BEYOND SURVIVAL: KEYS TO RESILIENCE AMONG WOMEN WHO EXPERIENCED CHILDHOOD SEXUAL ABUSE

by

Janet Olivia Scalzo

B.F.A., University of Windsor, 1978

B.A (Hons.), University of Windsor, 1984

M.A., Simon Fraser University, 1987

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Beyond Survival: Keys to Resilience Among Women Who Experienced Childhood Sexual Abuse

Author: _____
(signature)

J. Olivia Scalzo
(name)

August 12, 1991
(date)

APPROVAL

Name: J. Olivia Scalzo

Degree: Doctor of Philosophy

Title of Thesis: Beyond Survival: Keys to Resilience Among Women Who Experience Childhood Sexual Abuse

Examining Committee:

Chair: Dr. H. Weinberg

Dr. M. Kimball, Associate Professor

Dr. J. Marcia, Professor

Dr. W. Krane, Associate Professor

Dr. K. Bartholomew, Assistant Professor

Dr. J. Briere, Assistant Professor
Dept. of Psychiatry, University of Southern California School of Medicine
External Examiner

Date Approved July 18, 1991

ABSTRACT

Women who were victims of childhood sexual abuse often experience higher rates of symptomatology than do women who were not victimized; however, research indicates that permanent damage is not inevitable. To date, little information exists regarding the protective mechanisms that enable some victimized women to function well. The purpose of the present study was twofold: 1) to assess the quality of adjustment attained by sexual abuse victims relative to that attained by victims of other types of trauma and by non-victimized women; and 2) to explore possible protective mechanisms such as properties of the abuse, social support and finding meaning in trauma, which afforded protection against long-term harm.

One hundred women were interviewed to assess ego identity status, past traumatic experiences, and coping processes. They also completed the Tennessee Self Concept Scale (TSCS), Revised Symptom Checklist (SCL-90-R), Separation Anxiety Test (SAT), and Attachment Questionnaire (A-Q).

Since a substantial proportion of women reported both sexual and other traumas, a cluster analysis was used to derive meaningful groups for further analysis. Four groups emerged which were labelled No Trauma (N = 10), Non-Sexual Trauma (N = 41), Sexual Trauma (N = 4), and Sexual and Other Trauma (N = 45). Significant differences were found among

groups on the Family Self-Concept scale of the TSCS and on some A-Q variables that measured threatened separations and perceptions of early parenting. No significant differences were found among groups on SCL-90-R subscales or global indices using analyses of variance. Chi square analysis revealed significant group differences on ego identity. Women who had experienced sexual and other traumas were highest in identity status. Among women who had been sexually victimized, canonical correlational analysis revealed that properties of the abuse, social support and attachment were not significantly related to self-concept, psychological distress and identity status.

Of significance in the present study were the findings that the majority of sexually victimized women experienced multiple traumas and also were high in identity status. Differences between high and low identity women's early experiences were explored qualitatively. Possible protective factors such as supportive relationships, accomplishments, and finding positive meaning in trauma were noted. Directions for future research also were discussed.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

SEXUAL ABUSE

Despite growing confirmation of the harmful long-term effects that can result from unwanted sexual experiences in childhood or adolescence, permanent damage is not inevitable (Herman, 1981). Moreover, the effects of childhood sexual abuse are not immutable. Some individuals are resilient in the face of childhood adversity, using their experiences as a challenge to mastery and competence (Werner & Smith, 1982). The present study focussed on these "survivors" of childhood sexual abuse, the "keepers of the dream" (Garmezy, 1971) in order to explore protective mechanisms which facilitate adaptation in adulthood.

The present study had several purposes. The first was to explore the narrative histories of women who have experienced adversity in their youth and who report leading successful, fulfilling lives in order to elucidate both protective factors and coping strategies that may have enabled them to resist or recover from the effects of early traumatic experiences. The second purpose of the study was to compare the adjustment attained by women who experienced sexual abuse with that attained women who have experienced other types of trauma in order to determine whether sexual abuse victims are faced with a greater challenge to their coping capacities.

The present study focussed on women's narrative history, their stories of loss, trauma and recovery, for two reasons. First, since there is little extant research on recovery from sexual abuse, an exploratory approach using interviews would cast a wide net, and allow richer, more indepth material to be gathered from participants. It was expected that recurrent themes among women's descriptions of recovery processes would yield important directions for further research. Secondly, individuals' subjective experience, rather than objective fact or truth, is an integral aspect of understanding resilience and coping. Current conceptions of recovery from victimization (e.g., Finkelhor & Browne, 1985; Friedrich, 1990; Newberger & De Vos, 1988; Taylor, 1983) contend that the meaning individuals make of their experiences plays a significant role in self-perceptions of victimization and resolution. The extent to which individuals overcome traumatic events is related to finding meaning in the experience of victimization (Silver & Wortman, 1980; Silver, Boon & Stones, 1983). The interview format allowed women to articulate their understanding of the past and how they had integrated into the present. According to Cohler (1987),

> Resilience appears to be less an enduring characteristic than a process determined by the impact of particular life experiences among persons with particular conceptions of their own life history or personal narrative. Determinants of the stories that persons presently maintain of past adversity, together with factors leading them to overcome their misfortunes, are still not well understood. Interpretive approaches complement systematic predictive approaches in understanding the determinants

and course of vulnerability and resilience in the study of lives (p.406).

Prevalence of Sexual Abuse

Reports of the long-ranging harmful effects of childhood sexual abuse, in both professional (e.g., Gelinas, 1983; Herman, 1981) and popular (e.g., Armstrong, 1978; Rush, 1980) media, have dramatically increased during recent years. At the same time, researchers have focussed increasing attention on determining the prevalence of sexual abuse and the extent of long-term harmful effects among women who experienced childhood sexual abuse.

Estimated rates vary among studies, depending on the definitions of sexual abuse employed, the characteristics of the sample, and whether participants were self-selected or randomly chosen. During the past decade, several major surveys using randomly chosen community samples have been conducted in Canada (Badgley, 1984; Bagley & Ramsay, 1986) and the United States (Finkelhor, Hotaling, Lewis & Smith, 1990; Russell, 1986). These studies provide our best estimates to date on the prevalence of sexual abuse.

In Canada, a federally-appointed government committee undertook the task of assessing the nation-wide prevalence of sexual abuse in Canada. Badgley (1984) surveyed 2,008 randomly-chosen individuals living in communities across the country. The use of hand-delivered questionnaires, completed while the deliverer waited, resulted in a response rate of 94.1%. Of the women sampled, 33.8% reported sexual

experiences involving physical contact prior to the age of 18. When non-contact experiences such as witnessing exhibitionism were included, the level rose to 53%. The prevalence of sexual abuse also has been assessed in a random sample of women living in Calgary, Alberta. Bagley and Ramsay (1986) interviewed 377 women who had been part of a stratified random sample of 401 women surveyed one year earlier about mental health. The subsample completed questionnaires on current functioning and memories of parental behaviours prior to participating in an interview about past sexual experiences. Twenty-two percent of the women reported sexual abuse involving physical contact prior to the age of 16. An additional 10 subjects reported having been sexually assaulted but felt unable to elaborate on the experience; these women were excluded from the sexual abuse group. Had they been included, Bagley and Ramsay's prevalence rate would have risen to 24%.

In the United States, Finkelhor *et al.* (1990) conducted a national telephone survey of 2,626 randomly-chosen individuals. Twenty-seven percent of the women reported experiencing contact or non-contact sexual abuse prior to the age of 18. Employing a structured interview format to survey 930 randomly-sampled women living in the San Francisco area, Russell (1986) found that 38% of the women reported sexual abuse including physical contact prior to the age of 18. When non-contact abuse was included, the figure rose to 54%. Prior to the age of 14, 28% of the

women reported contact sexual abuse; 48% reported non-contact sexual abuse.

Based on these general population surveys, between 22% and 38% of women had experienced sexual abuse involving physical contact prior to the age of 18. Two trends emerged from these surveys. One the one hand, Russell's (1986) findings were comparable to those of Badgley (1984), despite differences in methods and samples used in the two studies; approximately one-third of their participants reported sexual abuse that involved physical contact. On the other hand, approximately one-quarter of the participants interviewed by Bagley and Ramsay (1986) and by Finkelhor *et al.* (1990) reported contact sexual abuse. Regional variations in reporting sexual abuse may underlie the differences in rates found among the four studies. Despite the low overall rate of abuse in Finkelhor *et al.*'s (1990) national survey, 42% of California women reported abuse, a percentage comparable to the rate reported in Russell's (1986) study of women living in San Francisco. The researchers suggested that Californians may be more aware of abuse and are more comfortable disclosing their experiences. Calgary, the site of Bagley and Ramsay's (1986) survey, may be a region in which residents are more conservative about disclosing abuse. When disclosure rates are averaged across a number of regions, as occurred in the American and Canadian national surveys, the results are quite similar. The American disclosure rate was 27% while the Canadian

disclosure rate was 33.8%. The issue of regional differences in reporting requires further research. Thus at the present time, the rate of women in the general population who have experienced sexual abuse involving physical contact prior to the age of 18 can be estimated at 27 to 34%.

Among special populations, sexual abuse rates are higher than the general population estimated rate. For example, childhood sexual abuse has been reported by 55 to 60% of adult psychiatric inpatients (Bryer, Nelson, Miller & Krol, 1987), adolescent psychiatric inpatients (Sansonnet-Haydon, Haley, Marriage & Fine, 1985), and prostitutes (Silbert, 1982). Also, childhood incest experiences were reported by 44% of women in a drug treatment program (Benward & Densen-Gerber, 1975).

Studies of college and university women indicate that sexual abuse rates parallel, or are somewhat lower than, general population rates. For example, using a variety of definitions of sexual activities reported by female undergraduates in Canadian and American samples, rates of 15% (Briere, 1984; Sedney & Brooks, 1984), 19.2% (Finkelhor, 1979, recalculated data from Painter, 1986), 22% (Fromuth, 1986) and 25% (Alexander & Lupfer, 1987) have been reported. As in general population studies, definitions of sexual activities, target ages of experiences (e.g., before the age of 14 or 16), and characteristics of the samples (self-

selected versus all undergraduates in a particular class) no doubt contributed to the variation in reported rates.

Despite the differences in prevalence of sexual abuse among all of the studies reported above, the findings consistently indicate that a substantial number of women experience sexual abuse in childhood or adolescence. The issue of variation in survey techniques discussed above reflects a concern with consistency as well as accuracy in recording prevalence rates of sexual abuse in various samples and in the general population. Aside from willingness to disclose sexual experiences, concern is also expressed by some researchers about the accuracy of recall of subjects, in particular that prevalence rates may be inflated by subjects whose memories of events may be distorted (or fantasized). Two studies (Bagley & McDonald, 1984; Femina, Yeager & Lewis, 1990) that addressed accuracy of recall found the opposite to be true. In both of these studies, subjects' histories of documented sexual or physical abuse in childhood were available to the researchers. When interviews were conducted with subjects during adulthood, discrepancies in disclosing a past history of abuse tended to involve denying or minimizing the experience. In Femina, *et al.*'s (1990) study, several subjects also reported abuse for the first time; again, the abuse had been verified during childhood. These subjects stated that they had felt too embarrassed or untrusting of others to disclose the abuse earlier. Thus these studies

support the conclusion that retrospective data regarding childhood abuse may elicit inaccurate prevalence rates in the direction of under-reporting, but that which is reported appears to be valid.

Long-term Effects of Childhood Sexual Abuse

Like the question of prevalence, the question of whether childhood sexual experiences have an impact on later functioning also has been the focus of considerable research during the past 15 years. One question addressed in the present study is why some sexual abuse victims do not experience serious long-term consequences. However, a review of the literature regarding the negative consequences commonly associated with a history of childhood sexual abuse is warranted before addressing the question of why some women do not experience such negative effects. The findings across samples are fairly consistent although the extent of long-term effects appears to vary depending on the sample studied, for example, college students or non-students seeking therapy. According to Browne and Finkelhor (1986), "as evidence ... accumulates, it conveys a clear suggestion that sexual abuse is a serious mental health problem, consistently associated with very disturbing subsequent problems in some important portion of its victims" (p. 72).

Community studies have found that women with a history of sexual abuse (including incest) report higher levels of

depression and general psychological distress (Bagley & Ramsay, 1986; Gold, 1986) than do non-abused women using standardized measures such as the Beck Depression and the Middlesex Hospital Questionnaire. Even when family background variables such as parental warmth are controlled, the differences on depression scores remained, leading to the conclusion that sexual abuse contributes independently to depression. Other difficulties reported by Bagley and Ramsay (1986) included higher rates of anxiety, suicidal ideation or self-harm, and psychiatric consultations as well as lower levels of self-esteem among women with a history of sexual abuse. Similarly, Greenwald, Leitenberg, Cado and Tarran (1990) found differences on the Global Severity Index (GSI) of the Brief Symptom Inventory between nurses with a history of sexual abuse and a matched control group of nurses. These differences remained even when perceived parental caring was controlled for using multivariate analyses. Although neither group's mean GSI fell within the clinical range, significantly more individuals' scores from the abused group were in the clinical range. The groups did not differ on measures of self-esteem, sexual satisfaction or frequency of sexual dysfunction. The latter results contrast with Gold's (1986) findings of differences among sexually abused and non-abused women on measures of sexual dysfunction. Women who had been sexually abused in childhood were more likely than non-abused women to be revictimized later in life. For example, Russell (1986)

found that victims of childhood sexual abuse were more likely than non-abused women to report having been raped or having been physically abused by a husband or other partner. Finally, there is some evidence (Peters, 1988, cited in Browne & Finkelhor, 1986) that substance abuse is experienced at higher rates among sexually victimized compared to non-victimized women. Only one study (Tsai, Feldman-Summers & Edgar, 1979) has failed to find differences on psychological measures between sexually abused and non-abused women recruited from the community. Interestingly, Tsai *et al.* specifically recruited women with a history of sexual abuse who considered themselves well-adjusted.

The findings from studies investigating long-term effects of sexual abuse among women seeking mental health services such as crisis intervention or psychotherapy parallel the findings reported from community studies. For example, compared with non-abused female clients of a community health centre, female clients with a history of childhood sexual abuse were significantly more likely to report having made at least one suicide attempt, to have a history of substance abuse, and to have been in a battering relationship (Briere, 1984). Suicide attempts in childhood or adolescence are especially associated with a history of childhood sexual abuse (Briere & Runtz, 1986; D. Gelinas, personal communication, 1985). Sexually abused women in Briere's (1984) study were also more likely than non-abused

women to report symptoms such as anxiety attacks, nightmares, difficulty sleeping, sexual dysfunction, fear of men, and fear of women. Other researchers have reported similar findings of higher rates of sexual difficulties (Bagley & McDonald, 1984; Langmade, 1983; Meiselman, 1978), difficulties in close relationships (Meiselman, 1978), substance abuse (Herman, 1981), poor self-esteem, suicide attempts and physical abuse by partners (Bagley & McDonald, 1984) among sexually abused women relative to non-abused women. Although Bagley and McDonald (1984) found a history of sexual abuse to be a more significant predictor of depression than a history of physical abuse, neglect, or separation from mother during childhood, other studies have not found this clear distinction among clinical groups. Both Herman (1981) and Meiselman (1978) found that substantial proportions of sexually abused and non-abused women in therapy evidenced depression.

The symptoms and long-term consequences of childhood sexual abuse reported by college women are remarkably similar to those reported in community and clinical samples. This is noteworthy since college samples are unrepresentative of the general population, at least in terms of socioeconomic status. More importantly, students as a group are presumed to be functioning well as evidenced by their ability to handle the demands of higher education (Painter, 1986). Thus it is especially significant that differences are found among students with a history of

sexual abuse compared to their non-abused counterparts. For example, using the Hopkins Symptom Checklist and a dissociation scale developed for their study, Briere and Runtz (1988b) found significantly more reports of bodily complaints, anxiety, depression and dissociation during the 12 months prior to the study among female students with a history of sexual abuse than among non-abused female students. The sexually abused students in the study also reported more dysfunctional sexual behaviour than did students who had been physically or psychologically abused (Briere & Runtz, 1990). In another study, (Sedney & Brooks, 1984) proportionately more sexually abused students than non-abused students reported depression, sleep difficulties, emotional problems and thoughts of self-injury. When those students who had experienced familial sexual abuse were compared to non-abused students, proportionately more of the former group reported having experienced depression or anxiety severe enough to see a doctor or be hospitalized for the problem than did the latter group. A history of sexual abuse has been associated with revictimization (rape or battery) later in life in the three studies that have examined this question (Alexander & Lupfer, 1987; Fromuth, 1986; Runtz 1987). Whereas Runtz (1987) found that abuse involving force or intercourse was especially associated with revictimization, Alexander and Lupfer (1987) failed to find differences in revictimization that were attributable to abuse involving intercourse. Abuse that included

intercourse, however, did significantly contribute to social maladjustment among sexually abused women. Although this group scored significantly higher on a measure of social maladjustment than did non-abused women, the mean scores of both groups were within the normal range (Harter, Alexander & Neimeyer, 1988). In contrast to other studies of college women, Fromuth (1986) found few differences between abused and non-abused students. Other than the higher rate of revictimization noted above, and a greater self-perception of promiscuity (which was unrelated to actual behaviour) among sexually abused compared to non-abused students, Fromuth found no differences between groups on measures of depression, self-esteem, locus of control, or self-rated sexual adjustment using Finkelhor's (1979) Sexual Self-Esteem Scale. Her findings differed from those of Finkelhor (1979) who reported that sexually abused college students scored significantly lower on the Sexual Self-Esteem Scale than did nonabused students. Fromuth found that the sexually-abused students differed from non-abused students on four of the nine scales and two global indices of the Hopkins Symptom Checklist. However, all but one of the scales, Phobic Anxiety, were better predicted by parental support than by a history of sexual abuse. Fromuth suggested several reasons for the lack of differences between sexually-abused and non-abused students in her study. First, using a very broad definition of sexual abuse, from a single incident of exhibitionism by a stranger

to repeated intercourse with a father may have diluted the differences between the abused and non-abused groups. Some support for Fromuth's hypothesis comes from the finding by Sedney and Brooks (1984) that differences between sexually-abused and non-abused students were greater when the former group was restricted to those students who had reported sexual abuse by a family member. Second, the average age of Fromuth's subjects was 19 and almost all were unmarried; sexual difficulties may not have manifested in such a young group. Third, Fromuth suggested that using a college sample may have excluded women who were seriously affected by sexual abuse. However, other studies, as noted above, have found significant degrees of distress among sexually-abused college students. What may have excluded seriously distressed women from Fromuth's study was her recruiting procedure. That is, by describing the study during recruitment as "exploring the effects of childhood sexual experiences on current adjustment" (p. 6), women who did not perceive themselves as adjusted, or who felt too distressed to discuss their experiences, may not have volunteered for the study. Other studies of college students (e.g., Finkelhor, 1979) employed a neutral description to recruit subjects, referring to the study as 'an investigation of how childhood experiences affect later development'. Since potential subjects were not cued to the sexual aspect of the study or to the focus on adjustment, sexually-abused women

experiencing a wider range of distress may have participated in these studies.

In summary, the results of studies of the long-term consequences of childhood sexual abuse offer fairly consistent evidence, across a variety of samples, that victimized women are affected by a range of symptoms and difficulties. These difficulties occur, in general, at a higher rate than among non-victimized women. It is noteworthy that these findings are obtained by studies employing an extensive definition of sexual abuse, including single episodes without physical contact (Browne & Finkelhor, 1986). Findings from studies employing multivariate analyses suggest, with some exceptions, that sexual abuse contributes to mental health difficulties over and above the effects of family background variables or other types of abuse.

Adjustment Following Childhood Sexual Abuse

Despite extensive evidence of adult maladjustment associated with a history of sexual abuse, a substantial proportion of victimized women evidence little or no symptomatology (Finkelhor, 1990). Although as a group victimized women appear impaired relative to non-victimized women, less than one-fifth of sexually abused women evidence serious psychopathology in adulthood (Browne & Finkelhor, 1986). Thus, it would be an exaggeration to state that

childhood sexual abuse inevitably causes permanent damage (Herman, 1981).

To date, investigations of healthy adjustment following sexual abuse have been limited, perhaps in part by the controversy surrounding the issue of harm. Until researchers established the potentially harmful effects of sexual abuse, investigation of mechanisms promoting recovery and aiding resilience could not occur. The long history of clinical literature claiming that sexual abuse, especially incest, is often fantasized or not particularly harmful (e.g., Bender & Blau, 1937; Henderson, 1983; Yorukoglu & Kemph, 1966) has been related to Freud's recantation of his seduction theory (1896/1959) and the resulting enthusiasm with which clinicians embraced his theory of infantile sexual fantasies (Miller, 1984; Peters, 1976). This clinical 'wisdom' stood in direct opposition to the subjective experience of many women that childhood sexual abuse does occur and is harmful. Political shifts instigated by the women's movement in the early 1970's fostered a shift in social awareness that sexual abuse occurred in much greater numbers and with more devastating consequences than previously assumed. Clinically, the shift in awareness led to research studies during the past 10 or 15 years that focussed primarily on demonstrating the pervasive harm associated with sexual abuse. Even when overt symptoms were absent, some researchers (e.g. Brooks, 1985; O'Brien, 1987) speculated that victims were in a state

of denial about the impact of abuse. While this may be true for some victims it is also the case that most studies looking at the harmful impact of sexual abuse find a substantial group of victims with little or no symptomatology (Finkelhor, 1990). One reason for this finding may be that some types of sexual abuse experienced by victims are less damaging than others. Studies investigating this hypothesis attempt to delineate the differential impact of sexual abuse based on aspects of the abuse experience such as timing, duration, degree of physical invasiveness and relationship to the perpetrator (e.g., Briere & Runtz, 1988b; Courtois, 1979; Finkelhor, 1979). The findings from these studies generally suggest that abuse of long duration involving penetration especially by a father figure is associated with greater symptomatology (Browne & Finkelhor, 1986). However, other studies (e.g., Courtois, 1979; Fromuth, 1986) found few differences among victims in response to abuse variables, indicating that properties of the abuse do not explain fully variations in outcome (Newberger & De Vos, 1988).

A lack of overt psychopathology does not necessarily imply the existence of psychological health. Although understanding types of abuse that may be especially harmful has significant implications for treatment delivery, especially as services for victims become strained (Mrazek & Mrazek, 1987), we do not know from such studies whether asymptomatic victims were unaffected by abuse or have

successfully overcome the impact of abuse. One conceptualization is that sexual abuse is a significant stress for a child; whether it contributes to later psychiatric difficulties is determined by the child's internal and external resources to cope with the stress (LaBarbera & Dozier, 1981). In general, given the pervasiveness of sexual abuse, the ways in which it affects women's lives and their ability to successfully meet life tasks is an important area of research. The study of well-functioning adults who experienced childhood sexual abuse may provide important information about factors related to their recovery such as formal or informal therapeutic support, or other developmental experiences (Painter, 1986).

As the harmful consequences of sexual abuse have become fairly well-established and accepted (Finkelhor, 1990) investigation of successful adjustment following sexual abuse has begun. Case studies or anecdotal reports of sexual and physical abuse victims who appeared to make good social and emotional adjustments (e.g., Crockett, 1984; Mrazek & Mrazek, 1987; Steele, 1986) have provided some initial hypotheses about personal attributes and environmental supports that foster recovery. For example, one follow-up study of physically abused children (Zimrin, 1986) utilized a multifaceted definition of adjustment including scholastic achievements, ratings of social adjustment and symptoms of emotional distress and a self-reported sense of fulfillment or constructive plans for the

future. Zimrin reported that, compared to physically abused children who demonstrated a high degree of psychopathology 14 years later, physically abused children who grew up to be well-adjusted had maintained hope for a better future, felt more in control of their destiny, did not see the abuse as due to negative self-attributes (e.g., beliefs of worthlessness or badness), were less self-destructive, demanded attention, and demonstrated better cognitive achievements. The well-adjusted group also were more likely to have had a supportive adult, or were responsible for someone else such as a younger sibling, during childhood. In general, Zimrin summarized the variables differentiating the two groups as activity versus passivity, positive evaluation of personal resources versus negative evaluation and the existence of a significant relationship with an external figure versus the absence of such a relationship. Despite these findings, Zimrin noted that the groups did not differ on some variables; the well-adjusted group still felt isolated, and had difficulty expressing emotions and establishing personal relationships. This study points out the fact that positive adjustment may occur in some areas of functioning but not others. Friedrich (1990) noted a similar fragmentation in self-development among sexual abuse victims. It is apparent that, in assessing successful outcomes following sexual abuse, a broad-based measure of adjustment is necessary. Studying scholastic achievement, psychological health, or the attainment of stable

relationships in isolation may overlook significant gaps in development.

Comprehensive conceptual models delineating the sources of trauma and recovery from sexual abuse experiences have begun to appear in recent years. Those that currently exist (e.g., Finkelhor and Browne, 1985; Newberger & De Vos, 1988) have placed increasing emphasis on the role of cognition, and human ecology, the fact that events do not exist in isolation but are embedded in the context of social relationships (Friedrich, 1990). Regarding the role of cognition, it appears that the way in which an event is appraised influences responses to that event. To some extent, "abuse is a function of the perception of being victimized" (Newberger & De Vos, 1988, p. 507). Erikson (1964) pointed out the important distinction between "actuality" or objective facts, and "reality" or one's phenomenological or subjective experience of actuality and what it means. Similarly, Conte (1985) distinguished between first order sources of trauma, those aspects of the sexual abuse event that cause stress, and second order sources of trauma, which may be produced by victims' emotional or psychological processing of abuse experiences. For example, experiencing threats during abuse may create fear. These models are based on the notion that individuals actively process information and attempt to make meaning of their experiences. The meaning victims make of sexual abuse

experiences also will inform their behaviour, in terms of coping efforts, and self-perceptions following abuse.

Nevertheless, individuals do not solely construct their experiences. They live in an environmental context that contributes to those psychological processes by which individuals interpret and respond to experience (Newberger and De Vos, 1988). A responsive environment provides opportunities for confiding, through which sexual abuse victims may find meaning in their experiences, (Pennebaker, 1985), and promotes feelings of connection with others. Feelings of connectedness may counteract the sense of stigmatization and isolation often reported by sexual abuse victims (Browne & Finkelhor, 1986) and may enhance self-esteem (Cobb, 1976). Research findings from studies that have addressed the role of support in overcoming sexual trauma have confirmed that supportive relationships ameliorate the effects of trauma (Conte & Schuerman, 1987; Wyatt & Mickey, 1988 cited in Friedrich, 1990) On a deeper psychological level, the ability to make use of supportive relationships is indicative of the presence of object attachments. Attachment theory (Bowlby, 1977) and research suggest that an individual develops internalized models regarding the availability of relationships and her or his ability to elicit help from others.

In summary, resilience and coping among sexual abuse victims is a complex, interactive process in which cognitions and behaviours evolve over time and influence one

another. Models of coping with sexual victimization are multidimensional, and include properties of the abuse, cognitive processes of appraisal and meaning-making, behavioural responses, and environmental support. Adaptation is itself a complex phenomenon. Most studies have focussed on assessing overt symptomatology, such as anxiety and depression. A deeper understanding of the impact of victimization in women's lives may be gained by examining the extent to which victims of childhood sexual abuse have been able to master developmental tasks such as the establishment of an ego identity.

Comparisons to Adjustment Following Other Types of Trauma

In assessing recovery from sexual trauma, it is important to compare the psychological functioning and adaptation of sexual abuse victims with that of victims who have faced other types of adversity such as physical or emotional abuse. The lack of complete consensus on the issue of outcomes following sexual abuse indicates that further research regarding the impact of multiple types of abuse or other adversities is warranted. Moreover, investigating all forms of abuse in a study is a more ecologically valid approach (Briere & Runtz, 1988b) since the occurrence of a single adversity in an individual's life is unusual (Rutter, 1985). Some adversities may catalyze others. For example, sexual abuse may be more likely to occur when children live without one of the natural parents for a period of time (Finkelhor, *et al.*, 1990).

As yet, few studies have assessed the relative effects of different types of abuse, or other traumatic experiences, on adjustment. Of three comparative studies done to date, results have been mixed. Although two groups of researchers (Bagley & McDonald, 1984; Briere & Runtz, 1990) found that sexual abuse affected sexual adjustment and behaviour, poor self-esteem was uniquely associated with psychological abuse in one study and with sexual abuse in the other study. In another study, Pennebaker (1985) found that sexually traumatized individuals reported significantly more illness symptoms and negative moods, than did non-traumatized individuals and individuals traumatized by non-sexual experiences such as parental death or divorce. The experience of sexual abuse may present a particularly challenging test of a victims' coping abilities, given the numerous ways in which abuse can affect their lives: self-image, bodily integrity, trust in relationships, and feelings of safety in the world are all threatened and potentially damaged. Psychologically, sexual abuse victims may experience their core sense of self as more threatened, given the physically intrusive nature of sexual abuse, than victims of other types of abuse or trauma. An issue of considerable interest addressed in the present study is whether sexual abuse presents a significantly greater, or unique, challenge to women's adaptive capacities. Does adjustment following sexual abuse differ from adjustment following other types of abuse or trauma? Also, does the

recovery process differ among women who have experienced different types of adversity? Finally, is there congruence between women's self-perceptions of having recovered from sexual abuse, their 'reality', and their levels of adjustment, their 'actuality'? If congruence exists, women who report recovery from sexual abuse should attain levels of adjustment similar to those obtained by women who have not been abused. Also, if women perceive themselves as having recovered from sexual abuse, understanding the pathways that led to their recovery (e.g., informal social support, formal therapeutic interventions) may provide important information for assisting other sexual abuse victims.

CHAPTER 2

RESILIENCE AND PROTECTIVE MECHANISMS

Research on Resilience

The study of resilience in children can be traced historically to "high-risk" research that began in the 1950's (Felsman & Vaillant, 1987). In particular, children who were genetically or environmentally predisposed for developing specific psychopathology, especially schizophrenia, were the focus of longitudinal studies. Since then, research has expanded to include the study of individuals considered vulnerable to a broader range of psychopathology.

In early work, 'invulnerability' (Garmezy & Neuchterlain, 1972) was used to describe children who were resistant to stress. This rather absolute term suggests that such children are impervious to stressors; by implication, invulnerability was seen to have only a constitutional base (Mrazek & Mrazek, 1987). More recently, it has been argued that resistance to stress varies in degree over time, and is based on both constitutional and environmental factors (Rutter, 1985). Thus, the relative concept of 'resilience' (Werner & Smith, 1982) is preferred. This temporal element may be especially important in the study of resilience among sexual abuse victims since clinical experience suggests that some victims' coping

strategies become maladaptive or break down over time, often following an unrelated crisis such as marital breakdown. As a process-oriented concept, resilience also favors a focus on healthy adaptation and coping with stressors. As Felsman and Vaillant (1987) point out, this emphasis on healthy adaptation parallels, and relies on theoretical and methodological advances in developmental ego psychology, especially in the areas of the ego's adaptive capacity (Freud, 1937; Hartmann, 1958), and the hierarchical organization of ego defenses (e.g., Haan, 1977).

