Abstract

How Childhood Sexual Abuse affects Adulthood Relationship Satisfaction in Women

by Megan Erin St.Aubin

April, 2010

Director: Elizabeth Carroll, JD

DEPARTMENT OF CHILD DEVELOPMENT AND FAMILY RELATIONS

Participants were 83 women between the ages of 18 and 25 years enrolled at a university. The present study examined how childhood sexual abuse (CSA) affects adulthood relationship satisfaction in women. Data were collected via Perseus, an online survey program. Two surveys were used to collect data, one that collected information about childhood sexual abuse history and the Relationship Assessment Scale (RAS). Findings suggest that trust and communication are common issues in relationships among individuals who have experienced abuse. Depression and withdrawal are also prevalent in childhood abuse victims. Results are discussed within the context of Finkelhor and Browne's Traumagenic Dynamic Model, which accounts for the effects of childhood sexual abuse. Depression, PTSD, night terrors and withdrawal were all evident in victims of childhood sexual abuse. This can be accounted for by Finkelhor and Browne's Betrayal dynamic that focuses on the trust that was broken as a result of someone the victim knew and trusted. PTSD and night terrors are often effects of CSA and can explain why they were evident among the female participants. Withdrawal can be a combination of the abuse itself or of the betrayal of a person that the victim knew and trusted. The RAS did not show any significance in relationship satisfaction and could be because of the length of time that has passed along with professional help.

*Keywords***:** child sexual abuse, depression, marital satisfaction, sexual abuse, child abuse, sexual function, sexual satisfaction

How Childhood Sexual Abuse affects Adulthood Relationship Satisfaction in Women

A Thesis

Presented To

The Faculty of the Department of Child Development and Family Relations

East Carolina University

In Partial Fulfillment

of the Requirements for the Degree

Masters in Science

by

Megan Erin St.Aubin

April, 2010

How Childhood Sexual Abuse Affects Adulthood Relationship Satisfaction in Women

by

Megan Erin St.Aubin

APPROVED BY:

DIRECTOR OF THESIS:_____

Elizabeth Carroll, JD

COMMITTEE MEMBER:_____

Sandra Triebenbacher, PhD

COMMITTEE MEMBER:_____

Blace Nalavany, PhD, LCSW

CHAIR OF THE DEPARTMENT OF CHILD DEVELOPMENT AND FAMILY RELATIONS

_____

Cynthia Johnson, PhD

DEAN OF THE GRADUATE SCHOOL:

_____

Paul J. Gemperline, PhD

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: Introduction

One of the most basic human and fundamental parts of intimate interpersonal relationships is sex (Arrington, Cofrancesco & Wu, 2004). Childhood sexual abuse (CSA) can alter that basic function and fundamental part of life such as self-perception. Self-perception is important in shaping sexual attitude in some individuals. Consequently, this altered self-perception negatively impacts interpersonal relationships (Arrington, Cofrancesco & Wu, 2004). CSA victims often have an altered view of both sexual activity and intimate relationships in general. This can result in the fear of an individual wanting to be involved with another individual.

CSA is a serious crime in our country and affects more than individuals realize (Summit, 1983). According to Gorey and Leslie (1997) prevalence estimates for child sexual abuse range from 3% to 62% in the general population. Estimates of the prevalence of childhood sexual abuse in the female population ranges from 15% to 33% (Polusny & Follette, 1995). Abuse can come in many forms including physical, sexual, emotional and financial. The most common form of abuse is sexual abuse and according to Haverkamp and Daniluk (1993) "sexual abuse of children is most frequently perpetrated by males upon females, with stepfather or biological father/daughter molestation being the most commonly reported form of sexual abuse" (p. 134). Siblings, extended family members, and stepmothers can be perpetrators as well. Not limited to females, males can be victims of abuse as well. Approximately "13%-16% of all men in this country were sexually abused during childhood" (Polusny & Follette, 1995, p. 143).

The most significant predictors for CSA are family characteristics (Alexander, 1992). Specifically, the absence of a biological parent, maternal availability, marital conflict and violence, the child's poor relationship with the parents, and the presence of a stepfather are key

characteristics involved in abuse. Second, a variety of family variables are associated with the long-term effects of child sexual abuse over the abuse itself. The way the family handles the allegations is associated with long-term effects. For instance, "family variables such as conflict and decreased cohesion among family members accounted for more of behavior problem among a sample of abused children than the severity of abuse, duration of abuse, and time elapsed since the abuse (Alexander, 1992). Other abuse-associated symptoms, according to Davis and Petretic-Jackson (2000) include: dissociation, anxiety, sexual dysfunction, sleep disturbance, anger/hostility, substance abuse, revictimization, low self-esteem and self-concept impairment, depression, self-blame, guilt, helplessness, self-mutilation, suicide, posttraumatic stress responses, obsessions and compulsions, and somatization. These effects can affect a relationship negatively because most of these symptoms can affect the victim in such a manner that can make them feel inferior within a relationship context. The most prevalent abuse symptoms will be discussed further within the article.

Relevance

Sexual abuse during childhood not only affects the individual but also the family unit as a whole. CSA affects the child's ability to have a secure attachment with his/her family members at the time of the abuse as well as future family members. Marriage and childbearing can bring up very traumatic events for CSA victims because as a child the victim may have lacked a healthy attachment with her own mother. Instead of being nurtured as a child, the parents who should have supported him/her ended up betraying him/her. Women who have experienced abuse beginning in childhood, particularly sexual abuse, are less likely to be in sustained marriages or stable cohabiting relationships and instead are more likely to experience

transitory unions (e.g., multiple short-term cohabiting unions with brief intervals between them) (Cherlin, Burton, Hurt & Purvin, 2004).

What is Child Sexual Abuse?

For the purpose of this paper child sexual abuse is defined as "the engagement of a child in sexual activities for which the child is developmentally unprepared and cannot give informed consent" (Draucker & Martsolf, 2008, p. 1034). Sexual abuse can take place between male to female, male to male, female to male, and female to female. This paper will focus on females who were sexually abused as a child by a man known to the victim. The abuse can be from a family member (e.g., parental figure, sibling, aunt, uncle, etc.) or a friend. More often the abuser is someone the victim knows and trusts. Trust is a very important dynamic that is affected and more detail will follow in the literature review.

CHAPTER 2: Literature Review

This literature review is based on a synthesis of systemic research synthesis by Rothman, Damrom-Rodriguez and Shenassa. A Systematic Research Synthesis (SRS) is "a procedural amalgam that uses structured protocols reflected in meta-analysis together with the flexible integrative qualities of the traditional review" (Borcherdt, Kilty, Richardson, Segal, Daley, Francis, Company, Press, Rothman, & Thomas, 1994, p. 137).

The SRS process included several stages (Rothman et al., 1994). Databases including Google Scholar, JStor, ERIC, PsychINFO and EBSCO were searched (1981 to the present) using the following key words: child sexual abuse, depression, marital satisfaction, sexual abuse, child abuse, sexual function, and sexual satisfaction. I also searched the more pertinent journals related to child sexual abuse, such as, *Child Abuse & Neglect, Child Maltreatment, Journal of Consulting and Clinical Psychology, Journal of Marriage and Family, Social Service Review, Journal of Child Sexual Abuse,* and *Family Relations*. A total of 37 studies were retrieved.

Effects on the Individual and Family

Sexual abuse during childhood affects an individual far longer than one can imagine. Not only does the child suffer symptoms such as post-traumatic stress or fear, sexually abused victims can face greater problems as an adult. Bogar and Hulse-Killacky (2006) reported that "survivors of repeated trauma, such as ongoing childhood sexual abuse, develop personality changes that result in the individual experiencing problems with even social problems with relationships and with identity" (p. 318). As the child transitions to adulthood, the foundation needed to develop appropriate adult to adult relationships is missing due to the betrayal from childhood. Relationships often suffer because that basic foundation based on attachment, on

which new relationships need to be built, was damaged during childhood. Chronic abuse may include a general impairment in interpersonal relationships that persist into adulthood (Baker & Duncan, 1985). The effects are not only pertinent to the individual but can affect both family and friends. Systemically CSA affects the individual as well as the family unit as a whole. Typically when abuse occurs there is more than just the physical or sexual abuse. Often times there is mental or emotional abuse that coincides with the physical aspect of abuse. As the victim faces the effects of abuse, the family does as well because the family has to learn to cope with the victim's history of abuse.

Since males are more likely to abuse females, there is a sense of power or dominance involved. According to Alexander (1992), "parental conflict, paternal dominance, and sexual abuse were all significantly related to psychological distress, dissatisfaction with current relationships, and lack of perceived social support" (p. 185). According to Briere (1992), individuals also can experience "posttraumatic stress, low self-esteem and guilt, anxiety, depression, dissociation, eating disorders, sexual problems, substance abuse, and suicide" (p. 196). CSA is viewed as a traumatic experience; however no single symptom is universal (Testa, VanZile-Tamsen, Livingston, 2005). While the effects on an individual can be extreme, the effects will vary from individual to individual. Some "reactions by victims are mild while some are life-threatening" (Feinauer, Middleton & Hilton, 2003, p. 201). These reactions can vary from simple anxiety problems to suicide and revictimization. The following section will discuss short and long-term effects of childhood sexual abuse for the individual as well as the family. Systematically, these effects will affect individuals differently both individually and within the context of the family. The present study, explored how childhood sexual abuse affected interpersonal relationships.

