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Introduction

It has been proposed that the psychological effects of childhood sexual abuse (CSA) may be long-lasting, perhaps even lifelong. Although the maltreatment occurred during childhood, CSA can negatively impact future adult relationships. Some commonly agreed upon long-term negative effects of CSA include sexual difficulties in adulthood and problems with establishing and maintaining trust in interpersonal relationships (Cobia, Sobansky, & Ingram, 2004). In this manner, the psychological effects of child sexual abuse often impact others besides the survivor of child maltreatment. The effects of CSA on significant others and, relationships more generally, are evident in the presenting concerns of patients seeking couple's counseling. Whether or not they disclose it, many couples seeking therapy do so because one or both parties have a history of sexual abuse (Maltz, 2002). Couples who include at least one survivor of CSA are at an increased risk of relationship dysfunctions that include, but are not limited to, unsatisfying sexual relations (Cobia, Sobansky, & Ingram, 2004). In addition to sexual and intimacy problems, survivors of CSA often develop or display various psychological problems and distress (Steel, Sanna, Hammond, Whipple, & Cross, 2004). To alleviate the dysfunctions that result from CSA, treatment options in the form of therapy and/or medication have been made available to victims of childhood sexual abuse (Hembree & Foa, 2003). Much of the literature related to treatment of CSA describes the effectiveness of different treatment modalities on reducing symptoms of anxiety, depression, personality disorders, and posttraumatic stress disorder. However, little is known regarding the effectiveness of the various treatment modalities on alleviating

sexual dysfunction and relationship dissatisfaction related to perceptions of others as benevolent in survivors of childhood sexual abuse. Research that compares the self-reported effectiveness of different treatment modalities including group therapy, pharmacological treatments and individual therapy in increasing adult relationship satisfaction for survivors of CSA is critical for appropriate and timely treatment planning. Most importantly, appropriate interventions for CSA can have a positive impact on adult relationships by increasing intimacy and by reducing sexual dysfunctions.

Prevalence

Although controversy exists related to incidence and prevalence rates of CSA, the consensus appears to be that a significant percentage of adult women have been sexually victimized in childhood. There is disagreement as to how prevalent of a problem CSA is in our society. Variations in reporting the prevalence of CSA and its impact may not be due to lack of research or to lack of evidence indicating that CSA is prevalent, but rather from methodological issues related to each individual study (Dennerstein, Guthrie, & Alford, 2004). Across different studies, definitions of sexual abuse, data collection methods, sampling techniques and cultural factors, amongst other things, are linked to variations in prevalence reporting (Roberts, O'Connor, Dunn, & Golding, 2004). The results of early studies have suggested that between 7 and 36% of women have been sexually abused (Finkelhor, 1993). The results of nationwide, random sample surveys and community surveys suggest that at least one in four girls, and one in ten boys will experience CSA (Finkelhor, 1993) prior to the age of 18.

In a more recent study, Roland (2002) concluded that 28% to 30% of women and 12% to 18% of men have been sexually abused (Roland, 2002). The high prevalence

rate in Roland's study, however, may be explained by her definitions of childhood sexual abuse. For the purposes of her study, the definition of sexual abuse included fondling, lewd sexual remarks, voyeurism, being exposed to pornography, and/or penetration (Cobia, Sobansky, & Ingram, 2004). Roland's broad definition of CSA may have increased the number of those who reported experiencing childhood sexual abuse. Roland incorporated many modalities of abuse in her study, thus yielding a high percentage of reported victims. The variance in prevalence rates cited across the literature illustrates how important it is to specify the definition of CSA that is used when reporting prevalence rates.

Much of the research concerning childhood sexual abuse has focused on the female population. The rationale behind this has been that girls seem to be at significantly greater risk for CSA than are boys. However, across eight epidemiological studies conducted by Finkelhor (1993), the mean ratio of female to male CSA victims was 2.5 girls for every one boy. This number reflects that approximately 29% of the victims were male, a number that is higher than was originally anticipated. It has been postulated that boys have been underrepresented because they are more reluctant to disclose or admit to sexual abuse than are girls (Finkelhor, 1993). These findings imply that more research is needed that can explore the effects of CSA on the underrepresented male victims of the population.

Taken together, the studies described above suggest that approximately 25% of women and 15% of men have experienced CSA. Several theoretical models have been proposed to explain the long-term psychological effects of CSA on interpersonal relationships.

Risk Factors for CSA

Epidemiological data reveal that sexual victimization risk increases in pre-adolescence. There appears to be a dramatic increase around age ten, preceded by a rise in vulnerability during ages six to seven. Approximately 10% of the victims are under age six, however this age group may be misrepresented because of a decrease or loss in retrospective memory (Finkelhor, 1993).

The family structure of the individual may also present a potential risk for CSA. Studies show that girls who reside in a home with a step-father, or a man that has no biological relationship to them, are at the greatest risk for sexual abuse. However, children who reside with one or both of their natural parents may be at risk as well because they may be abused by people inside and/or outside the family (Finkelor, 1993). The presence of both parents presents a slightly lower risk for CSA than a single parent home or a home with a step parent; however, the potential for abuse outside of the family is still present.

Theoretical Models

There have been a variety of theoretical models proposed to explain survivor responses to CSA that affect adult relationships. They include the Resilience Model, the Finkelhor and Browne Model, and Briere's Model.

Resilience Model

One theory that explores the factors involved in long-term responses to CSA is the resilience or hardiness model. Some researchers have proposed that the variation in responses to CSA may not be due to the CSA itself or any particular factor related to it

but rather, to the individual trait of hardiness. Hardiness can be defined as an internal protective factor that enables an individual to "bounce back" from negative experiences (Feinauer, Hilton, & Callahan, 2003). Hardiness may explain the difference in attribution styles of children and adults of CSA. Some children accept blame for their abuse and internalize a great deal of guilt and shame. By contrast, other children in the same situation do not believe that they are at fault. Instead, they correctly attribute blame and shame to the perpetrator (Feinauer, Hilton, & Callahan, 2003). These latter individuals are referred to as being hardy.

