UNIVERSITY OF ALBERTA

ATTRIBUTIONS AND ADJUSTMENT IN ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

BY

DEVONA THERESA GIBSON 

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in partial fulfillment of the requirements for the degree of MASTER OF SCIENCE

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled ATTRIBUTIONS AND ADJUSTMENT IN ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE, submitted by Devona Theresa Gibson in partial fulfillment for the degree of MASTER OF SCIENCE IN FAMILY STUDIES.

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ABSTRACT

In order to explore the relationship between attributions and adjustment, a community sample of 67 adult female survivors of childhood sexual abuse participated in an in-depth interview about the childhood sexual abuse, completed a paper and pencil measure of their attributions for the causes of the abuse, and completed two measures of adjustment. Survivors attributed the greatest blame to the abuser, and more blame to the abuser, non-abusing others and society than to themselves. Both characterological self-blame and behavioral self-blame were negatively related psychological, physical and interpersonal adjustment. In addition, blaming attributions to the abuser, non-abusing others, society or chance were either negatively related adjustment or not at all related to adjustment. The limitations of existing attributional measures and the need for better attributional measures are discussed. The implications of these findings for therapists and other professionals who work with adult survivors of childhood sexual abuse are also discussed.

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Introduction

Childhood sexual abuse has been identified as a significant social problem in our society. The exact incidence of child sexual abuse is unknown due to both underreporting (Becker & Coleman, 1988; Wolfe, Wolfe, & Best, 1988) and a lack of reliable statistics (Becker & Coleman, 1988). Estimates of the incidence of childhood sexual abuse of women have ranged from 15 to 45 % (Wyatt & Newcomb, 1990). The figure for the incidence of childhood sexual abuse in males has ranged from 6.5 % (McKenzie, 1991) to 33 % (one in three men) (Report of the Committee on Sexual Offences Against Children and Youth, 1984). A large part of this variability in the prevalence of child sexual abuse is likely due to the different ways sexual abuse was defined.[1] Whatever the exact prevalence, clearly a significant percentage of girls and boys are victims of child sexual abuse.

The short-term impact of sexual abuse can be devastating, but the effects do not appear to end with the termination of the abuse. Sexual abuse in childhood can have a long term impact on psychological, physical, sexual and interpersonal functioning. Some suggested long-term effects of childhood sexual abuse include depression, low self-esteem, Post-Traumatic Stress Disorder, sleep problems, sexual dysfunction, anxiety, dissociation, and multiple personalities (e.g., Heath, Donnan, & Halpin, 1990; Hoagwood, 1990; Jehu, 1989; Johnson & Kenkel, 1991; Morrow, 1991; Murphy, Kilpatrick, Amick-McMullan, Veronen, Paduhovich, Best, Villeponteaux, & Saunders, 1988; Wyatt & Newcomb, 1990).

[1] Definitions vary both in terms of what constitutes sexual abuse (e.g., contact vs. non-contact) and the age cutoff for childhood abuse (e.g., under 14/under 16/under 18 years of age).

One of the factors believed to be related to adjustment in survivors of child sexual abuse is self-blame. Some experts and clinicians have suggested that self-blame may aid positive adjustment, as it may be one way individuals can maintain a sense of control in their lives (Lamb, 1986; Shapiro, 1989). Some research with accident victims, victims of rape, and women who have undergone abortions has supported this contention (Bulman & Wortman, 1977; Janoff-Bulman, 1979; Mueller & Major, 1989). However, researchers dealing specifically with sexual abuse survivors have not found any positive relationship between self-blame for the abuse and adjustment (e.g., Hoagwood, 1990; Morrow, 1991). This poses problems for clinicians and raises some interesting theoretical questions.

The purpose of the present research was threefold: (a) to clarify the relationship between different types of self-blame (characterological and behavioral self-blame) and psychological functioning in a sample of female survivors of childhood sexual abuse; (b) to explore the relationships between the different types of self-blame and physical, interpersonal, and sexual functioning; and, (c) to explore the relationship between other attributions (others, situation, luck/chance) and psychological, physical, interpersonal, and sexual functioning. The present study was designed to clarify the nature of the relationships between attributions and adjustment. Further, the investigation of the relationship between self-blame and adjustment may aid in identifying appropriate therapy goals and approaches for assisting survivors of sexual abuse.

Conceptual framework

Frequently we make inferences, or attributions, about the causes of both our own behavior and the behavior of others. When something unexpected or traumatic happens to us, we often initiate the attribution process in an attempt to identify the cause of the event.

Attribution theorists suggest that we attempt to locate the cause as internal or external, and assess whether it is stable or unstable and whether it is controllable or uncontrollable (Weiner, 1985). These three dimensions - locus, stability and controllability - are considered to be important in making attributions for traumatic events.

First, when assigning causality for an event, we try to determine the locus or source of the cause. The locus of causality may be attributed to either internal or external factors (Weiner, 1985). This can also be thought of as the degree of participation (Shaver, 1975). For example, if something negative happens to someone, he or she decides if he or she actually did something to cause the abuse, or if the abuse occurred because of someone else (such as the abuser), or some factor in the situation. If the victim believes the abuser caused the abuse, he or she is making an external causal attribution. An external attribution locates the locus of causality outside of the person, in someone else or in the situation. However, if a victim of child sexual abuse believes he or she did something to cause the abuse or believes that the abuse continued as a failure on his or her part to do something to end the abuse, this is an internal attribution. An internal attribution, then, locates the locus of causality within the individual (e.g., the victim).

A second dimension involved in making attributions is stability. Some causes have the ability to change while others remain constant (Weiner, 1985). Thus, when we attribute the cause of an event to some source, we can do so to a source that is stable or unstable. Suppose we attribute the cause of some event to ourselves. We could attribute the cause to something about our character (a personality trait), or to something we did (our behavior). Traits such as personality are assumed to be internal and stable (Weiner, 1985). On the other hand, it is assumed that behavior can vary across situations. Thus, behavior is both internal and unstable (Weiner, 1985). Consider the different impact it would have if the

cause of sexual abuse was attributed to staying alone with the abuser, versus being too trusting or a bad child. The behavior of staying alone with the abuser is modifiable. The traits of trustworthiness or badness are not as easily modified.

We could also attribute the cause to an external source, either stable or unstable. For example, if the cause is attributed to the abuser, then the victim is making an external attribution. If the abuser is a parent, the victim is likely to consider this a stable factor where the likelihood of repeated abuse is high. On the other hand, if the abuser is a stranger whom the victim is unlikely to see ever again, the cause is unstable and external.

A third dimension is controllability. Certain causes are subject to voluntary control, while others are not (Weiner, 1985). This dimension is closely related to stability. Behaviors are considered to be under our voluntary control, while personality traits are not. If we hold some aspect of our character to blame for a negative event, we may come to view these events as out of our control, whereas blaming our behavior implies some personal control over the events (Peterson, Sewartz, & Seligman, 1981). In fact, it has been suggested that perhaps victims of traumatic events make internal attributions in an effort to maintain some sense of control (Janoff-Bulman, 1979; Bulman & Wortman, 1977). If an individual perceives that some aspect of the event was under his or her control, conceivably, the "next time" the event could be avoided.

In addition, it is possible that the victim could attribute the abuse to an external cause that is stable and which may be controllable or uncontrollable. For example, attributing the cause to a parent is both external and stable. Yet whether or not the victim believes that the abuse was under the parent's control is also an issue. The victim may believe that the parent could not control what he or she did (that is, the parent had some sort of uncontrollable compulsion to abuse children). In contrast, the victim may believe that

the parent made a conscious choice to abuse children; that is, the victim believes the parent had control over his or her actions.

Weiner (1985) claims that the types of attributions an individual makes has an effect on the emotions that the individual experiences, as well as on the individual's self-concept. The three dimensions discussed previously are related to the types of emotions an individual may experience. According to Weiner (1985), the locus of causality dimension is linked with feelings of self-esteem and pride; the controllability dimension is linked with feelings of anger, gratitude, guilt, and shame; and the stability dimension is linked with feelings of hopelessness. For instance, Weiner (1985) suggests that when a negative or traumatic event is attributed to internal causes, such as personality, there will be a negative effect on the individual's self-esteem. This is because personality is an internal cause that is generally stable and out of our control. Believing the abuse was caused by an internal factor that cannot be changed can be devastating.

From this theoretical perspective, the child sexual abuse victim who believes something about his or her personality caused the abuse would be expected to have low self-esteem. In contrast, if the traumatic event is believed to be caused by external factors, then there is little or no effect on self-esteem (Weiner, 1985). According to Weiner's line of reasoning, the victim who believes the offender caused the abuse will have better self-esteem than the victim who feels he or she caused it.

Weiner (1985) also suggests that shame may result when a negative event is attributed to a characteristic that is self-related and uncontrollable. Again, if the abuse is attributed to the victim's being a "bad" child, it is likely that she or he will feel shame as a result. Being a "bad" child is a trait which the child could not control. However, if the

abuse was attributed to the abuser, the child will not be as likely to feel shame because this control is not related to the self.

Finally, Weiner (1985) suggests that hopelessness may result when a negative event is attributed to stable causes. Whether or not a victim attributes the abuse to internal or external causes, if he or she attributes the abuse to a stable cause, he or she is likely to experience hopelessness and depression. However, if the victim attributes the abuse as occurring due to something he or she did, he or she may not experience hopelessness because there may have been some way to alter his or her behavior to stop the abuse from occurring.

The distinction between stable/unstable and controllable/uncontrollable factors appears to be important when making attributions for negative events. Janoff-Bulman (1979) suggested that victims of traumatic events often engage in either behavioral or characterological self-blame. Behavioral self-blame occurs when an individual blames himself or herself for engaging, or not engaging, in some behavior which led to the traumatic event or outcome (Janoff-Bulman, 1979). This type of blame suggests that the situation may have been in the victim's control and thus, modifiable. Characterological self-blame occurs when an individual blames himself or herself for the incident because of some character flaw (Janoff-Bulman, 1979). Characterological blame implies that it was something about the victim's character that led to the event. Usually, these character traits are regarded as unchangeable. According to Janoff-Bulman's conception of behavioral and characterological self-blame, these two types of attributions appear to fall on opposite ends of the continuums of stability and control. Behavioral self-blame suggests that causality belongs to factors that are under one's control and are relatively less stable. On the other

hand, characterological self-blame suggests that causality belongs to factors that are quite stable and often out of one's control.

Following Weiner's and Janoff-Bulman's line of reasoning, one would expect that those victims who engage in characterological self-blame for some traumatic event would have poorer adjustment than those who engage in behavioral self-blame. This notion, that the nature of the attribution one makes for a traumatic event our outcome is related to how well individuals cope with the traumatic event and to their subsequent adjustment, has generated a large body of research which is reviewed in the following section.

Literature Review

Early attributional research

Early researchers investigating the effects of attributions for a traumatic event on subsequent adjustment studied accident victims. They assessed the types of attributions victims made and then measured how those attributions affected adjustment following the accident. Bulman and Wortman (1977) found an interesting relationship between the amount of self-blame and the amount of other-blame and the victim's coping and adjustment. The more the accident victims blamed someone else, the worse they coped; the more victims blamed themselves, the better they coped (Bulman & Wortman, 1977). Bulman and Wortman argued that if victims attributed blame to someone else, the individual had little control over the traumatic event/outcome. If, on the other hand, the victim placed the blame on himself or herself, the victim would retain some sort of control over what happened. That is, the victim could have possibly controlled his or her actions, but it is unlikely she or he could have controlled the actions of someone else. Feeling that one could control his or her actions will not leave one feeling as helpless as would believing that one can not control the actions of others.

As a follow-up to this study, Janoff-Bulman (1979) then used these distinctions to compare depressed and non-depressed individuals who had experienced rape, and found that the two groups differed significantly in the amount of characterological self-blame. She found that the depressed individuals engaged in more characterological blame than did those who were not depressed. Results also indicated that characterological self-blame was negatively correlated with self-esteem (Janoff-Bulman, 1979, 1982). The reasons for this difference are unclear. It may be that by blaming an aspect of one's character for the traumatic event, one feels that there was nothing he/she could have done to change the

outcome. This is because one's character is stable and unchangeable. This is consistent with Weiner's (1985) suggestion that attributing a traumatic event to internal, stable causes will result in hopelessness and depression and have a negative impact on self-esteem. However, it may be the case that individuals who engage in characterological self-blame are concentrating on the present and what it was about them that makes them deserving of the event (Janoff-Bulman, 1979).

In contrast, the degree of behavioral self-blame in victims was associated with a more positive self-esteem, less depression, and perceived future avoidability (Janoff-Bulman, 1979, 1982). Interestingly, in the same study Janoff-Bulman found that the depressed and non-depressed groups did not differ in the amount of behavioral self-blame. Because those who engaged in only behavioral self-blame were not depressed, and those who blamed both their character and their behavior were depressed, Janoff-Bulman concluded that behavioral self-blame was adaptive, while characterological self-blame was not.

Janoff-Bulman's distinctions between behavioral and characterological self-blame have been used to assess victims' adjustment following various traumatic events, such as rape, cancer, loss of a child, coping with diabetes, renal failure, and accidents. Unfortunately, even though most studies have sought to extend the work of Bulman and Wortman and Janoff-Bulman, results have indicated that blaming oneself has had inconsistent effects on adjustment. Self-blame has been found to be associated with both positive and negative adjustment following a traumatic event. And, in some cases there has been no association at all between self-blame and adjustment. These findings are reviewed below.

Positive relationships between self-blame and adjustment. In an attempt to extend Bulman and Wortman's (1977) and Janoff-Bulman's (1979) work, Peterson, Schwartz and Seligman (1981) asked college students to make attributions for a number of good and bad hypothetical situations. The primary reason for the study was to address in more detail the causal role of attributions in depression. Results indicated that characterological self-blame was associated with depressive symptoms, while attributions to ones' behavior or to external factors were not (Peterson, Schwartz, & Seligman, 1981). This provided support for the work of Janoff-Bulman.

In another study with spinal-cord-injured patients, it was found that those who blamed themselves tended to be those who thought their disability could have been avoided (Schulz & Decker, 1985). Like the sample in Bulman and Wortman's (1977) study, those who coped better were those individuals who blamed themselves.

The relationship between self-blame and adjustment has also been examined in mothers of high-risk infants. Affleck, Allen, McGrade, and McQueeny (1982) found that about half of their sample assigned behavioral responsibility for their infants' medical problems to themselves or to others (i.e., doctors). These authors found that those mothers who blamed others reported more anxiety, depression and confusion than mothers who blamed themselves (Affleck et al., 1982). For these mothers of high-risk infants blaming oneself, as compared to blaming others, was associated with more successful coping with a traumatic event.

A similar study with mothers of seriously ill infants found that a significant proportion blamed at least a part of their child's medical condition on their own behavior (Tennen, Affleck, & Gershman, 1986). Like the previous study, behavioral self-blame was positively associated with the belief that they would be able to prevent the same occurrence

in the future. This, in turn, was associated with positive emotional adaptation. In contrast, blaming others was associated with greater mood disturbance (Tennen et al., 1986).

Attributional analyses have also been applied in the area of coping with diabetes, which presents a special challenge, particularly in children. Tennen, Affleck, Allen, McGrade and Ratzan (1984) proposed that causal attributions for the disease would affect how the disease was coped with by children. It was found that those children who made behavioral attributions to the self for having diabetes were coping with their illness better than children who made external attributions. In addition, those who made behavioral attributions to the self were rated (by doctors) as having the illness under better control than those who made external attributions (Tennen et al., 1984).

