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The moderating role of meaning and defense mechanisms in the association between child sexual abuse and romantic relationship dysfunction

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The Moderating Role of Meaning and Defense Mechanisms in the Association between Child

Sexual Abuse and Romantic Relationship Dysfunction

by

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Dedication

This dissertation is dedicated to those courageous and resilient women who have survived the trauma of childhood sexual abuse. You truly epitomize the strength of the human spirit. It is my sincere wish that this work will inspire new advances in psychological treatment and hope for a better tomorrow.

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ABSTRACT

The current study investigated whether finding meaning in relation to sexual trauma and using mature defense mechanisms would moderate the association between child sexual abuse (CSA) severity and relationship and psychological adjustment in a sample of undergraduate women with a history of child sexual abuse. CSA severity was measured both objectively (i.e., severity of the abusive event) and subjectively (i.e., self-reported perceptions of the severity of the abusive event). As predicted, the interaction of objective CSA severity and mature defenses uniquely predicted one of four aspects of romantic relationship functioning (i.e., dyadic cohesion or doing joint activities with one's partner), which provides strong support for a moderating effect of mature defenses on relationship adjustment for CSA survivors. In addition, Objective CSA Severity X Meaning and Perceived CSA Severity X Meaning were both significantly correlated with various aspects of psychological functioning. Similarly, Objective CSA Severity X Mature Defenses and Perceived CSA Severity X Mature Defenses were significantly correlated with psychological functioning. These findings provide mild support for a possible moderating effect of meaning and mature defenses on psychological adjustment for CSA survivors. Contrary to hypotheses, the interaction of perceived CSA severity

and mature defenses was not significantly related to relationship functioning. Also contrary to hypotheses, the interactions of Perceived CSA Severity X Meaning and Objective CSA Severity X Meaning were not significantly related to relationship functioning. Finally, results did not support the hypothesis that relationship functioning would moderate the association between CSA severity (objective and perceived) and psychological adjustment.

Chapter One

Introduction

Child Sexual Abuse

Child sexual abuse (CSA) has been defined as the involvement of a child in a sexual activity that he or she does not fully comprehend; that he or she is unable to give informed consent to; that he or she is not developmentally prepared for and cannot give consent to; and/or that violates the laws or social taboos of society (World Health Organization, 1999). Furthermore, the perpetrator must be an adult or another child who by developmental age is in a relationship of responsibility, trust, or power with the victim, and the sexual activity must be intended to satisfy the needs of the perpetrator (World Health Organization, 1999). Finally, the sexual activity is usually unlawful, and may include fondling, exposure, intercourse, child prostitution, and child pornography (World Health Organization, 1999). Other definitions used in the literature include direct or indirect sexual contact of a child with an adult, whether through force or consent (Friedrich, Urquiza, & Bielke, 1986); sexual contact between a child under 15 and someone at least 5 years older (Schaaf & McCann, 1998); and any unwanted sexual experience of a child under the age of 12 with someone at least 5 years older (Peters & Range, 1995). Epidemiological studies have suggested that 12-35 percent of women and 4-9 percent of men in the U.S. report having been sexually abused before the age of 18 (Putnam, 2003).

A large body of research has examined the short and long-term effects of CSA on its survivors. These data indicate that child survivors may demonstrate inappropriate sexualized behaviors, anxiety, depression, low self-esteem, withdrawal, attention and concentration problems, and Post-Traumatic Stress Disorder (PTSD) symptoms (Koverola, Pound, Heger, & Lytle, 1993; Merry & Andrews, 1994; Oates, O'Toole, Lynch, Stern, & Cooney, 1994). Similarly, adult survivors have been found to demonstrate anxiety, depression, low self-esteem, PTSD symptoms, substance abuse, eating disorder symptoms, and personality disorder symptoms (Hall, Tice, Beresford, Wooley, & Hall, 1989; Neumann, 1994; Neumann, Houskamp, Pollock, & Briere, 1996). Medical consequences of CSA have also been identified. For example, some studies have reported increased risk for gastrointestinal disorders (e.g., irritable bowel syndrome and chronic abdominal pain) and gynecological disorders (e.g., chronic pelvic pain) in adult survivors of CSA (Drossman, 1992; Fry, Crisp, Beard, & McGuigan, 1993; Scarinci, McDonald-Haile, Bradley, & Richter, 1994). In addition, deleterious effects on the sympathetic nervous system and the immune system have been observed in sexually abused girls (Putnam & Trickett, 1997). Despite the negative sequelae often associated with CSA, however, the research evidence suggests that there is a relatively large subgroup of survivors who seem to come away relatively unscathed from the experience (Kendall-Tackett, Williams, & Finkelhor, 1993; Runtz & Schallow, 1997; Savell, Kinder, & Young, 2006). As such, researchers have been interested in identifying protective factors and coping mechanisms in particular that are associated with healthy adjustment to CSA.

Some situational variables that have been shown to be protective against the effects of CSA in both the short and long-run include childhood factors, such as parental warmth (Wind & Silvern, 1994); social support (Testa, Miller, Downs, & Panek, 1992); support and belief from a nonoffending parent (Spaccarelli & Kim, 1995); and a positive family environment in general (Esparza, 1993; Spaccarelli et al., 1995). Coping variables associated with better adjustment in both child and adult survivors of CSA are said to include approach strategies (e.g., expressing feelings and seeking social support) and active problem solving (Coffey, Leitenberg, Henning, & Turner, 1996; Himelein & McElrath, 1996).

Runtz and Schallow (1997) conducted a study in which they employed structural equation modeling (SEM) to investigate whether coping and social support would mediate the relation between child maltreatment (i.e., sexual and physical abuse) and psychological adjustment in a sample of male and female undergraduates at a Canadian University. The results indicated strong evidence for the mediation hypothesis, such that the association between child maltreatment and adjustment was almost entirely accounted for by the mediating variables (i.e, social support and coping). With respect to coping, the strategies that were most significantly related to healthy adjustment were the expression of emotion and active pursuit of change and understanding. On the other hand, self-destructive behaviors (e.g., suicidality, substance abuse) and avoidant behaviors (e.g., trying to forget, ignoring feelings) were most strongly related to poor adjustment.

Merrill, Thomsen, Sinclair, Gold, and Milner (2001) conducted a similar study that examined the roles of parental support, coping strategies, and abuse severity in the psychological adjustment of female Navy recruits. The results revealed that participants

who reported high levels of parental support, including those with and without a history of CSA, had fewer psychological symptoms, whereas those who reported lower levels of parental support reported more symptoms. Structural equation models were also tested in order to determine whether coping behaviors mediate the effect of abuse severity and parental support on psychological symptoms. A fully mediated model in which parental support and abuse severity were only related to symptoms by way of coping was compared with a partially mediated model in which parental support and abuse severity were related to symptoms both directly and indirectly via coping. The results indicated that both models provided an adequate fit for the data. Furthermore, the fully mediated model fit the data as well as the partially mediated model, which suggested strong support for the mediation hypothesis. More specifically, the fully mediated model proposed that parental support led to constructive coping, which refers to proactive coping strategies, such as behavioral changes, cognitive reframing, and support seeking. On the other hand, abuse severity was proposed to lead to all 3 forms of coping included in the model: constructive coping; self-destructive coping (i.e., behavioral acting out such as substance abuse); and avoidant coping (i.e., attempts to deny or repress thoughts and feelings associated with the abuse). Finally, these 3 coping strategies were said to lead to psychological symptoms, such that constructive coping was associated with fewer symptoms, whereas self-destructive and avoidant coping were associated with more symptoms.

Coffey, Leitenberg, Henning, Turner, and Bennett (1996) also conducted a study in which they examined the relationship between coping strategies and psychological adjustment in a group of community women with a history of CSA and a comparison

group with no history of CSA. This study specifically aimed to identify the coping strategies used to deal with CSA (versus those used to deal with other stressors) and analyze how these CSA coping strategies would be related to adjustment. The results revealed a significant interaction between the type of stressful event (i.e., CSA versus another stressor) and coping method employed by the CSA group. Specifically, CSA participants employed engagement coping (i.e., active efforts to manage oneself and one's environment, such as talking to others) more often in dealing with non-CSA stressors. On the other hand, they employed disengagement coping (i.e., attempts to disengage from oneself and one's environment, such as avoiding thinking about the situation) more often in dealing with CSA. It is noteworthy that more severe abuse was related to increased use of both engagement and disengagement strategies for coping with the abuse. With respect to adjustment, it was found that disengagement coping specific to CSA and disengagement coping specific to *non-CSA* events were the only coping methods that uniquely predicted psychological adjustment. Specifically, coping with CSA via disengagement methods was associated with poorer adjustment. Finally, CSA-specific disengagement coping added significantly to the variance in adjustment, above and beyond abuse characteristics and methods of coping with non-CSA events.

Ullman (1997) investigated how different cognitions about the self, the world, and the abuse experience influence recovery from sexual assault in a sample of adult women from the community. Results showed that greater self-worth was associated with fewer self-reported psychological symptoms and higher self-reported recovery. On the other hand, external attributions of blame for the abuse were related to more self-reported symptoms. Finally, searching for meaning in one's victimization (versus having found

such meaning) was associated with more self-rated symptoms and lower self-rated recovery. The role of positive illusions and discovery of meaning in adjustment to trauma and CSA in particular will now be discussed.

Positive Illusions and Discovery of Meaning

For several decades now, the mental health community has emphasized the importance of rational and accurate thinking for psychological health. Recently, however, there has been a growing body of research examining the potentially beneficial effects of so-called positive illusions (Mazur, Wolchik, Virdin, Sandler, & West, 1999; Taylor, 1989; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Positive illusions refer to beliefs that represent *mild* positive distortions of reality (Fiske & Taylor, 1991). The social cognition literature has demonstrated considerable evidence that these unrealistic positive beliefs may actually be a normal part of human cognition (Fiske & Taylor, 1991; Taylor & Brown, 1988). Specifically, three types of positive illusions have been consistently identified as characterizing normal thought processes: self-enhancement, unrealistic optimism, and an exaggerated sense of personal control (Taylor & Brown, 1988). Self-enhancement involves the holding of positively biased beliefs about oneself, including biases about physical appearance, personality traits, and a variety of abilities. Unrealistic optimism refers to the holding of positive expectations in the face of negative situations from which positive outcomes may be unlikely. Lastly, an exaggerated sense of personal control refers to unrealistic beliefs about one's ability to control a situation or stressor that is heavily influenced by external factors. Another concept related to positive illusions has to do with the discovery of meaning in relation to negative events and experiences. It has been suggested that positive illusions may facilitate the reappraisal of

negative events, such that individuals come to view these events as catalysts to the discovery of new values and a fresh perspective on life (Taylor, 1983). In other words, individuals find meaning relative to the negative event.

At first glance, positive illusions may appear to be another form of avoidant coping, whereby individuals deal with stressors by ignoring or denying the objective reality of a situation. However, denial responses tend to increase as the magnitude of a stressor increases (Taylor et al., 1996), which restricts the incorporation of any negative information. On the other hand, positive illusions *do* allow for the acknowledgement of negative information because the distortions involved tend to be relatively mild in nature (Taylor, 1989). Another distinction between positive illusions and avoidant coping mechanisms is that positive illusions represent people's beliefs about their own characteristics, abilities, and future circumstances, while denial tends to be primarily concerned with external circumstances (Taylor et al., 1996). Finally, the research literature has actually shown that individuals who hold positive illusions are more likely to utilize active coping strategies involving proactive steps to deal with stressors (Aspinwall & Taylor, 1997).

Taylor and Armor (1996) attempted to explain the mechanisms by which positive illusions operate. As was mentioned earlier, positive illusions are believed to characterize normal human cognition (e.g., Fiske & Taylor, 1991). According to Taylor et al. (1996), negative or threatening events challenge positive illusions, and this causes people to make efforts to protect and enhance these illusions. Indeed, research has demonstrated that negative events result in increases in affective, physiological, cognitive, and behavioral activities compared to neutral or positive events (Taylor, 1991). More

specifically, people may develop even greater self-enhancement, unrealistic optimism, and perceptions of personal control when faced with threats to these beliefs (Taylor et al., 1996). For instance, breast cancer patients (Taylor, Lichtman, & Wood, 1984) and heart disease patients (Taylor, Helgeson, Reed, & Skokan, 1991) often believe that they have a high degree of control over their illness, despite compelling medical evidence to the contrary. People dealing with stressful events may also make downward comparisons in an effort to increase self-enhancement (Aspinwall & Taylor, 1993). For example, the aforementioned study on breast cancer patients revealed that 70 of the 72 women in the sample believed that they were doing better than other women with breast cancer (Taylor et al., 1984). Despite the fact that positive illusions represent a distorted version of objective reality, however, Taylor et al (1996) emphasized that the distortions are kept in check by external feedback, such as feedback from one's friends and family (Taylor & Brown, 1988). Another important point made by Taylor et al. (1996) about the workings of positive illusions was that these beliefs seem to be more active during the *implementation* of decisions aimed at dealing with stressors and problems, rather than during the deliberation process. This is perhaps because decisionmaking requires more realistic information processing, whereas decision implementation may benefit from the exaggeration and enhanced self-efficacy characterized by positive illusions (Taylor et al., 1996). Consistent with this position, a study by Gollwitzer and Kinney (1989) found that individuals in the implementation condition of a task were more likely to demonstrate an illusion of control over an uncontrollable apparatus when compared to individuals in the deliberation condition for the same task/decision. Finally, there is the question of what happens when positive illusions are disconfirmed by deteriorating events or

circumstances. Taylor et al., (1996) actually suggested that people with an optimistic outlook may be more flexible in their use of coping mechanisms and can, therefore, modify their cognitions and strategies effectively in order to deal with a worsening reality. Data collected from HIV seropositive gay and bisexual men indeed confirmed that dispositional optimism was not associated with psychological maladjustment when positive expectations were shattered (Neter, Taylor, & Kemeny, 1995). At this juncture, research findings on the effects of positive illusions on adjustment to illness, stress, and trauma will be discussed. Thereafter, the research literature on the relationship between positive illusions and adjustment to child sexual abuse in particular will be reviewed.

Recent studies have investigated the role of positive illusions and the discovery of meaning in physical health and disease outcomes. For example, Segerstrom, Taylor, and Fahey (1998) found a positive association between optimism and the number of CD4 (helper) T cells, which are important for effective immune system functioning, in stressed law school students. Similarly, a study by Taylor, Lerner, Sherman, Sage, and McDowell (2003) examined the association between self-enhancement and physiological (i.e., autonomic and hypothalamic-pituitary-adrenocortical [HPA]) responses to stress in 92 adults affiliated with the University of California (Los Angeles). While these physiological responses are generally believed to be adaptive in the short term because of prompting the "fight or flight" reaction, it is well established that recurrent activation of the autonomic and HPA systems can result in adverse consequences (e.g., coronary disease) for health (McEwen, 1998). As such, Taylor et al. (2003) hypothesized that self-enhancement would be associated with significantly less activation of the body's stress regulatory systems in response to psychological stressors. Consistent with this

hypothesis, results indicated that high self-enhancers had lower systolic blood pressure and a lower heart rate than low self-enhancers when confronted with stressful tasks. Although high self-enhancers showed lower cortisol levels - which suggests lower physiological arousal - than low self-enhancers at baseline, there was no difference in cortisol levels between the two groups when performing stressful activities. The researchers also tested whether psychological distress, psychological health, and psychological resources (e.g., adaptive coping) mediated the relationship between self-enhancement and physiological arousal. While none of these variables were found to mediate the association between self-enhancement and either heart rate or systolic blood pressure, psychological resources did mediate the path between self-enhancement and baseline cortisol levels. This suggests that high self-enhancers were able to maintain lower cortisol levels, which is one indicator of lower physiological reactivity, as a result of having more psychological resources (e.g., effective coping skills), (Taylor et al., 2003).