The fact that resilience exists is undisputed. Historical and literary accounts exist of individuals who have triumphed over impoverished or traumatic childhoods to reach outstanding levels of achievement in adulthood. On a less spectacular level, studies of traumatized individuals, as noted earlier, seldom report consistently negative reactions. In fact, according to Rutter (1979), even with the most severe stressors it is unusual for more than half of children to succumb. In the past five years victims of childhood sexual abuse have become the focus of resilience research. Interestingly, until childhood sexual abuse was recognized as a potential contributor to psychological difficulties the study of resilience among sexual abuse victims could not be addressed. As studies began to accumulate demonstrating that a history of childhood sexual abuse was associated with an array of immediate and long-term symptoms, it was noted that almost every study found a

substantial group of victims with little or no symptomatology (Finkelhor, 1990).

The study of resilience, then, has focussed on attempts to delineate protective factors, those attributes or aspects of the individual, or of the traumatic experience, that contribute to adaptation. Vulnerability research has enjoyed, by virtue of its developmental, life-span orientation, the benefit of prospective, longitudinal investigation. Some (e.g., Vaillant, 1977; Werner & Smith, 1982) have followed individuals for three and four decades. From their reports it is apparent that biological attributes such as infant temperament play a role in resilience. Due to the retrospective nature of the present study, the role of biological attributes in resilience (either directly, coping with the trauma, or indirectly, as an indicator of difficulties prior to the abuse) was not evaluated although it no doubt played a role in women's reactions to potential traumas. Individual differences were evaluated in terms of cognitive attributes (e.g., the meaning made of sexual experiences). Given that subjective responses to an event may be at least as important as the objective fact of the event itself, the significance of cognitive attributes as protective factors was evaluated in the present study.

Protective factors are defined as "influences that modify, ameliorate or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome" (Rutter, 1985, p. 600). These factors are defined

in terms of their effects and need not be pleasant or beneficial experiences per se. For example, confrontation in adulthood of one's abuser may be frightening and upsetting, but can have a tremendous positive effect in terms of resolving past abuse if the abuser acknowledges the abuse and assumes responsibility for it. Conversely, significant distress and decreased self-esteem might result if the abuser denies the experience. In this case, confrontation might be a risk factor for psychopathology (e.g., depression). Protective factors may include qualities or skills possessed by an individual or they may be life circumstances experienced by an individual. For example, cognitive flexibility, the ability to make meaning of traumatic experiences appears to ameliorate the stressful impact of such experiences (e.g., Taylor, 1983). Thus, both internal and external factors may play a role in adaptation. It seems clear that protective factors can operate throughout the life span.

Protective Factors Examined in the Present Study

Research, theory and logic suggest that many mechanisms can operate as protective factors. The potential protective factors explored in the present study have been grouped into three areas: experiential variables - aspects of the abuse experience itself as well as the number of stressors experienced; interpersonal variables - those factors involving social relationships; and cognitive variables.

These groups of variables, and research supporting their consideration as protective factors will be discussed in turn. In practice, as Rutter (1985) described, these factors do not operate in isolation. Childhood sexual abuse research has become more sophisticated over the years; instead of examining the effect of isolated aspects of the abuse on adult functioning, recent studies (e.g., Johnson & Kenkel, 1991; Kilpatrick, 1986; Russell, 1986) utilize multivariate analyses to assess the unique and overlapping effects of numerous variables on later functioning.

EXPERIENTIAL VARIABLES

The contribution of specific dimensions of sexual abuse to later symptoms has been the focus of clinical and empirical study. Full consensus has not been reached on the association of any specific aspect of sexual abuse with later symptoms, not only because of methodological and sampling differences among studies, but also because, to some extent, the impact of any event is unlikely to affect all individuals uniformly. Nevertheless, several aspects of sexual abuse appear to be more critical than others. In general, research findings point to the conclusion that asymptomatic children are more likely to have experienced sexual abuse that was of shorter duration, did not involve intercourse or the use of force, and was perpetrated by someone other than a father figure (Browne & Finkelhor, 1986). The age at which sexual abuse first occurred may

also contribute to later symptoms. In order to add to our understanding of the impact of specific dimensions of abuse, the present study examined degree of abuse, duration, timing, and relationship to offender as potential protective factors.

Timing

As noted earlier, there is some inconsistency in the research as to whether abuse that begins in childhood or in adolescence is less harmful. For example, studies of women in treatment (Hartman, Finn & Leon, 1987; Meiselman, 1978) and a community sample (Courtois, 1979) found more current distress and greater impact for prepubertal experiences. Other studies have failed to demonstrate a significant relationship between age of onset and severity of symptoms (Johnson & Kenkel, 1991; Langmade, 1983; Russell, 1986). Studies using multivariate analyses that controlled for other factors such as intercourse (Bagley & Ramsay, 1985 cited in Browne & Finkelhor, 1986; Finkelhor, 1979) failed to find an effect for age of onset.

Age of onset of sexual abuse appears to be a complex variable. First, it interacts with other variables such as relationship to the perpetrator, duration and frequency of abuse. For example, Hartman, Finn and Leon (1987) found that familial abuse began at an earlier age and involved a greater frequency of sexual contacts than did non-familial abuse. Second, age of onset also may be confounded with the

severity of abuse itself. Clinical experience suggests that sexual abuse of children often begins subtly and increases in severity as children develop. When adolescents are the first-time victims of abuse, however, it may be a more violent and intrusive act. Finally, age of onset may be confounded with the victim's appraisal of the event, either at the time of occurrence or much later. An argument can be made that abuse in adolescence may be more traumatic by virtue of the adolescent's ability to evaluate her role in the abuse, either her perceived responsibility for eliciting it or her failure to prevent it. The adolescent might also be aware of the social taboo against sexual abuse, especially given current media attention, leading to feelings of guilt (Tsai, *et al.*, 1979). A child may be protected by virtue of her naivete about sexual activities and social norms. Nevertheless, meaning-making is not a time-limited event. In adulthood, women may be able to 'make sense' of victimization that occurred during adolescence, even if it involves forgiving themselves for their perceived responsibility for the abuse. On the other hand, it may be very difficult for women to make sense of being victimized during childhood. They cannot understand what they could have done to deserve the abuse; acknowledging that they were innocent and helpless can be especially shattering to their sense of trust in the world. Certainly the complexity of this variable and the

inconsistency of previous research findings indicate that this variable is worthy of further study.

Duration

The duration of sexual abuse also is a complex variable, as it is correlated with relationship to offender, age of onset, and type of sexual activity. Not surprisingly, the impact of duration on later functioning is not clear cut. Nevertheless, a majority of the studies reviewed by Browne and Finkelhor (1986) found that a shorter duration of abuse was associated with less impact on functioning (e.g., Friedrich, Urguiza & Beilke, 1986; Russell, 1986; Sedney & Brooks, 1984; Tsai, *et al.*, 1979). Several studies found no effect for duration of abuse (e.g., Finkelhor, 1979; Langmade, 1983) while others reported a positive effect - abuse of longer duration was associated with less trauma and higher self-acceptance (Courtois, 1979; Seidner & Calhoun, 1984 cited in Browne & Finkelhor, 1986). Of interest were the findings by Briere and Runtz (1988b) that the total duration of sexual abuse was correlated with chronic somatization, anxiety and depression, and acute and chronic dissociation, but the actual number of incidents was not related to chronic or acute symptomatology. The issue regarding the effect of duration on later functioning remains unclear. Of two recent studies, one found no effect for duration of abuse (Johnson & Kenkel, 1991;) while the other found that sexual abuse of shorter duration was

related to poorer adjustment prior to therapy (Follette, Alexander & Follette, 1991). Both of these studies involved incest survivors. Given the likelihood that the impact of duration is related to relationship with the offender, the relative impact of duration (or any other aspect of the abuse experience) may not be adequately addressed in homogeneous samples.

Relationship to Offender

Whether abuse occurs within or outside the family appears to be related to degree of impact, although there is a lack of consensus among research findings on this variable too. For example, Sedney and Brooks (1984) reported fewer current symptoms such as depression and anxiety among college women who reported sexual experiences with non-relatives than did women whose sexual experiences involved family members, even after age of onset (before or after age 12) was considered. In their studey of female college students, Briere and Runtz (1988b) found that parental incest was correlated with chronic somatization, anxiety and dissociation. Kilpatrick (1986) found that identity of the sexual partner (parent or other relative versus non-relative) did not correlate with measures of adult functioning in isolation; however, use of force and abuse by a parent or other relative together were correlated with depression, marital discord and self-esteem problems. Other studies have failed to find a relationship between

relationship to the offender and later impact (e.g., Finkelhor, 1979; Russell, 1986).

More consistent is the finding that abuse by someone who is not a father figure correlates with a less negative impact (Finkelhor, 1990). Sexual abuse by father figures has been correlated with increased social maladjustment (Harter, *et al.*, 1988) and increased distress (Russell, 1986; Tufts, 1984 cited in Browne & Finkelhor, 1986) compared to sexual abuse by others.

Severity of Abuse

Research findings generally suggest that sexual experiences involving penetration or physical contact with unclothed genitals appears to be related to a more severe outcome in later functioning (Browne & Finkelhor, 1986). These types of sexual activity also appear to be associated with a higher level of depression initially (Hartman, Finn & Leon, 1987). Some studies have reported significant effects using a finer distinction in sexual activities. For example, women who did not experience penetration perceive themselves as less socially isolated (Harter, *et al.*, 1988) and acquire better adjustment following group therapy than do women who have experienced penetration (Follette, *et al.*, 1991). Russell (1986) found that 59% of women who experienced penetration reported feeling extremely traumatized compared with 36% of those who experienced physical contact with unclothed genitals and 22% of those

who experienced unwanted kissing or contact over clothing. Other studies have found no consistent effect for type of sexual activity (e.g., Finkelhor, 1979; Fromuth, 1986; Johnson & Kenkel, 1991). However, in their research review, Browne and Finkelhor (1986) found several studies confirming that the least serious forms of sexual contact are associated with less trauma. The debate has focused on whether penetration is more harmful than manual touching.

In summary, the general trends among empirical studies suggest that experiences involving less serious sexual abuse (molestation), occur in adolescence (after age 12), are of shorter duration, or are perpetrated by someone other than a father figure are associated with relatively less severe symptomatology among victims in adulthood.

INTERPERSONAL VARIABLES

Attachment

Perhaps one of the most fundamental, and significant, investigations of resilience was begun by Bowlby in the 1950's. Attachment theory grew out of his observations of young children's reactions to being separated from their mothers during hospitalizations (Bowlby, 1982). In particular, the ability to form secure affectional bonds with caretakers is considered a significant developmental achievement, one which will contribute to a child's competence in later social and emotional functioning. For example, Bowlby and his colleagues had noted that the

hospitalized children's reactions of protest, despair and detachment were similar to processes seen in older individuals experiencing disturbed personality functioning and who had suffered early life separations as well (Bowlby, 1982). A burgeoning field of research exploring attachment throughout the lifespan provides evidence to support the theory that quality of early affectional relationships with caretakers may underlie or have an impact on other relationships established in adulthood (e.g., Flaherty & Richman, 1986; Weiss, 1982). Bowlby's (1958, 1977, 1982) extensive writing regarding the effects of separation and loss on a child's conception of, and ability to form, affectional relationships offers a rich theory as to how children's personalities, and social and emotional functioning are shaped by these experiences. And conversely, attachment theory offers a lens through which individuals' resilience to traumatic or adverse experiences may be viewed. By providing a developmental framework within which individuals' representations of self, others, and self in relation to others can be assessed, information may be garnered about their ability to cope with adversity, on their own and through seeking and accepting help from others.

Because the quality of affectional bonds experienced by an individual is considered to have such an impact on other aspects of functioning throughout the lifespan, secure

attachments appear to constitute an important protective mechanism in coping with stressful events (Rutter, 1985).

Attachment Theory: As postulated by Bowlby (1977), attachment theory is "a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance...to which unwilling separation and loss give rise" (p. 201). Attachment theory is rooted in psychoanalytic theory (Bowlby, 1958) but eschews the assumption that gratification of instinctual drives for food or sexual gratification are the motivating force of behaviour and psychological development. According to classical psychoanalytic theory, relationships form secondarily to the satisfaction of physiological needs. Bowlby replaced psychic drives with a cognitive perspective involving mental representations. In particular, the child's early relationship with her or his mother (or other caregiver) and the internal representational model of that relationship which the child develops form the model upon which subsequent relationships are based (Bowlby, 1982).

Bowlby (1977) initially conceptualized attachment as a behaviour system based on the principles of control theory. The goal of attachment behaviour was seen as attaining or retaining proximity to some other preferred individual (Bowlby, 1977). During infancy, attachment behaviours

typically include smiling, crying, calling, following and clinging (Bowlby, 1958). Such behaviours on the part of the child also serve a biological function, eliciting care-giving from the attachment figure. When the caregiver is responsive, the child's proximity-seeking behaviour ceases and is replaced by exploratory behaviour. The caregiver thus provides a secure base from which the child can explore (Ainsworth, 1975). In Bowlby's theory, proximity-seeking and exploratory behaviours typically co-exist and alternate.

The establishment of an attachment relationship between caregiver and infant occurs within the first year of the infant's life. Although attachment behaviours decline in frequency and intensity with age, attachment remains an important aspect of human behaviour throughout the lifespan (Bowlby, 1984). For children and adults alike, attachment behaviours may intensify when individuals are distressed, ill or afraid.

Bowlby (1982) proposed that an inner cognitive organization underlies attachment behaviour, which he labelled an "internal working model". As a child's cognitive functions develop (beginning in the first year of life when, for example, object constancy is established), mental representations are generated regarding how the physical world may be expected to behave, how mother and significant others may be expected to behave, and how the child may be expected to behave in interaction with the world and with others (Bowlby, 1982, p. 354). The

development of internal models is thought to occur in relation to the development of other cognitive skills, including language and symbolic representation (Main, Kaplan & Cassidy, 1985). These internal working models form a heuristic basis for future relationships (Paterson & Moran, 1988).

It has been argued (Sroufe & Waters, 1977) that Bowlby's control systems aspect of attachment theory is insufficient to account for later developmental alternatives to proximity seeking (e.g., visual contact, internal representations); it is suggested instead that the goal of attachment is affective - the maintenance of a subjective sense of security. Proximity seeking is not automatically elicited; it depends on a subjective experience of security or insecurity. In their view, attachment is an organizational construct - discrete behaviours such as crying or clinging may not remain stable but patterns of behaviour that serve to maintain felt security will remain stable. The inclusion of affective experience provides an important mediational bridge between the behavioural and cognitive dimensions of attachment proposed by Bowlby.

Originally, Bowlby (1958) proposed that an infant's attachment-seeking behaviour tends to be directed toward one individual, typically the mother-figure. Although other attachments may be formed, these figures are considered secondary and form a hierarchy (Ainsworth, 1982; Bowlby, 1958). Research examining other caregivers as attachment

figures, and their importance relative to the mother, is somewhat scarce. Nevertheless, infants can and do become attached to figures other than, or in addition to, the mother (Rutter, 1980) including siblings (Heinecke & Westheimer, 1965), peers (Schwartz, 1972), fathers (Cohen & Campos, 1974; Lamb, 1977a, 1977b; Spelke, Zelazo, Kagan & Kotelchuck, 1973; Main & Weston, 1982) and day caregivers (Ricciuti, 1974, cited in Ainsworth, 1982). In adulthood intimate partners and friends may also serve as attachment figures (Weiss, 1982).

According to Bowlby (1977) there is "a strong causal relationship between an individual's experiences with his [sic] parents and his [sic] later capacity to make affectional bonds, and that certain common variations in that capacity...can be attributed to certain common variations in the ways that parents perform their roles" (p. 206). Parents who provide their children with a secure base and encourage them to explore from it by recognizing and responding to attachment-seeking behaviour will promote secure attachment. These children are described by Bowlby (1977) as having basic trust (Erikson, 1963), growing up to be secure, self-reliant, trusting, co-operative and helpful to others. When children have such experiences they develop internal representational models of themselves as "being both able to help [themselves] and as worthy of being helped should difficulties arise" (Bowlby, 1977, p. 206). Children who grow up without security-promoting experiences will be

anxious and insecure. According to Bowlby, research shows that insecure children have probably been exposed to at least one of certain types of parenting patterns including: one or both parents being persistently unresponsive to the child's care-eliciting behaviour and/or actively disparaging and rejecting her; discontinuities of parenting, occurring more or less frequently; persistent threats by parents not to love a child, used as a means of control; threats by parents to abandon the family; threats by one parent to desert or kill the other, or to commit suicide; guilt induced in a child by claiming that her behaviour will be responsible for the parent's death or illness; expectations that the child act as an attachment figure for the parent (role reversal) (Bowlby, 1977, p. 206-207).

As a child develops, interactions with individuals other than the mother may affect her or his internal representation of relationships and self-in-relationship. These experiences may either confirm or disconfirm her or his notion of security that was based on early relationships. For example, according to Skolnick (1986), "a father, grandparent, friend or teacher may provide alternative models of social reality" (p. 181). Werner and Smith (1982) considered grandparents to be 'resistance resources' who can provide continuity and support in an otherwise unstable situation and can buffer the effects of family strife (p. 160). The support and caring of fathers and grandparents also was found to be beneficial in a study

of children under 5 years of age who were raised by mentally ill mothers (Musick, Stott, Spencer, Goldman & Cohler, 1987) and in a study of infants whose mothers were unresponsive (Crockenberg, 1981). Therefore, when secure attachments have been imperiled by early life experiences, it appears that support from others may function as a protective mechanism in altering internal representations about relationships and the self in relation to others.

Based on such findings, women who experienced sexual traumas in childhood, especially familial victimization, might be expected to experience disrupted or insecure attachments. Internal working models of others as reliable and caring would be seriously affected. Several aspects of sexual victimization experiences may be quite relevant to the parenting patterns noted above. It is likely that the closer the relationship to the perpetrator (e.g., a father figure), the younger the age at which victimization begins, and the longer it continues, the more seriously would secure attachment be disrupted. The number of perpetrators by whom a child is abused also might be expected to undermine secure attachment. The longer victimization continues, or as the number of victimizations by different perpetrators increases, it seems increasingly likely that a child would develop a sense of herself as unworthy of love, and a sense of others as uncaring, hurtful or dangerous. Basic trust in others would be severly impeded by such experiences.

In the absence of positive, responsive attachment figures, a victimized child might come to see herself as unworthy of love or desirable only as an object of another's needs or hostility. However, the results of studies, such as those by Werner and Smith (1982), suggest that the availability of other supportive figures would serve as a counterpoint to negative relationships. Positive experiences with caring adults would enhance a sense of felt security and would confirm the child's sense of herself as lovable and worthy of help.

Attachment Research: i) Patterns of Attachment. Ainsworth (1982) elucidated a number of behaviours in addition to crying, clinging and so on that indicated the development of attachment between mothers and infants. However, she, and other researchers, found that such discrete behaviours are not stable across time or situations. Rather, a more useful area of study is behavioural patterns that have shown stability over time (Ainsworth, 1982). To do this, Ainsworth developed and validated the Strange Situation, a standardized procedure conducted in a laboratory setting (Ainsworth, Blehar, Waters & Wall, 1978; Ainsworth & Wittig, 1969). During increasingly stressful circumstances, the patterns of behaviour demonstrated by an infant upon being left by the mother with a stranger and upon reunion with mother were observed. Several distinct patterns of infant behaviour emerged. First, some infants displayed exploratory

behaviour with their mothers and contact seeking behaviour during the reunion episode; labelled Group B, these infants were considered securely attached. Other infants were classified as anxiously attached, and could be subdivided into two groups. Group A infants displayed exploration but avoidant behaviour with some proximity seeking during reunion episodes; this group was labelled anxious avoidant. Group C infants demonstrated impoverished exploration while with their mothers and both contact seeking and angry, resistant behaviour during reunion episodes; this group was classified as ambivalent attached. Using this system, the behaviour of most infants can be classified. Main and Weston (1982) report that about 10% of the infants from Caucasian middle-class families they studied could not be classified. Regardless of race or socioeconomic status, in nonclinical samples of infants typically 70% are classified as securely attached, 20% are anxious avoidant, and 10% are anxious ambivalent (Ainsworth, *et al.*, 1978).

ii) Attachment Stability. Research suggests that attachment patterns established in infancy are not immutable. The stability of attachment classifications appears to be determined by the stability of the caregiving environment (Thompson & Lamb, 1986). For example, using the Strange Situation paradigm, Waters (1978) found that 96% of 50 infants had the same attachment classification at 12 and 18 months. This middle-class sample was characterized by

two-parent families with stable paternal employment, residence and marital status (Vaughn, Egeland, Sroufe & Waters, 1979). Vaughn and his colleagues' (1979) study of 100 infant-mother dyads living in economically disadvantaged circumstances found that only 62% of infants obtained the same attachment classification at 12 and 18 months. Mothers whose infants shifted from secure to insecure attachment reported significantly higher scores on a life-stress inventory (completed during the second assessment) than did mothers whose infants were rated as securely attached at both assessments. On the other hand, no relation was found for stressful events among the mothers whose infants shifted from anxious to secure attachment ratings.

A subsample of maltreated or neglected infants identified in Vaughn *et al.*'s sample evidenced even less stability in attachment ratings at 12 and 18 months - only 48 percent (Egeland & Sroufe, 1981). Some infants shifted from secure to insecure attachments, but the reverse pattern also occurred.

It is apparent from such studies that attachment status can change over time, in either direction. In addition to the role of environmental stability suggested by the above studies, changes in maternal interaction may affect attachment quality (Thompson & Lamb, 1986). In particular, in studies of infant-mother dyads, maternal sensitivity and responsiveness have been found to play a role in the development and stability of secure attachment (e.g.,

Ainsworth, *et al.*, 1978; Crockenberg, 1981; Egeland & Farber, 1984). Of course, mother's responsiveness and mother's reports of stressful life events may be correlated. A stressed mother may be a less responsive mother. Whatever the reason, if the mother responds inconsistently or insensitively to her child, insecure attachment to the mother may result. If the mother's responsiveness does not change, and in the absence of other supportive attachment relationships, the child may develop an internal representation characterizing others as inconsistently responsive or unreliable.

iii) Attachment Status and Other Characteristics. Patterns of infant attachment behaviour in the strange situation have been compared to other aspects of social behaviour and psychological functioning as children develop. In general, such studies report that children who had been rated as secure infants are more socially competent, empathic, self-reliant and happier than those rated as insecure (Skolnick, 1986). For example, Matas, Arend and Sroufe (1978) found that, at 24 months of age, toddlers who had been securely attached at 18 months were more enthusiastic, persistent, cooperative and effective at problem-solving than were children who had been rated as insecurely attached. When this group of children was observed at age 5, those who had been securely attached were rated as more ego resilient and curious than were the other

children (Arend, Gove and Sroufe, 1979). In another study, children who were securely attached at fifteen months were rated at three and a half years as more self-directed, curious, and sympathetic to peers' distress than were insecurely attached children in a nursery school peer group (Waters, Wippman & Sroufe, 1979). The longitudinal study of economically disadvantaged families (described by Vaughn, *et al.*, 1979) reported that children who had been rated as securely attached at 12 and 18 months were rated as more sociable with peers at 20 to 23 months (Pastor, 1981), more compliant, persistent and enthusiastic in problem-solving tasks at 42 months (Erickson & Farber, 1983, cited in Thompson & Lamb, 1986), and more socially competent and less dependent in preschool at 4 to 5 years (Sroufe, Fox & Pancake, 1983) than were insecurely attached children.

iv) Attachment and Competence In Maltreated Children. Secure attachment also has been associated with resilience among abused and neglected children. In a prospective study, Farber and Egeland (1987) evaluated 4 groups of mistreating or neglecting mothers and their infants at 12, 18, 24 and 42 months. A subsample of these children were also evaluated later at preschool. The four groups were described as "physically abusive", "hostile/verbally abusive", "psychologically unavailable", and "neglectful". The behaviour of mothers in the physically abusive group ranged from frequent intense spanking to unprovoked angry

outbursts causing serious injuries to their children. The hostile/verbally abusive mothers chronically berated their children, found fault and harshly criticized them. Psychologically unavailable mothers were detached, emotionally unresponsive to their children, and appeared depressed and withdrawn. Neglectful mothers were irresponsible in day-to-day child care, lacking the skills to provide appropriate, consistent care for their children despite being interested in their well-being. In all of these cases, a variety of social service agencies were involved in providing interventions with the mothers.

The children from all four groups were found to be functioning poorly. Interestingly, children of psychologically unavailable mothers demonstrated the largest number of pathological behaviours (Egeland, Sroufe & Erickson, 1984). Within the physically abused group, some children did appear competent on measures of autonomous functioning, socialization and self-awareness; however, children who had been rated as competent at one assessment period often were not so rated by the following assessment period. Abused children who were competent at 24 months, 42 months and at preschool had a history of secure attachments, although the percentage of children who were competent decreased over time. When the children were studied at 18 months of age, receiving a rating of secure attachment was associated with relative stability in the mother's life and

the availability of a supportive family member, usually a grandmother (Egeland & Sroufe, 1981).

In addition to attachment status, information was collected on child temperament and behaviour, parental characteristics, parent-child interaction, life stress and life circumstances. This information was examined to account for competency among the maltreated children. There was little evidence that constitutional factors were important in making children less vulnerable (Farber & Egeland, 1987, p. 283). Rather, environmental factors appeared to be more important. In particular, a stable home (i.e., a two-parent family) and maternal support in the form of emotional responsiveness to the child were two of the most important factors. Among the children whose mothers were emotionally unavailable, few were competent; those who were competent had emotional support from fathers or grandparents.

v) Attachment Beyond Early Childhood. Research regarding attachment status and other characteristics beyond early childhood has recently received increasing attention. One longitudinal study conducted by Main and her colleagues (Main, *et al.*, 1985) found a significant correlation between attachment status in infancy and attachment status at six years of age, based on ratings of reunion behaviour between the children and their mothers. Moreover, secure attachment to mother in infancy was significantly correlated with the

6-year-old's responses to the question "What should the child do?" when shown a picture depicting the parents departing for a 2-week separation. Children who had been securely attached in infancy gave responses that were rated as more active ways of dealing with the separation (e.g., "he could go to his friend's house") than the responses given by insecurely attached children (e.g., "I don't know"). These findings support the hypothesis that securely attached children develop internal models of their parents as accessible and themselves as able to seek help when needed.

Recently, attachment measures for adolescents and adults have been developed. The Adult Attachment Interview (Main & Goldwyn, 1984; Main, *et al.*, 1985) has enabled researchers to investigate attachment status among older individuals based on representational models of early parent-child relationships and experiences. Main's three classifications, Secure, Dismissing, and Preoccupied, parallel Ainsworth's classifications of Secure, Avoidant and Ambivalent attachment. Using the Adult Attachment Interview in a study of adolescents, Kobak and Sceery (1988) found that Secure adolescents as a group appeared to be better adjusted than the Dismissing and Preoccupied groups. The pattern of Secure attachment was associated with higher ego-resilience, lower anxiety Q-sort ratings by peers, fewer symptoms of psychological distress and higher self-reported social competence. The Secure group also reported higher

levels of family support than did the Dismissing group. This latter finding suggested that secure adolescents see attachment figures as available and supportive during times of distress. The Dismissing group was rated by peers as more hostile than the Preoccupied group whereas the Preoccupied group was rated as more anxious than the Dismissing group. These findings support the notion that working models offer an organizational construct associated with different styles of affective regulation in distress-related contexts. Moreover, the patterns of adjustment found among adolescents generally appear to parallel the adjustments of the Strange Situation classifications with infants and children (Kobak & Sceery, 1988).

Another study of adolescents contributes to the picture of secure individuals as more competent and adaptive in distressing situations. Using a self-report measure of parent and peer attachment in a study of college students ranging in age from 17 to 20 years, Armsden (1986) found that adolescents who reported secure attachments to both parents appraised stressful family situations as more changeable and requiring less self-constraint, and used more problem-managing coping responses relative to emotion-managing responses than did adolescents who reported insecure attachments to both parents. These findings lend further support to Bowlby's (1982) notion that secure attachment facilitates the development of an internal

working model of oneself as competent in problem solving and coping with stressful situations.

Whereas Armsden suggested that attachment may be considered a vulnerability factor in models of stress and coping, another way of conceptualizing such results is to consider attachment to be a protective factor. That is, securely attached individuals' internal models of relationships as supportive and of themselves as competent in coping and eliciting help may ameliorate the impact of trauma by providing a source of positive self-esteem and internal locus of control, factors that are thought to contribute to resilience (Rutter, 1985). Alternatively, those who see themselves as competent in eliciting help may be more likely to do so. As will be discussed below, social support itself may function in several ways as a protective mechanism.

On the basis of research findings regarding attachment stability and the effects of maltreatment on attachment, one can speculate about the effect of sexual abuse on attachment. It seems likely that familial sexual abuse in particular, as a form of maltreatment, would be associated with insecure attachment. Attachment and victimization no doubt interact in a complex manner. For example, in the absence of secure attachment sexual abuse experiences might be expected to confirm an already established notion of others as unreliable and uncaring, and a sense of self as unworthy of caring. For the child who is securely attached,

sexual victimization might have a disconfirming effect on positive models of relationships. Also, if sexual abuse is a relatively isolated incident, experiences of other positive, supportive relationships may disconfirm or protect against the child's internal representational model shifting toward a negative view of others and self.

Maternal Support

It is generally accepted that social support mediates adults' responses to stress (cf. Cobb, 1976 for a review). Longitudinal studies of vulnerable children also have found that parental support is a protective factor in response to stessful events (e.g., Rutter, 1979; Werner, 1988; Werner & Smith, 1982). In a review of studies examining invulnerable children, several factors appear consistently, including the presence of a supportive family environment characterized by parental warmth, cohesiveness and closeness (Garmezy, 1983). Within the family, maternal support may be especially important (Farber & Egeland, 1987). Attachment theory would predict that stressful events trigger an increase in attachment needs which would likely be directed toward the primary caregiver, typically the mother. Also, if there is a risk of separation from the family (e.g., in the case of incest) following disclosures of sexual abuse the salience of maternal responsiveness might increase.

Research provides evidence for the role of maternal support following disclosure of sexual abuse as a protective

factor in functioning. Two studies (Adams-Tucker, 1982; Conte & Schuerman, 1987) found that sexually abused children who were not supported by adults on whom they depended experienced more emotional disturbance than did children who received support. Everson, Hunter, Runyon, Edelsohn, and Coulter (1989) found that incestuously abused children receiving less maternal support evidenced more symptoms of depression and low self-image than did children receiving more maternal support. Two studies reviewed by Browne and Finkelhor (1986) found that negative maternal reactions were related to more distress among children but positive maternal reactions were not related to less distress. One possibility for this finding is that negative or poor maternal support may lead to removal of the child from the home if child protection workers deem negative support to indicate the mother's inability to protect the child (especially if incest has occurred). Placement outside of the home would remove the child from other important sources of support (e.g., teachers, friends, church) (Everson, *et al.*, 1989). However, the results of one study addressing this issue (Everson, *et al.*, 1989) suggest that low maternal support has an impact on the child's functioning over and above the impact of being removed from the home. A study of adolescent incest victims offers further evidence that positive maternal support does have an impact; Johnson and Kenkel (1991) found that the more an adolescent rated her

mother as supportive, the less general psychological distress she evidenced on a self-report symptom index.

Addressing the impact of maternal support on adults who experienced sexual abuse in childhood is difficult due to the vagaries of memory. Nevertheless, whether a mother is supportive in fact or is perceived as being supportive is an interesting and important question. In studying social support in general, some researchers (e.g., Quinton, 1980 cited in Rutter, 1985) note the importance of distinguishing between the availability of social support and an individual's ability to make use of that support. According to Rutter (1985), *perceived* adequacy of social support at times of stress does seem to offer some buffer against disorder.

