



THE IMPACT OF CHILD SEXUAL ABUSE ON ADULT INTERPERSONAL FUNCTIONING: A REVIEW AND SYNTHESIS OF THE EMPIRICAL LITERATURE

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ABSTRACT. *The many studies that have examined the long-term impact of child sexual abuse (CSA) on adult functioning have primarily focused on the personal distress of survivors, largely ignoring the impact of CSA on interpersonal relationships. This article reviews empirical findings concerning the interpersonal distress of survivors as expressed in their intimate and sexual relationships. First, current conceptualizations of the relationship between CSA and interpersonal relationships are reviewed, with a focus on the theoretical models that appear to have implications for the long-term interpersonal sequelae associated with CSA. This is followed by a review of the research conducted on intimacy within the area of social psychology and a summary of the empirical findings related to intimacy functioning in CSA survivors. A hypothesized typology of intimacy functioning for survivors is suggested. The effects of CSA on three components of sexuality—sexual dysfunctions, underlying psychological components of sexuality, and sexual orientation—are discussed. Finally, the interpersonal issues believed to be most salient for CSA survivors in the therapeutic setting are discussed, along with implications for the client–therapist relationship. Methodological, assessment, and conceptual issues are discussed throughout. Recommendations for future research and clinical endeavors are suggested. © 2000 Elsevier Science Ltd. All rights reserved.*

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THE PROBLEM OF ABUSE of children was brought to the attention of lay and professional audiences alike with Kempe, Silverman, Steele, Droegemueller, and Silver's (1962) seminal publication on child physical abuse. Since that time there has been a proliferation of research dealing with all forms and aspects of child abuse. However, in the past two

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decades child sexual abuse (CSA) has become the primary focus of research investigating the role of child abuse in the development of subsequent adult psychopathology (Mullen, Martin, Anderson, Romans, & Herbison, 1996). The interest in the impact of CSA on its victims has been further fueled by findings of researchers investigating the sequelae of other forms of victimization, such as rape and domestic violence. Researchers investigating these forms of interpersonal victimization have documented the parallels between victim response to CSA and other forms of interpersonal violence, such as acquaintance rape, in attempting to chronicle the behavioral and cognitive impact of such victimization (Burkhart & Fromuth, 1996).

Empirical reviews have established that CSA is associated with a host of immediate (Kendall-Tackett, Williams, & Finkelhor, 1993) and long-term negative effects that continue into adulthood (Jumper, 1995; Neumann, Houskamp, Pollock, & Briere, 1996). Several psychological disorders and other complicating problems in adulthood have been linked to CSA (Beitchman et al., 1992). Abuse-associated symptom domains reported in the literature include dissociation, anxiety, sexual dysfunction, sleep disturbance, anger/hostility, substance abuse, revictimization, low self-esteem and self-concept impairment, depression, self-blame, guilt, and helplessness, self-mutilation, suicidality, posttraumatic stress responses, obsessions and compulsions, and somatization (Neumann et al., 1996).

However, survivors of CSA have been found to display considerable variability in both the range and severity of reported symptomatology (Briere & Runtz, 1993; Elliot & Briere, 1992; Johnson & Kenkel, 1991). Based on a review of 38 published studies that examined the relationship between CSA and psychological problems in adult women, Neumann et al. (1996) concluded that across methodologies, samples, and measures, CSA remained a general risk factor for the presence of later psychological problems. They also concluded that specific negative symptoms, such as revictimization and traumatic stress, were highly associated with a history of CSA. Associations between CSA and subsequent problems were also found to be stronger for survivors recruited from clinical samples. At present, a causal link has not been firmly established between specific psychological disorders and other complicating problems reported retrospectively by adult victims of CSA and sexually abusive experiences per se. Instead, it has been suggested that the relationship observed between sexual abuse and later psychological and sexual adjustment may be due to the confounding of sexual abuse with various moderating variables, such as negative family environment or other forms of child maltreatment (Briere, 1992a; Kinzl, Traweger, Guenther, & Biebl, 1994). Consequently, in the last several years, researchers have begun to examine more closely the role that moderating variables may play in explaining variability in negative psychological symptoms reported by CSA survivors. The moderating variables most often investigated include personality characteristics of the individual, events/situations antecedent or concurrent to the abuse, the nature of the abuse, environmental factors that were present subsequent to the abuse, and survivor postabuse conceptualizations of the abusive experience. These studies also have reported variability in survivor functioning. Such variability suggests that the psychological outcome of abuse cannot be predicted by a single factor (Kinzl et al., 1994), a conclusion that appears to be supported by the findings of recent meta-analytic reviews of the CSA literature (Jumper, 1995; Neumann et al., 1996).

In terms of survivor outcome, there remains debate as to whether negative psychological symptoms vary as a function of the specific form of abuse. One suggestion is that the experience of abuse produces common core symptoms of distress (Briere & Runtz, 1988; Moeller, Bachmann, & Moeller, 1993; Muenzenmaier, Meyer, Struening, & Ferber, 1993). It has alternatively been suggested that sexual abuse presents a unique constellation of symptoms that differentiates it from physical and emotional abuse in terms of its impact.

For example, Briere and Runtz (1990) found that sexual abuse was linked to maladaptive sexual behavior, while physical abuse was linked to interpersonal aggression, and emotional abuse was linked to low self-esteem. Reiker and Carmen (1986) reported that while CSA had a negative impact on a victim's sense of self, which increased the risks of self-destructive and suicidal behaviors, a similar yet less severe outcome was reported for victims of child physical abuse. Thus, while there is general agreement that child abuse is associated with significant long-term sequelae in adulthood, the extent to which each form of abuse generates either common or specific patterns of negative psychological symptoms remains an open question (Mullen et al., 1996; Neumann et al., 1996).

In addition to identifying the negative psychological symptoms that are indicative of personal distress, recent research has begun to examine the relationship between CSA and subsequent interpersonal functioning in adult survivors. Since CSA involves an intimate interpersonal violation, it follows that the interpersonal functioning in the intimate relationships of adult survivors may be affected by CSA (Briere, 1992b). The authors of this review conceptualize CSA as a social problem that has the potential to negatively affect the personal and interpersonal functioning of the victimized individual. Additionally, CSA has the potential to indirectly affect those who are important in the lives of survivors—partners, children, and friends—who desire to establish relationships with that individual. Thus, it appears vital to the personal and interpersonal psychological health of the survivor and those with whom she shares intimate relationships to understand how the dynamics of CSA may affect them in their relationships. The authors also believe that the literature addressing the adult interpersonal functioning of CSA survivors has relevance to other theory and research concerning the manner in which other forms of interpersonal trauma are processed in terms of the long-term impact on relationships. Therefore, research on the impact of CSA in the interpersonal domain of functioning is worthy of its own review.

The current article reviews progression of what the authors believe to be the most important empirical and clinical findings in the past 15 years about the impact of CSA on adult interpersonal relationships. Our review examines in depth the research findings that address the underlying psychological, cognitive, and affective components of the processes that influence the nature of survivors' interpersonal functioning. The authors chose this perspective because we believe that these components may be the driving forces behind the interpersonal functioning reported by survivors. We further believe that a broader conceptualization of the impact of CSA on interpersonal functioning will provide a better understanding of the complex nature of this impact and will have important implications for the treatment of adult survivors of CSA. We discuss two primary areas of interpersonal functioning, intimacy and sexuality, within partner relationships. We have chosen to focus on published empirical studies in this area, as well as relevant clinical findings in order to provide the most comprehensive current perspective.

This review is arranged into five main topic areas. The first area provides an overview of current conceptualizations of the relationship between CSA and interpersonal relationships. This section incorporates a discussion of theoretical models that best address interpersonal effects associated with CSA. The second area includes a brief review of the research conducted on intimacy within the area of social psychology, because this topic has been neglected within the clinical literature. This section also reviews the empirical and clinical literature findings related to intimacy functioning in CSA survivors. The third area discusses the effects of CSA on sexuality and provides an overview of the limitations in this research area, as well as a discussion of the reported prevalence rates of sexual dysfunctions in the general population and the survivor population. Three subcomponents of sexuality will be reviewed: sexual dysfunctions, underlying psychological components of sexuality, and sexual orientation. The methodological and assessment difficulties will

be briefly discussed for each component. The fourth area provides a brief overview of the interpersonal issues that survivors bring to therapy and their implications for the client–therapist relationship. Finally, we suggest a direction for future research endeavors within the area of long-term effects of CSA on survivors’ interpersonal functioning. The focus of this review will be restricted to exploration of the impact of CSA on women.¹

THE RELATIONSHIP BETWEEN CHILD SEXUAL ABUSE AND INTERPERSONAL RELATIONSHIPS

The literature on the long-term impact of CSA on adult survivors has used various schemata to categorize CSA sequelae. Most often negative correlates are expressed either as diagnostic disorders (e.g., posttraumatic stress disorder [PTSD], borderline personality disorder [BPD]) or descriptive symptomatic domains that are thought to be indicative of personal distress (Jumper, 1995; Neumann et al., 1996). However, it appears that diagnostic constructs “may not provide the most valid or useful distinctions when working with this population” (Polusny & Follette, 1995, p. 154). Although survivors may exhibit many symptoms that are characteristic of a disorder, more often the clinical picture is one of an incomplete syndrome. Indeed, a complex relationship exists between child abuse as a form of ecopathology (i.e., environmental adversity resulting from traumatic life events) and later symptomatology expressed as some form of psychopathology (Foy, 1992). Reliance on using a diagnostic system to characterize abuse survivors also ignores the interpersonal aspects or relational problems often reported by survivors. Alternatively, clinically and empirically validated descriptive categories have been used to organize long-term sequelae for CSA survivors. For example, Neumann et al. (1996) used a broad descriptive categorical approach (i.e., affective, behavioral, identity/relational, other psychiatric sequelae, and general symptomatology), within which specific negative correlates were grouped. Although researchers are now beginning to investigate the interpersonal functioning of CSA survivors, overall there has been a relative neglect of interpersonal issues. In general, researchers and clinicians have often attended more to problem behavior in the social realm (e.g., violence, substance use), neglecting the aspects of social functioning that involve the absence of positive social interactions (e.g., lack of trust, intimacy issues). However, these problems are often intimately linked to the internalized symptomatic distress (e.g., depression, dissociation, withdrawal) of CSA survivors. Briere (1992b) refers to such relationship problems (i.e., “relationships with important others”) as being in the “less visible social domain” (p. 49).