Taylor, Kemeny, Reed, Bower, and Gruenewald (2000) also investigated the association between positive illusions and physical health. More specifically, these researchers examined whether unrealistic optimism, a belief in personal control, and having a sense of meaning would predict the course of illness for 78 homosexual men infected with HIV. HIV was believed to be an ideal model for understanding the influence of these positive cognitions because seropositive individuals could be followed from the time of diagnosis - when many of them are asymptomatic - through symptom manifestation and death. Results showed that the men who were high on realistic acceptance of their own death died an average of 9 months earlier than those who were

low on realistic acceptance, even when controlling for potential confounds (e.g., age, time since diagnosis, number of AIDS-related symptoms, level of CD4 T helper cells, psychological distress, depression, suicidal ideation, and use of the AIDS medication zidovudine – i.e., AZT). Furthermore, negative HIV-specific expectancies were predictive of the onset of AIDS-related symptoms, especially amongst seropositive men who were experiencing bereavement from the loss of a close friend or romantic partner. This finding remained stable even when mood and health habits were controlled. It was also investigated whether the course of illness for seropositive participants who were bereaved was related to cognitive processing (defined as verbal statements indicative of effortful or long-lasting thoughts about the death of one's loved one) and finding a sense of meaning (defined as a major shift in values or perspective in response to the loss of one's loved one. Sixty-five percent of these participants were high on cognitive processing, while 40 percent were high on finding meaning. The vast majority of those who were high on finding meaning were also high on cognitive processing; however, only some of those who were high on cognitive processing were high on finding a sense of meaning. Primary analyses indicated that only the men who had found a sense of meaning in their loss maintained their CD4 T helper cells over the follow-up period (i.e., 4-9 months), after controlling for other predictors of HIV progression (e.g., number of HIV-related symptoms, initial CD4 T helper cell levels , health habits, and affect). In addition, only 3 of the 16 men who had found a sense of meaning died during the follow up period, whereas half of the 24 who had *not* found meaning died during this period. This study, therefore, provides compelling evidence of the beneficial effects of positive illusions on the course of terminal disease. Other studies of individuals infected with

HIV and AIDS have also revealed that those persons who held unrealistically optimistic views about the course of their illness showed slower disease progression (Reed, Kemeny, Taylor, & Visscher, 1999) and greater longevity (Reed, Kemeny, Taylor, Wang, & Visscher, 1994) than those who did not hold such optimistic views.

Studies have also investigated the impact of positive illusions and meaning on adjustment to external stressors. For example, the research literature on divorce has sought to identify various risk and protective factors that predict children's adjustment to this stressful event. One of the most widely studied variables related to post-divorce outcomes for children is cognitive appraisal (e.g., Lazarus, 1991; Meichenbaum & Fitzpatrick, 1993). Numerous studies have shown that negative cognitive errors of children are positively associated with psychological (Cole & Turner, 1993; Laurent & Stark, 1993; Mazur, Wolchik, & Sandler, 1992) and behavioral problems (Mazur et al., 1992). In contrast, Mazur et al. (1992) found that having a sense of meaning in relation to hypothetical divorce events were related to lower levels of aggression in children. Similarly, Krantz, Clark, Pruyn, and Usher (1985) demonstrated that positive appraisals of divorce were associated with parental reports of fewer behavioral problems in boys. A recent study conducted by Mazur et al. (1999) examined the impact of negative cognitive errors and meaning on internalizing and externalizing symptoms of children experiencing divorce-related stress. In addition, these researchers explored whether gender and age moderated the effects of negative cognitive errors and meaning. Results indicated that negative cognitive errors were significantly positively correlated with both child and maternal reports of internalizing and externalizing problems. On the other hand, finding a sense of meaning in the divorce was significantly negatively correlated with child and

maternal reports of internalizing problems and child reports of externalizing problems. Interaction analyses indicated that the effect of meaning and negative cognitive errors on adjustment problems differed depending on the age and gender of children. That is, the positive relationship between negative cognitive errors and adjustment problems was found to be stronger in boys (versus girls) and older children (versus younger children). Furthermore, the negative association between meaning and depression was stronger for girls than boys, while the negative association between meaning and conduct problems only held for older children.

Relatively few studies have evaluated the use of positive illusions and discovery of meaning as a coping mechanism for survivors of child sexual abuse (CSA). Nonetheless, the findings of existing studies have been promising. For instance, Silver, Boon, and Stones (1983) conducted a study in which they looked at the strategy of searching for meaning in a sample of adult incest survivors. They found that the women who reported having found meaning relative to the abuse event (e.g., viewing the experience as having made them emotionally stronger) had less psychological symptoms, higher self-esteem, and better social functioning than those who were not successful in their search for meaning (Silver et al., 1983). In addition, Moran and Eckenrode (1992) found that having a sense of personal control or internal locus of control for positive events was a protective factor for adolescent survivors of child maltreatment, including sexual abuse. Another study by Himelein and McElrath (1996) investigated cognitive mechanisms associated with resilience in a nonclinical sample of CSA survivors. In particular, they examined whether the CSA group differed from a control group in their level of overall adjustment (as indicated by measures of psychological health,

psychological distress, and life satisfaction) and their tendency to employ perceptions of personal control and unrealistic optimism. Secondly, they looked at whether the use of these positive illusions was associated with overall adjustment for both the CSA and control groups. Preliminary analyses showed that the two groups did not differ in overall adjustment or in their reported use of positive illusion as a general coping strategy. Consistent with the hypothesis that positive illusion use would be related to better adjustment, results indicated that nearly all of the variance in adjustment for both groups was accounted for by the illusion variables (i.e., sense of personal control and unrealistic optimism). These findings suggest that positive illusions can serve as a very powerful coping technique, even in the face of a severe traumatic stressor like sexual abuse. Like positive illusions, defense mechanisms are another means by which individuals sometimes cope with trauma. As such, a discussion of the role of these defense mechanisms in adjustment to trauma and CSA will now be presented.

Defense Mechanisms

Sigmund Freud was the first to introduce the idea that individuals distort their perceptions of reality in order to minimize negative psychological effects, especially anxiety (Kassin, 1998). The distortions are said to occur unconsciously in most instances, but at times may occur at the conscious level (Newman, 2001). Freud identified six major defense mechanisms that characterize human behavior and cognition. A brief description of these defense mechanisms follows.

First, repression refers to the "forgetting" or unconscious suppression of anxiety-provoking thoughts, memories, and feelings (Kassin, 1998). For example, survivors of traumatic events sometimes report that they have little or no recollection of the event.

Denial is a related defense that involves automatic exclusion from consciousness of threatening aspects of reality or the inability to acknowledge the true significance of such situations or events (White & Gilliland, 1975). In the case of a trauma survivor, minimizing the abusive experience might constitute denial. Projection involves projecting one's own unacceptable impulses or cognitions unto others, such that another person, rather than the self, is perceived as having those impulses or cognitions (Kassin, 1998). For instance, a man who is attracted to his brother's wife may begin to perceive that his brother's wife is attracted to him rather than to accept his own inappropriate thoughts and feelings. Reaction formation is another defense mechanism and it refers to the conversion of unacceptable feelings or cognitions into its opposite (White & Gilliland, 1975). A mother who smothers an unwanted and resented child with affection can be said to be demonstrating reaction formation. Rationalization involves creating alternative explanations for one's misfortunes because the true explanation is too threatening to accept (Kassin, 1998). For example, a failing student who blames the instructor for his bad grades, rather than acknowledge his lack of preparation, may be rationalizing. Lastly, Freud described sublimation as the channeling of unacceptable impulses or feelings into more socially acceptable outlets (Kassin, 1998). An example of this might be a male who satisfies his inappropriate aggressive urges by engaging in a more socially acceptable activity, such as joining the police force.

Additional defense mechanisms have also been identified in the literature. Displacement involves the transferring of intense feelings from one situation where such feelings cannot be expressed safely to another situation where they can. For example, an employee cannot express anger toward his boss, so he displaces the anger and expresses

it toward his family at home instead. Next, intellectualization refers to efforts to focus on factual or rational aspects of a stressful or traumatic event rather than on the emotional aspects. For instance, a wife whose husband has died from a terminal illness may tend to dwell on the biological intricacies of the illness in order to avoid dealing with the emotional pain associated with the loss. Regression is yet another defense and it involves returning to an earlier stage of development in order to reduce anxiety and distress. An example of this would be an adult woman who curls up in the corner of her room like a child when experiencing extreme distress because this was something that used to bring her comfort as a child. Finally, dissociation refers to the act of separating oneself from reality by way of a temporary alteration in consciousness or identity. For instance, theorists would suggest that someone who has endured a traumatic event may develop multiple personalities to separate themselves from the event.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychological Association, 2000) classified defense mechanisms and other coping styles into different levels according to how adaptive or dysfunctional they were assessed to be. Of the defenses described above, sublimation (i.e., channeling unacceptable impulses into more socially acceptable outlets) is the only one classified as being highly adaptive because it involves a balance between gratification and conscious awareness of thoughts, feelings, and their consequences. Displacement (i.e., redirecting inappropriate or negative emotions toward a safer target), dissociation (i.e., separating oneself from reality by altering consciousness or identity), intellectualization (i.e., focusing on the rational rather than emotional aspects of a stressful event), reaction formation (i.e., expressing behaviors that are the opposite of one's internal desires or feelings), and repression (i.e.,

forgetting important aspects of an adverse event) are classified as mental inhibitions and considered to be less adaptive because they keep certain cognitions, feelings, and impulses out of conscious awareness. Denial (i.e., failure to become aware of a negative event), projection (i.e., perceiving that others hold one's own unacceptable thoughts and impulses), and rationalization (i.e., developing alternative explanations for inadequacies or wrongdoings) are classified as being in the disavowal level of functioning. This level is said to be even less adaptive than mental inhibitions because it not only involves keeping unpleasant or unacceptable thoughts, feelings, etc. out of awareness, but it may also include misattributing these thoughts and feelings to external causes. Lastly, the DSM-IV classified extreme forms of projection (termed delusional projection) and denial (termed psychotic denial) as being at the level of defensive dysregulation. This level is described as being the most dysfunctional because regulatory mechanisms fail to keep defensive reactions "in check", which leads to a profound break from objective reality.

Despite these classifications provided by the DSM-IV, there has been very little empirical investigation into the role of defense mechanisms in adjustment to stress and trauma. As such, it is not clear whether these defenses (or which defenses) are generally protective against maladjustment, harmful, or both. The few existing studies that have looked at the association between defense mechanisms and adjustment, especially psychological symptoms, will now be discussed in detail.

Punamaki, Kanninen, Qouta, & El-Sarraj (2002) conducted a study in which they looked at the relationship between defense mechanisms and PTSD symptoms in a sample of Palestinian political ex-prisoners who reported being tortured during their detention. First, they analyzed the factor structure of a variety of defense mechanisms. Thereafter,

they directly examined the relationships between defenses and PTSD symptoms and between severity of torture and defenses. Finally, the researchers investigated whether defense mechanisms would moderate the association between severity of torture and PTSD symptoms. In other words, they were interested in whether defense mechanisms would serve as a protective factor against PTSD symptoms. Results revealed that a four-factor solution comprised of two immature defenses
(i.e., defenses that develop in childhood and are unconscious for the most part) and two mature defenses (i.e., defenses that develop later in life and are conscious for the most part) provided the best fit for the defense mechanisms. Factor I was labeled immature reality-distorting defenses because it was comprised of immature defenses that were said to produce distortions in reality (e.g., displacement). Factor II was labeled mature reality-based defenses because it included mature defenses that were said to be grounded in reality (e.g., sublimation). Factor III was described as consciousness-limiting defenses (mature) because these defenses were said to involve mental inhibition via internal manipulations and limiting conscious access to reality (e.g., denial). Lastly, Factor IV was labeled immature reality-escaping defenses because it included immature defenses that surround escaping reality (e.g., projection). With respect to the main effect of defense mechanisms on PTSD symptoms, it was found that the immature defenses were associated with high levels of PTSD symptoms, whereas mature defenses were associated with low levels of PTSD symptoms. Results also indicated a significant relationship between severity of torture and defenses, whereby high levels of torture were associated with low levels of mature reality-based defenses. Moderator analyses revealed that more severe torture was related to more PTSD symptoms for men who frequently used

immature reality-distorting defenses. Contrary to hypotheses, neither of the mature defenses (i.e., consciousness limiting defenses and mature reality-based defenses) significantly moderated the association between trauma severity and PTSD symptoms. In fact, for men who reported more severe torture, consciousness-limiting defenses were related to more PTSD symptoms.

Another study by Shilony and Grossman (1993) examined the role of depersonalization in the psychological adjustment of a sample of trauma survivors, including survivors of physical abuse, auto accidents, and sexual abuse/assault survivors. Depersonalization is a form of the defense mechanism known as dissociation and involves the experiencing of an altered state of reality wherein the individual feels like an outside onlooker to an assault on his/her physical person (Shilony & Grossman, 1993). Results revealed that 60 percent of the sample reported experiencing depersonalization during their traumatic experience(s). Furthermore, the depersonalization trauma group scored significantly *lower* than the non-depersonalization trauma group on somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, phobic anxiety, paranoid ideation, and overall psychological symptom severity. This difference between the two groups remained even after controlling for trauma severity and time elapsed since the occurrence of the trauma.

Lastly, Birmes et al. (2000) investigated the association between particular defense styles/mechanisms and risk for PTSD in a sample of trauma survivors, which included survivors of auto accidents, severe burns, violent assault, and sexual assault. Specifically, they looked at mature defenses (e.g., sublimation), neurotic defenses (e.g., reaction formation), and immature defenses (e.g., projection, denial, and dissociation) in

the trauma survivors with and without PTSD. Results showed that the PTSD and non-PTSD survivors did not significantly differ on their use of mature, neurotic, or immature defense mechanisms in general. However, they did differ on one neurotic defense mechanism (i.e., reaction formation), whereby the PTSD group was more likely to use reaction formation compared to the non-PTSD group. Note that no existing studies have examined the role of defense mechanism in adjustment to CSA in particular.

To summarize, then, positive illusions and defense mechanisms may operate as moderating factors in the association between trauma, including CSA, and psychological adjustment. Having reviewed the literature on factors related to *psychological* functioning of trauma and CSA survivors, our discussion will now focus on the importance of studying *interpersonal* functioning.

