t(457) = 4.50, p = .00. Finally, the two sites differed with regard to both general negative attributional style, t(452) = 6.22, p = .00, and sexual-specific negative attributional style, t(442) = 4.28, p = .00, with the non-urban sample reporting more negative attributional style for negative general and sexual-specific situations. Because of differences in demographics and differences in independent and dependent variables between samples, all subsequent analyses were conducted separately for each site.

For the purpose of this study, CSA was screened with a series of eight questions included in the Life Experiences Questionnaire (see description below). Participants in this study were defined as CSA survivors (CSAS) if they endorsed at least one experience of contact sexual abuse occurring before the age of seventeen. In the total sample, 62 women were identified as CSAS; this included 37 (12.71%) in the non-urban sample and 25 (15.06%) in the urban sample. These percentages are fairly consistent, but slightly

lower, than the percentages identified in past studies employing college samples (Fromuth, 1986; Porter, 1999). Due to incomplete questionnaire data, victimization status could not be determined for 29 of the 486 young women. These women were excluded from additional analyses, leaving a total sample of 457.

Of the 37 CSAS in the non-urban sample, 91.44% reported abuse by a single perpetrator, 5.71% reported abuse by two perpetrators, and 2.85% reported abuse by three or more perpetrators. Two-thirds of the sample (66.7%) reported intrafamilial abuse, and the other one-third (33.3%) reported abuse by a non-family member. Approximately one-half of survivors reported a single episode of CSA (53.5%), whereas 23.3% reported abuse lasting between one month and one year, 7% between one and two years, 11.6% between two and five years, and 4.7% between five and ten years.

In the urban sample, 80% reported abuse by a single perpetrator and the remaining 20% reported abuse by two perpetrators. Slightly over one-third (38.5%) of the urban sample reported intrafamilial abuse, whereas 61.5% reported abuse by a non-family member. Over one-half of survivors (57.1%) in the urban sample reported a single episode of CSA, whereas 32.1% reported abuse lasting between one month and one year, and 10.7% between two and five years.

Comparison of Groups on Abuse Variables

A series of independent t-tests were run to compare the CSAS in the nonurban sample to those in the urban sample on each of these abuse characteristics, as well as on several other abuse related variables (see Table 4) for means and standard deviations. The first set of independent t-tests compared the two groups of survivors with regard to length of CSA, number of perpetrators, and whether or not they experienced intercourse

as part of their abuse experience. Significant differences were found with regard to intercourse as part as abuse, with CSAS in the urban sample reporting higher rates $t(29.82) = 2.27$, $p = .03$, however no significant differences were identified between the two groups with regard to duration of abuse, $t(69) = -0.88$, ns, or number of perpetrators $t(50) = 1.02$ ns (Note: fractional degrees of freedom reflect tests in which unequal variances were not assumed). Four independent t-tests compared the amount of support CSAS felt they received from their parents while they were growing up. In the nonurban sample, CSAS reported receiving significantly more support from their mother figures than did CSAS in the urban sample $t(42) = -1.97$, $p \leq .05$. No significant differences were found for the support provided by father figures, $t(57) = -1.37$, ns. There was a trend for significance with regards to whether or not CSAS received victimization-focused counseling following the abuse, with CSAS in the nonurban sample receiving more counseling, $t(60) = -1.76$, $p = .08$. Two follow-up independent t-tests were conducted to examine whether the two groups of survivors were comparable with regards to the answer they gave to the question, "Do you think something like this could ever happen to you again?" No significant differences were found with regard to the answer to this question, $t(56) = -.40$, ns.

Measures

Life Experiences Questionnaire (LEQ). The LEQ includes questions regarding demographics and childhood sexual experiences. A history of CSA was screened with a series of eight questions asking participants whether or not as a child they had any sexual experience, ranging from exposure only to participation in intercourse. CSA was defined as contact abuse occurring before the age of 17. 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 subject. Information regarding identity of the perpetrator, and nature and length of the abuse experience was also assessed.

The LEQ is a revised version of the Past Experiences Questionnaire (PEQ; Messner et al., 1988), and is a self-report instrument with demonstrated reliability (Long, 2000). Psychometric properties of the scale are strong. Internal consistency for the eight questions used to screen for CSA in the LEQ was calculated with a sample of 648 women, and is considered good (Cronbach's alpha = .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 also good (Long, 2000). Specifically, kappas and percent agreement on items related to the identity of perpetrator (intrafamilial versus extrafamilial, .86 and 94%), duration of abuse (less than or greater than 1 year, 1.0, 100%), the nature of the sexual abuse (penetration versus no penetration, .91, 97%), and presence or absence of force (.39, 69%) all suggest a reliable scale. Similar results are seen in interclass correlation coefficients for items such as the age of onset of abuse (.99), the age of the perpetrator (.96), and the age difference between victim and perpetrator (.95). An internal reliability coefficient was calculated for 6 of the 8 items in this study (two items screening for non-contact abuse were excluded) and was found to be acceptable (α =.85).

Attributional Style Questionnaire (ASQ). Created by Peterson, et al. (1982), the composite negative attribution score from the ASQ was used as a rating of the participants' attributional style for negative events. Three subscale totals, one each for

internal, stable, and global attributions for bad events were also used for comparison purposes. The ASQ consists of a total of 48 questions and is designed to measure an individual's explanatory style for 12 hypothetical events. The measure requires respondents to think of and provide one major cause for each of the hypothetical events. They then rate their cause on a seven-point scale along internal, stable, and global dimensions, with higher scores reflecting more negative attributions along each dimension. Half of the situations are related to interpersonal relationships and half are related to achievement; additionally, half of the situations have negative outcomes and half have positive outcomes. The ASQ yields three attribution dimensions scores (i.e., internal, stable, and global) for positive events and three for negative events; composite positive and negative attribution scores can also be obtained by summing the three scale scores for positive and negative events, respectively. Peterson et al. (1982) reported the internal consistencies of the internality, stability, and globality scales as ranging from .44 to .69. Reported internal consistency for composite negative and positive scores were .72 and .75, respectively. Internal consistency was examined in the present study and was low for the subscales but comparable to those found in previous studies. Alpha for the internal subscale was .36, .58 for the stable subscale, and .63 for the global subscale. The internal consistency coefficient for composite negative attributional score in the present study was .74.

Attributional Style Questionnaire - Sexual-Specific (ASQ-SS). The ASQ-SS was designed to assess participants' attributional style for negative sexual events in the current study. The design of the ASQ-SS replicated the format of the ASQ, Peterson, et al.'s (1982) measure of general attributional style. Like the ASQ, this measure contains

48 questions and was designed to measure explanatory style for 12 hypothetical events; however, the events in the ASQ-SS are all sexual in nature. Half of the events are negative and half are positive. Likewise, an attempt was made to match the severity of the sexual scenarios of the ASQ-SS with the severity of the scenarios in the ASQ by having advanced graduate students and professionals in the field of child maltreatment read and rank the severity of each of 20 possible events. Those that matched the severity of the positive and negative events in the ASQ most closely were kept and incorporated into the ASQ-SS.

Consistent with the ASQ, the ASQ-SS required respondents to attribute one major cause for each sexual event depicted in the scale and subsequently rate this cause on a seven-point scale along internal, stable, and global dimensions; higher scores reflect more negative attributions along each dimension. The ASQ-SS was scored in the same manner as the ASQ. Responses to each of the three dimensions were summed, yielding three attributional dimensions scores for positive sexual events, and three for negative sexual events (i.e., internal negative attributions, stable negative attributions, and global negative attributions). Composite negative and positive sexual attribution scores were also obtained by summing the response items to the six negative and six positive sexual events depicted in the questionnaire.

Correlational analyses between the ASQ and the ASQ-SS total and subscale scores were conducted and the correlation coefficients are as follows: ASQ total and ASQ-SS total = .35, ASQ internal and ASQ-SS internal = .17, ASQ global and ASQ-SS global = .42, ASQ stable and ASQ-SS stable = .36. Therefore, it appears that there is some relationship between the two measures, but that the ASQ-SS measures a construct

significantly different from that measured by the ASQ. Internal consistency was examined as well, and was low to moderate. Alpha was .49 for the internal subscale, .62 for the stable subscale, and .74 for the global subscales. The internal consistency coefficient for the composite negative sexual attributional score in the present study was .80.

Scale of Sexual Risk Taking (SSRT). The Scale of Sexual Risk Taking (Metzler, Noell, & Biglan, 1992) was designed to measure high-risk sexual behavior in heterosexual adolescents. It is a 13-item, self-report scale with yes/no, open-ended, and Likert-choice response options. The total score was used to compare survivors and nonvictims on risky sexual behavior over the past year. For the purpose of the present study, one item with an open-ended response option was added to this scale. This item asked the respondent to report at what age (in number of months) they first engaged in voluntary sexual intercourse. This item was not included in the total score of the SSRT however. Rather, only six of the 13 items were included in the total risky sexual behavior score for the non-urban sample. These six items were those with the highest factor loadings in the development of this questionnaire and reflected the frequency of sex with promiscuous partners, number of sex partners in the past year, history of sexual transmitted disease infection, nonuse of condoms, sex with partners not well known to the particicipants. As was suggested by the creators of this measure, scores for these six items were standardized by calculating z-scores and then summed and averaged to provide an average SSRT risky behavior score. To measure suspected future participation in sexual behavior, the same six items were reworded into future tense. For example, the item, "In the past 12 months, how many times have you had intercourse

with someone you didn't know very well?" was changed to "In the next 12 months, how many times do you predict you will have sexual intercourse with someone you don't know very well." Again, as suggested by the creators of this instrument, the items were standardized and the mean of the z-scores became the average future risky sexual behavior score for each participant. Because of an error in the data collection phase of the present study, the total risky sexual behavior score used for the urban sample was an abbreviated 4-item total, as compared to the 6-item total used in the non-urban sample. The two items excluded screened for frequency of condom use and a history of sexually transmitted diseases. A correlational analysis was conducted to compare this 4-item total score with the 6-item total score and was .91, revealing that the two are strongly related.