To assess whether or not hardiness was a moderator for the effects of CSA, a female sample of adult CSA survivors was surveyed to determine level of hardiness and their perceived negative effects of CSA (Feinauer, Hilton, & Callahan, 2003). The perceived effects measured were severity of abuse and internalized shame related to relationship intimacy. As the severity of abuse increased, depression and anxiety increased, and the ability to form trusting and lasting intimate relationships in adulthood decreased. Hardiness was found to have a significant moderating effect on shame related to intimacy and perceived severity of abuse. Women assessed to have more hardiness internalized less shame and blame and reported significantly less intimacy dysfunction.

One explanation for the difference in hardiness is that the resilience factor may develop during the period of early childhood that is consistent with Erickson's autonomy versus shame and doubt stage (Feinauer, Hilton, & Callahan, 2003). As children complete tasks of autonomy, they develop the confidence that they need to impact their environment. They are able to connect with others and actively engage in life. If a child experiences a traumatic event during this stage of development he or she may have a

reduced ability to develop mastery over self and environment. Without positive role models, or mentors, hardiness skills may not be developed or may remain dormant. If the abuse occurs over a significant period of time, the damage to the children may be severe and their ability to recover may be compromised (Feinauer, Hilton, & Callahan, 2003).

Four Traumagenic Dynamics

Another theory that establishes a link between CSA and adult interpersonal functioning is Finkelhor and Browne's Model. Finkelhor and Browne (1985) suggest that there are four traumagenic dynamics that follow abuse. They are traumatic sexualization, betrayal, powerlessness, and stigmatization (Davis & Petretic-Jackson, 2000). These dynamics are thought to be present in all types of abuse, but the four together are unique to CSA. The dynamic that seems to have the most impact on adult interpersonal functioning is betrayal. In general, children are taught to trust adults and they expect to be protected by them. When a child is abused, this trust and security is lost and the child may feel a sense of betrayal. This loss of trust and betrayal can carry over into other relationships as the child gets older. As a result, the child may be suspicious of intimate relationships or isolate themselves and avoid intimate relationships all together. Betrayal may lead to poor judgment in relationships and to a constant search for redeeming relationships in adulthood (Finkelhor & Browne, 1985). Marital disruptions are thought to develop out of feelings of betrayal related to CSA and may emanate out of the anger felt by survivors about the circumstances surrounding their childhood abuse experiences (Finkelhor & Browne, 1985).

The second traumagenic dynamic is sexualization. This refers to the process by which a child's sexuality is inappropriately developed with regards to feelings and

attitudes towards sex as a result of childhood sexual abuse (Finkelhor & Browne, 1985). Sexualization may occur from the way in which the CSA is perpetrated or initiated. It may be that the child is rewarded for sexual performances and receives attention and affection that are contingent upon sexual acts. The child then develops misconceptions about sexual morality and behavior because of their experiences with sexual abuse (Finkelhor & Browne, 1985).

The impact of sexualization varies based upon the specific characteristics of the abusive experiences. This includes whether the child was forced or beguiled into the sexual activity, whether the child was active or passive in their response to the abuse, as well as the cognitive level of the child (Finkelhor & Browne, 1985). The literature supports the fact that CSA contributes to higher sexual awareness at an earlier age. This sexualization may also make the child more vulnerable to further sexual victimization in adulthood, oversexualization of all relationships, and perhaps even victimization of their own children (Finkelhor & Browne, 1985). In addition, sexually abused children may assume that any relationship with adults will include sexual contact (White & Allers, 1994).

The third dynamic, powerlessness, refers to the mental and emotional process by which a child's will, desire and sense of efficacy are continually threatened (Finkelhor & Browne, 1985). According to the authors, this dynamic essentially means that the perpetrator is continually invading the child. The child has no control over the abusive situation, and is often faced with many obstacles including disbelief if he or she attempts to stop the abuse. The child feels "powerless" to discontinue the situation and therefore may be vulnerable to continued sexual abuse (Finkelhor & Browne, 1985). The feeling of

powerlessness may lead individuals to become less assertive in adult relationships for fear and anxiety of not being in control (Davis & Petretic-Jackson, 2000).

Finally, Finkelhor and Browne (1985) discuss stigmatization as the fourth tramagenic dynamic. This refers to the negative attitudes and connotations that are usually communicated to the child regarding his or her abuse. These attitudes can affect the individual later in life because he or she may feel unworthy of intimate relationships because they perceive themselves as damaged by the abuse. This is especially the case if the CSA involved incest (Davis & Petretic-Jackson, 2000).

Briere's Model

Similarly to Finkelhor and Brown (1985), Briere (1992) conceptualized the interpersonal effects of CSA as having multiple causes. One explanation is that the difficulties occur because intermediate cognitive and conditioned responses develop during the abuse and continue into adulthood (Davis & Petretic-Jackson, 2000). These conditioned responses include mistrust of others, anger and fear of those with more perceived power, confusion about interpersonal closeness, and increased concerns regarding abandonment.

Another explanation for adult interpersonal difficulties after CSA is that there is an accommodation response to continued abuse. Accommodation responses could include sexualization, avoidance, and/or passivity. Interpersonal difficulties in adulthood are based on these accommodations if the abusive situation continues to be present in the individual's adult life (Davis & Petretic-Jackson, 2000). Such interpersonal attitudes may make it difficult to seek out emotional support from any new social or intimate relationship.

Effects of CSA

Trust

Much of the work done with CSA survivors has focused on the psychological effects that the abuse has on the individual victim of the abuse. CSA appears to contribute to several different psychopathologies. It has been postulated that CSA carries an elevated risk for many mental disorders including PTSD, suicide, depression, anxiety, low self-esteem, dissociation, obsessive compulsive disorder, phobias, paranoid ideation, substance abuse, eating disorders, and personality disorders (Roberts, O'Conner, Dunn, & Golding, 2004). All of these pathologies can contribute to difficulties in trust and sexual satisfaction in relationships.