While CSA survivors report difficulties associated with relationships, the specific nature and course of the impact of CSA on interpersonal relationships is unclear, since survivors report considerable variability in terms of the adequacy of such functioning. Some survivors are able to establish long-term, lasting, and healthy relationships with partners, while others display a pattern of many transient, casual relationships, even prostitution. Some survivors are extremely fearful and distrustful of men, women, and relationships; these survivors may actively avoid relationships. Other survivors continuously seek out relationships in an attempt to find one not characterized by fear and mistrust. Although clinicians

¹ While recognizing the legitimate status of male survivors of CSA and the commonalities of their victimization response, the reader is referred to other sources for a more in-depth discussion of the concerns of this group (Lew, 1988).

report that many survivors may experience specific sexual difficulties, including arousal dysfunction, desire dysfunction, and inorgasmia in their interpersonal relationships, others report no such difficulties. Overall, a substantial number of survivors report some degree of difficulty in sustaining sound, stable, and satisfying interpersonal relationships.

THEORETICAL MODELS OF CHILD SEXUAL ABUSE: ADDRESSING THE ASSOCIATION WITH ADULT INTERPERSONAL FUNCTIONING

A variety of theoretical models has been offered to explain survivor responses to CSA. These theories have been more clearly articulated to explain the immediate symptomatic outcome in children and are reviewed elsewhere (Kendall-Tackett et al., 1993). Although variability in symptomatic outcome among survivors would argue against applicability of core-domain theories (e.g., PTSD model, sexualized behavior model, and self-image model), within this group of theories, the PTSD model has garnered considerable attention. In part this may be attributed to PTSD theory being a “well-developed generalized theory of traumatic processing” (Kendall-Tackett et al., 1993, p. 173). Many symptoms reported by survivors of CSA are consistent with the diagnostic criteria of PTSD (Alexander, 1993; Finkelhor, 1988; Rowan, Foy, Rodriguez, & Ryan, 1994), and consequently many professionals have been quick to conceptualize the responses of CSA survivors as fitting within the framework of this disorder. However, there are problems with the PTSD conceptualization (Finkelhor, 1988). A PTSD model does not adequately account for all of the symptomatology characteristic of survivors of CSA. Indeed, the last two editions of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1987, 1994) have noted that children who have experienced sexual abuse may show a wide variety of responses. Additionally, symptoms that match PTSD criteria may only apply to a subset of child and adult CSA survivors (Alexander, 1993; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Finkelhor, 1988; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988). Also, it has been argued that CSA may not really fit with the PTSD formulation theoretically (Finkelhor, 1988). One of the biggest problems with the PTSD conceptualization is that it does not take into consideration the interpersonal nature of the abuse (Finkelhor, 1990). As Kendall-Tackett et al. (1993) have argued, while many survivors report symptoms which can be explained within the PTSD model, neither theory nor empirical findings support PTSD criteria as “universal to sexual abuse or as the most characteristic pattern” (p. 174).

Several models have been developed that are consistent with the pattern of multifaceted effects observed among survivors. The authors have selected four models that attempt to address the association between CSA and interpersonal functioning as being representative of the current thinking in this field. Three of these models, developed by Briere (1992b), Finkelhor and Browne (1985), and Polusny and Follette (1995), are broad in scope. Finkelhor and Browne’s model provides an alternative to the PTSD model. Their model is a comprehensive one that allows for the differentiation and theoretical explanation of symptomatic outcome. Briere’s model integrates the cognitive and coping aspects of recovery from CSA that are currently being researched. Polusny and Follette’s model focuses on emotional avoidance as a coping strategy of survivors and incorporates a variety of systems with which the individual comes into contact. A fourth model is derived from the work of Westerlund (1992). In a study of incest survivors involved in a self-help group, she categorized the perceived effects of incest into seven areas, several of which have special relevance to interpersonal functioning. All of these models provide a basis by which empirical research may investigate the process(es) and outcome(s) each propose.

Finkelhor and Browne (1985) conceptualized the impact of CSA in a model that suggests that there are four traumagenic dynamics present: traumatic sexualization, betrayal, powerlessness, and stigmatization. These dynamics are observed in various patterns for survivors of all types of traumatic events, but the four together are unique to CSA and are thought to be the cause of the distinctive effects of this trauma. Finkelhor and Brown comment that “These dynamics alter children’s cognitive and emotional orientation to the world, and create trauma by distorting children’s self concept, world view, and affective capacities” (p. 531).

Of the four traumagenic dynamics, betrayal seems most salient in terms of its impact on adult interpersonal functioning. In general, children are taught to trust adults and expect adults to protect them. When a child is abused, this trust and security may be shattered, and the child may feel a sense of betrayal. The child may discover that the adult has purposely harmed them, was lying to them, and was looking out only for the adult’s own interest. If the family is not supportive of the child when the abuse is disclosed, or knew of the abuse and did not protect the child, this provides an additional betrayal to the child. The sense of betrayal is believed to be greatest if the offender was emotionally close to the child, but it may also be a function of the circumstances of the abuse. This sense of loss and betrayal in childhood may carry over into other relationships as the child grows up. Finkelhor and Browne (1985) state that betrayal issues may be manifested in poor judgements of whom the survivor can or should trust, or it may lead to “a desperate search for a redeeming relationship” (p. 535). Survivors may also react to this betrayal by anger. They may be suspicious of intimate relationships or isolate themselves and avoid intimate relationships altogether. These responses to betrayal may also have a negative impact on a survivor’s potential to develop healthy intimate relationships. Additionally Finkelhor and Browne note that many marital disruptions revolve around the concept of betrayal and may emanate out of the anger felt by survivors.

The second traumagenic dynamic is sexualization. Sexualization “refers to a process in which a child’s sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse” (Finkelhor & Browne, 1985, p. 531). The authors state that sexualization may result from the manner in which the abuse is perpetrated, including the child being rewarded for performing sexually, receiving attention and affection contingent on sexual acts, misconceptions the child develops about sexual morality and behavior because of what is happening, and through memories of the abuse itself. The impact of sexualization may vary based on different aspects of the event, including whether force was used or the child was beguiled, whether the child was an active as opposed to a passive participant, and the cognitive level of the child (p. 531). The impact of sexualization in terms of intimacy functioning can manifest itself in a variety of ways. One of the most common effects of CSA reported in the literature is a heightened sexual awareness at an early age. This may lead to eroticized behaviors (Yates, 1982) in which survivors engage other children in a sexual manner in play, they are sexually aggressive toward other children or exhibit both of these behaviors (see Masson, 1995). As adults, sexualization may make survivors more vulnerable to later sexual assault, lead to an oversexualization of all relationships, and/or increase the possibility that these adults may sexually or physically abuse their own children (Finkelhor & Browne, 1985, p. 534).

The third dynamic is powerlessness, which refers to “the process in which the child’s will, desires, and sense of efficacy are continually contravened” (Finkelhor & Browne, 1985, p. 532). This dynamic evolves from the perpetrator’s continual invasion of the child. The child has no control over the abusive situation; if she tries to take action to stop the abuse, she is often faced with many obstacles, including threats of retaliation (from the

perpetrator) and disbelief (from the family and community). Finkelhor and Browne state that abuse that involves the threat of harm will likely lead to a greater sense of powerlessness; however, threats of harm are not necessary for this dynamic to evolve. They further state that children who are able to disclose the abuse, who are believed, and who are able to play a part in the discontinuation of the abuse may feel less powerless. One long-term consequence of CSA that has been hypothesized as having its genesis in this dynamic is revictimization, which may occur in a large number of survivors. The feeling of powerlessness may disable survivors to be assertive in later relationships. They may feel that they have no control over their bodies or what happens to them, thus inadvertently increasing the risk of being victimized again. Many survivors also report fear and anxiety related to a lack of control, which may originate in this dynamic.