Relationship Functioning

Romantic relationships are central to the lives of most people. When these relationships are satisfying, individuals experience elevated levels of general well-being and life satisfaction (Myers & Diener, 1995). On the other hand, relationship distress and instability can result in increased physical and psychological problems for partners as well as children (Glenn, 1990; Grych & Fincham, 1990). For instance, Prigerson, Maciejewski, and Rosenheck (1999) found that both marital dissatisfaction and divorce were associated with emotional problems, such as depression, and increased mental health service use by women. Similarly, Hintikka, Koskela, Kontula, Koskela, and Viinamaeki (1999) found that men and women in unhappy marriages were at significantly higher risk for common mental disorders as compared with those in happy marriages. Taken together, these research findings indicate that relationship satisfaction

and outcome can exert a powerful influence on one's mental health and quality of life as a whole. It is, therefore, alarming that more than half of all first marriages in the United States experience dissatisfaction and end in divorce (Council on Families in America, 1995). These observations have been the catalyst of extensive research on variables related to satisfaction and outcome in close relationships. Factors affecting relationship satisfaction and outcome can be divided into two broad categories: individual difference variables and relationship variables. Individual difference variables refer to characteristics of the individuals within the relationship, such as personality traits. On the other hand, relationship variables refer to interpersonal characteristics or processes, such as communication. In this section, a few individual difference variables that have been found to influence relationship satisfaction and outcome will be examined.

Several different personality traits have been identified as being significant predictors of relationship satisfaction and outcome. For instance, self-disclosure and expressiveness (Geist & Gilbert, 1996), hostility (Newton & Kiecolt-Glaser, 1995), dominance (Blum & Mehrabian, 1999), and pleasantness (Blum & Mehrabian, 1999) have all been found to account for a significant amount of the variance in relationship satisfaction. In addition, a number of studies have been done on the Big Five personality traits: neuroticism (emotional instability), extraversion (warm, cheerful, energetic, assertive, and adventurous behavior), conscientiousness (responsibleness), agreeableness (cooperativeness), and openness to experience. Several studies suggest that individuals who are high on neuroticism (based on participant's self-ratings and partner's ratings of participant) report greater marital dissatisfaction (Eyesenck & Wakefield, 1981; Karney & Bradbury, 1995; Karney, Bradbury, Fincham, & Sullivan, 1994; and Thomsen &

Gilbert, 1998) and are more likely to become divorced over a time span of 40 years (Kelly & Conley, 1987). In addition, the partners of individuals high on neuroticism also reported elevated levels of dissatisfaction in their relationships (Karney et al., 1994).

Watson, Hubbard, and Weise (2000) also looked at the relationship between personality traits and relationship functioning. They found that conscientiousness and agreeableness, as measured by participant's self-rating and partner's rating of participant, were consistent positive predictors of satisfaction for participants in dating couples. This study also found extraversion, also measured by participant's self-rating and partner's rating of participant, to be a strong positive predictor of participants' marital satisfaction (Watson et al., 2000). Likewise, positive affectivity of participants was positively correlated with participants' satisfaction, and negative affectivity of participants was negatively correlated with both participants' and partners' satisfaction for dating and married couples (Watson et al., 2000).

Attachment is another individual difference variable that has been linked to relationship functioning. Hazan and Shaver (1987) found that working models formed from child-caretaker attachment are related to corresponding relationship styles in adulthood. Their research showed that the prevalence of the 3 major attachment styles described by Bowlby is similar in infancy and adulthood: 70 percent show secure attachment (i.e., autonomous yet comfortable with trust and intimacy), 20 percent show avoidant attachment (i.e., excessively autonomous, distrustful, and anxious about intimacy), and 10 percent show anxious-ambivalent attachment (i.e., eagerly seeking intimacy yet anxious about rejection and abandonment), (Hazan & Shaver, 1987). Furthermore, the research literature indicates a relationship between adult attachment

style and relationship satisfaction. Individuals who have secure attachment styles report greater satisfaction in their relationships than do individuals with insecure attachment styles (Hammond & Fletcher, 1991; Hendrick & Hendrick, 1989; Senchak & Leonard, 1992). This might be due, in part, to evidence that secure attachment is associated with adaptive behaviors, such as less rejection and more support in marital problem-solving interactions (Kobak & Hazan, 1991). Numerous studies also indicate that people with secure attachment styles describe their relationships as having more positive and less negative emotion, and more emotional involvement and stability (Collins & Read, 1990; Feeney & Noller, 1991). In addition, anxiety about abandonment predicts higher levels of coercive communication, less mutual communication, and lower marital quality for both men and women, while comfort with closeness predicts more mutual communication and higher marital quality for men (Feeney, Noller, & Callan, 1994).

Finally, romantic beliefs of individuals have shown a significant association with relationship satisfaction. According to researchers, people's romantic beliefs are important in shaping their level of relationship satisfaction. It is important to point out that many romantic beliefs are unrealistic, but some unrealistic beliefs are maladaptive, while others are adaptive. Studies have found that individuals who endorse certain dysfunctional relationship beliefs are less likely to be satisfied in their relationships (Epstein & Eidelson, 1981). These beliefs include the idea that disagreement is destructive to a relationship, spouses should be able to read each others' minds, partners cannot change significant aspects of themselves, sexual performance should be perfect, and men and women have different emotional needs. Such beliefs are also negatively correlated with a couple's desire to improve their marital relationship (Epstein &

Eidelson, 1981). On the other hand, studies have found that people with strong, idealistic romantic beliefs (e.g., exaggerating the positive aspects of one's partner) generally tend to have higher motivation and persistence in their relationships (Taylor & Brown, 1988), which typically leads to greater satisfaction.

Along these lines, Jones and Stanton (1988) conducted a study to determine whether dysfunctional beliefs specific to romantic relationships would have a stronger association with marital dissatisfaction than general dysfunctional beliefs. Results indicated that general dysfunctional beliefs as a whole did not significantly correlate with marital distress, while dysfunctional beliefs related to relationships were significantly associated with dissatisfaction. Specifically, the belief that "disagreement is destructive" emerged as a significant predictor of distress for the individuals who held this belief. Another study looked at the effect of romanticism on relationship satisfaction (Jones and Cunningham, 1996). Romanticism refers to the degree to which an individual idealizes his/her partner and relationship. This variable was found to be a significant predictor of relationship satisfaction, whereby males and females holding these beliefs rated their level of relationship satisfaction significantly higher than those who did not hold them. Furthermore, romanticism on the part of participants was positively related to the satisfaction of their partners. The researchers provided a possible explanation for the relationship between romanticism and satisfaction: romantic behavior on the part of romanticizing individuals likely results in reciprocation of such behavior by their partners, which serves to increase both partners' relationship happiness. Relationship variables that predict relationship satisfaction and outcome will now be discussed.

Communication is one of the most widely cited variables in the relationship satisfaction literature. Numerous theorists and researchers have postulated that deficits in communication skills are a major source of relationship discord (e.g., Noller, 1993; O'Donohue & Crouch, 1996). Furthermore, communication skills have been said to distinguish between happy and distressed couples (Christiansen & Shenk, 1991). However, a more recent study conducted by Burleson and Denton (1997) sought to advance our understanding of the role of communication in relationship satisfaction. First, the researchers made a distinction between communication skills versus behaviors. They pointed out that previous studies have relied on communication behavior as an indicator of communication skill and explained that this approach is flawed because behavior is influenced by numerous other factors (e.g., motivation). Burleson & Denton (1997) also investigated how different factors may moderate the association between communication skills and relationship satisfaction in a sample of 60 married couples. Four broad communication skills were assessed in this study: communication effectiveness (i.e., producing messages that have their intended effect); perceptual accuracy (i.e., accurate comprehension of the intentions underlying another's message); predictive accuracy (i.e., accurate anticipation of how one's message will affect another); and interpersonal cognitive complexity (i.e., ability to process social information). Preliminary analyses indicated no overall difference between distressed and nondistressed couples on any of these communication skills. With respect to satisfaction, couples' cognitive complexity was associated with more positive feelings toward one's partner in the overall sample. Couples' predictive accuracy and perceptual accuracy were

also associated with more positive feelings toward their partner, but only in *nondistressed* couples.

Burleson & Denton (1997) also examined gender differences in the relationship between communication skills and satisfaction. It was found that husbands' perceptual accuracy was a positive predictor of their own marital satisfaction in *nondistressed* marriages, but a negative predictor of their satisfaction in *distressed* marriages. On the other hand, wives' predictive accuracy was positively associated with their own satisfaction in *distressed* marriages, but unrelated to satisfaction in *nondistressed* marriages. It was also examined whether the communication skills of one partner was related to the other partner's satisfaction. These analyses showed that in *nondistressed* couples, wives' communication skills were positively related to their husbands' satisfaction, whereas wives' skills did not influence husbands' satisfaction in *distressed* couples. Similar results were found for the impact of husbands' communication skills on their wives' satisfaction, though these effects were not as strong. To summarize, then, communication is an important predictor of relationship satisfaction, but this relationship is heavily influenced by moderating variables, such as type of communication skill and gender.

Another relationship variable that has been consistently linked to relationship satisfaction is interpersonal similarity (Blum & Mehrabian, 1999; White & Hatcher, 1984). For example, Burleson and Denton (1992) conducted a study in which they looked at similarity in social-cognitive and communication skills as it relates to marital satisfaction. Results indicated that similarity in these skills was positively related to marital satisfaction. In fact, low-skilled couples were no less happy with their marriages

than high-skilled couples. Furthermore, distressed spouses demonstrated greater dissimilarity in their social-cognitive and communication skills relative to non-distressed spouses.

Belief and attitude similarity have also been consistently linked to relationship satisfaction (e.g., Hendrick, 1981). According to Byrne (1971), people have a desire to hold "correct" attitudes and values. But since attitudes and values cannot be objectively verified, they turn to others for such validation. Thus, when people learn that another person shares their beliefs, this becomes a source of positive reinforcement. As learning principles have demonstrated, persons are drawn toward sources of positive reinforcement. Therefore, people are attracted to others with similar attitudes/values. To illustrate this, Jones and Stanton (1988) examined the association between belief similarity and marital satisfaction. They found that perceived similarity in couples' belief systems was negatively associated with marital distress. In addition, marital distress was greatest when belief dissimilarity involved dysfunctional relationship beliefs (e.g., disagreement is destructive) held by at least one partner.

In addition to similarity in cognitive-communication skills and beliefs, some researchers have explored the role of similarity in couples' perceptions of events. Beliefs and attitudes refer to preexisting ideas held by individual couple members about a wide variety of issues. In contrast, perceptions are defined as the interpretations and evaluations couple members make about shared experiences (Deal, Wampler, & Halverson, 1992). Deal et al. (1992) found that couples who were satisfied with their marriage were more likely to have similar perceptions about their relationship and their family. Furthermore, spouses that had congruent perceptions regarding one aspect of

their life (e.g., the marital relationship) also tended to have similar perceptions about other aspects of their common experience, such as the children. In contrast, spouses in less satisfying relationships did not perceive their marriage and family in the same way. Where one couple member saw something as being positive, the other saw it as negative.

Lastly, maintenance behaviors and expectations for such behaviors have been linked to relationship satisfaction in the literature. Maintenance behaviors refer to behaviors carried out by dyadic partners to keep their relationship in a particular state or condition (Dindia & Canary, 1993). According to Stafford and Canary (1991), there are five basic types of maintenance behaviors: positivity (cheerful and optimistic behavior), openness (self-disclosure and direct discussion of the relationship), assurances (messages emphasizing commitment to one's partner and relationship), social networks (reliance on shared friends and affiliations), and sharing tasks (equal responsibility for tasks facing the couple). Numerous studies have indicated that all five strategies are strong and consistent predictors of satisfaction (Canary & Stafford, 1992; Dainton, Stafford, & Canary, 1994; Stafford & Canary, 1991).

Dainton (2000) conducted a study to determine whether expectations regarding the use of maintenance behaviors by one's partner impact one's level of relationship satisfaction. Results showed a direct association between participants' perceptions of the extent to which their partner fulfilled their expectations for maintenance strategies and their level of satisfaction. More specifically, perceived fulfillment of expectations for assurances and the sharing of tasks were the strongest predictors of satisfaction. This study also sought to compare the frequency of maintenance behaviors relative to the discrepancy between expectations and actual behaviors as differential predictors of

satisfaction. Even though both factors were significantly associated with satisfaction, with greater frequency and lower discrepancy predicting higher satisfaction, it was found that the frequency of one's partner's use of maintenance behaviors was more strongly related to one's satisfaction than was the discrepancy between one's expectations for partner's behavior and partner's actual behavior. Finally, findings indicated that over time, perceptions of partner's use of maintenance strategies declined while expectations remained the same, thus increasing the gap between expectations and behavior. This was perhaps because maintenance strategies become more difficult to sustain over time and familiarity leads to more negative interactional styles (Stafford & Dainton, 1994).

To summarize, the identification of factors that impact satisfaction has been an important focus of research, given the role of romantic relationship satisfaction in people's physical and psychological health. Having reviewed some of the common predictors of relationship satisfaction, a discussion of the relevance of relationship functioning to child sexual abuse will now be provided.

Few studies have examined the interpersonal sequelae associated with a history of CSA. Existing studies show that survivors of CSA often report significant problems in romantic relationships (Davis & Petretic-Jackson, 2000; Westerlund, 1992). For instance, it has been shown that incest survivors often show patterns of avoiding intimate relationships (Jehu, 1989), limiting themselves to casual and transient relationships (Jehu, 1988), and continuously seeking an intimate relationship that would "make up" for their traumatic abusive experience (Jehu, 1988). In addition, CSA survivors tend to report greater levels of romantic relationship dissatisfaction than nonabused women (DiLillo & Long, 1999; Jehu, 1988). There is also consistent evidence of higher rates of separation

and divorce in community samples of CSA survivors (Finkelhor, Hotaling, Lewis, & Smith, 1990; Mullen, Martin, Anderson, Romans, & Herbison, 1994).

Given what we know about the important role of relationship satisfaction and stability in mental health outcomes (e.g., Grych & Fincham, 1990), it is clear that relationship functioning should be a major focus of research on child sexual abuse. Unfortunately, the existing literature has tended to focus largely on the psychopathology (especially PTSD) that often results from CSA, ignoring important interpersonal outcomes and interpersonal factors that influence such outcomes. Despite the relative paucity of research on the association between CSA and interpersonal functioning, however, a few researchers have developed theoretical models to describe the process by which CSA may adversely affect interpersonal functioning. Three of these models will now be described along with the existing empirical evidence for each.

Finkelhor and Browne (1985) proposed an impact model of CSA that includes four dynamics: betrayal, traumatic sexualization, powerlessness, and stigmatization. Betrayal is believed to relate to relationship functioning in that children are generally taught to trust adults and expect their protection, but sexual abuse destroys this sense of trust and security and may foster feelings of betrayal. These betrayal issues can carry over into adulthood and lead to many adverse interpersonal outcomes. For instance, the survivor's ability to judge who she can or cannot trust may be compromised or she may embark on a "desperate search for a redeeming relationship". Alternatively, the survivor might become suspicious of intimate relationships and avoid them, or she might develop misdirected anger toward her partner.