Short-term Effects on the Individual and Family

Short-term effects are those effects that occur right after a traumatic event, normally within the first six months. While these short-term effects may occur immediately after the traumatic event, they can last longer than six months and can be considered a long-term effect. The reason they are described as being a short-term effect is because of the onset of when the effect occurs. While long-term effects take longer to develop, short-term effects are normally immediate. Initial reactions to CSA involve posttraumatic stress, disruptions of normal psychological development, emotional pain, and cognitive distortions. The three primary reactions that the present study focuses on are Posttraumatic Stress Disorder (PTSD), emotional pain and cognitive distortion because all three of these can be related to relationship satisfaction.

Posttraumatic Stress. Posttraumatic stress refers to "certain enduring psychological symptoms that occur in reaction to a highly distressing, psychically disruptive event" (Briere & Elliott, 1994, p. 55). Some symptoms of PTSD include (1) frequent reexperiencing of the event through nightmares or intrusive thoughts, (2) a numbing of general responsiveness to, or avoidance of, current events, and (3) persistent symptoms of increased arousal, such as jumpiness, sleep disturbance, or poor concentration. A prominent characteristic of PTSD are flashbacks. Flashbacks include "sudden, intrusive sensory experiences, often involving visual, auditory, olfactory, and/or tactile sensations reminiscent of the original assault, experienced as though they were occurring in the present rather than as memory of a past event" (Briere & Elliott, 1994, p. 56). Triggers of flashbacks can include sexual stimuli or interactions, abusive behavior by other adults, disclosure of one's abuse experiences to others and reading or seeing sexual or violent media depictions.

Other PTSD symptoms that deal with thoughts and recollections include: repetitive, intrusive thoughts and/or memories of childhood sexual victimization—difficulties that many survivors of sexual abuse find both distressing and disruptive. These thoughts, images, and memories can affect an individual negatively. Since being with a partner involves intimate relations, such events could cause a victim to relapse into the vivid memories of their abuse.

Emotional Pain. Emotional pain includes depression, anxiety, anger and sexual dysfunction. All of these emotions can be both short-term and long-term effects of CSA. Although depression is most commonly reported among CSA victims, both anxiety and anger are also symptoms. Child abuse is both threatening and disruptive and may interfere with the "child's developing sense of security and belief in a safe and just world" (Briere & Elliott, 1994, p. 57). Anger, in children, is frequently expressed in behavioral problems, with abused children and adolescents displaying significantly more difficulties in this area than what are found typically in the general population. Another emotional pain suffered by CSA victims is sexual dysfunction. This can be both a short-term and long-term effect of CSA. CSA can create fear in the victims and this can be the fear of sexual intercourse because of the traumatic experiences during childhood. For adults, this can develop more into an association between sexual stimuli and pain (Briere & Elliott, 1994).

Cognitive distortion. Perceptions of helplessness and danger are thought to be a result from the fact that the child abuse occurred during the time when a child is helpless and cannot defend himself/herself against the abuser. The most predictable outcome of this dynamic is the victim's growing assumption that he or she has no other option and therefore experiences chronic ongoing, feelings of hopelessness regarding the future. Also the child may make assumptions about his or her inherent badness or misinterpretations of the maltreatment blaming him/herself.

Long-term Effects on the Individual and Family

Long-term effects are those effects that take a longer time to manifest and may not be present until adulthood. Some effects that CSA has on a relationship include difficulty with "interpersonal relationships and trust, anxiety and fear, sexual disturbance, depression and revictimization" (Leonard & Follette, 2002; Maniglio, 2009; Merrill et al., 2003; Roesler & McKenzie, 1994).

Anxiety and Fear. There is some evidence that women with a history of CSA suffer from generalized emotional symptoms such as fear, anxiety, and depression. CSA victims are "more likely than nonabused individuals to report fear of men, anxiety attacks, and problems with anger" (p. 106). Anxiety has been found to be more common among intrafamilial CSA victims. Anxiety was also significantly associated with a history of interfamilial but not extrafamilial sexual abuse. While anxiety symptoms among adult women appear to be associated with a history of CSA, it is not clear that this effect is independent of force or the threat of force at the time of the sexual abuse.

Depression. Women with a history of CSA were significantly more likely than victims who had not experienced CSA to experience a major depressive episode and to have more depressive episodes. Depression is one of the major disorders for which CSA victims are treated (Beitchman et al., 1992). Both depression and self-harm are reported significantly higher among CSA victims than among nonabused victims. The role of the child's family, especially the child's perception to the mother's response to the abuse and the degree of parental support, may be important mediating factors between CSA and depressive response in adulthood. Another indicator and onset of depression is the use of alcohol since it is a natural depressant. CSA

victims run the risk of developing substance abuse problems in later life (Downs & Harrison, 1998; Lee, Lyvers & Edwards, 2008).

More importantly, CSA has been associated with higher levels of alcohol symptoms in females. CSA victims who have a problem with substance abuse have "long been interpreted as a maladaptive coping mechanism for managing negative self-directed feelings resulting from their trauma" (Lee, Lyvers & Edwards, 2008, p. 350). According to Kessler and Magee (1994) childhood adversities also have been used to "predict adult depression, such as helplessness, low self-esteem, and interpersonal dependency" (p. 13). The problem with depression is that it tends to reoccur and this is prevalent with individuals who have experienced trauma at some point during their life (Kessler & Magee, 1994). Depression also leads to substance abuse and may be a means to block out and detach from their traumatic experiences (Lee, Lyvers & Edwards, 2008). In a study of childhood adversity in drug and alcohol dependent women, "51% of participants disclosed severe forms of CSA (including oral, anal or vaginal sexual penetration)" (Lee, Lyvers & Edwards, 2008, p. 350). CSA victims also experience depression, which is a major factor in numerous sexual dysfunctions (Meston, Rellini & Heiman, 2006).

Revictimization. Women are twice as likely to experience sexual abuse in adulthood if they were sexually abused as a child (Polusny and Follette, 1994). It has been suggested that the association between CSA and revictimization may be due to factors that force victimized children of the family out into high-risk situations for wife abuse or rape. CSA may also have a negative effect on self-esteem, therefore making women conspicuous targets for sexually exploitative men. Another variable that may expose women to vulnerable states is personality variables, such as a sense of worthlessness and self-blame. These variables could lead women to be revictimized or give them a reason to have a low self-esteem/low self-worth (Beitchman et al.,

1992). Meston, Heiman and Trapnell (1999) found that sexual abuse was associated with more promiscuous sexual attitudes and behaviors. For an example, high frequency of intercourse and masturbation, more explicit fantasies, and a greater chance of engaging in risky sexual behavior (Meston, Heiman & Trapnell, 1999).

Sexual Dysfunction. Meston and Heiman (2000) suggest victims of child sexual abuse often face "negative attitudes toward sexuality and intimate relationships in general" (p. 399). According to Leonard, Iverson and Follette (2008), sexual problems arise in women reporting CSA. Healthy sexual functioning is considered to be important for adults (Beitchman, Zucker, Hood, DaCosta, Akman & Cassavia, 1992). Child sexual abuse can result in some form of adult sexual disturbance or dysfunction and often makes the victims describe themselves in a negative manner. As a result, the victim often is 'less positive about sexual behavior' (Meston & Heiman, 2000, p. 405). According to Beitchman et al. (1992), "87% of 23 child sexual abuse victims reported being frigid, confused about their sexual orientation, or promiscuous" (p. 103). Beitchman et al. (1992) states that 40% of the CSA victims in the sample reported problems of sexual adjustment and that the lifetime prevalence of specific sexual disturbance reported by women indicated that 36% had a fear of sex, 32% had less sexual interest, and 36% had less sexual pleasure. DiLillo and Long (1999) stated that survivors "experience a variety of sexual problems, including decreased sexual satisfaction, increased sexual dysfunction, and a tendency to engage in multiple, short-term sexual relations" (p. 60). The highest rates of sexual disturbance were found in studies examining father-daughter incest or abuse involving penetration. According to Merrill et al. (2003) when a child experiences high levels of "revulsion, fear, anger, or powerlessness during CSA, he or she may be conditioned to associate sex with negative emotions and memories" (p. 987). These negative emotions may generalize

nonsexual experiences in adulthood thus leading to sexual dysfunctions, "including phobic reactions to sexual intimacy and avoidance of sex" (p.987). Avoidance of sex can be problematic for relationships, especially during adulthood when most individuals are beginning to settle down and look for long-term commitments. The fear of sex can lead to a fear of relationships in general because of the victim's past.