The fourth dynamic is stigmatization, which refers to “the negative connotations (e.g., badness, shame, and guilt) that are communicated to the child around the [abusive] experiences and that then become incorporated into the child’s self-image” (Finkelhor & Browne, 1985, p. 532). Finkelhor and Browne state that this dynamic may evolve directly from berating by the perpetrator, the secrecy that surrounds an incestuous relationship, the reactions of family and community upon disclosure or discovery, and from within the victim herself. The dynamic of stigmatization may play out in many forms in later interpersonal relationships. The survivor may feel that because of the incest, she is damaged and unworthy. She may give her body to others freely or seclude herself from relationships in reaction to this negative self-image. The guilt and shame that many sexual abuse survivors experience may also be a long-term projection of this dynamic.

Briere (1992b) conceptualized the interpersonal effects of CSA in a way different from, but not necessarily incompatible with, the conceptualization of Finkelhor and Browne. He stated that interpersonal difficulties develop from childhood sexual abuse in two ways. First, there are immediate cognitive and conditioned responses that continue into adulthood. This includes distrusting others, anger and fear of those with greater power, low self-esteem, ambivalence about interpersonal closeness, and concerns about abandonment. Second, there is an accommodation response to continuous abuse. Accommodation responses include avoidance, passivity, and sexualization. Briere states that although these reactions may be understandable as responses of a child to an abusive situation, their continuing presence in adulthood interferes with daily adult interpersonal functioning. As such, these interpersonal styles make it very difficult for the survivor to obtain support and acceptance through interpersonal relationships, the presence of which would have the potential to facilitate recovery.

The most recently formulated theoretical model designed to account for the effects of CSA was developed by Polusny and Follette (1995). This model highlights the function of emotional avoidance in determining the long-term effects of CSA. It incorporates system as well as individual components; these include the immediate systems in which the individual is involved (e.g., family and school), the interaction of these different systems with each other, systems outside the individual’s immediate contact, and the sociocultural environment of the individual. This model states that individuals with histories of CSA attempt to diminish thoughts and memories of the abuse through the use of many different coping behaviors, including dissociation, self-mutilation, substance abuse, casual sexual relationships, and avoidance of intimate relationships. The authors state that although these coping behaviors may serve to relieve the survivor’s pain initially, they may lead to negative effects in the long-term. Such long-term effects may include feelings of social isolation, sexual dysfunctions, and revictimization.

Westerlund (1992) chose to focus specifically on the sexuality of women who were self-referred survivors of childhood incest. Participants in her study of women recruited from

a self-help group completed both questionnaires and interviews. As part of her overall results, Westerlund used the participants' answers to open-ended questions and spontaneous reporting to provide an "overall sense of what the participants themselves perceived as significant [effects of the incest] and gave priority to in the absence of suggestion" (p. 47). In many ways, her use of the women's spontaneous responses provides a more "humane" expression of symptomatology than other empirical work, and yields a rich expression of the underlying schemata (i.e., thoughts and feelings) associated with behavioral symptomatology, the assessment of which has been sorely lacking.

Westerlund (1992) categorized women's responses concerning the perceived effects of incest into seven areas: personality, health, work, parenting, spirituality, intimacy, and sexuality. Women in this study reported that their personalities had been altered in some way by their CSA experiences, using such terms as: "emotional numbness" and a "lack of spontaneity." Issues with "chronic vulnerability to depression" and suicidal ideation as well as difficulties with trust were reported. Many reported that "a sense of stigmatization, isolation, and alienation from humanity had resulted from the incest" (p. 48). They referred to themselves as "in some respect developmentally delayed" or emotionally stunted in terms of development, and reported pervasive problems with negative sense of self and low self-esteem. Health problems included stress-related disorders, such as digestive disorders and permanent sleep disorders. They reported postural problems associated with depression and/or body shame as well as transitory or chronic problems with substance abuse—alcohol, drugs and food. Multiple appetitive abuses were common. Over half reported interference with work, which was most commonly characterized as "difficulties with authority figures or co-workers related to power, control or trust issues" (p. 48). Additionally, they reported problems with decision-making, issues of achieving recognition related to low self-esteem and fear of attack, and work concentration and completion problems, which they associated with general anxiety, depression, or both. While one subset of women believed that incest had prevented them from reaching their potential, another group reported a style of overachievement, describing themselves "driven to achieve in the interest of . . . self-esteem," and yet "often unable to take pleasure in accomplishments because they were 'never enough'" (p. 49). The majority of these women also believed that incest had in some way affected their spirituality, either positively or negatively. Specific issues reported by these women which related to parenting, intimacy and sexuality will be discussed in the sections below.

The value of these models is that they have added a new dimension to the conceptualization of the long-term effects of CSA. They suggest that researchers must attend to the interpersonal nature of the abuse itself and its implications for the subsequent interpersonal functioning of the survivor. They have opened a new avenue in terms of assessing the impact of CSA by positing that child sexual abuse may have a detrimental impact on the interpersonal as well as the personal functioning of CSA survivors.

INTIMACY

Although the clinical literature suggests that survivors' adult relationships may be characterized by lack of trust and intimacy, there has been only minimal empirical investigation of the nature of partner relationships of survivors (Polusny & Follette, 1995). Lack of research investigating the intimacy functioning of CSA survivors is surprising, considering that childhood abuse represents a severe breach of trust for the child. Because of the severity of childhood sexual abuse, it is logical to assume that children who have experienced CSA may continue to experience difficulties in trusting others in later relationships.

Such inability to trust may, in turn, continue to affect the survivor's experiences in intimate relationships as an adult, since trust plays a predominant role in the development of such relationships (Briere, 1992b; Finkelhor & Browne, 1985; Maltz & Holman, 1987). Briere (1992b) comments that intimacy disturbance is commonly expressed as fear, distrust, or ambivalence about interpersonal closeness and vulnerability. He attributes the difficulty in developing and maintaining intimate relationships reported by many survivors to the impact of CSA on the child's ability to trust. Because trust requires minimal defensiveness and a belief that others are safe, survivors find it hard to trust those who are important in their lives, irrespective of their "status as friends, lovers or colleagues" (p. 51). He believes that ambivalence and fear concerning attachment and interpersonal vulnerability represent the core intimacy problems experienced by CSA survivors. In support of this hypothesis, clinical researchers have reported several different patterns of problematic interpersonal styles reported by incest survivors, which are thought to relate to trust issues. These patterns include avoiding all intimate relationships (Jehu, 1989), limiting oneself to only casual and transient relationships (James & Meyerding, 1978; Jehu, 1988; Silbert & Pines, 1983), and continuously searching for an intimate relationship that is designed to "make up for" what was lacking in childhood (Jehu, 1988).

Conceptualizations of Intimacy in the Social Psychology Literature

The construct of intimacy has received little attention in the clinical literature, thus a brief review of intimacy as it has been formulated within the social psychology literature will be provided. First, general findings as to the components of intimacy will be reviewed. This will be followed by a discussion of survivors' intimacy functioning and its role in their primary relationships. Although many different conceptualizations of the construct of intimacy have been offered by social psychologists, overall, three general themes emerge in the literature. These themes include a sense of closeness and interdependence, a degree of self-disclosure, and the experience of affection or warmth within the partnership (Perlman & Fehr, 1987). Typically within this framework intimacy is conceptualized as referring to the quality of an ongoing relationship. There are currently five theoretical conceptualizations of intimacy noted in the social psychology literature (Van den Broucke, Vandereycken, & Vertommen, 1995). These conceptualizations have been commonly associated with formulations of marital intimacy. The first conceptualization is the lifespan developmental model advanced by Erikson and Sullivan and further elaborated by Marcia. Sullivan emphasized how intimacy involved the self-revelation and validation of aspects of the partner's attributes and world, while Erikson emphasized the fusion of identities of two caring individuals. The motivational model, similar to the developmental model, considers intimacy to be an individual characteristic displayed across contexts. Within this model intimacy is a stable motive that signals a "readiness to experience closeness, warmth, and communication" (Van den Broucke et al., 1995, p. 219). Individuals high in intimacy motivation show higher levels of self-disclosure, express greater trust and concern for others, and report greater marital enjoyment.

In contrast to these first two models, the next two models conceptualize intimacy as a characteristic of relationships, not individuals. The basic premise of the equilibration model is that individuals strive to maintain an optimal level of intimacy. "Being comfortable with a partner involves maintaining a balance between a desire to achieve and to avoid intimacy in the interactions" (Van den Broucke et al., 1995, p. 219). The equity model, an application of equity theory (see Walster, Walster, & Berscheid, 1978) defines intimacy as "a process by which a dyad attempts to move towards complete communication on all levels" (Hatfield, 1982, cited in Van den Broucke et al., 1995). Relationships in which

partners perceive equitable input and output ratios (in regards to intellect, physical attraction, etc.) are likely to achieve high levels of intimacy. Within this model, intimate relationships can be characterized as having a greater intensity of liking or loving, greater breadth of information exchanged, a degree of commitment, and an emergence of a "dyadic identity" (i.e., "we-ness"; Van den Broucke et al., 1995).

Finally, an integrated model proposed by Van den Broucke et al. (1995) outlines six structural dimensions of intimacy. This model involves three dimensions on the relationship level (affective, cognitive, and instrumental interdependence), two on the individual level (authenticity and openness) and one on the social network level (exclusiveness). Thus, intimacy involves emotional closeness (i.e., affective interdependence), validation of one's ideas and values (i.e., cognitive interdependence), implicit or explicit consensus about the rules that regulate the partners' interactions (i.e., instrumental interdependence), the ability to "be oneself" in the relationship (i.e., authenticity), the readiness to share ideas and feelings (i.e., openness), and the degree to which dyadic privacy is maintained in the relationship with others (i.e., exclusiveness).