The second dynamic of Finklehor & Brown's (1985) model is traumatic sexualization, which refers to the process in which a child's identity is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion due to sexual abuse. This factor can lead to overly sexualized attitudes and behaviors that may make survivors more vulnerable to later sexual assault and more inclined to oversexualize all relationships. The third dynamic, powerlessness, refers to the "process in which the child's will, desires, and sense of efficacy are continually contravened". This sense of powerlessness may diminish the survivor's ability to be assertive in later relationships and make her feel like she has no control over her body or what happens to her, which increases the risk of being revictimized.

The fourth dynamic of stigmatization may cause the survivor to feel that she is damaged and unworthy, such that she might give her body to others freely or isolate herself from relationships as a result of this negative self-image (Davis et al., 2000). Finkelhor & Brown's (1985) model has indeed received empirical support in the literature. Particularly, researchers have found evidence of relationship avoidance, casual relationships, and a search for redeeming relationships amongst CSA survivors (e.g., Jehu, 1989; Westerlund, 1992).

Briere (1992) also proposed a model explaining the mechanisms underlying the interpersonal impact of CSA. This abbreviated model holds that immediate cognitive and conditioned responses from the abuse (e.g., distrust of others, low self esteem, and ambivalence about interpersonal closeness) and accommodation responses (e.g., passivity, sexualization) to continued abuse may continue into adulthood and make it difficult for survivors to develop and maintain healthy relationships. This model has

been partially supported by findings of distrust, ambivalence, and oversexualization in the interpersonal functioning of CSA survivors (Blume, 1990; Westerlund, 1992).

The most recent model to explain the connection between CSA and relationship functioning was developed by Polusny and Follette (1995). Their model emphasizes the role of emotional avoidance in determining the long-term effects of CSA and describes these effects in terms of multi-systemic interactions (e.g., family, school, etc.). CSA survivors are said to employ various coping strategies in an effort to reduce or avoid memories of the abuse, including dissociation, substance abuse, casual sexual relationships, and avoidance of intimate relationships. While these behaviors may be effective in the short-term, they can result in feelings of social isolation and sexual dysfunction, which are significant interpersonal concerns. This model is supported by studies showing emotional avoidance, substance abuse, and sexual promiscuity amongst CSA survivors (Jehu, 1989; Westerlund, 1992). A description of the current study will now be provided.

Chapter Two

The Present Study

Psychological sequelae associated with the experience of CSA is perhaps the most widely studied topic in the sexual abuse literature. As such, it is well established that CSA is related to increased risk for various psychological concerns and disorders, including depression, PTSD, and substance abuse (Hall et al., 1989; Neumann, 1994; Neumann, et al., 1996). In this effort to understand the impact of CSA on psychological functioning, however, the abuse literature has neglected another important area of functioning that is often adversely affected by CSA: interpersonal functioning. In light of the robust association between relationship functioning and mental health outcomes, this represents a serious limitation in the abuse literature, given that interpersonal functioning could potentially put CSA survivors at even higher risk for mental health problems.

The proposed study, therefore, seeks to further the understanding of the association between CSA and romantic relationship functioning. This will be accomplished in two ways. First, the association between CSA and a number of romantic relationship outcomes will be examined directly. The relationship variables that will be analyzed are dyadic satisfaction, dyadic cohesion, affectional expression, and dyadic consensus, which are subscales of a widely used relationship satisfaction measure. CSA will be measured both dichotomously (i.e., sexually abused or not) and continuously in terms of severity. With respect to severity, this variable will be measured both

objectively and subjectively. That is to say, participants will be rated on the severity of their abusive experience based on objective criteria, which will include the type and number of sexual act(s) perpetrated and presence or absence of force. In addition, participants will be asked to provide a subjective rating of the degree of severity of their abusive experience. Next, it will be investigated whether mature defense mechanisms and having a sense of meaning moderate the association between sexual abuse and the relationship outcome variables. Finally, the current study will examine whether relationship functioning moderates the relationship between CSA and psychological functioning.

Hypotheses

It is hypothesized that:

1. *Discrete* CSA (i.e., abused versus non-abused) will be significantly negatively related to relationship functioning (i.e., affectional expression, dyadic consensus, dyadic cohesion, and dyadic satisfaction).
2. *Objective* CSA severity (i.e., severity based on objective criteria, such as type of sexual contact) will be significantly negatively related to relationship functioning.
3. *Perceived* CSA severity (i.e., severity based on the survivor's subjective appraisal) will be significantly related negatively related to relationship functioning.
4. The interaction of o*bjective* CSA severity and meaning will significantly predict relationship functioning.

5. The interaction of *perceived* CSA severity and meaning will significantly predict relationship functioning.
6. The interaction of *objective* CSA severity and mature defenses will significantly predict relationship functioning.
7. The interaction of *perceived* CSA severity and mature defenses will significantly predict relationship functioning.
8. The interaction of *objective* CSA severity and relationship functioning will significantly predict psychological functioning.
9. The interaction of *perceived* CSA severity and relationship functioning will significantly predict psychological functioning.

Chapter Three

Method

Participants

A total of 287 female participants who were involved in a heterosexual dating relationship at the time of the study were recruited from the undergraduate participant pool at the University of South Florida. Participants volunteered in exchange for course credit.

The age range of the participants was 18-46 years (M = 21, SD = 3.37). With respect to ethnicity, the majority of the sample was Caucasian (53.8%), 18.8% were African American, 18.4% were Latina, 5.9% were Asian, and the remaining 3% were from other ethnic groups. Most of the women (73.3%) lived in close proximity to their mate, while 26.7% considered themselves to be in a long-distance relationship. The vast majority of participants were single (94.8%), 3.8% were divorced, and the remaining 1% were either married or separated. The majority of participants (54.9%) reported being in their relationship between 1-5 years; 22.6% reported being in their relationship between 6-12 months; 14.6% reported being in their relationship less than 6 months; and 8% of the sample reported being in their relationship for more than 5 years.

Of the 287 participants, 192 women (67%) reported an absence of child sexual abuse, while 95 women (33%) reported a history of child sexual abuse. The mean age of onset of abuse was 13.5 years. The frequencies of each abuse item endorsed by the abuse sample are as follows: victim touching abuser's genitals = 27; abuser touching victim's

breasts or genitals = 43; oral sex = 12; vaginal intercourse = 11; anal intercourse = 2; forcible genital manipulation = 28; forcible oral sex = 10; forcible anal intercourse = 3; feeling sexually violated by someone's touch = 74; and unwanted sexual activity under the influence of alcohol or drugs = 16. Ninety two percent of the *abuse* sample rated the subjective severity of their abusive experiences as mild to moderate (i.e., a rating of 5 or less out of a possible rating of 10 on each perceived severity item), while 18 percent subjectively rated their abusive experiences as moderate to severe (i.e., a rating of more than 5 out of a possible rating of 10 on each perceived severity item). Nine participants or 3 percent of the sample reported receiving psychological treatment for their abusive experiences.

Measures

Demographics: Demographics were determined using a demographic data sheet asking participants to indicate their gender and partner's gender, age, race, romantic relationship status, marital status, length of current relationship, and whether their current relationship is a "long distance" one.

Relationship Functioning: Relationship functioning (i.e., affectional expression, dyadic cohesion, dyadic consensus, and dyadic satisfaction) was measured using a modified version of the Dyadic Adjustment Scale (DAS; Spanier, 1976). The DAS is comprised of four subscales (i.e., affectional expression, dyadic cohesion, dyadic consensus, and dyadic satisfaction) and contains items asking respondents to rate different aspects of their relationship on a five-point Likert scale. Different items on the DAS have different response labels, but all range from 1 to 5, such as 1 ("always disagree") to 5 ("always agree") and 1 ("all the time") to 5 ("never"). Scores on the

affectional expression subscale range from 4-20, dyadic cohesion scores range from 5-25, dyadic consensus scores range from 9-45, and dyadic satisfaction scores range from 9-45. Lower scores indicate poorer functioning in each area while higher scores indicate higher functioning. Subscale scores will be used in analyzing this variable. Modifications involved making the measure more relevant to dating couples as opposed to married couples and standardizing all responses on a five-point scale. A total of five items were deleted from the original measure, making the total number of items on the modified scale 27. It is believed that the modifications were justified because the DAS has been used in a number of studies on dating couples (e.g., Shapiro & Kroeger, 1991; Zak, Collins, Harper, & Masher, 1998). Internal consistency of the DAS is good, with values ranging from .70 for the 4-item Affectional Expression subscale to .95 for the complete instrument (Carey, Spector, Lantinga, & Krauss, 1993). Furthermore, the DAS demonstrates convergent validity with the Martial Adjustment Scale with a value of .87, and it demonstrates divergent validity with the Marital Disaffection Scale with a value of .79 (Lem & Ivey, 2000). Internal consistency for the current study was 0.83.

Childhood Sexual Abuse: For the purposes of the present study, childhood sexual abuse (CSA) was defined as any sexual contact between a child under the age of 16 and someone at least 5 years older; or unwanted and/or forcible sexual contact between a child under 16 and someone of any age. This definition was selected because it is the definition most commonly used in the CSA literature. CSA was measured using a modified version of the Early Sexual Experiences Survey (ESE; Bartoi & Kinder, 1998). The ESE is a 12-item measure that asks respondents to indicate whether or not they experienced various types of sexual encounters before the age of 16. Response options

for each item are 0 (“no”) or 1 (“yes”). A “yes” response to any of the first ten items on this scale was treated as meeting criteria for a history of CSA. Absence of a “yes” response to any of the first ten items was treated as having no history of CSA. For participants with a history of CSA, the number of “yes” responses was totaled to produce an objective CSA severity score ranging from 1-10, with 1 being the least severe and 10 being the most severe. The modifications made to the ESE involved the addition of two items at the end asking respondents who endorsed “yes” on any of the first ten items to rate the negative impact and degree of distress associated with the endorsed experience(s) on an 11-point scale, with 0 indicating no negative impact or distress and 10 indicating the most severe negative impact or distress. Responses to these items were summed to produce a perceived CSA severity score. Item 9 was also modified in order to specify that it applies to experiences of a sexual nature. Lastly, an item was added asking respondents to indicate how old they were when they had the first sexual experience endorsed. The ESE has demonstrated adequate reliability with internal consistency values around .79 (e.g., Young, Harford, Kinder, & Savell, 2007). Internal consistency for the present study was 0.70 for the first 10 items (i.e., objective CSA severity) and 0.93 for the last 2 items (i.e., perceived CSA severity).

Meaning: The degree to which participants have a sense of meaning associated with adverse experiences was measured using the short form of the Stress Related Growth Scale (SRGS; Park, Cohen, & Murch, 1996). The SRGS (short form) is a 15-item self-report measure that assesses positive cognitions and changes following traumatic events. Respondents are asked to rate items on a 3-point Likert scale going from 0 (“not at all”) to 2 (“a great deal”). Scores on the SRGS range from 0 – 45, with

lower scores indicating lower levels of meaning and higher scores indicating higher levels of meaning. Internal consistency values for the short form of the SRGS are between .90 and .95 (Frazier, Steward, & Mortensen, 2004). Internal consistency for the current study was 0.92.

Defense Mechanisms: Defense mechanisms were assessed using the 40-item version of the Defense Style Questionnaire (DSQ-40; Andrews, Singh, & Bond, 1993). The DSQ-40 is a self-report measure that asks respondents to rate statements corresponding to 20 different defense mechanisms on a 9-point Likert scale. These defense mechanisms are broadly categorized into three broad defense factors: mature, immature, or neurotic defenses. The mature defenses include suppression (i.e., consciously pushing threatening cognitions and feelings out of consciousness), humor (i.e., focusing on amusing aspects of a threatening situation), rationalization, anticipation (i.e., experiencing emotional reactions prior to possible future events and considering realistic alternative responses or solutions for such events), and sublimation. Immature defenses include projection, acting out (i.e., resorting to physical actions/behaviors rather than thinking about and discussing threatening thoughts and feelings), isolation (i.e., separating thoughts from the feelings originally accompanying them and focusing on those cognitions rather than the feelings) devaluation (i.e., attributing exaggerated negative qualities to oneself or others), autistic fantasy (i.e., excessive daydreaming as a substitute for relationships and action), denial, displacement, dissociation, splitting (i.e., failure to integrate negative and positive aspects of the self and others, thereby alternating between polar opposite thoughts and feelings, such as love and hate), and somatization (i.e., experiencing physical symptoms in response to threatening thoughts and situations).

Neurotic defenses include undoing, pseudoaltruism, idealization, reaction formation, and passive aggression. Subscale scores for each of the three defensive factors were used in analyses. The DSQ-40 has been validated in Western (Elklit, 1998) as well as Middle-Eastern (Andersen, 1998) and Asian populations (Ho & Shiu, 1995). Internal consistency values range from .58 - .80 and test-retest reliability over a 4-week period ranges from .75 to .85 for the three defensive factors (Cramer, 2000). In addition, the DSQ-40 has been shown to discriminate between anxious/depressed patients and normal controls (Sammallahti, Holi, Komulainen, & Aalberg, 1996). Internal consistency for the present study was 0.79.

Psychological Functioning: Psychological functioning was measured using the abbreviated form of the Brief Symptom Inventory (BSI; Derogatis, 1982). The abbreviated BSI is a 53-item self-report measure designed to assess common psychological symptoms. Respondents are asked to rate the extent to which each item/problem has distressed them over the past seven days on a 5-point Likert scale going from "not at all" to "extremely". The BSI consists of nine subscales: depression, interpersonal sensitivity, anxiety, phobic anxiety, paranoid ideation, somatization, obsessive-compulsive, hostility, and psychoticism. Both subscale scores and total scores (i.e., global severity index) were used in analyses. The BSI has demonstrated good reliability, with internal consistency values ranging from .71 (psychoticism subscale) to .83 (obsessive-compulsive subscale) for the subscales and test-retest reliability values of above .80 for the global severity index (Mental Measurements Yearbook, 1990). In addition, the measure has been shown to have good concurrent validity with the Wiggins content scales and the Tryon cluster scores on the Minnesota Multiphasic Personality

Inventory (MMPI), with correlations ranging from .30 to .72 (Mental Measurements Yearbook, 1990). The BSI has been used in both clinical and nonclinical samples, including college samples (Boulet & Boss, 1991; Cochran & Hale, 1985). Internal consistency for the present study was 0.96.

Procedures

Participants completed informed consent forms followed by self-report measures of demographics, relationship functioning, positive illusions, defense mechanisms, and psychological functioning in a single session. Demographic measures always came first in the questionnaire packet and the SRGS always followed the ESE. The order of the other questionnaires was randomized using a Latin square procedure. Although participants completed the questionnaire packet in a group setting (i.e., other participants were completing measures simultaneously in the same room), they were appropriately spaced in the room in order to ensure individual privacy when completing questionnaires). Informed consent forms and completed questionnaire packets were kept separate from each other in order to ensure anonymity of participants. Furthermore, one set of materials (i.e., informed consent or questionnaire packets) was always shuffled after each participant turned in her packet. After completing the measures, participants were thanked and debriefed. All procedures were approved by the Institutional Review Board of the University of South Florida. Participants were provided with referral resources in the event of adverse reactions to study participation.