Interpersonal Relationships. Research has suggested "child sexual abuse is associated with both initial and long-term alterations in social functioning" (Briere & Elliott, 1994, p. 61). Interpersonal relationships are important to normal development. Healthy interpersonal relationships would include being able to date and marry without implications but child sexual abuse puts a strain on aspects of life that involve attachment (e.g., marriage and child birth). Since the attachment during childhood is strained and often nonexistent, survivors of abuse have a difficult time coping with and managing attachment in adulthood. According to Briere and Elliott (1994) sexual abuse survivors typically report " having less interpersonal trust, less satisfaction in their relationships, more maladaptive interpersonal patterns, and greater discomfort, isolation, and interpersonal sensitivity" (p. 62). The patterns that CSA has on intimacy are profound and can include: (1) sexual dysfunction related to fear and vulnerability, (2) dependency on relationships, and (3) a history of multiple, brief sexual relationships (Briere & Elliott, 1994).

An important dynamic to victims of CSA is betrayal. DiLillo and Long (1999) stated "college-aged incest survivors experienced more problems in the area of dating" (p. 60). This may be due in pun to the face that CSA victims have been betrayed during childhood. Someone they knew and loved did not protect them and the one person that was never supposed to do harm to them did and that trust was broken. According to Briere and Elliott (1994) the "violation and

betrayal of boundaries in the context of developing intimacy can create interpersonal difficulties in many survivors" (p. 62). The betrayal can contribute to abuse survivors seeing themselves as worthless and often having low self-esteem. Cherlin, Burton, Hurt, and Purvin (2004) stated that traumatic events such as sexual experiences can produce feelings of betrayal, lack of trust, powerlessness as well as inappropriate sexual expectations.

According to Baker and Duncan (1985), because of the coercion and secrecy, sexual abuse creates even greater dilemmas for children. This causes a major problem in both sexual and intimate relations because it can cause risky behavior such as multiple partners, revictimization, dependency issues and lack of trust. It is not uncommon for abuse survivors to jump into abusive relationships because that is what the individual has experienced and known. According to Meston, Heiman and Trapnell (1999) forms of abuse are associated with the inability to trust. This lack of trust is the direct cause of the betrayal between the abuser and victim. The lack of trust can be detrimental to a relationship, especially during adulthood. The intimacy problems faced by CSA victims center primarily on vulnerability. This feeling of vulnerability tends to keep the victims from being in relationships. Victims are more likely to remain single or are more likely to divorce or separate spouses than those who have never been abused (Briere & Elliott, 1994). While some CSA survivors are able to establish long-term and healthy relationships, other CSA survivors are extremely fearful and avoid relationships. Ultimately, a substantial number or CSA survivors have difficulty sustaining stable, satisfying, and healthy relationships (Davis & Petretic-Jackson, 2000).

Conceptualization

The theoretical model most referenced in sexual abuse is that of Finkelhor and Browne. They developed a model called the Traumagenic Dynamics Model to account for the variety of symptoms experienced by victims of childhood sexual abuse. According to Feinauer, Middleton and Hilton (2003) a traumagenic dynamic is "an experience that alters children's cognitive and emotional orientation to the world, and creates trauma by distorting children's self-concept, world view, and affective capacities" (p. 203). According to Merrill, Guimond, Thomsen and Milner (2003), "conceptualization of traumatic sexualization suggests that some adults sexually abused as children will engage in sexual activity with many partners, whereas others will engage in little sexual activity and have few partners" (p. 987). Fear of sexual activity as well as an increase in promiscuity can affect relationships satisfaction, more specifically because in both instances, trust is a major issue.

There are four specific dynamics according to Finkelhor and Browne: stigmatization, betrayal, powerlessness, and traumatic sexualization. Below I have discussed the four specific dynamics with a focus on betrayal since it is the most important dynamic to the current study on interpersonal relationships.

Stigmatization

Stigmatization "refers to the negative connotations (i.e., badness, shame, and guilt) that are communicated to the child around experiences and that then become incorporated into the child's self-image" (Feinauer, Middleton & Hilton, 2003, p. 203). The dynamics of stigmatization distorts children's sense of their own value and worth (Finkelhor & Browne, 1985). This can be communicated in many ways such as directly from the abuser (by blaming

the victim of the activity, demean the victim, or furtively convey a sense of shame about the behavior). Stigmatization can come in the form of pressure from the abuser who seeks secrecy about the abuse. People within their family and within the community may also stigmatize children. This could mean that the community, as well as the family, may not believe the victim, criticize or make fun of the victim.

The dynamic of stigmatization is associated with the child feeling isolated and because of the stigma attributed to the victim, they may become involved in drug or alcohol abuse, criminal activity, or prostitution. In the most extreme cases, stigmatization can lead to being self-destructive and suicide attempts. According to Walser and Kern (1996) "adult CSA victims appear to engage in sexual behavior that is not considered acceptable in the U.S., often termed 'promiscuous'" (p. 321). Stigmatization can also be very detrimental to the child's self-image. Childhood sexual abuse distorts children's self-image and often leaves them feeling not worthy of a normal and carefree life. CSA victims who feel unworthy may live a life that is promiscuous which could lead to numerous other problems including and not limited to: drug and alcohol abuse, revictimization, depression, and Sexually Transmitted Diseases (STD's).

Betrayal

Betrayal "refers to the dynamic by which children discover that someone on whom they were vitally dependent had caused them harm" (Feinauer, Middleton & Hilton, 2003, p. 203). Betrayal can come from both the abuser and other family members that did not keep the victim safe from harm. Children may realize that the person who had been trusted manipulated them through lies or misrepresentations (Finkelhor & Browne, 1985). The dynamics of betrayal can also include a family member whom they trusted but was unable or unwilling to protect them or

believe them" (p. 532). Sexual abuse experiences that are between family members or between trusted people have the potential to involve more betrayal than experiences between strangers. The degree of betrayal is based on two factors; the shock of realizing what is actually happening; and the family's response to disclosure. Children who experience abuse have trust issues later in adulthood most especially if they did not have a supportive family. Children who grow up in families with no support network or who have families who deny there was any abuse, grow up to have more trust issues in adulthood and ultimately in relationships.

The grief of the loss of a trusted person can be detrimental to a victim. It is linked with depression. Since trust was lost, an individual may feel the need to try to gain that trust back and in return become clinging and dependent or not trusting at all. This can lead to impaired judgment about the trustworthiness of other people or relationships. Women, especially, are vulnerable and tend to jump into relationships that are physically, psychologically, and sexually abusive. Since victims often yearn to regain their lost trust, they tend to be revictimized because that is all that they know. The grief of loss could also affect the trust within a relationship. If there is a lack of trust, then this could lead to the dissatisfaction in the relationship most especially from the partner that was not abused. The partner may feel that the victim does not trust them and be pushed away.

Conversely, such as "hostility and anger, has been observed among sexually abused girls" (p. 536). Sometimes this barrier of mistrust can become a barrier towards men and towards relationships. Behavior problems, such as antisocial behavior and delinquency, are sometimes associated with victims of sexual abuse but more often it occurs in adolescents of sexual abuse. While most victims are more afraid there are some that are angry and therefore have no interest in relationships and intimacy.

Powerlessness

Powerlessness "refers to the process in which the child's will, desires, and sense of efficacy are continually contravened" (Feinauer, Middleton & Hilton, 2003, p. 203). The dynamic of powerlessness distorts children's sense of their ability to control their lives (Finkelhor & Browne, 1985). Powerlessness occurs in sexual abuse when child's space is repeatedly invaded against his or her will. This is exacerbated when the child tells another individual and nothing changes because the individual does not believe the child. This creates more fear in the child that in turn creates an intense feeling of powerlessness. Threatening a child as well as using force can increase that powerlessness in a child. A child that feels powerless will have difficulty establishing trusting relationships. The feeling of powerlessness can affect how responsive and open an individual is within the context of a relationship. More specifically, whether or not the individual's support group was responsive and supportive will influence how he/she will function within a relationship. If the victim's support network denied the abuse, then the likelihood that the victim will open up in a relationship decreases.

The two factors that come from the dynamic of powerlessness are fear and anxiety. Nightmares, phobias, hypervigilance, clinging behavior, and somatic complaints are often related to children who have been sexually abused. Powerlessness also affects a person's sense of efficacy and coping skills. Feelings of powerlessness have been linked with despair, depression, and suicidal behavior among adolescent and adult victims and it may also be related to environmental factors (i.e., employment) as revictimization.

Traumatic sexualization

Traumatic sexualization "refers to the process in which the child's sexuality is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse" (Feinauer, Middleton & Hilton, 2003, p.203; Merrill, Guimond, Thomsen & Milner, 2003). This can occur when a child is repeatedly sought after for sexual behavior that is inappropriate for his or her level of development. The child learns to use sexual behavior as a strategy for manipulating others to satisfy needs through exchange of affection, attention, privileges, and gifts for sexual behavior. Sexual behavior and morality are transmitted to the child with a negative connotation and the child's anatomy is given distorted importance and meaning. This can occur when very negative and frightening memories and events become associated with sexual activity.

There are many observed effects from sexual abuse that are connected to the dynamic of traumatic sexualization. It has been reported that victims often have an aversion to sex, flashbacks to the molestation experience, difficulty with arousal and orgasm, and vaginismus, as well as negative attitudes toward their sexuality and their bodies" (Finkelhor & Browne, 1985, p.534). Moreover, children seem to display knowledge that is not developmentally appropriate for their age, engage in sexual intercourse or oral-genital contact with school-aged peers and be confused especially regarding sexual identity. Another important notion is how the abuser treated the victim in regards of affection. If the abuser used sex as a means of affection then the victim will have confusion about how to give and receive affection later in adulthood. The victim may see having sex as the only means of giving and receiving affection.