As with other traumatic events, attributional responses for the cause of breast cancer can include self-blame and attributions to others. In one study, most of the sample believed they could have avoided getting breast cancer, and thus blamed some aspect of their behavior (Timko & Janoff-Bulman, 1985). These authors suggested that if the women believed that they would be able to control their behavior in the future, then they would believe they had control over the cancer recurring. In addition, the more women attributed their cancer to their personality or to others, the less they believed the mastectomy had successfully removed all the cancer. This, in turn, was negatively associated with psychological adjustment (Timko & Janoff-Bulman, 1985). However, attributions to behavior were positively associated with adjustment.

Negative relationships between self-blame and adjustment. For a number of people who have experienced traumatic events, it appears that blaming an aspect of their behavior is beneficial in adjusting to the event. Yet, in many other studies the relationship between either type of self-blame and adjustment has been found to be negative, which

contradicts the work of Bulman and Wortman (1977). For instance, the relationship between self-blame and adjustment has been investigated in a sample of individuals with end-stage renal disease (Witenberg, Blanchard, Suls, Tennen, McCoy, & McGoldrick, 1983). In this study, adjustment was measured by how patients were coping with the disease and by compliance with doctors' orders. It was found that those patients who blamed themselves were not adjusting well to the disease. Specifically, overall self-blame was associated with poor coping and poor compliance with doctors' orders (Witenberg et al., 1983). The authors speculated that this contradiction of the early work of Bulman and Wortman may be because self-blame is detrimental if it leads to attempts to change an unchangeable situation.

In another study with accident victims, the authors assessed the relationship between self-blame and recovery (Frey, Rogner, Schuler, Korte, & Havemann, 1985). Those patients who thought the accident was unavoidable or those who thought they were not at all responsible displayed better recovery than did those patients who held themselves responsible. Likewise, Nielson and MacDonald (1988) found that patients with spinal-cord injuries who blamed themselves were more likely to feel helpless, and reported greater anxiety, depression and hostility than did low self-blamers (Nielson & MacDonald, 1988). Unfortunately, neither of these studies made a distinction between behavioral and characterological self-blame.

Some research also examined the relationship between self-blame and coping in women who had abortions. While some women cope relatively well following an abortion, others experience problems. Research in this area has commonly examined women's attributions for their pregnancies. Studies have indicated that self-blame in general is more common than external blame (i.e., blaming others, chance, or the situation, Major, Mueller

& Hildebrandt, 1985; Mueller & Major, 1989). Four significant findings arose from this area of research. First, it was found that high characterological self-blame, compared to low characterological self-blame, was associated with higher depression and poorer functioning in women who had abortions (Major, Mueller, & Hildebrandt, 1985; Mueller & Major, 1989). In addition, it was found that those who blamed others or the situation experienced more adjustment problems and more depression than those who did not blame others or the situation. Finally, it was found that behavioral self-blame was unrelated to functioning or adjustment (Major, Mueller, & Hildebrandt, 1985; Mueller & Major, 1989).

Similarly, blaming others as the cause of one's breast cancer (Taylor, Lichtman, & Wood, 1984), or for a spinal-cord injury (Sholomskas, Steil & Plummer, 1990) has been related to poorer adjustment and coping. And, external blame in breast cancer victims, people with spinal-cord injuries, and women who have had abortions, has been associated with worse coping, which is consistent with the earlier research of Bulman and Wortman (1977) and Janoff-Bulman (1979).

In one of the few studies to sample children, Dollinger (1986) also found results opposite to those of Janoff-Bulman (1979; 1982). Child victims of a lightning strike at a soccer game were asked about their attributions for the disaster. He found that children who made *any* attribution (e.g., to chance, to nature, or to an act of God) were more upset than those who did not make an attribution. Only one child made a behavioral attribution; however, it was collective behavioral self-blame rather than individual self-blame. This child, who blamed everyone on the soccer field, was one of the most severely upset by the lightning strike (Dollinger, 1986). It thus appears, in this study, that making *any* attributions regarding cause led to emotional upset and poor recovery following a traumatic event.

Researchers also have examined the relationship between attributions and adjustment in victims of rape. Rape is an unexpected and traumatic event. Many victims cope with the event relatively well, yet others have an extremely difficult time (e.g., Janoff-Bulman, 1979; Meyer & Taylor, 1986). Some researchers have questioned whether this difference in adjustment may be a result, at least in part, of attributions for the rape. Meyer and Taylor (1986), like Janoff-Bulman, studied rape victims' causal attributions for the rape and their subsequent adjustment. They found that both characterological and behavioral self-blame were associated with greater fear and depression (Meyer & Taylor, 1986). Similarly, Frazier (1990) assessed the relationship between behavioral and characterological self-blame and adjustment with a sample of rape victims and found that both types of self-blame were associated with increased depression and poorer adjustment for victims.

The relationship between self-blame and distress has also been examined in a sample of burn patients. Kiecolt-Glaser and Williams (1987) found that both behavioral and characterological self-blame were related to reporting more pain and greater depression in the burn patients. Thus, the findings of this study contradict Janoff-Bulman's research and suggest that behavioral self-blame is not a positive reaction to coping with a traumatic event.

The loss of a child, during pregnancy or immediately after birth, is a tragic experience, and one study examined factors which may affect adjustment to this traumatic event (Graham, Thompson, Estrada, & Yonekura, 1987). These researchers found that the mothers most commonly attributed the death to God; and, those who did so were less depressed than those who did not. In addition, self-blame, when it did occur, appeared to be primarily behavioral. Perhaps most importantly, it was found that those mothers who blamed themselves were significantly more depressed than those who did not blame

themselves (Graham et al., 1987). Finally, a small percentage of women blamed other people; however, this was not significantly related to depression (Graham et al., 1987).

Similarly, Downey, Silver and Wortman (1990) examined the relationship between attributions and adjustment in a sample of parents who had lost a child to Sudden Infant Death Syndrome (SIDS). The parents were interviewed one month, three months and eighteen months after the loss. At each time, parents who thought attributing responsibility for the loss was important were more distressed than those parents who did not. More importantly, parents who attributed the cause of the death to themselves or to someone else were more distressed than parents who made different kinds of attributions (i.e., to chance) (Downey, Silver & Wortman, 1990).

AIDS is a traumatic event and has been associated with personal responsibility and blame more than any other disease (Moulton, Sweet, Temoshok, & Mandel, 1987). These authors found that when the cause of AIDS was attributed to the self, it was significantly related to dysphoria (i.e., anxiety and depression combined). There were no significant correlations for attributions to someone else or chance.

No relationship between self-blame and adjustment. While any type of self-blame may have either a negative or a positive effect on adjustment, it also appears that for some events any type of self-blame is neither adaptive nor maladaptive. In a sample of breast cancer victims, it was found that 95% of the sample made some sort of causal attribution for their cancer (Taylor, Lichtman, & Wood, 1984). In terms of responsibility attributions, the majority of the sample blamed chance and then themselves. However, there was no relationship between self-blame and adjustment. As mentioned earlier, although there were significant relationships between some types of attributions and adjustment in a sample of

women who had abortions, behavioral self-blame was unrelated to functioning or adjustment (Major, Mueller, & Hildebrandt, 1985; Mueller & Major, 1989).

In an extension of Bulman and Wortman's (1977) study, Heinemann, Bulka and Smetak (1988) examined attributions for traumatic injury in spinal-cord-injured patients. The most frequent attribution made by these patients was to chance, followed by the environment, self, and others. Those who blamed (overall self-blame) themselves tended to be younger and to see their injuries as avoidable; however, there was no relationship between disability acceptance or present happiness and attribution of injury responsibility. Overall these results contradict those of Bulman and Wortman.

In another extension of Bulman and Wortman (1977), with spinal-cord-injured patients, Sholomskas, Steil & Plummer (1990) found that attributions to the self or another were the most frequent attributions made by these patients. Attributions to the self were more likely to be to one's behavior rather than one's character. This is in contrast to Heinemann et al. (1988), whose sample was most likely to make attributions to chance and the environment. This may be due to the fact that Heinemann et al.'s (1988) sample was slightly older than that of Sholomskas et al. (1990) or it may be because the sample used by Heinemann et al. was comprised of more men than that used by Sholomskas et al. (71% vs. 55%, respectively). Consistent with Heinemann et al. (1988), Sholomskas et al. (1990) found that self-blame was not related to coping.

Finally, in a study which sampled women with impaired fertility, both behavioral self-blame and attributions to chance were not associated with symptoms of psychological distress (Mendola, Tennen, Affleck, McCann, & Fitzgerald, 1990). However, blaming others and blaming biomedical causes for the infertility were both related to poorer

stment.

Inconsistencies in the research

Past attribution research has focused on a number of different types of victimization. Victims of traumatic events make different types of attributions for these events; however, the relationship between these attributions and adjustment is inconsistent. A few studies (e.g., Schulz & Decker, 1985; Timko & Janoff-Bulman, 1985; Tennen, Affleck & Gershman, 1986) have continued to support the early work of Janoff-Bulman (1979), indicating that behavioral self-blame may be functional for some victims. A few studies have found no relationship between self-blame and adjustment (e.g., Taylor, Lichtman & Wood, 1984; Mendola et al., 1990). However, the majority of research reviewed here has found a negative relationship between any type of self-blame and adjustment (e.g., Nielson & MacDonald, 1988; Kiecolt-Glaser & Williams, 1987; Downey, Silver & Wortman, 1990; Frazier, 1990). Some possible explanations for these inconsistencies are discussed below.

One possible explanation for the differing findings is that there are often differences in the conceptual definition of blame (Shaver & Drown, 1986). Often people use causality, responsibility and blame interchangeably, while in fact they are referring to conceptually distinct ideas. The *cause* of an event is an antecedent that is sufficient for the occurrence of an outcome (Shaver & Drown, 1986, p. 701). In other words, "a" caused "b", if "a" did not happen, "b" would not result. *Responsibility* is more like the outcome of a process where the causal contribution of a person to producing the effect and the intent to bring about that effect are taken into account (Shaver & Drown, 1986). Lastly, *blame* occurs when one does not accept the offenders' justification or excuse because he or she believes the effect was intentionally brought about (Shaver & Drown, 1986; Tennen & Affleck, 1990).

In reviewing earlier research for the present study, it was found that the majority of studies were in fact studying factors which caused the negative event to occur (e.g., Witenberg et al., 1983; Mendola et al., 1990). For example, participants were asked to indicate the extent to which various factors were a cause for the event, or why they thought the event had happened. A few studies addressed responsibility alone (e.g., Janoff-Bulman, 1979; Heinemann, Bulka & Smetak, 1988). For example, Heinemann, Bulka & Smetak (1988) asked participants to rate the extent of responsibility they attributed to themselves, others, the environment and chance. Other studies examined causality and responsibility attributions together (e.g., Moulton et al., 1987; Downey, Silver & Wortman, 1990). For instance, participants were asked how often they had assigned responsibility for the event to themselves and other factors; they were also asked to indicate whether they thought the event had been caused by something they did and something about them as a person (Downey, Silver & Wortman, 1990). Further, it is unclear whether research participants attach the same meaning to the words "cause," "responsibility," and "blame" as do researchers. Thus, regardless of the term the researcher has used in asking about participants' attributions, the meaning of a participant's response remains unclear.

It is not clear if these differences in conceptualization influenced the findings. Some researchers have suggested that behavioral self-blame may really be a self-attribution for causality of an event (Shaver & Drown, 1986). However, it is possible that by saying one blames oneself for a negative event, one is taking responsibility for that event, particularly if the person feels there was something he or she could have done to avoid it (Shaver & Drown, 1986). If this is the case, those who feel they are the cause of the event should cope better because, presumably, they could control the outcome the "next time." Interestingly, this alternative may be unlikely because this was only true for a small number

of studies. A number of studies that addressed causal attributions showed either negative or no relationship with adjustment.

The manner in which the findings have been interpreted may also be due to problems with conceptualization. The majority of researchers concluded that *self-blame* was positively or negatively related to adjustment, or had no relationship to adjustment. Although researchers often sought (or attempted to measure) attributions of causality or responsibility, they tended to report attributions of blame (e.g. self-blame) which are conceptually distinct from the former terms. In these cases, the term self-blame was used interchangeably with causality or responsibility. In fact, only one study asked participants to rate the extent of responsibility for the event and then reported its findings in relation to responsibility and adjustment (Heinemann, Bulka & Smetak, 1988), rather than in relation to self-blame and adjustment. Most research has blurred the distinction among different types of attributions, thus it is unclear which type of attribution a researcher is interested in studying, which type is assessed in the research, and which type is reported.

A second possible explanation is whether there is a stigma attached to being the victim of a certain event. Some researchers have suggested that when a behavior is socially disapproved by others, attributions of blame will be less frequent than attributions of responsibility (Shaver & Drown, 1986). Other researchers have suggested that people tend to accept more causal responsibility for positive outcomes than for negative outcomes (Turnquist, Harvey & Andersen, 1988). Thus, people who are experiencing a good recovery from an illness such as cancer may be those who attribute causal responsibility for getting the illness to themselves. In the research reviewed here, stigma does not appear to have influenced adjustment in any particular way.

Further, in the research reviewed for the present study, most events had no stigma attached to them. Those that may have a stigma attached, rape and possibly abortion, showed a negative relationship between self-blame and adjustment. These are events in which other people typically place blame on the victim; thus it may be an indication that these participants have internalized that blame made by others.

It is also possible that there may be gender issues involved in the differing findings. The word "victim" generally refers to someone who is helpless or weak (Janoff-Bulman & Frieze, 1983). Women have stereotypically been regarded by society as helpless and weak, which has the implication that they would be unable to control the outcome of a negative event. If we follow Janoff-Bulman's line of reasoning we would expect that feeling helpless would lead to poorer adjustment. There does not appear to be a clear relationship between gender and the relationship between self-blame and adjustment. However, most of the studies with all male samples found that self-blame was negatively related to adjustment (e.g., Frey et al., 1985; Moulton et al., 1987). Perhaps there is something about the nature of the victimization that interacts with gender. Males were primarily involved in events in which they were the only individuals present (such as accidents). Females, in contrast, were primarily involved with medical events (such as breast cancer or loss of a child), or events involving another (such as rape).

The types of victimizations reviewed here can be divided into three types: 1) those that occurred in the past (e.g., end stage renal disease); 2) those that were one-time occurrences (e.g., accidents); and, 3) those that could recur (e.g., cancer or rape). The primary difference between these three types is that in those events where there is a possibility of recurrence, there also exists the possibility to prevent that recurrence. This belief in future control may in turn affect the type of attribution one makes. Janoff-Bulman

(1979) suggested that behavioral attributions to the self imply that one can control one's behavior in the future and thus prevent a recurrence. Following this line of thought, one would expect that when an event could recur, self-blame will be associated with positive adjustment. However, only three of the six studies where self-blame was positively related to adjustment were events that could recur (Affleck et al, 1982; Timko & Janoff-Bulman, 1985; Tennen, Affleck & Gershman, 1986). An interesting finding did emerge; that is, of the events having a negative relationship with self-blame and adjustment, only two out of eleven were possibly reoccurring(Meyer & Taylor, 1986; Frazier, 1990). Out of the other nine studies, seven were focusing on past events (Witenberg et al, 1983; Frey et al., 1985; Dollinger, 1986; Graham et al., 1987; Kiecolt-Glaser & Williams, 1987; Moulton et al., 1987;Downey, Silver & Wortman, 1990), and two were one-time only events (Nielson & MacDonald, 1988; Sholomskas, Steil & Plummer, 1990). Thus, the likelihood of the type of victimization affecting the attributions an individual makes and the subsequent adjustment are small.