The development of the SSRT took place in three steps. First, behaviors known to place one at moderate or high-risk of contracting sexually transmitted diseases, including HIV/AIDS, were used to guide item development. Next, a principal components analysis was performed to define the factors that comprise high and moderate risk, and finally the 13 variables that loaded at .40 or higher on the principal components analysis were averaged into the composite sexual risk taking score. High-risk items received twice the weight as moderate risk items. (These "high-risk" items were those six used in the present study.)

Two of these 13 variables/items, one of which inquires about the number of times the adolescent had sexual intercourse and the other of which asks the participant to report their number of sexual partners in the past year, require that the respondent report an exact number. Four of the items (e.g., "Have you ever had sexual intercourse with someone of the opposite sex?") require a yes/no response. The remaining seven items

inquired about the adolescent's frequency of participation in specific sexual activities; responses were chosen from a 5-item Likert scale, from "never" to "always."

Reliability and validity for this scale was examined across three samples of adolescents and is considered good (Metzler et al., 1992). Cronbach's alpha reliability coefficients were .75, .88, and .90 across the three samples. Construct validity was supported by significant correlations between the SSRT and several measures of other high-risk behaviors (e.g., alcohol and marijuana, and other drug use, antisocial behavior, and academic failure). In the present study, internal reliability was examined for each sample separately because of the difference in number of items used in the total risky sexual behavior score. The reliability coefficient for the urban sample (using the 4 items in the total score) was good (α =.80). The internal reliability of the non-urban sample was poor (α = .16) when using the 6 items total score and remained low when the abbreviated 4-item total score was examined (.17) within this sample. When internal reliability coefficients were re-calculated using the standardized z-scores they remained approximately the same for the urban sample (α = .79), but improved from .16 to .56 for the 6-item total used for comparisons in the non-urban sample.

Sexual Behavior Scale. Participation in typical sexual activity was measured by the total score from a 7-item scale that preceded the 13-items on the SSRT questionnaire. These seven items asked participants to report their frequency of participation in a range of sexual behavior (e.g., kissing, touching breasts, touching genitals) thought to be typical of adolescents (Marchi & Guendelman, 1995). A summed score of the seven items, reflecting overall frequency of participation in typical sexual behavior, was used for the

present study. Internal consistency was examined for the total sample of the present study and was found to be strong (α =. 93).

Alabama Parenting Style Questionnaire (APQ). The APQ (Frick, 1991) is a 42-item measure designed to assess parenting practices across six different subscale domains: involvement, positive parenting, parental monitoring/supervision, inconsistent discipline, corporal punishment, and other discipline practices. For the purpose of the present study, the subscale of parental monitoring/supervision was employed to examine parental supervision as a predictor of risky sexual behavior.

Item responses fell along a five-point Likert scale, from 1 (never) to 5 (always), indicating the frequency with which a particular behavior took place with lower scores reflecting more supervision. Total and individual subscale scores were calculated by summing the relevant items. Both parent and child forms of this measure are available in either self-report or telephone interview formats. The self-report version of child/adolescent form was utilized in the present study.

The APQ has demonstrated strong psychometric properties. Four-week test-retest reliability revealed alpha coefficient ranging from .69 to .89. Likewise, internal consistency was acceptable for most subscales of the child report form, with Cronbach's alpha ranging from .71 to .83 for parental involvement, .72 to .75 for positive parenting, .66 to .69 for parental monitoring/supervision, .53 to .66 for inconsistent discipline, and .41 to .58 for corporal punishment (Shelton, Frick, & Wootton, 1996). Convergent validity was measured across informant and assessment method. All five constructs revealed statistically significant correlations with informant and method. Additional support for the validity of this measure came from testing the relationship of the APQ to

the childhood diagnoses of disruptive behavior disorders (DBD) (e.g., attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder). Both formats of the ASQ distinguished children with and without DBD diagnoses. Internal consistency of the parental monitoring/supervision subscale was examined in the present study and was found to be strong ($\underline{\alpha}$ =.82).

The Adolescent Perceived Costs and Benefits Scale for Sexual Intercourse. The Perceived Costs and Benefits Scale created by Small, Silverberg, and Kerns (1993) consists of 20 items and was designed to assess the costs and benefits affiliated with participation in sexual intercourse as perceived by adolescents. This measure contains 10 items representing possible negative consequences (costs) of engaging in sexual intercourse and 10 items representing positive consequences/advantages (benefits) associated with sexual intercourse. Each set of 10 items is summed to provide a total cost score and a total benefit score. For the purpose of the present study, both the total cost and total benefit scores were used.

Possible Likert scale responses for each item range from 0 (strongly agree) to 3 (strongly disagree). The possible range of each subscale is 0 - 30 points, with higher scores representing higher perceived costs and/or benefits. Research suggests that a score greater than 15 indicates a respondent's belief that sexual intercourse does have associated costs and /or benefits (Small, Sileverberg, & Kerns, 1993).

Reliability for this measure was determined by administration to over 2000 7th through 12th grade students (Small et al., 1993). Internal reliability coefficients were .86 for each scale. Internal reliabilities were also examined in the present study and were considered acceptable for both the costs ($\underline{\alpha}$ =.75) and benefits ($\underline{\alpha}$ =.87) subscales.

CHAPTER IV

Results

Sexual Behavior of Participants

Of the 291 young women in the non-urban sample, 178 (61%) had engaged in voluntary sexual intercourse by the time of this study. Of these 178 participants, 0.6% reported first engaging in voluntary sex at age 12, 3.5% at age 13, 4.6% at age 14, 10.6% at age 15, 19.7% at age 16, 29.7% at age 17, 20.2% at age 18, 8.6% at age 19, and 1.1% at age 20. The average age of participants' first experience of voluntary sexual intercourse was 17 years, 1 month. The number of sexual partners participants reported having in the past year ranged from 1 to 11, with most non-urban participants (73.5%) reporting between 1 and 3 partners.

Of the 166 young women in the urban sample, 111 (70.3%) had participated in voluntary sexual intercourse by the time of this study. Data regarding age at initial voluntary sexual intercourse was not collected for this sample due to an error in the data collection phase of the study. Young women in the urban sample reported having between 0 and 8 sexual partners in the past year, with the majority (86.3%) reporting between 1 and 3 partners. An independent sample t-test revealed that the nonurban and urban sample did not significantly differ from one another with regard to whether they had engaged in voluntary sexual intercourse by the time of this study, $t(58) = 1.44$, ns.

Primary Analyses

Comparisons of Sexual Behavior Across Survivors and Nonvictims

As mentioned previously, analyses comparing sexual behavior across survivors and nonvictims were conducted separately for each geographical sample. A total of four independent sample t-tests were conducted with the non-urban sample to address the first set of hypotheses (1 a and 1 b), namely, whether survivors differed from nonvictims with regard to their participation in typical and high-risk sexual behaviors. Analyses conducted to examine typical sexual behavior used a sum total score of seven items from the Sexual Behavior Scale as an independent measure. Age at onset of sexual intercourse was examined by comparing participants' age in months at time of their first voluntary sexual intercourse. The z-scores from the 6 SSRT items with the highest factor loading were summed and averaged and employed as the dependent variable to examine participation in high-risk behavior during the past and future 12-month period. A Bonferonni correction alpha of .01 (.05/4) was used to control for the multiple planned comparisons conducted to address this set of research questions.

For the non-urban sample, no differences were found between survivors ($\underline{M}$ = 17.16, $\underline{SD}$ = 5.71) and nonvictims ($\underline{M}$ = 16.29, $\underline{SD}$ = 5.88) with regards to participation in typical sexual behavior over the past 12 months [$\underline{t}(286) = .84$, $\underline{ns}$]. Analyses also failed to support a difference between survivors ($\underline{M}$ = 198.11 months, $\underline{SD}$ = 20.44) and nonvictims ($\underline{M}$ = 205.01 months, $\underline{SD}$ = 17.47) with regard to the age at which they first experienced voluntary sexual intercourse (with the adjusted alpha) but a trend was apparent, $\underline{t}(177) = -1.84$, $p = .03$. Likewise, no differences were found between survivors ($\underline{M}$ = .05, $\underline{SD}$ = .65) and nonvictims ($\underline{M}$ = .01, $\underline{SD}$ = .57) with regards to their

participation in high-risk sexual behavior over the past twelve months, t(257) = .67, ns. Further, there were no differences in the amount of risky sexual behavior that survivors (M = .14, SD = .67) and nonvictims (M = .01, SD = .51) predicted they would engage in over the subsequent twelve months, t(194) = 1.19, ns.

Two additional independent t-tests were conducted to compare sexual behavior in the urban sample. Risky sexual behavior was examined with the abbreviated 4-item version of the SSRT. A Bonferonni corrected alpha of .025 (.05/2) was used to control for the number of comparisons. Significant differences were found with regard to participation in typical sexual behavior, with survivors (M = 20.6, SD = 5.48) reporting more participation in typical sexual behavior over the past 12 months than nonvictimized participants (M = 16.23, SD = 7.39), t(157) = 2.77, p = .00. Survivors (M = .49, SD = 1.01) were also significantly different from nonvictims (M = -.02, SD = .71) with regard to the amount of risky sexual behavior they engaged in over the past twelve months, t(22.09) = 2.19, p = .02.