Chapter Four

Results

Preliminary Analyses

The means, standard deviations, and ranges of the primary variables analyzed in the current study are presented in Table 1. Results of the analyses examining the relationship between discrete child sexual abuse and the primary criterion variables are shown in Tables 2 and 3. As hypothesized, analyses of variance indicated that discrete abuse was significantly related to dyadic consensus, $F (1, 284) = 4.49$, $p < .05$, such that women *without* a history of abuse reported higher dyadic consensus in their relationships than women *with* a history of abuse. Contrary to hypotheses, however, discrete abuse was not significantly related to affectional expression, $F (1, 282) = 0.77$, $p > .05$; dyadic satisfaction, $F (1, 236) = 3.64$, $p > .05$; or dyadic cohesion, $F (1, 282) = 0.96$, $p > .05$. Additional analyses of variance revealed that discrete sexual abuse was significantly related to most of the psychological functioning variables. More specifically, discrete abuse was related to somatization, $F (1, 279) = 9.26$, $p < .01$, interpersonal sensitivity, $F (1, 276) = 4.72$, $p < .01$, depression, $F (1, 279) = 4.64$, $p < .05$, anxiety, $F (1, 279) = 8.57$, $p < .01$, hostility, $F (1, 276) = 11.49$, $p < .01$, phobic anxiety, $F (1, 277) = 9.44$, $p < .01$, paranoid ideation, $F (1, 279) = 10.03$, $p < .01$, psychoticism, $F (1, 278) = 8.52$, $p < .01$, and the global severity index, $F (1, 263) = 8.35$, $p < .01$, whereby women *with* a history of child sexual abuse reported significantly higher levels of these psychological problems compared to women *without* a history of abuse. Contrary to predictions, correlation

analyses examining the relationship between sexual abuse severity and relationship functioning revealed that neither objective ($r = 0.02$, $p > .05$; $r = -0.12$, $p > .05$; $r = 0.12$, $p > .05$; $r = -0.09$, $p > .05$) nor perceived severity ($r = 0.04$, $p > .05$; $r = 0.13$, $p > .05$; $r = -0.02$, $p > .05$; $r = -0.03$, $p > .05$) was significantly related to the relationship functioning variables (i.e., dyadic cohesion, affectional expression, dyadic consensus, and dyadic satisfaction, respectively). These results are presented in Table 4. However, additional correlation analyses showed that sexual abuse severity was positively related to all of the psychological functioning variables. Table 5 depicts these results. Specifically, perceived sexual abuse severity and objective sexual abuse severity, respectively, were significantly related to somatization ($r = 0.33$, $p < .01$; $r = 0.25$, $p < .01$); interpersonal sensitivity ($r = 0.36$, $p < .01$; $p < .01$); obsessiveness-compulsiveness ($r = 0.29$, $p < .01$; $r = 0.19$, $p < .01$); depression ($r = 0.37$, $p < .01$; $r = 0.21$, $p < .01$); anxiety ($r = 0.34$, $p < .01$; $r = 0.25$, $p < .01$); hostility ($r = 0.34$, $p < .01$; $r = 0.27$, $p < .01$); phobic anxiety ($r = 0.36$, $p < .01$; $r = 0.29$, $p < .01$); paranoid ideation ($r = 0.45$, $p < .01$; $r = 0.25$, $p < .01$); psychoticism ($r = 0.33$, $p < .01$; $r = 0.21$, $p < .01$); and the global severity index ($r = 0.38$, $p < .01$; $r = 0.26$, $p < .01$).

Moderator Analyses

Moderator analyses (i.e., all interaction analyses) were performed solely on the abuse sample, which was comprised of 95 participants or 33 percent of the total sample. Correlation analyses were performed in order to test whether Child Sexual Abuse Severity X Meaning would be related to relationship functioning. The results of these analyses are presented in Table 6. Contrary to expectations, results showed that neither Perceived Child Sexual Abuse Severity X Meaning ($r = 0.08$, $p > .05$; $r = 0.09$, $p > .05$; r

= -0.01, p > 05; r = -0.02, p > .05) nor Objective Child Sexual Abuse Severity X Meaning (r = 0.02, p > .05; r = 0.03, > .05; r = 0.10, p > .05; r = -0.02, p > .05) was significantly related to the relationship functioning variables (i.e., dyadic cohesion, dyadic consensus, affectional expression, and dyadic satisfaction, respectively). Additonal correlation analyses were also performed in order to examine the relationship between the Child Sexual Abuse Severity X Meaning interactions and the psychological functioning variables. Table 7 presents these results. Both Perceived Child Sexual Abuse Severity X Meaning and Objective Child Sexual Abuse Severity X Meaning, respectively, were significantly positively related to somatization (r = .26, p < .05; r = .23, p < .05), obsessiveness-compulsiveness (r = .29, p < .01; r = .30, p < .01), interpersonal sensitivity (r = .28, p < .01; r = .24, p < .05), depression (r = .34, p < .01; r = .28, p < .01), anxiety (r = .32, p < .01; r = .29, p < .01), hostility (r = .28, p < .01; r = .23, p < .05), phobic anxiety (r = .31, p < .01; r = .31, p < .01), paranoid ideation (r = .36, p < .01; r = .26, p < .05), psychoticism (r = .28, p < .05; r = .22, p < .05), and the global severity index (r = .32, p < .01; r = .27, p < .01).

Correlation analyses were thereafter performed in order to examine whether Child Sexual Abuse Severity X Mature Defenses would be significantly related to the relationship functioning variables. The results of these analyses are presented in Table 8. Contrary to hypotheses, results indicated that neither Perceived Child Sexual Abuse Severity X Mature Defenses (r = 0.08, p > .08; r = 0.10, p > .05; r = -0.01, p > .05; r = 0.06, p > .05) nor Objective Child Sexual Abuse Severity X Mature Defenses (r = 0.02, p > .05; r = 0.03, p > .05; r = 0.10, p > .05, r = -0.02, p > .05) was significantly related to the relationship functioning variables (i.e., dyadic cohesion, dyadic consensus, affectional

expression, and dyadic satisfaction, respectively). Additional correlation analyses were performed in order to determine the relationship between Child Sexual Abuse Severity X Mature Defenses and psychological functioning. These results are presented in Table 9. It was found that both Perceived Child Sexual Abuse Severity X Mature Defenses and Objective Child Sexual Abuse Severity X Mature Defenses, respectively, were significantly positively related to somatization ($r = .27$, $p < .05$; $r = .21$, $p < .05$), obsessiveness-compulsiveness ($r = .25$, $p < .05$; $r = .24$, $p < .05$), depression ($r = .34$, $p < .01$; $r = .23$, $p < .05$), anxiety ($r = .29$, $p < .01$; $r = .21$, $p < .05$), phobic anxiety ($r = .30$, $p < .01$; $r = .27$, $p < .01$), and the global severity index ($r = .33$, $p < .01$; $r = .24$, $p < .05$). In addition, Perceived Child Sexual Abuse Severity X Mature Defenses was significantly positively related to interpersonal sensitivity ($r = .30$, $p < .01$), hostility ($r = .26$, $p < .01$), paranoid ideation ($r = .40$, $p < .01$), and psychoticism ($r = .29$, $p < .05$).

In order to test whether Child Sexual Abuse Severity X Meaning would uniquely predict relationship functioning, hierarchical regression procedures were performed between the Sexual Abuse Severity X Meaning variables (i.e, Perceived Child Sexual Abuse Severity X Meaning and Objective Child Sexual Abuse Severity X Meaning) and each of the relationship functioning variables. These results are shown in Tables 10-17. Contrary to hypotheses, neither Perceived Child Sexual Abuse Severity X Meaning ($R^2\Delta = 0.01$, $p > .05$; $R^2\Delta = 0.02$, $p > .05$; $R^2\Delta = 0.01$, $p > .05$; $R^2\Delta = 0.01$, $p > .05$) nor Objective Child Sexual Abuse Severity X Meaning ($R^2\Delta = 0.01$, $p > .05$; $R^2\Delta = 0.03$, $p > .05$; $R^2\Delta = 0.00$, $p > .05$; $R^2\Delta = 0.02$, $p > .05$) uniquely predicted any of the relationship functioning variables.

Regression analyses were next conducted in order to examine whether Child Sexual Abuse Severity X Mature Defenses would uniquely predict relationship functioning. These results can be found in Tables 18-25. As hypothesized, results revealed that Objective Child Sexual Abuse Severity X Mature Defenses uniquely predicted dyadic cohesion ($R^2\Delta = .04$, $p = .05$), which indicates a moderating effect. However, Objective Child Sexual Abuse Severity X Mature Defenses ($R^2\Delta = 0.00$, $p > .05$; $R^2\Delta = 0.03$, $p > .05$; $R^2\Delta = 0.04$, $p > .05$) did not uniquely predict any of the other relationship variables (i.e., dyadic consensus, affectional expression, and dyadic satisfaction, respectively). Also contrary to hypotheses, Perceived Child Sexual Abuse Severity X Mature Defenses ($R^2\Delta = 0.00$, $p > .05$; $R^2\Delta = 0.00$, $p > .05$; $R^2\Delta = 0.00$, $p > .05$; $R^2\Delta = 0.01$, $p > .05$) did not uniquely predict any of the relationship functioning variables (i.e., dyadic cohesion, dyadic consensus, affectional expression, and dyadic satisfaction, respectively).

Lastly, hierarchical regression analyses were conducted in order to test whether Child Sexual Abuse Severity X Relationship Functioning would uniquely predict psychological functioning. Tables 26-33 present these results. Contrary to hypotheses, neither Perceived Child Sexual Abuse Severity ($R2\Delta = 0.00$, $p > .05$; $R2\Delta = 0.01$, $p > .05$; $R2\Delta = 0.00$, $p > .05$; $R2\Delta = 0.02$, $p > .05$) nor Objective Child Sexual Abuse Severity ($R2\Delta = 0.01$, $p > .05$; $R2\Delta = 0.02$, $p > .05$; $R2\Delta = 0.00$, $p > .05$; $R2\Delta = 0.02$, $p > .05$) interacted with any of the four relationship variables (i.e., dyadic cohesion, dyadic consensus, affectional expression, and dyadic satisfaction, respectively) to uniquely predict psychological functioning as indicated by the global severity index.

Chapter Five

Discussion

The research literature has consistently shown that child sexual abuse (CSA) is related to a myriad of psychological and physiological sequelae for adult survivors (e.g., Neumann et al., 1996; Scarinci et al., 1995). However, only a few studies have investigated the negative interpersonal sequelae associated with CSA. As such, one of the purposes of the current study was to further the understanding of interpersonal sequelae related to CSA by examining the relationship between CSA(including both presence of abuse and severity of abuse) and four aspects of romantic relationship functioning (i.e., dyadic consensus, dyadic cohesion, affectional expression, and dyadic satisfaction) in a sample of adult female survivors.

Despite the negative outcomes frequently associated with CSA, the research literature has also demonstrated that a large number of survivors are able to adjust effectively following the trauma (e.g., Runtz & Schallow, 1997). As a result, recent studies have been interested in identifying specific coping mechanisms that protect against the risk of maladaptive outcomes for CSA survivors. However, existing studies have generally focused on psychological adjustment and consequently, protective variables related to healthy relationship adjustment have not been identified. The current study, therefore, sought to advance the understanding of protective factors related to healthy adjustment by investigating whether finding meaning in relation to the abusive

event(s) and utilizing mature defense mechanisms would moderate the association between CSA and the four relationship variables mentioned earlier.

Finally, given the well-established association between relationship dissatisfaction and psychological problems (e.g., Prigerson et al., 1999), the current study tested whether relationship satisfaction would moderate the association between CSA and psychological maladjustment.

Results found partial support for the hypothesis that discrete abuse (i.e., presence vs. absence of abuse history) would be significantly negatively related to relationship functioning. Specifically, discrete abuse was found to be negatively related to dyadic consensus, such that women with a history of CSA reported lower consensus in their relationships than women without a history of CSA. These findings are consistent with previous studies that have shown a significant association between a history of CSA and lower relationship satisfaction (e.g., Davis & Petretic-Jackson, 2000). Discrete abuse was not significantly related to dyadic cohesion, affectional expression, or dyadic satisfaction. Perhaps consensus was significantly related to abuse history because agreement with one's partner is one of the relationship areas that is most severely affected by CSA compared to other aspects of relationship functioning, such as cohesion (i.e., joint activities), affection, and global satisfaction. In this case, it might be important for psychological treatment of survivors to provide social skills training that emphasizes interpersonal agreement as a criterion for mate selection and communication and problem-solving skills training that emphasize consensus building and attainment.

Another explanation for the non-significant relationship between discrete abuse and dyadic cohesion, affectional expression, and global satisfaction is that the effect size

of the relationship between discrete abuse and these other aspects of relationship functioning is a small one, which may not have been detected by the current study due to insufficient power.

Additional analyses showed that discrete abuse was also significantly positively related to nine of the ten psychological problems analyzed in the current study (i.e., somatization, depression, anxiety, hostility, interpersonal sensitivity, phobias, paranoia, psychosis, and global psychopathology). These results are consistent with the existing literature, which has consistently demonstrated a positive relationship between a history of CSA and psychological maladjustment (e.g., Neumann, 1994).

Results did not support the hypotheses that objective and perceived CSA severity would be significantly related to dyadic consensus, dyadic cohesion, affectional expression, and dyadic satisfaction. These findings are not consistent with previous studies (e.g., DiLillo & Long, 1999; Jehu, 1988), which have shown a significant association between CSA and relationship functioning. Again, it is possible that these relationships are small effects that could not be detected by the power of the current study, which could only detect a medium or large effect.

Additional analyses did reveal, however, that both objective and perceived CSA severity were significantly positively related to all ten of the psychological problems analyzed in the current study (i.e., somatization, interpersonal sensitivity, obsessive-compulsive symptoms, depression, anxiety, hostility, phobias, paranoia, psychosis, and global psychopathology). While the moderate correlation between objective CSA severity and perceived CSA severity does suggest some overlap between these two variables, the fact that the correlation only corresponds to a small effect indicates that

objective and perceived severity at least partially tap into different constructs. This notion is further supported by the finding that the correlations between perceived severity and psychological functioning were consistently larger than the correlations between objective CSA severity and psychological functioning. The positive relationship between *objective* abuse severity and psychological problems is well documented in the CSA literature (Merrill et al., 2001). On the other hand, only one study (Martinez, 2006) to date, an unpublished manuscript, has examined and confirmed a significant relationship between *subjective* appraisals of CSA severity and psychological adjustment to CSA. Therefore, the finding of the current study that perceived abuse severity can significantly influence adjustment to abusive events, perhaps more so than objective severity, represents a major advancement in the CSA literature that has important implications for CSA survivors who are referred for psychological treatment. Specifically, assessment of survivors' appraisals of their abusive experiences and appropriate modification of any maladaptive cognitions may prove to be an effective focus of treatment.

With respect to the moderator hypotheses, there was partial support for the hypothesis that the interaction of CSA severity and mature defense mechanisms would significantly predict relationship functioning. Specifically, Objective CSA Severity X Mature Defenses was found to be a *unique* predictor of dyadic cohesion, which is consistent with the postulation that mature defenses moderates the association between CSA and relationship functioning. This finding represents another major advancement in the CSA literature because it demonstrates that using mature defenses to cope with CSA can protect against adverse relationship outcomes for CSA survivors, such as an absence of regular joint activities with their partner in intimate relationships. These

findings also suggest that clinicians might want to assess the defense mechanisms of clients with a history of CSA in order to replace maladaptive defenses (e.g., dissociation, projection, and denial) with more adaptive defenses (i.e., mature defenses), such as humor, anticipation, and sublimation. This would, of course, involve extensive clinical work because maladaptive defenses often develop in childhood (Punamaki et al., 2002) and have, therefore, become quite deep-seated by adulthood. Furthermore, maladaptive defenses tend to operate at the unconscious level (Punamaki et al., 2002), which can make them more difficult to identify.