Social Support and Confiding Relationships

In addition to the importance of parental support in fostering resilience, another protective mechanism commonly reported is the availability of a supportive older individual who serves as a positive role model (Garmezy, 1983). Especially in situations where parental support or stability is unavailable, a supportive adult can enhance a child's self-esteem and sense of self-worth (Steele, 1986; Werner, 1988; Zimrin, 1986). From an attachment theory perspective, these relationships provide an opportunity for secure attachments to develop. Such relationships, which contribute to the child's internal representational model of

self as lovable and of relationships in general as available and positive, should facilitate development of positive, reciprocal relationships in adulthood. The ability to establish and maintain intimate relationships in adulthood is considered a cornerstone of well-being and adaptation (e.g., Vaillant, 1977).

The role of social support for adults coping with stressful life events also has received considerable attention and is generally recognized as beneficial (cf. Caplan, 1981 for a review). Investigation of the role of social support seems to be of two types. In one type, studies examined the effect of marital relationships for women, in particular those who have experienced death of their mothers in childhood (e.g., Brown, Bhrolchain & Harris, 1975; Parker & Hadzi-Pavlovic, 1984) or who were raised in an institution (e.g., Quinton, Rutter & Liddle, 1984; Rutter & Quinton, 1984). In general, these studies found that having a supportive, intimate relationship decreased the likelihood of depression and other psychiatric symptoms. In the other type of research, studies examined a wider network of relationships including friends, social networks, and support groups (e.g., Henderson, 1977; Miller & Ingham, 1976). The availability of friendships has been found to protect against psychological distress in women (Miller & Ingham, 1976). Adult women who were sexually abused in childhood have given anecdotal evidence of the benefits provided by friends (Tsai, *et al.*, 1979); they more

frequently attributed their adjustment to friend and family support, including assurances of worth and blamelessness for the molestation, as well as understanding sexual partners, than to other factors.

Social support no doubt is a complex commodity that serves several psychological functions. In addition to the importance of social support in establishing and maintaining affectional bonds (Weiss, 1982), social support provides an opportunity for confiding which in turn likely serves at least three important cognitive functions in promoting adaptation. One, talking about stressful events with another person may enhance problem-solving skills (e.g., discovering actions that can be taken to alter the situation). Two, the opportunity to vent about the stressful event, by confiding in another person, may enhance understanding of the experience. Three, confiding about victimization experiences may elicit reciprocal confiding; this would decrease feelings of isolation and stigmatization leading to a less negative self-image. The findings of Silver, Boon and Stones (1983) support the second conjecture that confiding enables individuals to make sense of their experience. In their study, women who had at least one person in whom they could confide about their incest experiences were significantly more likely to have made some meaning of the experience than women who did not have such a relationship. Furthermore, significant differences in coping were found between women who had made sense of their

experience and those who had not found meaning but were still searching. For example, the former group of women reported less psychological distress, better social adjustment, and higher levels of self-esteem on standardized psychological tests than did the latter group. In Pennebaker's (1985) study, individuals who had experienced childhood traumas and who had not confided with others about the events reported more symptoms and diseases, took more non-prescription medication, and went more to physicians than did traumatized individuals who had confided in others, and individuals who had not had traumatic experiences. Thus, confiding about traumatic experiences appears to be a potent protective mechanism.

COGNITIVE VARIABLES

The role of cognition in the evaluation of events follows a tradition of critical philosophy, espoused by Kant, whereby a person actively organizes experience by making judgements and interpretations (McCann, Sakheim & Abrahamson, 1988). Bowlby's tenet that early experiences contribute to an internal representational model of relationships that may influence later views of relationships also is rooted in this tradition. More specifically, victimization research, which often examines the impact of victimizing experiences on victims' assumptions about the world (e.g., Silver & Wortman, 1980;

Taylor, Wood & Lichtman, 1983), hypothesizes a large cognitive component to the experience of being victimized.

Lazarus (e.g., Lazarus & Folkman, 1984), who is one of the main contributors to the focus on cognitions in coping with stress, has extended and refined the theoretical perspective in several important ways. First, he distinguished between appraisals and reappraisals of events which relates to his redefinition of coping as a process rather than as a trait. For example, if a parent is assumed to care for a child, sexual attention may cause a child to feel threatened; this might shatter her assumptions about how a parent (or authority or care-giving figure) behaves. Out of this experience, a new set of assumptions about the world would develop, and might initiate a new set of behaviours (e.g., avoidance of intimate relationships or authority figures). On the other hand, the event may not be appraised at the time as threatening or negative. But later in life, for example, when her view of parent-child relationships may have changed as a result of experiences such as finding a supportive partner or becoming a parent herself, she may re-evaluate the early event. In Lazarus' terminology, the event will be reappraised; the outcome, again, may occur in either a positive or negative direction. Thus events may be appraised and reappraised over time requiring coping efforts over time. Second, Lazarus distinguished between problem-focused coping and emotion-focused coping. Whereas problem-focused coping refers to

actions that can be taken to alter a situation emotion-focused coping serves to alter one's feelings about a situation that is not changeable. This is an important feature in studying victims of sexual abuse who may have been powerless, due to lack of understanding or physical strength, to stop the abuse thus preventing problem-focused coping efforts. Emotion-focused coping may also be the major type of effort utilized by adults in coping with childhood experiences. Although some women take actions such as instigating judicial proceedings, the primary type of coping strategy may be directed at altering their feelings or cognitions about the past abuse.

The search for meaning in one's experiences is a particular emotion-focused cognitive process that appears to be significant in coping with traumatic events (Taylor, 1983). For example, attempts to find meaning in adversity occur following a variety of traumatic events, such as severe physical illness or injury (Bulman & Wortman, 1977; Taylor, 1983), death of one's child (Chodoff, Friedman & Hamburg, 1964) or one's spouse (Parkes, 1970), rape (Burgess & Holmstrom, 1974) or internment in a concentration camp (Frankl, 1963). Finding meaning appears to be a powerful tool in reorganizing one's view of the world, and one's place in that world, at the same time that it provides a sense of control over events in one's world. Understanding why an event happened enables one to maintain a feeling of control over the likelihood of its occurrence in the future.

In this way, one gains a sense of mastery over the event, another self-cognition thought to be important in adapting to traumatic events (Taylor, 1983). Mastery may be a misleading concept, however, suggesting that a traumatic event is forgotten or left behind as one 'moves on' in life. In fact, research by Silver *et al.* (1983) suggested that negative feelings and memories associated with incestuous experiences continued to exist in women's consciousness, albeit in a reduced fashion, long after the event ended.

Some research results support the significance of meaning-making in recovery from incest. Silver *et al.* (1983) found that incestuously abused women who had made sense of their experience reported less psychological distress, higher self esteem and greater resolution of the experience than women who were still searching for meaning. Nevertheless, the majority of women (80%) who found meaning continued to search for answers, albeit less frequently or intensely than the latter group. The researchers also found that the former group still functioned at a lower level than normative samples on the measure of psychological distress and social functioning. In another study of female incest survivors, Draucker (1989) studied the mediational role of cognitive variables such as finding meaning in recovery from incest. She hypothesized that the more incestuous the experience, as defined by closeness of relationship to the offender, the more traumatic its effects. The role of cognitive variables, such as finding meaning and regaining a

sense of mastery over the event, in mediating between levels of incestuousness and current functioning was assessed using path analysis. Although Draucker found a positive relationship between level of accomplishment of finding meaning (as assessed by a questionnaire) and current functioning on measures of depression, self-esteem and social role functioning, there was no relationship between incestuousness and current functioning in her sample. Therefore, the mediational model was not supported. Despite the limitations of Draucker's study, especially the use of a single aspect of the abuse experience as a measure of trauma, her results do provide some support for the role of cognitive factors in adult functioning among incest victims.

Finally, some researchers (e.g., Lazarus & Folkman, 1984; Rutter, 1985) have suggested that any coping effort may be better than none. What may be most important is the feeling that one can affect one's situation, if not in the past, then in the present and the future.

CHAPTER 3

IDENTITY

Most studies investigating the long-term impact of sexual abuse on women have focussed on discrete variables such as clinical symptomatology or self-esteem. While these studies provide information about some victims' psychological maladjustment in adulthood, a broader understanding of how sexual abuse shapes women's lives is needed (Painter, 1986). To date, we know relatively little about how sexual abuse victims cope with developmental tasks. The construct of ego identity provides a good measure of the extent to which individuals successfully negotiate the major developmental task of adolescence, that is establishing a coherent, stable sense of themselves in the world and in relation to others.

Erikson (1963) proposed that personality development occurs throughout the life-span in an epigenetic sequence and within a cultural context. Each stage of development presents the individual with a crisis, or turning point, the resolution of which leads to strength or maladjustment (Erikson, 1968). The crisis faced in adolescence, and the hallmark of a movement to adulthood, is the achievement of an ego identity. Inability to do so results in identity diffusion. The sense of ego identity involves "the accrued confidence that one's ability to maintain inner sameness and

continuity, one's ego in the psychological sense is matched by the sameness and continuity of one's meaning for others" (Erikson, 1959, p.89). According to Marcia (1980) identity is "an internal, self-constructed, dynamic organization of drives, abilities, beliefs, and individual history" (p. 159). The experiential quality of identity was described by Erikson (1968) as a sense of psychosocial well-being, a feeling of being at home in one's body, or knowing where one is going. Individuals with a firm sense of identity have a consistent sense of who they are in relation to their past, present and future, and in relation to others (Josselson, 1988a). Individuals with diffuse identities are less sure of their uniqueness from others and rely more on external sources to evaluate themselves (Marcia, 1980). One of the key principles of Erikson's theory is that resolutions of crises re-occur throughout the life cycle. Thus, despite adolescence being a critical period for identity development, the elements of an individual's identity may be reformulated and reorganized over time.

Based on Erikson's writings, Marcia (1966) developed a semi-structured interview to measure of ego identity development. Two criteria were used: 1) Exploration, that is, whether an individual had experienced a period of exploring alternatives, and 2) Commitment, whether an individual had made firm decisions about an occupation and ideology. Based on the process variables of exploration and commitment, Marcia outlined four identity statuses

representing points along a continuum of ego identity formation. Identity Achievers have undergone a period of exploration and have made commitments on their own terms. They maintain a sense of flexibility about their choices. Moratoriums are in the process of exploring alternatives; their commitments are rather vague. Foreclosures have not explored alternatives; rather, they have made commitments that are often based on parental wishes. These individuals' personalities have a somewhat rigid quality. Identity Diffusions may or may not have experienced a crisis. In either case, they lack commitments and may be willing to take up or abandon options quite easily.

The identity statuses were initially validated using male samples. Subsequently, extensive research, using a variety of behavioural, cognitive and personality variables, has confirmed the construct validity of the identity statuses. These research findings have been reviewed extensively by Bourne (1978a; 1978b), Marcia (1980), Marcia, Waterman, Matteson, Orlofsky and Archer (in preparation) and Waterman (1982). Results have indicated that both male and female Foreclosures endorse authoritarian values more than the other statuses whereas Moratoriums endorse such values the least (Marcia, 1966; Marcia & Friedman, 1970; Schenkel & Marcia, 1972). Among males, Moratoriums obtain the highest scores and Foreclosures obtain the lowest scores on a measure of anxiety (Marcia, 1967). Identity Achievements and Moratoriums are less liable to change their self-

evaluations in response to external feedback (Marcia, 1967) and function at higher levels of moral reasoning (Podd, 1972; Poppen, 1974, cited in Marcia, 1980) than do Foreclosures and Diffusions. The statuses do not differ in intelligence (Cross & Allen, 1970; Marcia, 1966; Marcia & Friedman, 1970) although differences in grades (St. Clair & Day, 1979) and difficulty of college majors (Marcia & Friedman, 1970) have been found. Achievements and Moratoriums have more successful, mature intimate relationships than do Foreclosures and Diffusions whose relationships tend to lack depth and genuine closeness (Orlofsky, Marcia, & Lesser, 1973). In general, identity achievement is associated with good adaptive capacities, and intrapersonal and interpersonal adjustment while identity diffusion is associated with difficulties in coping and poorer adjustment (Neuber & Genthner, 1977; Waterman, 1982).

In general, with male samples, Identity Achievements and Moratoriums obtain similar scores on a variety of measures, and differ from Foreclosures and Identity Diffusions who obtain similar scores (e.g., Marcia, 1966). Prior to 1977, studies of women indicated a different pattern in status groupings. Female Achievements and Foreclosures were similar and differed from Moratoriums and Diffusions (e.g., Schenkel, 1975). For example, Foreclosures were lowest in anxiety whereas Diffusions were highest (Marcia & Friedman, 1970). Achievement and Foreclosure women also were more resistant to conformity

pressure than were Moratoriums and Diffusions (Toder & Marcia, 1973). The 1970's were a time when women pursuing non-traditional ambitions or choices probably did not receive much social support. Marcia (1980) speculated that a Foreclosure identity might be adaptive for women. Since 1977, however, of 16 studies with discernable patterns, 12 have demonstrated the Achievement-Moratorium and Foreclosure-Diffusion grouping among both men and women (Marcia, Waterman, Matteson, Orlofsky & Archer, in preparation). In addition to a political shift toward greater acceptance of women's expanding choices and roles, Marcia *et al.* reported that Moratoriums, rather than Foreclosures, perform similarly to Achievements on psychoanalytically-based measures, such as Hansburg's separation-individuation index. Using more sophisticated measures appears to detect the move by Moratoriums away from the conventional adjustment of Foreclosures (Ginsburg & Orlofsky, 1981).

Women's Identity

When the investigation of identity formation was extended to females, a new content area was added to the measure (Marcia & Friedman, 1970) to reflect Erikson's theoretical formulations that feminine development occurs through establishing an intimate relationship with a chosen mate. Other research (Douvan & Adelson, 1966) also suggested that adolescent boys and girls may follow

different pathways to identity with girls; while autonomy was important for boys, interpersonal issues were important for girls. Thus, in extending the identity status interview for women, questions were asked about attitudes toward premarital intercourse (Marcia & Friedman, 1970). Greater concern in this area for young women in our society also may reflect societal issues, in that women often have the greater responsibility for decisions regarding birth control, and abortion (Waterman & Nevid, 1977). Using the modified identity interview, Marcia and Friedman reported that identity statuses could be applied to women and could discriminate among women on variables such as authoritarianism, self-esteem and anxiety.

In assessing the relative importance of sexual identity for women, Schenkel and Marcia (1972) found that sexual attitudes and religion had more predictive power than occupation on measures of authoritarianism, anxiety and self-esteem. For girls, social relationships, sexual attitudes and the choice of a future mate did appear to be important (Schenkel & Marcia, 1972) thus lending support to Erikson's idea that women's identity constellates around sexual, interpersonal issues.

An array of research findings lend further support to Erikson's thesis. In a study of Danish students, Matteson (1977) found that women had undergone exploration in the area of sex-roles more often than had men. Values, a content area used instead of religion, and sex-roles

discriminated among women in the different statuses on several personality measures; no significant differences were found among statuses on the basis of occupational or political areas. These results paralleled Schenkel and Marcia's findings (1972). However, sex-roles were also important for the men in Matteson's study. Men demonstrated higher levels of commitment on sex-roles and values than occupational or political content areas; the most powerful content area in predicting differences among men on personality measures was sex-roles. Hodgson and Fischer (1979) reported that male college students explored identity through issues of competence and knowledge as manifested in career and ideological decisions. Although female college students appeared to have several viable choices in identity development, evidence suggested that their explorations constellated around relational issues. That is, women sought to get along with others in ways that satisfied themselves and others important to them. This sense of taking into account the relational context also seemed apparent in Grotevant and Thorbecke's (1982) study of high school students. Whereas boys' pursuit of an occupational identity was related to an instrumental orientation without concern for the negative evaluations of others, occupational identity for girls was related to working hard and avoiding competition. Again, it appears that women are more aware of their embeddedness in a relational matrix. In their phenomenological study of adolescents, Josselson,

Greenberger and McConochie (1977) found that boys' identity oriented around their development of autonomy while girls' development had a greater interpersonal focus. In their study of college students, Waterman and Nevid (1977) found that males and females demonstrated similar patterns on occupation and ideology; however, in the area of sexual identity, women were more likely to be achieved while males were more likely to be foreclosed. Based on the assumption that an individual is more likely to undergo a crisis in an area of personal importance, the finding of a higher incidence of crisis among women suggested that sexual issues are important female identity. Bilsker, Scheidel and Marcia (1988) found that sexual-interpersonal issues were more predictive of women's identity status while ideology was more predictive for men. No difference was found for the predictive power of the occupation area. A significantly higher proportion of women than men rated sexual-interpersonal issues as more important than ideology for self-definition.

Although research findings have been quite consistent in illuminating the relational pathway by which women explore and resolve their search for an identity, Erikson's thesis that women's identity constellates around selecting a mate appears unwarranted. Rather, it appears that women's decisions about who they are, what they will do and what they stand for take into account what they mean to others who are important to them (Josselson, 1988a). In her study

of New Zealand women, Kroger (1986, cited in Marcia, *et al.*, in preparation) found that, "rather than decisions about individual content areas, meta-decisions about how to balance competing identity contents and at the same time consider the implications for significant others seemed to capture identity concerns for many women " (p. 15).

Qualitative Descriptions of Women's Identity

Several researchers have constructed portraits of young and mature women (Josselson, 1973, 1988a; Marcia & Miller, 1980) in each of the identity statuses, based on extensive interview material such as salient developmental influences, history of significant object relationships, self-description, early memories, dreams and fantasies. The portraits of each status are remarkably consistent despite the differences between the samples: Josselson's subjects were interviewed first in their early 20's and were re-interviewed 12 years later while Marcia and Miller's cross-sectional study included subjects whose ages ranged from early 20's to late 50's.

Josselson (1973, 1988a) found that Foreclosures attempted to reproduce positive experiences of early familial relationships with their own companions and children. Although successful in their careers, their search for security usually was realized in relationships, not in work. In late adolescence, they had difficulties establishing peer relationships and tended to stay within

the family's supportive environment. In general, Foreclosures appeared unable to establish enough trust outside the family for friendships to develop. During childhood or adolescence they felt different, rejected, or isolated; they also had mothers who were possessive and themselves fearful and isolated. Relationships with their fathers also tended to be intensely affectionate and idealized. As adults, they remained close to their families of origin, especially their mothers.

Achievements, in contrast, were characterized in adolescence by self-confidence and a struggle for independence. They valued their own competence for its intrinsic rewards. Typically, Achievements' relationships with one parent was intense and ambivalent (often their mothers) while the relationship with the other parent was unconflicted. They were more likely than any other group to speak of experiences in which they could be on their own and survive. Although they moved away from parental expectations, they were capable of using peer support to confirm their explorations. They chose relationships with men who would be supportive rather than protective. As adults, they were most likely of the groups to have changed professions after college, having become disillusioned with the bureaucratic structures in which they found themselves. In general, they demonstrated flexibility in the expression of their identity. For Achievements, like Foreclosures, work was not central to their identities. Although

relationships also were primary in Achievements' lives, they were more likely to have found a balance between work, relationships, and interests.

Moratoriums were the most homogeneous group. In adolescence, they evidenced a sense of guilt, often involving feelings of disappointing their parents. While they struggled to reject identifications with their mothers, who were described as overprotective, Moratoriums clung to idealized images of their fathers. Moratoriums also were more likely than the other groups to idealize a peer and to report daydreams of great success. Like the Achievements they often chose a boyfriend who would support them as they struggled to disengage from their families. As adults, Moratoriums continued to focus on relationships, rather than self-achievement, as a source of self-esteem and ideas of how to live. They became closer to their mothers in adulthood than did the other groups. In general, they were introspective and oriented to their feelings.

Diffusions comprised the least homogeneous group. For some of these women, their early lives were characterized by loss of a parent or emotional neglect. For others, their parents had set no real expectations upon which they could build an identity. In general, Diffusions were unable to form positive identifications with their parents; they tended to rely on fantasy for images of potential identities. As adults, some Diffusions were able to find

relationships through which they were able to organize their inner sense of self.

In studying married women, Marcia and Miller (1980) noted that Foreclosures' identity was centred on relationships with their families. Most Achievements had gone through a 3-stage process of accepting social roles, rejecting them, and finally resolving issues by finding a balance between their relational and achievement needs. They saw themselves as competent and independent. Moratoriums struggled with wanting to be themselves but also wanting to perform well as wives and mothers; similar to Josselson's Moratoriums, these women felt guilty. Diffusions had very poor self-esteem and feared being hurt or betrayed. Although currently in relationships, they, too, apparently hoped for a potentially better relationship around which to structure themselves internally. This is consistent with Josselson's finding that Diffusions seemed to cherish possibilities and were reluctant to give them up by making a commitment to any one choice.

Early Trauma, Family Variables and Identity

Based on his clinical experience, Erikson (1959, 1968) noted that particular characteristics were commonly found in the families of adolescents experiencing psychopathology and identity diffusion, or confusion. While the mother tended to be loving, in a desperate, intrusive way, the child tended to withdraw or shy away. Erikson (1968) referred to

this incompatibility as a "reciprocal negative reaction" (p. 176). For the most part, Erikson's patients had fairly unremarkable childhood histories in terms of trauma. However, he noted that a severe physical trauma such as an operation, accident or a severe sexual traumatization, usually in connection with a separation from home, seemed frequent.

Research suggests that trauma does not invariably disrupt identity development. Although Josselson (1973) reported that a significant sub-group of Diffusions had experienced early severe psychological trauma such as neglect or loss of a parent, several other sub-groups of Diffusions had not been traumatized. Also, trauma was not restricted exclusively to Diffusions' lives. For example, one Foreclosure spoke extensively, during both interviews, of the impact of her father's death when she was 11 (Josselson, 1988a). In a sample of high school females, St. Clair and Day (1979) found that two-thirds of the Achievements had experienced parental divorce or death, while less than one-fifth of members of the other statuses had such experiences.

The ability to make use of social support may be an important protective factor in facilitating identity development despite experiencing trauma. Among the women Josselson (1973) studied, the quality of object relationships seemed to differentiate the statuses. Diffusions as a group had been unable to establish positive

identifications with either parent while Achievements formed peer connections, and used relationships for support rather than for protection or idealization. These relationships provided an important anchor while Achievements relinquished families ties in their struggle for independence.

CHAPTER 4

THE PRESENT STUDY

When viewed together, a common theme emerges from the literatures on attachment, ego identity development, coping and resilience: the ability to form and utilize relationships for support is a vital mechanism in fostering adjustment and adaptation. Embeddedness in relationships is especially important for women's psychological development. Studies of women who have been sexually abused also indicate that those who have had social support and have been able to find meaning in their experiences perceive themselves to be well-adjusted. Their perceptions are borne out on standardized measures of psychological health.

Sexual abuse, unlike other types of abuse or trauma, may pose a pervasive threat to victims' relational capacities. The negative effects often reported by sexual abuse victims, including feelings of isolation, stigmatization, fear of men and women, dissociative symptoms, sexual problems, may all mitigate against victims' ability, or desire, to establish relationships with peers or intimates. Sexual abuse victims who do not experience lasting psychological damage may have been able to sustain positive connections with others that facilitated their resilience. Several questions seem important. Do non-symptomatic victims have supportive relationships with friends or intimates that facilitated their recovery from abuse? Do they

confide about their experiences with these individuals? On a another level, are non-symptomatic victims well-adjusted? Do they have the capacity to establish secure relationships; have they established an ego identity?

The Present Study

The purpose of the present study was to elucidate potential protective mechanisms within a group of well-functioning women who were sexually abused in childhood or adolescence. Based on attachment and coping literature, it was expected that attachment style, supportive relationships and meaning-making would mediate recovery from sexual abuse. Since little research exists on protective mechanisms that facilitate recovery, the present study sought to uncover information about processes that victimized women perceived as having enhanced their coping or adjustment. To do this, women were interviewed about a range of topics including traumatic events in childhood or adolescence, processes that they felt had helped in coping with adversity, and whether they had made the experience meaningful. In addition, information was elicited regarding early and current relationships, school experiences, and accomplishments.

To date, most research on the long-term effects of sexual abuse has focussed on demonstrating symptoms of illness or psychological distress, social maladjustment or poor self-esteem. The current study extended this body of research by assessing psychological distress and self-concept. In addition to the traditional measures of adjustment, the extent to which

participants had successfully resolved the developmental crisis of ego identity development (Erikson, 1959, 1968) also was assessed. According to Waterman, identity achievement is associated with good adaptive capacities while identity diffusion is associated with difficulties in coping.

Hypothesis 1

It is hypothesized that sexually victimized women will be less well-adjusted than non-sexually victimized women and non-victimized women. Specifically, women who experienced sexual abuse will obtain lower scores on self-concept and identity status measures, and higher scores on psychological distress scales, than will women who experienced other types of trauma and women who experienced no trauma.

The rationale for this hypothesis was based on extensive research that sexually abused women as a group are more symptomatic than non-sexually abused women. Research evidence suggests that sexual abuse differentially contributes to harmful consequences (Briere & Runtz, 1990) and does so above and beyond other types of trauma (e.g., Bagley & McDonald, 1984). There is scant evidence that self-perceived adjustment following sexual abuse is borne out on standardized measures of adjustment. Both self-perceptions and standardized measures of adjustment were included in the present study to assess the possibility that sexually victimized women who perceive themselves as well-

functioning may, nonetheless, be less adjusted than non-sexually traumatized women and non-traumatized women.

Hypothesis 2

Among women who were sexually abused, the seriousness of sexual abuse, age when abuse began, relationship to perpetrator, maternal support following abuse and attachment style will be related to measures of adjustment. Specifically, sexual abuse involving physical contact, by a father-figure, prior to the age of 12, and lack of maternal support will be associated with poorer self-concept, lower identity status, and greater psychological distress. Insecure attachment style also will be associated with poorer adjustment than will be a secure attachment style.

The rationale for this hypothesis is based on the sexual abuse literature in which levels of symptoms vary in relation to properties of the abuse experience (e.g.,Browne & Finkelhor, 1986; Finkelhor, 1990). The relative contribution of these factors to adjustment will be determined using multivariate analysis.

METHOD

Subjects

Subjects were 100 women, 21 years of age or older, who were recruited primarily from senior level classes at Simon Fraser University. Research suggests that the critical period for identity formation occurs between the ages of 18 and 21 years (e.g., LaVoie, 1976; Meilman, 1979; Munro & Adams, 1977). The age of 21 was chosen as the minimum criterion for inclusion in the present study since this would increase the likelihood that participants had constructed an identity. This maximized the opportunity to evaluate the impact of critical events on identity development.

An attempt was made to gather information about the participation rate based on the total number of women who were informed about the study. The author attempted to do this by noting the total number of women in each class, the number of eligible women (based on age), volunteer rate and follow-through rate (those volunteers who completed the study). This was not entirely successful since some women did not return the sign-up sheets in class, despite requests by the researcher and later, their Teaching Assistants, to do so. Although definitive information about overall rates of participating could not be ascertained, participation among those who did return the sign-up sheets was tabulated. Approximately 250 women were informed of the study through Psychology and Women's Studies courses. Two

hundred and five women returned sign-up sheets; 154 met the age criterion for eligibility. Of these 154 women, 111 (72%) volunteered as potential participants for the study. Thirty of these potential participants ultimately did not participate in the study. The majority of them could not be contacted or could not find the time to participate; also, several women intimated that they were facing current crises and stated that the subject of the study potentially was more upsetting or anxiety provoking than they had thought at the time they volunteered. Of the 71 women who began the study, three dropped out after the first appointment leaving 68 women (61% of volunteers) who completed the study. Overall, 72% of the eligible women volunteered and 44% completed the study.

Some participants were recruited outside of classes. Through pamphlets placed at the Women's Centre, Psychology Common Room, SFU residences, and through personal contacts of the researchers, an additional 40 women volunteered for the study. Thirty-two (80%) completed the study.

Measures

Background Information

Information on several demographic variables was elicited (see Appendix A). Participants provided their age, place of birth, marital status, current year in university and university major, and highest level of completed education and occupation of each parent. Parents' occupations were classified using an

updated version of Duncan's (1961) Socioeconomic Index (Featherman & Stevens, 1982).

Tennessee Self Concept Scale

The Tennessee Self Concept Scale (TSCS) (Fitts, 1965) provides a multi-dimensional description of self concept. It consists of 90 self-descriptive statements such as "I am a member of a happy family" and "I am satisfied with the way I treat other people". Ten items from the Minnesota Multiphasic Personality Inventory (MMPI) L Scale (Hathaway & McKinley, 1967) are included and comprise the Self-Criticism scale. The Clinical and Research Form of the TSCS was used in the present study. The TSCS is self-administered and requires approximately 13 minutes to complete (Fitts, 1965). Individuals indicate, using a 5-point scale that ranges from "completely true" (5) to "completely false" (1), how true each item is for them. Items are equally divided between positive and negative connotation.

Norms for the TSCS were developed using a varied sample of 626 people (Fitts, 1965). The group was made up of approximately equal numbers of females and males, Blacks and Caucasians, who ranged in age from 12 to 68 years. All socioeconomic, intellectual and educational levels were represented in the sample. Although Fitts (1965) noted that the sample was overrepresented by Caucasians, college students and 12 to 30 year olds, he considered the norms for different groups generalizable. Recent research suggests, however, that this may not be the case.

For example, Hoffman and Gellen (1984) found significant differences from normative means on the five subscales of the external dimension, the three subscales of the internal dimension, the Self-criticism score and the Total Positive score in their sample of university graduate students when means and standard deviations were computed separately for blacks, whites, females, males and three age levels. Only the data for black subjects were consistent with the normative means. Lack of generalizability of Fitt's (1965) norms across culture and gender has also been reported by Sharpley and Hattie (1983) using an Australian university student sample.

Test-retest reliability for scores on the TSCS, based on data obtained from a sample of 60 college students over a 2-week period, are in the .60 to .92 range (Fitts, 1965). Test-retest reliability coefficients for the scores used in the present study are as follows: Self Criticism .75; Total Positive .92; Physical Self .87; Personal Self .85; Family Self .89; Social Self .90; Total Variability .67; General Maladjustment .87.

Content validity for the TSCS was determined by the method whereby the scale was originally developed (Fitts, 1965). Items initially gathered from other self-concept measures and from self descriptions of patients and non-patients were categorized by themes. These themes were sorted into a 3 by 5 scheme that included an Internal Dimension (Identity, Self-Satisfaction and Behaviour) and an External Dimension (Physical, Moral-Ethical, Personal, Family and Social). Finally, seven clinical psychologists classified the items according to this scheme.

Only those items for which there was perfect agreement were retained in the final version of the scale.

According to Fitts (1965), construct validity for the TSCS has been demonstrated through discrimination between groups of psychiatric patients and non-patients from the normative group. Also test scores were compared for the normative group of non-patients and a group of people at the other extreme of the psychological health continuum, those characterized as "psychologically integrated" who were hypothesized to differ from the norm group in a direction opposite from that of the patient group (Fitts, 1965). The hypothesis was confirmed. The TSCS showed differences on almost all score means and standard deviations, in the predicted directions, for these two sets of group comparisons. Scores that did not discriminate among these groups, such as the Self Criticism Score and the Variability Scores, have been found to discriminate among different diagnostic groups of psychiatric patients (Huffman, 1964, cited in Fitts, 1965).