Two additional exploratory independent sample t-tests were run for each site to examine whether survivors were different from nonvictims with regard to the number of sexual partners they had over the past year. Participants who reported never having engaged in voluntary sexual intercourse were excluded from this analysis. Significant differences were not found for the non-urban sample, t(220) = .24, ns, but were found for the urban sample. Survivors in the urban sample reported a greater number of sexual partners in the past year (M = 2.25, SD = 1.74) than did nonvictims (M = 1.48, SD = 1.24), t(107) = 2.30, p = .01.

Overall, the hypotheses that survivors engage in both more typical and risky sexual behaviors than nonvictims were not supported in the nonurban sample. In urban sample, however, survivors were significantly more likely to participate in both typical and high-risk sexual behavior, and also reported having a greater number of sexual partners over the past year than did nonvictims.

Comparisons of Attributions Across Survivors and Nonvictims

The second set of hypotheses (2 a and 2 b) regarding differences in attributions made by survivors and nonvictims were also conducted separately for each geographical sample. Two independent sample t-tests, one to compare victimization status and general attributional style, the other to compare victimization status and sexual-specific attributional style, were conducted for each sample. In each case, the dependent variable was the composite negative attribution score from the ASQ or the ASQ-SS, respectively. Alpha was set at .025(.05/2).

Unexpectedly, survivors ($\underline{M}$ = 13.07, $\underline{SD}$ = 2.14) and nonvictims ($\underline{M}$ = 12.91, $\underline{SD}$ = 1.90) in the non-urban sample did not differ with regard to their general negative attributional style for negative events, $\underline{t}(286) = .48$, $\underline{ns}$. Similarly, no differences were found between survivors ($\underline{M}$ = 12.22, $\underline{SD}$ = 2.57) and nonvictims ($\underline{M}$ = 11.99, $\underline{SD}$ = 2.41) in the non-urban sample with regard to the negative attributions made for negative sexual-specific events, $\underline{t}(284) = .53$, $\underline{ns}$. Therefore, the hypotheses that survivors, as compared to nonvictims, would endorse a more negative general attributional style and more negative sexual-specific attributional style for negative events were not supported in the non-urban sample.

Comparisons for the urban sample produced relatively similar results. Again, survivors (M = 11.89, SD = 2.16) and nonvictims (M = 11.66, SD = 1.79) did not differ with regard to general negative attributional style, t(158) = .57, ns. However there was a trend for a difference with regard to sexual-specific attribution style, with survivors evidencing a more negative sexual-specific attributional style (M = 11.67, SD = 2.96) than nonvictims (M = 10.81, SD = 2.61), t(158) = 1.52, p = .07. In sum, the results did not support significant differences in general or specific-specific attributional style across victimization groups at either geographical site.

Follow-up, exploratory independent sample t-test analyses to examine whether survivors differed from nonvictims on any of the three subscales (i.e., internal, stable, and global), that comprise the general negative attribution total score were not conducted because of the low reliabilities of these subscales. Follow-up analyses with the sexuality-specific attributional style subscales were also unable to be conducted due to low reliabilities.

Predictive Relationship of Attributional Style to Participation in Sexual Behavior

To address the third set of hypotheses (3 a, 3 b, and 3 c), it was proposed that two hierarchical regression analyses be conducted to examine whether attributional style predicted participation in risky sexual behavior above and beyond parental supervision, costs, and benefits associated with sexual intercourse. These hypotheses were unable to be examined as originally proposed because the expected relationships between general attributional style and high-risk sexual behavior were not supported. Likewise, in the nonurban sample, sexual-specific attributional style was not related to high-risk sexual behavior.

A total of two adapted hierarchical regression analyses were conducted in order to examine predictors of participation in both risky and typical sexual behavior in the urban sample. The first adapted regression analyses was identical to the regression as it was originally proposed, however the adapted analyses did not include the variables of perceived costs or perceived benefits because these variables were identified as unrelated to high-risk sexual behavior in the urban sample (see below). The second adapted regression was conducted because significant differences in CSAS and nonvictims' participation in typical sexual behavior were identified in the urban sample. This was also viewed as a valid follow up analysis because of the significant relationship between typical sexual behavior and victimization status and sexual-specific attributional style in the urban sample. Predictor variables were entered into the regression in the same pattern as were the variables expected to predict participation in high-risk sexual behavior with the exception that perceived costs and benefits were excluded because of the failure to identify a significant relationship between these variables and participation in typical sexual behavior in the urban sample (see below).

Prior to these regression analyses, two correlational matrices were conducted to examine the inter-relationships between all independent and dependent variables in each geographical sample. The purpose of this analysis was to identify possible covariates for inclusion in or exclusion from the adapted regression analyses. The first correlation matrix, which examined the relationships between all dependent and independent variables in the non-urban sample, revealed relatively few significant relationships (see Table 7 for all r and p values). Risky sexual behavior in the non-urban sample was significantly and positively related with participation in typical sexual behavior,

participation in future risky sexual behavior and number of benefits associated with participation in sexual intercourse. Perceived costs of participating in sexual intercourse were significantly and inversely related to participation in risky sexual behavior. Conversely, neither parental supervision, victimization status, nor either type of attributional style was related to participation in risky sexual behavior in the non-urban sample. Participation in typical sexual behavior was not significantly related to any other variable. Victimization status was not significantly related to any of the expected variables, including costs, benefits, parental supervision, general attributional style, or sexual-specific attributional style, or participation in any type of sexual behavior.

In the correlation matrix conducted with the urban sample, participation in risky sexual behavior was found to be significantly and positively related to negative sexual-specific attributional style, CSA history, low levels of parental supervision, and participation in typical sexual behavior. Participation in risky sexual behavior was not related to perceived costs or benefits of sexual intercourse. A similar pattern presented for participation in typical sexual behavior, which was significantly and positively related to negative general attributional style, negative sexual-specific attributional style, CSA history, low parental supervision, and participation in risky sexual behavior but was not related to perceived costs or benefits. Victimization status in the urban sample was unrelated to general attributional style, sexual-specific attributional style, costs and benefits, but was significantly related to rates of participation in both risky and typical sexual behavior and low parental supervision.

Findings from these correlational matrices informed two adjusted regression analyses. The first regression analyses examined the relationship of parental supervision,

sexual attributional style, and victimization status to participation in risky sexual behavior. Costs and benefits of sexual intercourse were excluded from each of these regression analyses because they were identified as unrelated to the high-risk sexual behavior of urban young adults in the second correlation matrix. Three blocks of predictor variables were entered into the regression analysis in the following order: block 1 = parental supervision, block 2 = sexual-specific attributional style, and block 3 = victimization status (see Table 8).

The first variable entered, parental supervision was not significantly related to participation in risky sexual intercourse, however a trend was evident, $\underline{F}$ (1, 134) = 2.919, $\underline{p}$ = .09. The second variable, sexual-specific attributional style, was identified as a significant predictor but only accounted for 2% of the variance. When the influence of parental supervision and sexual-specific attributional style were considered together in the second step, they were statistically significant predictors, and together accounted for 4% of the variance, $\underline{F}$ (1, 134) = 3.028, $\underline{p}$ = .05. The third and final variable, victimization status, was also significantly related to high-risk sexual behavior but again only a small amount of varaiance (5%) was accounted for, $\underline{F}$ (3, 134) = 3.716, $\underline{p}$ = .01. When combined with the other two variables of interest, the overall model remained significant predictor of participation in high-risk sexual behavior but accounted for only 8% of the overall variance.

The second hierarchical regression analyses employed the same predictor variables as the first, however the dependent variable in this regression was participation in typical sexual behavior rather than participation in high-risk sexual behavior. The three variables were entered into the regression analysis in the following order: block 1 =

parental supervision, block 2 = sexual-specific attributional style, and block 3 = victimization status (see Table 9).

In this model, the first variable, parental supervision, presented as a significant predictor of participation in typical sexual activity, accounting for approximately 3% of the variance independently, F (1, 146) = 3.962, p = .05. The second variable, sexual-specific attributional style, was also a significant predictor of participation in typical sexual behavior, accounting for 4% of the variance independently. When these two variables were combined in the second step of the regression model, the combined variance accounted for was 6%, which was statistically significant, F (2, 146) = 4.276, p = .02. The third and final hypothesized predictor variable, victimization status, was a significant predictor, accounting for 4% of the variance. When entered into the final step of the model, the three variables accounted for 8% of the variance overall, F (3, 146) = 4.312, p = .01.

CHAPTER V

Discussion

Theories within the field of CSA suggest that exposure to sexual behavior or sexual information during childhood can potentially interfere with normal sexual development, sometimes leading to abnormal sexual behavior and sexual maladjustment later in life (Tharinger, 1990). Notably, in previous research, childhood sexual abuse survivors (CSAS) have demonstrated a propensity to engage in a variety of high-risk sexual behaviors during adolescence and adulthood (Evanston, Fiscella, Kitzman, Cole, Sidora, & Olds, 1998, Fergusson, Horwood, Lynskey, 1997; Krahe, Scheinberger-Olwig, Waizenhoper, & Kolpin, 1998; Luster & Small, 1997; Miller, Monson, Norton, 1995; Stock, Bell, Boyer, Connell, 1997) that increase their susceptibility to disease, pregnancy, and further victimization (Abma, Driscoll, Moore, 1998; Brooks-Gunn & Furstenburg, 1989; Devine et al., 1993; Graber & Brooks-Gunn, 1995; Jessor, 1992). Many studies have speculated that survivors use sexuality in ways different from nonabused youth (Finkelhor & Browne, 1985; Mayall & Gold 1995). Therefore, understanding the sexual belief system of adolescent CSAS and the way it may differ from nonabused samples is especially important. Yet, to date, no study employing a sample of CSAS and an appropriate comparison sample has broadly examined the relationship of cognitive style to sexual decision-making and subsequent sexual behavior. Rather, only three studies have examined factors that impact the sexual decision-making of CSAS, and none of

these have investigated similarities and differences in the sexual attributions of abused and nonabused youth (Fromuth, 1986, Huerta-Franco & Malacara, 1999; Orr & Downs, 1985).