It is also possible that differing means for measuring attributions can account for the subsequent differences in outcomes (Tennen & Affleck, 1990). Some studies (e.g., Bulman & Wortman, 1977; Mueller & Major, 1989) used only rating scales to measure attributions. The rating scales themselves often had different endpoints, ranging from 6 to 12 point scales. Some studies (e.g., Tennen et al., 1984; Downey, Silver & Wortman, 1990) relied on content coding of participants' responses. The problem with this type of measurement is that there may be problems with the reliability of the coder(s). Other studies used both means of assessing attributions (e.g., Tennen, Affleck & Gershman, 1986; Moulton et al., 1987; Sholomskas, Steil & Plummer, 1990). It is interesting to note that those studies which found no relationship between self-blame and adjustment all used both

content coding and rating scales. When two scales measuring the same construct obtain similar results, it is likely that the results will be more reliable than when only one measure is used.

In addition to problems with the conceptualization or measurement of "blame," another possible explanation for the differing findings is the different methods used to measure adjustment or adaptation following the negative event (Tennen & Affleck, 1990). Adjustment has been measured by means of standardized psychological measures, by self-reports of adjustment, and by reports of adjustment by professional staff working with research participants. Even though standardized paper and pencil measures were often used, the same measures were not commonly used across studies. Some studies (e.g., Affleck et al., 1982) used measures of general mood state (i.e., anxiety, depression, anger, fatigue, vigor and confusion were measured all at once), while others used measures of depression alone (e.g., Nielson & MacDonald, 1988), and still others used broad measures, such as the Symptom CheckList-90-Revised (SCL-90-R), to obtain a index of overall adjustment (e.g., Downey, Silver & Wortman, 1990). Unfortunately, there does not appear to be a clear relationship between the type of adjustment measure used and the resulting relationship between self-blame and adjustment.

There are a number of factors that could potentially explain the differing outcomes in the existing literature on attributions and adjustment. However, it is not clear if there is any one factor that is influential. It may be that a number of these factors work in conjunction to produce differing results. There is a need to explore this issue further, but it is beyond the scope of the present study. However, it appears that attributions may have implications for adjustment to some negative life events. What, then, does research suggest about the

nature of the relationship between self-blame and adjustment in adult survivors of childhood sexual abuse?

Self-blame in survivors of childhood sexual abuse

Many victims of sexual abuse place the blame for the abuse they experienced upon themselves. Clinicians have identified a number of reasons reported by their clients for this self-blame. Many victims feel that they are to blame because they reacted passively (Jehu, 1989). They may feel that if they had resisted in some way that it would not have happened. In addition, many victims felt they were to blame because they did not immediately disclose the abuse (Jehu, 1989). The failure to disclose may lead some victims to believe that if they had disclosed the abuse it would have stopped. Finally, some victims may believe they were sexually abused because they were bad; therefore, they deserved the abuse as a type of "punishment" (Jehu, 1989). Regardless of the reasons survivors blame themselves, clinicians and researchers have wondered about the impact of self-blame upon adjustment. This literature is reviewed in the following section.

Research with children. For many clinicians, the goal of therapy with sexually abused children has been to reduce guilt and eliminate self-blame (e.g., Giaretto, 1982; Kempe & Kempe, 1984; Sgroi, 1975; Sturkie, 1983). Lamb (1986) claims that although therapists and others often mean well when they tell children that the sexual abuse was not their fault, this approach may be harmful. In trying to tell children that they are not to blame, we may actually be eliminating what little sense of power and control that these children have left (Lamb, 1986; Shapiro, 1989). Sexually abused children may believe that they had choices in the situation (e.g., not revealing the abuse) which may allow them to maintain a perception of control over what happened to them. In fact, Lamb (1986) and

others (Shapiro, 1986) suggest that behavioral self-blame in children who have been sexually abused may actually be functional for the children. Therefore, a goal of therapy with sexually abused children may be to attempt to reduce or eliminate characterological self-blame, while attempting to maintain or support behavioral self-blame as it is may be the key to retaining some sense of control in the future (Shapiro, 1989). Although this perspective holds some intuitive appeal, it does not seem to be supported by research with children and adolescents.

When Morrow (1991) asked adolescent victims of incest why they thought they had been abused (in an open-ended question), he found that 17 % blamed themselves, 44 % blamed the offender or the situation, and 40 % responded they did not know why. He then compared the adjustment of victims who made internal/self attributions (although no distinction was made between behavioral and characterological self-blame) and those who made external attributions. Those who attributed the abuse to the self, reported significantly lower self-esteem and greater depression than those who attributed the abuse to external factors. This suggests that self-blame is not functional.

However, another study assessing the adjustment of adolescent incest victims found that personal attributions of responsibility for the incest were **not** significantly related to a global measure of distress (Johnson & Kenkel, 1991). Unlike Morrow, these authors did make a distinction between characterological and behavioral self-blame. Yet, while the incest victims had significantly higher scores on depression and anxiety than the adolescent norms, these measures of psychological functioning were not significantly related to characterological or behavioral self-blame for the abuse (Johnson & Kenkel, 1991). These two studies suggest that self-blame is not related to, or is negatively related to, adjustment

in children and adolescents who were sexually abused. But, what relationship does self-blame have with adjustment in adults?

Research with adults. Gold (1986) examined the long-term effects of childhood sexual abuse on adult women. She found that women's general attributional style was related to their adult functioning. When compared to women who were not sexually abused, Gold (1986) found that women who had experienced sexual abuse were more likely to attribute bad events in general, to internal, stable, and global factors (Gold, 1986). She also found that those women who reported low self-esteem and psychological distress were more likely to have an attributional style similar to that of characterological self-blame (Gold, 1986). Although Gold did not actually measure attributions for the sexual abuse, she concluded that characterological self-blame had a negative effect on adjustment.

Using Janoff-Bulman's (1979) conceptualization of behavioral and characterological self-blame, Hoagwood (1990) investigated women's current and past perceptions of blame for their childhood sexual abuse. She compared women's responses to several blame items as a child and as an adult. She found that women reported blaming themselves less and others more as adults than they did as children. She also found that there were no differences between the absolute amounts of behavioral and characterological self-blame women reported they had as children. However, as adults, women reported a greater amount of characterological self-blame relative to behavioral self-blame. Hoagwood suggested that perhaps children do not make the distinction between one's behavior and one's character; thus when they blame themselves the result is that they blame both their character and behavior. It may be only as adults that women are able to make a distinction between these two aspects of self-blame. This may be partly due to the developmental, moral, and cognitive stage of the child.

Although Hoagwood found that characterological self-blame was more intense than behavioral self-blame for adults, unfortunately she did not use this distinction when examining the relationship between blame and adjustment She did find that women who blamed themselves more as children were more depressed and had lower self-esteem as adults. Perhaps this is because they have carried the issue of self-blame with them for so long. Further, women who blamed themselves as adults, compared to women who blamed their abuser, were more depressed and had poorer self-concepts. Although Hoagwood's (1990) results support the idea of two distinct types of self-blame, her research did not make this distinction when investigating the relationship between self-blame and adjustment. Thus, it is not possible to determine if behavioral self-blame and characterological self-blame differentially related to adjustment.

Interestingly, Heath et al. (1990) did not find a significant relationship between any type of attribution (i.e., self, offender, victim, and society) and anxiety, depression, or hostility in adult victims of childhood sexual abuse; that is, there was no relationship between any type of attribution and any of the measures of adjustment. Overall, victims had more adjustment problems than non-victim norms, but degree of blame of any type was not related to adjustment.

In summary, there is no evidence to support the notion that either behavioral or characterological self-blame for childhood sexual abuse is functional for adult survivors. What is less clear, is whether either type of self-blame is maladaptive.

Summary

In summary, attributions for negative life events can be located in the self, other people, the situation or chance. Early attributional research suggested that victims of

negative life events more poorly coped when they blamed someone else than when they blamed themselves (Bulman & Wortman, 1977).

Subsequent theorizing suggested that there are two distinct types of self-blame: characterological and behavioral. It was hypothesized that those individuals who blamed their character would experience poorer adjustment than those who blamed their behavior for a traumatic event (Janoff-Bulman, 1979), perhaps because one's behavior is generally perceived to be under one's control, whereas one's character is perceived to be fairly stable. While some research supported this notion (e.g., Major, Mueller, & Hildebrandt, 1985; Mueller & Major, 1989), other studies found no relationship between self-blame and adjustment (e.g., Heath et al., 1990; Johnson & Kenkel, 1991), and still other studies found that both behavioral and characterological self-blame were associated with poorer adjustment (e.g., Frazier, 1990; Kiecolt-Glaser & Williams, 1989; Meyer & Taylor, 1986). Due to these inconsistent findings, it is important to explore further the nature of the relationship between both characterological and behavioral self-blame and the subsequent adjustment of adult survivors of child sexual abuse.

Moreover, few studies have examined the relationship between other types of attributions and adjustment. Some research found that victims of non-sexual traumatic events who blamed others tended to experience significantly poorer adjustment than those not blaming others (Bulman & Wortman, 1977; Major, Mueller, & Hildebrandt, 1985; and, Mueller & Major, 1989). Other research, with sexual abuse victims, found that blaming the abuser was positively associated with self-esteem and self-concept and negatively associated with depression (Hoagwood, 1990). And, researchers who have investigated the relationship between attributions to chance or the situation found that these factors tended to be related to increased depression and decreased adjustment (Janoff-Bulman, 1979;

Major, Mueller, & Hildebrandt, 1985; Mueller & Major, 1989). Since only a few studies have investigated the relationships between attributions to factors other than the self and adjustment, there is a need for more research in this area.

In addition, it is apparent from the review of the literature that most studies examining the correlates of any type of self-blame have focused on a limited number of measures of adjustment. Typically, measures of adjustment employed in past research included measures of depression, anxiety, and self-esteem (e.g., Briere & Runtz, 1993; Frazier, 1990; Gold, 1986; Heath, Donan & Halpin, 1990; Hoagwood. 1990; Hunter, 1991; Jehu, 1989; Johnson & Kenkel, 1991; Morrow, 1991; Mueller & Major, 1989; Peterson, Schwartz & Seligman, 1981). These are all measures of psychological functioning. Yet survivors of child sexual abuse experience adjustment problems in an number of areas. In addition to problems in psychological functioning, survivors also experience problems in physical, sexual, and interpersonal functioning. Yet, few studies have examined the effects of self-blame or other attributions on physical, sexual, and interpersonal functioning. Relationships between different kinds of attributions and physical, psychological, sexual, and interpersonal functioning have important clinical implications for treatment planning.

Study Purpose and Hypotheses

The purpose of this study was to: (a) clarify the relationship between self-blame (character and behavioral) and psychological functioning in a sample of female survivors of childhood sexual abuse; (b) explore the relationship between self-blame (characterological and behavioral) and physical, interpersonal, and sexual functioning; and, (c) explore the relationship between other attributions (others, situation, luck/chance) and psychological, physical, interpersonal and sexual functioning. It was hypothesized that:

1. both characterological and behavioral self-blame would be negatively related to psychological, physical, interpersonal, and sexual adjustment as an adult;

2. blaming the perpetrator would be positively related to psychological, physical, interpersonal, and sexual adjustment (but this relationship was expected to be weaker than the hypothesized relationship between self-blame and adjustment);

3. blaming other people would be positively related to psychological, physical, interpersonal, and sexual adjustment (although this relationship was expected to be weaker than the hypothesized relationship between self-blame and adjustment); and,

4. blaming chance or luck would be negatively related to psychological, physical, interpersonal, and sexual adjustment (however, this relationship was expected to weaker than the hypothesized relationship between self-blame and adjustment).

Methodology

Sampling Procedure

This research utilized data that was collected as part of a larger research project[2]. The sample included 67 adult women who experienced childhood sexual abuse (i.e., sexual abuse prior to the age of 18 years) either by members of their family or by non-family individuals. Childhood sexual abuse was operationalized as both contact and non-contact sexual abuse. Contact abuse included fondling, kissing in an inappropriate manner, and attempted or completed vaginal, oral, or anal intercourse. Non-contact abuse included exhibitionism, voyeurism, and pornography.

Three means were used to recruit women in the original study: paid advertisements, public-service announcements, and posters. The paid advertisements ran in two local newspapers and asked adult women who had been sexually abused as children if they would like to volunteer for a study. (See Appendix A for a copy of the advertisement.) The public-service announcements were broadcast on local radio and television stations, detailing the same information. (See Appendix B for a copy of the announcements.) Posters were also placed around the University of Alberta campus, and elsewhere in the city of Edmonton (e.g., at grocery stores) to recruit volunteers. These posters carried the same information as the advertisements in the newspaper.

Procedures in the Original Study

Initial contact with the women was made over the telephone. Based on hearing about the study or seeing an advertisement, women phoned for more information or to schedule a

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[2] This study utilizes data collected as part of an ongoing project: *"Self-Blame and Adjustment in Survivors of Childhood Sexual Abuse"* directed by B. Skrypnek at the University of Alberta.

time to participate. During this initial contact, the women were provided with the following information:

> "This study is part of an ongoing program of research of Dr. Berna Skrypnek here at the University of Alberta. Besides Dr. Skrypnek, myself and another researcher are currently involved in helping to collect and analyze the data. We are conducting the study in order to understand more about the thoughts, feelings, and problems of women who have been sexually abused as children. We ask you to participate in one session, which involves an interview and completing several paper and pencil questionnaires. The session is expected to take approximately two hours to complete. The session usually takes place in an office we have at the University of Alberta.
>
> The first part of this study involves an interview. The interview begins by asking you some very general questions about your background, such as your age, education, occupation, family, etc. Then we will move on, and you will be asked to talk about the sexual abuse you experienced as a child. We recognize that some of these questions may be upsetting for you and we want you to know that should you decide to participate, you do not have to answer any question you do not feel comfortable answering. We also want you to know that you will be treated with sensitivity and respect. If at any time you wish to stop the interview, we will. You will be in control of what happens. With your permission, we will audio-tape the interview so that I do not have to take so many notes. Afterwards the

interviews will be transcribed, that is typed up, with all names or other identifying information omitted. Then the tapes will be destroyed. Neither the interview nor the questionnaires will identify you; we will simply use an identification number. After the interview, you will be asked to complete several paper and pencil questionnaires. These ask you about your thoughts about why the abuse occurred; about your emotions; and about problems that you might be experiencing (such as sleep problems, headaches, worries, anxiety, etc.). Although we would like participants to complete all the questionnaires for research purposes, you, of course, should only answer those questions you wish to answer or feel comfortable answering.

I know this has been a quick description of the study. Do you have any questions about the study? Is there anything else I can tell you?"

Once any questions were answered, the women were asked if they would like to participate. Due to the sensitive nature of the study, some of the women did decide not to participate. When this happened, they were thanked for their interest and told that if they changed their minds at a later date they were welcome to call again. If any of the women seemed unsure about their decision they were told to take as long as they needed to think about it and to call back if they decided to participate or if they had more questions about the study. Finally, for those women who did decide to participate, the interviewer arranged a time and place for the interview to take place. In most instances, the interviews took place in an office at the University of Alberta. However, occasionally, interviews were held elsewhere due to transportation or childcare concerns, or if the women were uncomfortable

with the university setting. The women were given instructions on how to get to the office (or, if needed, the interviewer obtained instructions to get to the alternate location). Interview times were arranged according to the women's and the interviewer's schedules.

Interview procedures. No matter where the interview was held, it was extremely important that some sort of rapport be established prior to beginning. Thus, when the women arrived for their interview, the interviewer first introduced herself and asked if they would like anything to drink (this was only if the interview was held in the office). Inquiries were usually made about how easily they found the office, or about the weather, or some other "small talk." This type of conversation was important as it served to put the women at ease about the interview. In addition, to give the interview room a more comfortable feel, the office was furnished with a large easy chair for the interviewee, an end table, dried flower arrangement etc.