Some research findings suggest that the internal structure and construct validity of the TSCS are not consistent with the dimensions proposed by Fitts. Using exploratory and confirmatory factor analyses and an ANOVA model adapted from multitrait-multimethod research, Marsh and Richards (1988) found consistent support for the internal structure of only three of the External scales (Family, Physical and Social Self). They found little support for the internal structure of any of the Internal scales. Support for convergent and discriminant

validity was strongest for the Physical, Social and Family scales based on correlations between TSCS responses, Self Description Questionnaire III (Marsh & O'Niell, 1984) responses, and external observer ratings in a sample of participants in an Outward Bound program. In another study, factor analysis of item responses from 743 graduate students produced moderate support for the proposed structure of the TSCS (Gellen & Hoffman, 1984; Hoffman & Gellen, 1983). Using a principal components analysis with Varimax rotation three subscales of the external dimension, Social Self, Personal Self and Physical Self, were confirmed as unitary factors. These results are consistent with those of earlier researchers (e.g., Gable, LaSalle & Cook, 1973; Vacchiano & Strauss, 1968). The Self-Criticism Scale also emerged as a unitary factor.

Despite recent research that questions some aspects of the validity of the TSCS, evidence supports the reliability and validity of some of its subscales and it is used widely in research. Bearing in mind its limitations, the TSCS was utilized in the present study since it offers a multidimensional evaluation of self-concept. Scores were analyzed only on those dimensions that have demonstrated some consistency with the intended internal structure of the instrument: Self-Criticism (SC), Physical, Personal, Family, and Social Self. In addition, the Total Positive score (P) and General Maladjustment score (GM) were analyzed.

Revised Symptom Checklist

Self-report symptom checklists were initially developed to assess the effectiveness of psychotherapy, one criterion of which was the level of psychological discomfort experienced by patients (Parloff, Kelman & Frank, 1954). One such measure, the SCL-90-R (Derogatis, 1977), has several precursors including the Cornell Medical Index (Wilder, 1948), the Hopkins Symptom Checklist-58 (Mattsson, Williams, Rickels, Lipman & Uhlenhuth, 1969) and the Symptom Checklist-90 (Derogatis, Lipman & Covi, 1973). According to Derogatis (1977) the SCL-90-R measures nine dimensions of psychological symptoms and is appropriate for use among a wide range of individuals including non-patients as well as medical and psychiatric patients. Five dimensions (Depression, Anxiety, Somatization, Obsessive-Compulsive, Interpersonal Sensitivity) were developed empirically through factor analytic studies (e.g., Derogatis, Lipman, Covi & Rickels, 1971); four dimensions (Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism) were developed using rational techniques (Derogatis *et al.*, 1973). In a recent review of literature regarding the psychometric properties of the SCL-90 (which differs slightly from the SCL-90-R) Cyr, McKenna-Foley and Peacock (1985) noted that this measure has not consistently demonstrated stable independent dimensions of symptom distress across social class and diagnostic groups. Nevertheless, it does seem to provide a measure of general psychological distress (e.g., Brophy, Norvell & Kiluk, 1988).

The SCL-90-R requires 12 to 15 minutes to complete. Individuals are asked to rate on a 5-point scale ranging from "not at all" (0) to "extremely" (4) the amount of discomfort

experienced by each of the 90 items during the past seven days, including the day on which the inventory is completed. Examples of items include "Headaches", "Difficulty making decisions" and "Feeling critical of others".

Reliability of the SCL-90-R was determined utilizing a sample of 219 "symptomatic volunteers" (Derogatis, Rickels & Rock, 1976). Internal consistency was calculated with coefficient alpha. Coefficients for the nine dimensions ranged from .77 for Psychoticism to .90 for Depression. Reliability for the entire test, using the Spearman-Brown correction for split-half reliability, is .94 (Brophy *et al.*, 1988). Test-retest reliability based on a sample of 94 psychiatric outpatients assessed 1 week after an initial interview produced coefficients that ranged between .78 for Hostility and .90 for Phobic Anxiety (Derogatis, 1977).

The SCL-90-R appears to have good convergent validity but minimal discriminant validity. Using the SCL-90 in an inpatient sample Dinning and Evans (1977) found that the highest correlations between symptom dimensions occurred with analogous scales on other measures including the MMPI, Beck Depression Inventory (BDI; Beck, 1967), and the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch & Lushene, 1970). For example, the depression dimension showed peak correlations with the BDI (r=.70) and the MMPI *D* scale (r=.48). On the other hand, the SCL-90 showed little discriminant validity because the dimensions correlated significantly with most of the other measures' subscales. For example, moderate to high correlations

(.46 to .72) were obtained between all SCL-90 dimensions and the BDI and A-Trait of the STAI; each of the SCL-90 dimensions correlated to a significant degree with each of the MMPI scales, except the *Mf* and *Ma* scales (p. 308). Similarly, in their outpatient sample Brophy *et al.* (1988) reported peak correlations between six of the SCL-90-R factors and their corresponding MMPI scale. Each dimension of the SCL-90-R also significantly correlated with the BDI and with several MMPI scales indicating a lack of evidence for discriminant validity.

As noted earlier, the SCL-90-R has not fared well in studies that have examined its factor structure, a measure of the construct validity of an instrument. During its development Derogatis and Cleary (1977) factor analyzed the dimensional structure of the SCL-90-R using a "Procrustes procedure", a confirmatory variation of factor analysis designed to rotate factors to a target matrix. They reported a good match between theoretical and empirical factors for eight of the nine dimensions; the Psychoticism dimension was not replicated. However, there was also some crossover of items from the Anxiety to the Phobic Anxiety dimension and the Interpersonal Sensitivity did not contain three of the nine hypothesized items.

Criticisms of Derogatis and Cleary's (1977) study include their failure to report the percentage of variance explained by each factor and the correlations between symptom dimensions derived from the factors (Clark & Friedman, 1983). Several researchers have reported rotated factor solutions varying from 5 to 12 factors (e.g., Cyr & Atkinson, 1986; Evenson, Holland,

Mehta & Yasin, 1980) but there is consistent agreement that the first unrotated factor accounts for a disproportionately large amount of variance. For example, using data from unselected psychiatric outpatients, Brophy *et al.* (1988) found 5.29 times as much variance accounted for by the first factor compared to the second factor. Evenson *et al.* (1980) reported 6.50 times and Hoffman and Overall (1978) reported 9.25 times as much variance accounted for by the first factor compared to the second factor. Using psychiatric inpatients, Clark and Friedman (1983) and Holcomb, Adams and Ponder (1983) reported that the first factor accounted for more than eight times as much variance as the second factor. In all of these studies the first factor was labelled Depression. Intercorrelations among the dimensions have also been found to be fairly high in studies of outpatient and inpatient psychiatric subjects. For example, Brophy *et al.* reported correlations between .48 and .70 among six factors. Correlations with the total score also ranged from .74 to .91. Dinning and Evans (1977) and Clark and Friedman (1983) both reported correlations among factors that averaged .67.
The high proportion of variance accounted for by the first unrotated factor plus the intercorrelations among factors have lent support to the conclusion that the SCL-90-R is a single measure of global distress rather than a multidimensional instrument.

Despite the possibility that respondents may distort their responses on any self-report measure, Derogatis (1977) decided not to include validity scales in the SCL-90-R. The results of

several studies suggest that the SCL-90-R may be reactive to respondents' response sets. Dinning and Evans (1977), and Brophy et al. (1988) found significant correlations between all of the SCL-90-R dimensions and the MMPI validity scales. To identify respondents who attempt to "fake bad" or "fake good" (or who have "augmenting" versus "repressive" response styles) Derogatis suggests examining two of the SCL-90-R's global scores, the Positive Symptom Total (PST) and the Positive Symptom Distress Index (PSDI). As a general rule, women in a non-patient population with a PST score of 4 or less are denying their symptomatic distress whereas women with a PST score of more than 60 are dramatizing their distress (Derogatis, 1977; p. 36). The PSDI is also a measure of "intensity": the overall score is "corrected" for the number of symptoms endorsed by respondents.

Despite discrepancies between empirical factors and theoretical dimensions on the SCL-90-R, it has been noted that "certain factors consistently emerge through repeated empirical investigations of the SCL-90R (sic) with various populations" (Brophy *et al.*, 1988, p. 338). In addition to using the SCL-90-R as a measure of general symptomatic distress, it has been suggested that "reliable subscales might be used to confirm the relative contribution of traditional clinical states to the overall distress" of individuals (Mazmanian, Mendonca, Holden & Dufton, 1987, p. 146). This was the approach chosen in the present study. The dimension scores used were those that have most often emerged in factor analytic studies: Depression, Somatization, Obsessive-Compulsive, Phobic Anxiety and Hostility

(Brophy *et al.*, 1988; Clark & Friedman, 1983; Cyr, Doxey & Vigna, 1988; Evenson *et al.*, 1980; Hoffman & Overall, 1978; Holcomb *et al.*, 1983). The three global scores, Global Symptom Index (GSI), PST and PSDI were also used.

Ego Identity Status Interview

The extended version of the Ego Identity Status Interview (ISI) (Rogow, Marcia & Slugoski, 1983), a semi-structured interview developed by Marcia (1966), was used to classify participants' ways of dealing with the psychosocial task of ego identity achievement described by Erikson (1959). Identity statuses are defined by two processes: exploration, the presence or absence of a decision-making period; and commitment, the extent to which an individual has made a personal investment in each of five content areas. The five areas include occupation, religion, political ideology, sex role attitudes, and attitudes concerning premarital sexual activity (Marcia, 1980; Marcia & Friedman, 1970). These content areas form the basis of the Late Adolescent Form of the ISI (see Appendix B). Also, a version of the interview developed for use with adults (Marcia, Waterman, Matteson, Orlofsky & Archer, in preparation) was used in the present study (see Appendix C). The adult interview evaluates family-career role choices instead of attitudes toward premarital sex. The interview was used to classify participants in one of four identity statuses: Achievement, Moratorium, Foreclosure, and Diffuse.

Initial construct validation of the ego identity statuses, as measured by the ISI, was carried out by Marcia (1966) using variables theoretically associated with the achievement of ego identity including concept-attainment under stress, patterns of goal-setting, and authoritarianism. In a sample of male college students, Marcia found that subjects with achieved identities performed better on the concept-attainment task than other identity status subjects. Foreclosed subjects scored higher on endorsement of authoritarian values and set goals unrealistically high compared to other identity status subjects. Following Marcia's work, extensive research (reviewed by Bourne, 1978a, 1978b; Marcia, 1980; Waterman, 1982) has substantiated the reliability of the ISI to discriminate identity statuses and has further elucidated the characteristics of individuals within each of the statuses. For example, compared to Foreclosure and Identity Diffusion males, Identity Achievement and Moratorium males obtain higher autonomy scores (Matteson, 1977), are more internally oriented (Waterman, Buebel & Waterman, 1970 cited in Marcia, 1980), are less likely to change their self-evaluations in response to external feedback (Marcia, 1967), tend to take more personal responsibility for their lives (Neuber & Genthner, 1977) and are more capable of intimate relationships (Orlofsky, Marcia & Lesser, 1973). Moratoriums are the most anxious whereas Foreclosures are the least anxious of the statuses (Marcia, 1967). These findings are consistent with Erikson's theory. Because Identity Achievements and Moratoriums demonstrate greater progression toward internalized control and values than do

Foreclosures and Diffusions, the former two statuses are grouped together as high identity whereas the latter two statuses represent low identity.

Among females, the high/low grouping of the statuses in research findings has been somewhat less consistent. For example, research findings indicated that, compared to low identity females, high identity females obtain higher self-esteem scores (Prager, 1976 cited in Marcia, 1980), have a more internal locus of control (Ginsburg & Orlofsky, 1981; Marcia & Miller, 1980), are more field-independent (Schenkel, 1975), and are more conforming in an Asch-type situation (Toder & Marcia, 1973). On anxiety measures, Moratoriums and Diffusions tend to obtain higher scores than do Foreclosures (Schenkel & Marcia, 1972); however, Identity Achievements also obtain high scores (Marcia & Friedman, 1970). Scores on a measure of authoritarianism among females parallel scores obtained by males. Foreclosures obtain high scores and Moratoriums obtain low scores (Marcia & Friedman, 1970; Matteson, 1974 cited in Marcia, 1980; Schenkel & Marcia, 1972).

Despite some variation in the characteristics of each of the statuses, research has supported the construct validity of ego identity. Interrater reliability of the ISI is fairly good; usually in the range of 80% (Marcia, 1980).

Wallace-DeLozier Attachment Questionnaire

The Attachment Questionnaire (A-Q) (see Appendix D) used in the present study was adapted by Levitz-Jones (1983) from DeLozier (1982) and Wallace (1977). The A-Q, derived from attachment theory literature (DeLozier, 1982), elicits information about individuals' early experiences of separation from parents (actual and threatened) or loss of parents through events such as hospitalization, divorce or death. The duration of each separation and the individual's age at the time the separation or loss occurred are also elicited. Individuals also provide ratings of perceived parental availability and responsiveness during childhood to needs for support, play, comfort and problem-solving. Perceptions are rated on a 5-point rating scale ranging from "Never" (1) to "Very Often" (5).

The A-Q has been used as a structured interview (e.g., DeLozier, 1982; Levitz-Jones, 1983) requiring approximately 1 hour to complete. In the present study the A-Q was administered as a paper and pencil measure. In order to gather information regarding potentially traumatic experiences in childhood or adolescence, participants were asked to include all separations and losses they had experienced until the age of 16 years. When rating parents' availability and responsiveness, participants were asked to respond only on the basis of their childhood experiences (e.g., up to the age of 12 years). The items on parents' availability were adapted by Levitz-Jones from the Home Environment Interview (Robins, 1980 cited in Levitz-Jones, 1983).

Completion of the questionnaire required approximately 15 minutes.

No information is available regarding the reliability and validity of the A-Q. Nevertheless, it was included in the present study as it elicited a wide range of information about childhood separation experiences as well as quantitative information about perceived family experiences. The A-Q was used to supplement the descriptive information obtained through the Past Experiences Interview (described below).

Separation Anxiety Test

The Separation Anxiety Test (SAT) is a semi-projective instrument designed by Hansburg (1972) for use in clinical settings to assess patterns of responses to separation and loss experiences. Derived from psychoanalytic and attachment theory, the SAT is based on the assumption that individuals' responses will reveal defense mechanisms mobilized against separation anxiety, the nature of their object relations and capacity for autonomy (Hansburg, 1972). Although it was initially designed for use with adolescents, researchers have extended the use of the SAT to adult samples (e.g., DeLozier, 1982; Hansburg, 1978; Levitz-Jones & Orlofsky, 1985).

The SAT consists of 12 black and white ink drawings. Care was taken in developing the drawings to avoid facial expressions that might provide cues to emotional reactions. Each drawing includes a caption that describes the situation (e.g., "The girl will live permanently with her grandmother and without her

parents"). Six drawings represent "mild" separation situations which were considered usual childhood experiences (e.g., "The mother has just put this child to bed"; "The child is leaving her mother to go to school"). The remaining six drawings represent "strong" separation situations: less frequent experiences that were associated with severe trauma, permanent loss or change for the child (e.g., "After an argument with the mother, the father is leaving"; "The judge is placing the child in an institution"). Mild and strong pictures are presented in random order, although four of the mild pictures appear near the beginning and three of the strong pictures appear at the end of the test. Accompanying each picture are seventeen statements describing feelings or reactions to the separation. These statements, developed using theoretical and rational techniques, represent psychic mechanisms that might occur in a separation situation including rejection, impaired concentration, well-being, withdrawal, somatization, loneliness, evasive denial, adaptation, phobic anxiety, anxiety, projection, anger, identity stress, intrapunitive reaction, fantasy, sublimation, and empathy.

The SAT is administered by instructing individuals to imagine that they are the child in each picture and to respond as though the situation had occurred or might have occurred during their childhood. They are asked to choose as many of the 17 available responses as they wish to indicate how the child in the picture feels. Subjects also are asked to indicate for each picture whether they recall having experienced the situation depicted (the Mental Set Response). The mental set response and

statement choices are recorded by the researcher on a response sheet.

Responses for mild and strong pictures are summed into groups and calculated as percentages of the total number of responses given. These grouped sums comprise scores on six psychological systems: attachment need (e.g., sum of rejection, loneliness, and empathy), individuation capacity, painful tension, hostility, reality avoidance and self-evaluation (self-love loss, self-esteem preoccupation and identity stress). The pattern of responses on these systems then are used to describe an attachment profile. Hansburg (1972; 1980) defined criteria for secure, anxious, detached and excessive self-sufficiency attachment styles.

Norms for the SAT were developed using a sample of approximately 250 adolescents aged 11 to 14 years (Hansburg, 1980). Adolescents in the study were either living in residential treatment centres or institutions or were still living with their family. He found a reasonable degree of internal consistency for an early version of the SAT using the split-half method. The total consistency coefficient for odd and even cards was .885. Individual item consistency correlations ranged from .50 to .70 (Hansburg, 1972, p. 50). Investigating the reliability of the final version of the SAT in a sample of parents and children in intact families, Black (1981) found an overall consistency coefficient of .86. Internal consistency coefficients for the six response systems ranged from .67 to .73. Adequate test-retest reliability for a 6-month interval was found

as well. The overall test-retest reliability coefficient was .84; coefficients for response systems ranged from .61 to .81.

Hansburg's (1980) adolescent norms provide response ranges (weak, adequate and strong) on the six psychological systems. Norms based on adult data are unavailable at the present time. However, it appears that adolescent norms are applicable to adult test profiles. For example, Hansburg (1978) found no significant differences in pattern responses when the test profiles of elderly subjects were compared with those of 100 young adolescents.

Initial support for the validity of the SAT was obtained by comparing adolescents' SAT profiles with independently written psychiatric assessments (Hansburg, 1972). Several other studies have provided support for the SAT's validity. For example, Hansburg (1972), compared 250 SAT profiles from adolescents separated from their families and living in residential treatment centres and institutions and adolescents living with their families. The latter group showed healthier profiles than did the former group. In a study comparing abusing and non-abusing mothers, DeLozier (1982) found that abusing mothers experienced more threats of separation or abandonment and threats to their physical well-being by parental figures and experienced a higher frequency of some types of parental absence and father absences for a longer period of time than did non-abusing mothers. Abusing mothers in the study exhibited a significantly higher level of current attachment disorder, especially anxious attachment, as assessed by the SAT than did non-abusing mothers.

Using the SAT in a study of college women, Levitz-Jones and Orlofsky (1985) found that high intimacy women demonstrated fewer separation disorders than did low intimacy women. The SAT also has been used to study attachment in relation to identity among college students. Kroger (1985) found that high identity statuses showed fewer anxious attachment patterns than secure attachment or detachment patterns. In his study of 97 elderly individuals (Hansburg, 1978), those living at home and leading active social or work lives obtained SAT profiles higher in individuation and lower in attachment need than did those living in nursing homes or with less active lives. In summary, these studies support the validity and utility of the SAT as a measure of individuals' reactions to situations of separation and loss.

In previous studies, some adjustments were made to Hansburg's (1972) complex criteria to place all subjects in an attachment category (Clarke, 1988). In the present study, the scoring criteria developed by Clarke (1988) were used to classify protocols into one of four attachment categories (see Appendix E). The four categories were secure attachment, anxious attachment, self-sufficiency detached and dependent detached. According to Hansburg (1980), individuals in the self-sufficiency detached category demonstrate high levels of individuation responses that also are much higher than attachment responses. Such individuals appear to be quite confident of their ability to remain at ease with strong separations. Individuals who are dependent detached, however, are seen as highly dependent on others but resistant to closeness.

Past Experiences Interview

This semi-structured interview (See Appendix F) was developed by the author to elicit information about childhood or adolescent traumatic experiences and potential protective factors. A range of topics was explored including past and present relationships with family, friends and romantic partners, and school experiences. Also explored were critical or difficult experiences during childhood and adolescence, coping strategies, perceived social support as an aid to recovery from difficult life events and whether meaning had been found in adversity. History of psychological intervention, both professional and non-professional, suicidal ideation, self-destructive behaviour, and physical health was also assessed.

Some of the questions regarding family relationships were based on a general description of the Berkeley Adult Attachment Interview (Main & Goldwyn, 1984). Information regarding critical life events, coping strategies and keys to resolution were adapted from Avery and Taubert's (1982) Critical Events Interview.

Procedure

Initial contact with most participants was made through classes and tutorials in Psychology and Women's Studies at Simon Fraser University. The study was described in each class as a project designed to examine the development of women's sense of self and to explore the impact of critical events in childhood or adolescence on that development. These critical events were said

to include both "positive" and "negative" or difficult experiences. The researcher also stated an interest in learning about how women had coped with or resolved past difficult experiences. Possible benefits of participating in this study were described to encourage participation. These included the experience of participating in a research study, the opportunity to contribute to research aimed at helping other women with similar experiences, and the opportunity to reflect upon one's past experiences and sense of self.

Following this introduction sign-up sheets (see Appendix G) were handed out to all women in the class. They were asked to indicate their age group (less than 21; 21 or older), regardless of their interest in participating in the study, so that participation rates could be determined. Women who met the age criterion and who were interested in hearing more about the study were asked to provide their names and telephone numbers so that they could be contacted individually. The completed sign-up sheets were returned to the researcher.

Some women were recruited from the general university community using several procedures. First, sign-up sheets were posted at the Women's Centre and Psychology Common Room. Second, sign-up sheets were posted at two women's residences. Third, sign-up sheets were delivered to all apartments housing women at the co-ed residence. Women interested in participating in the study returned their completed sign-up sheets to the Psychology Department. Third, research assistants, acquaintances, and some

women who participated in the study referred women whom they thought might be interested in the study.

All interested women were contacted by telephone. When women had been recruited from outside of classes, the author first ascertained the extent of their knowledge about the study, and then described the research in the same manner as had been done in classes. When contacting women who had been recruited within classes, the description of the study was repeated. All other aspects of the recruiting procedure were similar regardless of the initial source from which women had been recruited. Given that discussing traumatic events might elicit emotional distress during or following the interview, this aspect of the study was described in some detail so that women could make an informed decision about participating in the study. For example, it was stated that having experienced traumatic events was not a criterion for participation in the study; however, if women had experienced traumas the researcher was interested in understanding the impact of those events on their developing sense of self. The ways in which women had resolved, or were in the process of resolving, these past experiences would also be of interest to the researcher. Some events were described that women might have experienced when they were younger and which the researcher felt might be significant in their self-development. Examples included chronic illness; sexual, physical, or emotional abuse; or parental divorce.

The procedure of each research appointment was outlined. Women were advised that consent to audiotape interviews would be

requested. Methods to ensure confidentiality and anonymity of all questionnaires and audiotapes were outlined. All questionnaires and audiotapes were assigned code numbers. Audiotapes were not listened to by any persons other than the researcher and research assistants, for purposes of reliability checks. (Some participants also requested that tapes not be heard by specific research assistants or persons in the Psychology Department; these requests were noted and honoured.) Results would be reported for groups of women; if portions of interviews were quoted, all identifying information would be deleted or altered to prevent identification of the participant. Women also were advised that tapes would be erased and questionnaires would be destroyed following the study's completion.

Two appointment times lasting 2 hours each were scheduled for women who agreed to participate. An attempt was made to schedule appointments no more than 1 week apart; due to scheduling conflicts and cancellations this was not always possible. Appointment intervals ranged from 1 day to 6 weeks. Seventy-six participants completed both appointments within 1 week; an additional 19 completed them within 3 weeks. Only five participants were seen at an interval of 4 to 6 weeks. Most interviews were conducted at Simon Fraser University; when women preferred, interviews were conducted at their homes.

A pilot study was done in order to develop the content and order of presenting questions for the Past Experiences Interview and to assess the time required to complete the questionnaires

and interviews. Ten women, from Introductory Psychology classes as well as graduate students in Psychology, participated in this phase of the research. Based on these interviews, two appointments, each 2 hours long, were used to gather the data. These data were not analyzed.

The following procedure was used for the study. Each participant met with one of four female Research Assistants for the first meeting. The Research Assistants were unaware of the primary researcher's hypotheses. After the process of the meeting was described, the participant read an information sheet describing the study (see Appendix H), signed a consent form (see Appendix I), and received a feedback form provided by the University Ethics Committee (see Appendix J) to ensure that students have an opportunity to anonymously express concerns about research projects. The participant completed a Background Information data sheet. The TSCS (Fitts, 1965) and the SCL-90-R (Derogatis, 1977) were administered while the Research Assistant read a book or sat quietly with the participant.

The Identity Status Interview (Rogow, *et al,* 1983) was administered and audiotaped following completion of the questionnaires. This interview took approximately 60 to 90 minutes to complete, depending on the life experiences and verbal style of the participant. The Research Assistant decided, based on the age and circumstances of each participant (e.g., if she was still living at home), whether to administer the adolescent or adult form of the Identity Status Interview. Seventy-eight

participants were interviewed using the adult version and 22 participants were interviewed using the adolescent version.

The second meeting was conducted by the author. At the beginning of this appointment, the participant was asked whether she had any concerns or questions regarding the first meeting. This served to elicit feedback, bring out questions and establish rapport. The process for the meeting was outlined. The participant was informed that she could decline to answer any questions that made her feel uncomfortable.

In the first 30 minutes, the A-Q (DeLozier, 1982; Levitz-Jones, 1983, Wallace, 1977) and SAT (Hansburg, 1972) were administered. The Past Experiences Interview was administered and audiotaped during the following 60 to 90 minutes. Participants were asked if they had experienced a "difficult or traumatic" event during childhood or adolescence, such as parents' divorce, the death of someone to whom they felt close, a prolonged illness, physical, sexual, or emotional abuse, or immigration or family moves that caused the loss of friendships or other relationships. Participants were advised that the notion of a difficult experience was subjective - similar events are experienced differently by individuals - and they were asked to describe an event that felt difficult for them. In some cases, participants disclosed several difficult events such as divorce, family separations, alcoholism and abuse. When this occurred, participants were asked to describe the event which they felt had the most significant impact on their sense of self. This event was discussed first, followed by questions about the

abuse experience. Initially, some participants did not disclose an experience of sexual abuse. In all interviews, participants were asked specifically if they recalled being sexually molested or abused, or receiving unwanted sexual attention, while they were growing up. If such an incident was disclosed at this point in the interview, it was then discussed.

At the end of the interview, the participant was debriefed by discussing the purpose of the study and answering any questions she had about the research. Her emotional reactions during and after the interview were discussed to deal with any distress caused by the research experience. The possibility was raised by the researcher that feelings and memories might emerge during the next few days as a result of having disclosed information in the interview. The participant was advised that she could contact the researcher if she felt increasing or continuing distress and, if necessary, referral for crisis counselling could be made. (One participant did call to request assistance, stating that she realized she was coping less well than she had described in the interview.) When it was judged appropriate by the researcher (e.g., if a participant disclosed recent suicidal ideation during the clinical interview or expressed interest in pursuing therapy) the University Counselling Service was suggested as a resource for crisis and ongoing counselling. Each participant was paid $5.00 for her contribution to the study.

CHAPTER 5

QUANTITATIVE RESULTS

Characteristics of the Sample

The 100 participants ranged in age from 21 to 56 years. The mean age of the sample was 31 years. The majority of participants were born in Canada (81%). Ten percent were born in India, Southeast Asia, Africa or South America while 9% were born in Europe or Australia. Approximately half (46%) of the participants were single; the other half were married (29%) or not living with their partners due to separation, divorce or widowhood (25%). The women in the study had attended university for an average of 3.6 years, ranging from 1 to 15 years. This extensive range was due to the fact that some women were completing graduate degrees or had multiple degrees.

Because participants were recruited in two ways, from classes (N = 68), or through flyers and personal contacts (N = 32), analyses of group differences on demographic and several trauma variables were conducted to determine whether the two groups differed in any way. There were no significant group differences on chi square analyses of marital status, mother's education, or father's education. Analyses of variance revealed no significant differences between the two groups on age, mother's or father's occupation, or number of non-sexual traumas reported. Women recruited outside of classes had attended university longer (M = 4.38) than had women recruited within

classes (M = 3.29), $F(1, 98) = 4.58$, $p < .03$. Women recruited outside of classes also reported significantly more sexual traumas (M = 1.31) than did women recruited within classes (M = 0.51), ($F(1, 98) = 13.07$, $p < .0005$). This difference may have occurred because individuals who referred subjects did not know the study's purpose, but did know of the author's research and clinical interests in sexual abuse. Although women recruited from outside of classes had experienced more sexual abuse than had women recruited within classes, chi square analysis indicated that the two groups did not differ in terms of the severity of abuse experienced. Due to the general lack of differences between the groups, all subjects were combined in further analyses.

Traumatic Experiences Reported by Participants

Ten women did not recall experiencing any traumatic events while growing up. Forty-nine women reported having unwanted sexual experiences that included physical contact with a person who was at least three years older prior to the age of 16. The types of sexual traumas they reported ranged from fondling of breasts through clothing, to repeated intercourse with a father-figure. In addition, there were five reports of covert incest (Hyde, 1986), such as excessive attention by a father to his daughter's sexuality or sexual shaming by a mother. These incidents were not coded as sexual victimization. Nevertheless, women who reported these experiences were very upset by them

and several were actively questioning whether they had repressed memories of overt sexual abuse.

Sexual incidents were divided into two categories, depending on whether physical contact had occurred above or beneath clothing. The first category was labelled Sexual Abuse, and the second was labelled Molestation. Sexual abuse included experiences of forced or unforced unclothed physical genital contact with a person at least 3 years older than the victim or someone using direct force or threat (Sorrenti-Little, Bagley & Robertson, 1984). This category subsumed Russell's (1986) Serious and Very Serious Sexual Abuse categories. Molestation, equivalent to Russell's Least Serious Sexual Abuse category, included physical contact over clothing. The categories used in the present study were based on the findings, described previously, that unclothed physical contact, including penetration, is associated with more serious negative effects than is physical contact over clothing. Using these categories, 18 women reported Molestation experiences and 31 women reported Sexual Abuse experiences.

In the Molestation group, the age at which molestation began ranged from 2 to 16 years; mean age of onset was 9.5 years. Eight women reported molestations that were single incidents. For 9 women, molestation involved several incidents, while one woman was molested for over a year. Five of 18 women (27.8%) reported molestations by two different perpetrators. Overall, perpetrators included strangers (N = 5), known non-family members such as friends of the family, babysitter's sons,

neighbours and teachers (*N* = 12), members of the extended family (*N* = 4, all uncles), and parent figures (*N* = 2, both fathers).

In the Sexual Abuse group, age of onset ranged from 3 to 15; mean age of onset was 8.2 years. Twelve of 31 women (38.7%) reported multiple sexual victimizations, some of which were molestations. Victimization by two perpetrators were reported as frequently (*N* = 6) as victimization by 3 and 4 perpetrators (*N* = 6). Women in the Sexual Abuse group often described sexual abuse in terms of the extent to which it progressed rather than giving details of all the acts they had experienced. Thus, the types of abuse reported below do not represent their total experiences but, rather, their most serious experiences. The most frequent report was of genital fondling and manual penetration (*N* = 32), followed by being forced to masturbate the perpetrator (*N* = 9), and oral rape (*N* = 5). Two women reported forced sexual intercourse by step-fathers. Six women reported that abuse consisted of a single incident, 22 women experienced abuse that consisted of several incidents, and three women experienced repeated incidents for longer than one year. Perpetrators included strangers (*N* = 6), known non-family members, such as babysitter's sons, neighbours, family friends, hired workers, a priest and a doctor (*N* = 30), extended family members such as uncles, cousins, grandfathers, and older brothers (*N* = 14) and step-fathers (*N* = 3). Two of the known non-family member abusers were female.