Current Study

CSA is serious and is most often unrecognized. How CSA affects individuals during childhood is substantial and the impact can continue into adulthood and often affects relationships. The purpose of this paper is to examine how childhood sexual abuse affects adulthood relationship satisfaction. The research questions for this study relate to adulthood relationship satisfaction and how CSA can affect an individual's likelihood to function in a relationship. The following questions were asked: (a) Does childhood sexual abuse affect relationship satisfaction in adulthood? (b) What are the outcomes of childhood sexual abuse in adulthood relationships? and (c) How does sexual satisfaction change after experiencing childhood sexual abuse? My hypotheses were drawn from Finkelhor and Browne's Traumagenic Dynamics Model, which includes stigmatization, betrayal, powerlessness and traumatic sexualization. I hypothesized those participants who reported childhood sexual abuse will have more dissatisfaction in relationships due to the many effects that CSA has on an individual. The second hypothesis was drawn from the dynamic of betrayal. Since a lack of trust can often increase the likelihood of substance abuse problems, the present study hypothesized that victims of childhood sexual abuse will experience more substance abuse and depression more often than those individuals who have never been abused. Substance abuse and depression often accompany CSA and can lead to dissatisfaction in relationships.

CHAPTER 3: Method

Sample

The respondents were 83 women from East Carolina University ranging in age from 18 to 25 years. The sample contained 18 (22.8%) participants that had experienced sexual abuse as a child and 61 (77.2%) participants that had no history of child sexual abuse. There were four participants that did not answer the question. Table 1 provides details regarding the sample's ethnicity, marital status, education and annual income level.

Measures

Two measures were used to rate relationship satisfaction in women for individuals who had been sexually abused as a child and for those who had not been sexually abused as a child. There were two measures that were used: the Demographic Survey and the Relationship Assessment Scale (RAS).

Demographic information. The demographic survey collected information about background of the participants. It also asked for regarding whether or not the participant experienced sexual abuse during childhood, ages 0-18.

Relationship Assessment Scale. The second measure focused on relationship satisfaction. The Relationship Assessment Scale (RAS), is a 7-item Likert Scale and has an established reliability .86. The RAS was based on a 5-item Marital Assessment Questionnaire. The RAS made revisions to the Marital Assessment Questionnaire so it could include a more diverse population. Changes included substitution of the word "partner" for the word "mate" and the word "relationship" for the word "marriage" which

Table 1

Demographic information

Characteristics	Percentages	*N*
Ethnicity		
Caucasian	76.8%	63
African American	18.3%	15
Asian	3.7%	3
Hispanic/Latina	1.2%	1
Marital Status		
In a relationship	50 %	41
Single	41.5%	34
Married	8.5%	7
Education		
GED	12.2%	10
Some College	50%	41
Associates Degree	11%	9
Bachelors Degree	23.2%	19
Masters Degree or higher	3.7%	3
Annual Income		
College student/work part time	72.8%	59
Less than $20,000	14.8%	12
$20,000-$30,00	6.2%	5
$30,000-$40,000	2.5%	2
$40,000-$50,000	2.5%	2
More than $50,000	1.2%	1

*1 participant did not answer questions regarding marital status and education (*N*= 82) and there were 2 participants that did not answer the question regarding annual income (*N*= 81).

allowed the scale to be relevant for individuals who were not necessarily married or with a heterogeneous partner (Hendrick, 1988).

The RAS was used in two studies, with the first study consisting of 125 subjects who reported themselves to be "in love." In the second study, the scale was administered to 57 couples in ongoing relationships. An analysis supported the alpha reliability of .86 and was correlated with relevant relationship measures.

Procedure

Permission to conduct this research was approved by the Institutional Review Board (IRB) at East Carolina University. Participants were recruited via announcements posted on Blackboard. Blackboard is an online educational resource that allows professors to post class materials as well as grades. Female college students between the ages of 18-25 met the criteria for the study. The sample consisted of those who had been abused and those who had not who opted to participate in the study. At the bottom of the announcement was a link that directed the participant directly to the survey that was developed though a program called Perseus. Perseus is a web-based application that allows researcher to create, deploy, and analyze web surveys. Once the participant was on the Perseus website, he/she was able to either give consent or exit the survey. By entering the date on which they were taking the survey, they gave signature consent. After giving consent they were able to take both the surveys back-to-back. The total number of questions was thirty including the demographic information as well as the RAS. The survey was broken up into six sections: basic information, childhood sexual abuse history, professional help, intimate relationship satisfaction, sexual satisfaction, and the last section was the RAS. The participants were able

to see all the questions at once and were also able to skip any section that either was not applicable to the individual, or they did not feel comfortable answering. Each section had a comment underneath the title explaining what the section was asking. At the completion of the survey, the participant was thanked for their time.

CHAPTER 4: Results

Basic Information

The sample consisted of 83 women from East Carolina University where 22.8% (*n*=18) of the sample had experienced abuse during childhood. The remaining 77.2% (*n*=61) had no previous experience with childhood sexual abuse. Among the total sample, within the context of their relationship, 16.9% (*n*=14) had felt scared or fearful, 22.9% (*n*=19) had anxiety issues, 42.2% (*n*=35) had trust issues, 42.2% (*n*=35) had communication issues and 7.2% (*n*=6) had showed no interested within their relationship. Either in past or current relationships 2.4% (*n*=2) has experienced alcoholism, 4.8% (*n*=4) had drug addictions, 7.2% (*n*=6) showed signs of post traumatic stress disorder (PTSD), 9.6% (*n*=8) had experienced night terrors, 33.7% (*n*=28) had experienced depression, 7.2% (*n*=6) had experienced withdrawal symptoms, and 57.8% (*n*=48) had no problems. Of those who experienced CSA 55% (*n*=10) had previous experiences of depression. Table 2 displays the results of t-tests for variables such as depression, PTSD, night terrors, withdrawal, alcoholism, and drug abuse between participants who had a history of CSA as well as those who had no history of CSA. Depression, PTSD, night terrors, and withdrawal were all significant at the $p < .05$.

Child Sexual Abuse History

Eighteen women (22.8%) in the sample had experienced sexual abuse during childhood. The abuse ranged from when the victims were 4-18 years of age. Table 3 provides details on the age of the onset of CSA. The largest percentage of the sample was abused between the ages of 10-12 years (33.3%, $n = 6$), followed by the years prior to and after the onset of puberty. Ninety-four point four percent (*n*=17) knew their abuser with 5.6% (*n*=1) not knowing their

abuser. There was one participant that did not describe the relation to the abuser. The majority of the sample described their relation to the abuser as "other" because the choices did not fit their relationship to the abuser. Victims were most frequently abused by: other 52.9% (*n*=9), brother 11.8% (*n*=2), uncle 11.8% (*n*=2), father 5.9% (*n*=1), stepfather 5.9% (*n*=1), sister 5.9% (*n*=1) and grandfather 5.9% (*n*=1).

Professional Help

Of those women who reported abuse, 61.1% (*n*=11) sought professional help either during or after the abuse while 38.9% (*n*=7) did not seek out any help. Table 4 provides the age the victim sought help and from whom they sought professional help.

The victims rated how helpful the professional help was to them personally with "1-being not helpful" and "5-being extremely helpful." A psychologist (8.4%) was the most popular form of professional help among abused victims. The majority concluded that seeking professional help was "3-somewhat helpful" (45.5%) or "4-helpful" (36.4%).

Intimate Relationship Satisfaction

For the purpose of this study, intimate relationship satisfaction was defined as a relationship in which the individuals are intimately sexual. The total of both abused and nonabused participants, described their lifestyle as being in an intimate relationship (63%, *n*=51) while 37% (*n*=30) described themselves as not being in an intimate relationship. Fourteen participants (25.9%) reported being in their relationship/marriage less than 1 year, 25.9% (*n*=14) between 1-2 years, 38.9% (*n*=21) between 2-5 years, and 9.3% (*n*=5) between 6-10 years.

Table 2

Depression, PTSD, Night Terrors, withdrawal, alcoholism and drug abuse among CSA victims

	Childhood Sexual Abuse (CSA)	No CSA
Variables		
Depression*	*55.6%*	*26.2%*
Posttraumatic Stress Disorder* (PTSD)	*27.8%*	*1.6%*
Night Terrors*	*33.3%*	*3.3%*
Withdrawal*	*27.8%*	*1.6%*
Alcoholism	*5.6%*	*1.6%*
Drug Abuse	*11.3%*	*3.3%*

* $p < .05$

Table 3

Age of onset of Childhood Sexual Abuse

	Percentage	*N*
Age		
Younger than 4 years	5.6%	1
4-6 years	16.7%	3
7-9 years	22.2%	4
10-12 years	33.3%	6
13-18 years	22.2%	4

Twenty-nine participants did not answer the question. Within the context of the relationship, 13.2% (*n*=7) said they had experienced problems in the past as a result of CSA while 86.8% (*n*=46) said they had not experienced any problems in the past. There was no significance between those who had experienced CSA (22.8%, *n*=18) and those who had not experienced CSA (77.2%, *n*=61), $t(77) = 1.33$, $p=.19$.