Next, the interviewer repeated the information that the women received over the telephone. This was done in order to clarify any questions the women may have had. The women were given a copy of the information sheet to keep for their own records. (See Appendix F for a copy of the information sheet.) Prior to signing the consent form, three important issues were addressed. First, it was stressed to each woman that her participation was completely voluntary and that she could withdraw at any time. Second, the interviewer reassured each woman that all efforts would be used to maintain her confidentiality. Finally, the interviewer asked each woman for permission to tape the interview. Once any questions and concerns were addressed, the participant read, signed and dated the consent form. (See Appendix G for a copy of the consent form.)

Interview design. Although the interview schedule seems quite structured, the set of structured questions only served to guide the interviewer and help keep the interview

moving smoothly. (See Appendix H for a copy of the interview schedule.) The questions were asked in an open-ended manner to allow the women to express themselves freely. The response lists on the interview schedule existed for ease of recording. Respondents were not required to choose an answer from a set response. During the interview, care was taken to prevent guiding the women into certain answers. However, if the respondent did not provide the relevant type of information, the interviewer probed the respondent by asking further questions and moving through the interview schedule in a sequential manner.

The interview began with some demographic questions such as date of birth, family of origin information, education, occupation, marital status, etc. In the next part of the interview the women were asked about any abuse they may have experienced as an adult. This was followed by the major part of the interview which dealt with the experience of sexual abuse. This section of the interview was generally the least structured and gave the women the freedom to tell their stories in their own words and in a way that was comfortable for them. It was important, particularly in this section, to convey understanding and respect for the women. The fourth part of the interview was directly related to this study's research question, as it asked the women why they think the abuse occurred. One question was designed specifically to address the idea of self-blame: "Many women mention that at times they have blamed themselves. Have you ever blamed yourself?" (See page 13 of the interview schedule in Appendix H.) The final portion of the interview asked the women about their healing experiences. As can be seen, the interview questions moved from the general to the more specific. Placing the least threatening questions at the beginning gave the women time to become comfortable with the interview process, and make the more threatening questions easier to answer. The interview typically lasted from an hour to an hour-and-a-half, depending on the individual respondent.

Once the interview was completed, if the women wished they were given a five to ten minute break. The interview then moved on to the questionnaires. Four different questionnaires were included. In order, these were 1) "Why We Think Sexual Abuse Happens to Us" Questionnaire, (2) Test Of Self-Conscious Affect (TOSCA; Tangney, Wagner, Fletcher & Gramzow, 1992), (3) Trauma Symptom Checklist 40 (TSC-40; Elliot & Briere, 1992),and (4) Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1983). The "Why We Think Sexual Abuse Happens to Us" questions were asked first because it is one of the most important parts of the study, and so that these responses could not be affected by the other instruments. Although the usual procedure is to put questionnaires in random order, the other measures were put in order of importance to the exploratory pilot study. Also, this data is from a pilot study and it was not thought that a large sample would be obtained. The importance of reading all instructions was stressed to the respondent. In addition, the women were informed that they should not put their names on the questionnaires, and that they could take as long as they needed. Finally, the women were told that they would be left alone to complete the questionnaires, and that the interviewer would check in occasionally to see if they had any questions. The time needed for completion of the questionnaires generally ranged from 20 to 30 minutes.

After the questionnaires were completed, participants were debriefed. The debriefing began by telling the women about some of the factors that have been found to be related to adjustment in adults. In addition, the women were asked if they felt any of these factors had significantly affected them. The interviewer also attempted to assess and address any concerns or questions the women had regarding the session. Participants were informed that they could write or phone the project supervisor, Dr. Berna Skrypnek, or the interviewer if they had any concerns or questions at a later time, or if they would like a

copy of the results. The women were given a sheet with this information. (See Appendix I for a copy.) It was recognized that the very nature of the subject discussed in the interview might be distressing for some women. Therefore, a Resource Sheet identifying places women could go for help was also provided to the women. (See Appendix J.) The interviewer stressed the importance of contacting any of these resources in the event that they did experience problems after the interview. And, the women were again reminded that occasionally participants could experience a delayed reaction to the interview. Should this happen, it was suggested that they contact their own therapist (if they had one), or the resources on the list, and to call Dr. Skrypnek. Finally, the women were thanked for their participation and courage in telling their stories. Debriefing usually required about 5 to 10 minutes more of the participants' time.

Ethical issues

Informed consent. All possible steps were taken to ensure that participants were able to give their fully informed consent prior to the interview. They were informed of any possible risks and side effects they might experience as a result of participating. The participants were also informed of all procedures and the types of questions that would be asked. In addition, they were assured of their right to withdraw from the study at any time.

Particularly in an area that is as sensitive as sexual abuse, it was very important that safeguards were taken to protect the participants. That is why all participants were given a detailed description of the types of questions that would be asked. An additional safeguard that was added was to provide all participants with a resource list. This resource list provided the women with information about where to go for help if they found their participation in the study distressing.

Providing fully detailed information allowed participants to decide for themselves if they would like to take part in the study. As an extra protection, all participants read and signed a consent form to indicate that they understood the nature of the study.

Confidentiality and anonymity. The topic of sexual abuse is a very sensitive one and some participants may have wished to remain anonymous. This was difficult to do because participants were asked to sign a consent form prior to beginning the interview. Thus, if the women expressed concerns they were told to provide a false name. As far as we are aware, no-one provided a false name. Steps were taken to ensure that all information gathered during the interview session remained confidential. Participants were instructed not to place their names on the questionnaires. When the interview tapes were transcribed, all names and identifying information were omitted. All that serves to link the interview and the questionnaires together is an identification number. Finally, only the interviewers and the research supervisor had access to the original interview information.

Measures

In the present study, the measures used from the original study to test the hypotheses were: "Why We Think Sexual Abuse Happens to Us" (developed by Skrypnek for use in this research), the Trauma Symptom Checklist (Elliot & Briere, 1992), and the Symptom Checklist-90-Revised (Derogatis, 1983). Each is briefly discussed below.

Attributions. To assess participants' current causal attributions for their childhood sexual abuse, two types of attributional measures were adopted from measures used in previous attribution research (i.e., Gold, 1986; Heath, Donan, & Halpin, 1990; Hoagwood, 1990; Janoff-Bulman, 1979; and Skrypnek, 1980). First, participants were asked to rate to what extent each of several factors (i.e., self, society, abuser, others and chance) were

reasons why they were sexually abused. Responses were on a 7-point, Likert scales, anchored at "do not blame at all" (1) and "completely blame" (7).

The second attributional measure used slight modifications of Janoff-Bulman's questions to assess behavioral and characterological self-blame. The first question asked respondents to rate to what extent they blamed their sexual abuse on something about their behavior (behavioral self-blame), for example, something they did or did not do, or how they acted. The second question asked to what extent respondents blamed the abuse on something about the type of person they were as a child; for example, their personality, moral character or traits (characterological self-blame). The response format used for these questions was also a 7-point Likert rating scale, anchored at "do not blame at all" and "completely blame". These attributions questions appeared in the "Why We Think Sexual Abuse Happens to Us" questionnaire (see Appendix C for a copy of this measure).

The pilot study on which this thesis was based attempted to consistently measure "blame" attributions and thus used that term in the measures. Also, this term will be used in the interpretation of the findings in an attempt to get around some of the confusion in the conceptualization of the term "blame". However, there is no way of knowing how the "blame" questions were interpreted by participants.

Functioning and Adjustment

Adjustment refers to an individual's level of functioning or an individual's response (psychological, physical, interpersonal, etc.) to his or her surroundings and events that affect him or her. Adjustment is relative and refers to whether an individual exhibits poor or good functioning and adjustment in relation to "normal" standards. We were particularly interested in any problems an individual might be experiencing in day-to-day functioning. Most research with survivors of childhood sexual abuse has focused on psychological functioning but clinicians have identified problems in interpersonal, physical and sexual functioning, as well. The measurement instrument scales for adjustment that were used in this study are discussed in the following section.

TSC-40. The Trauma Symptom Checklist-40, or TSC-40,was developed to be used as a measure of traumatic impact in clinical research (Elliot & Briere, 1992; see Appendix D for a copy of this measure). This measure is notable in that it was designed specifically to assess the impact of childhood sexual abuse on adult adjustment (Briere & Runtz, 1989). There are forty items in the questionnaire, and each item is rated on 4-point scale (0-3) ranging from "never" to "very often". The six subscales include anxiety, depression, dissociation, sexual abuse trauma index, sexual problems, and sleep disturbance. Evidence indicates that the subscales are significant discriminators of sexually abused individuals. In addition, the total scale has internal consistency reliability of .90 (Elliot & Briere, 1992). This study used the sleep disturbance (e.g., insomnia, restless sleep, etc.), anxiety (e.g., feeling tense, headaches, etc.), depression (e.g., sadness, uncontrollable crying, etc.), and sexual problems subscales (e.g., low sex drive, sexual overactivity, etc.) (Elliot & Briere, 1992). The sleep disturbance subscale, which was used as an indicator of physical functioning, has an alpha of .77 (Elliot & Briere, 1992). The anxiety and depression

subscales, which were used as measures of psychological functioning, have alphas of .66 and .70, respectively (Elliot & Briere, 1992). Finally, the sexual problems subscale, which was used as a measure of sexual functioning, has an alpha of .73 (Elliot & Briere, 1992).

SCL-90-R.. The Symptom Checklist-90-Revised, or SCL-90-R, was developed to measure symptomatic psychological distress (Derogatis, 1983; see Appendix E for a copy of this measure). There are ninety items in the questionnaire. Each item is rated on a 5-point scale of distress (0-4), with poles ranging from "not-at all" to "extremely". There are nine subscales in the measure, which include somatization, obsessive-compulsive behaviors, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism (Derogatis, 1983). Factor analysis provided evidence of construct validity for each of the nine subscales; also, discriminant and convergent validity between the SCL 90-R subscales and the MMPI has been established (Derogatis, 1989). This study used the depression, anxiety, interpersonal sensitivity, and somatization scales. The depression subscale was used because it reflects a broad range of the manifestations of depression (Derogatis, 1983). The anxiety subscale is made up of a set of symptoms that are clinically associated with high levels of manifest anxiety (Derogatis, 1983). This includes both physical and clinical components of anxiety. Both anxiety and depression are generally reported as measures of psychological functioning. The interpersonal sensitivity subscale focuses on feelings of personal inferiority especially when compared to others (Derogatis, 1983). In this study, this subscale was used as a measure of interpersonal functioning. Finally, the somatization subscale assesses distress that originates from perceptions of bodily dysfunction (Derogatis, 1983). This subscale was used as a measure of physical functioning.

Internal consistency of the subscales ranges from alphas of .77 to .90. The highest alpha (.90) was obtained on the depression scale (Derogatis, 1983), indicating that the items on the subscales are fairly homogenous. Test-retest reliability is high, with coefficients ranging between .81 and .94 (Derogatis, 1989). This indicates that this measure is useful for assessing relatively stable traits.

While both the TSC-40 and SCL-90-R would provide an overall adjustment score, we were particularly interested in problems in specific areas of adjustment such as psychological, interpersonal, physical, and sexual functioning. These distinct aspects of functioning and adjustment are discussed below.

Psychological functioning. Psychological functioning refers to any psychological problems (i.e., intrapsychic characteristics) an individual may experience from day-to-day, such as nervousness, anxiety, depression and paranoia. Psychological functioning was measured using the depression and anxiety subscales from the Symptom Checklist-90-Revised and the Trauma Symptom Checklist. Psychological functioning is the most common measure of adjustment used in past research, and depression and anxiety have been the standard symptom measures used to assess this type of functioning in the literature.

Physical functioning. Physical functioning refers to any physical or bodily problems an individual may experience from day-to-day. This can include sleep disorders and illnesses. Physical functioning was measured using the somatization scale for the Symptom Checklist-90-Revised and the sleep disturbance subscale from the Trauma Symptom Checklist. The somatization subscale assess a variety of physical problems, and the sleep disturbance subscale assesses problems with sleep (such as insomnia or restless sleep).

Sexual functioning. Sexual functioning refers to any problems or difficulties an individual may be experiencing sexually, such as a lack of desire, sexual overactivity, or physical problems related to sex. Sexual functioning was measured using the sexual problems subscale from the Trauma Symptom Checklist. This sexual problems subscale of the Trauma Symptom Checklist is not a completely adequate measure of sexual functioning as it measures primarily psychosocial problems related to sexual functioning. Although not perfect, the measure gets at several important aspects of sexual functioning (such as feelings about sex and sexual activity levels).

Interpersonal functioning. Interpersonal functioning refers to how an individual relates to and gets along with other people on a daily basis. Interpersonal functioning was measured using the interpersonal sensitivity scale from the Symptom Checklist-90-Revised. Again, this is a rather limited measurement of interpersonal functioning, because it only assesses some of the components we typically associate with interpersonal functioning (such as how we feel around other people), but it does not asses other important components (such as trust). Still, the measure gets at several important aspects of interpersonal functioning and is the only measure of interpersonal functioning available in this research.

Results

Sample and Demographics

Participants were 67 women over the age of eighteen from Edmonton and the surrounding communities. The age of participants ranged from 19 years to 60 years of age, with a mean age of 36 years. Thirty-three percent (n=22) of the sample were single (never married), 30 % (n=20) were married, 13 % (n=9) of the women were living common-law, and 24 % (n=16) were divorced or separated. About two thirds (67 %) of the participants had been married or lived common-law at some time in their lives.

Twenty-one percent (n=14) of the respondents had not more than a high school diploma, 6 % (n=4) had some technical or trade school education, 48 % (n=32) had some college or university education; 21 % (n=14) had a bachelor's degree and 4 % (n=3) had a master's degree. Over half (62%, n=38) the sample was employed, either full or part-time. The remainder of the sample were students (5%, n=3), home-makers (9%, n=6), or unemployed (24%, n=16). Areas of employment varied from unskilled and skilled jobs (24 %, n=12), the clerical/service industry (26 %, n=13), managerial and professional occupations (16 % each, n=8 each), to full-time home-makers (14 %, n=7). The remaining 4% (n=2) were employed in unspecified areas.

The majority (73%, n=49) of participants lived with both parents while they were growing up, 18% (n=12) lived only with their mothers, 1% (n=1)lived only with their fathers, and 8 % (n=5)lived with people other than their parents while they were growing up. About half of the participants (53 %, n=33) were raised in major urban centers, 27% (n=17) in smaller cities and towns, 18% (n=11) in rural areas, and 2% (n=1) were raised in other countries. Most (82%, n=55)) of the sample had two or more siblings, 15% (n=10) had only one sibling, and 3% (n=2) of the sample were only children. The mean number of

siblings was 3.6. Thirty-nine percent (39 %, n=26) of the participants were the first born, 36% (n=24) were the middle child, 22% (n=15) were the youngest, and 3% (n=2) were only children.

Of those participants who had partners, 98% (n=43) of these partners were aware of the abuse the participants experienced as children. For 66 % (n=29) of the women, abuse was not an aspect of their current relationships; whereas 34 % (n=15) had experienced some type of abuse in their present relationship. However, 67 % (n=45) of the sample had been in an abusive relationship at some point in their adult life, while 33% (n=22) had not.

Forty-two percent (42 %, n=28) of the sample had experienced only intrafamilial abuse, 12% (n=38) had experienced only extrafamilial abuse, and forty-six percent (46 %, n=30) had experienced both extrafamilial and intrafamilial abuse.