In contrast to these professional conceptualizations of intimacy, Waring, Tillman, Frellick, Russell, and Weisz (1980) chose to define intimacy based on what laypersons believed about the qualities of relationships. Waring et al. asked 50 adults to describe what intimacy meant to them. Four basic themes emerged. The first theme consisted of sharing thoughts, dreams, and beliefs. The second involved sexuality as an aspect of intimacy, particularly the affection and commitment aspects of sexuality. The third contained exclusion criteria, in that intimacy did not consist of anger, resentment, or criticism, as these result in interpersonal distance. The fourth theme required an adequate sense of self as a precursor to intimacy. From these themes, Waring et al. developed a working definition of intimacy involving eight dimensions: affection, expressiveness, compatibility, sexuality, cohesion, autonomy, identity, and conflict resolution. While this working definition has been empirically validated, it is not, unfortunately, grounded in theory. Thus, intimacy is reduced to an aggregate of dimensions. In addition, distinctions between experiential and behavioral variables, as well as between individual and dyadic dimensions of intimacy are lacking. Most importantly, some of the elements in the model can more accurately be considered behavioral indices or consequences that serve to signal that intimacy has been achieved as opposed to the actual construct.

Essentially, there appear to be two opposing views about intimacy. The first assumes that individuals have certain capacities for relating to others, their behaviors reflect those capacities, and they relate to others in a consistent manner over time (Acitelli & Duck, 1987). The second assumes that relationships are uniquely shaped over time, based on the reinforcing influence of one partner's behavior on the other. What appears to be missing in the literature is the knowledge of how the qualities that each individual brings to a relationship (i.e., readiness) interact with relational or dyadic qualities. It can be argued that conceptualizations of intimacy must incorporate both aspects (Acitelli & Duck, 1987) to reflect the "interaction of personal and situational influences" (Van den Broucke et al., 1995, p. 220). As Van den Broucke et al. (1995) comment, although "as a quality of a personal relationship at a certain point in time, intimacy primarily refers to a dyadic phenomenon, that is, the degree of connectedness or interdependence between two partners . . . relationships only exist by the grace of the individuals who build and sustain them" (p. 222).

The models discussed above reflect characteristics and attributes of normative intimate relationships. The authors are not aware of any published studies that have tested applicability of these models to describe patterns of intimacy functioning in CSA survivors. It appears, however, that integration of personal and situational influences may be particu-

larly important for understanding the intimacy functioning of survivors. Because of their CSA experience, survivors may approach potential intimate relationships with a preexisting negative view of interpersonal relationships. This view appears amenable to change, so as to allow healthy intimacy functioning. Trust, power, control, fears of abandonment, dependency, and safety issues as well as the difficulty of integrating sexual and emotional intimacy, all of which are all salient for survivors, can be addressed in the context of therapy and/or with a partner with whom the survivor feels comfortable enough to trust and work on issues of intimacy until change is achieved. "There are reports of women having successful relationships with caring men who help the adult survivor develop capacities for intimacy and satisfying sexuality" (Blum, 1988).

The Impact of Child Sexual Abuse on Intimacy

While the clinical literature suggests that CSA has a major impact on the interpersonal functioning of survivors (Briere, 1992b; Courtois, 1988; Herman, 1981; Jehu, 1988; Westerland, 1992), there are few empirical studies that have examined the effects of CSA on intimacy. Even fewer studies have explored the issues of intimacy and sexual functioning concurrently. The sexual problems experienced by CSA survivors have been conceptualized in two ways: the first interprets sexual problems as isolated sequelae, while the second views them as one expression of a larger constellation of symptoms involving disrupted interpersonal relatedness (Mullen, Martin, Anderson, Romans, & Herbison, 1994). Thus, intimacy and sexuality must be investigated simultaneously to determine the association between these aspects of interpersonal functioning and their specific dynamics within a survivor's relationships. Similarly neglected have been the psychological dynamics (i.e., survivor's affect, cognitions, and attitudes) that underlie intimacy and sexuality; instead researchers have concentrated on the survivors' behavioral expressions of such constructs as expressed in sexual behavior/ dysfunction.

We believe that a review of the clinical and research literature suggests that difficulties in survivors' interpersonal relationships can be expressed in several different interactional patterns. It also appears that at least three patterns appear across clinical and research studies, although no formal typology of survivor intimacy functioning has been developed. The first pattern is one in which the survivor has difficulties with or a fear of intimacy, experiences great mistrust, and does not know how to relate to others. She may have boundary issues concerning how she relates to others and may sexualize relationships that are not sexual. She may be able to have sexual relations without overt difficulties; however, these sexual interactions are likely to be casual, transient, and numerous. When these relationships risk becoming intimate, the survivor is likely to end them. This may occur because the closer the survivor gets to someone, the more vulnerable she is, and there is a greater risk that she will be hurt again. The second pattern involves a fear and active avoidance of both intimacy and sexuality. In the third pattern the survivor has issues with both intimacy and sexuality, but these concerns are overridden by the need to be in a relationship. Consequently, she continues to search for a relationship in which she will not feel fear, distrust, and vulnerability. Within this pattern, some survivors also may lack the judgment necessary to determine whom they can trust, lack an adequate sense of self-worth, or both. They may become involved in relationships with men who abuse them psychologically, physically, and sexually, thus continuing the cycle of abuse.

Although these behavioral descriptions of intimacy functioning and consequent expressions of sexuality have been identified in the survivor literature (Blume, 1990; Briere, 1992b; Jehu, 1988; Meiselman, 1978; Westerland, 1992), researchers and clinicians have not identified them as mutually exclusive patterns. Some clinical researchers have sug-

gested that survivors may show aspects of more than one pattern at the same time or different patterns over time (Blum, 1988; Jehu, 1988). With the exception of Westerlund (1992), who argues that many of the survivors she sampled reported changes in sexual "lifestyles" over time or a pattern of an alternation of sexual "lifestyles" during adulthood, clinical researchers also have failed to explore the dynamics or mechanisms (e.g., therapy, supportive relationships), which might be involved in the change of intimacy patterns in survivors over time. It must also be noted that the most severe intimacy dysfunctions have been reported in clinical samples of survivors. Presently there is little information about the level of intimacy achievement in higher functioning, nonclinical samples of CSA survivors.

The following studies have documented examples of the first pattern of interpersonal functioning discussed above. This pattern includes a fear of intimacy, mistrust of men and interpersonal relationships, the oversexualization of relationships, and involvement in casual, transient sexual relationships. Jehu (1988) found that 29% of women in a treatment program for abuse survivors reported oversexualizing relationships with men, while 51% reported doing so in the past. Jehu stated that this subset of survivors viewed all relationships as having sexual components to them, even if this perception was inappropriate or unrealistic.

Several explanations have been offered for this oversexualization of relationships. As children, these women were given affection or gifts for sexual activity, and so still believe that sex can be used to get what they want in their adult relationships (Herman, 1981). Sex may also be viewed as validation of their worthiness (Laviola, 1992). A third explanation is that because of their CSA experience, some survivors cannot easily separate the notions of affection and sexuality (Meiselman, 1978). They believe that to get love, they have to give sex (see also Blume, 1990; Laviola, 1992; Maltz, & Holman, 1987). Briere and Runtz (1993) have suggested that because a sense of intimacy was strongly linked with sexuality in the past, sexual relationships may be the only way that some survivors know how to achieve the intimacy they desperately want. This phenomenon of oversexualization of relationships has also been discussed in the literature on the effects of CSA on children (Yates, 1982).

This oversexualization may involve cognitive and/or behavioral components. As an example of the cognitive component of the oversexualization of relationships, Jehu found that 86% of the women endorsed the statement, "No man could care for me without a sexual relationship." Even if these women are not interested in sexual relationships with men, they may believe that men only want sex from them. One example of a behavioral manifestation of the phenomenon of oversexualization in survivors is an involvement in many brief, casual sexual relationships. For example, Jehu (1988) found that 17% of his sample reported being "promiscuous," and that 60% reported having been "promiscuous" at some time in the past. Additionally, 48% endorsed the statement "I don't have the right to deny my body to any man who demands it." Several explanations for this behavior have been offered. Jehu suggests that survivors may engage in fleeting or promiscuous relationships in an almost compulsive manner because they feel obliged to do so, not because of their sexual desires. This sense of obligation can be expressed in other ways as well. For example, Maltz and Holman (1987) report that some survivors come to believe that their role in sexual activity is a submissive one; they are to please the partner, regardless of their own desires, or lack thereof. They also suggested that because the survivor's childhood sexual experiences were coercive, these women never learned how to set interpersonal boundaries or to be assertive. "Abuse survivors often feel at a loss as to how to prevent sexual activity from occurring or how to interrupt it once it has begun" (p. 52).