Ninety participants reported non-sexual traumas or difficult events. The types of experiences included parental

divorce or separation, parents' death, emotionally ill or alcoholic parent(s), physical violence among family members, severe arguments between parents, separations from the family, physical and emotional abuse, emotional neglect, chronic illness and physical handicaps, or moving away from friends. Many of these incidents were disclosed by participants in the course of discussing early relationships. Other incidents were disclosed when asked to describe traumas or difficult events that had a significant impact on their sense of self. All incidents reported by participants were recorded. However, because participants were not asked to describe all traumatic events experienced in childhood or adolescence, the incidents reported may not be an accurate indication of the total number of traumas experienced.

In the present study, emotional abuse and neglect were based on participants' subjective definitions. Emotional abuse included having been criticized, humiliated or denigrated in terms of one's self-worth, sexuality, or capabilities by a parent. Emotional neglect was coded when participants described a lack of emotional or physical affection or inattention to their emotional needs from parents. Participants were considered to have been physically abused if they reported receiving excessive spankings (e.g., more than 20 occasions) that resulted in soft tissue damage, were hit on the head with a hard object on more than several occasions, being beaten with an object (including a parent's fist) on more than several occasions, were yanked or thrown about, kicked or had a bone broken by a parent. In general, physical abuse was considered to involve a pattern of

behaviour in which a parent inflicted physical punishment to the point of injury. The types of trauma and percentage of participants who reported them are shown in Table 1.

Derivation of Groups for Comparison

At the beginning of the study, it was anticipated that three groups would be compared: sexually traumatized, non-sexually traumatized, and non-traumatized women. However, it became apparent during interviews that women's reports of sexual victimization frequently were embedded in a matrix of other traumatic experiences such as family dysfunction, parental divorce, physical and emotional abuse. Some women reported that the sexual victimization they experienced had less of an impact on their lives than did other traumas they experienced. Assigning multiply traumatized women to a sexual trauma group, in effect, would ignore other negative experiences that had preceded or co-occurred with sexual victimization and would present an artificial picture of women's experiences. Instead, a cluster analysis of cases (Engelman, 1990) was performed in order to group women, on the basis of several variables, more meaningfully for comparison.

Cluster analysis initially considers each individual or case as a separate cluster. Cases are joined using the distance between cases, or clusters of cases, in a stepwise process until all cases are combined into one cluster. Individuals are grouped into clusters such that individuals in the same cluster are more like each other than they are like individuals in other clusters

Table 1

Percentage of Participants Reporting Traumatic Events in Childhood or Adolescence

Type of Event	Non-Sexual Trauma (*N* = 41)	Sexual and Other Trauma (*N* =45)
Parents Divorced	17.1	26.7
Parents Separated	7.3	4.4
Parent Death	0.0	6.6
Parent Attempted Suicide	0.0	2.2
Emotional/Mental Illness (Parent)	14.6	15.5
Parent Alcoholic	34.1	37.7
Family Dysfunction	26.8	31.1
Child Witnessed Parental Violence	19.5	20.0
Death of Other Significant Figure	4.9	6.6
Separation from Family	4.9	20.0
Addition/Loss of Sibling	7.3	4.4
Physical Abuse	14.6	24.4
Emotional Abuse	26.8	31.1
Emotional Neglect	14.6	15.5
Physical Disability	4.9	2.2
School Failure	0.0	2.2
Other (e.g., illness, moving)	31.7	28.9
Mean No. of Events	2.29	2.78
Standard Deviation	1.23	1.36

Note: Percentages are greater than 100 because some participants reported more than one traumatic event.

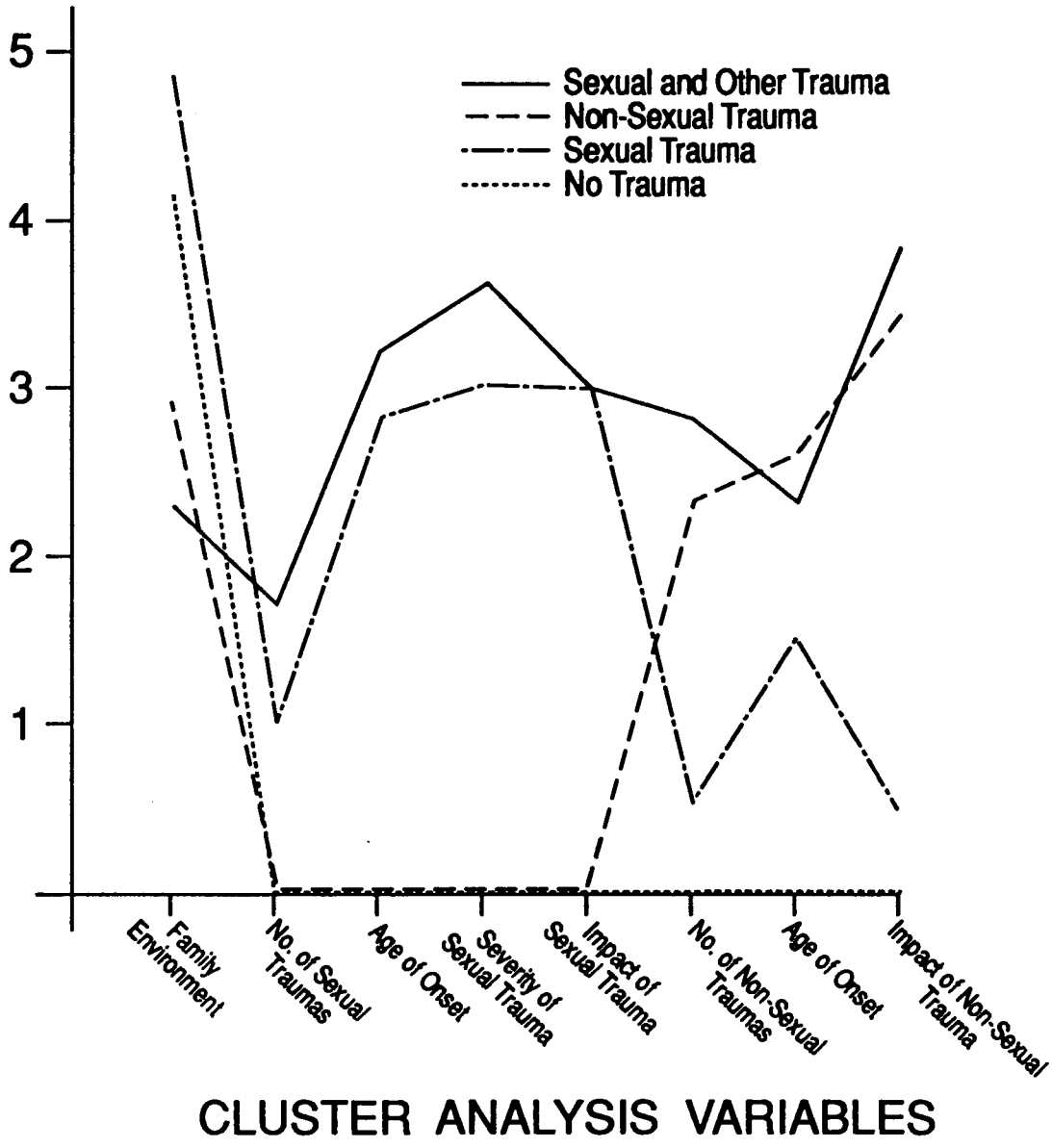
(Hair, Anderson & Tatham, 1987). A number of analyses, using a large set of trauma and family variables, resulted in some clusters that comprised single individuals until the final step in the clustering process. That is, these individuals' profiles of responses were unique. In order to obtain clusters that contained at least several individuals, a reduced set of variables was used. The variables included in the analysis were those that assessed family factors and properties of sexual victimization such as its duration, age of onset, and identity of the perpetrator. In addition, a variable reflecting individuals' subjective experiences of trauma was included based on the researcher's interest in this aspect of trauma. Given the incidence of non-sexual traumas among most participants in the sample, variables were included that paralleled properties of sexual victimization, such as age of onset. Therefore, the variable set comprised a Family Environment variable, four sexual trauma variables (Number of Incidents, Age of Onset, Severity, Impact of Experience) and three non-sexual trauma variables (Number of Incidents, Age of Onset, Impact of Experience). Reports of the age at which traumas occurred ranged from 1 to 16 years. Therefore, Age of Onset was grouped into 5 categories: 1) birth to 2 years, 2) 3 to 6 years, 3) 7 to 9 years, 4) 10 to 12 years, 5) 13 to 16 years. Family Environment and Impact of Experience were rating scales derived post hoc from interview material. Based on participants' descriptions of family relationships, cohesion, and discord, Family Environment was coded from (1) unstable/violent to (5) stable/positive. Impact

of Trauma was derived from descriptions of effects and duration of effects described by participants, and was coded from (1) no impact to (4) severe impact. The 'no impact' category was included as a few women reported events that others might consider traumatic, but which they experienced as non-traumatic, or positive. To assess the reliability of the interview-based ratings, a subset of interviews (20%) was independently rated on Family Environment and Impact of Trauma scales by a Research Assistant. Agreement was obtained on 18 of 20 Family Environment ratings (*kappa* = .93) and 19 of 20 Impact of Trauma ratings. (*kappa* = .91).

This variable set yielded four clusters, of which none contained single individuals (see Figure 1). Women who had not experienced any difficult events comprised the No Trauma group (*N* = 10). Women who experienced traumas other than sexual victimization comprised the Non-Sexual Trauma group (*N* = 41). The Sexual Trauma group included women who experienced sexual victimization, but no other type of trauma (N = 4). The largest cluster included women who reported both sexual and non-sexual traumas, labelled Sexual and Other Trauma (*N* = 45). It was notable that the Sexual and Other Trauma group reported the most negative experiences of all the groups. That is, compared to the other groups, the Sexual and Other Trauma group reported the least stable or positive family environment, more sexual traumas that were of greater severity, and more non-sexual traumas. The types of traumas reported by the two groups are listed in Table 1.

Figure 1

Groups Derived from Cluster Analysis of Cases



Analyses of Group Differences

Differences on demographic variables among the four groups were analyzed using analysis of variance and chi square analysis. The groups did not differ in terms of marital status, age, university level, parents' occupations or education.

Group differences on means scores for five subscales of the Tennessee Self-Concept Scale (TSCS) (self-criticism, physical, personal, family, and social self-concepts) as well as the overall score and general maladjustment score were assessed using analysis of variance. Means and standard deviations for the four groups and TSCS normative mean scores are presented in Table 2. All groups' scored at the 99th percentile on the General Maladjustment scale. To protect against inflated Type I errors, a Bonferroni-corrected significance level of $p < .007$ was used. A significant difference was found among groups on one scale, family self-concept, $F(3, 96) = 4.32$, $p < .007$. A Bonferroni pairwise corrected comparison was conducted to determine the pattern of differences among group means on this scale. A significant difference was found between the No Trauma group ($M = 75.90$) and Non-Sexual Trauma group ($M = 67.10$), and between the No Trauma and Sexual and Other Trauma groups ($M = 66.82$) ($p < .05$). Thus the women who had not experienced traumas had significantly higher family self-concepts than did women who had experienced non-sexual or sexual and other traumas.

The four groups were then compared on subscales and global indices of the SCL-90-R using analysis of variance. Group means and standard deviations are presented with normative means

Table 2

Group Means and Standard Deviations on the Tennessee Self Concept Scale

	No Trauma (N = 10)	Non-Sexual Trauma (N = 41)	Sexual Trauma (N = 4)	Sexual and Other Trauma (N = 45)	TSCS Norm Sample
Self-criticism	32.00	38.34	39.00	36.64	35.54
(s.d)	(4.94)	(5.15)	(6.73)	(5.72)	(6.70)
Physical Self	69.50	65.92	67.25	65.73	71.78
	(5.21)	(8.21)	(11.15)	(10.62)	(7.67)
Personal Self	71.10	65.93	71.25	66.13	64.55
	(6.03)	(8.14)	(8.22)	(9.11)	(7.41)
Family Self	75.90[a,b]	67.10[a]	74.50	66.82[b]	70.83
	(6.31)	(8.59)	(8.39)	(8.32)	(8.43)
Social Self	71.80	71.68	68.75	69.18	68.14
	(7.45)	(5.71)	(7.27)	(7.43)	(7.86)
Total Positive Score	365.10	344.59	355.25	342.24	345.57
	(22.30)	(27.32)	(24.60)	(33.68)	(30.70)
General Maladjustment	65.10	66.59	65.00	66.16	98.80
	(4.33)	(5.12)	(2.45)	(5.33)	(9.15)

a, b $p < .05$.

for non-patient females in Table 3. None of the analyses reached significance.

Identity status ratings were assigned to each participant based on the identity interview. The initial rating for each interview was done by the original interviewer, one of four research assistants trained in identity status ratings. Two of the research assistants independently rated a subset of the interviews (25%). Interrater agreement was obtained on 13 of the 25 interviews. A third independent rating was done by the primary researcher on the 12 disputed interviews. The primary researcher's rating agreed with the initial rating on nine of the 12 interviews. Thus, two-thirds agreement was obtained for 22 of the 25 ratings. Kappa for this set of ratings was .84, suggesting that, overall, interrater reliability was good.

Two chi square analyses were conducted to examine group differences on identity status. Using a Bonferroni correction for two analyses, a level of significance of .025 was adopted which provided a nominal familywise error rate of .05. Chi square analysis indicated significant differences between groups on identity status, X^2 (9, N = 100) = 24.85, $p < .003$. Frequency distribution of identity statuses among groups is shown in Table 4. Several groups accounted for these differences. The Sexual and Other Trauma group significantly differed from the Non-Sexual Trauma group, X^2 (3, N = 86) = 8.50, $p <$ .04, and from the No Trauma group, X^2 (3, N = 55) = 14.06, $p < .003$. The Non-Sexual Trauma group also differed significantly from the No Trauma group, X^2 (3, N =51) = 8.77, $p < .03$. When Identity

Table 3

Group Means and Standard Deviations on the Revised Symptom Checklist-90

	No Trauma (N = 10)	Non-Sexual Trauma (N = 41)	Sexual Trauma (N = 4)	Sexual and Other Trauma (N = 45)	SCL-90 Norm Sample
Somatization	.58	.47	.33	.71	.36
(s.d)	(.47)	(.42)	(.46)	(.65)	(.42)
Obsessive-Compulsive	.60	.80	.50	.95	.39
	(.53)	(.60)	(.29)	(.70)	(.45)
Depression	.47	.89	.58	.98	.36
	(.57)	(.75)	(.36)	(.69)	(.44)
Phobic Anxiety	.14	.14	.07	.17	.13
	(.24)	(.29)	(.15)	(.30)	(.31)
Hostility	.33	.51	.75	.57	.30
	(.55)	(.53)	(.69)	(.58)	(.40)
Global Severity Index	.48	.61	.43	.69	.31
	(.53)	(.44)	(.31)	(.49)	(.31)
Positive Symptom Distress Index	1.35	1.51	1.33	1.56	1.32
	(.40)	(.40)	(.28)	(.38)	(.42)
Positive Symptom Total	26.60	32.90	26.75	37.40	19.29
	(19.99)	(16.98)	(16.62)	(18.47)	(15.48)

Table 4

Frequency Distribution of Identity Statuses Among Groups

	Identity Status			
	Diffusion	Foreclosure	Moratorium	Achievement
No Trauma	2	7	0	1
Non-Sexual Trauma	17	10	11	3
Sexual Trauma	0	2	2	0
Sexual and Other Trauma	10	7	16	12
Total	29	26	29	16

statuses were pooled into High (Achievement-Moratorium) and Low (Foreclosure-Diffusion) categories, a significant difference was found among groups, X^2 (3, N = 100) = 12.33, $p < .006$.

Ratings of secure and insecure attachment styles on the Separation Anxiety Test (SAT) were to be done using Clarke's (1988) category criteria. However, 47 profiles remained unclassified using his criteria. These profiles did not fit the criteria in several ways: an insufficiently elevated Painful Tension percentage, a reversed response pattern on Attachment/Individuation raw scores, or an insufficiently elevated percentage on Painful Tension/ Reality Avoidance/ Hostility. The pattern of Attachment and Individuation percentages required for inclusion in each attachment category of Hansburg's (1972, 1980) and Clarke's scoring systems are similar. Therefore, these patterns were used exclusively to assign the unclassified profiles to attachment categories. Using these limited criteria, all of the unclassified profiles were assigned to an attachment category. The frequency of distribution of groups in the four attachment categories is shown in Table 5. The four groups did not differ significantly on distribution among the SAT categories, X^2 (9, N = 100) = 3.86, $p < .9$. Also, a chi square analysis of attachment categories and identity status did not detect significant differences, X^2 (9, N = 100) = 7.43, $p < .59$. The frequency of distribution of identity statuses among attachment categories is shown in Table 6.

Table 5

Frequency Distribution of Attachment Categories Among Groups

	Attachment Category			
	Dependent Detachment	Self-Sufficient Detachment	Anxious Attachment	Secure Attachment
No Trauma (*N* = 10)	0	3	3	4
Non-Sexual Trauma (*N* = 41)	3	12	13	13
Sexual Trauma (*N* = 4)	0	2	1	1
Sexual and Other Trauma (*N* = 45)	4	9	18	14
Total	7	26	35	32

Table 6

Frequency Distribution of Attachment Categories Among Identity Statuses

	Attachment Category			
	Dependent Detachment	Self-Sufficient Detachment	Anxious Attachment	Secure Attachment
Diffusion (*N* = 29)	3	4	9	13
Foreclosure (*N* = 26)	1	9	10	6
Moratorium (*N* = 29)	2	7	12	8
Achievement (*N* = 16)	1	6	4	5
Total	7	26	35	32

Attachment Questionnaire (A-Q) rating scales and questions regarding threatened or actual separations (see Appendix D) were grouped to create separation and parenting variables for analysis of group differences. The variables were labelled as Number of Separations prior to age 12 (sum of questions 1 through 11 plus 19), Separation Threats prior to age 12 (sum of questions 20, 21, 22), Family Environment (mean of questions 27, 28, 29), Maternal Availability (mean of 30a, 31a, 33a), Paternal Availability (mean of 30b, 31b,33b), Reliance on Mother (mean of 32a, 34a), Reliance on Father (mean of 32b,34b), Maternal Emotional State (mean of 35a through 35h), Paternal Emotional State (mean of 35a through 35h), Maternal Insensitivity (mean of 35i, j, k), and Paternal Insensitivity (mean of 35i, j, k). Data were missing on some variables. The number of cases included in analyses of variance ranged from 92 to 100. Group means and standard deviations on A-Q variables are shown in Table 7. To protect against inflated Type I errors due to the number of analyses performed, a Bonferroni corrected significance level of $p < .004$ was used. Analyses of variance revealed significant differences among groups on Family Environment, $F(3, 95) = 8.10$, $p < .0001$, Maternal Availability, $F(3, 96) = 4.81$, $p < .0037$, Paternal Availability, $F(3, 95) = 15.50$, $p < .0000$, Reliance on Father, $F(3, 95) = 7.70$, $p < .0001$, and Maternal Insensitivity, $F(3, 96) = 5.07$, $p < .0026$. On two variables, Separation Threats and Reliance on Mother, analysis of variance using the Brown-Forsythe correction for unequal variances indicated significant group differences on both Separation Threats, $F(3, 94) = 12.01$, $p < .0005$, and Reliance on Mother, $F(3, 36) = 6.73$, $p < .001$.

Table 7

Group Means and Standard Deviations on Attachment Questionnaire Variables

	No Trauma (N = 10)	Non-Sexual Trauma (N = 41)	Sexual Trauma (N = 4)	Sexual and Other Trauma (N = 45)
Number of Separations (s.d)	7.22 (6.24)	6.33 (5.57)	6.75 (5.06)	10.45 (6.33)
Separation Threats	9.60[a] (0.70)	10.85 (1.67)	9.25 (0.50)	11.69[a] (1.99)
Family Environment	3.64[a] (0.48)	3.24[a] (0.80)	3.80[b] (0.37)	2.66[a,b] (0.77)
Maternal Availability	4.03 (0.73)	3.44 (1.10)	4.67[b] (0.27)	3.09[b] (1.02)
Paternal Availability	4.13[a,b] (0.55)	3.26[a,b] (0.87)	4.08[a] (0.42)	2.39[a] (0.98)
Reliance on Mother	3.70[b] (1.34)	3.15[b] (1.35)	4.88[a] (0.25)	2.71[a] (1.11)
Reliance on Father	2.85[a] (1.16)	2.46[a] (1.05)	3.13[b] (0.25)	1.69[a,b] (0.88)
Maternal Emotional State	2.35 (0.66)	2.87 (0.84)	2.03 (0.28)	2.94 (0.72)
Paternal Emotional State	1.98 (0.39)	2.57 (0.61)	2.06 (0.53)	2.76 (0.80)
Maternal Insensitivity	2.10[b] (0.80)	2.73 (0.91)	1.58[b] (0.32)	3.06[b] (1.05)
Paternal Insensitivity	2.37 (0.85)	2.68 (0.93)	1.58 (0.74)	3.02 (0.98)

a, group means differ at $p < .01$.
b, group means differ at $p < .05$.

Bonferroni corrected pairwise comparisons were then used to determine the nature of between-group differences on A-Q variable means. On Separation Threats, the Sexual and Other Trauma group (M = 11.69) experienced more threats than did the Non-Trauma group (M = 9.60) ($p < .01$). On Family Environment, the Sexual and Other Trauma group mean (M = 2.66) was significantly lower than means of the Non-Trauma group (M = 3.64) and the Non-Sexual Trauma (M = 3.24) group ($p < .01$), or the Sexual Trauma group (M = 3.80) ($p < .05$). On Maternal Availability, the Sexual and Other Trauma group mean (M = 3.09) was significantly lower than the Sexual Trauma group mean (M = 4.67) ($p < .05$). On Paternal Availability, the Sexual and Other Trauma group mean (M = 2.39) was significantly lower than the three other group means ($p < .01$). In addition, the Non-Sexual Trauma group mean (M = 3.26) was significantly lower the Non-Trauma group mean (M = 4.13) ($p < .05$). For Reliance on Mother, the Sexual and Other Trauma group mean (M = 2.71) was significantly lower than the Sexual Trauma group mean (M = 4.88) ($p < .01$). In addition, the Non-Sexual Trauma group mean (M = 3.15) was significantly lower than the Non-Trauma group mean (M = 3.70) ($p < .05$). For Reliance on Father, the Sexual and Other Trauma group mean (M = 1.69) was significantly lower than the Non-Trauma (M = 2.85) and Non-Sexual Trauma group mean (M = 2.46) at $p < .01$, and lower the Sexual Trauma group mean (M = 3.13) at $p < .05$. On Maternal Insensitivity, the Sexual and Other Trauma group mean (M = 3.06) was significantly lower than the means of the Non-Trauma group (M = 2.10) and the Sexual Trauma group (M = 1.58) ($p < .05$).

Overall, Hypothesis 1 was not supported. Women who had been sexually victimized, whether experiencing only sexual trauma or sexual and other traumas, did not demonstrate greater psychological distress, lower self-concept or lower identity than did women who had been non-sexually traumatized or women who had not experienced traumas.

A multivariate analysis was conducted to determine whether potential protective factors such as maternal support, attachment style and properties of the sexual experience were related to outcomes on the TSCS, SCL-90-R and identity status among participants who had experienced sexual abuse or molestation (N = 49). Maternal support was not included in the analysis since 40 of the participants did not disclose the experience to their mothers at the time it occurred. A canonical correlation analysis was conducted with TSCS Total P score, SCL-90-R GSI score and identity status in one set, and Age of Onset, Number of Victimizations, Relationship to Perpetrator, Extent of Victimization (i.e., touching to intercourse), and attachment style in the other set. The analysis revealed no significant relationships in the data.

Therefore, Hypothesis 2 was not supported. Properties of sexual victimization and attachment style were not related to degree of psychological distress, self-concept or identity status among women who had been sexually victimized.

CHAPTER 6

QUALITATIVE RESULTS

A content analysis of information obtained through the Past Experiences Interview was conducted to elucidate recurrent themes from participants' descriptions of the effects of early traumatic experiences and the ways in which they had coped with or come to terms with traumas. A comparison of the experiences reported by the Sexual and Other Trauma group and the Non-Sexual Trauma group are presented, in tabular form, in Appendix K.

Sexual and Other Trauma Group

The 45 participants in this group reported a range of childhood experiences in relation to their mothers. Seventeen women (37.8%) felt close or extremely close to their mothers. An additional two women (4.4%) "adored" their mothers but felt that it was not reciprocated or that they competed with a sibling for their mother's attention. Fourteen participants (31.1%) reported that they were not close to their mothers or did not go to mothers with their problems. These relationships were described as "distant", "not there", or "utilitarian". Four women (8.9%) reported conflicted relationships with mothers. Role reversal, in which the child parented her mother, was reported by four women (8.9%). Another four women (8.9%) described their

mothers as unpredictable, frightening, abusive or invasive. Thus, in this group mother-child relationships were less likely to be characterized as positive or close (37.8%) than as negative or distant (62.2%). During adolescence, approximately half (44.4%) of participants reported conflicted relationships with their mothers. The majority of participants (64.4%) also felt rejected by a parent during childhood.

Emotionally, a substantial proportion of participants felt confused, isolated, withdrawn or "living in a world of one's own" during childhood (35.6%) or adolescence (15.6%). One woman described this state as "being stunned" while growing up. Similar proportions of participants reported intense mood swings or feeling overly sensitive during childhood (28.9%) or adolescence (8.9%). The predominant report was of heightened sensitivity, either to being hurt or to the emotional states of others. This was often described as "having poor boundaries". Among this group's self-descriptions, another notable characterization was that of being aggressive toward others, (usually peers or siblings), defiant, tough or argumentative during childhood (31.1%) or adolescence (28.9%).

More participants in this group than in the other groups had considered or attempted suicide, and had experienced depressions or eating disorders. A substantial proportion (44.4%) had considered committing suicide, some to the point of considering which method to use. Also,

approximately one fifth of the women in this group (17.8%), had attempted suicide or made suicidal gestures, for example by wrist-slashing or taking pills. Two women (4.4%) had been hospitalized because of these attempts. Approximately half of the participants (48.9%) had experienced depressions at some time in their lives. Eight women (17.8%) reported eating disorders; five women (11.1%) reported having been addicted to alcohol.

The majority of women (80.0%) were, or had been, in therapy at some point. Individual therapy was reported by half of the participants who had therapy experiences, while the other half reported both individual and group therapy involvement.

Participants reported a range of negative ways in which they had been affected by sexual victimization. Among the effects reported, four main themes emerged: 1) feelings of shame, guilt and stigma, 2) mistrust of others, 3)sexual difficulties, and 4) feelings of fear, vulnerability or powerlessness. The first theme, reported by 48.9% of victimized women, included statements such as "I felt dirty", "I felt responsible for it", and "I felt I should have known that it could happen". Shame was the most frequently reported feeling within this theme. Mistrust of others was reported by 37.8% of participants. While one of these participants spoke of mistrusting and avoiding the perpetrator after being victimized, among the other participants mistrust extended to men in general (N = 6), or

to people in general (N = 10). For example, one woman stated, "all the rules about who's supposed to take care of you were gone; there was nothing sacred, no rules. It was hard to trust people". Sexual difficulties, reported by one-third of participants, included decreased sexual pleasure, inability to engage in specific sexual acts related to the abuse, and avoidance of sexual relationships. Eleven of the participants (24.4%) had delayed dating until after high school. Three of these participants, who were in their middle to late 20's, found sexuality so frightening or aversive that they had not yet had a sexual relationship. Feelings of fear, vulnerability and powerlessness, reported by 20% of participants, also tended to generalize beyond the victimization itself. Participants reported feeling unsafe in the world, unable to protect themselves, or powerless in all relationships. Other effects reported by participants included confusion about attractiveness and sexuality (11.1%) or about their feelings toward the perpetrator who was a member of the extended family (4.4%), or anger at the abuser (6.7%). According to one of the women reporting anger, "I wasn't angry then, but I am now. I'm angry that I was expected to protect the abuser. You're supposed to say, 'it's ok, don't do it again, but I won't tell anybody'." Two women (4.4%), who had been abused by priests felt that their religious beliefs had been profoundly shaken; one of the women, for whom the church had provided a sense of community, "lost God" when she was abused.

Twenty participants (44.4%) felt that both sexual and non-sexual victimizations continued to affect them to some degree, while two (4.4%) felt a continuing impact by sexual victimization, but not by other past traumas. Seventeen participants (37.8%) felt that past sexual traumas no longer had any impact on their functioning, but that other traumatic experiences did continue to negatively affect them. Six participants (13.3%) felt that neither type of trauma had a continuing impact on their lives. Looked at another way, 22 women (48.9%) were still experiencing effects of sexual victimization, such as mistrust of others or sexual difficulties, while 37 women (82.2%) continued to experience difficulties that they associated with having experienced non-sexual traumas.

Three women (6.7%) who had been sexually victimized did not report being negatively affected by the experience. Two of the women had been sexually abused while one had been molested. One of the sexually abused women felt that the experience had been pleasurable.

Participants reported a variety of experiences and activities that had helped them cope with victimization. At some point in their lives, almost half of participants (42.2%) had denied, minimized or repressed their experiences. A striking finding was that seven of the participants (15.5%) had repressed their experience for a period of time, compared with only one (2.4%) of the non-sexually victimized participants. Seven women (15.5%)

reported 'shutting down' or 'cutting off feelings'. To distract them from their difficulties, six women reported reading (13.3%) or fantasizing (13.3%); three women (6.7%) had become caretakers, listening to others' problems rather than disclosing their own difficulties. Two women (4.4%) had diffused the impact of victimization by joking about it. Another two women described how they coped with the experience by setting goals or having plans for their lives; this pragmatic style was more notable among participants in the Non-Sexual Trauma group (14.6%).

More participants in this group than in the Non-Sexual Trauma group reported activities or experiences that had helped them in coping or resolving the experience of victimization. The most common activity mentioned by the group (33.3%) was reading self-help books. Others (13.3%) used writing as a means of expression, or purging, and understanding their experiences. Whether through books or through some other means, some women (11.1%) reported that knowing others had the same problem was helpful. A related theme of connectedness was discerned among women (11.1%) who reported that a sense of belonging to a community, such as a therapeutic community, was beneficial. For at least one of these women, connectedness was a global concept. She stated, "I believe that when one person benefits, people universally benefit. So, part of my motivation to take bad stuff and make it better is a strong sense of community to people universally, to humanity". Others (11.1%) reported

having a strong sense of justice; they knew that the abuse was wrong and that people should not treat one another badly. All but one of these women had this opinion at the time of the victimization. Similarly, some women (11.1%) had never blamed themselves for being abused; they held the perpetrator responsible for the abuse. Another type of awareness was helpful for some participants: 13.3% of women consciously decided, as early as the age of 12, to be different from their families, or from the abuser. According to one woman,

> I believe I was fortunate because I could either work hard to be unlike my father or I could have followed the same path. Instead of becoming a prostitute or a 'druggy', I've put all my energy into being good.

Some women (14.3%) benefitted from having others validate their experience as abuse or receiving reassurance that they were not at fault. For others (15.6%), feminist theory, which offers an analysis of violence in society and factors that lead to violence against women and children, was a source of validation, reassurance and connectedness with others. Experiences of success, such as academic or athletic achievement, were considered helpful to 26.7% of participants. Spiritual beliefs sustained several women (11.1%), notably those who felt they had no one in their lives for support.