Summary of Primary Analyses

The purpose of the current study was to contribute to the literature on sexual decision-making and child sexual abuse by furthering what is known about the factors that impact the sexual behavior of young adult survivors of childhood sexual abuse. The first set of hypotheses in the present study focused on the examination of the typical and risky sexual behavior of CSAS as compared to a control sample of nonvictimized young women. These research hypotheses were examined separately for each site and the findings revealed significant discrepancies across sites.

In the nonurban sample, no differences were identified between CSAS and nonvictims' rates of participation in high-risk sexual behavior over the past twelve months, participation in typical sexual behavior over the past 12 months, or the age at which participants had their first experience of voluntary sexual intercourse. There were also no differences in the amount of risky sexual behavior survivors and nonvictims predicted they would engage in over the subsequent twelve months.

Interestingly, examination of the urban sample provided support for the hypotheses. Survivors in this sample reported greater participation in typical and risky sexual behavior over the past 12 months than did nonvictimized participants. No comparisons were made for the age of onset of sexual intercourse or predicted participation in sexual behavior over the subsequent 12 months due to an error in data collection.

Thus, differences in sexual behavior of CSAS and nonvictims were identified in the urban sample, but not in the nonurban sample. Several possibilities can account for these site differences. In general, CSAS in the nonurban sample endorsed less intrusive forms of CSA, were more likely than survivors in the urban sample to receive parental support while growing up, and were more likely to receive counseling specific to their CSA experiences. Given this, it would be expected that CSAS in the nonurban sample might evidence better adjustment than their counterparts in urban sample, thereby accounting for the lack of differences identified in risky and typical sexual behavior. Notably, severity of CSA has been identified as a moderating variable in past studies. For example, in a review paper examining the relationship between depression and CSA, Beichman et al., (1992) conclude 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.

Another possibility is that participants in the nonurban sample possess strong, conservative beliefs about sexuality, beliefs that may exert influence on their sexual behavior to a greater degree than would a history of CSA. For instance, if participation in sexual intercourse is affiliated with greater stigma for the CSAS and nonvictims in the nonurban sample, this might reduce the likelihood that they would engage in sexual behavior, regardless of their abuse history. Although this is a possible explanation, it is not entirely supported, as participants in the nonurban sample also reported significantly less perceived costs and more perceived benefits of participation in sexual intercourse than did the urban sample. Likewise, there were no overall significant differences in

rates of participation in typical or high-risk sexual behavior identified between the two sites in the present study.

Finally, significant differences in religion and ethnicity were identified between the geographical regions in the present study. Such demographic variables have been identified as moderators of CSA outcome in past literature (Beichman et al., 1992; Lipovsky & Kilpatrick, 1992) and must therefore be considered as possible moderators of outcome in the present study. Differences in CSA prevalence and outcome as moderated by ethnicity has received only limited attention to date, however, much more work is needed to identify how such differences might account for the differences in adjustment of CSAS. Likewise, due to a lack of research regarding the impact of religious affiliation upon sexual behavior, it is unclear in what way religious affiliation in the present study may have impacted the present findings.

The second set of hypotheses predicted differences in the causal attributions made by CSAS and nonvictims. It was specifically hypothesized that survivors would be more likely than nonvictims to report a more negative general attributional style for negative events and a more negative attributional style for sexual-specific negative events. Unexpectedly, CSAS and nonvictims in the non-urban sample did not differ in their general attributional style for negative events, or in the attributions they made about sexual-specific negative events. Comparisons of the urban sample produced relatively similar results. No significant differences were identified with regard to general negative attributional style. A trend with regard to sexual-specific attribution style was identified, suggesting the possibility that survivors are more likely than nonvictims to make negative attributions about sexual-specific events. In sum, though, no significant differences in

general or sexual-specific attributional style across victimization groups were identified for either geographical site.

In addition to predicting differences in the attributional styles of CSAS and non-victims, this study also predicted that general attributional style would be related to participation in high-risk sexual behavior. This relationship was not supported as well. Overall, no relationships were identified between CSA status, participation in sexual behavior, and general attributional style for the nonurban sample. In the urban sample, CSA status was related to sexual behavior but neither of these variables was related to general attributional style.

Such findings are largely inconsistent with past studies, which have identified significant differences in the general attributional styles, abuse-specific attributions, and self-blame attributions of CSAS when compared to nonvictimized samples (Gold, 1986; Mannarino & Cohen, 1996; Wenninger & Ehlers, 1998; Arata 1999). Past studies have also supported attributional style as a predictor of adjustment following CSA (e.g., depressive sympomatology, self-esteem, PTSD) (Mannerino & Cohen, 1996; Porter, 1999; Wenniger and Ehlers, 1998; Wolfe, Gentile, and Wolfe (1989). In these studies though, abuse-specific attributions have often received more support as predictors of outcome than have general attributional style (Mannerino & Cohen, 1996).

The failure to identify a difference in general attributional style is not easy to explain, especially given that differences have been identified in past research and notably, the predicted relationships between CSA status and attributional style were unsupported at both sites, suggesting that degree of intrusiveness or severity of abuse does not mediate this relationship. It is possible, however, that the relationship between

general attributional style and CSA history, as identified in past studies, was moderated by a variable not present in the current study.

Differences in methodology could also possible account for the lack of significant findings in the present study. First, the majority of the studies that have examined the attributional style of CSAS to date have employed samples of victimized children in their studies and therefore have used measures of attributional style specific for use with children (e.g., Hazzard, et al., 1995, Feiring, Coates, & Taska, 2001; Feiring, Taska, & Lewis, 2002).

Of the four adult studies that have investigated differences in attributional style of adult CSAS and nonvictims, three of the four employed the Attributional Style Questionnaire, the same measure used in the present study. Of these three, two identified significant differences in the negative attributional styles of CSAS and nonvictims. These two studies did not use the Attributional Style Questionnaire as it was used in the present study. Rather, Wenninger and Ehlers (1998) employed an expanded version of the measure, which included the original 6 items plus an additional 18 hypothetical negative events and Gold (1986) employed the original version of the ASQ in her study, but combined the total score from this measure with scores from two other measures of attributional style and used this total combined scores to identify differences between CSAS and nonvictimized samples. Porter (1999) used the Attributional Style Questionnaire as it was used in the present study and, like the present study, failed to identify differences between the victimized and nonvictimized groups.

Importantly, this study was the first study to attempt to measure sexuality-specific attributional style, and to investigate whether this variable would predict participation in

risky and typical sexual behavior. The present study specifically hypothesized that CSAS would endorse a more negative sexual attributional style than would nonvictims. A trend toward significance was identified in the urban sample, but overall the results suggest that CSAS make attributions about negative sexual events that are similar to, and no more negative than those made by their peers without CSA histories.

Although sexual-specific attributional style has not before been examined, support for this hypothesized difference is indeed present in the existing literature. Finkelhor and Brown (1986) theorize that CSAS interpret sexual situations in a way that is discrepant from children with no CSA history and that these differences in interpretation result in differences in sexual behavior. Although significant differences in sexual-specific attributional style were not identified at either site, the trend identified in the urban sample suggests a tendency for CSAS to make more negative sexual attributions, namely attributions that reflect a belief that sexual victimization is due to something about the victim and that this cause will be consistent across time and situations. Notably, the survivors in the urban sample endorsed more severe sexual abuse experiences (more intrusive, less parental support, and less abuse-specific counseling following abuse) than those in the nonurban sample. This suggests that differences in the severity of abuse experienced by survivors at either site may account for differences in sexual-specific attributional style.

Another possibility is that that the measure of sexuality-specific attributional style employed in the present study needs to refined, and that better methods of examining sexual-specific attributions might have revealed significant differences. The measure of sexual-specific attributional style in the present study was modeled after the Attributional

Style Questionnaire, a general measure of attributional style, and required that participants read and respond to 6 brief scenarios depicting negative sexual events. Although the internal consistency of the Sexual-Specific Attributional Style Questionnaire was strong, this scale included a relatively small number of items to measure a variable (sexual-specific attributional style) that has not before been examined in the sexual abuse literature. Therefore, it would likely be beneficial for future research to employ an expanded measure of sexual-specific attributional style and identify which items on the expanded version best assess the variable of sexual-specific attributional style. It might also be beneficial for future research to begin examining differences in sexual-specific attributional style from a qualitative level. For example, it may be helpful to compare the responses of victimized and nonvictimized women in focus groups, and to then use this information to construct the expanded quantitative measure of sexual-specific attributional style.

Of course, it is possible that CSAS and nonvictims do not actually differ in the types of attributions they make about sexual situations. It is also possible that sexual-specific attributional style is moderated by abuse severity, with CSAS with chronic or more severe abuse demonstrating styles different from CSAS with less severe histories. Unfortunately, much more research is needed before these conclusions can be drawn with confidence. For example, much progress has been made in identifying differences in the sexual behavior of CSAS and nonvictims, however, no studies to date have attempted to identify which CSAS are most likely to engage in high-risk sexual behavior nor have studies provided information about the percentages of CSAS in different types of samples that demonstrate such behavior. This information would greatly contribute to this body

of literature and assist researchers examining variables such as sexual-specific attributional style to more accurately explain their findings.

The final set of hypotheses in this study were intended to build upon the findings of the first two sets of comparisons. It was proposed that general and sexual-specific attributional style would predict participation in sexual behavior above and beyond the variance accounted for by parental supervision and perceived costs and benefits of sexual intercourse.