Sexual Satisfaction

For the purpose of this study, sexual satisfaction was defined as a state of contentment by an individual whose sexual desires are being fulfilled. Participants were asked to rate (1-5) their current relationship or marriage regarding sexual satisfaction with "1- being extremely unhappy" and "5- being extremely happy". Of the total sample, 7% (*n*=4) rated their sexual satisfaction as unhappy, 7% (*n*=4) rated their sexual satisfaction as somewhat happy, 31.6% (*n*=18) rated their sexual satisfaction as happy, 36.8% (*n*=21) rated their sexual satisfaction as extremely happy, and 17.5% (*n*=10) were not sexually active. There was no significant difference between those that had experienced CSA and those who had no history of CSA, $t(77) = 1.15$. Within the context of the relationship or marriage, 1.3% (*n*=1) of the total sample had seen professional help and 98.8% (*n*=79) had not seen professional help regarding sexual satisfaction/dissatisfaction. There was a significant difference between those who experienced CSA and those had no history of CSA, $t(77) = 2.5$, $p = .012$. Among the participants who had a history of abuse who had also seen a professional regarding sexual satisfaction/dissatisfaction, 7.1% had seen a professional 10 times or more. Professional help was seen as helpful by 6.3% while the remaining 93.8% did not seek any form of help.

Table 4

Professional Help

	Percentage	*N*
*Age**		
Younger than 10 years	10%	1
13-15 years	10%	1
15-18 years	30%	3
18 and older	50%	5
*Professional Help***		
Psychologist	8.4%	7
Counselor	7.2%	6
Psychiatrist	4.8%	4
Physician	2.4%	2
Teacher	2.4%	2
Police	1.2%	1

*Only 10 participants described at what age professional help was sought.

** The participants were allowed to select multiple choices for professional help and that explains why there were more answers given when only 11 participants actually sought help.

The participants who had experienced CSA were asked if memories of CSA had affected past or current relationships with "1-being never" and "5-being always," 9.8% (*n*=8) said never, 4.9% said almost never (*n*=4), 4.9% (*n*=4) said sometimes, 8.5% (*n*=7) said almost always, and 1.2% (*n*=1) said always. The final question regarding sexual satisfaction asked how supportive and understanding the spouse or partner was regarding previous experience with CSA with "1-being not supportive/not understanding" and "5-being very supportive/very understanding." The sample concluded that 1.2% agreed that their spouse or partner was somewhat not supportive/not understanding, 2.4% agreed that their spouse or partner was somewhat supportive/somewhat understanding, 1.2% agreed that their spouse or partner was supportive/understanding and 11% agreed that their spouse was very supportive/very understanding.

Relationship Assessment Scale (RAS)

Participants completed the Relationship Assessment Scale (RAS) based on their current relationship/marriage or if currently single, the most previous past relationship. There was no significance between victims who had experienced abuse and those who had not experienced abuse on relationship satisfaction. There could be a number of reasons why this could be the case. The first reason could be the potential for survey fatigue given that the RAS ended up being the last seven questions of the survey. Participants could have gotten tired and careless. Another reason there may have been no significance is that enough time has passed along and with professional help, the participants' current relationship may be satisfactory. Since the majority of professional help was sought over the age of 18, the participants may have a better understanding of their past and may have moved forward.

CHAPTER 5: Discussion

The purpose of this study was to explore how childhood sexual abuse affects adulthood relationship satisfaction in women. There were 83 participants in the study where 18 had experienced abuse, while 61 had no previous history of abuse and the remaining 4 did not answer the question. The majority reporting experiencing CSA were Caucasians and there could be many reasons for this. In particular, it is the African American culture to not be vocal about their problems, with a small percentage reporting their experiences of abuse (Wyatt, 1990). They believe that information regarding personal self and family stays within the family. Given this ethnic cultural variation, there are probably cases that go unreported. Another important finding is that most the victims who reported having experienced abuse are either married or in a relationship. This could be because of the age group I sampled and that the college years are a time of dating and finding your mate. It could also be that these individuals are genuinely happy and have surpassed the feelings of abuse. The most common problems experienced among the participants were communication and trust issues. This was also true in those who had experienced CSA. Communication and trust issues are typical concerns/problems in relationships especially between the ages of 18-25 years. Communication and trust are more than likely a result of the betrayal from the abuser. The abuser was supposed to protect the victim and instead he/she caused harm. Depression was another issue in either current or past relationships. Thirty-three percent of the participants had experienced depression at some point within the context of their relationship. Depression was also an important factor described by most the of the CSA victims as experiencing during past relationships. This supports my hypothesis that CSA

victims will experience more depression due to their traumatic experience. Depression, PTSD, Night Terrors and withdrawal were all evident in victims of childhood sexual abuse. This can be accounted for by Finkelhor and Browne's Betrayal dynamic that focuses on the trust that was broken as a result of someone the victim knew and trusted. PTSD and Night Terrors are often effects of CSA and can explain why they were evident among the female participants. Withdrawal can be a combination of the abuse itself or of the betrayal of a person that the victim knew and trusted. The RAS did not show any significance in relationship satisfaction and could be because of the length of time that has passed along with professional help.

Most of the sample had not experienced abuse (77.2%), however 22.8% reported having experienced abuse during their childhood. The onset of abuse began between the ages of 0-4 years (N=1) with 10-12 years of age being the time it occurred the most often (N=6). This could be due to the fact that the onset of puberty for females is between that ages of 10-12 years and that is when the body starts to develop. The years prior to 10 (ages 7-9) and the years following 12 (ages 13-18) were also frequent for the onset of abuse. While abuse did occur before the age of 7, the abuse mainly took place leading up to and during puberty. The majority of the sample 85% knew their abusers while 15% did not know their abuser. In other studies, the stepfather was most often reported as the abuser, in this study, the participants most often checked the term "other" if none of the other choices correctly suited their choice. The term "other" could have implied a family friend, aunt, grandmother and stranger. Brother and uncle were the majority of the abusers, followed by father, stepfather, grandfather and sister.

Of the sample that reported abuse, 61% sought professional help either during or after the abuse while 38.9% did not seek any help. Victims did not seek professional help

until between the ages of 15-18, with the majority waiting until they were 18 or older. This could be for a number of reasons including, never reported the abuse and needed professional help later; they had seen help previously but needed more help now that they were older; they been forced to go by court or official reasons, or they could not afford the help or it was not supported. There could have been many reasons for this, but 50% did not seek professional help until they were 18 years or older. The top three professions that were seen by CSA victims in this study were psychologists, counselors, and psychiatrists (mental health professions). These professions are normally the top choices because they encourage the individual to talk about their experiences leading them to understand that is was not their fault. The majority concluded that seeking professional help was "somewhat helpful." Participants that had experienced CSA and who had a history of seeing a professional seem to be more satisfied within the context of their relationship.

Sixty-three percent described their relationship as intimate where as the remaining 37% were not in an intimate relationship. The majority of the participants had been in their relationship/marriage for 2-5 years followed by 25.9% sustaining in a relationship between 0-5 years. Within the context of the relationship only 13.2% participants had experienced problems in the past while 86.8% had not experienced any relationship problems. There are a number of potential reasons why this could be the case; first off, there has been some time that has elapsed and maybe the victim has been able to heal; also the professional help may have helped the victim to manage and cope with the traumatic event.

Participants were asked to rate their current relationship or marriage regarding sexual satisfaction between 1-5 with "1-being extremely unhappy" and "5-being extremely happy." The highest percent of the participants described their sexual satisfaction as extremely happy (36.8%). The data was surprising regarding whether the participant had seen professional help regarding sexual satisfaction. The findings revealed that only 1 person who had experienced CSA had seen professional help regarding sexual satisfaction in their current relationship.

Despite what DiLillo and Long (1999) found with college-aged incest survivors experiencing more problems in the field of dating, the findings of this study suggest that for the most part, the relationships of the participants in this study are satisfactory. Since the RAS has shown no significance difference between those who experienced CSA and those with no history of CSA, it does not appear that CSA affects relationship satisfaction. The finding, however, does not support my hypothesis that participants who report CSA will have more dissatisfaction in relationships. This could be because of the time span as well as the professional help that was sought.

What was interesting is that the participants were asked if memories of CSA affected their current relationship and the findings suggest that the majority were split with 9.8% saying "never," 4.9% saying "almost never," 4.9% saying "sometimes," 8.5% saying "almost always," and 1.2% saying "always." The remaining 70.7% did not answer the question because it was not applicable. The last question asked how supportive and understanding the partner was regarding previous experience with CSA and the highest percentage accounted for their spouse/partner being very supportive and understanding.