These psychological disorders are not limited to childhood. Unfortunately, unresolved issues with child sexual abuse may manifest in the form of pathology during adolescence as well. In a study using the self-reports of abused victims as well therapist and case manager reports, researchers found differences between adolescents who were physically and/or sexually abused and those who were not. Adolescents with histories of both physical and sexual abuse had elevated depression and anxiety compared to those who were not abused at all, or were only physically abused. (Naar-King, Silvern, Ryan, & Sebring, 2002). In addition to those symptoms, the participants in the study also had elevated levels of Post Traumatic Stress (PTS). Factors contributing to severity of PTS were the severity of the acts themselves and concomitant sexual abuse (Naar-King, Silvern, Ryan, & Sebring, 2002). Those factors that contributed to PTSD as a result of CSA also contributed to difficulties in the individual's interpersonal relationships,

particularly with issues related to trust.

Disruption of Attachment and Trust

Attachment theory states that when a child is born he or she develops a certain bond, or attachment, to the primary care giver. The infant relies on this caregiver for life-sustaining support and nourishment. The consistency of the care giving facilitates an attachment between the child and the caregiver. Once the child feels securely attached to caregivers, he or she can then begin to explore other persons and form bonds with them. According to Bowlby (1988), attachments formed in childhood may play a significant role throughout the lifespan.

One of the major premises of attachment theory is that early attachment patterns influence individuals' development across the life span. It has been postulated that children construct their self-concept, perceptions of others, and social relationships out of their experiences with primary caregivers (Colman & Widom, 2004).Children with secure attachment patterns experience effective, consistent care giving and form internal working models of the self as worthy and of others as responsive and supportive (Trusty, Ng, & Watts, 2005). That is, they are able to depend on caregivers to provide for their essential basic needs and provide a safe nurturing environment. As a result, children who are securely attached are low in anxiety and low in avoidance (Trusty, Ng, & Watts, 2005). These children can use their sense of security and form bonds and social attachments of their own. Arguably, children who are sexually abused, especially by caregivers, are unable to form secure attachments in childhood. This inability to develop attachments in childhood may generalize into adulthood and prevent them from establishing satisfying romantic relationships.

When an individual develops secure attachments in childhood they develop the security and skills necessary to aid them in their recovery of traumatic and/or stressful situations. It has been suggested that children who experience childhood physical and/or sexual abuse do not have the opportunity to develop secure attachments that serve to buffer them from the stress of extreme negative or traumatic situations that can happen throughout the lifespan (Twaite &Rodriguez-Srednicki, 2004). Twaite and Rodriguez-Srednicki (2004) compared and contrasted CSA survivors with victims of another type of trauma, that is, terrorism. They found that CSA survivors may experience more serious symptoms of PTSD than people who have witnessed live terrorists attacks such as the bombing of the World Trade Center in 2001 (Twaite & Rodriguez-Srednicki, 2004). Adult secure attachment and dissociation were found to be mediating factors in the development of these severe stress reactions (Twaite & Rodriguez-Srednicki, 2004).

Twaite and Rodriguez-Srednicki's (2004) study illustrates the idea that attachment appears to be a mediator for stress reactions, especially when an individual is confronted with a novel situation. New intimate relationships can be considered novel situations. Therefore, failure to develop secure attachments in childhood often leads to the inability to develop secure intimate relationships in adulthood.

Much of the research concerning attachment is conducted in children. Studies on emotional attachment in adolescence and adulthood are lacking, especially in the area of emotional experiences and the expression of these in social situations (Consedine & Magai, 2003). However, an individual's attachment in childhood almost directly influences his or her attachment style in adulthood. Attachment patterns in adulthood are of particular importance given the potential impact they can have on the interpersonal

interactions of CSA survivors. If the attachment issues are not addressed in childhood they may generalize into adulthood, which may result in difficulties in developing a sense of trust and problems with sexual satisfaction (Consedine & Magai, 2003).

Trust in inter-personal relationships

There have been many studies that have examined the long-term impact that CSA has on adult psychological functioning, however, most of them have focused primarily on the personal distress of the survivors while largely ignoring the impact on interpersonal relationships (Davis & Petretic-Jackson, 2000). Reliance on using a diagnostic system to characterize abuse ignores the interpersonal or relational problems often reported by survivors. When relational problems have been considered, the focus has been on the impact of the resulting problem behaviors in the social realm (e.g. violence, substance abuse, etc.) while neglecting aspects of social functioning that involve the absence of positive social interactions, such as lack of trust and intimacy concerns (Davis & Petretic-Jackson, 2000).

As previously mentioned in Finkelhor and Browne's model, powerlessness, one of the four traumagenic factors, may mediate the psychological distress in women that have experienced CSA. Powerlessness may also mediate the severity of maladaptive social relationships in women following abuse (Kallstrom-Fuqua, 2004). That is, the more powerless the women felt as the time of their childhood abuse, the more uncomfortable they were in social and intimate relationships. They had difficulty in their establishing and/or maintaining intimate relationships due to decreased trust in others and a fear of becoming involved in relationships where they risk vulnerability (Kallstrom-Fuqua, 2004).

In this manner, the symptoms of child sexual abuse affect more than just the victim. That is to say, the symptomatic effects of CSA may affect the individual's relationship with their friends, spouses, children, and extended family. Many of the symptoms that may affect a survivor's relationship with their loved ones are those associated with PTSD. One of the effects of PTSD is decreased trust. Survivors may avoid intimate relationships for fear of re-victimization or betrayal. These symptoms and fears may change relationships and attitudes towards marriage, work, and children.

Social learning theory may help explain the findings related to the relationship between CSA and interpersonal difficulties. Social learning theory maintains that individuals learn to interact with social partners by observing and engaging in role modeling of the actions of significant peers and others. Furthermore, childhood sexual abuse increases distortions in a child's perceptions of relationships and has been found to affect relationships with persons of the opposite sex (Cobia, Sobansky, & Ingram, 2004) Data from one study indicated that familial and social interactions were more deficient in children who had been abused by a father figure (Scott & Feiner, 1999) as compared to any other member of the family. Father-child incest is considered to be one of the most traumatic forms of abuse with long-lasting negative outcomes and poor prognosis for proper adjustment (Ketring & Feinauer, 1999). Abuse by fathers is especially detrimental since the father or parental figure is supposed to be teaching the child to trust and develop appropriate social relationships with others. As a result of abuse perpetrated by a parent, the child learns poor social behaviors from their perpetrators and then assumes those qualities in their own social relationships.