Contrary to predictions, Objective CSA Severity X Mature Defenses was not significantly related to dyadic consensus, affectional expression, or dyadic satisfaction, nor was Perceived CSA Severity X Mature Defenses significantly related to any of the four relationship variables. Also contrary to predictions, the hypothesis that the interaction of CSA severity (objective and perceived) and having a sense of meaning related to CSA events would significantly predict relationship functioning was not supported. Like other non-significant findings discussed above, it is possible that the relationship between CSA Severity X Meaning and relationship functioning is a small effect that could not be detected by the current study due to insufficient power.

Additional analyses did show, however, that both Objective CSA Severity X Meaning and Perceived CSA Severity X Meaning were significantly positively related to all ten of the psychological functioning variables (i.e., somatization, interpersonal sensitivity, depression, anxiety, hostility, phobias, paranoia, obsessive-compulsive symptoms, psychosis, and overall psychopathology). Furthermore, Objective CSA Severity X Mature Defenses and Perceived CSA Severity X Mature Defenses were

significantly positively related to somatization, obsessive-compulsive symptoms, depression, anxiety, phobias, and overall psychopathology. Perceived CSA Severity X Mature Defenses was also significantly positively related to interpersonal sensitivity, hostility, paranoia, and psychosis. It is notable that the correlations between the CSA Severity X Meaning and CSA Severity X Mature Defenses interactions and psychological symptoms were all lower than those of the main effects, which is consistent with a possible moderating effect of meaning and mature defenses in psychological adjustment for CSA survivors. These results are consistent with previous studies that have shown that finding meaning and using mature defenses can moderate the relationship between traumatic events and psychological adjustment (e.g., Punamaki et al., 2002; Silver et al., 1983).

Despite promising findings, the current study had important limitations that must be mentioned. First, the sample was comprised solely of undergraduate females, which may not be representative of the general population of CSA survivors in terms of severity of abuse and overall adjustment. Consequently, it is not clear whether the results of the current study would generalize to other CSA populations, such as community and clinical samples. Furthermore, most of the participants were unmarried and, therefore, it is uncertain whether similar results would be found in a primarily married sample.

Unfortunately, these sampling problems are not unique to the current study. Sampling issues have been a source of concern in terms of understanding and interpreting findings in the CSA literature as a whole. Three of the major sampling techniques that have been observed in the CSA literature include random sampling, nonprobability sampling of college students (i.e., the method employed in the present study), and

requesting volunteers from the population (Goldman & Padayachi, 2000). Results of any study may vary depending upon the sample used because each type of sample may be composed of survivors with a particular background and a particular pattern in their abuse history, which are factors that could certainly influence outcomes that are measured (e.g., Spaccarelli & Kim, 1995). For example, some studies have often found lower rates of CSA incidence in college populations (e.g., 12% of females and 5% of males per Haugaard & Emery, 1989) compared to community (e.g., 20% of females and 5-10% of males per Finkelhor, 1994) and clinical samples (e.g., 50% of females and 16% of males per Callahan, Price, & Hilsenroth, 2003). Furthermore, college samples are generally composed of individuals with higher socioeconomic and educational levels as well as better overall psychological health (Goldman & Padayachi, 2000). As a result, it is reasonable to expect that findings from one type of CSA sample may not generalize to other CSA samples.

An excellent example of this generalization problem can be found in the meta-analysis conducted by Rind et al. (1998), which investigated the long term outcomes of CSA. The authors concluded that overall, CSA was not significantly related to adverse psychological outcomes as was previously contended. These findings were naturally very startling and raised serious questions about whether CSA was as important to psychological functioning and general wellbeing as the research community believed. However, there was one important factor in Rind et al.'s (1998) meta-analysis which jeopardized their major conclusions: they only examined studies using college samples! In contrast to their findings, other studies have found a robust relationship between CSA and psychological maladjustment in clinical samples (e.g., Goodman, Dutton, & Harris,

1995). Clearly, then, the results from any study on CSA has to be interpreted within the context of the particular sample used.

Another sampling issue in the CSA literature has to do with sample heterogeneity (Saywitz, Mannarino, Berliner, & Cohen, 2000). Within any sample of CSA survivors - whether college, community, or clinical – there is often tremendous variability in the abusive experiences of these individuals (Saywitz et al., 2000). Nevertheless, researchers frequently treat CSA as a discrete construct and classify individuals with vastly different abusive experiences into one generic CSA group (Haugaard, 2000). Outcome data from such a group would, therefore, be the result of an overall mean that is not sensitive enough to detect unique patterns in particular subgroups of participants. For instance, contact sexual abuse has been associated with poorer psychological outcomes than non-contact sexual abuse (e.g., Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000). Use of force and having a closer relationship to the offender are also consistent predictors of psychological symptoms (Spaccarelli, 1994).

In addition to sampling issues, the current study had limitations with respect to power. More specifically, the sample size was only large enough to detect a medium effect with a power of .80. A larger sample of abused women would have provided the power to detect smaller effects. For instance, the moderating effect of meaning on relationship adjustment may be a small one. Similarly relationship functioning may be a small moderator of psychological adjustment for CSA survivors.

Instrumentation represents yet another limitation of the current study. Because perceived severity was assessed solely on the basis of two items created for the purposes of the study, it is possible that participants' perceptions of CSA severity were not fully

tapped. Perhaps additional items would have yielded a more accurate measure of perceived severity.

Like other issues discussed earlier, instrumentation also poses a challenge in the wider CSA literature. Many studies have relied on unstandardized CSA measures, such as the one used to measure CSA severity in the present study, whose reliability and validity have not been well verified (Briere, 1992). Part of the problem is that only few standardized measures exist that were developed specifically for use with CSA survivors, which has caused researchers to rely on generic and/or unstandardized instruments (Mannon & Leitschuh, 2002). In a review of methodological issues in CSA research, Mannon & Leitschuh (2002) identified 41 different measures of CSA used in the existing literature, 24 of which were unstandardized. It is also important to mention that measures that use few (e.g., less than 4) and broad CSA screening questions yield much lower rates of CSA than those that use more questions and more specific questions (Wyatt, 1985; Wyatt & Peters, 1986). Needless to say, the findings studies using unstandardized measures that have not been validated must be interpreted with caution.

Another important limitation of the current study, and the CSA literature in general, relates to the definition of child sexual abuse itself. The present study defined CSA as any sexual contact between a child under the age of 16 and someone at least 5 years older; or unwanted and/or forcible sexual contact between a child under 16 and someone of any age. However, it seems like every word in the term *child sexual abuse* has been defined differently by different researchers (Haugaard, 2000). For instance, some researchers have defined *child* as being a person under the age of 18 (e.g., Wyatt, 1985), whereas others have set the cutoff at under 16 (e.g., Wurr & Partridge, 1996).

With respect to the sexual component, there is also some degree of ambiguity and inconsistency regarding which behaviors are and are not considered to be sexual. For example, some researchers might argue that a father who bathes his 7 year old daughter is engaging in sexual behavior, while others might disagree. What constitutes abuse is another source of debate amongst CSA researchers. Many have contended that abuse requires the presence of some observable harm (e.g., Rind, Tromovitch, & Bauserman, 1998), but others would insist that certain acts are abusive, whether or not they result in demonstrable harm (Haugaard, 2000).

As one might imagine, combining these varied conceptualizations of the component parts of CSA has resulted in a number of different definitions of CSA as was mentioned earlier. For example, Friedrich et al. (1986) defined CSA as direct or indirect sexual contact of a child with an adult, whether through force or consent (notice that the authors did not include any age limits in their definition). Schaaf and McCann (1998), on the other hand, defined CSA as any type of sexual contact between a child under 15 and someone at least 5 years older. Peters and Range (1995) had a similar definition but used the cutoff age of 12 as opposed to 15 to define a child. Finkelhor (1979) had yet another definition of CSA: sexual activity between a child and an older person, including simulated, attempted or actual intercourse, kissing, hugging or fondling in a sexual manner, sexual overtures and exhibitionism occurring between a child of 12 or under and an adult over 18; or between a child of 12 or under and a person more than 5 years older than the child; or between an adolescent and an adult at least 10 or more years older than the adolescent.

As a result of these variations in how CSA has been defined by researchers, the samples of CSA survivors from existing studies have been markedly different in terms of their age and their abusive experiences (Haugaard, 2000). Furthermore, the epidemiology of CSA has been difficult to determine because depending on the definition of CSA employed, a different rate of incidence is obtained. For example, previous studies have found that 12 percent of women in college samples report a history of CSA (e.g., Haugaard & Emery, 1989), whereas the current study found a rate of 33 percent in the undergraduate women sampled. Consequently, it has been difficult to compare different studies in an effort to make global interpretations and develop a reliable and comprehensive body of knowledge on CSA.

Another methodological concern in the present study and many other CSA studies is the reliance on retrospective reports of CSA (Hulme, 2004). This methodology is inherently fraught with problems surrounding the accuracy of survivors' memories of their abusive experiences, given that adult survivors are trying to recall the details of incident(s) that occurred several years earlier. Consequently, the results generated from these retrospective studies have limited reliability and validity.

Finally, internal validity is a major limitation of the current study and the CSA literature as a whole. Although many important risk, protective, and mediating factors associated with CSA outcomes have been identified, most studies have used non-experimental designs that do not fulfill the 3 necessary criteria for inferring causality between variables: covariation between variables, time-order relationship between variables, and elimination of alternative explanations for findings (Kazdin, 2003). As such, it is difficult to infer causal links between CSA and these variables. CSA studies

have generally used cross-sectional, longitudinal/prospective, and retrospective designs (Briere, 1992), which are correlational designs that can only reveal the degree to which variables are related (Trochim, 2005). Cross-sectional and retrospective designs only satisfy the first requisite condition for causality, which is covariation between variables (Kazdin, 2003). Longitudinal or prospective designs offer some advantage over these two designs in that they can establish a time-order relationship between CSA and predictor or outcome variables, in addition to simply showing covariation (Trochim, 2005). However, the absence of random assignment to groups or levels of the independent variable (IV) precludes the inference that the IV caused changes in the dependent variable (DV) because alternative explanations could have caused those changes (Kazdin, 2003). As such, longitudinal designs fail to fulfill the third criterion for causality (i.e., ruling out alternative explanations).

It is important to note that the lack of internal validity in the CSA literature is due in large part to ethical constraints. That is, it would be unethical in most instances to implement experimental designs using random assignment in an effort to identify factors that cause CSA and adverse outcomes associated with it. For example, it would obviously be unethical (as well as illegal) to randomly assign individuals to a CSA condition in order to determine whether CSA is causally related to psychological adjustment.

Limitations notwithstanding, the current study has elucidated several areas in which research on the moderating effects of mature defenses and meaning on CSA adjustment might be advanced. For instance, it would be important to investigate the moderating role of meaning and mature defenses on interpersonal adjustment of different

populations of CSA survivors, such as clinical samples, community samples, and married samples. In addition, longitudinal studies that follow CSA survivors over time would help to elucidate whether the effect of meaning and defense mechanisms on adjustment differs over time. Finally, it would be useful to further explore the moderating role of meaning and mature defenses on psychological adjustment of CSA survivors.

Table1

Descriptive Statistics for Continuous Variables

Variable	Mean	SD	Range
CSA Severity Objective	0.81	1.44	0.00-7.00
CSA Severity Perceived	6.35	5.82	0.00-18.00
Dyadic Consensus	35.72	4.76	16.00-64.00
Affectional Expression	12.36	1.56	7.00-17.00
Dyadic Cohesion	19.76	2.62	11.00-25.00
Dyadic Satisfaction	31.64	2.95	22.00-38.00
Somatization	0.96	0.92	0.00-5.43
Obsessiveness-Compulsiveness	1.71	1.35	0.00-9.50
Interpersonal Sensitivity	1.69	1.43	0.00-7.50
Depression	1.19	1.14	0.00-5.83
Anxiety	1.20	1.08	0.00-5.67
Hostility	1.35	1.10	0.00-7.00
Phobic Anxiety	0.92	0.95	0.00-6.00
Paranoid Ideation	1.38	1.13	0.00-6.20
Psychoticism	1.11	1.10	0.00-6.60
Global Severity Index	0.21	0.18	0.00-1.05
Meaning	18.21	8.86	0.00-31.00
Mature Defenses	5.70	1.16	1.50-8.63

CSA = Child Sexual Abuse

Table 2

Analysis of Variance between Discrete Child Sexual Abuse and Relationship Functioning

Variable	Group	N	Mean	SD	F	Cohen's d
Dyadic Consensus	Abused	94	34.86	4.53	4.49*	-0.27
	Non-Abused	192	36.13	4.83		
Dyadic Cohesion	Abused	95	19.97	3.06	0.96	0.12
	Non-Abused	189	19.65	2.37		
Affectional Expression	Abused	95	12.48	1.57	0.77	0.11
	Non-Abused	189	12.31	1.56		
Dyadic Satisfaction	Abused	79	31.13	3.42	3.64	-0.25
	Non-Abused	159	31.90	2.67		

*$p \leq .05$

Table 3

Analysis of Variance between Discrete Child Sexual Abuse and Psychological Functioning

Variable	Group	N	Mean	SD	F	Cohen's d
Somatization	Abused	92	1.20	1.04	9.23**	0.37
	Non-Abused	189	0.85	0.83		
Obsessive-Compulsive	Abused	93	1.91	1.48	2.83	0.21
	Non-Abused	189	1.62	1.28		
Interpersonal Sensitivity	Abused	92	1.95	1.54	4.72*	0.27
	Non-Abused	186	1.56	1.35		
Depression	Abused	93	1.40	1.25	4.64*	0.27
	Non-Abused	188	1.09	1.07		
Anxiety	Abused	92	1.47	1.26	8.57**	0.36
	Non-Abused	189	1.07	0.96		
Hostility	Abused	93	1.66	1.30	11.49**	0.40
	Non-Abused	185	1.20	0.95		
Phobic Anxiety	Abused	93	1.16	1.18	9.4**	0.18
	Non-Abused	186	0.80	0.78		
Paranoid Ideation	Abused	93	1.68	1.29	10.03**	0.39
	Non-Abused	188	1.23	1.02		
Psychoticism	Abused	92	1.38	1.21	8.52**	0.36
	Non-Abused	188	0.98	1.02		
Global Severity Index	Abused	89	0.26	0.21	8.40**	0.37
	Non-Abused	176	0.19	0.16		

*p ≤ .05, **p ≤ .01

Table 4

Correlations between Child Sexual Abuse Severity and Relationship Functioning Variables