Although participants may not have attributed direct benefit to school experiences, a substantial proportion

(35.6%) reported that they liked school. This finding contrasts with the Non-Sexual Trauma group, wherein 24.4% reported liking school. Women in the present group often described school as "a refuge", "an escape", and "a place I felt I belonged". Five women (11.1%) had become "teacher's pet"; another mentioned teachers as "surrogate parents".

Like the Sexual Trauma group, the majority (75.6%) of participants in this group reported that two or more people who had been supportive and helpful in coming to terms with trauma. Supportive individuals included friends, mentioned by 61.8% of participants, therapists (47.1%), family members (35.3%), partners or husbands (23.5%), and teachers (11.1%). According to one woman, "every time I get close to someone I realize I'm okay and that my experiences aren't very different from what others experience". This woman described how important a close female friend had been:

> B. and I became bosom buddies throughout high school....We were such good friends, I really think she turned things around for me. It's quite amazing to think one friendship can be so important, but when I think of what happened to me during those years...it was really because B. and I were so close. Our self-esteem grew together.

Eight participants (17.8%) had found one person who was supportive. The one supportive individual for these participants included three therapists, two teachers, a mother, intimate partner and a family physician. For three

of these women, who were among the most severe distressed women in the study, the teacher or physician had a powerful impact. According to one woman, "my Grade 9 teacher talked to me like I was a person, not this weird thing. He made me feel that I could speak, that I had things to say. He helped me realize that I was a person." Another woman who had been sexually abused, became anorexic and experienced delusions described the importance of her physician to her recovery in the following manner:

> He said "I know you're not crazy." Although it wasn't my cure, *that* made the difference, at the time, between me dying and not dying....because I figured he cared and he didn't have to. A lot of people reacted to me like I was a very strange person, which I'll admit I was, but they reacted like I wasn't a *human* person, so to have somebody care was a big deal.

Only three participants (6.7%) in this group reported that they did not have a supportive relationship.

The meaning that women made of their experiences were similar in this group and in the Non-Sexual Trauma group. However, the descriptions reported by this group more often gave the impression that they had gained a sense of mastery over their experiences by rendering negative aspects of the victimization experience in a positive light. As one woman said, "I turned lemons into lemonade". For example, more than half (53.3%) of the women reported feeling grateful for the experience of trauma as it had made them more empathic

toward others, they had learned from the experience or had transformed its negative effects into positive attributes. For example, one woman who felt abandoned as a child transformed it, in adulthood, by valuing her independence and inner strength. According to one woman who had been sexually abused, whose family life was chaotic and who had to leave a home at 12 to attend high school in another community,

> I don't think [the experiences] made me stronger, but they have made me, in the end, more alive, more who I am, more 'in the world'. I have a broader understanding of what's going on around me; I'm more creative, better able to do what I want, better as a mother because I have some understanding for my baby of what's important.

Another woman, who had experienced multiple sexual victimizations, physical and emotional abuse, stated,

> there's little I can conceive [of] that could strip away my sense of self because I've already been through so much. Maybe I had to go through it to learn something. Maybe it's all part of a spiritual journey. It's certainly given me a sense I may not have had [otherwise]...any survivor of sexual abuse has an empathy - I feel solidarity with those women.

For more than one third (40%) of participants, finding meaning led to self-acceptance, giving themselves permission to acknowledge their feelings (especially anger) or deciding

to attend to their own needs rather than trying to accommodate to the rules or ideas of others. These women made statements such as, "I know what's best for me", "I have to be myself", or "I have to do what makes me happy". Thirteen of the participants (28.9%) felt that the experience had made them strong or independent, or had helped them to become aware of their inherent strength. Another eight women (17.8%) felt that having understood the experience, either their role in it, or the motivations of others, gave them a sense of resolution.

For six of the participants (13.3%), their traumatic experiences or the process of recovery, became the inspiration for career choices, such as working with sexually abused children. For example, one woman who had been sexually abused by a priest stated,

> I needed to know that there was something greater than me, to make life meaningful, worth living again. I struggled with it, and found God again. I realized I needed to help people find [spirituality] for themselves, so out of that experience I got my life work. There's nothing more profound than that! So, in a way, thank goodness he abused me.

Only two women in this group (4.4%), and three in the Non-Sexual Trauma group (7.3%), engaged in downward social comparison in coming to terms with their experiences. Interestingly, one woman (2.2%) in the present group felt

that negatively comparing her experience to that of other women impeded her ability to resolve it.

The majority of women (73.3%) in the group were still in the process of resolving or coming to terms with their experience. Some of these women considered resolution to be a life-long process of self-awareness and self-improvement. Two women (4.4%) had not made sense of the sexual victimization. Another woman stated that "it doesn't have any meaning - it was senseless stuff - but it's given me a perspective. I understand what others go through and I know what's abusive and what isn't."

During the interview, some women elaborated on sources or experiences that had enabled them to come to terms with victimization in positive ways. Ten women (22.2%) credited their parents who had believed in them, loved them, fostered their independence, or modelled strength in overcoming adversity. Six (13.3%) women had felt unconditional love by another person such as a grandparent. As one of these women said, "at every major life change there has been somebody who believed in me, even when I didn't believe in myself". Eight women (17.8%) felt that they were inherently strong, capable, or independent. This sense was best exemplified by a woman who stated,

> I'm a fighter, that's how I approach the world. My idea is you can keep knocking me down, I'll keep getting up, and you'll get tired of knocking me

> down....My only fear is that there's a limited quantity of [will] and that I'll run out of it.

Five women (11.1%) felt that their intellectual capacity had enabled them to come to resolution. One woman stated,

> [in addition to] raw courage, I owe a debt to my crazy father - he encouraged my intellect. That's been a bridge that's permitted me to draw in the [other aspects of my self] that I had lost. It enabled me to manage conceptually so [that] I had the security to deal with things emotionally.

Four women (8.9%) used their adversity as a strong motivation for self-development. One of these women stated, "I know the people I'll really thank in my life are people like my mother, who I hated, but if I didn't have to resist that stuff I don't think I'd be the person I am". Finally, as another woman said, "success is the best revenge".

Non-Sexual Trauma Group

The early relationships and emotional self-descriptions reported by the 41 participants in this group were generally similar or less negative than those of participants in the Sexual and Other Trauma group. For example, in both groups approximately one third of participants (39% in this group compared to 37.8% in the Sexual and Other Trauma group) reported having a close or extremely close relationship with their mothers. The proportion of women who experienced their mothers as emotionally unavailable (36.6% compared to

31.1%), conflicted (9.8% compared to 8.9%), frightening or unpredictable (9.8% compared to 8.9%) or whose "adoration" of their mothers was not reciprocated (7.3% compared to 4.4%) also was fairly comparable between groups. Overall, similar proportions of women in this group (61%) compared to the Sexual and Other Trauma group (62.2%) described negative or distant mother-child relationships. A smaller proportion of women in the present group (29.3% compared to 44.4%) reported conflict with their mothers during adolescence or felt rejected by a parent while growing up (56% compared to 64.4%).

Compared to participants in the Sexual and Other Trauma group, a larger proportion of participants in this group described themselves as isolated, confused or guarded in childhood (43.9% compared to 35.6%) or adolescence (24.4% in this group compared to 15.6%). Reports of intense emotions in this group during childhood (24.4%) or adolescence (14.6%) were predominantly of mood swings; few women reported feeling overly sensitive. Another notable finding was that fewer non-sexually traumatized women (17.1% compared to 31.1%) characterized themselves as "tough", defiant or aggressive during childhood. Interestingly, like the Sexual and Other Trauma group participants (28.9%), almost one third of women (29.3%) in the present group adopted a defiant stance in adolescence.

More than one third of the participants (36.6%) reported suicidal ideation; one tenth (9.8%) had attempted

suicide or made suicidal gestures. One woman (2.4%) was hospitalized as a result. Less than one fifth (17.1%) had experienced depression. Five women (12.2%) had been addicted to alcohol while four women (9.8%) had been bulimic.

Over half of the participants (58.5%) in this group reported being in therapy compared to 80% of women who experienced sexual and other types of trauma. Twelve of the 24 women had been in individual therapy only (50%), three had participated in group therapy only (12.5%), and nine had participated in both individual and group therapy (37.5%).

As in the Sexual and Other Trauma group, participants in the present group utilized a variety of strategies to cope with their difficulties. However, less than half as many women (19.5% compared to 42.2%) in this group had used denial, minimization or repression as a way of coping with their feelings. Also, fewer women (9.8% compared to 15.5%) reported 'shutting off feelings'. Eight (19.5%) used reading and four (9.8%) used fantasy or daydreaming as an escape.

Three women (7.3%) reported that non-sexual traumas, including parental divorce or having an alcoholic parent, did not have a significant negative impact on their lives. Of the remaining 38 women who reported negative consequences following non-sexual traumas, the majority (73%) continued to feel that past traumas had an impact on their

functioning. This is a smaller proportion than reported in the Sexual and Other Trauma group (82.2%).

As noted in the previous section, fewer participants in this group than in the Sexual and Other Trauma group described activities or experiences that were helpful in coming to terms with their difficulties. For example, one third as many women in this group as in the Sexual and Other Trauma group reported that reading self-help books (12.2% compared to 33.3%), writing (4.9% compared to 13.3%), or achieving success in other aspects of their lives (4.9% compared to 26.7%) had been helpful. Knowing that others had similar problems or having a sense of belonging to a community were helpful for four participants (9.8% compared to 22.2%). Three women (7.3% compared to 11.1%) reported that religious or spiritual faith had sustained them. Another three women reported that feminism (7.3% compared to 15.6%) was useful in understanding and coming to terms with victimization. Approximately one third as many women in this group (4.9%) as in the Sexual and Other Trauma group (13.3%) had rejected or decided to disengage from their families. For example, one of the women in the present group, who lived with her father following her parents' divorce, had refused to have contact with her physically abusive mother at the age of 13. At the time of the interview, she was still refusing to see or talk to her mother, and was still terrified of her. One woman (2.4% compared with 14.3%) found that validation of her experience

enabled her to come to terms with being abused. None of the participants in this group reported benefitting from reassurance that they were not to blame, a self-perception of blamelessness, or a sense of justice.

Twenty-seven women in this group (65.9%) reported having two or more supportive relationships that were instrumental in coming to terms with adversity in contrast to 75.6% of women in the Sexual and Other Trauma group who reported several supportive relationships. Family members (37.8%) and teachers (11.8%) were mentioned by similar proportions of women in this group and in the Sexual and Other Trauma group (35.5% and 11.1% respectively). Supportive friends (74.1% compared to 61.8%) and partners or husbands (33.3% compared to 23.5%) were mentioned by more women in the present group; therapists (37% compared to 47.1%) were mentioned less frequently. According to one woman who was physically and emotionally abused by an alcoholic parent,

> It's really helped to have kept myself interacting with others and the rest of the world, having new experiences in the world that add a new view to the picture of who I am....Associations with others counter the view I got in my family.

Of the seven participants who reported only one supportive relationship (17.1% compared to 17.8%), all but one was a family member. Also, seven participants in the present group (17%) reported that they had not received support or

assistance from anyone. This proportion was larger than in the Sexual and Other Trauma group (6.7%).

As noted earlier, the ways that women in this group made sense or found meaning in adversity were similar to those of women in the Sexual and Other Trauma group. However, the extent to which negative experiences were seen as having some benefit occurred less frequently in the present group. For example, eight women (19.5%) felt grateful for having experienced adversity, that they had learned something from it, or that it gave them more empathy for others, compared to 24 women (53.3%) in the Sexual and Other Trauma group. Six women (14.6%) in the present group, compared with eight (17.8%) in the Sexual and Other Trauma group, said that they had gained some understanding of the events. However, for two women in the present group who reported understanding their experiences, this was of little comfort. According to one woman, "I've thought about it, intellectualized it, and I understand it, but I don't feel any better about it". For the other woman, whose early experiences included living in a home with a critical mother and an alcoholic, volatile father, where verbal arguments were the norm among family members, and occasionally erupted into physical violence, making sense of her experiences was extremely difficult:

> I should just say the facts or something, because I don't know if, when I say things, I interpret things or if they're really true. [My family] would say I was

> overly dramatic and overly sensitive, which might be the case, but I don't know if that makes it true...or am I not feeling what's really true?...So, I can think of things, but it doesn't change things.

Nine of the participants in this group (22% compared to 40%) had become self-accepting as a result of finding meaning and had realized that their own needs and values were more important than accommodating to others' values. None of the participants in this group described acknowledgement of feelings as an aspect of resolving past experiences. Although none of the women reported feeling that adversity had made them stronger, eight women (19.5%) realized that their strength or independence had enabled them to cope with and overcome adversity. None of the participants in the present group reported that traumatic experiences had inspired their career choices.

As in the Sexual and Other Trauma group, the majority of non-sexually traumatized women (56.1%) were still engaged in the process of coming to terms with past experiences. Three women (7.3%) had not made sense or found meaning in their experiences. According to one of these women, who had been emotionally neglected and reported feeling depressed for years, "I just think it's a shitty way to grow up. I don't believe in that 'deprivation makes you a better person' crap". She conveyed a sense of resignation when describing how she had coped with her strong sense of being alone in the world:

> My upbringing was that you always just do it, but there's no pattern of excellence in our family. I feel I'm not able to make choices, I don't have any way of getting out of getting by. I take the path of least resistance. The only thing you can do, if you're not coping, is to kill yourself and even that decision takes more guts than I have.

Another woman, who had grown up in the midst of "constant fighting" with an authoritarian father who administered humiliating punishment, also conveyed a sense of resignation by saying, "it happened, so what can you do? It's over, it won't happen again - that's a good thought - you just live your life and don't think about it". Finally, one of the women had given up trying to understand the physical abuse she had experienced as a child:

> I had to come to the point of accepting that there may be no answer, or I would be totally ungrounded. I just have to let it go. I can't search my whole life for the reasons...it's a way of letting myself 'off the hook', to get on with my life.

Similar proportions of participants in this group and in the Sexual and Other Trauma group (22%) cited parental love or encouragement as a source of their strength. A somewhat smaller proportion of women in this group (9.8%) had felt loved by another individual, compared to reports by 13.3% of participants in the Sexual and Other Trauma group. Eight participants in the present group (19.5% compared to

17.8%) credited inherent strength or independence as a key to their ability to cope with and overcome adversity. For example, a woman who had experienced emotional abuse by her parents, and who found "a mentor" in her best friend's mother, said

> I inherited determination from both parents, so I have a core in me that's determined, stubborn, a fighter. That, linked with a mentor figure and getting that support to just carry on [made the difference]. If that mentor figure was not around would I be different? It's hard to know. Maybe I would have sought out another one.

Another woman also considered strength and support to be essential ingredients in overcoming adversity. She stated, "you can handle anything. The thing itself has no positive or negative value; it's all in the support you get from society and how you handle it. The thing itself doesn't have to ruin your life". Although one woman in this group considered her intellectual capacity to be a source of strength, she was tentative in her assessment:

> I have an extremely intelligent mind which means that I can't help but be aware of problems and find solutions, but maybe that's not true....I have confidence because my parents instilled a belief that I could do anything I wanted...I don't necessarily believe it all the time.

Although not representative of the group, statements like those of the woman above that were tentative, or that gave

the impression of 'just doing it' as a way of coping with trauma, were noted more often in the present group than in the Sexual and Other Trauma group. For example, one woman commented on a pattern of survival that she and her siblings had adopted. She stated, "what we've all done is to focus our main efforts on work...we all tend to overwork or be workaholics. Maybe we've focussed on 'doing' rather than 'being'". As she described the process of coming to terms with her past, she also noted that,

> I came away from my family being able to take care of myself, on a practical level, as long as I kept the lid on everything. In the past five years, since more and more of the conflict...has been coming into the open, my attention is focussed on feelings [rather than on] practicality.

This woman's latter comments were similar to statements made by some participants in the Sexual and Other Trauma group about the importance of acknowledging feelings and striving toward an integrated sense of self. Another woman in the present group, who had been anorexic, and whose alcoholic stepfather had been emotionally abusive toward her, and physically abusive toward her mother on occasion, also conveyed a sense of fragmentation when she stated, "I've been saying 'time will heal all wounds'. In a sense, I've intellectualized it so much I've made it safe, boxed it in, like I did with my body, instead of saying 'it's me' and living it."

Sexual Trauma Group

In this small group, all four of the participants felt close to their mothers during childhood. None of the participants in the group felt isolated or withdrawn, nor were they overly sensitive or excessively moody while growing up. One participant described herself as "headstrong" during childhood; another reported "rages" and conflict with her mother in adolescence. None of the participants felt rejected by their parents. All of the participants did well at school and three of the four enjoyed school.

Of the participants in this group, one had been in therapy. Two reported suicidal ideation. During adolescence, one of these women attempted suicide while another self-mutilated by slashing. One woman had periods of depression and abused drugs during adolescence.

The sexual victimizations experienced by this group included molestation, genital fondling, and forced masturbation of the perpetrator. All of the participants felt that the experience had a negative impact on them, including guilt, aversion to physical contact with others and vigilance regarding 'body signals', low self-image, poor body image, sexual problems and periods of depression. At the time of the interview, three women felt that the abuse continued to affect their behaviour or sense of self.

Two participants coped with the experience by reading and writing. One woman had received help through a sexual assault crisis centre. Similar to the reports of women in the Sexual and Other Trauma group, some women in the Sexual Trauma group reported that self-analysis (N = 1), having a moral sense that the abuse was wrong (N = 1), and receiving reassurance or validation (N =2) were helpful. Supportive relationships played a major role in coming to terms with victimization for three of the participants. The individuals with whom participants discussed the events provided reassurance or were non-judgmental and included close friends, parents and a boyfriend. Although not of direct assistance, the fourth participant credited her father, "who likes challenges to overcome", for her feeling that she could adapt to events, positive or negative, without it changing her inner sense of self. Through the experience of being sexually abused, this young woman had learned that

> you have to believe in yourself; what somebody else did may contribute to your lack of confidence but it's not going to change your fundamental self - *that* you can always make as strong as you want. No matter what happens outside, it's how you handle it inside that's important."

Two participants had tried to make sense of their own role in the victimization. For example, one woman needed to understand why she had not disclosed the abuse; eventually

she had been able to forgive herself for having remained silent. Although she had resolved the experience to the extent that it did not interfere with her daily life or ability to have intimate relationships, she stated that "it's often there - something hasn't been completed". At some point in the future, this woman planned to enter therapy, to talk about the abuse. Another woman who had been molested over a period of months at the age of 10 stated

> I needed to resolve how I let it happen to me; by talking with people, I knew society thought it was wrong, but how was I involved? I saw that I was not the adult in control. I had less control than I thought I had; that may have been a detriment of feeling so adult at that age.

Self-forgiveness, through her religious beliefs, was also instrumental in this woman's resolution of the experience. Two women spoke of having learned to trust themselves or their feelings. Another woman felt that the experience of sexual victimization had made her stronger. Finally, as another woman said, "I survived because I'm willful; I've always been determined. I was a good child but at 15 I thought, 'I wonder if people really mean what they say?' I don't take things at face value. It's bad, but it's an important survival skill". This woman, like some of the women in the Sexual and Other Trauma group, converted a potentially negative attribute - mistrust of others - into a

positive attribute. Of the women in the group, two were actively working toward resolution and were considering confronting their abusers.

No Trauma Group

The ten participants in this group generally reported positive family experiences. None of them felt rejected by their parents during childhood. Unlike the other groups, few of them had conflict with their mothers during adolescence and only one participant reported rebelling against her parents. As one participant stated, "my parents gave me a sense of importance, of belonging. Because I was valued I feel important; now I don't need others to tell me, because I was brought up to know that I was important". None of the participants described themselves as defiant or aggressive, either as children or adolescents. Two participants considered themselves to have had moods swings or intense moods when they were children. Only one participant felt isolated during adolescence; the others were sociable and happy. As a group, they did well at school and enjoyed it. Not surprisingly, this group of participants reported less suicidal ideation (N = 2), fewer suicide gestures (N = 1), and less involvement in psychotherapy (N = 1) than did participants in the other groups.

Sexual and Other Trauma Group: Potential Protective Factors

The majority of women (62.2%) in the study who had experienced sexual and other traumas were found to have high identity. High identity, as noted earlier, is associated with good adaptive capabilities whereas low identity is associated with poor coping. Given this relationship, an additional qualitative analysis was conducted, comparing high identity women in the Sexual and Other Trauma group to low identity women in the group, to elucidate potential protective factors that might have contributed to better adjustment. The experiences reported by the two groups are presented, in tabular form, in Appendix L.

Women who were high in identity experienced an average of 1.5 sexually victimizing experiences compared to 1.8 experiences among women who were low in identity. Fewer of the high identity women (60.7%) experienced sexual abuse than did low identity women (70.6%). Moreover, among high identity women, sexual abuse began at a later age (9 years on average) than among low identity women, (7 years on average). The mean age of onset among high identity women who had been molested (39.3%) was also later (11 years) than among low identity women (29.4%, 8.4 years).

A larger proportion of high identity women than low identity women reported physical abuse (25% compared to 11.8%), separations from their families (17.9% compared to 11.8%), family dysfunction (21.4% compared to 11.8%) and

parental death (3.6% compared to 0%). On the other hand, fewer high identity women reported emotional abuse (17.9% compared to 35.3%), emotional neglect (7.1% compared to 11.8%), parental divorce or separation ((10.7% compared to 35.3%), parental mental or emotional illness (7.1% compared to 17.7%), parental alcoholism (14.3% compared to 52.9%), witnessing physical violence among family members (10.7% compared to 17.7%), death of a significant figure other than a parent (3.6% compared to 11.8%), and addition or loss of a sibling (0% compared to 11.8%).

Although similar proportions of high and low identity women (42.9% and 47.1% respectively) reported feelings of shame and guilt, and sexual difficulties (17.9% and 17.6% respectively) following sexual victimization, a smaller proportion of high identity women than low identity women felt unsafe or vulnerable (21.4% compared to 41.2%), or mistrusted others (17.9% compared to 29.4%). A smaller proportion of high identity women reported continuing sexual difficulties (28.6% compared to 47.1% of low identity women) that they attributed to the sexual victimization experience. Eight high identity women (28.6%) felt that sexual victimization was relatively less significant than other traumas they had experienced; none of the low identity women reported this. In fact, four low identity women (23.5%) felt unsure about the long-term effect or extent of sexual victimization that they had experienced. Repression was

more prominent among low identity women (23.5%) than among high identity women (10.7%).

High and low identity women differed in several ways regarding what they considered helpful in coping or coming to terms with early trauma. A larger proportion of high identity women than low identity women reported as helpful reading self-help books (39.3% compared to 23.5%), experiences of success or positive feedback (35.7% compared to 11.8%), therapy group participation (28.6% compared to 17.6%), feminist theory (25% compared to 0%), faith (28.6% compared to 0%), validation of their experience (14.3% compared to 0%), and rejecting, or disengaging from, their families (21.4% compared to 11.8%). In contrast, fewer high identity women reported as helpful knowing that victimization was wrong, or that they were blameless (17.9%) than did low identity women (29.4%).

Of those who reported supportive relationships that had been helpful in overcoming early trauma, 82% of high identity women had several supportive relationships while 18% had found one helpful person. Among low identity women, 17.6% had dealt with issues on their own. More than half (64.7%) had several supportive relationships; 17.6% reported having one supportive person.

Of the meanings that women found in early trauma, a larger proportion of high identity women than low identity women felt that they had become stronger (35.7% compared to 17.6%), had transformed negative feelings or effects into

positive attributes (39.3% compared to 5.9%), or felt grateful for what they had learned through adversity (28.6% compared to 11.8%). Similar proportions of high and low identity women felt greater empathy or connectedness to others (35.7% and 35.3% respectively), or found careers (14.3% and 11.8% respectively) as a result of their experience.

When asked to describe their role in the family, 50% of the high identity women reported being 'the responsible one' compared to 35.3% of low identity women. These women cared for younger siblings or felt that a parent relied upon them. Six high identity women (21.4%) felt that they had been scapegoats whereas none of the low identity women perceived themselves this way. Of interest were the comments by two low identity women (11.8%) that they had been "non-existent" in their families.

Fewer of the high identity women had close relationships with their mothers during childhood (32.1% compared to 47.1% of low identity women). Half of the high identity women experienced conflict with their mothers during adolescence compared to 35.3% of low identity women. Although a somewhat larger proportion of high identity women reported having close relationships with their fathers (28.6% compared to 23.5%) they also reported more often having frightening or abusive fathers (14.3% compared to 5.9%).

Approximately one third of high identity women reported being tough, aggressive or defiant in childhood (35.7%) or adolescence (32.1%). This description was given by approximately one fourth of low identity women (23.5% in both childhood and adolescence). Feelings of isolation or confusion were reported by fewer high identity women in childhood (32.1% compared to 41.2% of low identity women). However, more high identity women than low identity women (21.4% compared to 5.9%) reported feeling this way during adolescence.

At some point in their lives, a larger proportion of high identity women experienced depression (53.6%) and eating disorders (21.4%) than did low identity women (41.2% and 11.8% respectively). Similarly, more of the high identity women had been in therapy (82.1%) than had low identity women (76.5%).

A larger proportion of high identity women reported doing well at school (85.7% compared to 29.4% of low identity women) or enjoying school (50% compared to 11.8%). Of interest was the fact that almost half of the low identity women (41.2%) compared to approximately one fifth of the high identity women (21.4%) reported disliking or hating school.

Currently, the majority of high identity women (64.3%) were not involved in an intimate relationship, although most had been in such relationships. Approximately one fourth (21.4%) reported being in supportive, positive relationships

whereas 7.1% reported being in troubled relationships. This contrasted with the low identity women, of whom 47.1% had partners, boyfriends or husbands. A similar proportion (41.2%) were involved in a supportive intimate relationship while 7.1% of the women described their relationships as troubled. A small proportion of high and low identity women reported that they actively avoided intimate relationships (7.1% and 11.8% respectively).

When asked about potential sources of their resilience or ability to overcome sexual traumas, women typically described positive relationships or inherent capabilities. Among the relationships described by women in this group, especially during childhood, a larger proportion of high identity women (71.4%) than low identity women (52.9%) felt loved or valued by parents, relatives or teachers. Four women with high identity (14.3%) also reported that friends or therapists had been a source of strength in adulthood. According to one of the women with high identity,

> I always considered myself stronger than others around me. I usually turned things into a challenge that I had to overcome....I always felt I had a right to be here, but also that I was special, if to nobody else, then to me. I must have got enough confirmation of that to be able to stand all the rest. My mother - no matter what she did wrong in the rest of life - she loved us.

Finding strength later in life was suggested by another woman with high identity who commented,

> I date [finding strength] back to when I was 18. I was doing well at school and had friends. I was happy with my life; and I had a sense of ecstasy, of "I can do it!". And that's always been with me since then; no matter how bad it gets I believe I have options, I believe in my capabilities. At some level I know I can survive, I am a survivor - that's been my underlying philosophy.

In summary, the experiences of trauma and recovery among high and low identity women differed in several notable ways. Although the majority of both high and low identity women had been sexually abused, low identity women more often experienced this type of victimization. Whether molested or sexually abused, low identity women were first victimized at a younger age. Perhaps not surprising, given these experiences, was the fact that low identity women felt more vulnerable or unsafe and more mistrusting of others following sexual victimization. They also experienced more emotional abuse, parental separation or divorce, and living with an alcoholic parent. By contrast, high identity women were more often physically abused, lived in a chaotic or dysfunctional home, had more conflicted relationships with their mothers and felt that rejecting or disengaging from their families was an important step in overcoming early trauma. During childhood or adolescence, they had more

nurturing, stable adults in their lives from whom they developed a sense of self-worth or competence; in working through past traumas, more high identity women benefitted from the support of several individuals. They were more aggressive or defiant but also more often experienced a sense of accomplishment through academic or social success at school. Finally, high identity women more often felt that some benefit had accrued from past trauma; they had transformed the potentially devastating consequences of victimization into self-perceptions of strength, independence, and self-understanding.

CHAPTER 7

DISCUSSION

Unlike previous studies that have found higher rates of symptomatology among female college students who experienced childhood sexual abuse than among non-abused students (Alexander & Lupfer, 1987; Briere & Runtz, 1988a; Fromuth, 1986; Sedney & Brooks, 1984), the present study found very few differences on measures of adjustment between women who experienced sexual victimization, non-sexual victimization, or no victimization in childhood or adolescence. The difference among groups in the present study on the Family Self scale of the Tennessee Self-Concept Scale was comparable to Alexander and Lupfer's finding that women who had not been sexually abused had significantly higher physical and family self-concepts than did women who had been sexually abused.

The lack of symptomatic distress or poorer self-concept among sexually victimized women relative to other women in the present sample may have occurred for several reasons. First, compared to other studies of college students, the sample size in this study was small. In particular, few women in the present study reported having had non-traumatic lives, at least during childhood and adolescence. Combined with the number of groups examined, the small sample size may have impeded the sensitivity of the adjustment measures

to group differences. Second, there is some evidence (Briere & Runtz, 1988b) that certain symptoms such as anxiety and depression may occur at low, but chronic, frequency. The assessment of symptoms within a brief period of time (7 days) may have been insufficient to detect abuse-related symptoms. Third, the older age of women in the present study may have had an effect on reported distress. While other studies of college women generally report a mean or median age of 19 years (Briere & Runtz, 1988b; Fromuth, 1986; Sedney & Brooks, 1984) the mean and median age of the present sample was 31 years. In the author's clinical experience, women tend to go through a period of re-evaluating their lives in their late 20's, often making life changes (such as ending relationships, changing careers, or having children) or entering therapy to confront unresolved issues. If this was the case among women in the present study one might expect that, in general, they would be less distressed than would be younger women. A fourth possibility is that the study may have drawn from a population of women who were relatively well-adjusted. In contrast to previous studies of sexually victimized women that have recruited students using a general statement about early childhood experiences, the recruitment procedure in the present study explicitly introduced the idea of having coped with, or come to terms with, past traumas. Some women may have used an internal sense of distress as an indicator of whether they had coped with traumatic experiences, and

therefore, 'qualified' for the present study. That is, women who were relatively asymptomatic may have perceived themselves as having coped with past traumas. Conversely, women who experienced continuing feelings of distress may not have perceived themselves as having coped with past traumas, and may have excluded themselves from the study. There was some indication that this type of self-selection occurred. For example, several women who expressed interest in the study later declined to participate, alluding to the fact that they were feeling overwhelmed by personal difficulties. As Browne and Finkelhor (1986) noted in their review of literature on the long-term effects of sexual abuse, all but one study (Tsai, *et al.*, 1979) that looked for negative effects among sexually abused women found them. For the most part, the present study, like Tsai, *et al*'s study, was not looking for negative effects, and did not find them. While the issues of sample size and measures limit making a definitive conclusion that participants were asymptomatic, given their scores on adjustment measures used in the study they were not symptomatic.

The absence of differences on the Tennessee Self Concept Scale, other than on the family self-concept scale, suggests that the measure may not be sensitive to the ways in which self-esteem or self-concept clinically might be affected by sexual abuse. The General Maladjustment Scale in particular appeared to be an invalid measure, given that all group means on this scale would be interpreted as

evidencing clinical levels of psychopathology. A more appropriate measure of self-esteem among sexually victimized women might be a scale such as that devised by Briere and Runtz (1990). Their measure assesses aspects of self-esteem such as guilt and severe self-criticism that are affected by sexual victimization.

The failure of the multivariate analysis to detect an association between properties of sexual victimization and attachment with adjustment and identity was also constrained by the sample size. It is also likely that the limited range of sexual victimization experiences among women in the study, especially the low incidence of more severe forms such as repeated intercourse with a father-figure, further impeded the detection of any correlations among variables.