Several authors have stated that children with abuse histories are more likely than

their counterparts to make statements that suggest dissatisfaction with their relationships when describing their closest friend (Colman & Widom, 2004). These statements often follow into adulthood. These individuals often feel that they may not be able to confide and trust in their friends, and so they report dissatisfaction in their social relationships.

The perceived lack of intimacy in survivors of CSA does not appear to differ between males and females. It has been proposed that childhood abuse may negatively affect both males and females in the same way when it comes to the ability to establish and maintain healthy intimate relationships including friendships (Colman & Wisdom, 2004). As such, both male and female survivors may have difficulty establishing and maintaining intimate relationships because of mistrust and fear of betrayal.

Not only are many CSA survivors often reluctant to get involved in intimate relationships, many also are unhappy in the relationships they choose to pursue. Women who were sexually abused as children report greater dissatisfaction in relationships and marital disruption if married (Colman & Widom, 2004). Although there may be difficulties within the marriage for some survivors of CSA, one study suggested that there are no differences in the marital status of those who had been sexually abused and those who had not been abused (Dennerstein, Guthrie, & Alford, 2004). In fact, results suggested that the biggest difference in adult relationships was the quality of the relationship in marriages involving a CSA survivor. Sexual and relationship functioning was significantly affected by CSA only in terms of the victims feelings for their partners (Dennerstein, Guthrie, & Alford, 2004). The more emotional intimacy that there was between the victims and their partners the more sexually satisfied they appeared to be with their partners.

While some CSA survivors report difficulties associated with relationships, the specific nature and course of impact of CSA on adult intimacy and closeness is still unclear (Davis & Petretic-Jackson, 2000). This may be due to the fact that there is variability in responses related to interpersonal functioning in survivors of CSA. Some survivors are able to establish long-term, lasting, and healthy relationships with partners while others display a pattern of many transient, casual relationships or dangerous, promiscuous behaviors such as prostitution. While some female survivors are extremely fearful and distrustful of men and actively avoid relationships, others continuously seek out relationships in an attempt to find one not characterized by fear and lack of trust (Davis & Petretic-Jackson, 2000).

The effects of CSA on adult relationships do not seem to differ by gender. Both male and female adult survivors of CSA have reported higher rates of cohabitation, walking out, and divorce compared to those who had not experienced CSA (Colman & Widom, 2004). The only suggested difference between men and women who experienced CSA was in sexual satisfaction. CSA distorts a woman's concept of sexual normalcy, such that when women start their own adult relationships their idea of normal sexual relations has been distorted. This contributes to greater dissatisfaction in sexual experiences (Cobia, Sobansky, & Ingram, 2004).

Sexual Functioning

Despite the high prevalence rates of CSA, its effects on adult sexual functioning is complex and still not clearly understood (Loeb, Williams, Carmona, Rivkin, Wyatt, Chin, & Asuan-O'brien, 2003). Research shows that CSA may result in an aversion toward sex or in an increase in interest or oversexualization. High-risk sexual behaviors have been

associated with sexual victimization. Studies have found that adolescent girls who have been sexually abused are more likely to refrain from contraceptive use than their non-abused counterparts (Loeb, Williams, Carmona, Rivkin, Wyatt, Chin, & Asuan-O'brien, 2003)

A recent university study noted that female victims of CSA report several sexual dysfunctions including loss of sexual desire, disorders, and orgasm disorders (Loeb, T.B., Williams, J.K., Carmona, J.V., Rivkin, I., Wyatt, G.E., Chin, D. & O'brien, 2003). Furthermore, college-aged women with a history of CSA have also reported having negative attitudes towards sexuality. Much of the research examining sexual functioning is usually aimed at addressing issues of sexual performance and desire and symptomatic responses to sexual disorders such as low arousal achievement, orgasmic dysfunction, and vaginismus (Loeb et al., 2003). However much of the reviewed research has focused on the symptoms themselves without much regards to etiology or individual differences in sexual responses among individuals with a history of CSA.

It appears that both men and women are sexually affected by CSA, however, symptomatic responses do differ by gender. Female CSA survivors have reported difficulties with lubrication and experience sexual arousal disorders that are associated with their victimization. Male survivors, however, have similar effects but perhaps more so. Men have reported erectile dysfunction, premature ejaculation, and low sexual desire (Loeb et al., 2003). The most significant difference between adult male and female responses to CSA is in the psychological adjustment involved in sexual functioning (e.g. sexual self-esteem, and sexual arousability). Women with a history of CSA tend to be slightly less adjusted than men. While men may experience more physiological

difficulties related to sex, women tend to have more psychological problems which may interfere with the ability to become aroused (Loeb, et al., 2003). There have been many studies that have yielded results that show that women with histories of CSA have high incidences of sexual difficulties. These include avoidance disorder, arousal disorder, and anorgasmia (Bartoi & Kinder, 1998). The survivor's sexual difficulties can affect her ability to develop healthy and satisfying intimate relationships, often leading to relationship dissatisfaction (Finkelhor, Hotalig, Lewis & Smith, 1989).

Treatment for CSA

Some victims of CSA never seek treatment because they either engage in self blame for the mistreatment or deny that the abuse even occurred (Ullman & Filipas, 2005). In addition, many CSA survivors never report having been abused because of the social stigma surrounding childhood sexual abuse. Victims fear unsupportive responses or negative social reactions to their abuse. As a result these individuals decide not to seek treatment (Ullman & Filipas, 2005). Individuals that do not seek treatment for CSA may have difficulty maintaining healthy relationships in adulthood because they lack the ability to form secure attachments. They may be plagued with recurring psychological trauma for the rest of their lives or until they seek treatment. For those who do seek treatment, there are several therapeutic and pharmacological options available.

Medication

There is a strong relationship between PTSD and child sexual abuse (Ullman & Filipas, 2005). Use of medications have been found to alleviate psychological symptoms that are comorbid with PTSD and that present frequently in survivors of CSA including depression, panic disorders, and generalized anxiety disorder (Hembree & Foa, 2003).