In the non-urban sample, less perceived costs and more perceived benefits of participation in sexual intercourse were related to more participation in risky sexual behavior. No relationship was identified between participation in high-risk sexual behavior and parental supervision or victimization status in the nonurban sample. Participation in typical sexual behavior was not significantly related to any variable other than participation in risky sexual behavior for the nonurban sample. Victimization status was not significantly related to any of the dependent or independent variables in the nonurban sample.

Findings conducted with the urban sample revealed an almost opposite pattern of results. The results of the correlations suggest that participants who engage in more risky sexual behavior also engaged in more typical sexual behavior and received less parental supervision in childhood and adolescence. Victimization status was also significantly related to high-risk sexual behavior, with CSAS evidencing more participation than nonvictims. Participation in risky sexual behavior was not, however, related to perceived costs or perceived benefits, as was the case in the nonurban sample. Participants with a history of CSA, and participants with less parental supervision during childhood and

adolescence, were most likely to engage in high rates of participation in typical sexual behavior as well. Like participation in high risk sexual behavior, participation in typical sexual behavior were unrelated to perceived costs or benefits of sexual intercourse in the urban sample. Victimization status was related to rates of participation in both risky and typical sexual behavior and low parental supervision in the urban sample but was also unrelated to perceived costs and benefits.

In sum, parental supervision, perceived costs and perceived benefits, and victimization status were differentially related to participation in sexual behavior at each site. The results here suggest that rates of parental supervision impacted participation in risky sexual behavior for participants in the nonurban sample, but did not seem to impact the sexual behavior of urban adolescents. This finding is especially interesting given that there was not a significant difference in rate of parental supervision reported across sites.

Conversely, parental supervision was related to victimization status in the urban sample, with a history of CSA being related to lower parental supervision, but not the nonurban sample. Past studies have suggested that children who receive less supervision are more likely than those who are well supervised to be sexually abused. Support for this statement was found in the urban sample, but not the nonurban sample in this study. This finding may be explained when the identity of perpetrator across samples is considered. Specifically, 66% of the CSAS in the nonurban sample reported CSA by intrafamilial perpetrators, whereas the majority of CSAS in the urban sample, 62%, reported extrafamilial abuse. Therefore, it may be understood how parental supervision did not make much of an impact in the sample where the majority of CSA took place within the home, or at least within the family. In the urban sample, where the majority of

CSA was inflicted by perpetrators outside of the family, parental supervision did make a difference, probably by limiting the exposure children had to potential perpetrators.

It is also of interest that perceived costs and benefits appeared to influence the sexual behavior of nonurban, but not urban adolescents. This finding may be somehow related to demographic or geographical differences unfortunately, we are only able to speculate how these may be related given the scarcity of previous research. There is also another clinically important interpretation. That is, that when youth perceive sex as more beneficial and less costly this is reflected in their sexual behavior as it was in the nonurban sample; however, when they perceive sex as more costly and less beneficial, as was the case in the nonurban sample, this does not appear to influence their sexual behavior. This interpretation is consistent with literature that reports limited success for "safer-sex interventions" which attempt to educate adolescents about the negative consequences of sexual behavior with the goals of lowering their participation in sex and increasing their contraception use when they are sexually active (Bailey & Piercy, 1997).

Finally, victimization status was unrelated to all variables in the nonurban sample but was significantly related to participation in risky sexual behavior, typical sexual behavior, and parental supervision in the urban sample. Again, the differences in severity of CSA experienced by the CSAS at each of the two sites likely accounts for these differences. Specifically, CSAS in the nonurban sample endorsed more positive abuse related characteristics, including more support from their mothers while growing up, less penetration during CSA, and more victimization focused counseling following CSA, than did the CSAS in the nonurban sample. Thus, it is hypothesized here that survivors reporting greater severity of abuse (as measured by these aforementioned variables) may

demonstrate more negative outcomes of than survivors with less severe abuse experiences. This might explain the relationship between victimization status and sexual behavior in the urban but not nonurban samples here.

As part of the third set of analyses, it was further hypothesized that general attributional style would be associated with participation in high-risk sexual behavior, above and beyond costs, benefits, and parental supervision, and that CSAS status would moderate this relationship. In other words, it was expected that participation in risky sexual behavior would be inversely related to perceived costs and parental supervision and positively related to benefits of participation in sexual intercourse, and that negative general attributional style would predict rates of risky sexual behavior for CSAS but not for nonvictims. Similarly, it was hypothesized that sexual-specific attributional style would predict sexual behavior above and beyond that accounted for by parental supervision and perceived costs and benefits, however this was hypothesized to be true for both survivors and nonvictims.

These hypotheses were unable to be examined as originally proposed for several reasons. First, there was a failure to identify a relationship between participation in high-risk sexual behavior and general attributional style in both samples. Second, risky sexual behavior was unrelated to parental supervision in the nonurban sample and unrelated to costs or benefits in the urban sample. Finally, high-risk sexual behavior was not related to sexual-specific attributional style in the nonurban sample. Two exploratory regressions were subsequently conducted and will be discussed later.

Comparisons Across Sites

A number of important differences were identified between the two sites employed in this study. The urban and nonurban samples significantly differed on perceived costs of sexual intercourse, perceived benefits of participation in sexual intercourse, general attributional style, and sexual-specific attributional style. Demographic differences with regard to racial/ethnic makeup and religious affiliation were also identified. It is likely that the significant differences in race/ethnicity and religion identified between the two sites significantly contributed to the patterns of findings identified in the present study. Unfortunately, little research in the area of child maltreatment has focused on exploring differences in the way CSA is impacted by geographical, ethnic, or religious differences. Therefore, no specific generalizations can be made about the way in which these demographic differences impacted the findings here. Unfortunately, this limits the generalizability of the current findings. These findings highlight the importance for future studies within the field of CSA to make an effort to further explore the influence of geographical, demographic, ethnic, and other social markers that may mediate the prevalence, impact, or outcome of CSA.

Comparisons of CSAS across Sites

The CSAS in each geographical sample were also compared on several variables specific to their abuse experiences. Participants in the nonurban sample were less likely than participants in the urban sample to have experienced sexual intercourse as part of CSA. Nonurban participants also reported feeling more supported by their mothers during childhood, and a trend suggested that they were more likely than urban CSAS to receive victimization-focused treatment. Additionally, the majority of CSAS in the

nonurban sample reported abuse by a family member, whereas the majority of the CSAS in the urban sample reported extrafamilial abuse.

Differences in severity of CSAS, rather than demographic differences, appeared to mediate some of the findings here, such as the relationship between victimization status and participation in risky and typical sexual behavior. Although it is important to acknowledge the differences in CSA characteristics in the current study and the impact they had on the interpretation of the present findings, these differences, like the differences in demographic variables, may limit the generalizablity of the findings. For instance, findings from this study emphasizes the need to consider the relationship between child sexual abuse characteristics and geographical location (i.e., what accounts for the differences intrafamilial versus extrafamilial abuse). However, differences in abuse characteristics as mediated by geographical location have not been well investigated, and it would be premature to conclude that children sexually abused in urban areas will on average experience more severe abuse experiences as compared to children sexually abused in nonrural areas.

Summary of Exploratory Findings

A number of exploratory analyses were conducted in addition to those originally proposed. First, analyses examined whether survivors differed from nonvictims with regard to their number of sexual partners over the past year. Number of sexual partners was considered an important variable to examine because it was more specific than high-risk sexual behavior in general and it had received support in differentiating CSAS from nonvictims in past studies (Fergusson, 1997; Krahe et al., 1998). Significant differences were not found for the non-urban sample. However, significant differences were

identified for CSAS and nonvictims in the urban sample, with CSAS reporting a greater number of sexual partners in the past year than nonvictims. Thus, consistent with the initial findings, site differences present here are likely a product of the difference in severity of the CSA in the urban sample as compared to the CSAS in the nonurban sample.

Because hypothesized differences between CSAS and nonvictims on dimensions of general negative attribution style and sexual-specific negative attribution style were not supported, t-tests were conducted on the three individual subscales that comprise each respective total attribution score (i.e., internal, stable, and global). In the non-urban sample, no differences between survivors and nonvictims were found, nor were there significant differences in the urban sample. Trends were identified in the urban sample; one for general global attributions and the other for sexual-specific internal attributions. This failure to identify differences in the negative attributional styles of victims and nonvictims is, again, very difficult to explain. As was previously suggested, methodology in the present study may have attributed to the failure to identify differences if, indeed, the Attributional Style Questionnaire alone is not robust or specific enough to assess the important aspects of attributional styles within samples of CSAS.

Two exploratory regression analyses were conducted to examine the relationship of parental supervision, sexual-specific attributional style, and victimization status on participation in risky sexual behavior for the urban sample. Results of this analysis did not support parental supervision as an individual significant predictor of participation in risky sexual behavior for the urban sample. The second variable, sexual-specific attributional style, was statistically significant on its own but accounted for only 2% of

the variance. The third variable, victimization status, was also significantly related to participation in high-risk sexual behavior, accounting for 5% of the variance.

A second hierarchical regression analysis was conducted to examine the relationship of the same variables on participation in typical sexual behavior in the urban sample. In this regression analysis, parental supervision presented as a significant predictor of participation in typical sexual activity, but accounted for only a small amount of the overall variance. Sexual-specific attributional style also demonstrated a significant relationship to typical sexual behavior but accounted for only 4% of the variance. Likewise, the third variable was significantly related and also accounted for 4% of the overall variance.

Thus, parental supervision demonstrated a small, but significant influence on a participant's decision to engage in high-risk sexual behavior. Sexual-specific attributional style also contributed only a small, albeit significant, amount of influence upon decision-making, which may not translate into clinical significance. Notably, a history of CSA was the variable that most influenced participant's decisions to engage in high-risk sexual behavior in the urban sample of the present study. Unfortunately, the mechanism though which CSA is impacting the high-risk sexual behavior of adolescents remains unclear. Clinically, this suggests that it is especially important for professionals to screen for a history of sexual abuse when they are seeing youth who are engaging in high-risk sexual behavior, and that intervening on this level may be more important than the consideration of other related variables like the amount of parental supervision they are receiving or their sexual-specific attributional style.