It was somewhat surprising that the groups were similarly distributed among attachment categories despite differences in victimization experiences. However, this finding was consistent with the results of another study using the Separation Anxiety Test (Schachere,1988) in which only one difference was found, on attachment responses to mild separation stimuli, among groups of female college students who had been physically, emotionally, or sexually abused, or who had not been abused. Schachere speculated that the lack of differences might have been related to an absence of serious forms of abuse among participants, or to the resilience of individuals who experienced relatively mild trauma. The lack of differences in the present study

also might have been due to the high functioning and age of the participants. Given that the SAT normative sample comprised distressed adolescents, the test may not be valid among adults in non-clinical samples. Instead, according to Kroger and Haslett (1988), the SAT may assess transient separation-individuation phases. In support of this argument was the finding that only a weak link existed between attachment styles assessed over a 2 year period. In their study of college students who were in their early 20's, an association between secure attachment and Achieved identity was found (Kroger, 1985), a relationship that was not detected in the present study. In the present study, almost half of Diffuse women were securely attached. This somewhat surprising distribution was also reported by Kroger and Haslett (1988) and was interpreted as reflecting the diverse nature of those who are labelled Diffuse. Kroger and Haslett further noted that Moratoriums were evenly distributed in secure and nonsecure attachment styles, Foreclosures were more likely to be nonsecure, by a ratio of 5 to 1, and Achievements were more likely to be secure, by a ratio of more than 2 to 1. Some similar trends in distribution between secure and nonsecure attachment styles occurred in the present study. Foreclosures were more likely to be nonsecure (3.3 to 1), and Moratoriums were fairly evenly distributed in secure and nonsecure styles (1.4 to 1). Conversely, Achievements were less likely to be secure, by a ratio of 1 to 2.2. Among nonsecure styles,

more than one third of Achievements were self-sufficient detached. This pattern is consistent with the finding that, at least among women who experienced sexual and other traumas, more Diffuse women than Achieved women were in committed relationships. One possibility is that the SAT may have detected differences in current intimate relational status rather than an enduring attachment style. Such a distinction is important since the quality and function of relationships varies among individuals in the different identity statuses (Josselson, 1988; Orlofsky, *et al.*, 1973). The SAT may not be sufficiently sensitive to detect such differences among adults.

The lack of significant differences among groups on attachment status may also have been due to an order effect. For all participants, the Attachment Questionnaire preceded the SAT. While this order may have made separation issues salient to women, those who had an investment in presenting themselves as doing well may have become somewhat defensive in their responses. The tendency of protocols to be unclassified on the basis of a low Painful Tension score supports the possibility that defensiveness may have occurred among some women. Further evidence for this possibility was suggested by some women's comments that the SAT response choices did not offer enough positive responses. Thus the face validity of the SAT, which is weighted in the direction of negative responses to separations, combined with a heightened awareness of past

separations, may have constrained some women from acknowledging distress in their responses.

One of the most notable findings in the present study was the extent to which women who had been sexually victimized frequently experienced other types of traumas, including multiple sexual traumas. The presence of other forms of maltreatment among women who have been sexually abused has been noted by previous researchers (e.g., Brooks, 1985). For a substantial proportion of women in the present study, sexual victimization occurred within a context of physical and emotional abuse, or family dysfunction. Women who had been sexually and otherwise victimized perceived more conflict in their early family relationships and felt less able to go to their parents with problems than did other women. They generally saw their parents as less supportive, their fathers as less available, their mothers as more critical, and had a poorer concept of themselves in relation to their families than did women who had been non-sexually victimized or women who had not been victimized. Relative to these ongoing challenges to their adaptive capacities, some women felt that sexual victimization had exerted less of a negative impact than if it had occurred in isolation. On the other hand, for some women, sexual abuse was the 'final straw'. As noted by Courtois (1979), women's responses to having been sexually victimized were, in some ways, unique.

Because the findings from the present study were based on a self-selected sample, the prevalence of different types of maltreatment and trauma, and the extent to which they covary, cannot be considered representative of other victimized individuals' experiences. Nevertheless, the findings lend credence to the view that an ecological perspective, wherein all forms of maltreatment experienced by a child are taken into account, may be a more valid approach to studying the effects of early maltreatment than is research that examines types of maltreatment independently (Briere & Runtz, 1988a; Rosenberg, 1987). Moreover, the context in which maltreatment occurs, as well as the occurrence of other types of trauma, may provide confirming or disconfirming information to a child's understanding of victimizing experiences as being due to aspects of the situation or aspects of themselves. Such interpretations likely influence the extent to which a child perceives herself as having been victimized and as having some role or responsibility in being victimized.

The sexual victimization experiences reported by women in the present study were similar to those noted by Briere and Runtz (1988b) in their college sample, with the exception of experiences involving completed intercourse. Completed intercourse was reported by approximately half as many women in the present study as in Briere and Runtz's study, although the incidence in both studies was less than 10%. The samples were comparable in terms of age of onset,

the presence of abuse by a parent, and the number of women who had been abused by more than one person. The small number of women in the present study who reported completed intercourse suggests that the sample may have underrepresented the more severe forms of sexual victimization. The incidence of completed intercourse and oral-genital contact also were infrequent in Fromuth's (1986) study of college women. University samples in general may underrepresent women who have experienced severe sexual abuse (Finkelhor, 1979).

Women's reports of the long-term effects of sexual victimization were similar to those previously reported by incest victims (Russell, 1986). More women in the present study perceived themselves as having felt shame or guilt, fearfulness, sexual difficulties or mistrust of others as a result of sexual victimization than did women in Russell's study. However, such a comparison should be viewed with caution since both studies utilized content analysis of participants' reports and may have categorized women's statements somewhat differently. Nevertheless, the similarity of reports by women in these two studies suggests that sexual victimization has serious negative effects whether it occurs within or outside of the family.

Differences in identity status, which are associated with differences in adaptive capacities (Waterman, 1982), were used as the basis for exploring potential protective factors. In the present study, the finding that more

sexually victimized women were high in identity than were non-sexually victimized or non-victimized women suggests that, as a group, the sexually victimized women had attained a degree of good functioning. Among the women who experienced sexual and other traumas, there were some differences in victimization experiences between women who were high in identity and those who were low in identity. Whereas high identity women more often experienced physical abuse, low identity women were more often emotionally abused, lived with an alcoholic parent and experienced parents' divorce. That the former group also described being more aggressive or defiant is consistent with the finding by Briere and Runtz (1990) that physical abuse, compared to sexual and emotional abuse, was uniquely associated with aggression toward others while emotional abuse was uniquely linked with low self-esteem. Sexual abuse occurred more often, and both sexual abuse and molestation occurred at an earlier age, among low identity women compared to high identity women. This combination of factors may have posed a particularly difficult challenge to women's coping capacities. The association of less serious sexual victimization and better adjustment noted in the present study were consistent with the experiences reported by well-adjusted and poorly adjusted women in Tsai *et al.*'s (1979) study. The latter group in their study was more likely to experience severe forms of sexual abuse that were of longer duration. Although more of the low identity women

in the present study had been sexually abused, the majority of high identity women also had experienced severe forms of sexual victimization. This finding supports the notion that some women are able to achieve good adjustment despite experiencing serious childhood sexual trauma.

Although women varied in their self-perceptions of resolution and adjustment following past traumas, many felt that they had achieved some degree of contentment and academic or career success in their lives. This contrasted with the extent to which these same women still felt affected by early trauma. The notion of 'vulnerable but resilient' seemed applicable to many of these women. Also, the fact that most women continued to be affected to some degree by early trauma despite finding meaning or making sense of it is similar to the finding by Silver, *et al.* (1983) that women who had made sense of incest experiences reported more psychological symptoms than a population of nonpatient 'normal' adults but fewer symptoms than incest victims who were still searching for meaning.

The disparity between self-perceptions of resolving past trauma and continuing to be affected by it raises a question as to whether women in the study were engaging in 'impression management' or other psychological defense operations, such as denial or compartmentalizing of negative and positive experiences. At some point in their lives, a proportion of sexually victimized women had used such operations to minimize, deny or repress memories of abuse or

their feelings about it. The process of coming to terms with, or working through, past trauma involves a recognition of the impact it had, and continues to have, in victims' lives (Reiker & Carmen, 1986). In fact, the few individuals who reported being unaffected by sexual abuse seemed more likely to be engaging in denial.

Integrating aspects of the self, including strengths, skills, self-perceptions and individual history into a dynamic structure underlies Erikson's theory of ego identity development (Marcia, 1980). More generally, the development and integration of several aspects of psychological and social functioning are thought to indicate mental health and well-being. For example, when asked what a normal person should be able to do well, Freud is said to have responded, "To love and to work" (Erikson, 1968). Other researchers (e.g., Jahoda, 1958; Jourard & Landsman, 1980) have attempted to expand on the criteria of mental health by including such factors as positive attitudes toward the self, autonomy, mastery in work and relationships and psychological integration. These definitions share common themes of developing the self, and the self in relation to others, through the ability to function autonomously and interdependently. In contrast, clinicians have noted the tendency of sexual abuse victims to develop aspects of the self, such as intellectual capacities, to the exclusion of relational or other aspects of normal development (e.g., Friedrich, 1990; Gelinas, 1983). This tendency was also

apparent among women in the present study. The fact that all participants in the present study were university students indicated that they had attained a level of adjustment that enabled them to function adequately, or better, in this sphere of their lives. Since academic and career achievements are praised in our society, women who have been sexually victimized may focus their efforts at recovery and success, at least initially, on this pathway of becoming independent or autonomous. In this way, they would gain increased self-esteem, a sense of competence and personal power, all of which might offset the feelings of vulnerability, stigma and powerlessness that are associated with sexual victimization (Finkelhor & Browne, 1985). The development of competence and independence may not, however, enhance victimized women's ability to enter into intimate, reciprocal relationships; work and achievements may occur to the exclusion of relational development. As one woman noted, focussing attention on work and "doing" was a way to avoid "being" or relating to others. Whether achievement strivings enhance self-development or serve to avoid intimacy, what seems clear is that intimacy posed an especially difficult challenge for women in the study. The majority of both high and low identity women who had been sexually victimized were not involved in committed relationships at the time they were interviewed. It was notable that several high identity women were quite proud of their self-sufficiency and had rejected the notion of making

a life-long commitment to any relationship. Other women had disengaged from dysfunctional relationships and were exploring the idea of achieving healthier relationships. In terms of the "vulnerable but resilient" quality shared by the women in the study, resilience can be seen in their autonomous achievement-oriented capacities. Given the mistrust, sexual stigmatization and feelings of helplessness that are the legacy of sexual victimization, it is hardly surprising that many of the women avoided becoming too close to others. They continued to feel vulnerable to being used, hurt, abandoned or shamed by others.

It must be noted that the above definitions of mental health involve a fairly high standard of functioning. While most, if not all, of the women in the study had 'survived' adversity enough to cope with daily living, some women were functioning at a higher level. What facilitated sexually victimized women's ability to engage in the process of integration? Some tentative conclusions can be drawn from the differences in high and low identity women's experiences and ways of responding to victimization. Such a comparison is not meant to negate the degree of adjustment that the latter group had achieved, but rather to elucidate possible protective factors that facilitated some women's attainment of a higher level of identity and adjustment.

Based on qualitative analysis, more women who were high in identity experienced early relationships that were positive, consistent or caring. Also, they more often had

supportive relationships, including therapeutic relationships, that were perceived as helpful in coming to terms with adversity. Similarly, high identity women more often reported that group therapy participation had been beneficial. Although high and low identity women did not significantly differ on the measure of attachment, the greater frequency of caring relationships reported by high identity women may have afforded them some protection from diminished self-worth, one of the effects associated with sexual victimization (Browne & Finkelhor, 1986). In fact, a number of women described the importance of love or encouragement from adults during childhood. Knowing that there was at least one person in the world who loved them was a source of strength and determination in overcoming adversity. Other supportive relationships during adulthood, whether with friends, therapists or intimate partners provided an opportunity for ventilation, receiving reassurance and positive feedback. These self-reports of the benefit provided by positive relationships were consistent with other researchers' findings that relationships with supportive adults during childhood (Conte & Schuerman, 1987, Steele, 1986; Zimrin, 1986) or adulthood (Tsai, *et al.*, 1979) enable physically and sexually abused children to become well-adjusted adults. The women who had such relationships may have been able to develop basic trust in others as a result of positive early relationships. It was interesting that more of the high identity women made

conscious decisions to disengage from their families as part of their efforts to make better lives for themselves. In part, having found nurturance outside of their families may have enabled women to recognize, and reject, the conflicts within their families (Miller, 1988). In contrast, it was interesting that fewer low identity women reported having early caring relationships and more often experienced feelings of vulnerability and mistrust following sexual victimization.

Reports of having and benefitting from positive relationships raise a question about whether temperamental differences might underlie the ability of some women to elicit support and benefit from it. Due to the retrospective nature of the study this question could not be addressed. There is some evidence (Werner, 1988) that, as children, resilient individuals are better able to elicit positive attention from adults than are non-resilient individuals. No doubt the ability to elicit attention and to benefit from it are interactive processes. In contrast, Zimrin (1986) noted that physically abused children who were belligerent and had a sense of control over their lives ('I can do anything if I set my mind to it') were more likely to be well-adjusted in adulthood than were abused children who were compliant, passive or fatalistic. A substantially larger proportion of high identity women considered themselves to have been aggressive or belligerent children or adolescents. In support of Zimrin's findings, it

appeared that being demanding facilitated resilience. On a more general level, being demanding or aggressive is also being active. Rutter (1985) suggested that any coping effort may be better than none.

Most of the women who had experienced sexual trauma, or other types of adversity, had found some meaning or made sense of it. More high identity women than low identity women felt that they had gained strength, learned important skills or transformed negative aspects of victimization into positive attributes, for example, by construing vigilance as heightened perceptiveness. These reports were consistent with Taylor's (1983) finding that women who construed a positive meaning to having cancer were better adjusted than women who could not find anything positive in the experience. Other studies have found that adolescent and adult incest victims (German, Habenicht & Futcher, 1990; Russell, 1986) and battered women (Walker, 1984) perceived themselves to be stronger, more empathic or more independent as a result of victimization experiences. In another study, (McCrae & Costa, 1986) individuals rank ordered the effectiveness of the coping mechanisms they used. Faith, drawing strength from adversity, self-adaptation, and seeking help were all highly ranked. The mechanisms considered least effective by those who used them were indecisiveness, self-blame, wishful thinking, isolation of affect and passivity. Thus there is a consistency in these and other studies of coping with victimization (e.g., Silver

& Wortman, 1980) that a substantial number of individuals find something positive in adversity. Taylor (1983; Taylor & Brown, 1988) referred to this as a positive illusion. In defense of the negative connotations that might be associated with the term, she noted that the process of finding meaning or construing benefit is not illusory; individuals often learn from their experiences and the meaning gained can greatly enrich their lives (Taylor, Wood & Lichtman, 1983). According to many women in the study they too had used the meaning found in early trauma to live fuller lives. As one woman noted, "just keeping afloat" in life was not good enough. Rather than referring to illusions, a term that is somewhat open to misinterpretation, the positive meanings that women made of their traumatic experiences might be better captured by the label 'transformational cognitions'.

Successful experiences were also more frequently associated with high identity. These women more frequently described accomplishments as helpful in the process of recovery, found school positive or enjoyable, and perceived themselves as academically successful. Doing well at school and establishing relationships with teachers or peers appeared to facilitate a self-perception of accomplishment and competence. According to Erikson's theory (1968), achieving a sense of competence precedes the task of identity development. For girls, competence may involve social success or "the art of getting along" with others

(Josselson, 1988b). The association of intellectual achievements and other accomplishments with resilience is consistent with findings from other studies (e.g., Quinton, Rutter & Liddle, 1984; Rutter, 1987; Zimrin, 1986).

In summary, three general factors, positive relationships, transformational cognitions and accomplishments, emerged from the qualitative analysis of high and low identity women's descriptions of recovery processes and past experiences. These factors were consistent with previous research findings of factors that were associated with resilience among individuals who experienced childhood adversity.

Based on findings in the present study, identity status, in contrast to more clinical measures such as the SCL-90-R and TSCS may be a richer, more useful measure to detect differences in psychological development among asymptomatic, well-functioning women who have experienced childhood sexual victimization. Although women in the present study obtained scores within the normal range on measures of psychological distress and self-concept, differential identity status distributions and differences in self-perceptions of coping efforts and recovery processes suggested that the identity status interview may have tapped psychological processes such as introspection, attention to feelings and the ability to use relationships to facilitate self-development that are common to both identity development and the process of coming to terms with

childhood adversity. Erikson (1968) proposed that achieving an identity involves a process of integrating personal history, childhood identifications, and abilities within a cultural context. This process is conceptually similar to the tasks that appear to underlie the process of coming to terms with victimization.

Directions for Future Research

Further research on protective factors that facilitate women's resilience or recovery from sexual abuse is warranted. The limitations of the present study, particularly the small sample size and the low frequency of severe forms of sexual abuse, provide some important directions for conducting future research in this area. First, despite the differences in identity status between women who experienced non-sexual traumas, sexual and other traumas, or no traumas, the findings in the present study left open the question of whether sexually victimized participants were, in fact, asymptomatic. One way to approach this question in future research would be to screen a larger sample of women who have experienced varying degrees of sexual victimization in order to differentiate symptomatic and asymptomatic women. Interviews with these groups of women would shed further light on protective factors that facilitate resilience. A more in-depth phenomenological approach might be useful in exploring further the impression gained from the present study that

some women become well-functioning despite continuing to feel negatively affected by childhood sexual victimization. Including sexually victimized women from the general community would be an important addition to future research in the area of resilience since their experiences may be quite different from those of women in student populations.

Given the importance of relational connectedness to women's identity, the relationship between attachment style and adjustment among sexually victimized women deserves further study. Sexual traumas often have a severe impact on women's relational capacities in terms of trust, openness, and sexual intimacy. The ability to establish secure attachments would seem intuitively to be a significant indicator of adaptation. Rather than using a measure such as the SAT, one of the adult attachment measures which are based on relationships with parents, peers and romantic partners (e.g., Bartholomew, in press; Main *et al.*, 1985) might be more useful.

Retrospective research investigating recovery and adaptation to childhood sexual trauma may need to adopt a broader ecological perspective, or life-span approach, than has already been proposed (Newberger & De Vos, 1988; Rosenberg, 1987). The factors that enhance or impede individuals' abilities to come to terms with childhood adversity occurs within the context of support and other traumas experienced throughout the life-span. Traumatic experiences in adulthood such as sexual revictimization or

serious illness were not assessed in the present study although several women reported having experienced such events. The influence of trauma in adulthood on individuals' capacities to integrate earlier traumas would be an important addition to future research.

Finally, one caution must be noted regarding the interpretation of research findings that explore resilience among women who have been sexually victimized. The fact that some victimized women did not manifest serious forms of psychopathology must not lead to the conclusion that sexual abuse is harmless as some researchers have suggested (e.g., Henderson, 1983). The findings from the present study indicated that women who were sexually victimized and experienced other types of trauma had experienced more depressions, suicidal thoughts and attempts, and eating disorders than had women who experienced non-sexual traumas. The findings also indicated that some of the sexually victimized women were functioning well. By their own reports, however, these women also continued to experience the effects of victimization in their lives as they coped with dysfunctional family relationships, as they attempted to establish friendships and intimate relationships that were based on trust and reciprocity instead of fear and powerlessness, and as they attempted to raise their own children in ways that they themselves had not experienced - to feel loved, lovable, safe, and strong in the world.

The understanding to be gained from the experiences of resilient women will benefit others, both children and adults, who may not yet have entered the recovery process. The keys to resilience described by women in this study offer important reminders about the value of caring and validating experiences. Whether as clinicians, parents or friends, by taking seriously the child or adult who has been victimized, we can serve as "corrective witnesses" (Miller, 1988), thereby counteracting the potentially damaging effects of childhood sexual victimization.

Chapter 8

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APPENDIX A

BACKGROUND INFORMATION SHEET

Date of 1st Interview_____ Date of 2nd Interview_____

Interviewer_____

Subject Code_____

Age:_____

Marital Status:_____

Place of Birth:_____

Number of Years in Canada:_____

Current Year in University:_____

University Major:_____

Mother's Education (circle one):

a. incomplete high school
b. high school graduate
c. incomplete university
d. university graduate or higher
e. other (please specify):_____

Father's Education (circle one):

a. incomplete high school
b. high school graduate
c. incomplete university
d. university graduate or higher
e. other (please specify):_____

Mother's Occupation_____

Father's Occupation_____

APPENDIX B

EGO IDENTITY STATUS INTERVIEW: LATE ADOLESCENT FORM

General Opening

How old are you?

What year are you in? (if college)
How long have you been out of high school? (if not college)
What have you been doing since high school? (if not college)

Where are you from? Where did you grow up?
Where do you live now? Do you live with you parents, on your own, with someone else?
How do you feel about living where you do?

Are both you parents alive?
(if not) At what age were you when your _____ died?

Have your parents ever been separated or divorced?
(If yes) How old were you when this occurred?
What happened for you then? Lived with whom? How was it for you?
Any stepparents?
Who are the most important parental figures for you? (Use there persons for next questions calling for "father" and "mother".)

Tell me about your father's educational background.
What type of work does he do?

And you mother, what is her educational background?
What type of work does she do?

Any brothers or sisters? Tell me about them.

Occupation

How did you decide to come to SFU?

What are you majoring in?

How did you come to decide upon_____?

What do you plan to do with_____?

What seems attractive to you about_____(either the major area of study, the future application of the area, or both, if appropriate)?

What other things have you considered besides_____?

When did that occur?
Tell me about how that was for you.

How do you feel about your current position with respect to _____?

Most parents have plans for their children, things they'd like them to do or go into. Did yours have any plans like that for you?

How do your parents feel about what you're doing now? About your future plans?

How willing do you think you'd be to change doing or going into_____ if something better came along. (If S responds: "What do you mean by better?") - Well, what might be better in your terms?

Religion

Do you have any particular religious affiliation or preference?

How about your parents, do they have any religious preference?
What religion was each of your parents raised in?

How important is religion to your parents?
(If important) Can you give any examples?

Tell me about your religious beliefs as they stand now. (If S cannot articulate these, then ask more specific questions; e.g.:) How do you feel about personal versus organized religion? Do you think that there's a God? What is the basis for your standards in resolving moral issues?

Was there ever a time when you came to question or doubt your religious beliefs? (If so) Tell me about that time; what was it like for you? What types of things did you question? What started you thinking about these questions?
How serious were these questions for you?
How did you resolve your questions at that time?

Are there still undecided areas for you? (If so) How important are they?
What do you think will happen in terms of your beliefs?

Did you used to be active in religious activities, e.g., youth groups, attending services, observing holidays? Were you in (catechetical classes, confirmed, Bar Mitsvahed)?

How about now, are you active in any of the above?
Do you get involved in discussions about religious issues?

(IF so) Tell me about them.

How do you think you'll raise your children with respect to religion? Why?

Politics

Do you have any particular political preferences?

How about your parents, what is each of their political preferences?
How important is politics in your home?
(If important) Can you give me some examples?

Tell me about your political views as they stand now.
Are there any social issues about which you feel strongly?
Tell me about them.

How did you come to develop your beliefs?
What do you feel have been the most important influences on your political-social ideas?

Have you ever gone through periods of doubt or questioning about your beliefs?
(If so) Tell me about that period. What was it like? How did you resolve the questions?

How do your parents feel about your beliefs as they stand now?
Are there differences between your beliefs and those of your parents?

Have you ever taken any political action, like joining groups, participating in demonstrations, electoral campaigns, writing letters to the government or newspapers?

Do you think that your beliefs might change much in the future?
(If so) How do you think they might change?

How would you like to see your children raised with respect to political issues? Why?

Sex Role Attitudes

Now, I'd like to change the topic area a bit. I'd like to talk with you about your ideas of men's and women's roles in society today.

What characteristics do you associate with femininity? With masculinity?

Do you think that there are psychological differences between men and women?
(If so) Tell me what you think about them; what are they; where do they come from?

Do you think that men and women behave differently?
(If so) How do you account for these differences?

How do you think things should be in terms of what women and men are supposed to be like?

How do your beliefs apply to you in your own life? Do they make a difference in what you do?
(If so) Can you give me some examples?

Have you always thought pretty much the way you do now, or have your ideas changed substantially from when you were younger?
(If changed) Tell me how that came about.

What are your parents' beliefs in this area?
Do you discuss these things with them?
What do they think about your ideas?
What would you do with your own children around the issue of sex roles?
How would you raise them?

Are there any areas of concern remaining for you?
(If so) How do you think they'll be resolved?

Can you see your ideas changing much in the future, or are they pretty stable?

Sexuality

Finally, I'd like you to tell me some of your beliefs concerning your own sexual behaviour.

What are your attitudes concerning sexual intercourse? When do you think it's all right to be sexually intimate with another person? When not?

How did you develop these ideas?
Have they changed much since you were younger?
(If so) Tell me how they changed and what led to that change?

Do these beliefs make much difference to you in terms of what you actually do in relationships?

How about your parents? What do they think about sexual relationships?
Do you discuss your views with them?

What do they think about your beliefs?

How about your children, how would you raise them with respect to the issue of sexuality?

How likely do you think you are to change your views in the future?

Summary

In this interview, we've covered 5 areas: occupational plans, religious beliefs, political attitudes, sex role attitudes, and personal standards concerning sexual intimacy. Which of the areas do you think is most important to you in defining who you are? That is, if you could pick only one area upon which to base your identity, which would you pick? Which one would be next in importance? Which is the least important? Which is the next least in importance?

APPENDIX C

EGO IDENTITY STATUS INTERVIEW: ADULT FORM

General Opening

Are you married?
(If yes) How long have you been married?
Do you have children, and if so, how many?
(If yes) What are their ages?

What area are you living in now? How long have you lived there? Where are you from originally?
(If appropriate) Where is your husband from?

How did you come to move into that neighbourhood?
How do you feel about living there?
Have you become involved in any local community activities?
(If yes) Can you describe what you do with the group(s)?

Can you tell me something about your educational background?
(If appropriate) And what is your husband's educational background? What type of work is he doing now?

What was your father's educational background?
And what (is/was) his occupation?
How about your mother, what education did she have?
Has your mother been employed outside the home?

Do you have any brothers or sisters?
(If yes) Are they older or younger than you?

Family Roles

(For respondents who are married)

How did you come to meet your husband?
How long did you know him before you married?

How did your decision to marry change the plans that you previously had at that time?

Did you find the decision to marry a difficult one to make, or was it what you always wanted to do?
(If appropriate) What influenced your decision at the time?

How did your parents feel about your marrying when you did?

Looking back on it, are you glad that you married when you did?
(If not) Why? What would you have done differently?

(If appropriate) Was the timing of your first child planned or was it unexpected?
(if appropriate) Why did you feel starting a family at that time was desirable?

How did you feel when you learned that you were going to be a mother?
Looking back on it, are you glad that you started a family when you did?
(If not) Why? What would you have done differently?

(For respondents who have not married)

Have you thought about the possibility of marriage for you?

(If appropriate) At what point in your life would you like to marry?
Why do you consider that a favourable time?
(If preferring not to marry) Why would you like to remain single?
How do your parents feel about you not marrying up until now?

Have you thought about having children at some point?
(If appropriate) At what time in a marriage do you feel it would be best for you to have children?
Why is that a favourable time?
(If preferring not to have children) Why would you prefer not to have children?

(For all respondents)

What do you see as the advantages of being a wife and a mother?
What do you see as the disadvantages or limitations?

How would you compare your ideas about a family with those of your mother?

Have you ever gone through an important change in your thinking about family roles? (If yes) Please describe the changes.

What started you thinking about these questions?
How did you go about working out your ideas?
Who may have influenced your decisions?
At this point do you believe your ideas are fairly well worked out or are you still working on them?
(If still working on them) What are you doing at this point to work out your thinking?

Do you think there is any conflict between being a wife and mother and pursuing a career?
(If yes) How will it interfere?

How do you think you (have/will) resolve(d) that conflict?
How much concern (do/did) you have over this question?

How does your husband feel about your attitudes about being a wife and mother?

Do you see your ideas about being a wife and mother changing or do you think they will remain pretty stable?

Education

What are you planning to major in?
(If not sure) Are there any fields you are considering?

Do you have any ideas about what you'd like to do after graduation?

How did you come to decide on _____? (Ask concerning future plans, if known, otherwise concerning major field. If no definite field mentioned, omit)

When did you first become interested in _____?
What do you find attractive about _____?
Were there any other fields that you considered?

How seriously (were/are) you considering each of the fields you mentioned?

(For students who have specified a decision)
Did you ever feel that you were actively deciding between _____ and _____?
Was this a difficult decision to make?
What influenced your choice?

(For students who have not specified a decision)
Do you feel that choosing a career is something that you're trying to work out now, or do you feel that this is something where you can let time take its course and see what happens?
Do you have any idea when you would like to have this decision made by?
How are you going about getting the information you'd like to have in order to make a decision?
Do you feel that this is an important decision for you to make now or are you more concerned with other things right now?

How willing would you be to change your plans from _____ if something better came along?

(If a possibility for change is indicated)
What might you change to? What might cause such a change?
How likely do you think such a change might be?

(If appropriate) Husbands usually have some feelings about their wife's education and plans. What are your husband's feelings about your studies?
Do you think he may have a preference for one plan or another, even if he never would try to pressure you about it?

Do you think attending school helps or hinders your marriage? In what ways?
Do you find it difficult to attend school and manage the responsibility of a husband?
(If yes) Where do you find the most problems arising?

How do you think your attending school has affected your children?

Did you ever have any uncertainty about whether you should have started school again or should continue?
(If appropriate) Was it a difficult decision to make?
What helped you to resolve your uncertainty?
(If appropriate) How are you going about trying to resolve your uncertainty? How important is this question for you now?

Future Plans

At this point, are you considering making any major changes in your life concerning work, education, or family?
(If yes) What type of change are you considering?
What do you hope to be able to gain from making such a change?
How likely to you think it is that you will be able to make such a change?

How does your husband feel about the possibility of such a change?

As you look ahead, five to ten years, do you think you will be making any major changes in your life concerning work, education, or family?
(If yes) What type of change do you think you may make?
What do you hope to be able to gain from making such a change?
How likely to you think it is that you will be able to make such a change?

Religion

Do you have any religious preference?
Do your parents have any religious preference? If so, in what religion were each of your parents raised?
Have they both continued in that religion?

How important is religion in your parents' home?
(If important) Can you give me some examples?

Does your husband have a religious preference?

Are your currently active in church or church groups (Adapt for Jewish faith)
(If not active) How about in the past, were you ever active in church groups?
(If not already answered) How frequently do you usually attend church services?
What is your reason for attending services?
How important would you say religion is in your life?

I'd like to find out where you stand on questions on the existence of God and the importance of organized religion. (If Catholic, add: and the authority of the Pope).

How do your parents feel about your religious beliefs?

Are there any important differences between your beliefs and those of your parents? Your husband?

Was there ever a time when you came to question, to doubt, or perhaps to change your religious beliefs?
What types of things did you question or change?
What started your thinking about these questions?
How serious were these questions for you?
Do you feel that you've resolved these questions for yourself or are you still working on them?

(If resolved) What helped you to answer these questions?

(If unresolved) How are you going about trying to answer these questions?

At this point, how well worked out do you think your ideas in the area of religion are?

Do you think your ideas in this area are likely to remain stable or do you believe that they may very well change in the future?