The common drugs used to treat such symptoms are selective seratonin reuptake inhibitors (SSRIs)**,** monoamine oxidase inhibitors **(**MAOIs), and tricyclic antidepressants (TCAs). PTSD is often treated with a combination of psychotherapy and medication (Hembree & Foa, 2003).

Medication therapy has been studied to address the sexual concerns of women as well. Sildenafil (Viagra) has been used experimentally in women to increase arousal and sensuality response. Since Viagra became available, many men and women have requested prescriptions to help solve their sexual problems even when the source of their complaints were emotional rather than physical (Berman, Berman, Bruck, Pawar, & Goldstein, 2001)**.** Only a minority of women with CSA have responded positively to sildenafil (Berman et al., 2001). This finding suggests that the effects of CSA on disruption of sexual arousal may be due to psychological rather than physical factors. There is no research that addresses the efficacy of medication as it relates to relationship satisfaction. This may be due to the notion that medication cannot be used to treat issues related to trust.

Therapy

Therapy practices most often used to treat PTSD and anxiety are exposure therapy, cognitive therapy and stress inoculation therapy. Exposure therapy has been found to be the most effective in helping individuals who have been sexually abused (Hembree & Foa, 2003). Of those individuals who seek therapy in adulthood 63% have been sexually abused as children. Although the literature suggests that therapy has been effective in alleviating the effects of CSA, the specific treatment approach should be based on the conceptual framework behind the specific pathologies that result from CSA such as

PTSD (Nurcombe et al., 2000. The hope is that treatment that focuses on alleviating immediate symptoms of CSA may also help reduce the long-term effects that can include decreased trust in others and difficulties with sexual functioning.

More than ever before, women are undertaking therapy with the purpose of coming to terms with their sexual abuse in childhood (Oz, 2001). Although after successful therapy most issues become easier to deal with, therapy at times may become quite trying for everyone involved. The first stage in treatment is disclosing the history of abuse to the spouse. Often this disclosure disrupts the already fragile balance within the relationship. During therapy, the survivor's energy is focused on confronting her own fears and anger related to the CSA. This takes away energy that was previously devoted to work, interpersonal relationships and day-to-day living. Often spouses and children begin to feel neglected. The survivor may be unable to relate to their children except in anger, especially if the child is around the same age they were when their abuse began. Sexual relations become almost impossible. Many therapists suggest couples therapy if the marriage manages to endure through the individual's therapy (Oz, 2001).

Despite some common trends in the psychological effects of CSA in relationship satisfaction, sexual functioning and issues related to trust, researchers warn against thinking of sexual abuse victims as one unitary group. Some studies have shown that individual personality traits make treatment more or less successful (Dale, Allen, & Measor, 1998). Furthermore, the effectiveness of therapy is also a function of the therapist. Some therapists may have marked success with one client while other therapists may not (Dale, Allen, & Measor, 1998). The client has to be comfortable disclosing his or her past feelings of fear and guilt with the therapist (White & Allers, 1994).

In trials assessing the success of different treatments for CSA, the most effective were found to have involved group therapy and combined individual and group play therapy (Nurcombe, Wooding, Marrington, Bickman, & Roberts, 2000). Over the past decade there has been increased interest in using play therapy as an early intervention for child abuse (White & Allers, 1994). Howe and Silvern (as cited in White & Allers, 1994) state that during play therapy the goal is to encourage the child to master feelings of anxiety and guilt by providing opportunities to take an active part in recreating previously overwhelming situations. Although there is some evidence supporting the benefits of play therapy in general, its use for treating abuse and neglect has not been fully supported (White & Allers, 1994).

If the play therapy is unsuccessful then psychological difficulties resulting from sexual abuse may persist into adulthood. Other persistent traits that are common in sexually abused victims are flat affect, withdrawn social skills, and hypervigilance towards their surroundings and other people.

Group Therapy

More recently, group therapy or group support has become an area of study in CSA survivors (Hembree & Foa, 2003). Although the literature on the topic is limited, it has been argued that group formats provide important benefits for survivors of CSA, such as mutual support and the opportunity to learn from shared experiences. Therefore, group sessions may be more useful than individual therapy and psychological debriefing after trauma (Hembree & Foa, 2003). Individuals participating in a study attributed the success of group programs to the fact that they felt well received by other members of the group given that they had endured similar experiences. Hembree and Foa (2003) also argue that

unlike group sessions, there is no evidence to suggest that individual debriefing after trauma actually prevents subsequent trauma-related psychopathology.

In a long-term study which assessed the interpersonal functioning of women after group therapy, the results overall were positive for group treatment. In this study, the participants were made to engage in a time determined, intensive group therapy treatment. They were informed beforehand that they would be confronting issues that they were actively trying to repress (Vaa, Egner, & Sexton, 2002). Client symptoms of CSA reduced dramatically from pre- to post-treatment. This was particularly true for those who were highly symptomatic (i.e., poor social interaction as well as multiple psychological sequelea). After the multimodal group therapy sessions, many of the participants continued with follow-up sessions. Most importantly, interpersonal functioning was shown to improve with post-treatment follow-up sessions (Vaa, Egner,& Sexton, 2002). It appears that long-term group therapy had positive effects for these women in terms of improved interpersonal functioning.

Taken together, the literature reviewed on treatment of CSA suggests that although medication may have positive effects in the treatment of anxiety, it has limited use for presenting concerns related to trust. In regard to individual therapy, there are some inconsistencies regarding the effectiveness in treating intimacy concerns after CSA. Some of the literature states that therapy is effective whereas other studies indicate that therapy is not effective. In general, studies have shown that group therapy can be effective for individuals with interpersonal difficulties. Given the mixed findings described above, more research is needed to compare the efficacy of medication, psychosocial therapies, and combined modalities of treatment in increasing relationship

satisfaction in individuals with histories of CSA (Hembree & Foa, 2003). The proposed research project is designed with that purpose in mind.