Attributions

The participants in this study made a number of attributions for the sexual abuse they experienced as children. To determine whether participants attributed differing degrees of blame to the self, abuser, non-abusing others, society, and chance, a repeated measures analysis of variance was conducted. The analysis revealed that survivors attributed differing degrees of blame to each of the attributional sources, $F(4,236) = 45.55$, $p < .001$. As shown in Table 1, the greatest amount of blame was attributed to the abuser. Surprisingly, the least amount of blame was attributed to the overall self.

Table 1

Mean Attribution of Blame Ratings for Different Sources

Source	Blame (n=67) Mean	S.D
Over all Self-Blame	2.21	1.61
Characterological Self-Blame	3.09	2.19
Behavioral Self-Blame	2.71	2.17
Abuser	6.24	1.33
Non-Abusing Others	3.89	1.82
Society	4.11	2.12
Luck/Chance	2.90	1.99

Adjustment

To determine the adjustment levels of participants in this study, a comparison between the means obtained on each of the adjustment measures used and the "norms" for survivors of sexual abuse and for the general population, when available, was done. These results are shown in Tables 2 and 3. Since standard deviations were not provided in manuals and the published literature for these comparison means, no statistical tests could be conducted.

Table 2

SCL-90-R - Mean Adjustment Scores for the Present Study and the General Population

SCL90R Subscales	Present Study Means	Normal Means [a]	Psychiatric Outpatient Means[a]	Psychiatric Inpatient Means [a]
Somaticism	1.28	.36	.87	.99
Obsess.-Compuls.	1.69	.39	1.47	1.45
Interp. Sens.	1.54	.29	1.41	1.32
Depression	1.62	.36	1.79	1.74
Anxiety	1.30	.30	1.47	1.48
Hostility	1.26	.30	1.10	.94
Phobic Anxiety	.82	.13	.74	.96
Paranoid Ideation	1.27	.34	1.16	1.26
Psychoticism	.85	.14	.94	1.11
TOTAL	1.25	.31	1.26	1.30

[a] From *SCL-90-R® Administration, scoring and procedures manual - II* by L.R. Derogatis, 1983, Towson, MD: Clinical Psychometric Research.

Table 3

TSC-40 - Mean Adjustment Scores for the Present Study and Abused/Non-Abused Populations

TSC 40 Subscales	Present Study Means (with sd)	Sexually Abused Sample Means [a] (with sd)	Non-Sexually Abused Sample Means [a] (with sd)
Anxiety	9.05 (4.22)	4.74 (2.95)	3.80 (2.66)
Depression	11.04 (4.75)	6.98 (3.39)	5.74 (3.25)
Sleep Problems	9.89 (4.26)	5.84 (3.06)	5.03 (3.03)
Sexual Problems	8.06 (5.33)	5.02 (3.40)	3.77 (2.99)
TOTAL	44.95 (16.22)	26.02 (12.05)	20.91 (11.11)

[a] From "Studying the long-term effects of sexual abuse: The Trauma Symptom Checklist (TSC) Scales: by D.M. Elliot & J. Briere. In *Rape and sexual assault, Vol. III*, A.W. Burgess (Ed.), 1991, Garland Publishing.

Adjustment and Attributions

Self-blame. To investigate the relationship between self-blame and adjustment, participants responses on the "Why We Think Sexual Abuse Happens to Us" questionnaire, a paper and pencil measure asking them to rate their overall level of self-blame as well as their levels of characterological and behavioral self-blame was correlated with the depression and anxiety subscales on SCL-90-R and TSC40, respectively. (For a complete correlation matrix please see Appendix K.) The overall level of self-blame was significantly related to anxiety on the anxiety subscales of SCL-90-R and TSC40 ($r = .29$, $p < .05$; $r = .36$, $p < .005$, respectively). Overall self-blame showed a trend towards being associated with the depression subscale on SCL-90-R ($r = .24$, $p < .10$) but there was no

significant relationship between overall self-blame and the TSC40 depression subscale (r = .13, ns). As expected, behavioral self-blame was significantly associated with both the SCL-90-R and TSC40 depression subscales (r = .32, $p < .01$; r = .34, $p < .01$, respectively) and the SCL-90-R and TSC40 anxiety subscales (r = .30, $p < .05$; r = .39, p = .001, respectively). Characterological self-blame was also significantly related to depression (r = .28, $p < .05$; r = .38, p = .001) and anxiety (r = .32, $p < .01$; r = .40, p = .001) on both scales. These results indicate that the degree of self-blame is positively related to the degree of depression and anxiety one may experience.

To investigate the relationship between self-blame and physical adjustment, overall self-blame, characterological self-blame and behavioral self-blame were correlated with the somaticism subscale on SCL-90-R and the sleep disturbance subscale on TSC40. Overall self-blame showed a trend towards being related to somatic complaints (r = .24, $p < .10$) but was not related to any sleep disturbances (r = .11, ns). As predicted, characterological self-blame was significantly associated with both somatic complaints (r = .36, $p < .005$) and sleep disturbances (r = .29, $p < .05$). This indicates that characterological self-blame, in this sample, is associated with physical symptoms of poor adjustment. Behavioral self-blame showed a trend towards more somatic complaints (r = .23, $p < .10$) but had no significant relationship to sleep disturbances (r = .17, ns).

To investigate the relationship between self-blame and interpersonal adjustment, overall self-blame, characterological self-blame and behavioral self-blame were correlated with the interpersonal sensitivity subscale on SCL- 90-R. Overall attributions to the self also showed a trend to being positively associated with the reported number of interpersonal problems (r = .23, $p < .10$). As expected, both behavioral and

characterological self-blame showed a trend to being associated with interpersonal problems (r = .21, r = .23, p < .10, respectively).

To investigate the relationship between self-blame and sexual adjustment, overall self-blame, characterological self-blame and behavioral self-blame were correlated with the sexual problems subscale on TSC40. Correlation coefficients revealed that sexual adjustment was not significantly associated with overall self-blame (r = .01, ns), nor with behavioral or characterological self-blame (r = .16 and r = .19, p < .10, ns, respectively).

Attributions to the perpetrator. Contrary to predictions, no significant relationships were found between attributions to the perpetrator and any measure of adjustment.

Attributions to others. To investigate the relationship between attributions to non-abusing others and psychological adjustment, blaming others was correlated with anxiety and depression subscales on SCL-90-R and TSC40. Contrary to predictions, blaming others was significantly related to both the SCL-90-R and TSC40 subscales of anxiety (r = .25, p < .05; r = .30, p < .05, respectively). Also contrary to predictions, the depression subscale on TSC40 was significantly related to blaming others (r = .25, p < .05); however, there was only a weak relationship between the SCL-90-R depression subscale and blaming others (r = .23, p < .10). These results indicate that blaming others is related to anxiety and possibly depression. Attributions to others were not significantly related to measures of physical, sexual or interpersonal adjustment.

In most cases, respondents did specify which others they felt were to blame for the abuse. The most frequently mentioned others were mom, dad (when he was not the perpetrator), siblings and grandparents. Attributions to mom showed a trend towards being associated with depression, as measured by TSC40 (r = .28, p < .10). Attributions to mom

were not significantly related to any other adjustment measure. Unfortunately, only attributions to mom were reported frequently enough (n=45) to carry out analysis.

Attributions to society. To investigate the relationship between attributions to society and adjustment, correlations were computed for attributions to society and each of the adjustment measures. Attributions to society showed a trend towards being associated with somatic complaints ($r = .21$, $p < .10$) but not to any other adjustment measure.

Attributions to luck. To investigate the relationship between attributions to luck and adjustment, attributions to luck were correlated with adjustment measures on the SCL-90-R and TC40 scales. Attributing childhood sexual abuse to luck was not related at all to depression. Attributions to luck were related to TSC40 anxiety subscale ($r = .31$, $p < .05$) but not to SCL-90-R anxiety subscale. Similarly, attributions to luck were significantly related to somatic complaints ($r = .30$, $p < .05$) but not to sleep disturbances. Finally, neither sexual nor interpersonal adjustment were found to be significantly related to attributions to luck ($r = .06$, ns, and $r = .13$, ns, respectively).

Discussion

The primary purpose of this thesis was to investigate and clarify the relationship between self-blame and adjustment in a sample of adult women survivors of childhood sexual abuse. The research also sought to examine the relationship between adjustment and attributions to other sources than the self (often neglected in past research). In investigating the relationship between attributions and adjustment this research also attempted to include a broader range of measures of adjustment than the typical measures of depression and anxiety.

As a result of this research, two important observations can be made about attributions and adjustment. First, although self-blame is often considered by researchers and clinicians to be a common characteristic of survivors of childhood sexual abuse, this study found that survivors attributed significantly more blame to the abuser, non-abusing others (particularly mothers and other family members) and society than to themselves. Second, consistent with other literature (e.g., Heath et al., 1990; Hoagwood, 1990; Mueller & Major, 1989; and, Sholomskas et al., 1990) this study found that blaming attributions were either negatively related to adjustment or else were not related to adjustment at all.

Generally, self-blame was negatively related to adjustment in adult female survivors of childhood sexual abuse. Specifically, both characterological and behavioral self-blame were negatively related to measures of depression and anxiety (which are common measures used to reflect psychological adjustment or functioning). In addition, characterological self-blame was positively related to somatic complaints and sleep disturbances and tended to be negatively related to interpersonal sensitivity. Although weaker (or less statistically reliable), behavioral self-blame had a similar relationship to physical and interpersonal adjustment. Finally, self-blame of any type was not related to

the measure of sexual adjustment. These findings replicate and extend previous studies investigating the relationship between self-blame and adjustment in survivors of childhood sexual abuse and clearly do not provide any support for the notion that self-blame is functional for survivors.

Survivors in this study attributed significantly more blame to the abuser and society than to themselves. In fact, survivors attributed the greatest blame to the abuser. Although this finding is consistent with other research (e.g., Heath et al., 1990; Hoagwood, 1990; Morrow, 1991), it generally receives little attention by clinicians or researchers. It would seem that if attributions of blame to the abuser and society are stronger than those to the self, their relationship to adjustment should be equally important to investigate and understand.

It was predicted that perpetrator blame would be positively related to adjustment, but surprisingly, blaming the perpetrator for the childhood sexual abuse was not related to any kind of adjustment. This finding is contradictory to Hoagwood's (1990) finding that women who blamed their abuser were less depressed and had higher self-esteem. The results from the present study may be due to three reasons. The most obvious reason is because there really is no relationship between adjustment and blaming the perpetrator. Further, the lack of relationship between blaming the abuser and adjustment may be a result of problems with the measure. For example, most of the present sample had more than one abuser. Thus, when respondents were asked to rate to the extent to which they blamed the abuser, it is not clear if they thought of one abuser, or if they put all the abusers into one abuser category and rated them. The latter would contribute to error in the measure which would reduce the likelihood of detecting a relationship even if it exists. Another potential measurement problem relates to this measure's restricted range. Abuser-blame was the

most extreme of all the blame measures and had the smallest standard deviation. This kind of restriction in variability will make it difficult to detect a correlational relationship. Both these potential measurement problems suggest a need for better attributional measures in this kind of research. Finally, for most of this sample, it has been a significant number of years since their abuse occurred and any blame they associated with the abuser may be so far in the past that it had no effect on current adjustment. This may be because the conditions associated with the abuser that gave rise to fear, anxiety and blame no longer exist and thus no longer contribute to an individual's adjustment (Miller & Porter, 1983). This possibility again points to a need for better attributional measures that can distinguish between present and past attributions for events.

Although participants attributed more blame for their abuse to society and to non-abusing others than they did to self, these attributions did not seem to play the same role in adjustment as did self-blame attributions. In fact, attributions to society were not significantly associated with any measure of adjustment, which is consistent with other attribution studies (Frazier, 1990; Meyer & Taylor, 1986).

Interestingly, participants reported blaming non-abusing others more than they blamed themselves, and as much as blaming society. Participants blamed their mothers, non-abusing fathers, siblings and grandparents. Mothers were the family member most likely to be blamed. This study found that blame to non-abusing others was negatively related to psychological adjustment. Why would survivors of childhood sexual abuse blame non-abusing family members and why would these attributions be related adjustment problems? It is possible that as a child, a participant could have told someone, such as a mother, about the abuse and she was not believed or nothing was done to stop it. Thus, others may be blamed for allowing the abuse to continue. This may be likely given that the

most frequently mentioned others were parents, siblings and grandparents. These are all people a child believes would help and protect her and the fact that they did not could have serious psychological implications. Children may feel a lot of anger toward a parent who did not protect them from abuse. Although Hemingson & Skrypnek (1994) and Skrypnek & Hemingson (1994) found that survivors perceive their families as playing a significant role in causing or contributing to abuse, the exact role of the family has received little attention in the research.

And finally, survivors attributed about the same amount of blame for their childhood sexual abuse to bad luck/chance as they did to themselves. These attributions to chance were negatively related to some measures of adjustment and were not related to others.

Although this research found only negative or no relationships between attributions and adjustment, the reasons for these relationships remain unclear. Most research on attributions and adjustment has claimed or speculated that attributions affect adjustment and clinicians have worked to help survivors change what they believe to be unhealthy cognitions in order to improve adjustment.

How and why might attributions affect adjustment? When a negative event, such as sexual abuse, occurs it often begins a process of attempting to identify why it occurred. Individuals tend to run their lives on the basis of a variety of assumptions that help them plan, set goals, and make sense of their lives (Janoff-Bulman & Frieze, 1983). When a negative or traumatic event occurs, these assumptions are often shattered (Janoff-Bulman & Frieze, 1983; Silver et al., 1983); it destroys their sense of having control in their lives. Thus, finding a purpose or meaning for the negative event may help individuals to cope and regain control; attributions are one way individuals make sense of an event.

Weiner (1985) suggested that attributions to the self are likely to result in feelings of shame and guilt, particularly if they are also seen as uncontrollable (Weiner, 1985). Similarly, Weiner also suggested that if the negative event is attributed to a stable factor, hopelessness may result. Both types of attributions may result in poorer adjustment because they do not provide any sense of regaining control. In contrast, Weiner also suggested that attributions to external factors were likely to result in little or no relationship with adjustment. It may be that it is easier to accept that one has no control when the cause is outside of the person in question. Interestingly, this is not entirely consistent with the results of the present study. This study found that attributions to non-abusing others were significantly related to depression and anxiety.

Attributions to luck were not related to any measures of adjustment except anxiety and somatic complaints. Previous research has been inconclusive, indicating that attributions to luck or chance are associated with better adjustment (Frey et al., 1985), poor adjustment (Major, Mueller & Hildebrandt, 1985), or have no relationship at all with adjustment (Downey, Silver & Cohen, 1990; Frazier, 1990; Taylor, Lichtman & Wood, 1984). Attributing a negative event to a factor such as luck implies that there was nothing one could do to control the outcome. Feeling a loss of control over one's life may lead some individuals to experience anxiety about the outcome of future negative events. This anxiety, in turn, may manifest itself in various somatic complaints. Further, it is possible that attributions to luck or chance simply do not apply to a recurring such as sexual abuse (Silver, Boon & Stones, 1983). This may be because attributions to luck imply a sudden, unexpected event; the first time sexual abuse occurred may have been sudden or unexpected, but for most of this sample, the sexual abuse was chronic and ongoing.