(If they may change) In what direction do you think your beliefs might change?
What might bring about such a change?
How likely is it that such a change might occur?

(If evidence of continued thought to religious questions)
How important is it to you to work out your ideas in the area of religion?
Are you actively trying to work out your beliefs now or are you more concerned with other things right now?

How would you like to see your own children raised with respect to religion? Why?

Politics

Do you have any political preferences? (If asked "What do you mean?" respond: Either party preference or a position on the liberal-conservative dimension.)
Do you consider yourself as general liberal, moderate, or conservative?

Does your father have any political preferences?
Does your mother have any political preferences?
How important is politics in your parents' home?
(If important) Can you give me some examples?

Does your husband have any political preferences?

Are there any political or social issues that you feel pretty strongly about?

What would you like to see done about _____?

Are there other issues which you have views about?
What would you like to see done (in each of the areas mentioned)?

How did you come to develop the beliefs that you are expressing?
What do you feel have been the most important influences on you concerning these questions?

Have you ever taken any political action, like joining groups, participating in demonstrations, participating in election campaigns, writing letters to government or other political leaders?

What led you to become involved in these activities?

(If no issues or activities were discussed)
Do you feel that you are actively trying to arrive at a set of political beliefs or do you feel that the area of politics isn't very important to you at the present time?
(If now actively trying)
Can you tell me something about the types of things you are thinking about?
How are you going about getting the information you need to make a decision? How important is it for you to work out these ideas?

Are there any important differences between your views and those of your parents? Your husband?

Was there ever a time when you found your political ideas undergoing change - where you believed one thing and then, several months or years later, found you had very different ideas on the same issue?
What led you to make that type of change?

At this point do you believe that your political beliefs are likely to be stable over time or do you feel that they may very well change?

(If they may change) In what direction do you think your beliefs might change?
What might bring about such a change?
How likely is it that such a change might occur?

How would you like to see your own children raised with respect to politics? Why?

Sex Roles

I'd like to find out something about how you see the feminine role.

There are a variety of behaviours and traits that different people associate with being feminine; what characteristics do you usually associate with femininity?

How do you see women expressing a feminine role today?

Is that the way you would like to be feminine or would you like to express femininity in a different way?

What advantages and disadvantages do you see as associated with the feminine role in society?

How did you come to learn what it means to be feminine?
Do you feel that is something that came rather naturally for you or were there times when you were uncertain as to how you should act? Can you give some examples?

How was your behaviour in this area influenced by your parents?
How about the effects your brothers and sisters may have had?
Are there any important differences between the ways in which you and your mother express femininity?

How do your views of femininity compare with those of your husband?

Are there any areas of behaviour which you are still questioning as a female?
(If yes) What is the nature of your uncertainty?

Why do you think this is an issue for you?
How are you going about trying to work out your ideas about what you should do?

Do you see your ideas about femininity remaining stable or do you see them as changing in the future?

How would you like to see a daughter of your own raised with respect to femininity? Why?

In raising children, do you believe there are any important differences in how you should treat boys and girls?
Do you believe you (will/are) raising your own children in ways very different from the way you and your husband were raised? In what ways?

Closing

As you reflect on your life at this point, what would you say are your greatest satisfactions?
What would you say are the areas of greatest dissatisfaction?
On balance, how satisfied or dissatisfied would you say you are with where you are at the present time?

What are your most important personal objectives in the next five years?
What are you doing now that will help you toward that goal?

APPENDIX D

ATTACHMENT QUESTIONNAIRE

To help me understand how things were for you as a child, I would like to ask you about some of your early experiences.

1. Were you ever hospitalized for any reason when you were younger? No____ Yes____ If yes:
   How many times?_____
   How old were you?_____
   How long was each hospitalization?_____
   What was the reason(s) for the hospitalization?_____
   _____
   _____
   _____

2. Was your mother ever hospitalized when you were younger? No____ Yes____ If yes:
   How many times?_____
   How old were you?_____
   How long was each hospitalization?_____
   What was the reason for the hospitalization?_____
   _____
   _____
   _____

3. Was your father ever hospitalized when you were younger? No____ Yes____ If yes:
   How old were you?_____
   How long was each hospitalization?_____
   What was the reason for the hospitalization?_____
   _____
   _____

4. Did your mother's profession or job cause her to travel away from home? No____ Yes____ If yes:
   How old were you during the absences?_____
   How long did the absences last?_____

5. Did your father's profession or job, for reasons other than military service or duty, cause him to travel away from home? No____ Yes____ If yes:
   How old were you during the absences?_____
   How long did the absences last?_____

6. Was you father away from home due to military service (such as Vietnam) or other duty away from home?
   No____ Yes____ If yes:
   How old were you during the absences?_____
   How long did the absences last?_____

7. Did you ever attend boarding school? No____ Yes____
If yes:
At what age(s)?_____
How many years did you attend?_____

8. Were there family problems such as marital difficulties between your parents that caused your mother to leave home for a period of time? No____ Yes____ If yes:
How old were you during the separations?_____
How long did the separations last?_____

9. Were there family problems such as marital difficulties between your parents that caused your father to leave home for a period of time? No____ Yes____ If yes:
How old were you during the separations?_____
How long did the separations last?_____

10. Were there family problems such as illness or other problems of other relatives (e.g. grandparents) that caused your mother to be absent from home for a period of time? No____ Yes____ If yes:
How old were you during the separations?_____
How long did the separations last?_____

11. Were there family problems such as illness or other problems of other relatives (e.g. grandparents) that caused your father to be absent from home for a period of time? No____ Yes____ If yes:
How old were you during the separations?_____
How long did the separations last?_____

12. Were your parents divorced? No____ Yes____ If yes:
How old were you at the time of the divorce?_____

13. Did you have stepparents? Stepmother? No____ Yes____
Stepfather? No____ Yes____
If yes:
How old were you when this person became your stepparent?_____

14. Is your mother currently living? No____ Yes____
If no:
How old were you at the time of her death?_____
What was the cause of her death?_____

15. Is your father currently living? No____ Yes____
If no:
How old were you at the time of his death?_____
What was the cause of his death?_____

16. Are you an adopted person? No____ Yes____ If yes:
At what age were you adopted?_____

17. Was there any loss through death or separation of someone very close to you? No____ Yes____ If yes:
How old were you?_____
Please explain_____
_____
_____

18. Did you ever live for a period of time without your parents, with:
Relatives: No____ Yes____ Age_____ How long_____
Friends: No____ Yes____ Age_____ How long_____
Foster family: No____ Yes____ Age_____ How long_____
In an orphanage or other institution:
No____ Yes____ Age_____ How long_____
On your own: No____ Yes____ Age_____ How long_____
If yes to any of the above, please explain:_____
_____
_____

19. Were there any other periods of separation, for any reason, between you and other members of your family?
No____ Yes____ If yes:
How old were you during those separations?_____
How long did the separations last?_____
Please explain_____
_____
_____

20. Did either of your parents threaten divorce or separation, even though they remained together?
No____ Yes____

21. Did either of your parents ever threaten to commit suicide?
Mother: No____ Yes____
Father: No____ Yes____

22. When you were younger, do you remember a form of discipline used by your parents that included any of the following?
a) threatening to call the police or other authorities to come and get you?
No____ Yes____
b) threatening to leave you some place if you didn't behave?
No____ Yes____
c) threatening to send you to a foster home, juvenile hall or similar place?
No____ Yes____
d) threatening to send you to live with relatives or other people?
No____ Yes____

e) threatening to withdraw love or care?
No____ Yes____

f) threats of any other type?
No____ Yes____

If yes to any of the above, please explain:_____

_____

_____

Note: Answering the following questions requires circling a number on a five point rating scale, ranging from never (1) to always or very often (5). Please circle one number for each question. For example, if your answer is never, circle the number 1. If it is "rarely" you might circle the number 2, etc. You may refer to the following guide when determining your answers:

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

23. When you were a child, do you remember thinking or worrying that one or both of your parents might be hurt or killed from an accident or illness?

Never_____Very Often
1 2 3 4 5

24. Did you ever have the feeling as a child that you were responsible for either of your parent's safety or happiness?

Never_____Very Often
1 2 3 4 5

25. Did you ever have the feeling as a child that your actions or attitudes would be the cause of either of your parents becoming ill, dying or committing suicide?

Never_____Very Often
1 2 3 4 5

26. When you were a child, did you feel that your parents overprotected you, babied you or were overly worried about your safety and well-being?

Never_____Very Often
1 2 3 4 5

Note: The following questions ask about your childhood relationships with your mother and father. If you have no memory of one of them and had no step or adoptive parent or substitute guardian during your upbringing, ignore the questions referring to that parent. If you have memories of both a natural and a stepparent - for example, a natural mother and a stepmother - respond to the items asking about your mother by thinking about the mother who you feel was most influential in your upbringing.

27. Some parents do a lot of things with their children (such as reading books together, playing together, working around the house together, going visiting and showing interest in their friends and activities). Considering these activities and others, would you say that:

a) your mother did things with you:

Never_____Very Often
1 2 3 4 5

b) your father did things with you:

Never_____Very Often
1 2 3 4 5

28. Some parents hug or kiss their children a lot. Others are more reserved. Would you say that:

a) your mother hugged or kissed you:

Never_____Very Often
1 2 3 4 5

b) your father hugged or kissed you:

Never_____Very Often
1 2 3 4 5

29. Some parents are seldom home when the children are there because they are always working, visiting, playing sports, shopping, at a club or bar, etc. Would you say that:

a) your mother was gone a lot for any reasons like that:

Never_____Very Often
1 2 3 4 5

b) your father was gone a lot for any reasons like that:

Never_____Very Often
1 2 3 4 5

30. Some parents are available to talk when they are at home with their children, others are not. Would you say that:
  a: your mother was available to talk to you:

Never_____Very Often
1 2 3 4 5

  b)your father was available to talk to you:

Never_____Very Often
1 2 3 4 5

31. Some parents are very dependable - doing things they say they will, others are not. Would you say that:
  a) your mother was dependable:

Never_____Very Often
1 2 3 4 5

  b) your father was dependable:

Never_____Very Often
1 2 3 4 5

32. Some children talk to their parents about problems they are having such as with teacher, school or friends. Did you:
  a) talk to your mother about problems:

Never_____Very Often
1 2 3 4 5

  b) talk to your father about problems:

Never_____Very Often
1 2 3 4 5

33a. When you did go to your mother with problems, was she able to figure out what to do:

Never_____Very Often
1 2 3 4 5

  b. When you did go to your father with problems, was he able to figure out what to do:

Never_____Very Often
1 2 3 4 5

34a. When you were upset or sad about something, did you go to your mother for comfort:

Never_____Very Often
1 2 3 4 5

b. When you were upset or sad about something, did you go to your father for comfort:

Never_____Very Often
1 2 3 4 5

35. In general, was your mother someone who:
a) seemed to enjoy her life:

Never_____Very Often
1 2 3 4 5

b) felt sad a lot of the time:

Never_____Very Often
1 2 3 4 5

c) was angry at home a lot of the time:

Never_____Very Often
1 2 3 4 5

d) was angry with people outside the family:

Never_____Very Often
1 2 3 4 5

e) had unpredictable changes of mood:

Never_____Very Often
1 2 3 4 5

f) was sick a lot or suffered from emotional problems, mental illness or alcoholism:

Never_____Very Often
1 2 3 4 5

g) was oversensitive - got her feelings hurt easily:

Never_____Very Often
1 2 3 4 5

h) had no energy - everything seemed too much for her:

Never_____Very Often
1 2 3 4 5

i) was very critical - frequently found fault with what you did:

Never_____Very Often
1 2 3 4 5

j) was unsympathetic to or insensitive to many of your needs and feelings:

Never_____Very Often
1 2 3 4 5

k) was intrusive - overly involved in your life:

Never_____Very Often
1 2 3 4 5

35. How about your father? Was he someone who:
a) seemed to enjoy his life:

Never_____Very Often
1 2 3 4 5

b) felt sad a lot of the time:

Never_____Very Often
1 2 3 4 5

c)was angry at home a lot of the time:

Never_____Very Often
1 2 3 4 5

d) was angry with people outside the family:

Never_____Very Often
1 2 3 4 5

e) had unpredictable changes of mood:

Never_____Very Often
1 2 3 4 5

f) was sick a lot or suffered from emotional problems, mental illness or alcoholism:

Never_____Very Often
1 2 3 4 5

g) was oversensitive - got his feelings hurt easily:

Never_____Very Often
1 2 3 4 5

h) had no energy - everything seemed too much for him:

Never_____Very Often
1 2 3 4 5

i) was very critical - frequently found fault with what you did:

Never_____Very Often
1 2 3 4 5

j) was unsympathetic to or insensitive to many of your needs and feelings:

Never_____Very Often
1 2 3 4 5

k) was intrusive - overly involved in your life:

Never_____Very Often
1 2 3 4 5

APPENDIX E

CLARKE'S SAT CATEGORY CRITERIA

I. Secure Attachment

-a normal attachment percentage (20 - 25%) and a normal individuation percentage (16 - 28%) or
-an above normal attachment percentage (> 25%) and an individuation percentage greater than or equal to the norm (> 16%) plus the attachment percentage minus the individuation percentage is less than plus nine percent (att% - indiv% < +9%);
-an above normal painful tension percentage (> 17%);
-a general pattern of hostility, painful tension, and reality avoidance percentages greater than 35% and less than 55% when combined.

II. Anxious Attachment

-the mild attachment raw score greater than or equal to the mild individuation raw score;
-an above normal attachment percentage (> 25%) and a below normal individuation percentage (< 16%) or
-an attachment percentage score greater than or equal to the norm (> 20%) plus the attachment percentage minus the individuation percentage is greater than plus eight percent (att% - indiv% > +8%);
-a general pattern of hostility, painful tension and reality avoidance percentages greater than 45% and less than 70% when combined.

III. Self-sufficiency Detached

-the strong individuation raw score greater than or equal to the strong attachment raw score;
-an individuation percentage greater than or equal to 20% and an attachment percentage less than 20% or
-an above normal individuation percentage (> 28%) plus the individuation percentage is greater than the attachment percentage;
-a general pattern of hostility, painful tension and reality avoidance percentages greater than 30% and less than 50% when combined.

IV. Dependent Detached

-an attachment percentage less than 20% and an individuation percentage less than 20%;
-a general pattern of hostility, painful tension and reality avoidance percentages greater than 45% and less than 70% when combined.

APPENDIX F

PAST EXPERIENCES INTERVIEW

FAMILY BACKGROUND

Tell me about your family when you were born...
Do you have brothers/sisters?
Did other children come into your family after you were born?
How would you describe yourself in your family? (e.g., family role, position, characterization)
Would other members of the family agree with your perception of yourself?

What is your earliest memory?

Did you do things together as a family when you were growing up?
Did it feel like a close family?

Did you have contact with grandparents, uncles, aunts, cousins when you were growing up?
Did your parents or other relatives tell you stories about your family? Do you know your parents' and grandparents' stories? (e.g., growing up, meeting, their lives etc.)

Did you ever run away from home?

Are you still living at home?
(If yes) What will cause you to leave home?
(If no) Why did you leave home - what were the circumstances?
Did you say goodbye to your parents? siblings?
How have you stayed connected with your family?

EARLY RELATIONSHIPS

How would you describe your relationship with your mother when you were a child?
With your father?
Have there been any major changes in your relationships with your parents?
How do you feel about your parents currently?

What was your relationship like with your sibling(s)? Who were you closest to\least closest to?
How have the relationships changed over the years?

What was your parents' relationship like?
If they argued, how severe did the arguments get (e.g., yelling, throwing things, physical violence)?
Was there a time when your parents threatened to separate?
Are your parents still together?

How would you describe yourself emotionally as a child?
As an adolescent?
What did you do when you were upset in childhood?
Can you remember being held by your parents for comfort when you were a child?
Did you ever feel rejected by your parents in childhood?
(*If yes*)Why do you think now that your parents behaved as they did?

CRITICAL EVENTS

One of the things I'm interested in discovering during this study is how women cope with difficult or traumatic events that occurred when they were younger.

Some of these events might be: growing up in a family where there was alcoholism or violence, parents' separation or divorce, death of a family member or close friend, a serious illness requiring hospitalization or prolonged bedrest, sexual abuse, or physical abuse.

Did you experience any of these, or other critical events, before you turned 16?

Which one(s)?

(*If more than one of the events is mentioned*:)
Which one of the events has been most significant in your life? which has been least significant?
Let's talk about the most significant experience first...

(If sexual abuse was not mentioned, following all of the questions below say, "Returning to the experiences I mentioned previously, do you recall ever having been sexually abused or molested, or receiving unwanted sexual attention prior to the age of 16? If unsure, give definition of sexual abuse. If yes, repeat questions below for all sexual abuse/molestation experiences mentioned)

Can you tell me something about the experience.
e.g., What happened? When did it happen? How long did it go on?
How did you act with regard to the event?

(For sexual abuse)
Did you know the person who abused you? Was force used? Threats of harm?

Did you tell anyone what happened to you?

(**If yes**) Who did you tell? What was their response?
Did you ever talk to (person mentioned above) about it again?

(**If no**) Who would you have liked to tell?
What stopped you from telling (above mentioned person)?

(*If there was no specific event, as mentioned in above list*)
Was there an event (internal, e.g., realization, awareness, or external) in your life, as a child or teenager, that you think had an impact on your sense of self, that made you feel different or changed you? (*If yes, discuss event using similar questions above*)

(*For any of above named events*)
What impact do you think this experience had on you then?
What about now? Does it still affect you?
In what way?

(*For sexual abuse*)
Do you have nightmares or flashbacks about the event now?
Who or what helps you get through those now?

Do you have any contact with the person who abused you?
What are your feelings about it?

Coping Strategies

What were the things you did in order to get through?
Who or what helped you get through the experience then? How?

Who or what hurt (or was unhelpful)? How?

Key To Movement

Did you finally work it out/through? How did it work out?
Who or what could have helped you work it out more quickly or more easily?

Meaning

What does the event mean to you now? What did you learn from it? How are you different because of it?

Keys to Survival

How is it, do you think, that you went through these kinds of experiences but 'survived' them, coped successfully with them?
Do you have a theory as to how you have been able to overcome the effects of these experiences?

INTERVENTION HISTORY

Have you ever seen a mental health professional?

Has anyone in your family of origin had contact with a mental health professional?

Have you been involved in a self-help or therapy group?

Have you ever felt depressed?
Have you ever thought seriously of committing suicide or injuring yourself? Did you act on those thoughts?
Do you have any fears or phobias?
How severe are they?
Have you ever had a substance abuse/addiction problem?
Have you ever had an eating disorder or felt excessively concerned about dieting, body image etc.?

SOCIAL SUPPORT

Currently, how do you handle stress?

If you have a problem, how do you try to solve it?
Would you talk to someone? Who would you go to first? Next?

POSITIVE EVENTS

What positive events or experiences have you had that have made you feel different?
How are you different because of it?

SCHOOL AND ACTIVITIES

Tell me about your school experiences.
e.g.Did you skip or fail any grades?
Did you take any special classes?
What were your grades like?
What were your best/worst subjects?
Did you have any behaviour problems? learning problems?

Did you participate in any school activities?
Did you play any sports?
Organized sports? what kinds

Did you have any hobbies? interests?
Were you involved in any groups?

What activities are you involved in currently?

RELATIONSHIPS

Did you have friends when you were growing up?
Did you have a few close friends or were you part of a group?
Were your friends acceptable to your parents?

Have you been in a serious/committed relationship?
Are you currently in such a relationship?

(If asked 'what is serious?', respond 'what would be serious for you?')
How many/how long did they last?
Was it difficult for you to become emotionally intimate with someone?

Do you plan to/do you have children? Do you/will you tell them stories about their family? Do they have contact with cousins, grandparents etc.?

What effect do you think your experience of negative events will have on your children, if any? How will it affect how you raise your children?

FUTURE PLANS

What have been the major accomplishments/satisfactions in your life to date?
Looking ahead, what are your future plans and dreams for yourself?

REASONS FOR PARTICIPATING IN THIS STUDY

What was your interest/motivation for volunteering?

APPENDIX G

STUDY SIGN-UP SHEET

WOMEN'S EXPERIENCES: CRITICAL LIFE EVENTS

The ways in which women cope with critical events and integrate these experiences into their lives has not yet been thoroughly explored by researchers. Yet this information may have significant implications for assisting other women in coping with such experiences.

To address this important issue, a research study is being conducted which will explore the relationship between critical events (e.g., family experiences in childhood and adolescence) and self-development. The extent to which these critical events, both positive and negative, shape one's sense of self, and the factors that lessen or help overcome the impact of negative experiences, will be the focus of this study.

Women who are at least 21 years old are invited to participate in this research study by contacting:

OLIVIA SCALZO
Psychology Department
291-3354

or by completing the section below and leaving it at the Psychology Department General Office

Your participation in this study is most appreciated. In return, you will be paid $5.00 upon completion of the interviews. In addition, you may find it a useful opportunity to reflect upon your experiences, values and beliefs.

I am at least 21 years old: Yes___ No___

I would like to discuss participation in the research project described above: Yes___ No___

Name:_____

Phone Number:_____

Best time(s) to call:_____

APPENDIX H

INFORMATION SHEET

CRITICAL LIFE EVENTS: WOMEN'S EXPERIENCES

This study will examine the role that family experiences in childhood and adolescence play in self development. The extent to which both positive and negative early experiences shape one's sense of oneself and the factors that lessen or help overcome the impact of negative experiences will be the focus of this study.

Your voluntary participation in this project entails signing a consent form, thus signifying your agreement to completing several paper and pencil measures and to being interviewed about your values and attitudes regarding occupational choices, ideology, and sex roles, and about events you may have experienced in childhood or adolescence such as death of a close relative, parents' death, financial catastrophe, extended illness, sexual or physical abuse, or extended separations from family. The interviews will take approximately four (4) hours, divided over two occasions. You may withdraw your consent to participate at any point during that time and any information collected will be destroyed. The interview will be tape-recorded, for experimental purposes. Therefore, some of these tapes will be heard by one other person (the co-researcher) besides the interviewer.

The tapes will not be identifiable by name or other personally identifying information; rather, each tape will carry a code number key known only to the two researchers. The key and tapes will be stored in a locking filing cabinet in a private office at Simon Fraser University. At the end of the project the tapes will be erased; if this is not the case, you will be asked for voluntary informed consent to that effect. These procedures are to ensure that all information remains anonymous and confidential.

After your interviews, I will be available to discuss this project in more detail with you. I would also welcome any comments that you may have with respect to any aspect of your participation in it.
Thank you for your interest and involvement in this project.

Olivia Scalzo, M.A.
Psychology Department

APPENDIX I

INFORMED CONSENT BY SUBJECTS TO PARTICIPATE IN A RESEARCH PROJECT

The University and those conducting this project subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of subjects. This form and the information it contains are given to you for your own protection and full understanding of the procedures, risks and benefits involved. Your signature on this form will signify that you have received the document described below regarding this project, that you received adequate opportunity to consider the information in the document, and that you voluntarily agree to participate in the project.

Having been asked by Olivia Scalzo of the Psychology Department of Simon Fraser University to participate in a research project, I have read the procedures specified in the document entitled:

Critical Life Events: Women's Experiences

I understand the procedures to be used in this project and the personal risks to me in taking part.
I understand that the interview will be audiotaped.
I understand that I may withdraw my participation in this project at any time.

I also understand that I may register any complaint I might have about the project with the chief researcher named above, or with her supervisor, Dr. Meredith Kimball, or with the Chairman of the Psychology Department, Simon Fraser University, Dr. R. Blackman.

I may obtain a copy of the results of this study, upon its completion, by contacting Olivia Scalzo, Department of Psychology, Simon Fraser University.

I agree to participate by completing several paper and pencil measures and by being interviewed as described in the document referred to above, during the period:

____/____ 19 to ____/____/ 19 at _____.
(day)(mo.) (day)(mo.)
DATE_____NAME(please print)_____
ADDRESS_____
SIGNATURE_____SIGNATURE OF WITNESS_____

APPENDIX J

SFU RESEARCH ETHICS REVIEW COMMITTEE

SUBJECT FEEDBACK FORM

Completion of this form in optional, and is not a requirement of participation in the project. However, if you have served as a subject in a project and would care to comment on the procedures involved, you may complete the following form and send it to the Chairman, University Research Ethics Review Committee. All information received will be treated in a strictly confidential manner.

Name of Principal Investigator:_____

Title of Project:_____

_____

Department:_____

Did you sign an Informed Consent Form before participating in the project?_____

Were you given a copy of the Consent Form?_____

Were there significant deviations from the originally stated procedures?_____

I wish to comment on my involvement in the above project which took place:

_____

(Date) (Place) (Time)

Comments:_____

_____

_____

_____

_____

Completion of this section is optional

Your name:_____

Address:_____ Telephone:_____

This form should be sent to the Chairman, University Ethics Review Committee, c/o Vice-President, Research and Information Systems, Simon Fraser University, Burnaby, B.C., V5A 1S6

APPENDIX K

PERCENTAGES OF EXPERIENCES REPORTED BY WOMEN IN NON-SEXUAL TRAUMA GROUP AND SEXUAL AND OTHER TRAUMA GROUP

Experience	Sexual and Other Trauma (N = 45)	Non-Sexual Trauma (N = 41)
Mother-Child Relationship:		
Positive/Close	37.8	39.0
Negative/Distant	62.2	61.0
Mother-Adolescent Conflict	44.4	29.3
Felt Rejected by Parent(s)	64.4	56.0
Felt Confused/Isolated:		
In Childhood	35.6	43.9
In Adolescence	15.6	24.4
Mood Swings/Sensitivity:		
In Childhood	28.9	24.4
In Adolescence	8.9	14.6
Aggressiveness/Defiance:		
In Childhood	31.1	17.1
In Adolescence	28.9	29.3
Suicidal Thoughts	44.4	36.6
Suicide Attempts/Gestures	17.8	9.8
Depression	48.9	17.1
Eating Disorder	17.8	9.8
Substance Addiction	11.1	12.2
Psychotherapy Involvement	80.0	58.5
Individual Therapy	50.0	50.0
Group Therapy Only	0.0	12.5
Individual and Group	50.0	37.5
Impact of Trauma:		
Negative	93.3	92.7
Neutral/No Impact	4.4	7.3
Positive	2.2	0.0
Continued Negative Impact:		
Of Sexual Trauma	48.9	
Of Other Traumas	82.2	73.0

Coping Activities:		
Denial/Repression/Minimization	42.2	19.5
Repression	15.5	2.4
'Shutting Down' Feelings	15.5	9.8
Reading as Distraction	13.3	19.5
Fantasy	13.3	9.8
Setting Goals/Making Plans	4.4	14.6
Activities That Facilitated Resolution of Trauma:		
Reading Self-Help Books	33.3	12.2
Achievements/Successes	26.7	4.9
Sense of Connectedness	22.2	9.8
Feminism	15.6	7.3
Validation of Experience	14.3	2.4
Writing	13.3	4.9
Disengagement from Family	13.3	4.9
Religious/Spiritual Faith	11.1	7.3
Sense of Justice	11.1	0.0
Never Blamed Self	11.1	0.0
Helpful Relationships:		
Two or More People Helped	75.6	65.9
One Person Helped	17.8	17.1
Nobody Helped	6.7	17.1
School Experiences:		
Liked School	35.6	24.2
Meaning Found in Trauma:		
Felt Grateful for Experience Due to Increased Empathy, etc.	53.3	19.5
Increased Self-Acceptance	40.0	22.0
Increased Strength/Independence	28.9	0.0
Increased Understanding	17.8	14.6
Career Inspiration	13.3	0.0
Downward Social Comparison	4.4	7.3
No Meaning Found	4.4	7.3
Resolution Not Complete	73.3	56.1
Sources of Strength:		
Parents' Support	22.2	22.0
Others' Support	13.3	9.8
Belief in Inherent Strength	17.8	19.5
Intellectual Capabilities	11.1	2.4
Adversity as Motivation	8.9	0.0

APPENDIX L

PERCENTAGES OF EXPERIENCES REPORTED BY HIGH IDENTITY GROUP AND LOW IDENTITY GROUP

Experience	High Identity Group (N = 28)	Low Identity Group (N = 17)
Mean Number of Sexual Victimization Incidents	1.5	1.8
Sexual Molestation	39.3	29.4
Mean Age of Onset (years)	11.0	8.4
Sexual Abuse	60.7	70.6
Mean Age of Onset (years)	9.0	7.0
Physical Abuse	25.0	11.8
Family Dysfunction	21.4	11.8
Separations from Family	17.9	11.8
Emotional Abuse	17.9	35.3
Parental Alcoholism	14.3	52.9
Witnessed Physical Violence	10.7	17.7
Parents Divorced/Separated	10.7	35.3
Parent Emotionally Ill	7.1	17.7
Emotional Neglect	7.1	11.8
Parental Death	3.6	0.0
Death of Other Close Person	3.6	11.8
Addition/Loss of Sibling	0.0	11.8
Family Role:		
Responsible for Others	50.0	35.3
Scapegoat	21.4	0.0
Non-Existent	0.0	11.8
Mother-Child Relationship:		
Positive/Close	32.1	47.1
Negative/Distant	67.9	52.9
Father-Child Relationship:		
Postive/Close	28.6	23.5
Frightening/Abusive	14.3	5.9
Mother-Adolescent Conflict	50.0	35.3
Felt Confused/Isolated:		
In Childhood	32.1	41.2
In Adolescence	21.4	5.9

Aggressiveness/Defiance:		
In Childhood	35.7	23.5
In Adolescence	32.1	23.5
Depression	53.6	41.2
Eating Disorder	21.4	11.8
Psychotherapy Involvement	82.1	76.5
Impact of Trauma:		
Feelings of Shame and Guilt	42.9	47.1
Feeling Unsafe/Vulnerable	21.4	41.2
Mistrust of Others	17.9	29.4
Sexual Difficulties (Past)	17.9	17.6
Sexual Difficulties (Present)	28.6	47.1
Coping Activities:		
Denial	14.3	11.8
Repression	10.7	23.5
Fantasy	17.9	11.8
Activities That Facilitated Resolution of Trauma:		
Reading Self-Help Books	39.3	23.5
Achievements/Successes	35.7	11.8
Therapy Group Participation	28.6	17.6
Feminism	25.0	0.0
Disengagement from Family	21.4	11.8
Religious/Spiritual Faith	17.9	0.0
Sense of Justice/No Self-Blame	17.9	29.4
Validation of Experience	14.3	0.0
Writing	14.3	11.8
Sense of Connectedness	10.7	11.8
Downward Social Comparison	0.0	11.8
Helpful Relationships:		
Two or More People Helped	82.0	64.7
One Person Helped	18.0	17.6
Nobody Helped	0.0	17.6
School Experiences:		
Did Well at School	85.7	29.4
Liked School	50.0	11.8
Disliked School	21.4	41.2
Meaning Found in Trauma:		
Felt Grateful for Experience Due to Increased Empathy, etc.	28.6	11.8
Transformational Cognitions	39.3	5.9
Increased Strength/Independence	35.7	17.6
Increased Empathy/Connectedness	35.7	35.3
Increased Self-Acceptance	28.6	23.5
Increased Understanding	21.4	35.3
Career Inspiration	14.3	11.8

Sources of Strength:		
Support (Parent or Other)	71.4	52.9
Current Relational Status		
Not in Relationship	64.3	41.2
In Positive Relationship	21.4	41.2
In Troubled Relationship	7.1	5.9
Avoid Relationships	7.1	11.8