Variable	Perc Sev	Obj Sev	Dyadic Consen	Dyadic Cohesion	Affection Expression	Dyadic Satisfaction
Perceived Severity	1.00	0.43**	-0.02	0.04	0.13	-0.03
Objective Severity	-	1.00	-0.12	0.02	0.12	-0.09
Dyadic Consensus	-	-	1.00	0.43**	0.01	0.39**
Dyadic Cohesion	-	-	-	1.00	0.07	0.37**
Affectional Expression	-	-	-	-	1.00	-0.07
Dyadic Satisfaction	-	-	-	-	-	1.00

**$p \leq .01$
Perc Sev = Perceived Child Sexual Abuse Severity
Obj Sev = Objective Child Sexual Abuse Severity
Dyadic Consen = Dyadic Consensus

Table 5

Correlations between Child Sexual Abuse Severity and Psychological Functioning Variables

Variable	Perc Sev	Obj Sev	Som	Obsess-Comp	Interpers Sensitivity	Dep	Anx	Host	Phobic Anx	Para Idea	Psych	GSI
Perc Sev	1.00	0.43**	0.33**	0.29**	0.37**	0.34**	0.34**	0.34**	0.36**	0.45**	0.33**	0.38**
Obj Sev	-	1.00	0.25**	0.21**	0.19**	0.21**	0.25**	0.27**	0.29**	0.25**	0.21**	0.26**
Somatization	-	-	1.00	0.77**	0.77**	0.84**	0.86**	0.81**	0.82**	0.75**	0.82**	0.89**
Obsess-Comp	-	-	-	1.00	0.78**	0.79**	0.79**	0.78**	0.76**	0.74**	0.77**	0.87**
Interpers Sens	-	-	-	-	1.00	0.88**	0.88**	0.87**	0.87**	0.88**	0.88**	0.94**
Depression	-	-	-	-	-	1.00	0.88**	0.86**	0.86**	0.85**	0.93**	0.95**
Anxiety	-	-	-	-	-	-	1.00	0.87**	0.88**	0.83**	0.89**	0.95**
Hostility	-	-	-	-	-	-	-	1.00	0.87**	0.85**	0.87**	0.93**
Phobic Anx	-	-	-	-	-	-	-	-	1.00	0.83**	0.86**	0.93**
Paranoid Ideation	-	-	-	-	-	-	-	-	-	1.00	0.87**	0.92**
Psychoticism	-	-	-	-	-	-	-	-	-	-	1.00	0.95**
GSI	-	-	-	-	-	-	-	-	-	-	-	1.00

**p ≤ .01

Perc Sev = Perceived Severity
Obj Sev = Objective Severity
Som = Somatization
Obsess-Comp = Obsessiveness-Compulsiveness
Interpers Sensitivity = Interpersonal Sensitivity
Dep = Depression
Anx = Anxiety
Host = Hostility
Phobic Anx = Phobic Anxiety
Para Idea = Paranoid Ideation
Psych = Psychoticism
GSI – Global Severity Index

Table 6

Correlations between Child Sexual Abuse Severity X Meaning and Relationship Functioning Variables

Variable	Perc Sev X Mean	Obj Sev X Mean	Dyadic Cons	Dyadic Cohes	Affection Exp	Dyadic Sat
Perc Sev X Mean	1.00	0.54**	0.09	0.08	-0.01	-0.02
Obj Sev X Mean	-	1.00	0.03	0.02	0.10	-0.02
Dyadic Consensus	-	-	1.00	0.43**	0.01	0.39**
Dyadic Cohesion	-	-	-	1.00	0.07	0.37**
Affection Exp	-	-	-	-	1.00	-0.07
Dyadic Sat	-	-	-	-	-	1.00

**$p \leq .01$
Dyadic Cons = Dyadic Consensus
Dyadic Cohes = Dyadic Cohesion
Affection Exp = Affectional Expression
Dyadic Sat = Dyadic Satisfaction
Perc Sev = Perceived Severity
Obj Sev = Objective Severity
Mean = Meaning

Table 7

Correlations between Child Sexual Abuse Severity X Meaning and Psychological Functioning Variables

Variable	Perc Sev X Mean	Obj Sev X Mean	Som	Obsess-Comp	Interpers Sens	Dep	Anx	Host	Phobic Anx	Para Idea	Psych	GSI
Perc Sev X Mean	1.00	0.54**	0.26*	0.29**	0.28**	0.34**	0.32**	0.28**	0.31**	0.36**	0.28**	0.32**
Obj Sev X Mean	-	1.00	0.23*	0.30**	0.24*	0.28**	0.29**	0.23*	0.31**	0.26*	0.22*	0.27**
Somatization	-	-	1.00	0.77**	0.77**	0.84**	0.86**	0.81**	0.82**	0.75**	0.82**	0.89**
Obsess-Comp	-	-	-	1.00	0.78**	0.79**	0.79**	0.78**	0.76**	0.74**	0.77**	0.87**
Interpers Sens	-	-	-	-	1.00	0.88**	0.88**	0.87**	0.87**	0.88**	0.88**	0.94**
Depression	-	-	-	-	-	1.00	0.88**	0.86**	0.86**	0.85**	0.93**	0.95**
Anxiety	-	-	-	-	-	-	1.00	0.87**	0.88**	0.83**	0.89**	0.95**
Hostility	-	-	-	-	-	-	-	1.00	0.87**	0.85**	0.87**	0.93**
Phobic Anx	-	-	-	-	-	-	-	-	1.00	0.83**	0.86**	0.93**
Paranoid Ideation	-	-	-	-	-	-	-	-	-	1.00	0.87**	0.92**
Psychoticism	-	-	-	-	-	-	-	-	-	-	1.00	0.95**
GSI	-	-	-	-	-	-	-	-	-	-	-	1.00

*p ≤ .05, ** p ≤ .01
Som = Somatization
Obsess-Comp = Obsessiveness-Compulsiveness
Interpers Sens = Interpersonal Sensitivity
Dep = Depression
Perc Sev = Perceived Severity
Obj Sev = Objective Severity
Host = Hostility
Phobic Anx = Phobic Anxiety
Para Idea = Parnoid Ideation
Psych = Psychoticism
Anx = Anxiety
GSI = Global Severity Index
Mean = Meaning

Table 8

Correlations between Child Sexual Abuse Severity X Mature Defenses and Relationship Functioning Variables

Variable	Perc Sev X Mat Def	Obj Sev X Mat Def	Dyadic Cons	Dyadic Cohes	Affection Exp	Dyadic Sat
Perc Sev X Mat Def	1.00	0.30**	0.10	0.08	-0.01	0.06
Obj Sev X Mat Def	-	1.00	0.03	0.02	0.10	-0.02
Dyadic Consensus	-	-	1.00	0.43**	0.01	0.39**
Dyadic Cohesion	-	-	-	1.00	0.07	0.37**
Affectional Expression	-	-	-	-	1.00	-0.07
Dyadic Sat	-	-	-	-	-	1.00

**$p \leq .01$
Dyadic Cons = Dyadic Consensus
Dyadic Cohes = Dyadic Cohesion
Affection Exp = Affectional Expression
Dyadic Sat = Dyadic Satisfaction
Perc Sev = Perceived Severity
Obj Sev = Objective Severity
Mat Def = Mature Defenses

Table 9

Correlations between Child Sexual Abuse Severity X Mature Defenses and Psychological Functioning Variables

Variable	Perc Sev X Mat Def	Obj Sev X Mat Def	Som	Obsess-Comp	Interpers Sens	Dep	Anx	Host	Phobic Anx	Para Idea	Psych	GSI
Perc Sev X Mat Def	1.00	0.30*	0.27*	0.25*	0.30**	0.34**	0.29**	0.26*	0.30**	0.40**	0.29**	0.33**
Obj Sev X Mat Def	-	1.00	0.21*	0.24*	0.20	0.23*	0.21*	0.19	0.27**	0.21	0.14	0.24
Somatization	-	-	1.00	0.77**	0.77**	0.84**	0.86**	0.81**	0.82**	0.75**	0.82**	0.89**
Obsess-Comp	-	-	-	1.00	0.78**	0.79**	0.79**	0.78**	0.76**	0.74**	0.77**	0.87**
Interpers Sens	-	-	-	-	1.00	0.88**	0.88**	0.87**	0.87**	0.88**	0.88**	0.94**
Depression	-	-	-	-	-	1.00	0.88**	0.86**	0.86**	0.85**	0.93**	0.95**
Anxiety	-	-	-	-	-	-	1.00	0.87**	0.88**	0.83**	0.89**	0.95**
Hostility	-	-	-	-	-	-	-	1.00	0.87**	0.85**	0.87**	0.93**
Phobic Anx	-	-	-	-	-	-	-	-	1.00	0.83**	0.86**	0.93**
Paranoid Ideation	-	-	-	-	-	-	-	-	-	1.00	0.87**	0.92**
Psychoticism	-	-	-	-	-	-	-	-	-	-	1.00	0.95**
GSI	-	-	-	-	-	-	-	-	-	-	-	1.00

*p ≤.05, p≤ .01
Som = Somatization
Obsess-Comp = Obsessiveness-Compulsiveness
Interpers Sens = Interpersonal Sensitivity
Dep = Depression
Anx = Anxiety
Host = Hostility
Mat Def = Mature Defenses
Phobic Anx = Phobic Anxiety
Para Idea = Paranoid Ideation
Psych = Psychoticism
GSI = Global Severity Index
Perc Sev = Perceived Severity
Obj Sev = Objective Severity

Table 10

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Meaning and Affectional Expression

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	0.22	2.14	0.04	0.05	0.09
Meaning	-0.08	-0.75	0.46		
Step 2					
Obj CSA Sev X Meaning	-0.10	-0.32	0.75	0.00	0.75

Obj CSA Sev = Objective Child Sexual Abuse Severity

Table 11

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Meaning and Affectional Expression

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.10	0.98	0.33	0.01	0.54
Meaning	-0.07	-0.68	0.50		
Step 2					
Perc CSA Sev X Meaning	-0.30	-1.15	0.26	0.01	0.26

Perc CSA Sev = Perceived Child Sexual Abuse Severity

Table 12

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Meaning and Dyadic Consensus

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	-0.05	-0.50	0.62	0.00	0.87
Meaning	0.02	0.20	0.84		
Step 2					
Obj CSA Sev X Meaning	0.47	1.54	0.13	0.03	0.13

Obj CSA Sev = Objective Child Sexual Abuse Severity

Table 13

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Meaning and Dyadic Consensus

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.03	0.30	0.77	0.00	0.95
Meaning	0.01	0.10	0.92		
Step 2					
Perc CSA Sev X Meaning	0.36	1.36	0.18	0.02	0.18

Perc CSA Sev = Perceived Child Sexual Abuse Severity

Table 14

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Meaning and Dyadic Satisfaction

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	0.02	0.18	0.86	0.00	0.96
Meaning	0.03	0.21	0.83		
Step 2					
Obj CSA Sev X Meaning	-0.41	-1.22	0.23	0.02	0.23

Obj CSA Sev = Objective Child Sexual Abuse Severity

Table 15

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Meaning and Dyadic Satisfaction

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.01	0.12	0.91	0.00	0.96
Meaning	0.03	0.24	0.81		
Step 2					
Perc CSA Sev X Meaning	-0.28	-0.98	0.33	0.01	0.33

Perc CSA Sev = Perceived Child Sexual Abuse Severity

Table 16

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Meaning and Dyadic Cohesion

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	-0.08	-0.73	0.47	0.03	0.25
Meaning	0.16	1.59	0.12		
Step 2					
Obj CSA Sev X Meaning	-0.27	-0.87	0.38	0.01	0.38

Obj CSA Sev = Objective Child Sexual Abuse Severity

Table 17

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Meaning and Dyadic Cohesion

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.04	0.34	0.73	0.03	0.31
Meaning	0.15	1.44	0.15		
Step 2					
Perc CSA Sev X Meaning	-0.23	-0.87	0.39	0.01	0.39

Perc CSA Sev = Perceived Child Sexual Abuse Severity

Table 18

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Mature Defenses and Dyadic Consensus

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	-0.03	-0.32	0.75	0.05	0.09
Mature Defenses	0.23	2.23	0.03		
Step 2					
Obj CSA Sev X Mat Def	-0.11	-0.21	0.83	0.00	0.83

Obj CSA Sev = Objective Child Sexual Abuse Severity
Mat Def = Mature Defenses

Table 19

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Mature Defenses and Dyadic Consensus

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.04	0.41	0.68	0.06	0.08
Mature Defenses	0.23	2.21	0.03		
Step 2					
Perc CSA Sev X Mat Def	-0.18	-0.34	0.74	0.00	0.74

Perc CSA Sev = Perceived Child Sexual Abuse Severity
Mat Def = Mature Defenses

Table 20

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Mature Defenses and Affectional Expression

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	0.20	2.08	0.04	0.16	0.00
Mature Defenses	-0.35	-3.57	0.00		
Step 2					
Obj CSA Sev X Mat Def	0.84	1.73	0.09	0.03	0.09

Obj CSA Sev = Objective Child Sexual Abuse Severity
Mat Def = Mature Defenses

Table 21

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Mature Defenses and Affectional Expression

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.10	1.02	0.31	0.14	0.00
Mature Defenses	-0.36	-3.59	0.00		
Step 2					
Perc CSA Sev X Mat Def	-0.20	-0.38	0.70	0.00	0.70

Perc CSA Sev = Perceived Child Sexual Abuse Severity
Mat Def = Mature Defenses

Table 22

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Mature Defenses and Dyadic Satisfaction

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	0.04	0.35	0.73	0.04	0.19
Mature Defenses	0.21	1.80	0.08		
Step 2					
Obj CSA Sev X Mat Def	-1.00	-1.66	0.10	0.04	0.10

Obj CSA Sev = Objective Child Sexual Abuse Severity
Mat Def = Mature Defenses

Table 23

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Mature Defenses and Dyadic Satisfaction

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.04	0.37	0.71	0.05	0.19
Mature Defenses	0.21	1.82	0.07		
Step 2					
Perc CSA Sev X Mat Def	-0.52	-0.86	0.40	0.01	0.40

Table 24

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Mature Defenses and Dyadic Cohesion

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	-0.07	-0.65	0.52	0.01	0.57
Mature Defenses	0.09	0.83	0.41		
Step 2					
Obj CSA Sev X Mat Def	-1.06	-2.02	0.05	0.04*	0.05*

*$p \leq .05$
Obj CSA Sev = Objective Child Sexual Abuse Severity
Mat Def = Mature Defenses

Table 25

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Mature Defenses and Dyadic Cohesion

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.06	0.55	0.58	0.01	0.60
Mature Defenses	0.09	0.83	0.41		
Step 2					
Perc CSA Sev X Mat Def	-0.10	-0.18	0.86	0.00	0.86

Perc CSA Sev = Perceived Child Sexual Abuse Severity
Mat Def = Mature Defenses

Table 26

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Dyadic Consensus and Global Severity Index

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	0.29	0.28	0.01	0.15	0.00
Dyadic Consensus	-0.25	-2.48	0.02		
Step 2					
Obj CSA Sev X Dy Cons	-1.08	-1.25	0.21	0.02	0.21

Obj CSA Sev = Objective Child Sexual Abuse Severity
Dy Cons = Dyadic Consensus

Table 27

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Dyadic Consensus and Global Severity Index