Herman and Hirschman (1977) have offered an alternative conceptualization of the tendency to engage in casual, transient sexual relationships. They theorize that many children distanced themselves from the CSA experience as a defense or coping response. As adults they may continue to distance others in their intimate relationships, and so may engage in sexual encounters to counteract this sense of isolation. Herman and Hirschman report that in their clinical sample, the “distance and isolation which these women experienced was uniformly painful, and they made repeated, often desperate efforts to overcome it. Frequently, the result was a pattern of many brief unsatisfactory sexual contacts” (p. 750). Westerlund (1992) also reports that several survivors in her clinical sample described compulsive sex as relating to issues of power and control or as a way to avoid emotional feelings by focusing on physical feelings. Others viewed it as a way to express anger at themselves, describing it as a “self-abuse tool” in which anger, not sex, was the “real drive” (p. 66), or as a way to express anger at others. According to Westerlund,

Whatever satisfaction was derived from the expression of anger through “promiscuity,” [many] respondents who [reported that they] had been “promiscuous” tended to report that “promiscuity” was “emotionally self-destructive” for them. As one respondent commented, “In the end, of course, the person I was hurting most was me. It took me a long time to realize that, to see how destructive it all was.” (p. 69)

Although many researchers have conceptualized possible associations between CSA and reported “promiscuity,” it should be noted that not all survivors who describe themselves as being “promiscuous” exhibit sexually indiscriminate behavior. For example, Fromuth (1986) found that women with histories of CSA reported being “promiscuous” more often than women without such histories, although the actual number of reported sexual partners did not differ between these groups. Fromuth suggested that survivors engage in negative self-labeling; thus, self-reports of promiscuity may not reflect their actual behavior.

Prostitution may be considered an extreme example of this pattern of involvement in transient, casual relationships. A few studies have shown that a significant proportion of prostitutes reports a history of CSA (Bagley & Young, 1987; James & Meyerding, 1978; Silbert & Pines, 1983). Silbert and Pines (1983) interviewed 200 former and current street prostitutes, aged 10–46, and found that 60% of this sample reported a history of sexual abuse during childhood. Seventy percent of these women stated that childhood abuse had some effect on their entry into prostitution. James and Meyerding (1978) conducted two studies of prostitutes in 1970/71 and 1974/75. Sixty-five percent of their adolescent sample in the first study and 52% of the second sample reported a history of sexual abuse. In Jehu’s (1988) treatment sample of survivors, 15% reported having been prostitutes in the past and 1% were currently involved in prostitution. James and Meyerding suggest that survivors may develop a sexual self-objectification that goes beyond the usual objectification of women by society, and that combined with the trauma of childhood sexual abuse, this may “lessen one’s resistance to viewing oneself as a salable commodity” (p. 41).

Jehu (1989) states that some survivors may experience a fear of intimacy that, while not necessarily evident in casual or impersonal sexual relationships, may emerge within a more committed relationship. When these survivors are involved in superficial relationships, they are able to shut off or block the intimate aspects of the relationships and function sexually. However, when relationships become intimate, survivors begin to experience difficulties; they may be unable to function sexually with their intimate partner (Blume, 1990; Herman & Hirschman, 1977; Westerlund, 1992). A *sex-intimacy dichotomy* may develop, in which the survivor has difficulty integrating sexual and intimacy functioning

within one relationship. Jehu (1989) refers to this compartmentalization of the sexual intimacy and the emotional intimacy functions of relationships as the “splitting” phenomenon. One explanation for “splitting” is that the greater the intimacy in a relationship, the greater the likelihood that the woman will reexperience the same feelings elicited by the abuse, particularly if she was emotionally close to the offender (Jehu, Gazan, & Klassen, 1985). Feinauer (1989) hypothesized that many children cope with the abuse through denial and continue to utilize this coping mechanism in adulthood. Intimacy may serve to interfere with the denial and cause the survivor to begin reexperiencing the distress. Westerlund (1992) suggested that “the split” occurred because these survivors viewed sex as an obligation when relationships were perceived as more intimate; some women reported that they felt more dependent and vulnerable and experienced more flashbacks and conflicts with partners. It appeared that erotic interest was associated with emotional detachment, while emotional attachment was associated with erotic disinterest.

The difficulties that some survivors may have with intense, committed relationships is also reflected in the differential rates of marriage and divorce reported for abused and nonabused women, although the results regarding such statistics are equivocal. Many studies have reported that fewer sexually abused women get married, and those that do marry typically have higher rates of divorce than their nonabused counterparts (Mullen, Romans-Clarkson, Walton, & Herbison, 1988; Van Buskirk & Cole, 1983). For example, in a community sample, Bagley and Ramsay (1986), found that 6% of the nonabused women and 13% of the abused women had never been married. Additionally, 5% of the nonabused women and 12% of the abused women were either divorced or separated. Although Mullen et al. (1994) found no difference in the number of abused and nonabused women who were currently in a close relationship, cohabitating, or married, abused women were more likely to have cohabitated before the age of 20, be divorced or separated, have larger families, and to have become pregnant at an earlier age. These results were more pronounced for women whose abuse culminated in intercourse. Many studies have also found that abused women reported lower marital and relationship satisfaction than did their nonabused counterparts (Finkelhor, Hotaling, Lewis, & Smith, 1989; Hunter, 1991; Jehu, 1988; Polusny & Follette, 1995). In their college community sample, Jackson, Calhoun, Amick, Maddever, and Habif (1990) found that women with incest experiences reported more difficulties with dating and social activities.

The second pattern of intimacy functioning that has been documented in the clinical research literature involves the survivor’s avoidance of all intimate and sexual relationships. Intimacy implies increased closeness and increased dependency, and with increased dependency comes increased risk (Holmes & Rempel, 1989). For some abuse survivors, the risk associated with being vulnerable and the possibility of “getting hurt” again may be a risk they are not willing to take. Their distrust of men may be so great that they are unable or unwilling to involve themselves in an intimate relationship. Courtois and Leehan (1982) reported that some survivors of CSA exhibited tremendous fear of closeness and distrust of others. Jehu (1989) found that 68% of the women in a clinical sample reported that they feared men and 90% endorsed the statement that “No man can be trusted.” In an earlier study, Jehu (1988) found that 45% of the women he sampled reported that they avoided long-term relationships with men. Some of the women in Westerlund’s (1992) sample remarked that they used drugs, alcohol, or food as “safe companions” to fill emptiness and provide comfort. For these women this strategy was associated with self-protection, allowing them to further avoid intimacy.

It has been suggested that avoidance may be more common in women whose offenders had a close emotional relationship with them. As children, these women learned that intimacy was directly related to being vulnerable and getting hurt or abused; consequently

some survivors continue to generalize this belief within their current adult relationships. Westerlund (1992) reported that incest survivors in her study “universally experienced difficulties with trust extend[ing] from ‘guardedness’ to ‘suspiciousness of everyone’s motives’ to ‘hypervigilance as a way of life’ to ‘a lack of trust in life itself’” (p. 48).

The third pattern of intimacy functioning that has been identified involves a continuous search on the part of the CSA survivor for intimate relationships that will be “redeeming,” (Summit & Kyrso, 1978) and will “make up for” the affection, love, and protection lacking in childhood (Courtois & Leehan, 1982; Finkelhor & Browne, 1985; Herman & Hirschman, 1977; Jehu, 1988). Although not always, at times this search may predispose some survivors to continued revictimization, increasing the risk for a continual cycle of abuse in their adult relationships. For example, in one clinical sample study (Jehu, 1988), 91% of the survivors who reported involvement in a current relationship also reported oppression by their partners. In 33% of the relationships, the CSA survivor reported physical abuse by her male partner. Tsai and Wagner (1978) labeled this phenomenon (i.e., survivors becoming involved with men who abuse them) as “repetition compulsion” (p. 422), and commented that these men often resembled the perpetrator of the childhood abuse. This finding has been confirmed in other studies of survivors (Van Buskirk & Cole, 1983; Westerlund, 1992). It has been hypothesized that some survivors will tolerate the continued cycle of abuse because of their desperate need for intimacy and low self-worth. This interpretation is plausible, given that many survivors devalue themselves, and overvalue, and subordinate themselves to, men (Briere, 1992b; Jehu, 1988). For example in Jehu’s 1988 sample, 51% of the women stated that they overvalued men. The low self-esteem of many survivors may also contribute to increased risk of self-denigration and acceptance of male criticism and abuse. Herman and Hirschman (1977) reported that almost all of the incest survivors in their clinical sample referred to themselves as “bitches,” “witches,” or “whores” (p. 751) in the course of their clinical interviews. One explanation Herman and Hirschman offered for the low self-esteem and self-denigration that characterized these survivors was that most of these women also reported that they had obtained some “pleasure” out of the CSA experience (see also Tsai & Wagner, 1978). Such “pleasure” may have derived from feeling special because they were placed in the mother’s role, given special treatment or affection from their fathers, or experienced physical pleasure. Deriving some form of pleasure left them feeling guilty, self-blaming, and ashamed. Consequently, these women believed that they did not deserve to be cared for or loved (i.e., damaged goods syndrome); they deserved only men who would manipulate and abuse them (Herman & Hirschman, 1977; Jehu, 1988). For example, 58% of survivors in Jehu’s (1988) sample endorsed “Only bad, worthless guys would be interested in me.” Other explanations for the tolerance of adult revictimization in abusive relationships may include the survivor’s inability to learn and apply assertive skills in relationships, or her lack of awareness that abusive behavior in intimate relationships is not normative and that nonabusive relationships are a viable option (Jehu et al., 1985; Jehu, 1988; Van Buskirk & Cole, 1983). It has been suggested that this nonassertive role may also have been modeled by survivors’ mothers, who may have been passive and submissive in response to a domineering, controlling men (Jehu et al., 1985).