Limitations

There are a number of limitations of the current research. First, the data was collected from a small population of female college students in a Southeastern/Mid-Atlantic University. Narrowing the population to such a small demographic made the sample small. The second major limitation to the study was the participants had to be females between the ages of 18-25. This limited the number of individuals who would have been able to participate. This created an even smaller sample, but due to my study being focused on relationship satisfaction, the focus was on young female adults. Another limitation to the current study was that as data was collected via an internet based survey program, there is no way of knowing whether or not the data collected was from only females. The fourth major limitation is given the sensitive nature of the topic; some participants may have felt shame or have been fearful in taking the survey and in such cases, opted out of the research study. With the current research topic being childhood sexual abuse and the prevalence of abuse in society, the sample was small. Only a small percentage of the population experiences abuse and using a college campus with age and gender restrictions limited the sample.

Another limitation was on the clarity of the question asking about education background. One of the answer choices was "high school/GED" and since this survey was used to measure CSA in college-aged students in a university setting the question could have been more clearly stated. Another question that would need to be clarified with more options was the question about "the relation to the abuser." The majority of the participants selected the term "other" which needed to be broken down to add aunt, grandmother, family friend and stranger.

If this study is ever to be replicated it would be wise to conduct the study using the RAS as well as some measure that indicates sexual satisfaction. Given that the RAS was not significant in the present study could be due to many facts including survey fatigue, professional help, and time since the abuse.

Future Research

There has been significant research done on childhood sexual abuse and the effects it has on the individual, but not on specific aspects. An important focus should be on how CSA affects men and women differently and how the effects are similar. Another important issue is that it needs to address how CSA affects the individual earlier in life as compared to later in adulthood after marriage. CSA will inevitably affect individuals differently at different stages in life because of developmental milestones that every individual faces such as being a teenager, going to college, dating, getting married, and having a child. The importance lies on how CSA affects individuals differently with and without counseling over many years. Another area for future research should include ethnic differences and how CSA may differ across different cultures. Most of the current literature is based on a random sample rather than a sample purposely selected. While there is literature regarding different ethnic populations and childhood sexual abuse, there is not enough as cultural continues to influence lives. If the study is replicated there needs to be an instrument that focuses on sexual satisfaction in conjunction with the RAS.

Conclusion

While CSA is more common than people realize or report, it seems to not be an issue in the relationships from this particular study. More information is needed on relationship satisfaction and CSA. With the combination of time and professional help, the relationships were healthy and satisfactory. While the RAS did not find any significance between CSA and relationship satisfaction, many factors could have contributed to that outcome. It also could be that time and professional help are key indicators to coexisting in a healthy relationship. The one thing that stands true is that communication and trust are two key issues that may be a result of CSA. While it is apparent in most relationships whether there is a history of abuse or not, it was most certainly apparent in CSA victims. Depression was also a key figure in CSA victims and this could be due to the CSA trauma or it could be a buildup of trust and communication problems. Along with depression, PTSD, Night Terrors and withdrawal were all significant to victims of CSA. There definitely are negative effects with CSA victims, but more research needs to be done to pinpoint exactly what causes relationship satisfaction.

References

Alexander, P.C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology, 60*, 185-195.

Arrington, R., Confrancesco, J., & Wu, A.W. (2004). Questionnaires of measure sexual quality of life. *Quality of Life Research, 13*, 1643-1658.

Baker, A.W., & Duncan, S.P. (1985). Child sexual abuse: A study of prevalence in Great Britain. *Child Abuse & Neglect, 9*, 457-467.

Banyard, V.L., & Williams, L.M. (1996). Characteristics of child sexual abuse as correlates of women's adjustment: A prospective study. *Journal of Marriage and Family, 58*, 853-865.

Beitchman, J.H., Zucker, K.J., Hood, J.E., & DaCosta, G.A. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect, 16*, 101-118.

Bogar, C.B., & Hulse-Killacky, D. (2006). Resiliency determinants and resiliency processes among female adult survivors of child sexual abuse. *Journal of Counseling & Development, 84*, 318-327.

Bolan, R. M., & Scannapieco, M. (1999). Prevalence of child sexual abuse: A corrective metanalysis. *Social Service Review,* 281-313.

Borcherdt, Bill, Kilty, Keith, Richardson, Virginia, Segal, Elizabeth, Daley, James, Francis, Taylor, Company, H.W., Press, Haworth, Rothman, Jack, & Thomas, Edwin.

Briere, J. (1992). Methodological issues in the study of sexual abuse effects. *Journal of Counseling and Clinical Psychology, 60*, 196-303.

Briere, J.N., & Elliott, D.M. (1994). Immediate and long-term impacts of child sexual abuse. *The Future of Children, 4*, 54-69.

Cherlin, A.J., Burton, L.M., Hurt, T.R., & Purvin, D.M. (2004). The influence of physical and sexual abuse on marriage and cohabitation. *American Sociological Review, 69,* 768-789.

Davis, J.L., & Petretric-Jackson, P.A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior, 5*, 291-328.

DiLillo, D., & Long, P. J. (1999). Perceptions of couple functioning among female survivors in child sexual abuse. *Journal of Child Sexual Abuse, 7*, 59-76.

Downs, W.R., & Harrison, L. (1998). Childhood maltreatment and the risk of substance problems in later life. *Health and Social Care in the Community, 6*, 35-46.

Draucker, C.B., & Martsolf, D.S. (2008). Storying childhood sexual abuse. *Qualitative Health Research, 18, 1034*-1048.

Feinauer, L., Middleton, K.C., & Hilton, G.H. (2003). Existential well-being as a factor in the adjustment of adults sexually abused as children. *The American Journal of Family Therapy, 31*, 201-213.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530-541.

Gorey, K., & Leslie, D. (1997). The prevalence of child sexual abuse: Intergrative review adjustment for potential response and measurement bias. *Child Abuse & Neglect, 21*, 391-398.

Haverkamp, B., & Daniluk, J.C. (1993). Child sexual abuse: Ethical issues for the family therapist. *Family Relations, 42*, 134-139.

Hendrick, S.S. (1988). A generic measure of relationship satisfaction. *Journal of Marriage and the Family, 50*, 93-98.

Kessler, R.C., & Magee, W.J. (1994). Childhood family violence and adult recurrent depression. *Journal of Health and Social Behavior, 35*, 13-27.

Kilpatrick, A. C. (1986). Some correlates of women's childhood sexual experiences: A retrospective study. *The Journal of Sex Research, 22*, 221-242.

Lee, S., Lyvers, M., & Edwards, M.S. (2008). Childhood sexual abuse and substance abuse in relation to depression and coping. *Journal of Substance Use, 13*, 349-360.

Leonard, L.M., Iverson, K.M., & Follette, V.M. (2008). Sexual functioning and sexual satisfaction among women who report a history of childhood and/or adolescent sexual abuse. *Journal of Sex & Marital Therapy, 34*, 375-384.

Leonard, L.M., & Follette, V.M. (2002). Sexual functioning in women reporting a history of child sexual abuse: Review of the empirical literature and clinical implications. *Annual Review of Sex Research, 13*, 346-388.

Maniglio, R. (2009). The impact of child sexual abuse on health: A systemic review of reviews. *Clinical Psychology Review, 29*, 647-657.

Merrill, L.L., Guimond, J.M., Thomsen, C.J., & Miller, J.S. (2003). Child sexual abuse and numbers of sexual partners in young women: The role of abuse severity, coping style, and sexual functioning. *Journal of Consulting & Clinical Psychology, 71*, 987-996.

Meston, C.M., & Heiman, J.R. (2000). Sexual abuse and sexual function: An examination of sexually relevant cognitive processes. *Journal of Consulting & Clinical Psychology, 68*, 399-406.

Meston, C.M., Rellini, A.H., & Heiman, J.R. (2006). Women's history of sexual abuse, their sexuality, and sexual self-schemas. *Journal of Consulting & Clinical Psychology, 74*, 229-236.

Meston, C.M., Heiman, J.R., & Trapnell, P.D. (1999). The relation between early abuse and adult sexuality. *The Journal of Sex Research, 36*, 385-395.

Polusny, M.A., & Follette, V.M. (1995). Long-term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied & Preventive Psychology, 4*, 143-166.

Rothman, J., Damron-Rodriguez, J., & Shenassa, E. (1994). Systemic Research Synthesis-conceptual integration of meta-analysis. In J. Rothman & E. J. Thomas (Eds.), Intervention research: *Design and development for human service* (133-162). Birminghamton, NY: Routledge.

Roesler, T.A., & McKenzie, N. (1994). Effects of childhood trauma on psychological functioning in adults sexually abused as children. *The Journal of Nervous and Mental Disease, 182*, 145-150.

Roosa, M.W., Reyes, L., Reinholtz, C., & Angelini, P.J. (1998). Measurement of women's child sexual abuse experiences: An empirical demonstration of the impact of choice of measure on estimates of incidence rates and of relationships with pathology. *The Journal of Sex Research, 35*, 225-233.

Summit, R.C. (1983). The child sexual abuse accommodation syndrome. *Child Abuse & Neglect, 7*, 177-193.

Testa, M., VanZile-Tamsen, C., & Livingston, J.A. (2005). Child sexual abuse, relationship satisfaction, and sexual risk taking in a community sample of women. *Journal of Consulting & Clinical Psychology, 73*, 1116-1124.