The Proposed Project

This study is designed to assess interpersonal trust and sexual functioning of adults who were sexually assaulted as children based on the type of treatment or therapy they received. The research question addresses whether or not receiving treatment for sexual abuse in childhood contributes to more trust and sexual satisfaction in adulthood compared to those who do not receive treatment

Definition of Terms

Sexual Abuse

Childhood sexual abuse is defined as the unlawful engaging of an individual age 18 or younger in any type of sexual act. Sexual acts can be any tactile, genital, oral, or anal manipulation of the person age 18 or under. Sexual abuse includes forcing the individual to reciprocate the aforementioned actions.

Pre and Post Puberty

For the purposes of this study, the age of onset of abuse will be assessed at two age ranges (pre-puberty and post-puberty). Puberty is the sexual maturation that signals the beginning of reproductive potential in human beings. The most dramatic sign of puberty in girls is the onset of menarche which typically happens between the ages of 11 – 13 years old with the mean age being about 12. 8 years of age (Pinyerd & Zipf, 2005). For boys, pubertal onset is evidenced by an increase in testicular size which may occur

between the ages of 9.5-13.5 years. The mean age for puberty in males however is 12 years old (Pinyerd & Zipf, 2005). For the proposed study, pre-puberty is defined as ages 12 years or under, and post puberty will be defined as ages 12 years and older.

Therapy

Therapy is defined as psychosocial/psychotherapeutic counseling provided by a licensed mental health professional. The therapeutic interventions may be conducted on and individual basis, or in the form of group therapy. Medication treatment involves the individual taking prescribed medications.

Interpersonal Functioning

Finally, trust is defined as how much faith or confidence the individual has in their partner or in their close relationship. Sexual satisfaction (i.e. feelings of closeness to partner before, during, and after sex) refers to, the ability to engage in sexual activities and the ability to enjoy those activities.

Rationale

As indicated above, the current study will examine the relationship between treatment modalities for CSA and satisfaction with adult interpersonal functioning. In pursuing this research question, several factors that warrant consideration have been identified in the literature including age of onset of abuse, age when treatment was received, and type of treatment received.

Age of onset of abuse is an important variable as it may effect the development of psychopathology. Burman, Stein, Golding, Sielgel, Sorenson, Forsythe, & Telles (1988) reported that sexual abuse survivors who were victimized before the age of 15 years were more likely to suffer from mental disorders than those abused slightly later. In that same

year, Peters' (1988) findings failed to support Burman et al. (1988) in that he found that older age of onset had a more substantial negative impact than if the individual was abused earlier. His results indicate that individuals abused at an older age developed the same pathologies as their younger counterparts; however, they had increased risk of depression and drug abuse (Bartoi, Kinder, & Tomianovic, 2000). However, other studies have been inconclusive in their efforts to determine if the role of age is a significant factor in the psychological effects of CSA (Bartoi et al., 2000).

Another factor that warrants attention is age when treatment was received. It has been postulated that the earlier treatment is initiated then the better the prognosis will be. The idea is to decrease the length of time in which an individual has to suffer with symptoms such as depression or PTSD (Davis & Petretic-Jackson, 2000). The earlier the intervention in is implemented the less the individual with will engage in self-blame and distrust of others, therefore reducing future relationship satisfaction (Vaa, Egner, & Sexton, 2002).

Another factor of importance is the type of treatment received. Very little is known about the significance that the different types of treatment have on adult trust in interpersonal relationships**.** There are several modalities of treatment for the effects of CSA, including individual therapy, pharmacotherapy, and group therapy. As previously mentioned, there is no evidence to suggest that the use of medication is helpful in improving trust on relationships. More research has been conducted in the areas of individual and group therapies. Studies have found individual therapy to be effective in treating the psychological impact of CSA, such as PTSD, but very little improvement in interpersonal functioning is seen (Nurcombe et al., 2000). The inability to develop

intimate relationships may pose an obstacle to any form of treatment since the development of intimate relationships is critical to treating CSA (Briere, 1992). There is some evidence to suggest that group (interpersonal therapy) is effective in improving intimate relationships and relationship satisfaction. Several studies conducted on women in group setting have noted dramatic improvements in their ability to develop and maintain satisfactory relationships (Vaa, Egner, & Sexton, 2002; Hembree & Foa, 2003; & Talbot, Conwell, O'Hara, Stuart, Ward, Gamble, Watts, & Tu, 2005).

In a similar vein, there is evidence that CSA affects adult sexual functioning. However, few studies have compared the effectiveness of different treatment modalities on adult sexual functioning and interpersonal satisfaction. Therefore, the present is designed to explore what forms of intervention are most effective in increasing trust in interpersonal relationships and sexual functioning in adulthood, and at what ages they seem to have the greatest effect.

The two independent variables in this study are type of treatment received (medication, individual psychotherapy, or support/group therapy) and age of onset of CSA (pre-puberty or post-puberty). The dependent variables are interpersonal trust and sexual functioning.

Research Questions

One question addressed in this study is whether having any type treatment at all will make a difference. Also, if having treatment is found to make a difference in perceived trust in intimate relationships, and what modality of treatment (i.e., individual, pharmacological, or group therapy) is most effective? Finally, if a difference is discovered, will treatment contribute to more trust in close interpersonal relationships, or

will the difference be primarily of a sexual nature?

Age of onset of abuse is also a major focus of the proposed research project. The scant literature that has broached the subject has been rather inconclusive, therefore suggesting a need to further research the topic. The age at which an individual was abused may play a significant role in the prognosis for social and intimacy functioning. The results of the proposed research may provide implications for therapists and mental health professionals in their treatment of survivors of CSA. That is to say that therapeutic interventions may have the potential to be more tailored to the specific nature of CSA based on whatever modality of treatment is found to be the most effective in increasing sexual and emotional intimacy with this population.

Method

Participants

The goal is to recruit 180 men and women who report CSA who will fall into the following groups in approximately equal numbers: 1) individuals who received individual therapy or counseling with a licensed mental health professional, 2) individuals for whom medication was prescribed by a licensed physician or psychiatrist to assist in coping with their abuse (e.g., Lithium, Wellbutrin, Seroquel, SSRIs, MAOIs, etc.), and 3) individuals who participated in support groups or group therapy for survivors of CSA. In addition to being divided by treatment category, the sample will also be divided according to whether they report that the abuse occurred over a single or multiple episodes.