Overall, the clinical and empirical research reviewed above demonstrates that CSA can have a powerful impact on a survivor’s ability to be involved in intimate relationships. However, there are many questions about intimacy in CSA survivors that are as yet unanswered. Future research that explores these patterns of intimacy using standardized measures and nonclinical samples of CSA survivors may provide much needed clarification and have important implications for the treatment of survivors’ interpersonal difficulties.

SEXUALITY

One area of interpersonal functioning that has received greater attention in the empirical literature is sexual functioning of survivors (Finkelhor et al., 1989; Jehu, 1989; Mackey, Hacker, Weissfeld, Ambrose, Fisher, & Zobel, 1991). It is not surprising that many survivors experience postassault sexual dysfunctions (Becker, Skinner, Abel, & Cichon, 1986), given that sexual assault is forced sexual contact, which is the ultimate violation and invasion of a person's body and psyche. Survivors often "view sexual activity not as a means of coming together with a cherished other, but as an opportunity for coercion, exploitation, and shame" (Buttenheim & Levendosky, 1994). Studies of survivors of sex crimes have found that some survivors experience sexual difficulties years after the abuse. In fact, in their clinical sample, Becker et al. (1986) found that some women reported that they were still experiencing difficulties up to 40 years after their assault.

Many theories have been offered to explain this long-term sexual dysfunction. The two-factor learning theory posits that sexual problems evolve through classical conditioning. The CSA experience initially serves as an unconditioned stimulus that elicits fear and anxiety in a survivor. The sexual aspect of CSA becomes conditioned to evoke a negative response in the victim, and this reaction may generalize to all or to selective sexual situations, behaviors, and/or interactions. Subsequent victim avoidance of sexual stimuli then perpetuates the continued negative response to sex.

The traumagenic dynamic of sexualization (Finkelhor & Brown, 1985) implicated in intimacy disruption has also been hypothesized to result in specific sexual problems in adulthood (Beitchman et al., 1991; Kendall-Tackett et al., 1993), although this relationship has not been demonstrated empirically. "Sexual contact associated in a child's memory with revulsion, fear, anger, a sense of powerlessness, or other negative emotions can contaminate later sexual experiences" (Finkelhor & Browne, 1985, p. 535). Jehu (1989) states that distorted beliefs and cognitions about sexuality and relationships may play a large role in the development of sexual dysfunctions in survivors of CSA. "Clearly, a victim's sexual functioning and satisfaction are liable to be impaired if she feels that lovemaking is wrong, dirty, or evil, even when it occurs in the context of a relationship between herself and her regular partner" (p. 58). As indicated previously, some survivors report feeling obligated to have sexual relations. This sense of obligation may contribute to feelings of discomfort, dissatisfaction, and anger, all of which have the potential to interfere with normal sexual functioning.

Limitations of the Research on Sexual Functioning in CSA Survivors

While there have been many studies of the sexual functioning of adult women survivors of CSA in the last decade, the existing literature on survivor sexual functioning has yielded equivocal findings. While some studies report that a large percentage of abused women experience significant sexual difficulties as adults (Becker, Skinner, Abel, Axelrod, & Cichon, 1984; Jehu, 1989), others conclude that abused women do not experience significantly more sexual difficulties than nonabused women (Alexander & Lupfer, 1987; Greenwald, Leitenberg, Cado, & Tarran, 1990; Parker & Parker, 1991). In part, this disparity may be attributed to variation in samples, as well as the conceptual and methodological problems associated with the majority of these studies.

Many of these studies are limited in that they have investigated sexual functioning using clinical samples of survivors (Becker, Skinner, Abel, Axelrod, & Cichon, 1984; Jehu, 1989; Tsai, Feldman-Summers, & Edgar, 1979). Additionally, many studies have not used control groups and/or psychometrically sound assessment measures. Typically, studies have conducted only limited assessment of the survivor's level of sexual functioning

(Finkelhor et al., 1989; Roesler & McKenzie, 1994; Tsai et al., 1979). Some studies have assessed current sexual functioning using only one or two questions (Roesler & McKenzie, 1994). For example, Finkelhor et al. (1989) conducted a telephone survey to investigate the relationship between sexual abuse and sexual satisfaction, marital status, religion and attitudes. One question, “(G)enerally speaking, would you say that your intimate relationships with the opposite sex are very satisfactory, or fairly satisfactory, or fairly unsatisfactory, or very unsatisfactory?” (p. 382) was used to determine the level of current sexual satisfaction.

A major limitation of the research on sexual functioning is that many studies limit the scope of investigation to behavioral aspects of sexuality, such as the ability to achieve orgasm and to attain arousal (Jayne, 1981; Tharinger, 1990). Although it is understandable that the focus on the behavioral aspects of survivor sexual functioning in past studies reflects a desire to identify easily quantifiable behavioral dysfunctions, this approach may be too narrow in terms of providing a true understanding of the complexities of sexual difficulties experienced by survivors. Typically diagnostic criteria from the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* are used to assess sexual dysfunctions. However, the problem with this assessment strategy is its emphasis on the physiological and behavioral dysfunctions (e.g., the frequency of intercourse) to the neglect of “psychological or emotional factors that may affect the quality of a sexual relationship” (Mackey et al., 1991, p. 91). Using frequency of intercourse as a measure of sexual functioning assumes that sexually dysfunctional persons would engage in intercourse less frequently. Yet, for a variety of reasons, people may have intercourse quite frequently but not like it or want it (Morokoff, 1989; Wincze & Carey, 1991).

More salient is the finding that some subset of sexual abuse survivors cannot always be differentiated from nonabused counterparts if behavioral indicators alone (e.g., frequency of intercourse) are used to assess sexual functioning. Indeed, the critical difference may be in how survivors feel and think about sexuality. Herman and Hirschman (1977) stated that survivors were afraid that “they were unable to love. The sense of an absence of feeling was most marked in sexual relationships, although most women were sexually responsive in the narrow sense of the word; that is, capable of having orgasms” (p. 750). Thus, while clinical researchers have examined sexual functioning from the perspective of a survivor’s personal distress (e.g., sexual dysfunctions), they have largely ignored the issue of how a survivor’s response to her sexual victimization may impact her sexual interpersonal relationships. It is clear that these psychological difficulties (e.g., intimacy issues related to trust, power, control, alienation, self-esteem, fear of betrayal and abandonment, preoccupation with safety in relationships, a tendency to conceal feelings, a longing for dependency, difficulty with self-protection, and confusion regarding limits and boundaries) may be the driving force behind the sexual dysfunctions. Westerlund (1992), remarking on the limitations of this area of research, notes that “[m]ost glaring was the sense that while the sexual problems experienced by women with incest histories had been categorized and catalogued, the subjective experience underlying the difficulties and dysfunctions had been largely ignored” (p. 22). This relative lack of attention given to psychological and interpersonal factors in the CSA survivor sexual functioning literature is also mirrored in the general sexual dysfunction treatment literature (Rosen & Leiblum, 1995). As early as 1981, Jayne urged researchers investigating sexual dysfunction to “go beyond the mere objective facts in order to account for female sexuality and include the subjective aspects of the sexual response” (p. 4).

The Prevalence of Sexual Dysfunction

Sexual dysfunction is not an uncommon problem, and is certainly not exclusive to survivors of CSA. Masters and Johnson (1970) reported that half of all American couples experience some form of sexual dysfunction in their lifetime. Several community studies conducted in the late 1970s (Frank, Anderson, & Rubinstein, 1978; Hite, 1976, cited in Wincze & Carey, 1991) assessed prevalence of sexual dysfunction, specifically related to desire dysfunction. In both the Frank and Hite studies, approximately 34% of women and 16% of men reported experiencing low sexual desire. A more recent study (Rosen, Taylor, Leiblum, & Bachmann, 1993) examined the prevalence of sexual dysfunction in a sample of women in an outpatient gynecological clinic. Rosen et al. found that 38.1% of the women reported anxiety or inhibition, 16.3% reported lack of pleasure, 15.4% reported orgasmic difficulties, 13.6% reported lack of lubrication, and 11.3% reported pain during intercourse. These studies did not question respondents about histories of CSA, so it is not known to what extent CSA may have contributed to the reported sexual dysfunctions.

Prevalence rates of sexual dysfunctions reported for CSA survivors have been quite variable. This variability can be attributed both to use of different definitional criteria for CSA and sexual dysfunctions across studies and the variation across samples (i.e., community, college, and clinical samples). For example, studies using college samples generally have reported a lower prevalence of sexual dysfunctions in abuse survivors (Alexander & Lupfer, 1987; Fritz, Stoll, & Wagner, 1981; Parker & Parker, 1991). In fact, a recent review of the literature on the prevalence of sexual dysfunctions in abused women (Clarke, 1993) found that four of the five studies that reported no differences between abused and nonabused groups had sampled college students. A recent meta-analysis of the relationship between CSA and adult psychological adjustment also found fewer sexual adjustment problems in college samples of survivors (Jumper, 1995).