The two regression analyses largely demonstrated similar findings with regards to the relationships between the predictor variables and their relationship to risky and typical sexual behavior. While parental supervision, sexual-specific attributional style, and victimization status were supported as significant predictors, the small amount of variance accounted for by each and for the combination of the three in each regression analyses may not translate into clinical significance. These findings suggest that variables that have received relatively strong support as predictors of sexual-decision making for nonvictimized adolescents (e.g., parental supervision) may not be related in the same way or as significantly to sexual-decision making for CSAS. Sexual-specific attributional style as measured in the present study received some support as a predictor of sexual behavior, which is reason to continue to refine and examine this variable in future studies. Finally, the results of these regression analyses suggest that victimization status may not be as strong of a predictor for participation in high-risk sexual behavior as the literature suggests.

Strengths and Weaknesses of the Current Study

This study improved upon past studies in that it attempted to explore situational and cognitive variables that predict sexual decision-making and sexual behavior in CSAS. Likewise, this was the first study that has attempted to examine the sexual-specific attributional style of CSAS. A large sample with an appropriate comparison group was employed in the present study. Additionally, data were collected from young adults residing in urban and nonurban areas was also a strength, which thereby allowed for comparisons across the two sites. The current findings underscored the need to keep geographical location of the sample in mind when interpreting the findings of research

conducted in the area of sexuality and child sexual abuse and to be cautious when applying the research findings to demographically different samples. Finally, all measures in the present study demonstrated known reliability, with the exception of the measure of sexual-specific attributional style created for the present study, and were more complete in their assessment of several constructs that have been measured with single items in previous studies (e.g., sexual behavior, victimization status).

It is necessary to acknowledge the limitations of the present study. First, the current study relied upon a cross sectional design using self-report data. Indeed, the retrospective design of this study limits the accuracy of the information provided by the participants in that all self-report data is subject to bias and reconstruction and problems with method variance. However, steps were taken to limit this problem, such as asking participants to report only their sexual experiences over the past year. Information regarding variables such as history of CSA and parental supervision during childhood and adolescence, however, may have been influenced by deterioration of memory over time. Although the majority of measures employed in the present study demonstrated strong psychometric properties, some of these measures evidenced quite low internal reliability coefficients when assessed within the current sample. Additionally, the current study employed a sample of college students and therefore generalizations to other samples must take this into consideration.

Another major limitation in the present study was the failure to account for sexual victimization experiences that occurred after the age of 17. The CSA literature strongly suggests that CSAS are more likely than young women without a history of CSA to be revictimized in adolescence and adulthood (Messman-Moore & Long, 1996). This

finding is particularly relevant to the present study because of the impact that multiple sexual victimizations may have upon sexual attributions and behavior. Unfortunately, this variable could not be controlled for in the present study, because rape during adolescence and young adulthood were not assessed. Further, this study was limited in that it did not investigate the role of other factors thought to influence sexual behavior, such as media, parental attitudes, relationships with parents, pressure to engage in sexual intercourse, access to contraception, or physical, cognitive, or emotional maturity.

In conclusion, the current study revealed a number of interesting findings, yet failed to support many of the hypotheses as were originally proposed. Differences in findings across sites emphasize a need to further explore the relationship between sexual behavior and CSA history and also emphasized the need to consider demographic variables and abuse severity. Much additional research appears needed to clarify the relationship between attributional style and sexuality, with the need to take methodology being into account. Further, the focus of sexual-specific attributional style, as measured in the present study, revealed interesting findings and appears to be a variable worth further examination.

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APPENDIXES

APPENDIX A

LIFE EXPERIENCE QUESTIONNAIRE

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. Have you ever received counseling?
(0) No
(1) Yes

12 . Have you ever received counseling to address issues about a childhood sexual experience?
(0) No
(1) Yes

13. How supported did you feel by your caregivers when you were growing up?
(0) Not supported at all
(1) Somewhat supported
(2) Very supported

a. By your female caretaker _____ b. By your male caretaker _____

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 years 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.

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

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

16. 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

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

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

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

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

21. 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 (13 through 20), please go to the next page.
If you answered "no" to questions 13 through 21 (all must be answered "no"), you are finished with this 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 21 and answer the questions again for the second person in Column #2. Repeat if you were involved with a third person in Column #3.

21. 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.

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

Age _____ Age _____ Age_____

23. 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

24. 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)

25. 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)

26. 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)

27. 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)

28. 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)_____

29. 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)_____

30. 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)

31. 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				great deal of control
(1)	(2)	(3)	(4)	(5)

Involvement with second person:

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

Involvement with third person:

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

32. 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				great deal of control
(1)	(2)	(3)	(4)	(5)

Involvement with second person:

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

Involvement with third person:

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

33. 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				great deal of control
(1)	(2)	(3)	(4)	(5)

Involvement with second person:

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

Involvement with third person:

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

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

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

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

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

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

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

APPENDIX B

ATTRIBUTIONAL STYLE QUESTIONNAIRE

Attributional Style Questionnaire

DIRECTIONS

Read each situation and vividly imagine it happening to you.

1) Decide what you believe would be one major cause of the situation if it happened to you and write this cause in the blank provided.
2) Answer three questions about the cause by circling one number per question. Do not circle the words.

YOU MEET A FRIEND WHO COMPLIMENTS YOU ON YOUR APPEARANCE.

1) Write down the one major cause: _____

2) Is the cause of your friend's compliment due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

3) In the future when you are with a friend, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

4) Is the cause something that just affects interactions with friends, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

YOU HAVE BEEN LOOKING FOR A JOB UNSUCCESSFULLY FOR SOME TIME.

5) Write down the one major cause: _____

6) Is the cause of your unsuccessful job search due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

7) In the future when you look for a job, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

8) Is the cause something that just influences looking for a job, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

YOU BECOME VERY RICH.

9) Write down the <u>one</u> major cause: _____

10) Is the cause of your becoming rich due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

11) In your financial future, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

12) Is the cause something that just affects obtaining money, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

A FRIEND COMES TO YOU WITH A PROBLEM ANDYOU DON'T TRY TO HELP HIM/HER.

13) Write down the <u>one</u> major cause: _____

14) Is the cause of your not helping your friend due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

15) In the future when a friend comes to you with a problem, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

16) Is the cause something that just affects what happens when a friend comes to you with a problem, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

YOU GIVE AN IMPORTANT TALK IN FRONT OF A GROUP AND THE AUDIENCE REACTS NEGATIVELY.

17) Write down the one major cause: _____

18) Is the cause of the audience's negative reaction due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

19) In the future when you give talks, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

20) Is the cause something that just affects giving talks, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

YOU DO A PROJECT WHICH IS HIGHLY PRAISED.

21) Write down the one major cause: _____

22) Is the cause of your being praised due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

23) In the future when you do a project, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

24) Is the cause something that just affects doing projects, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

YOU MEET A FRIEND THAT ACTS HOSTILEY TOWARDS YOU.

25) Write down the one major cause: _____

26) Is the cause of your friend acting hostile due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

27) In the future when interacting with friends, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

28) Is the cause something that just affects interacting with friends, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

YOU CAN'T GET ALL THE WORK DONE THAT OTHERS EXPECT OF YOU.

29) Write down the one major cause: _____

30) Is the cause of your not getting work done due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

31) In the future when doing work that others expect, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

32) Is the cause something that just affects doing work that others expect of you, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

YOUR SPOUSE (BOYFRIEND/GIRLFRIEND) HAS BEEN TREATING YOU MORE LOVINGLY.

33) Write down the one major cause: _____

34) Is the cause of your spouse (boyfriend/girlfriend) treating you more lovingly due to something about
you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7	Totally due to me

35) In the future with your spouse (boyfriend/girlfriend), will this cause again be present?

Will never again be present	1	2	3	4	5	6	7	Will always be present

36) Is the cause something that just affects how your spouse (boyfriend/girlfriend) treats you, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7	Influences all situations in my life

YOU APPLY FOR A POSITION THAT YOU WANT VERY BADLY (E.G., IMPORTANT JOB, GRADUATE SCHOOL ADMISSION, ETC.) AND YOU GET IT.

1) Write down the one major cause: _____

2) Is the cause of your getting the position due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7	Totally due to me

3) In the future when you apply for a position, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7	Will always be present

4) Is the cause something that just influences apply for position, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7	Influences all situations in my life

YOU GO OUT ON A DATE AND IT GOES BADLY.

41) Write down the one major cause: _____

42) Is the cause of you of the date going badly due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

43) In the future when you are dating will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

44) Is the cause something that just influences dating, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

YOU GET A RAISE.

45) Write down the one major cause: _____

46) Is the cause of your getting a raise due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	1	2	3	4	5	6	7 Totally due to me

47) In the future on your job, will this cause again be present?

Will never again be present	1	2	3	4	5	6	7 Will always be present

48) Is the cause something that just affects getting a raise, or does it also influence other areas of your life?

Influences just this particular situation	1	2	3	4	5	6	7 Influences all situations in my life

APPENDIX C

ATTRIBUTIONAL STYLE QUESTIONNAIRE SEXUAL-SPECIFIC

Attributional Style Questionnaire – Sexual Specific

1) Read each situation and vividly imagine it happening to you.
2) Decide what you believe would be one major cause of the situation if it happened to you and write this cause in the blank provided.
3) Answer three questions about the cause by circling one number per question. Do not circle the words.

While walking to your car, a stranger jumps out of the bushes and tries to sexually assault you.