Based on guidelines described by Cohen (1988), a minimum of 180 participants will be assessed to detect a medium effect with a power of .85. As mentioned earlier, significantly more women than men choose to seek treatment for sexual abuse. Ideally,

the sample size will illustrate this trend.

Research participants will be recruited via the Internet. The researcher will post electronic invitations into public chat rooms that center on topics of a sexual nature, including past abuse. It is thought that individuals who voluntarily choose to enter these chat rooms and discuss such topics might be appropriate participants. Self-selected participants who click on the link (i.e., invitation to participate) will be presented with an information page that provides basic information about the purpose of the study in a manner that does not excessively jeopardize the integrity of the study (See Appendix A). On the information page the participant will have to electronically "sign" that they are at least 18 years of age by clicking on the *submit* button. Participants are free to withdraw at any point during the completion of the surveys; however, participants cannot withdraw once the surveys have been submitted.

Materials and Procedure

Once the participant has read the information page, if they still choose to participate in the research then they may progress to the next page, which will be the cover letter (See Appendix B). The opportunity to participate will also be made available to students at Barry University. To preserve anonymity, the researcher will post the same invitation (i.e. the same one that will be posted in the chat rooms), on the Barry University Undergraduate Website. They will be directed to the link for the study, and will read the same information page. From there, the student may choose whether or not they want to participate, if qualified. Extra-credit will not be made available for participation in this study. This is because there is no way for the participant to receive extra-credit and maintain the anonymity of their participation in this research project.

All surveys will be completed using the Survey Monkey software. This program is designed for conducting research on the internet. All data that is gathered will remain anonymous, as no identifying information will be requested. Survey Monkey is a secure data base, such that only the primary researcher and advisor may have access to the information gathered from the surveys.

Trust Scale

To assess interpersonal trust, the Trust Scale will be utilized. The Trust Scale was developed by Rempel, Holmes, & Zanna (1985) in order to measure levels of trust in close interpersonal relationships. The 26 items in the Trust Scale represent three domains: predictability, dependability, and faith. The items in the predictability domain were designed to measure perceptions of consistency and stability in the relationship. The items in the dependability domain were constructed to measure perceptions of confidence in the relationship in situations of potential risk for being hurt. Items in the faith domain measure perceptions related to confidence regarding responsiveness and caring by the partner. The 26 items are on a 7-point scale in which a rating of -3 represents "strongly disagree", 0 represents neutral, and 3 represents "strongly agree" (Rempel, Holmes, & Zanna, 1985). Overall reliability for the trust scale as used for both men and women yield a Cronbach's alpha of .81. Individual subscales of faith, dependability and predictability have reliabilities of .80, .72, and .70 respectively (Rempel, Holmes, & Zanna, 1985).

Sexual History Form

To assess the sexual functioning of the participants in this study, the Sexual History Form (SHF) will be used. This is a multiple choice questionnaire that is used to assess sexual functioning in both men and women on the basis of frequency of sexual

activity, desire, arousal, orgasm, and pain (Creti, Fichten, Amsel, Brender, Schover, Kalogeropoulos, & Libman, 1998). It has been widely used in sex therapy clinics and in clinical trials evaluating the efficacy of sex therapy (Creti et al., 1998). The current, psychometrically validated version of the questionnaire contains 46 items which will also be administered to participants via the Internet (See Appendix D). Because some of the questions are related only to men while others relate only to women, only twelve of the questions are used to calculate global sexual functioning. Those questions are answered on a scale from 1 to 9. Each individual score is then divided by 9. The global functioning score will be the result of summing all twelve proportions and dividing by the number of items. This will yield a global sexual functioning score greater than zero and less than one, where lower scores equal better functioning (Creti et al., 1998). Cronbach's alpha for male global sexual functioning is .65 whereas chronbach's alpha for female global sexual functioning is between .50 and .70 (Creti et al., 1998). Although there is minimal psychological risk from completing this questionnaire, some participants may be uncomfortable answering questions about their sexuality. In light of this possibility, participants will be provided with information including phone numbers related to mental health resources that they can access in the event that they experience any discomfort as a result of completing the SHF or any of the other questionnaires included in the study. Specifically, participants will be provided with the contact information of major counseling hotlines in Florida and nationwide.

Finally, a demographics questionnaire will be included to obtain the background information of the participants (See Appendix E). Demographic information will include the individuals age, gender, and marital status. In addition to this information, questions

will be asked regarding the age at which sexual abuse started, how many times he or she has been sexually abused, what type of treatment the person received, and the relationship of the perpetrator to the CSA survivor. As stated above, participants will be provided with information including phone numbers related to mental health resources that they can access in the event that they experience any discomfort as a result of completing the demographic questionnaire or any of the other questionnaires included in the study.

Design and Analysis

A two (age of onset) x three (treatment type) multivariate analysis of variance (MANOVA) will be computed to assess the presence of differences in interpersonal trust and sexual functioning according to age of onset, treatment type received, or relevant interactions between the two. Age of onset will consist of two levels (i.e., pre-puberty and post-puberty), while treatment type will consist of three levels (i.e., individual therapy, group therapy, and medication).

To investigate main effect for treatment type, cells will be compared vertically. Also, to determine main effects for age of onset cells, will be compared horizontally (see Figure 1-1).

Individual Therapy	Medication	Group Therapy	
18	8	3	Pre –puberty (ages 1-11)
9	2	1	Post-puberty (ages 12 to 17)

Figure 1-1: This matrix illustrates the 2 x 3 factorial based on the two proposed independent variables. There are three levels of treatment type, and two levels for degree of abuse.

Hypotheses

H1: It is expected that there will be a main effect for treatment type. Those that participated in either type of psychotherapy (i.e., individual and group therapy) will score significantly higher on the sexual functioning scale and on the interpersonal trust scale than those that were treated by medication alone.

H2: Furthermore, it is expected that group therapy will have a greater effect on interpersonal trust scale scores than will individual therapy. This prediction is based on the idea that the social support offered in group treatment should facilitate the development of more trust in personal relationships. As such, it is expected that social support will be a more powerful factor in adult relationship satisfaction and functioning than individual attention in the form of individual therapy.