Higher rates of sexual difficulties and dysfunctions are reported in studies using clinical samples of CSA survivors. Tsai et al. (1979) reported that "the impacts of the molestation on women in the clinical group appear to be similar to the impacts of rape on the victim several months after the assault" (p. 414), in terms of reported level of sexual satisfaction. When comparing clinical and nonclinical abused groups and a nonabused control group, Tsai et al. (1979) found that the clinical group reported significantly more sexual problems than did the other two groups. Becker et al. (1986) found that 59% of a treatment sample comprised of childhood abuse and/or rape survivors stated that they were experiencing at least one sexual problem, compared to 17% of nonabused women in a control group. Sixty-six percent of survivors reported they had experienced two or more sexual problems; 69% of the total survivor sample attributed their sexual difficulties to their assault. Of 51 women with histories of CSA in a treatment group sampled by Jehu (1989), 94% reported sexual dysfunctions.

Community samples have reported variable rates of sexual dysfunctions in CSA survivors. Mackey et al. (1991) explored the current sexual functioning of survivors of adult sexual assault by comparing women who experienced one abuse event, more than one event, and a history of CSA. Although 80% of the sample reported sexual dysfunction, the greatest impairment was reported by women who had experienced one abuse event and those with histories of CSA in addition to their adult assault. Similarly, Gorcey, Santiago, McCall-Perez (1986) found that 85% of women in the CSA survivors group of their community sample reported difficulties in sexual functioning and sexual relationships. However, Greenwald et al. (1990) sampled a group of nurses and found no differences in sexual functioning between abused and nonabused groups.

In addition to different rates of sexual dysfunctions being reported between abused

and nonabused groups, qualitative differences have also been found. Becker et al. (1986) examined the sexual functioning of women with histories of rape and/or incest and women with no such histories. Not only did abused groups report significantly more sexual dysfunctions, they reported different types of dysfunctions as well. Problems reported by the nonabused women “were more suggestive of a decline in the quality of the total sexual experience than of the occurrence of specific symptoms” (p. 46). These problems included boredom and less intense orgasms; the women did not report an associated loss of sexual desire. Abused women reported more specific difficulties, such as fear of sex, lack of desire, and arousal dysfunction. Another difference between abused and nonabused groups was the duration of the difficulties reported. The abused group reported more chronic difficulties, sometimes lasting many years. Thus, although there are great differences in prevalence of sexual dysfunctions reported by survivors of CSA, the literature suggests that abuse survivors typically report more sexual difficulties as well as different types of difficulties compared to nonabused women.

Empirical Support of the Impact of Child Sexual Abuse on Sexuality

Sexual problems associated with CSA have been reported in a number of empirical studies of child and adolescent victims of sexual abuse in which survivors were 18 or younger. Most of these studies have been conducted in the last decade (Kendall-Tackett et al., 1993). Samples have been typically drawn from assessment or treatment programs and have combined victims of both intrafamilial and extrafamilial abuse. By far, the most commonly studied postabuse symptom has been sexualized behavior (Kendall-Tackett et al., 1993). Following CSA, children may act out sexually in age-inappropriate ways toward adults and other children (Hotte & Rafman, 1992; Van Buskirk & Cole, 1983). This may take the form of offending against other children (Masson, 1995; Sheldrick, 1991), masturbating excessively or publicly, being obsessed with sexual thoughts and fantasies (Friedrich & Luecke, 1988), requesting sexual stimulation from other children or adults, exhibiting seductive behavior, and frequently exposing their genitals (Browne & Finkelhor, 1986). “Children who have been traumatically sexualized emerge from their experiences with inappropriate repertoires of sexual behavior, with confusions and misconceptions about their sexual self-concepts, and with unusual emotional associations to sexual activities” (Finkelhor & Browne, 1985, p. 531). For a more extensive discussion of the impact of CSA on children, readers are referred to reviews of empirical studies by Beitchman, Zucker, Hood, daCosta, and Akman (1991) and Kendall-Tackett et al. (1993).

There is a great amount of variability reported about the effect of CSA on long-term sexual adjustment. Some studies report a high prevalence of sexual dysfunction within abused groups and large differences in sexual functioning between abused and nonabused groups (Becker et al., 1986; Gold, 1986; Herman, 1981; Jehu, 1988; Meiselman, 1978). Other studies report no dysfunction within abused groups and/or no differences between groups (Alexander & Lupfer, 1987; Greenwald et al., 1990). A description of the empirical findings concerning the relationship between CSA and the different categories of adult sexual dysfunction follows.

Desire dysfunction. Clinical researchers in the area of sexual dysfunction have conceptualized a number of possible causes for lack of desire for sexual relations. For example, Wincze and Carey (1991) identify three different affective characteristics or states that may accompany a lack of desire for sexual relations. The first is a neutral feeling; the person is just not concerned with sex. It is not very important to her and she can take it or leave it. The second is a negative feeling; the person feels guilty and/or depressed

about the lack of desire. She feels abnormal. The third characteristic is a feeling of fear and/or anxiety; the person is afraid of sexual activity and attempts to avoid it. H. S. Kaplan (1979, cited in Beck, 1995) proposed that low sexual desire is the “result of intrapsychic anxiety, ranging in level from mild (e.g., guilt over sexual pleasure) to moderate (e.g., fear of intimacy) to deep anxiety (e.g., unconscious fears of injury)” as well as anger, and these emotions suppress “sexual desire by provoking negative emotional states” (p. 920, cited in Beck, 1995). These affective states associated with desire problems reported in the dysfunction literature correspond to the affective patterns associated with intimate dysfunction, which have been reported by survivors of CSA.

Clinical researchers have reported that some CSA survivors state a preference for celibacy. For this group of women, abstaining from sex provides a sense of being in control over one’s sexuality. Celibacy also allows freedom from the perceived negative psychological impact (e.g., shame, fear) of sexuality (Jehu, 1988; Westerlund, 1992). When survivors in this group engage in sexual relations, it is often out of a sense of obligation, and some report that they cannot wait for the experience to end. This pattern is termed either *impaired motivation* (Jehu, 1988) or *desire dysfunction* (Becker, Skinner, Abel & Cichon, 1986). Lack of desire may be directed toward one person, one situation, or it may be generalized to all sexual activity (Jehu, 1988). Typically a relatively high frequency of women reporting a lack of sexual desire have been identified in clinical samples of CSA survivors. In Jehu’s study, 56% of the women reported having little to no desire for sexual activity. Jehu (1988) offered several possible explanations for the low level of sexual desire reported by this group of survivors including: depression, other difficulties with partners, fear of intimacy, or other sexual difficulties that result in sex being painful, dissatisfying, or stressful. Similarly, in the Becker et al. (1986) study, 56% of the abused women and 6% of the nonabused women reported low sexual desire. The prevalence rates of desire dysfunction reported in college populations have been variable. Jackson et al. (1990) found that 50% reported inhibited sexual desire. In contrast, Fromuth (1986) found that CSA was not related to sexual desire in her college sample. A community study by Greenwald et al. (1990) found no difference in sexual desire between abused and nonabused women.

Kaplan and Harder (1991) developed a scale to assess the psychological functioning underlying sexual desire (i.e., subjective discomfort and conflict). This instrument, the Sexual Desire Conflict Scale for Women, is intended to “reflect women’s subjective discomfort and conflict in relation to their own sexual desire” (Kaplan & Harder, 1991, p. 1275). Kaplan administered the instrument to a sample consisting of three groups of women: CSA survivors, survivors of nonsexual trauma, and women with no trauma history. CSA survivors reported significantly higher conflict regarding sexual desire compared to women in the other groups. Kaplan states that these women may have normal desire for sexual relations, but are in conflict with these feelings because of their abuse histories. “[A]dult experience of sexual desire will have accrued conflictual meanings which interfere with an ability to incorporate and accept the desirous elements of their personalities” (Kaplan, 1990, p. 15). CSA survivors may cope with these sexual feelings by denying them and avoiding sexual activity, or try to gain control of them by initiating many casual sexual interactions. “Each end of the spectrum of sexual behaviors/symptoms—from aversion to compulsion—may represent an over-determined response to the individual’s experience of *desire*” (p. 20).

In summary, at least in the studies reviewed involving clinical samples, a significant proportion of abused women reported little to no desire for sexual activity or reported conflict regarding their feelings of desire. Future research in the child abuse and sexual dysfunction fields should examine the role that CSA plays in the development of this

disorder and the possible implications that such a history may have for treatment.² It is also important to determine the factors that account for differential rates of sexual desire dysfunction reported in clinical, college, and community samples.

Phobias. Another category of sexual dysfunction reported in clinical research with CSA survivors is sexual phobias. Jehu (1988) described this problem as a fear of, or aversion to, certain sexual acts or aspects of sexual activity typically associated with memories of specific aspects of the abuse. He stated that CSA survivors who experience sexual phobias may exhibit intense and irrational anxiety, sweating, nausea, vomiting, diarrhea, or palpitations. In Jehu's treatment sample, 58% of the sexually abused women reported a sexual phobia or aversion. Similarly, in Becker et al.'s (1986) treatment sample, 54% of abused women (rape and CSA) versus 24% of nonabused women experienced fear of sex. Mackey et al. (1991) found that 75% of the CSA survivors in their community sample reported some type of fear when anticipating sexual intimacy. Major themes in this area were mistrust, flashbacks, lack of control, fear of emotional and physical closeness, and fear of losing a partner. Gorcey et al. (1986) found that 43% of the abused women in their community sample reported a fear of sex. The authors are unaware of any college studies that have explored this variable.