1) Write down the one major cause: _____

2) Is the cause of the stranger's behavior due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

3) In the future when you are walking to your car, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

4) Is the cause something that just affects walking to your car, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

You and your sexual partner talk openly about sex and agree to use contraception every time you have sex.

5) Write down the one major cause: _____

6) Is the cause of your open communication and contraception use due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

7) In the future, in romantic relationships, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

8) Is the cause something that just affects when your romantic relationships or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

You get a late night phone call and the caller threatens to break into your home and rape you.

9) Write down the one major cause: _____

10) Is the cause of the phone threat due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

11) In the future when you receive threatening calls will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

12) Is the cause something that just affects threatening phone calls or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

A classmate that you don't care for finally stops asking you out on dates and leaves you alone.

13) Write down the one major cause: _____

14) Is the cause of your classmate leaving you alone due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

15) In the future when you are asked out by someone you don't care for, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

16) Is the cause something that just affects interactions with classmates, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

You are undressing in your room and see someone staring at you through your window.

17) Write down the one major cause: _____

18) Is the cause of this incident due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

19) In the future when you are getting dressed, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

20) Is the cause something that just affects when you are undressing at home, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

The person you have had a crush on for a long time finally asks you out on a date.

21) Write down the one major cause: _____

22) Is the cause of you being asked out on a date due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

23) In the future when you are asked out on a date will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

24) Is the cause something that just affects interactions with dating partners, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

You are in a movie theater and a stranger begins to whisper sexual advances to you.

25) Write down the one major cause: _____

26) Is the cause of the stranger's behavior due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

27) In the future when you are in the movie theater, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

28) Is the cause something that just affects your attendance at movies, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

You feel safe and confident interacting sexually with your current partner.

29) Write down the one major cause: _____

30) Is the cause of your feeling safe due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

31) In the future when you feel safe and confident in sexual interactions, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

32) Is the cause something that just affects feeling safe and confident in sexual interactions, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

There are many situations in which you let people do sexual things with you when you really don't want to do them.

33) Write down the one major cause: _____

34) Is the cause of your being sexual when you don't want to due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

35) In the future when you are in potentially sexual situations, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

36) Is the cause something that just affects unwanted sexual interactions, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

You get your physical and emotional needs met in a sexual relationship with your boyfriend.

37) Write down the one major cause: _____

38) Is the cause of your getting your needs met due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

39) In the future when you are in romantic relationships, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

40) Is the cause something that just affects interactions with boyfriends, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

When someone wants to be sexually involved with you, you don't know how to say no when you mean no.

41) Write down the one major cause: _____

42) Is the cause of your inability to say no due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

43) In the future when you someone wants to be sexually involved with you and you don't know how to say no, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

44) Is the cause something that just affects sexual interactions, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

You get tested for HIV/AIDS and other sexually transmitted diseases and find that you are healthy and disease free.

45) Write down the one major cause: _____

46) Is the cause of your good health due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

47) In the future when you are tested for sexually transmitted diseases will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

48) Is the cause something that just affects your sexual health or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

APPENDIX D

SCALE OF SEXUAL RISK TAKING/SEXUAL BEHAVIOR SCALE

Scale of Sexual Risk Taking

Directions: How often have you engaged in the following behaviors with someone of the opposite sex?

If you are not romantically interested in persons of the opposite sex please check here _____ and complete this questionnaire with regard to how often you engage in the following behaviors with someone of the same sex.

1. Holding hands?
   never _____
   almost never _____
   sometimes _____
   often _____
   almost all the time _____

2. Kissing?
   never _____
   almost never _____
   sometimes _____
   often _____
   almost all the time _____

3. French kissing for a long time?
   never _____
   almost never _____
   sometimes _____
   often _____
   almost all the time _____

4. Breasts touched over clothes?
   never _____
   almost never _____
   sometimes _____
   often _____
   almost all the time _____

5. Breasts touched with no clothes on?
   never _____
   almost never _____
   sometimes _____
   often _____
   almost all the time _____

6. Touching genitals over clothes?
   never _____
   almost never _____
   sometimes _____
   often _____
   almost all the time _____

7. Touching genitals with no clothes on?
   never _____
   almost never _____
   sometimes _____
   often _____
   almost all the time _____

8a. Have you ever had voluntary sexual intercourse?
   _____ Yes
   _____ No

8b. At what age (in months) did you first have voluntary sexual intercourse?

   _____ months

9. How many times in the last year have you had voluntary sexual intercourse?

   _____ number of times had sexual intercourse

10. Altogether during the past year, with how many different people have you had as voluntary sexual partners?

   _____ number of sexual partners

11. In the past 12 months, how many times have you had voluntary sexual intercourse with someone you didn't know very well?

   _____ Never
   _____ Once
   _____ Twice
   _____ At least three times

12. Have you had voluntary sexual intercourse in the past year with a partner who you knew was having sex with other people?

   _____ Yes
   _____ No

13. How many times have you had sex in the past year with a partner who you knew was having sex with other people?

   _____ number of times

14. Generally, in the last year, how often has alcohol been a part of your sexual activities?
_____ Never
_____ Occasionally
_____ Half the time
_____ Often
_____ Always

15. Generally, in the last year, how often have marijuana or drugs other than alcohol been a part of your sexual activities?
_____ Never
_____ Once
_____ Twice
_____ At least three times

16. Have you had voluntary sexual intercourse in the last year with someone who injects drugs?
_____ Never
_____ Once
_____ Twice
_____ At least three times

17. When you have voluntary sex, how often do you use some kind of birth control?
_____ Never
_____ Once
_____ Twice
_____ At least three times

18. When you have voluntary sexual intercourse, how often does your partner(s) wear a condom?
_____ Never
_____ Once
_____ Twice
_____ At least three times

19. Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, or chlamydia?
_____ Yes
_____ No

APPENDIX E

ALABAMA PARENTING STYLE QUESTIONNAIRE

APQ

Instructions: The following are a number of statements about you family. Please rate each item as to how often it TYPICALLY **occurred in your home while you were growing up.** The possible responses are Never (1), Almost Never (2), Sometimes (3), Often (4), Always (5).

	Never	Almost Never	Sometimes	Often	Always
1. Your failed to leave a note or let your parents know where you were going	1	2	3	4	5
2. You stayed out in the evening past the time you were supposed to be home.	1	2	3	4	5
3. Your parents did not know the friends you were with.	1	2	3	4	5
4. You went out without a set time to be home.	1	2	3	4	5
5. You went out after dark without an adult with you.	1	2	3	4	5
6. Your parents got so busy that they forget where you were and what you were doing	1	2	3	4	5
7. You stayed out later than you were supposed to and your parents didn't know it	1	2	3	4	5
8. Your parents left the house and didn't tell you where they are going	1	2	3	4	5
9. You come home from school more than an hour past the time your parents expected you to be home	1	2	3	4	5
10. You were at home without an adult being with you	1	2	3	4	5

APPENDIX F

ADOLESCENT PERCEIVED COSTS AND BENEFITS SCALE

Perceived Costs and Benefits Scale

Instructions: Below are some of the reasons that people give for NOT having sexual intercourse. Please indicate how much you agree or disagree with each reason. If you're not sure, give your best guess.

Responses: 0 = Strongly agree 1= Agree 2= Disagree 3= Strongly Disagree

Young People <u>Don't</u> Have Sex Because:

1. _____ They think it is morally wrong or against their religion.
2. _____ They don't want to get a sexually transmitted disease (STD) or a disease like AIDS.
3. _____ Their parent(s) don't approve.
4. _____ They don't feel old enough to handle it.
5. _____ Their friends won't approve.
6. _____ They or their partner might get pregnant.
7. _____ They aren't in love with anyone yet.
8. _____ They don't need it to make them happy.
9. _____ They would feel guilty.
10. _____ They or their partner might get pregnant, which might mess up their future plans for college, school, or a career.

Instructions: Below are some of the reasons that people give for having sexual intercourse. Please indicate how much you agree or disagree with each reason. If you're not sure, give your best guess.

Young People <u>Have</u> Sex Because:

1. _____ It helps them forget their problems.
2. _____ It makes them feel grown up.
3. _____ They *want* to get pregnant or become a parent.
4. _____ As a way to get or keep a boyfriend or girlfriend.
5. _____ It makes them feel good.
6. _____ It makes them feel loved.
7. _____ They want to fit in with their friends.
8. _____ They want to see what it's like.
9. _____ It makes them feel more confident and sure of themselves.
10. _____ People they admire or look up to make it seem like a "cool" thing to do.

APPENDIX G

TABLES

Table G1.

Factors That Influence Adolescent Sexual Decision-Making About Sexual Behavior

Authors (Year Published)	Factors Supported	Factors Not Supported
Buzwall & Rosenthal (1996)	self-efficacy to say no to unwanted sex sexual self-esteem permissive sexual attitudes worry about negative consequences	
Green, Johnson, & Kaplan (1992)	cognitive capacity/formal operational thinking cognitive egocentrism	past use of contraception
Huerta-France & Malaeara (1999)	age knowledge of STD's sexual attitudes positive affective responsiveness of family family problem solving love for partner	
Juhasz, Kaufman, & Meyer (1986)	love for partner attraction to partner to please a partner curiosity	
Juhasz & Sonnenshein-Schneider (1987)	possible consequences morality/religiosity desire for physical gratification desire for intimacy intelligence degree of excitability	
Kalof (1995)	egalitarian gender role attitudes physical desire emotional gratification	
Langer & Girard (1999)	substance and drug use rational decision making poor condom attitudes perception of peer condom use low condom use intention	

(table continues)

Table 1 continued.