Walser, R.D., & Kern, J.M. (1996). Relationships among childhood sexual abuse, sex guilt, and sexual behavior in adult clinical samples. *The Journal of Sex Research, 33*, 321-326.

Wyatt, G.E. (1990). The aftermath of child sexual abuse of african american and white american women: The victim's experience. *Journal of Family Violence, 5*, 61-81.

APPENDIX A: IRB Approval

University and Medical Center Institutional Review Board
East Carolina University, 600 Moye Boulevard
1L-09 Brody Medical Sciences Bldg. • Greenville, NC 27834
Office **252-744-2914** • Fax **252-744-2284** • **www.ecu.edu/irb**
Chair and Director of Biomedical IRB: L. Wiley Nifong, MD
Chair and Director of Behavioral and Social Science IRB: Susan L. McCammon, PhD

TO: Megan St. Aubin
2240 Geenville Blvd., Apartment 104
Greenville, NC 27858

FROM: UMCIRB

DATE: February 25, 2010

RE: Approval for Revision to Previously Approved Human Research

TITLE: "How Childhood Sexual Abuse Affects Adulthood Relationship Satisfaction in Women"

UMCIRB #10-0085

Your request for revision to the aforementioned approved study underwent review and approval using expedited review on February 22, 2010. It was the determination of the UMCIRB Chairperson (or designee) that this revision does not impact the overall risk/benefit ratio of the study and is appropriate for the population and procedures proposed.

Please note that any further changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. A Progress Report for continuing or final review must be submitted to the UMCIRB prior to the date of the most current UMCIRB approval (insert date). The investigator must adhere to all reporting requirements for this study.

The aforementioned revision has been approved from **February 22, 2010,** to **February 8, 2011**.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.

Electronic copy: Dr. Carroll
Ms. Epley

To Whom it May Concern,

Thank you for taking the time to read this. My name is Megan St.Aubin and I am a graduate student. In fulfillment of the Master's Degree I am in the process of writing a thesis and my topic is "How Childhood Sexual Abuse Affects Adulthood Relationship Satisfaction in Women." I ask that if you are a female between the ages of 18-25 years that you please take the time to answer a few questions regarding childhood sexual abuse and intimate relationship satisfaction.

To participate in this study you do not have to have been abused but only females make take this survey. At the bottom of this email there is a link that will direct you to Perseus where you will see a consent form. Read the information regarding the study and either you can give consent or not give consent at the bottom. This is completely voluntary and anonymous and no one will see your answers. After giving consent you will two short surveys that should only take about 15-20 minutes of your time to complete. If at any point you feel uncomfortable you may stop the survey with no penalty.

Thank you once again for taking the time. Below is the hyperlink to Perseus. Once you get to the survey, there will be a consent form. By clicking "I give consent" and entering today's date you are giving consent to participate in the study.

If you have any questions or concerns please feel free to email me at mes0901@ecu.edu. If you feel uncomfortable about the survey, you may stop at anytime. If you feel you need someone to talk to feel free to contact REAL Crisis Intervention, Inc. (252)-758-HELP (4357).

Thank you,
Megan St.Aubin

How Childhood Sexual Abuse Affects Adulthood Relationship Satisfaction
Childhood Sexual Abuse

UMCIRB
APPROVED
FROM 02.22.2010
TO 02.08.2011

CONSENT DOCUMENT

Title of Research Study:	How childhood sexual abuse affects adulthood relationship satisfaction in women
Principal Investigator:	Megan St.Aubin
Institution:	East Carolina University
Address:	2240 Greenville, NC 27858 Apt. 104 Greenville, NC 27858

Telephone #:(252)-333-9904

PURPOSE AND PROCEDURES

- The purpose of this research study is to examine how childhood sexual abuse affects adulthood relationship satisfaction in women.
- You will be asked to complete first the consent form and then two surveys: a survey that asks about your background and information regarding whether or not you have experienced childhood sexual abuse, and a questionnaire about intimate relationships.
- After reviewing the details of the research study you will have the opportunity to whether or not to give consent to the study.

POTENTIAL RISKS AND DISCOMFORTS

Survey questions include information about whether or not you experienced sexual abuse. Due to the research study being voluntary you have the right to stop answering at tany time. You also have the right not to answer any questions on the survey. If

answering the survey questions causes emotional upset, and you would like to talk with someone about this, you may call the REAL Crisis Center at (252) 758-HELP (4357).

POTENTIAL BENEFITS

There may be no personal benefit from your participation but the knowledge received may be of value to humanity.

SUBJECT PRIVACY AND CONFIDENTIALITY OF RECORDS

Your privacy and confidentiality will be maintained by the surveys being anonymous.

COSTS OF PARTICIPATION & COMPENSATION

You will not receive any monetary compensation for your participation in this study, nor will it cost you anything.

VOLUNTARY PARTICIPATION

Participating in this study is voluntary. If you decide not to be in this study after it has already started, you may stop at any time without losing benefits that you should normally receive. You may stop at any time you choose without penalty.

PERSONS TO CONTACT WITH QUESTIONS

The investigators will be available to answer any questions concerning this research, now or in the future. You may contact the investigators, Megan St.Aubin at phone number (252)-333-9904 (days, nights and weekends). If you have questions about your rights as a research subject, you may call the Chair of the University and Medical Center Institutional Review Board at phone number 252-744-2914 (days). If you would like to report objections to this research study, you may call the ECU Director of Research Compliance

at phone number 252-328-9473.

CONFLICTS OF INTEREST

This study is funded by Megan St.Aubin which is supporting the costs of this research.

Neither the research site, nor Megan St.Aubin will receive any financial benefit based on the results of this study.

CONSENT TO PARTICIPATE

Title of research study: How childhood sexual abuse affects adulthood relationship satisfaction in women.

Thank you for taking the time to complete this survey in fulfillment of my graduate thesis. If you have any questions, please contact me at mes0901@ecu.edu. Given the nature of the topic it will be online so there will be no signature. Instead by checking the box below and entering today's date it will satisfy legal requirements for a signature. If you do not wish to give consent, please check the box that says, "I do not give consent".

☐ I give consent _____ _____ _____
month day year

☐ I do not give consent

University and Medical Center Institutional Review Board
East Carolina University, 600 Moye Boulevard
1L-09 Brody Medical Sciences Bldg. • Greenville, NC 27834
Office **252-744-2914** • Fax **252-744-2284** • **www.ecu.edu/irb**
Chair and Director of Biomedical IRB: L. Wiley Nifong, MD
Chair and Director of Behavioral and Social Science IRB: Susan L. McCammon, PhD

TO: Megan St.Aubin, CDFR Department, ECU

FROM: UMCIRB

DATE: February 11, 2010

RE: Expedited Category Research Study

TITLE: "How Childhood Sexual Abuse Affects Adulthood Relationship Satisfaction in Women"

UMCIRB #10-0085

This research study has undergone review and approval using expedited review on 2/9/10. This research study is eligible for review under expedited category number 7 (Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies). The Chairperson (or designee) deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **2/9/10** to **2/8/11**. The approval includes the following items:

- Internal Processing Form (dated 2/1/10)
- Consent Document (dated 10/30/08)
- Demographic Survey
- Relationship Assessment Scale

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.

CONSENT DOCUMENT

Title of Research Study:	How childhood sexual abuse affects adulthood relationship satisfaction in women
Principal Investigator:	Megan St.Aubin
Institution:	East Carolina University
Address:	2240 Greenville, NC 27858 Apt. 104 Greenville, NC 27858
Telephone #:	(252)-333-9904

PURPOSE AND PROCEDURES

- The purpose of this research study is to examine how childhood sexual abuse affects adulthood relationship satisfaction in women.
- You will be asked to complete first the consent form and then two surveys: a survey that asks about your background and information regarding whether or not you have experienced childhood sexual abuse, and a questionnaire about intimate relationships.
- After reviewing the details of the research study you will have the opportunity to whether or not to give consent to the study.

POTENTIAL RISKS AND DISCOMFORTS

Survey questions include information about whether or not you experienced sexual abuse. Due to the research study being voluntary you have the right to stop answering at tany time. You also have the right not to answer any questions on the survey. If

UMCIRB APPROVED
FROM 2-9-10
TO 2-8-11

answering the survey questions causes emotional upset, and you would like to talk with someone about this, you may call the REAL Crisis Center at (252) 758-HELP (4357).

POTENTIAL BENEFITS

There may be no personal benefit from your participation but the knowledge received may be of value to humanity.

SUBJECT PRIVACY AND CONFIDENTIALITY OF RECORDS

Your privacy and confidentiality will be maintained by the surveys being anonymous.

COSTS OF PARTICIPATION & COMPENSATION

You will not receive any monetary compensation for your participation in this study, nor will it cost you anything.

VOLUNTARY PARTICIPATION

Participating in this study is voluntary. If you decide not to be in this study after it has already started, you may stop at any time without losing benefits that you should normally receive. You may stop at any time you choose without penalty.