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.38	3.96	0.00	0.22	0.00
Dyadic Consensus	-0.29	-2.97	0.00		
Step 2					
Perc CSA Sev X Dy Cons	-0.81	-0.94	0.35	0.01	0.35

Perc CSA Sev = Perceived Child Sexual Abuse Severity
Dy Cons = Dyadic Consensus

Table 28

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Affectional Expression and Global Severity Index

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	0.26	2.56	0.01	0.12	0.00
Affectional Expression	0.19	1.79	0.08		
Step 2					
Obj CSA Sev X Aff Exp	-0.56	-0.61	0.55	0.00	0.55

Obj CSA Sev = Objective Child Sexual Abuse Severity
Aff Exp = Affectional Expression

Table 29

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Affectional Expression and Global Severity Index

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.35	3.51	0.00	0.17	0.00
Affectional Expression	0.20	1.96	0.05		
Step 2					
Perc CSA Sev X Aff Exp	0.46	0.57	0.57	0.00	0.57

Perc CSA Sev = Perceived Child Sexual Abuse Severity
Aff Exp = Affectional Expression

Table 30

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Dyadic Cohesion and Global Severity Index

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	0.29	2.88	0.01	0.11	0.01
Dyadic Cohesion	-0.15	-1.48	0.14		
Step 2					
Obj CSA Sev X Dy Cohes	-0.76	-1.08	0.29	0.01	0.29

Obj CSA Sev = Objective Child Sexual Abuse Severity
Dy Cohes = Dyadic Cohesion

Table 31

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Dyadic Cohesion and Global Severity Index

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.39	3.89	0.00	0.18	0.00
Dyadic Cohesion	-0.21	-2.08	0.04		
Step 2					
Perc CSA Sev X Dy Cohe	-0.30	-0.43	0.67	0.00	0.67

Perc CSA Sev = Perceived Child Sexual Abuse Severity
Dy Cohe = Dyadic Cohesion

Table 32

Hierarchical Multiple Regression Analysis between Objective Child Sexual Abuse Severity X Dyadic Satisfaction and Global Severity Index

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Objective CSA Severity	0.35	3.44	0.00	0.25	0.00
Dyadic Satisfaction	-0.37	-3.61	0.00		
Step 2					
Obj CSA Sev X Dy Sat	-1.14	-1.38	0.17	0.02	0.17

Obj CSA Sev = Objective Child Sexual Abuse Severity
Dy Sat = Dyadic Satisfaction

Table 33

Hierarchical Multiple Regression Analysis between Perceived Child Sexual Abuse Severity X Dyadic Satisfaction and Global Severity Index

Variable	Beta	t	Sig	$R^2\Delta$	Sig
Step 1					
Perceived CSA Severity	0.37	3.69	0.00	0.27	0.00
Dyadic Satisfaction	-0.38	-3.74	0.00		
Step 2					
Perc CSA Sev X Dyadic Sat	-1.19	-1.24	0.22	0.02	0.22

Perc CSA Sev = Perceived Child Sexual Abuse Severity
Dyadic Sat = Dyadic Satisfaction

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Appendices

Appendix A

Demographics

1. Are you currently in a romantic relationship with **one and only one** person?

   _____ YES _____NO

2. What is your marital status?

   _____ Married

   _____ Single (never been married)

   _____ Separated

   _____ Divorced

3. Please indicate the length of your relationship with your current partner. Check one.

   _____ less than 6 *months*

   _____ 6 – 12 *months*

   _____ 1 – 5 *years*

   _____ more than 5 *years*

4. Do you consider yourself to be in a long distance relationship?

   _____ YES _____ NO

5. What is *your* gender?

   _____ MALE _____ FEMALE

6. What is the gender of *your partner*?

   _____ MALE _____ FEMALE

7. What is your age? _____

8. Which of the following best describes your ethnic background? Check one.

   _____ African American/Black

   _____ Hispanic/Latino

   _____ Caucasian

   _____ Asian

   _____ Arab

   _____ Native American

Appendix B

ESE

We would like to get an idea about the type of sexual experiences you may have had before the age of 16 (15 and younger). Please answer yes or no to the following questions in terms of that time.

Before the age of 16 (15 and younger)

	No	Yes
1. Did you ever touch the genitals of someone at least 5 years older than you?	0	1
2. Did someone at least 5 years older than you ever touch your genitals or breasts (besides for a physical examination)?	0	1
3. Did you engage in oral sex (cunnilingus and/or fellatio) with someone at least 5 years older than you?	0	1
4. Did you engage in vaginal intercourse with someone at least 5 years older than you?	0	1
5. Did you engage in anal intercourse with someone at least 5 years older than you?	0	1
6. Were you forced into genital manipulation that was unwanted by anyone of any age?	0	1
7. Were you forced into oral sex (cunnilingus and/or fellatio) that was unwanted by anyone of any age?	0	1
8. Were you forced into anal intercourse that was unwanted by anyone of any age?	0	1
9. Were you ever touched in a way that made you feel sexually violated?	0	1
10. Did you engage in any unwanted sexual activity while too intoxicated or influenced by drugs to give consent?	0	1

11. If you answered yes to ANY of the first 10 questions, how old were you when you first had the experience (if there were multiple experiences, think of the one that occurred when you were youngest)? _____ (write your response here)

12. Have you ever received psychological treatment?	0	1
13. If yes, was sexual abuse one of the issues covered?	0	1

14. If you answered "yes" to ANY of the first 10 questions, please rate the extent to which your experience has had a negative impact on your life (0 being no negative impact at all, 5 being a moderate negative impact, and 10 being a severe negative impact; CIRCLE ONE) 0 1 2 3 4 5 6 7 8 9 10

15. If you answered "yes" to ANY of the first 10 questions, please rate the extent to which your experience has distressed you (0 being not distressed at all, 5 being moderately distressing, and 10 being severely distressing; CIRCLE ONE) 0 1 2 3 4 5 6 7 8 9 10

Appendix C

SRG

For this questionnaire, please consider the most stressful sexual experience you endorsed in the previous questionnaire (if you did not endorse any of the sexual experiences in that questionnaires, then consider the most stressful experience you had before age 16)

Read the following statements and respond to each item using the scale below:

"0" (not at all), "1" (somewhat), or "2" (a great deal).

Because of this stressful event:

1. I learned to be nicer to others.	0	1	2
2. I feel freer to make my own decisions.	0	1	2
3. I learned that I have something of value to teach others about life.	0	1	2
4. I learned to be myself and not try to be what others want me to be.	0	1	2
5. I learned to work through problems and not just give up.	0	1	2
6. I learned to find more meaning in life.	0	1	2
7. I learned to how to reach out and help others.	0	1	2
8. I learned to be a more confident person.	0	1	2
9. I learned to listen more carefully when others talk to me.	0	1	2
10. I learned to be open to new information and ideas.	0	1	2
11. I learned to communicate more honestly with others.	0	1	2
12. I learned that I want to have some impact on the world.	0	1	2
13. I learned that it's OK to ask others for help.	0	1	2
14. I learned to stand up for my personal rights.	0	1	2
15. I learned that there are more people who care about me than I thought.	0	1	2

Appendix D

DSQ-40

This questionnaire consists of a number of statements about personal attitudes. *There are no right or wrong answers*. Using the 9-point scale shown below, please indicate how much you agree or disagree with each statement by *circling* one of the numbers on the scale beside the statement. For example, a score of **5** would indicate that you neither agree nor disagree with the statement, a score of **3** that you moderately disagree, a score of **9** that you strongly agree.

1	2	3	4	5	6	7	8	9
Strongly disagree								***Strongly agree***

1. I get satisfaction from helping others and if this were taken away from me I would get depressed.
   1 2 3 4 5 6 7 8 9

2. I'm able to keep a problem out of my mind until I have time to deal with it.
   1 2 3 4 5 6 7 8 9

3. I work out my anxiety through doing something constructive and creative like painting or woodwork.
   1 2 3 4 5 6 7 8 9

4. I am able to find good reasons for everything I do.
   1 2 3 4 5 6 7 8 9

5. I'm able to laugh at myself pretty easily.
   1 2 3 4 5 6 7 8 9

6. People tend to mistreat me.
   1 2 3 4 5 6 7 8 9

7. If someone mugged me and stole my money, I'd rather he be helped than punished.
   1 2 3 4 5 6 7 8 9

8. People say I tend to ignore unpleasant facts as if they didn't exist.
   1 2 3 4 5 6 7 8 9

9. I ignore danger as if I was Superman.
   1 2 3 4 5 6 7 8 9

10. I pride myself on my ability to cut people down to size.
    1 2 3 4 5 6 7 8 9

11. I often act impulsively when something is bothering me.
1 2 3 4 5 6 7 8 9

12. I get physically ill when things aren't going well for me.
1 2 3 4 5 6 7 8 9

13. I'm a very inhibited person.
1 2 3 4 5 6 7 8 9

14. I get more satisfaction from my fantasies than from my real life.
1 2 3 4 5 6 7 8 9

15. I've special talents that allow me to go through life with no problems.
1 2 3 4 5 6 7 8 9

16. There are always good reasons when things don't work out for me.
1 2 3 4 5 6 7 8 9

17. I work more things out in my daydreams than in my real life.
1 2 3 4 5 6 7 8 9

18. I fear nothing.
1 2 3 4 5 6 7 8 9

19. Sometimes I think I'm an angel and other times I think I'm a devil.
1 2 3 4 5 6 7 8 9

20. I get openly aggressive when I feel hurt.
1 2 3 4 5 6 7 8 9

21. I always feel that someone I know is like a guardian angel.
1 2 3 4 5 6 7 8 9

22. As far as I'm concerned, people are either good or bad.
1 2 3 4 5 6 7 8 9

23. If my boss bugged me, I might make a mistake in my work or work more slowly so as to get back at him.
1 2 3 4 5 6 7 8 9

24. There is someone I know who can do anything and who is absolutely fair and just.
1 2 3 4 5 6 7 8 9

25. I can keep the lid on my feelings if letting them out would interfere with what I'm doing.
    1 2 3 4 5 6 7 8 9

26. I'm usually able to see the funny side of an otherwise painful predicament.
    1 2 3 4 5 6 7 8 9

27. I get a headache when I have to do something I don't like.
    1 2 3 4 5 6 7 8 9

28. I often find myself being very nice to people who by all rights I should be angry at.
    1 2 3 4 5 6 7 8 9

29. I am sure I get a raw deal from life.
    1 2 3 4 5 6 7 8 9

30. When I have to face a difficult situation I try to imagine what it will be like and plan ways to cope with it.
    1 2 3 4 5 6 7 8 9

31. Doctors never really understand what is wrong with me.
    1 2 3 4 5 6 7 8 9

32. After I fight for my rights, I tend to apologize for my assertiveness.
    1 2 3 4 5 6 7 8 9

33. When I'm depressed or anxious, eating makes me feel better.
    1 2 3 4 5 6 7 8 9

34. I'm often told that I don't show my feelings.
    1 2 3 4 5 6 7 8 9

35. If I can predict that I'm going to be sad ahead of time, I can cope better.
    1 2 3 4 5 6 7 8 9

36. No matter how much I complain, I never get a satisfactory response.
    1 2 3 4 5 6 7 8 9

37. Often I find that I don't feel anything when the situation would seem to warrant strong emotions.
    1 2 3 4 5 6 7 8 9

38. Sticking to the task at hand keeps me from feeling depressed or anxious.
    1 2 3 4 5 6 7 8 9

39. If I were in a crisis, I would seek out another person who had the same problem.
    1 2 3 4 5 6 7 8 9

40. If I have an aggressive thought I feel the need to do something to compensate for it.
    1 2 3 4 5 6 7 8 9

PLEASE CHECK TO SEE THAT YOU HAVE ANSWERED ALL THE QUESTIONS.

Appendix E

DAS

Most persons have disagreements in their relationships. Please indicate below the appropriate extent of agreement or disagreement between you and your partner for each item on the following list.

5 = Always agree
4 = Frequently agree
3 = Sometimes disagree
2 = Frequently disagree
1 = Always disagree

____ 1. Matters of recreation
____ 2. Religious matters
____ 3. Demonstration of affection
____ 4. Friends
____ 5. Sex relations
____ 6. Conventionality (correct or proper behavior)
____ 7. Philosophy of life
____ 8. Aims, goals, and things believed important
____ 9. Amount of time spent together
____ 10. Making major decision
____ 11. Leisure time interests

Please indicate below approximately how often the following items occur between you and your partner.

1 = All the time
2 = Most of the time
3 = Sometimes
4 = Rarely
5 = Never

____ 12. How often do you discuss or considered terminating the relationship?
____ 13. In general, how often do you think things between you and your partner are going well?
____ 14. Do you confide in your mate?
____ 15. Do you ever regret entering this relationship?
____ 16. How often do you and your partner quarrel?
____ 17. How often do you and your mate "get on each other's nerves"?

18. Do you kiss your mate?

Every day	Almost every day	Occasionally	Rarely	Never
5	4	3	2	1

19. Do you and your mate engage in outside interests together?

All of them	Most of them	Some of them	Very few of them	None of them
5	4	3	2	1

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

1 = Never
2 = Less than once a month
3 = Once or twice a month
4 = Once a day
5 = More often

____ 20. Have a stimulating exchange of ideas
____ 21. Laugh together
____ 22. Calmly discuss something
____ 23. Work together on a project

There are some things about which couples sometimes agree and sometimes disagree. Indicate the degree to which each item below caused differences of opinions or problems in your relationship during the past few weeks.

1 = Never
2 = Rarely
3 = Sometimes
4 = Frequently
5 = All the time

____ 24. Being too tired for sex
____ 25. Not showing love

26. These numbers represent different degrees of happiness in your relationship. "Happy" represents the degree of happiness of most relationships. Please circle the number that best describes the degree of happiness, all things considered, of your relationship.

1 = Extremely unhappy
2 = Somewhat unhappy
3 = Slightly unhappy
4 = Happy
5 = Very happy

27. Please circle the number of *one* of the following statements that best describes how you feel about the future of your relationship.

5 I want very much for my relationship to succeed, and will do all that I can to see that it does

4 I want very much for my relationship to succeed, and *will do my fair* share to see that it does.

3 It would be nice if my relationship succeeded, but *I can't do much more than I am doing* now to make it succeed.

2 It would be nice if it succeeded, but *I refuse to do anymore than I am doing* now to keep the relationship going.

1 My relationship can never succeed, and *there is no more that I can do* to keep the relationship going.

About the Author

Angela Fairweather was born and raised in the country of Belize. She received a Fulbright merit scholarship in 1995 to complete her undergraduate education and received her B.A in Liberal Arts and Sciences from the University of Kansas in 1997. In 2001, she received a graduate scholarship from the Organization of American States (OAS) and earned an M.A. in Psychology from the University of Dayton in 2002. Dr. Fairweather entered the Clinical Psychology Ph.D. program at the University of South Florida in 2004 and completed her predoctoral internship at the University of Medicine & Dentistry of New Jersey in 2008.

Dr. Fairweather's primary research interests are in the relation between romantic relationship functioning and health and in psychological factors related to medical illness. She has co-authored two publications and has presented her research at national conferences. Her primary clinical interests are in behavioral medicine, trauma, and addiction.