Authors (Year Published)	Factors Supported	Factors Not Supported
Levinson, Jaccard, & Beamer (1995)	physical pleasure sense of deprivation when not sexually active	HIV knowledge
Miller, Norton, Fan, & Christopherson (1998)	parent-adolescent communication early age of pubertal development intentions to participate in sexuality behavior	
Perkins, Luster, Villarruel, & Small (1998)	age suicide ideation grade point average alcohol use being home alone religiosity negative peer group	family support parental monitoring school climate
Pete & Desantis (1990)	desire for relationship to be based on trust invulnerability to negative consequences family structure (unsupervised free time, parent expectations, ineffective authority) inability to discuss sex with friends or family inability to obtain birth control	
Rosenthal, Burklow, Lewis, Succop, & Biro (1997)	physical attraction curiosity time spent alone with partner considerate treatment from partner	
Rosenthal, Lewis, & Cohen (1996)	control person feels in sexual situations use of drugs and alcohol time spent alone with partner curiosity desire to be accepted by peers need to exert control and mastery physical gratification to enhance emotional intimacy	
Schensul (1998)	self-image peer pressure stress	

Table G2.

Factors Examined Across Studies of Sexual Decision-Making

Factor name	# of studies
Sexual attitudes (e.g., the degree of permissiveness)	2
Love for partner	2
Decision-making ability	2
Communication with parents (about sex or in general)	2
Age	2
Religiosity	2
Curiosity	3
Substance use	3
Emotional gratification	3
Consequences of sexual behavior	3
Parental supervision	4
Physical gratification	6

Table G3.

Cognitive Factors Investigated in Sexual Decision-Making Literature

Factor name	# of studies
Attitudes (e.g., regarding condom use, degree of permissiveness)	2
Perception of peer condom use	1
Decision-making ability	2
Gender role attitudes	1
Perceived amount of control in sexual situations	1
Expectations about outcome of sex	3

Table G4

Group Mean & Standard Deviations for Survivor Comparisons Across Geographical Sites

	Non-Urban Mean (SD)	Urban Mean (SD)	t(df)	p
Length of CSA experience	2.63 (2.08)	2.21 (1.70)	-0.88 (69)	ns
Number of perpetrators	1.13 (.43)	1.27 (.55)	1.02 (50)	ns
Intercourse as part of CSA [a]	.03 (.17)	.24 (.44)	2.27 (30)	.03
Support by mother [b]	1.78 (.48)	-1.50 (.59)	-1.97 (42)	.05
Support by father [b]	1.38 (.79)	1.09 (.75)	-1.37 (57)	ns
CSA focused counseling [a]	.30 (.46)	.12 (.33)	-1.76 (60)	.08
Can I control whether it will happen again? [c]	1.58 (.94)	1.48 (.87)	-0.40 (56)	ns

Note. [a] 0 = no, 1 = yes; Higher scores reflect higher perceived costs and benefits, [b] Higher scores reflect more support, [c] Higher scores reflect the belief of less control.

Table G5.

Chi Square Comparisons of Demographic Variables across Geographical Sites

	% Non-Urban	% Urban	χ^2 (df)	p
Ethnicity			119.07 (5)	.000
Caucasian	80.7	45.3		
African-American	4.4	29.4		
Hispanic	3.0	1.8		
Native American	7.9	0		
Asian American	1.3	12.8		
Other	2.4	10.4		
Religious Affiliation			71.30 (4)	.000
Protestant	75.6	37.5		
Catholic	14.0	34.7		
Jewish	0.0	1.8		
Nonaffiliated	6.1	9.3		
Other	4.1	16.7		
Marital Status			4.90 (4)	ns
Current romantic relationship			.10 (1)	ns
Received counseling in past			.42 (1)	ns

Table G6.

Group Means & Standard Deviations for Sample Comparisons by Geographical Sites

	Non-Urban Mean (SD)	Urban Mean (SD)	t(df)	p
Typical sexual behavior in Last 12 months	16.41(5.86)	16.90 (7.29)	.73 (271)	ns
Risky sexual behavior in last 12 months	-.04 (70)	.05 (.78)	-1.19 (267)	ns
Perceived costs of sexual intercourse [a]	9.59 (4.14)	11.51 (4.47)	-4.61 (452)	.000
Perceived benefits of sexual intercourse [a]	15.5 (6.17)	13.0 (5.48)	4.49 (369)	.000
Parental supervision [b]	24.9 (5.67)	25.4 (7.49)	-.746 (269)	ns
General negative attributional style [c]	12.9 (1.93)	11.70 (1.85)	6.55 (446)	.000
Sexual-specific negative attributional style [c]	12.02 (2.43)	10.94 (2.68)	4.26 (436)	.000

Note. All comparisons included 327 participants or more. Low degrees of freedom reflects tests in which equal variances were not assumed.

[a] Higher scores reflect higher perceived costs and benefits, [b] Lower scores reflect more parental supervision, [c] Higher scores reflect more negative attributional styles

Table G7

Intercorrelations Between All Dependent and Independent Variables

Non Urban

	ASQ	ASQ -SS	Risky Sex (4)	Risky Sex (6)	Typical Sex	Future Sex	Benefit	Cost	APQ	CSA status
ASQ	--	.34**	-.07	-.10	-.05	.09	-.05	-.09	.08	.03
ASQ - SS		--	-.03	-.03	.14*	.01	-.07	-.03	.11	.03
Risky Sex (4)			--	.91**	.26**	.65**	-.14*	.17**	.12*	.05
Risky Sex (6)				--	.28**	.66**	-.13*	.16*	.09	.04
Typical Sex					--	.08	.02	.07	.08	.05
Future Sex						--	-.12	.18*	.18**	.09
Benefit							--	-.29**	-.10	-.04
Cost								--	.12*	.10
APQ									--	.01
CSA Status										--

Urban

	ASQ	ASQ-SS	Risky Sex (4)	Typical Sex	Benefit	Cost	APQ	CSA
ASQ	--	.27**	.08	.21**	.02	.01	.17*	.05
ASQ - SS		--	.17*	.18*	-.09	.05	.17*	.12
Risky Sex (4)			--	.22**	.05	.11	.18*	.23**
Typical Sex				--	.05	.11	.22**	.22**
Benefits					--	-.04	-.10	.04
Costs						--	.10	.13
APQ							--	.22**
CSA Status								--

Note: Non-Urban N's: ASQ = 288; ASQ-SS = 286; Risky Sex (4) = 282 (6) = 259;

Typical Sex = 288; Future Sex = 196; Benefits = 290; Costs = 290; APQ = 291; CSA = 291

Urban N's: ASQ = 160; ASQ-SS = 152; Risky Sex (4) = 145; Typical Sex = 159; Benefits = 163;

Costs = 164; APQ = 164; CSA = 166. Variance in N reflects missing data for each questionnaire.

Table G8

Summary of Hierarchical Regression Analyses for Variables Predicting Participation in Risky Sexual Behavior for the Urban Sample

	Variable	B	SE B	β	F
Step 1					
	Parental Supervision	.02	.01	.15	2.92
Step 2					
	Sexual-specific Attributional Style	.05	.03	.15	3.03*
Step 3					
	Victimization Status	.43	.19	.19	3.72**

Note: $R^2 = .02$ for step one; $^{\Delta}R^2 = .02$ for step two; $^{\Delta}R^2 = .04$ for step three. * $p \leq .05$.

** $p \leq .01$.

Table G9

Summary of Hierarchical Regression Analyses for Variables Predicting Participation in Typical Sexual Behavior for the Urban Sample

	Variable	B	SE B	β	F
Step 1					
	Parental Supervision	.15	.08	.16	3.96*
Step 2					
	Sexual-specific Attributional Style	.46	.22	.17	4.28*
Step 3					
	Victimization Status	3.23	1.58	.17	4.31*

Note: $R^2 = .03$ for step one; $^{\Delta}R^2 = .03$ for step two; $^{\Delta}R^2 = .03$ for step three. * $p \leq .05$.

** $p \leq .01$.

APPENDIX H

INSTITIUTIONAL REVIEW BOARD

Oklahoma State University
Institutional Review Board

Protocol Expires: 3/6/02

Date : Wednesday, March 07, 2001 IRB Application No AS0135

Proposal Title: DECISION MAKING IN YOUNG ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE AND NONVICTIMS

Principal Investigator(s) :

Tracy Fehrenbach
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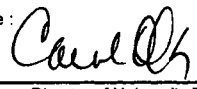
Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s) : Approved

NOTE: THE PROJECT APPROVAL IS FOR ONE YEAR. APPROVAL TO CONTINUE THE STUDY BEYOND THE APPROVAL DATE WIL BE REQUIRED

Signature : 

Carol Olson, Director of University Research Compliance

Wednesday, March 07, 2001
Date

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modifications to the research project approved by the IRB must be submitted for approval with the advisor's signature. The IRB office MUST be notified in writing when a project is complete. 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 2

Candidate for the Degree of

Doctor of Philosophy

Dissertation: SEXUAL DECISION-MAKING IN YOUNG ADULT CHILD SEXUAL ABUSE SURVIVORS AND NONVICTIMS

Major Field: Psychology

Biographical:

Education: Received a Bachelor of Arts degree with Honors in Psychology from the University of Missouri, Columbia, Missouri in May of 1997. Received a Masters of Science in Psychology degree from Oklahoma State University, Stillwater, Oklahoma in December of 2000. Completed the Requirements of the Doctor of Philosophy in Psychology at Oklahoma State University in December, 2002.

Professional Experience: Practicum student and research coordinator for treatment outcome study for children with sexual behavior problems at Center for Child Abuse and Neglect, Oklahoma Health Sciences Center, 1998 – 2000. Practicum student on the Partners Project, a grant funded treatment intervention study targeting youth engaged in high-risk sexual behavior at University Hospital, Oklahoma Health Sciences Center, 2002 – 2001. Completed a clinical internship at the University of Medicine and Dentistry of New Jersey, June 2001 – 2002.

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