H3: There will also be a main effect for age of onset of abuse. Those who were sexually abused before the onset of puberty will have lower sexual functioning scores than those who were abused after puberty started. This is hypothesized because of the temporal relationship present between the onset of sexual abuse and the individual's sexual development.

H4: There will be an interaction between group therapy and pre-puberty as those individuals will report higher scores on the sexual functioning scale and on the interpersonal trust scale.

Results

The sample size consisted of 41 participants (N = 41). Of the 41 participants, 37 were female and 4 were male. Treatment type breakdown revealed that 27 participants had received individual therapy, 10 received medication, and 4 received group therapy. Furthermore, 29 of the participants were in the pre-puberty category, whereas 12 were in the post-puberty category. Figure 1-2 provides a visual representation of the sample distribution.

Individual Therapy	Medication	Group Therapy	
18	8	3	Pre –puberty (ages 1-11)
9	2	1	Post-puberty (ages 12 to 17)

Figure 1-2: Sample distribution across variable.

A one-way multivariate analysis of variance (MANOVA) was conducted to determine the effects of three types of treatments (individual therapy, group therapy, and medication) on the two dependent variables (sexual functioning and trust in relationships). There were no significant differences found among the three types of treatment on sexual functioning and trust.

Analysis of variances (ANOVA) was conducted on each dependent variable as follow-up tests to the MANOVA. The Bonferonni Method was used to test each ANOVA at the .025 level.

All analyses computed were found to be nonsignificant. Analyses revealed no significant differences in effect of treatment type upon sexual functioning and trust.

Given that main effects were non-significant, post hoc analyses were not appropriate and were not performed.

Discussion

It was expected that treatment type and age of sexual abuse (pre versus post puberty) would have an effect on sexual functioning and trust among adult survivors of CSA. The results of the study did not support the hypotheses. There were no significant differences among the three treatment types (individual, group and medication) and their influence on sexual functioning and trust in intimate relationships among adult survivors of childhood sexual abuse. The lack of differences found among treatment types may be due to the fact that treatment type and age of onset of CSA do not influence interpersonal functioning among adults with a history of CSA. However, there is also the possibility that the lack of differences reported in the current study may be due to three important limitations of the study; small sample size, the eligibility criteria for participation in the study, and the final distribution of participants across treatment groups..

The most noteworthy of the three limitations was the limited sample size. The small sample size can be attributed to many factors. One potential factor is the impersonal nature of recruitment of participants that is often associated with online research. In the present study, less than 50% of the ideal number of subjects volunteered to participate in the present study. The lack of ideal participation in the study may have been due in part to difficulties in recruiting participants via online chat rooms and invitations. The impersonal nature of these online invitations posted on websites and chat rooms may have affected the motivation and desire of potential subjects to participate in

the study. It is important to note that due to the online nature of the recruitment of participants, subjects were not offered any form of incentives for their participation in the study. The lack of incentives offered and impersonal nature of recruitment on such a sensitive topic (childhood sexual abuse) may have contributed to a lack of motivation to participate in the study.

The sensitive nature of the research topic itself may have been an important contributing factor to the limited participation of subjects that met the inclusion criteria., Information regarding childhood sexual abuse requires self-reports from the survivors. Considering the sensitive nature of the topic, collecting data via the Internet was intended to allow individuals to participate and share their experiences in a totally anonymous, confidential, and safe environment. However, it appears that individuals were reluctant to participate in this study even though they were guaranteed complete anonymity. Given that survivors of CSA may experience residual emotional distress from their childhood experiences, perhaps many individuals avoided participating in the present study because of their belief that participation in the study would remind them of the emotional turmoil surrounding their sexual abuse. In fact, one common symptom of posttraumatic stress disorder, a condition often encountered in survivors of CSA, is the avoidance of stimuli that may remind the victim of the abuse.

Another factor that may have affected the sample size is the amount of time allotted to data collection. Data for the present study was conducted over a six-month period. This may not have been enough time to collect data for such a sensitive topic. Given the notion that many CSA survivors may have been reluctant to participate due to the sensitive nature of the topic, a more extended period of time to collect data may have

been warranted. Allowing more time for data collection may have increased the likelihood of reaching more participants that feel more comfortable completing surveys regarding sensitive topics such as their sexual functioning.

A second important limitation of the study was the eligibility criteria for participation. The eligibility criteria stipulated that participants must be in a current romantic relationship in order to participate in the study. Feedback in the form of emails from individual interested in participating in the study revealed that several participants with a history of childhood sexual abuse were not in a current relationship at the time of the study, and thus did not meet the inclusion criteria. Several potential participants reported their desire to participate in the study, as well as their disappointment that they could not be included in the study due to their relationship status (i.e., were not in a relationship at the time of the study). While more individuals completed the surveys than those who were represented in the results, only those participants who met all of the inclusion criteria (as mentioned above) were used. The feedback from potential participants that did meet the inclusion criteria suggests that a larger sample size may have been obtained by broadening the eligibility criteria to individuals with a history of CSA that had been in a romantic relationship at some point in the past two years.

A third limitation to the present study that may have affected the lack of differences found among treatment type on sexual functioning and trust was the final distribution of participants across treatment categories. There were substantially more individuals in the individual therapy category than in the group therapy and medication categories. As a result, the data were not distributed in a manner that would allow detection of significant differences between the treatment groups on the two dependent

variables.

It is very difficult to establish proper effect size with such a small sample size (N = 41). The small sample size undoubtedly affected the power and thus the sensitivity of the statistics employed to detect differences among treatment groups and the dependent variables. Therefore, no definitive conclusions can be made regarding the influence of the different types of treatment on trust and sexual functioning among adult survivors of childhood sexual abuse. Further testing with less time restrictions and a larger sample size will be useful in determining whether such differences really exist and their potential implications for future research and treatment planning

It may be beneficial for future studies on adult functioning and childhood sexual abuse to explore gender differences in the sexual functioning and trust of CSA survivors. In the present study some participants were abused by family members whereas others were sexually abused by non-relatives. Future studies may explore whether or not the relationship of the CSA survivor to the abuser (relative versus non-relative) makes a significant contribution to the quality of intimate relationships of adult CSA survivors.

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