Attributions to the abuser and non-abusing others may also be associated with a anger but may not lead to a deeper understanding of why abuse occurred. Interestingly, those who have been able to make some sense out of their experience, and have moved on with life, cope better than those who have found no meaning and are still searching (Silver et al., 1983). While there is evidence that many victims of negative life events do ask "Why me?" and initiate an attributional process to answer this question, we know very little about the process. Some research has speculated that initial attributions may be simple and that over time explanations for a negative event may become more complex and take in a broader perspective (Silver, Boon & Stones, 1983; Skrypnek & Hemingson, 1994). Thus, simpler attributions may include the self, the perpetrator or others, whereas more complex attributions will go beyond these towards broader factors such as family functioning or society (Hemingson & Skrypnek, 1994; Skrypnek & Hemingson, 1994). This shift from simple to complex attributions may also occur because individuals do not attribute causality of a present event to impersonal factors because this may remove a sense of control (Miller & Porter, 1980). However, over time it may not be as important to retain that control, which could result in a willingness to attribute the cause to non-controllable external factors (Miller & Porter, 1980), such as society or luck.

Some researchers have speculated that more adjustment problems seem to be associated with simple attributions (self, perpetrators) that are associated with guilt, shame and anger. More complex attributions seem to move past the anger and guilt and allow a deeper understanding of how the abuse happened and may not have the same negative implications for functioning (Hemingson & Skrypnek, 1994; Skrypnek & Hemingson, 1994).

Summary and Limitations

This study found that attributions were negatively related to adjustment and that not only were attributions related to psychological functioning but also physical and interpersonal functioning. This study found no evidence that any type of simple attribution was related to positive functioning. Specifically, no evidence that self-blame was functional for survivors or that self-blame contributed to positive adjustment was found. However, the present study had several limitations.

The first limitation of the present study was that the results were only correlational; therefore, it is not possible to infer cause and effect. While it is possible to say that various attributions may be related, either positively or negatively, to adjustment, it is not possible to say that various attributions caused subsequent adjustment problems.

A further limitation of the present study is that the sample is neither random, nor representative, therefore it is not appropriate to generalize findings to all child sexual abuse survivors. The women who volunteered to participate in the study may differ significantly from women who choose not to participate. For example, those women who did choose to participate may have more recall of the abuse they experienced. Those women who chose to participate may currently be (or have been) in therapy/counseling and they may have already dealt with a number of issues related to the sexual abuse. Consequently, findings are only generalizable to those survivors who are similar to the volunteers for the study. Unfortunately, no record was kept of the number of women who decided not to participate. This is largely due to the fact that such a large response was not expected. The researchers estimate that about one in ten chose not to participate. In addition, the data are retrospective in nature. There may be factors that intervene after the sexual abuse and before the present study. For example, the experience of being in therapy may significantly

affect women's thoughts and feelings about the abuse. Also, the data may be incomplete as many survivors of childhood sexual abuse experience loss of memory.

Clinicians and past research have suggested that childhood sexual abuse can have long-term implications for physical, psychological, sexual and interpersonal functioning. However, previous research has almost exclusively focused on psychological functioning. The present study attempted to assess adjustment in each of the four areas, yet found that this sample had significant psychological problems associated with attributions for the abuse. While this study did attempt to measure physical, sexual and interpersonal adjustment in relation to attributions, it is important to be careful about drawing any conclusions based on these simple measure of attributions. In addition, it is often not clear to what extent respondents based their ratings on past or present beliefs.

It is also necessary to point out that these areas of functioning are not mutually exclusive nor are the subscales. For example, sexual functioning had psychological, interpersonal and physical components. The TSC-40 subscale best taps the psychological aspect of sexual functioning, and to lesser extent, the physical aspect. And, for example, the anxiety subscale of the TSC-40, which was used as a measure of psychological functioning, clearly includes a physical component.

Just as the subscales used were not mutually exclusive, they were not as comprehensive as they could have been. For instance, there were only two subscales used to measure physical adjustment; furthermore, somatic complaints and sleep disturbances represent only a fraction of the physical problems a participant may have been experiencing. Similarly, only one subscale each was used to measure sexual and interpersonal adjustment. This poses a problem as these subscales may not have been sensitive enough to capture important aspects of these constructs. Although these are not

perfect, nor comprehensive, measures of all areas of functioning, the goal was to assess functioning in a broader manner than in previous research and in a manner that would better reflect the scope of functioning affected by childhood sexual abuse.

In order to further understand the relationship between attributions and adjustment, future research needs to incorporate the following:

a. more qualitative research (like Skrypnek & Hemingson, 1994) needs to assess what kinds of attributions survivors make spontaneously;
b. better attributional measures that can assess how attributions change over time and can measure simple and complex attributions and which can differentiate between casual, responsibility and blaming attributions;
c. studies which include broader and better measures of functioning;
d. develop theory which clarifies the underlying processes linking attributions and adjustment;
e. investigate whether there is a causal relationship between attributions and adjustment and investigate how altering attributions may impact on adjustment;
f. if attributions are found to be causally related to adjustment, then there is a need to investigate the role therapy may play in facilitating a survivor's attributional process towards those attributions related to more positive functioning; and,
g. investigate survivors' perceptions of the role of the family in contributing to or causing the abuse, and the effect of blaming the family for the abuse.

Conclusions

The results of the present research suggest that both behavioral and characterological self-blame are associated with psychological dysfunction and poor coping. Thus, clinicians should take care in discussing self-blame in therapeutic situations with survivors of childhood sexual abuse. Such discussions may have maladaptive effects. Finally, because child sexual abuse has such long-reaching, often devastating effects on the functioning of adult survivors, it is important that research in this area continues in order to help us understand which factors contribute to positive adjustment and functioning.

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APPENDIX A

ADVERTISEMENT IN THE EDMONTON EXAMINER

STUDY ON CHILDHOOD SEXUAL ABUSE

University of Alberta Being conducted to examine women's thoughts and feelings. If you were sexually abused when you were under 18 years and would like to participate in this research call Devona or Amanda at 492-5303.

APPENDIX B

PUBLIC SERVICE ANNOUNCEMENT BROADCAST ON LOCAL RADIO AND TELEVISION STATIONS

Researchers at the University of Alberta are conducting a study with adult women who were sexually abused as children. They are interested in learning about women's thoughts, feelings, and problems in connection to their experiences of childhood sexual abuse. If you were sexually abused when you were under 18 years and would like to participate in this research, please call Devona or Amanda at 492-5303.

APPENDIX C

QUESTIONNAIRE

Why We Think Sexual Abuse Happened to Us

The Why We Think Sexual Abuse Happens to Us Questionnaire

The following questions ask you to consider a number of possible reasons why you might think that you were sexually abused as a child. A number of these may apply to you, or none of these may apply to you.

Two steps are required in order to answer the questions. First of all, for each factor consider whether you think that factor is a reason or explanation for "WHY" you were sexually abused as a child. Secondly, rate the extent to which you think the factor was the reason for "Why" the sexual abuse occurred by circling the number along the scale which best describes how you feel.

1. To what extent do you think each of the following factors are reasons as to why you were sexually abused as a child? (Circle the number which best reflects how much you blame that factor for the sexual abuse).

	do not blame at all						completely blame
a. Self	1	2	3	4	5	6	7
b. Abuser	1	2	3	4	5	6	7
c. Society	1		3	4	5	6	7
d. Chance/ Bad Luck	1	2		4	5	6	7
e. Other people. (These are people other than your abuser who you think are to blame.)	1	2	3	4	5	6	7
f. If you did rate "other people" any number other than 1, then please indicate who these other people are and rate each person separately as to the extent you blame them (e.g., my grandfather).							
_____	1	2	3	4	5	6	7
_____	1	2	3	4	5	6	7
_____	1	2	3	4	5	6	7
_____	1	2	3	4	5	6	7
_____	1	2	3	4	5	6	7

2. To what extent do you blame your childhood sexual abuse on something about your behavior, (e.g., what you did or did not do or how you acted)? (Circle the number which best corresponds to how you feel).

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

3. To what extent do you blame your childhood sexual abuse on the type of person you are or were as a child. (e.g. personality, moral character, traits, etc.)? (Circle the number which best corresponds to how you feel).

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

APPENDIX D

QUESTIONNAIRE

TSC-40

TSC-40

Please indicate how often you have experienced the following in the last two months

		Never	Occasionally	Fairly often	Very often
1)	Headaches	0	1	2	3
2)	Insomnia (trouble getting to sleep)	0	1	2	3
3)	Weight loss (without dieting)	0	1	2	3
4)	Stomach problems	0	1	2	3
5)	Sexual problems	0	1	2	3
6)	Feeling isolated from others	0	1	2	3
7)	"Flashbacks" (sudden, vivid, distracting memories)	0	1	2	3
8)	Restless sleep	0	1	2	3
9)	Low sex drive	0	1	2	3
10)	Anxiety attacks	0	1	2	3
11)	Sexual overactivity	0	1	2	3
12)	Loneliness	0	1	2	3
13)	Nightmares	0	1	2	3
14)	"Spacing out" (going away in your mind)	0	1	2	3
15)	Sadness	0	1	2	3
16)	Dizziness	0	1	2	3
17)	Not feeling satisfied with your sex life	0	1	2	3
18)	Trouble controlling temper	0	1	2	3
19)	Waking up early in the morning and can't get back to sleep	0	1	2	3
20)	Uncontrollable crying	0	1	2	3
21)	Fear of men	0	1	2	3
22)	Not feeling rested in the morning	0	1	2	3
23)	Having sex that you didn't enjoy	0	1	2	3
24)	Trouble getting along with others	0	1	2	3
25)	Memory problems	0	1	2	3

		Never	Occasionally	Fairly often	Very often
26)	Desire to physically hurt yourself	0	1	2	3
27)	Fear of women	0	1	2	3
28)	Waking up in the middle of the night	0	1	2	3
29)	Bad thoughts or feelings during sex	0	1	2	3
30)	Passing out	0	1	2	3
31)	Feelings that things are "unreal"	0	1	2	3
32)	Unnecessary or over-frequent washing	0	1	2	3
33)	Feelings of inferiority	0	1	2	3
34)	Feeling tense all the time	0	1	2	3
35)	Being confused about your sexual feelings	0	1	2	3
36)	Desire to physically hurt others	0	1	2	3
37)	Feelings of guilt	0	1	2	3
38)	Feelings that you are not always in your body	0	1	2	3
39)	Having trouble breathing	0	1	2	3
40)	Sexual feelings when you shouldn't have them	0	1	2	3

APPENDIX E

QUESTIONNAIRE

SCL-90-R

SCL—90—R®

SIDE 1

INSTRUCTIONS:

Below is a list of problems people sometimes have. Please read each one carefully, and circle the number to the right that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example below before beginning, and if you have any questions please ask about them.

SEX

( ) MALE

( ) FEMALE

NAME

LOCATION

EDUCATION

MARITAL STATUS MAR SEP DIV WID SING

DATE MO DAY YEAR

ID. NUMBER

AGE

VISIT NUMBER

EXAMPLE HOW MUCH WERE YOU DISTRESSED BY:	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Bodyaches	0	1	2	(3)	4

HOW MUCH WERE YOU DISTRESSED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Headaches	1	0	1	2	3	4
2. Nervousness or shakiness inside	2	0	1	2	3	4
3. Repeated unpleasant thoughts that won't leave your mind	3	0	1	2	3	4
4. Faintness or dizziness	4	0	1	2	3	4
5. Loss of sexual interest or pleasure	5	0	1	2	3	4
6. Feeling critical of others	6	0	1	2	3	4
7. The idea that someone else can control your thoughts	7	0	1	2	3	4
8. Feeling others are to blame for most of your troubles	8	0	1	2	3	4
9. Trouble remembering things	9	0	1	2	3	4
10. Worried about sloppiness or carelessness	10	0	1	2	3	4
11. Feeling easily annoyed or irritated	11	0	1	2	3	4
12. Pains in heart or chest	12	0	1	2	3	4
13. Feeling afraid in open spaces or on the streets	13	0	1	2	3	4
14. Feeling low in energy or slowed down	14	0	1	2	3	4
15. Thoughts of ending your life	15	0	1	2	3	4
16. Hearing voices that other people do not hear	16	0	1	2	3	4
17. Trembling	17	0	1	2	3	4
18. Feeling that most people cannot be trusted	18	0	1	2	3	4
19. Poor appetite	19	0	1	2	3	4
20. Crying easily	20	0	1	2	3	4
21. Feeling shy or uneasy with the opposite sex	21	0	1	2	3	4
22. Feelings of being trapped or caught	22	0	1	2	3	4
23. Suddenly scared for no reason	23	0	1	2	3	4
24. Temper outbursts that you could not control	24	0	1	2	3	4
25. Feeling afraid to go out of your house alone	25	0	1	2	3	4
26. Blaming yourself for things	26	0	1	2	3	4
27. Pains in lower back	27	0	1	2	3	4
28. Feeling blocked in getting things done	28	0	1	2	3	4
29. Feeling lonely	29	0	1	2	3	4
30. Feeling blue	30	0	1	2	3	4
31. Worrying too much about things	31	0	1	2	3	4
32. Feeling no interest in things	32	0	1	2	3	4
33. Feeling fearful	33	0	1	2	3	4
34. Your feelings being easily hurt	34	0	1	2	3	4
35. Other people being aware of your private thoughts	35	0	1	2	3	4

Please continue on the following page ▶

SCL--90--R

SIDE 2

	HOW MUCH WERE YOU DISTRESSED BY		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
36	Feeling others do not understand you or are unsympathetic	36	0	1	2	3	4
37	Feeling that people are unfriendly or dislike you	37	0	1	2	3	4
38	Having to do things very slowly to insure correctness	38	0	1	2	3	4
39.	Heart pounding or racing	39	0	1	2	3	4
40	Nausea or upset stomach	40	0	1	2	3	4
41.	Feeling inferior to others	41	0	1	2	3	4
42.	Soreness of your muscles	42	0	1	2	3	4
43.	Feeling that you are watched or talked about by others	43	0	1	2	3	4
44.	Trouble falling asleep	44	0	1	2	3	4
45.	Having to check and double-check what you do	45	0	1	2	3	4
46.	Difficulty making decisions	46	0	1	2	3	4
47.	Feeling afraid to travel on buses, subways, or trains	47	0	1	2	3	4
48	Trouble getting your breath	48	0	1	2	3	4
49.	Hot or cold spells	49	0	1	2	3	4
50.	Having to avoid certain things, places, or activities because they frighten you	50	0	1	2	3	4
51.	Your mind going blank	51	0	1	2	3	4
52.	Numbness or tingling in parts of your body	52	0	1	2	3	4
53.	A lump in your throat	53	0	1	2	3	4
54.	Feeling hopeless about the future	54	0	1	2	3	4
55.	Trouble concentrating	55	0	1	2	3	4
56.	Feeling weak in parts of your body	56	0	1	2	3	4
57.	Feeling tense or keyed up	57	0	1	2	3	4
58.	Heavy feelings in your arms or legs	58	0	1	2	3	4
59.	Thoughts of death or dying	59	0	1	2	3	4
60.	Overeating	60	0	1	2	3	4
61.	Feeling uneasy when people are watching or talking about you	61	0	1	2	3	4
62.	Having thoughts that are not your own	62	0	1	2	3	4
63.	Having urges to beat, injure, or harm someone	63	0	1	2	3	4
64.	Awakening in the early morning	64	0	1	2	3	4
65.	Having to repeat the same actions such as touching, counting, or washing	65	0	1	2	3	4
66.	Sleep that is restless or disturbed	66	0	1	2	3	4
67.	Having urges to break or smash things	67	0	1	2	3	4
68.	Having ideas or beliefs that others do not share	68	0	1	2	3	4
69.	Feeling very self-conscious with others	69	0	1	2	3	4
70.	Feeling uneasy in crowds, such as shopping or at a movie	70	0	1	2	3	4
71.	Feeling everything is an effort	71	0	1	2	3	4
72.	Spells of terror or panic	72	0	1	2	3	4
73.	Feeling uncomfortable about eating or drinking in public	73	0	1	2	3	4
74.	Getting into frequent arguments	74	0	1	2	3	4
75.	Feeling nervous when you are left alone	75	0	1	2	3	4
76.	Others not giving you proper credit for your achievements	76	0	1	2	3	4
77.	Feeling lonely even when you are with people	77	0	1	2	3	4
78.	Feeling so restless you couldn't sit still	78	0	1	2	3	4
79.	Feelings of worthlessness	79	0	1	2	3	4
80.	The feeling that something bad is going to happen to you	80	0	1	2	3	4
81.	Shouting or throwing things	81	0	1	2	3	4
82.	Feeling afraid you will faint in public	82	0	1	2	3	4
83.	Feeling that people will take advantage of you if you let them	83	0	1	2	3	4
84.	Having thoughts about sex that bother you a lot	84	0	1	2	3	4
85.	The idea that you should be punished for your sins	85	0	1	2	3	4
86.	Thoughts and images of a frightening nature	86	0	1	2	3	4
87.	The idea that something serious is wrong with your body	87	0	1	2	3	4
88	Never feeling close to another person	88	0	1	2	3	4
89.	Feelings of guilt	89	0	1	2	3	4
90.	The idea that something is wrong with your mind	90	0	1	2	3	4

APPENDIX F

CONSENT FORM INFORMATION SHEET

CONSENT FORM INFORMATION

Title: Thoughts, Feelings and Problems Related to Childhood Sexual Abuse

Investigators: Dr. Berna Skrypnek, Ph.D. (492-0192)
Devona Gibson, B.A. (492-5303)
Amanda Gibson, B.A. (492-5303)

Purpose: We are interested in learning about the relationship between women's thoughts, feelings and problems in connection to their experiences of childhood sexual abuse.