PERSONS TO CONTACT WITH QUESTIONS

The investigators will be available to answer any questions concerning this research, now or in the future. You may contact the investigators, Megan St.Aubin at phone number (252)-333-9904 (days, nights and weekends). If you have questions about your rights as a research subject, you may call the Chair of the University and Medical Center Institutional Review Board at phone number 252-744-2914 (days). If you would like to report objections to this research study, you may call the ECU Director of Research Compliance

UMCIRB APPROVED
FROM 2-9-10
TO 2-8-11

at phone number 252-328-9473.

CONFLICTS OF INTEREST

This study is funded by Megan St.Aubin which is supporting the costs of this research.

Neither the research site, nor Megan St.Aubin will receive any financial benefit based on the results of this study.

CONSENT TO PARTICIPATE

Title of research study: How childhood sexual abuse affects adulthood relationship satisfaction in women.

Thank you for taking the time to complete this survey in fulfillment of my graduate thesis. If you have any questions, please contact me at mes0901@ecu.edu. Given the nature of the topic it will be online so there will be no signature. Instead by checking the box below and entering today's date it will satisfy legal requirements for a signature. If you do not wish to give consent, please check the box that says, "I do not give consent".

☐ I give consent _____ month _____ day _____ year

☐ I do not give consent

UMCIRB APPROVED
FROM 2-9-10
TO 2-8-11

**********IMPORTANT INFORMATION**********

Continuing Review/Closure Obligation

As a investigator you are required to submit a continuing review/closure form to the UMCIRB office in order to have your study renewed or closed before the date of expiration as noted on your approval letter. This information is required to outline the research activities since it was last approved. You must submit this research form even if you there has been no activity, no participant s enrolled, or you do not wish to continue the activity any longer. The regulations do not permit any research activity outside of the IRB approval period. Additionally, the regulations do not permit the UMCIRB to provide a retrospective approval during a period of lapse. Research studies that are allowed to be expired will be reported to the Vice Chancellor for Research and Graduate Studies, along with relevant other administration within the institution. The continuing review/closure form is located on our website at www.ecu.edu/irb under forms and documents. The meeting dates and submission deadlines are also posted on our web site under meeting information. Please contact the UMCIRB office at 252-744-2914 if you have any questions regarding your role or requirements with continuing review.
http://www.hhs.gov/ohrp/humansubjects/guidance/contrev0107.htm

Required Approval for Any Changes to the IRB Approved Research

As a research investigator you are required to obtain IRB approval prior to making any changes in your research study. Changes may not be initiated without IRB review and approval, except when necessary to eliminate an immediate apparent hazard to the participant. In the case when changes must be immediately undertaken to prevent a hazard to the participant and there was no opportunity to obtain prior IRB approval, the IRB must be informed of the change as soon as possible via a protocol deviation form.
http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm#46.103

Reporting of Unanticipated Problems to Participants or Others

As a research investigator you are required to report unanticipated problems to participants or others involving your research as soon as possible. Serious adverse events as defined by the FDA regulations may be a subset of unanticipated problems. The reporting times as specified within the research protocol, applicable regulations and policies should be followed.
http://www.hhs.gov/ohrp/policy/AdvEvntGuid.htm

Version 02-26-07

APPENDIX B: Demographic Survey

APPENDIX B: Demographic Survey

Childhood Sexual Abuse

Consent Form. Thank you for taking the time to complete this survey in fulfillment of my graduate thesis. If you have any questions, please contact me at mes0901@ecu.edu. Given the nature that the survey is online, there will be not signature. Instead by entering today's date below will satisfy legal requirements for a signature. If you do not wish to give consent, please exit the survey now. Thank you.

Date (MM/DD/YYYY)

Thank you for taking the time to answer this survey. It should only take about 15-20 minutes of your time. You are free at any time to quit the survey if you feel uncomfortable. The survey is completely anonymous and strictly voluntary. I thank you once again for your time.

Basic Information

1. What is your race/ethnicity?

- Caucasian
- African American
- Hispanic/Latina
- Native American
- Asian

2. What is your current marital/partner status?

- Single
- In a relationship
- Married
- Divorced
- Widow
- Partner

3. If you have had problems within the context of the relationship, read the list below and check any/all that apply:

- [ ] Scared/Fear
- [ ] Anxiety Issues
- [ ] Trust Issues
- [ ] Communication Issues
- [ ] No Interest

4. What is the highest level of education completed?

- ○ High School/GED
- ○ Some College
- ○ Associates Degree
- ○ Bachelors Degree
- ○ Masters Degree or higher

5. What is your annual income?

- ○ < $20,000
- ○ $20,000-$30,000
- ○ $30,000-$40,000
- ○ $40,000-$50,000
- ○ > $50,000
- ○ I am a student and only work part-time

6. Have you in the past or currently suffer from any of the following?

- [ ] Alcoholism
- [ ] Drug Abuse
- [ ] PTSD (Post Traumatic Stress Disorder)
- [ ] Night Terrors

- [ ] Depression
- [ ] Withdrawal
- [ ] None of the above

Childhood Sexual Abuse History

Childhood Sexual Abuse is defined as "forced or coerced sexual behavior imposed on a child (under the age of 18), and sexual activity between a child and older person whether or not obvious coercion is involved" (Polusny and Follette, 1995, p. 145).

7. As a child were you at any time sexually abused? *(If no, skip to question 15)*

- ○ Yes
- ○ No

8. If yes, at what age did the abuse begin?

- ○ Younger than 4 years of age
- ○ Between 4-6 years of age
- ○ Between 7-9 years of age
- ○ Between 10-12 years of age
- ○ Between 13-18 years of age

9. Did you know the abuser? *(If no, skip to question 11)*

- ○ Yes
- ○ No

10. If so, what was the relation?

- ○ Mother
- ○ Father
- ○ Step-mother

- Step-father
- Brother
- Sister
- Uncle
- Grandfather
- Teacher
- Camp Counselor
- Minister
- Other

Professional Help

If you did not see professional help regarding the abuse, skip to question 15.

11. During the abuse or after the abuse ended did you see a professional for help?

- Yes
- No

12. If you sought professional help, at what age did you seek the help?

- Younger than 10 years old
- 10-13 years old
- 13-15 years old
- 15-18 years old
- 18 or older

13. From who did you see professional help?

- Police
- Physician
- Teacher

- [ ] Counselor
- [ ] Psychologist
- [ ] Social Worker
- [ ] Psychiatrist

14. On a scale from 1 to 5 (1= not helpful, 5= very helpful) how helpful was the professional help to your personal life?

- ○ 1 (Not helpful)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (Very helpful)

Intimate Relationship Satisfaction

The following questions will inquire about intimate relationship satisfaction which is defined as a relationship in which an individual is intimately involved.

15. Are you currently in a intimate relationship*? (If not, please skip to question 19)*

- ○ Yes
- ○ No

16. How long have you been in your current relationship/marriage?

- ○ Less than 1 year
- ○ 1-2 years
- ○ 2-5 years
- ○ 6-10 years
- ○ 10 + years

17. Have you had any problems being in an intimate relationship due to your childhood abuse?

- Yes
- No

Sexual Satisfaction

The following questions inquire about sexual satisfaction. Sexual satisfaction is defined as a state of contentment by an individual whose sexual desires are being fulfilled.

18. How would you rate your sexual satisfaction since you have been in a relationship or married on a scale from 1-5? (1= Extremely unhappy, 5= Extremely happy)

- 1
- 2
- 3
- 4
- 5
- Not sexually active

19. When in a relationship or marriage, have you ever seen a professional related to sexual satisfaction/dissatisfaction? *(If no, skip to question 22)*

- Yes
- No

20. If you answered yes to the above question, how many times have you had to see a professional?

- Once
- 2-5 times
- 6-10 times
- 10 + times
- Not applicable

21. If so, did the professional help on a scale from 1-5? (1= never, 5= always)

- 1
- 2
- 3
- 4
- 5
- Not applicable

22. In your past or current relationship, how often have memories of childhood sexual abuse affected your relationship on a scale from 1-5? (1= never, 5= always)

- 1
- 2
- 3
- 4
- 5
- Not applicable

23. How often is your partner responsive and understanding for your experiences with childhood sexual abuse on a scale from 1-5? (1= not understanding/supportive, 5= very understanding/supportive)

- 1
- 2
- 3
- 4
- 5
- Not applicable

APPENDIX C: Relationship Assessment Scale (RAS)

APPENDIX C: Relationship Assessment Scale (RAS)

Please mark the letter for each item which best answers that item for you.

How well does your partner meet your needs?

A	B	C	D	E
Poorly		Average		Extremely well

In general, how satisfied are you with your relationship?

A	B	C	D	E
Unsatisfied		Average		Extremely satisfied

How good is your relationship compared to most?

A	B	C	D	E
Poorly		Average		Excellent

How often do you wish you hadn't gotten in this relationship?

A	B	C	D	E
Never		Average		Very often

To what extent has your relationship met your original expectations:

A	B	C	D	E
Hardly at all		Average		Completely

How much do you love your partner?

A	B	C	D	E
Not much		Average		Very much

How many problems are there in your relationship?

A	B	C	D	E
Very few		Average		Very many

NOTE: Items 4 and 7 are reverse scored. A=1, B=2, C=3, D=4, E=5. You add up the items and divide by 7 to get a mean score.