Procedure: The study involves one session, which will consist of an interview and paper and pencil questionnaires. The interview will probably take about 1 to 1½ hours to complete. There are four paper and pencil questionnaires that take approximately 30 to 40 minutes to complete. The interview will be conducted in an office at the University of Alberta. If this is not comfortable or convenient for you an alternative location will be arranged.

Possible Side Effects: The interview asks you about the nature and extent of the childhood sexual abuse and this may be upsetting for you to recall. You will be treated with sensitivity and respect; therefore, if the interview becomes too upsetting we will stop.

Confidentiality: With your permission the interviews will be audio-taped. The tapes will be transcribed. After typing the tapes, the tapes will be destroyed. All names and any other information that might identify you will be deleted from the transcripts. Data from the questionnaires you complete will be entered into a computer using an identification number. The data analysis will **not** reflect the individual identities of participants.

Time Commitment: The study will require approximately two hours of your time.

Withdrawal: **As your participation is completely voluntary, you may withdraw from this study at any time without prejudice.**

Research Results: You may write or phone us for a copy of the research results. The address is: Dr. Berna Skrypnek
3-38 Assiniboia Hall
Department of Human Ecology
University of Alberta
Edmonton, Alberta T6G 2E7 Telephone: 492-0192 or 492-5303

APPENDIX G

CONSENT FORM

CONSENT FORM

I acknowledge that the nature of this study has been described to me and that any questions that I may have asked were answered to my satisfaction. I have been provided with an information sheet on the study and have read it. I understand that I am being asked to participate in one interview which will be taped (if I give my permission) and to complete four paper and pencil questionnaires. I understand that the interview and questionnaires will require about 2 hours to complete in total. I understand that the interview and questionnaires will be completed at the University of Alberta, or some other location, at my convenience. I have been assured that my responses during the interview and my responses on the questionnaires will be kept completely confidential.

I understand that I may keep a copy of the information sheet and this consent form, and I know that should I have more questions at any time, I may contact any one of the people involved in the research:

_____ _____

Signature of Participant Signature of Researcher

_____

Date

APPENDIX H

INTERVIEW SCHEDULE

CHILDHOOD SEXUAL ABUSE INTERVIEW SCHEDULE

(These questions are to be read by the interviewer during the interview.)

The first part of the study is an interview. The interview will begin with some very general questions about you and your background (like age, your family, employment, etc.) and then will move on to questions about the sexual abuse you experienced as a child.

With your permission, I would like to tape the interview as this allows me to obtain the most accurate information and I don't have to be distracted by taking detailed notes. Is this OK?

(If at any point you want me to turn it off, just let me know.) Do you have any questions?

I am turning on the tape recorder now. Let's begin the interview!

DEMOGRAPHICS

First, can you tell me something about yourself? When you were born? Where you grew up?

1. Date of birth? _____/_____/_____
   day / month / year

2. Where were you born? _____
   town, province, country

3. Where did you grow up? _____
   town, province, country

4. Did you live with your parents when you were growing up?
   _____ Father
   _____ Mother
   _____ Other (specify _____)

5. What kind of work did your father do when you were growing up? _____

   What about your mom? Was she a stay-home mom or did she work outside the home? (Part-time/full-time) _____

6. Do you have any brothers and sisters?

_____ Yes Can you tell me a little bit about them? How many and what are their ages? (note gender and age)

_____ ___ _____ ___
_____ ___ _____ ___
_____ ___ _____ ___

_____ No

7. Tell me about the schooling you've had. (Record the highest level.)

_____ Grade 6 or less
_____ Grade 7 - 9
_____ Grade 10 or 11
_____ Grade 12
_____ Other _____

_____ Some technical/trade school/certificate
_____ Some college/college diploma
_____ Some university
_____ Bachelor's degree
_____ Master's degree
_____ Doctoral degree
_____ Professional degree (MD, DDS, LLB)

8. Did religion play a role in your family when you were gro·.ing up?

_____ Yes How important a role would you say religion played in your family when you were growing up?

_____ extremely important
_____ very important
_____ ·erately important
_____ ·what important
_____ t all important
_____ r religious affiliation when you were

_____ N

9. Do you ha· volvement that plays a role in your life today?

_____ Yes ..nation or describe faith _____
_____ No

10. Tell me about any paid or unpaid work you do.
(Check as many as applies. Probe as necessary).
Are you a part-time or full-time student?
Are you on unemployment or social assistance, etc.?

____ Employed full-time
What type of job do you have? _____ sales clerk, steno, banker, etc

How long have you had your job? _____ specify whether weeks, months, years

____ Employed part-time
What type of job do you have? _____ sales clerk, steno, banker, etc.
How long have you had your job? _____ specify whether weeks, months, years

_____ Full-time student
Program of study? _____
Institution? _____

_____ Part-time student
Program of study? _____
Institution? _____

_____ Full-time homemaker
Have you ever worked outside the home? _____
When did you last work outside the home? (date last day worked?) _____
What type of job did you have? _____

_____ Unemployed, not looking for work
When did you last work? (date last day worked?) _____
What type of job did you have? _____

_____ Unemployed, looking for work
When did you last work? (date last day worked?) _____
What type of job did you have? _____

_____ Retired
When/date? _____
What type of job did you have? _____

_____ Social assistance

____ Other, please specify ___

11. Now, I'd like to ask you a few questions about your marital status and living situation.

What is your current marital status?
_____ Single, never married
Are you currently in a relationship? _____ Yes _____ No
Do you live alone? _____ Yes
_____ No With whom do you live? _____

If not currently living with parents, ask

How old were you wh ou first left your parents' home? _____

___ Married

Is this your first marriage?

Yes

No How many times have you been married?_____

How old were you when you were married (**for the first time**)? _____

How old were you when you first left your parents' home? _____

_____ Common law/cohabiting

Is this the first partner with whom you've lived common law?

_____ Yes

No With how many partners have you lived? _____

How old were you when you first lived common law? _____

How old were you when you first left your parents' home? _____

_____ Separated

Was this your first marriage?

_____ Yes

_____ No How many times have you been married?_____

How old were you when you were married (**for the first time**)? _____

How old were you when you first left your parents' home? _____

_____ Divorced

Was this your first marriage?

_____ Yes

_____ No How many times have you been married?_____

How old were you when you were married (**for the first time**)? _____

How old were you when you first left your parents' home? _____

_____ Widowed

Was this your first marriage?

_____ Yes

_____ No How many times have you been married?_____

How old were you when you were married (**for the first time**)? _____

How old were you when you first left your parents' home? _____

12. Do you have any children?

_____ Yes _____ No

If YES, how many _____

Are they boys or girls? _____ girls _____ boys

How old are each of your children? Start with the age of the eldest child.

Child 1 - _____ yrs	Child 6 - _____ yrs
Child 2 - _____ yrs	Child 7 - _____ yrs
Child 3 - _____ yrs	Child 8 - _____ yrs
Child 4 - _____ yrs	Child 9 - _____ yrs
Child 5 - _____ yrs	Child 10 - _____ yrs

FOR THOSE CURRENTLY IN A RELATIONSHIP, answer questions 13-15.
For those NOT currently in a relationship, SKIP to question 16.

13. Tell me about your current relationship. What's it like [Probe: Can you tell me how you communicate? How are your needs met in your relationship?]

14. Does your partner know that you were sexually abused as a child?
_____ Yes _____ No

15. Has this relationship ever been abusive in any way (**check all that apply**)

____ No
____ Physically abusive
____ Sexually abusive (pushed or pressured into sex psychologically or physically)
____Emotionally abusive (constant criticisms/put downs, name-calling, controlled, punished)

Now I'd like to ask you some general questions about your experiences since you've turned 18.

16. As an adult (since turning 18 years old), have you ever been sexually assaulted (by someone you know or a stranger)?
_____ Yes How many times? _____
_____ No

17. As an adult (since turning 18 years old), have you ever been sexually harassed?
_____ Yes How many times? _____
_____ No

18. In the past, as an adult (not considering your current relationship), have you ever been in a relationship that was abusive in any way?
_____ No
_____ Physically abusive
_____ Sexually abusive (pushed or pressured into sex psychologically or physically)
_____ Emotionally abusive (constant criticisms/put downs/name-calling/controlled/punished)

CHILDHOOD SEXUAL ABUSE

Now we are going to switch the focus and concentrate on the sexual abuse you experienced as a child. Some women find it difficult and upsetting to talk about, whereas others don't. I think that it takes a lot of courage to discuss these childhood experiences, and if at any point you wish to stop the interview or if you want the tape recorder turned off, just let me know.

If you are ready, can you tell me about the sexual abuse you experienced as a child?

Probe to find out:

1. PERPETRATOR
   - Can you remember who it was?
   - What was the perpetrator's age?
   - How is the perpetrator related to you? (father, cousin, friend, stranger, baby-sitter, mailman, etc.)

2. VICTIM
   - Do you remember when it first started? How old were you?
   - Do you remember how old you were when it ended?

3. SEXUAL ABUSE
   - Can you tell me what the perpetrator did?
     (PROBE: did intercourse occur? was respondent forced to do anything? etc.)
   - Can you remember how often the abuse occurred?
     - was it once a month?
     - once a week?
     - twice a month?
     - twice a week?
     - other?

- Did you ever receive any special favors, material things, or even better treatment from the perpetrator for being abused?

- Were you ever threatened in any form by the abuser?

4. DISCLOSURE

1. As a child (before the age of 18), did you ever tell or try to let someone know about the abuse you experienced either by directly telling someone or indirectly trying to let someone know?

If the respondent answers "no", then:

N1. You are like so many survivors who never tell as children. Children can have many reasons for not telling. Can you think back and recall some of the reasons why you didn't tell as a child?

(Probe) As a child, can you remember what you were thinking or feeling about the abuse experience and how these thoughts and feelings might have kept you from telling? (If repression took place, probe as appropriate.)

If respondent reports confusion about thoughts and feelings, say: "Sexual abuse can be a very confusing experience. Many people report difficulty in sorting out their thoughts and feelings about what happened. As, a child, did you feel so confused about what had happened that you didn't know how to tell?"

a. As a child, how did you think others would react if you told?

b. Were you afraid that telling would negatively affect you or those around you in some way?

c. Sometimes children are afraid that they won't be believed. Were you afraid that you might not be believed?

d. Were you afraid that you might be blamed in some way for the abuse?

e. Were you afraid that you might be seen differently or treated differently if you disclosed the abuse? (Were you afraid that you might be seen as bad or dirty because of the abuse? Were you afraid that you might not be loved as much because of the abuse?)

If respondent answers "yes", then:

Y1. Can you tell me about the first time that you told, or tried to let someone know about the abuse?

Y2. Whom did you tell (try to tell)?

Y3. When did you tell? (Probe to find out how long after the first incident occurred before the respondent told/tried to tell. Probe to find out if disclosure took place while the abuse was ongoing or how long after the last incident if the abuse ceased prior to disclosure)

Y4. How did you go about telling (trying to tell)? What did you do or say?

Y5. Were there any factors that influenced your decision to tell and/or choice of confidante?

Y6. Did you have any thoughts regarding what you hoped would or would not happen as a result of telling (trying to tell)?

Y7. What was _____'s reaction to your disclosure? Do you remember anything that s/he did or said?

a. Did you feel that you were believed by _____? Did s/he do or say anything that led you
to feel that you were believed?

b. Did _____ do or say anything that indicated that s/he blamed anyone for the abuse?

c. Did you ever feel that _____ blamed you in any way for what happened?

d. Do you remember what actions, if any were taken by _____ to protect you from further abuse?

e. Do you remember anything else that was done at the time to help you or support you after you told (e.g., counseling)?

f. Do you feel that _____ was emotionally supportive after you told (warm, accepting, cold, rejecting, etc.)? Why or why not?

Y8. How did telling (trying to tell) _____and his/her reaction to your disclosure make you feel?

Y9. After telling (trying to tell), was there ever a time when you wished you hadn't told? Or were particularly glad that you had told? (Ask for explanation. Why?)

Repeat for each attempt at disclosure.

2. As an adult, have you ever told or tried to let someone know about the childhood abuse you experienced either by directly telling someone or indirectly trying to let someone know?

If respondent answers "no", then:
N1. This interview must be a pretty big step for you to take. I want to thank you for being willing to talk with me. It takes a lot of courage to be able to share something so personal. We really think that this is important research and what you share will help us. Can you tell me a bit about your reasons for not telling since becoming an adult? Are these different or the same as your childhood reasons?

If respondent answers "yes", then (for the first and any other significant disclosure experience):
Y1. Do you remember the first time that you told or tried to tell someone as an adult?

Y2. Whom did you tell (try to tell)?

Y3. How did you go about telling (trying to tell)? (What did you do or say?)
Y4. Why did you decide to tell _____? (Probe: Were there any changes in you or your circumstances that enabled you to disclose now)

Y5. How did telling _____ make you feel (e.g. relieved, stronger, ashamed. anxious, etc.)?

Y6. What did you hope would happen when you told _____?

Y7. What was_____'s reaction to being told? Do you remember what s/he did or said?

(specifically)

a. Did you know that _____ believed you? (Did _____ do or say anything that led you to feel you were believed?)

b. Did _____ do or say anything that indicated that s/he blamed anyone for the abuse?

c. Did you ever feel that _____ blamed you in any way for what happened?

d. Do you feel that _____ was emotionally supportive after you told? Why or why not?

e. Do you remember anything else that was done or said at the time to support you (e.g.. encouraged to seek counseling, etc.)

Y8. How did _____ ____'s reaction make you feel (e.g., bad/good, loved, accepted/rejected)?

Y9. After telling (trying to tell) as an adult, has there ever been a time when you wished that you hadn't told? Or, were particularly glad that you had told? (Ask for explanation. Why?)

REPRESSION

- Did you ever forget parts of the abuse or total parts of the abuse?

- Did you have total recall of the abuse?

- Do you remember all of the abuse?

DISSOCIATION

- Do you remember how you coped with the sexual abuse as it occurred to you?

5. Did you ever need to see a doctor or were you ever hospitalized as a result of being abused as a child? _____ Yes _____ No (If yes, please ask respondent to explain.)

What happened? _____

_____

_____

_____

6. Do you remember anything else that happened in your childhood or adolescence that related to sexual abuse? Anything at all that made you feel uncomfortable?

_____

_____

_____

Thank you for telling me this. It takes a lot of courage to talk about these experiences in your childhood. (ASK RESPONDENT IF SHE WOULD LIKE TO TAKE A BREAK BEFORE YOU PROCEED.) If it is OK, I'd like to move on and now ask you some questions about how you thought about the abuse as a child and how you think about it now.

WHY WE THINK SEXUAL ABUSE OCCURRED

This part of the interview will ask you to consider why you think the abuse occurred. If possible, I would like you to tell me about your thoughts and feelings on why the abuse occurred.

1. When something happens to us, like sexual abuse, we often ask ourselves "WHY" or "WHY DID THIS HAPPEN TO ME?" or "WHY ME?"

   Have you ever asked yourself 'WHY DID THIS SEXUAL ABUSE HAPPEN TO ME?"

   ____ Yes

   ____ No

2. As you look back now and think about your experience of being sexually abused as a child, why do you think it happened? (If only one reason is given, probe for other reasons.)

_____

_____

_____

_____

3. Do you remember whether, as a child, you asked the question "Why me?" "Why is this happening to me?" Yes Or No

   Do you remember any reasons why you thought the sexual abuse was happening when you were still a child?

_____

_____

4. As you reflect on reasons why the abuse occurred, have your thoughts changed over time? [Probe: Describe how they have changed? When did the way you think about the abuse change? What contributed to these changes?]

---

5. Many women mention that at times they have blamed themselves. Have you ever blamed yourself?

Notes to Interviewer: Probe to get clarification about the reasons participants spontaneously share in response to above questions. If participants only offer one reason, ask if there are other reasons why they think the abuse happened to them, **but** do **not** lead them to reasons that they do not spontaneously mention.

Thank you for talking about reasons why you think you were abused. Now I would like to ask you some questions about your healing.

HEALING PROCESS

1. In what ways do you think that your experience of being sexually abused affected your life growing up? (i.e. in terms of self-esteem, friendships, relationships with family members, school, sports, puberty, development of sexuality, etc.)

2. In what ways do you think that your experience of being sexually abused affects your life now? (i.e. in terms of self-esteem, relationships with partners/other family members/children, work, health, leisure activities, etc.)

3. At what point do you feel that you are in your healing process?

4. What has contributed to your healing? (i.e. experiences, people, events, etc.)

   Probe about nonprofessional contributions to healing
   - friends
   - partners
   - children
   - self-help groups
   - special experiences
   - turning points, etc.

5. Have you ever sought counseling or therapy?

____ No

If no, have you ever wanted to seek therapy but did not?

_____ Yes Why not? _____

_____ No

5. Have you ever sought counseling or therapy?

_____ Yes

If yes, can you tell me that therapy has been like for you?

Probes

1. How old were you when you first sought counseling? ____ years old

2. Do you remember why you first sought counseling? (any particular event that precipitated seeking counseling)

_____

3. How was this experience for you? _____

_____

_____

4. Have you seen more than one therapist?

_____ Yes How many _____

_____ No

What happened to make you seek out someone else?

_____

_____

5. Are you currently in therapy/counseling?

_____ Yes How often do you go?

_____ daily
_____ more than once per week
_____ weekly
_____ every two weeks
_____ monthly
_____ only occasionally as needed

_____ No

6. What was happening to make you seek counseling this current time?

_____

_____

6. We have talked about where you are at in your healing and about some of the experiences or people who have contributed to your healing. **Where do you want to go from here in terms of continuing your process or journey of healing? What do you want to have happen?**

OTHER GENERAL COMMENTS

Is there anything else in regards to the sexual abuse that would be helpful in understanding the abuse? Are there important things that I should have asked but didn't? For example, things about your childhood or you now? Do you have any questions that you would like to ask me at this time?

AGAIN, THANK RESPONDENT FOR PARTICIPATING THE INTERVIEW PORTION OF THE STUDY!

Proceed to instructions for Part 2

Debriefing Form

Now that you have completed the interview and questionnaires, I would like to provide you with some further information about our study and ask you about your reactions to the study.

Research and clinical practice with survivors has indicated that a number of factors are related to adjustment later in life, and in this study we asked you about a number of these factors. The type of sexual abuse (for example, whether or not intercourse occurred) has been found to affect adult adjustment. Overall, it appears that those survivors who experienced intercourse have more problems as an adult. In addition, the survivor's relationship to the offender has been found to affect adjustment. In general, the closer the relationship between the offender and the survivor, the more significant the impact is. Also, survivors often make statement of self-blame about the sexual abuse they experienced as a child. Some experts believe that any type of self-blame is related to more problems as an adult. However, other experts disagree and say that some types of self-blame may actually aid adjustment late in life. Finally, whether or not the survivor disclosed about the abuse, and the reaction of others to this disclosure has also been found to affect adjustment as an adult.

Do you feel like some of the factors have affected you? (PROBE: Has any one factor been more significant in how you feel abut the abuse you experienced?)

I would also like to ask you if the questionnaires you just filled made sense to you? Or, were there some questions that you thought id not make sense at all?

How did you find the experience of participating in this research? Did you find the experience helpful? In what ways? Was the experience disturbing for you in any way? Many women may find that it brings up painful memories, and we have therefore provided a list of resources for you in case you do need to talk to someone about this (Provide interviewee with resource list).

Were there any questions you expected to be asked, but that I did not ask?

Is there anything else you would like to tell me about?

Do you have any final questions?

I would like to provide you with an information sheet in case you have any questions about our study at a later date. If you would like the results of the study, please contact any of us at the numbers provided . (ve information sheet)

I would like to thank you for your participation in our research. It was very courageous of you and the knowledge we have gained will help other survivors.

APPENDIX I

FINAL INFORMATION SHEET

FINAL INFORMATION SHEET

I want to thank-you for your participation in this research. It is appreciated as I know how valuable time is. In addition, the research would not have been possible without your help. So thank-you for the gift of your time and your experience.

If you would like the results of this research please feel free to contact me or:

Dr. Berna Skrypnek
3-38 Assiniboia Hall
Department of Human Ecology
University of Alberta
Edmonton, Alberta
T6G 2E7

Sexual abuse experienced as a child may leave one with many questions, thoughts or feelings. It can have an impact on the quality of one's relationships in a significant manner. In any event no matter how you have experienced the sexual abuse, if you feel the need to explore any issue in a supportive context, then there are a number of agencies which provide professional and supportive counseling services.

APPENDIX J

RESOURCE LIST

RESOURCE LIST

Sexual Assault Center
#400, 9939 Jasper Avenue
Edmonton, Alberta
423-4102
Services:
1. **Crisis Line**- Offers 24 hour service for survivors or for those who have been assaulted in the past or present. Call 423-4121
2. **Counseling Services**- Individual counseling services for those in crisis. Call for an appointment.
3. **Group Therapy**- Offers a series of counseling groups on a short-term basis. For example, a group will run once a week for a duration of 8 weeks.

The Support Network
#302, 11456 Jasper Avenue
Edmonton, Alberta
482-0198
Services: Provides a variety of services for the general public which include personal counseling, family counseling and self-help group directory; Directory of Community Services, Suicide Prevention and Bereavement Services; and volunteer training for distress line.

Distress Line
Edmonton, Alberta
482-435
Services: Offer 24 hour supportive listening for those who need it. Staff are trained to be effective listeners and how to deal with crisis situations. Access to the Mobile Mental Health Crisis Team.

Catholic Social Services
8815-99 Street
Edmonton, Alberta
432-1137
Services: Offers counseling services to survivors as well as intensive weekend workshops for women who have experienced sexual assault. Also offers survivors therapy groups.

U of A Sexual Assault Center
040J Student's Union Building
University of Alberta
492-9771
Services: Provides crisis intervention; short-term support and assistance; assistance through-out healing process; and referrals for long-term assistance for adult survivors, acquaintance and stranger assault and dating violence.

RESOURCE LIST (continued)

Sara - Sexual Assault Recovery Anonymous
Contact: Lynn at 496-5866
This is a mutual aid/self-help group for survivors of sexual abuse. The group meets weekly, and deals with topics related to the impacts of abuse.

Community Service Referral Line
Phone: *482-4636*
This service provides information and referral to over 3,000 community agencies.

The Family Center
9912-106 Street, Edmonton, Alberta
423-2831
Services: Offers individual and group therapy for survivors; trained therapists work on a sliding scale.

U of A Student Counseling Services
225 Athabasca Hall
University of Alberta
492-5205
Services: Offers individual counseling, as well as groups for survivors.

Private Therapists
There are a number of therapists who are skilled in counseling women who have experienced sexual assault. The Sexual Assault Center has compiled a list of qualified therapists. Therapists will differ in their fees and approaches. For further information about therapists skilled in dealing with sexual assault, contact the Sexual Assault Center at 423-4102.

APPENDIX K

CORRELATION MATRICES

	ATTBB	ATTCB	ATTSELF	SCL90DEP	SCL90ANX	SCL90INT	SCL90SOM
ATTribution Behavioral Blame	1.0000 (66) p=						
ATTribution Characterolo gical Blame	.5765 (66) p= .000	1.0000 (66) p=					
ATTribution to SELF	.6695 ** (64) p= .000	.4589 ** (64) p= .000	1.0000 (65) p=				
SCL90 DEPpression	.3225 ** (66) p= .008	.2797 * (66) p= .023	.2376 (65) p= .057	1.0000 (67) p= .			
SCL90 ANXiety	.3011 ** (66) p= .014	.3249 ** (66) p= .008	.2983 ** (65) p= .016	.7347 (67) p= .000	1.0000 (67) p= .		
SCL90 INTpersonal Sensitivity	.2115 * (66) p= .088	.2284 * (66) p= .065	.2270 * (65) p= .069	.7093 (67) p= .000	.763[illegible] (67) p= .000	1.0000 (67) p= .	
SCL90 SOMatic complaints	.2330 * (66) p= .060	.3624 ** (66) p= .003	.2399 * (65) p= .054	.4973 (67) p= .000	.6152 (67) p= .000	.5550 (67) p= .000	1.0000 (67) p= .

2-tailed significance "." is printed if a coefficient could not be computed
** Significant Relationship * a Trend

	ATTBB	ATTCB	ATTSELF	TSC40ANX	TSC40DEP	TSC40SLP	TSC40SEX
ATTribution Behavioral Blame	1.0000 (66) p= .						
ATTribution Characterological Blame	.5765 (66) p= .000	1.0000 (66) p= .					
ATTribution to SELF	.6695 ** (64) p= .000	.4589 ** (64) p= .0000	1.0000 (65) p= .				
TSC40 ANXiety	.3907 ** (66) p= .001	.4013 ** (66) p= .001	.3607 ** (65) p= .003	1.0000 (67) p= .			
TSC40 DEPpression	.3383 ** (66) p= .005	.3844 ** (66) p= .001	.1309 (65) p= .299	.5058 (67) p= .000	1.0000 (67) p= .		
TSC40 Sleep problems	.1665 (66) p= .182	.2861 * (66) p= .020	.1057 (65) p= .402	.4284 (67) p= .000	.6680 (67) p= .000	1.0000 (67) p= .	
TSC40 SEXual problems	.1590 (66) p= .202	.1899 (66) p= .127	.0169 (65) p= .894	3258 (67) p= .007	.4977 (67) p= .000	.2093 (67) p= .089	1.0000 (67) p= .

2-tailed significance "." is printed if a coefficient could not be computed
** Significant Relationship * a Trend

	ATTOTHER	ATTMOM	ATTPERP	ATTSOC	ATTLUCK	SCL90DEP	SCL90ANX	SCL90INT	SCL90SOM
ATT to Others	1.0000 (65) p= .								
ATT to MOM	.7099 (45) p= .000	1.0000 (45) p= .							
ATTribution to PERpetrator	NA	NA	1.0000 (67) p= .						
ATTribution to SOCiety	NA	NA	NA	1.0000 (65) p= .					
ATTribution to LUCK	NA	NA	NA	.1391 (62) p= .281	1.0000 (62) p= .				
SCL90DEP	.2282 * (65) p= .068	.1760 (45) p= .248	-.1358 (67) p= .273	.1730 (65) p= .168	.0564 (62) p= .663	1.0000 (67) p= .			
SCL90ANX	.2497 ** (65) p= .045	.1977 (45) p= .193	-.1753 (67) p= .156	.1684 (65) p= .180	.1350 (62) p= .295	.7347 (67) p= .000	1.0000 (65) p= .		
SCL90INT	.1502 (65) p= .233	.1972 (45) p= .194	-.0243 (67) p= .845	.1318 (65) p= .295	.1273 (62) p= .324	.7093 (67) p= .000	.7637 (67) p= .000	1.0000 (65) p= .	
SCL90SOM	.1727 (65) p= .169	.1779 (45) p= .242	-.1565 (67) p= .206	.2066 * (65) p= .099	.3043 ** (62) p= .016	.4973 (67) p= .000	.6152 (67) p= .000	.5550 (67) p= .000	1.0000 (65) p= .

2-tailed significance "." is printed if a coefficient could not be computed
NA = Not Available ** Significant Relationship * a Trend

	ATTOTHER	ATTMOM	ATTPERP	ATTSOC	ATTLUCK	TSC40ANX	TSC40DEP	TSC40SLP	TSC40SEX
ATT to Others	1.0000 (65) p= .								
ATT to MOM	.7099 (45) p= .000	1.0000 (45) p= .							
ATTribution to PERpetrator	NA	NA	1.0000 (67) p= .						
ATTribution to SOCiety	NA	NA	NA	1.0000 (65) p= .					
ATTribution to LUCK	NA	NA	NA	.1391 (62) p= .281	1.0000 (62) p= .				
TSC40ANX	.2968 ** (65) p= .016	.1210 (45) p= .428	-.0993 (67) p= .424	.1507 (65) p= .231	.3051 ** (62) p= .016	1.0000 (67) p= .			
TSC40DEP	.2461 ** (65) p= .048	.2801 * (45) p= .062	-.0486 (67) p= .696	.0701 (65) p= .579	.1539 (62) p= .232	.5058 (67) p= .000	1.0000 (67) p= .		
TSC40SLP	.1946 (65) p= .120	.2173 (45) p= .152	.0018 (67) p= .988	.1537 (65) p= .222	.1455 (62) p= .259	.4284 (67) p= .000	.6680 (67) p= .000	1.0000 (67) p= .	
TSC40SEX	-.0141 (65) p= .911	.0388 (45) p= .800	.0623 (67) p= .617	-.1134 (65) p= .368	.0607 (62) p= .639	.3258 (67) p= .007	.4977 (67) p= .000	.2093 (67) p= .089	1.0000 (67) p= .

2-tailed significance "." is printed if a coefficient could not be computed
NA = Not Available ** Significant Relationship * a Trend

	SCL90DEP	SCL90ANX	TSC40ANX	TSC40DEP
SCL90DEP	1.0000 (67) p= .			
SCL90ANX	.7347 (67) p= .000	1.0000 (67) p= .		
TSC40ANX	.5942 (67) p= .000	.7260 (67) p= .000	1.0000 (67) p= .	
TSC40DEP	.6489 (67) p= .000	.4935 (67) p= .000	.5058 (67) p= .000	1.0000 (67) p= .

2-tailed significance "." is printed if a coefficient could not be computed