Jehu (1988) suggests that phobic reactions may be attributed to memories of specific aspects of the abuse. For example, fellatio may evoke fear in a woman whose offender forced her to engage in this activity. Experiencing flashbacks to the molestation during sexual activity may also initiate a phobic reaction to sex. Women who were forcibly molested or coerced into sex may also become phobic in subsequent sexual interactions unless they are in complete control of the sexual activity, in which case they may be able to experience arousal. Some survivors may become phobic if they experience physical pleasure during sexual activity. Jehu suggests this reaction may derive from the guilt and shame associated with the experience of physical pleasure during the CSA episode. A common consequence of sexual phobias is a reduction in the range or frequency of sexual activity. A sexual phobia typically involves an element of anticipatory anxiety; the survivor is sufficiently sexually inhibited so as to not want to engage in any form of sexual activity, thereby impairing her sexual desire (Jehu, 1988). Subsequent avoidance of sexual activity is likely to maintain the fear of sex.

Vaginismus and dyspareunia. Vaginismus is a spastic contraction of the vaginal muscles and is an involuntary reflex response to the threat of vaginal penetration. If there is sexual activity, it will occur with great pain. This is usually accompanied by a fear of penetration, which could occur either before or after the onset of vaginismus (Jehu, 1979, cited in Jehu, 1988). Seven percent of the abused women in Jehu's treatment sample reported having this difficulty. In Becker et al.'s (1986) treatment sample, 2% of abused (i.e., rape and CSA) versus 0% of nonabused women reported this problem. Jackson et al. (1990) found that 10% of abused women reported this problem in their college/community sample. LoPiccolo and Stock (1986) stated that women who sought treatment for sexual dysfunctions and who reported incestuous abuse in childhood were "especially likely to present with vaginismus as part of their sexual dysfunction" (p. 161). The only explanation offered for the relationship between vaginismus and CSA has been offered by Jehu. He

²A recent review of the literature on hypoactive sexual desire disorder (Beck, 1995), which includes information on models of the etiology, maintenance, and treatment of the disorder, makes no mention of CSA and adult sexual assault.

states that vaginismus may be a result of pain in current sexual activity or a learned response to painful intercourse during childhood abuse, in which case the woman develops an involuntary avoidance reaction.

Dyspareunia occurs when the woman experiences pain during intercourse. Jehu (1988) states that this may be due to lack of lubrication or involuntary muscular contractions (i.e., vaginismus). In clinical studies, Jehu found that 27% of the abused women reported this difficulty and Becker et al. (1986) found that 11% of the abused group (i.e., rape and CSA) reported this problem compared with none of the nonabused group. In a college/community study, Jackson et al. (1990) found that 25% of abused women reported problems in this area.

Arousal dysfunction. Some survivors of CSA may not experience impairment in sexual desire but instead experience problems in the arousal phase of the sexual response. Arousal difficulties include physical and/or psychological arousal components. Arousal dysfunction may be generalized (i.e., primary) or occur with certain partners or in certain situations (i.e., secondary; American Psychiatric Association, 1994). Within clinical samples, Jehu (1988) found that 49% of the abused women reported this difficulty; Becker et al. (1986) reported that 51% of the abused (i.e., rape and CSA) women reported problems with sexual arousal compared to 24% of the nonabused women. Greenwald et al. (1990) did not find any difference in rates of arousal difficulties reported by abused and nonabused women in a community sample. In a college/community sample, Jackson et al. (1990) stated that 35% of abused women reported inhibited sexual excitement.

Jehu (1988) has hypothesized that arousal dysfunction in CSA survivors may stem in part from the lack of control experienced during the abuse. As is true with sexual phobias, the survivor may be able to experience arousal if she can be in control of the sexual activity. Arousal problems also may be associated with the process of dissociation. Abused children may attempt to cope or defend against abusive events by dissociating themselves from the abuse experience (Briere, 1992b); many survivors continue to use this strategy into adulthood with other partners. It would appear to make sense that if a woman is not emotionally "present" during the sexual activity, becoming aroused would be difficult for her (Jehu et al., 1985).

Orgasmic dysfunction. Another difficulty reported by many survivors is the inability to achieve orgasm. These women may be sexually functional in all other respects, but unable to achieve climax/orgasm. There are three types of orgasmic dysfunction identified in the clinical literature on sexual dysfunction: primary/lifelong orgasmic dysfunction, which occurs when the woman cannot have an orgasm at all, secondary/acquired orgasmic dysfunction, which occurs when the woman has been able to achieve orgasm at one point, but no longer can, and situational secondary/situational orgasmic dysfunction, which occurs when the woman cannot achieve an orgasm in certain situations, but can in others.

Within clinical samples, Jehu (1988) found that 45% of abused women reported having an orgasmic dysfunction of some type. Becker, Skinner, Abel, Axelrod, and Cichon (1984) found that the type of abuse (i.e., rape, incest, or both) experienced by a survivor did not predict the type of sexual difficulty experienced except for primary nonorgasmia. This dysfunction was more prevalent in the group that had experienced both rape and incest. Tsai et al. (1979) found that abused women in her clinical sample reported significantly fewer orgasms during intercourse than those in either the nonclinical abused group or the nonabused control group. However, there were no differences in frequency of orgasms during masturbation reported across groups. Becker et al. (1986) found that the nonabused group in their sample actually reported more difficulties in primary and situational second-

ary nonorgasmia; the abused group reported more difficulties with secondary nonorgasmia. In a community sample, Mackey et al. (1991) compared rape and CSA survivors and found that only the CSA survivors (25%) reported difficulties with orgasm. Within college samples, Jackson et al. (1990) found that 45% of abused women reported inhibited orgasm, whereas Fromuth (1986) found no difference between abused and nonabused groups.

Jehu has hypothesized that orgasmic difficulties may occur because of fear of loss of control over one's body or because of a lack of arousal (Jehu, 1988). Maltz and Holman (1987) also suggest that the survivor has learned through her childhood experiences how to pleasure a partner, but may not be aware of how to pleasure herself or how to ask her partner to pleasure her.

Psychological Components of Sexual Dysfunctions

Psychological components of sexual dysfunctions involve underlying cognitive and affective schemata associated with the expression of sexuality and include such aspects as desire for sexual activity, level of comfort with sexual activity or sexuality as a whole, sexual communication, pleasure, anxiety, guilt, fear, interpersonal trust, and intimacy. Few studies have examined these specific areas of functioning. However, those that have examined these constructs have reported that these components have a great impact on the sexual functioning of survivors. For example, Mullen et al. (1994) found that 25% of abused women in their sample "believed that their own attitudes and feelings about sex were likely to cause problems or disrupt the satisfaction such relationships brought them, as opposed to only 12% of the [women in the nonabused] control [group]" (p. 39). However, most of these studies of women's sexual responses to CSA have been limited in terms of the adequacy with which the psychological components were assessed.

Becker, Skinner, Abel, Axelrod, and Cichon (1984) found that difficulties with "response inhibiting problems" were reported three times more often than orgasmic problems and seven times more often than intromission problems (i.e., vaginismus and dyspareunia). These investigators hypothesized that sex becomes anxiety-provoking for the survivor because of its association with the childhood sexual assault; this anxiety causes the survivor to "relabel her sexual feelings as either reduced or absent altogether" (p. 18). They also suggested that it is not only the assault itself, but the loss of trust in a perpetrator who was emotionally close to the child that leads to the increase of problems for incest survivors. Becker et al. found that sexual relationships, more than other interpersonal relationships, are based on trust and that this loss of trust "most probably has a particularly enduring impact on future relationships" (p. 18).

The Becker, Skinner, Abel, Axelrod, and Cichon (1984) study made a significant contribution to the literature relating CSA and sexual dysfunctions since it articulated the importance of psychological components in sexual functioning. However, a structured interview format was used to provide this information. Standardized assessment instruments were not used since these were not readily available at the time. Unfortunately, only those psychological components reported by survivors were discussed. From subsequent clinical and research reports involving survivor responses to open-ended questions, it now appears that many other components could be evaluated that would allow for a more comprehensive, multifaceted conceptualization of sexual dysfunctions in CSA survivors. This would necessarily have implications for both clinical assessment and treatment. Future research must assess a wider range of psychological components using standardized instruments, which should provide a challenging task for clinical researchers.

Psychological aspects associated with sexual desire (i.e., perception of sex as obligatory, decreased desire or passive/active avoidance of sexual intimacy, emotional detachment,

and adverse feeling states [e.g. anger, anxiety, mistrust]), and components of arousal (i.e., decreased satisfaction or pleasure and flashbacks) were investigated in the community sample interviewed by Mackey et al. (1991). Rape survivors were assigned to one of three groups: those who had experienced one abuse event, those with multiple abuse experiences, and those who had histories of CSA as well as an adult rape experience. Since this study focused on victims' responses to adult sexual assault, there was no group that consisted solely of adult CSA survivors. Dysfunction was assessed in two ways. First, five open-ended questions were asked about the effect the assault had on the survivors' relationships in general, and specifically on affection, tenderness, communication, pleasuring, and intercourse. Second, the investigators used cognitive imagery to assess the level of fear associated with anticipating sexual intimacy and to explore what the survivors required for sexual satisfaction. Women in all groups reported that their assaults had the greatest impact on their relationships in general; in addition, affection, communication, pleasuring, and intercourse were all affected to varying degrees in all groups. For the women with histories of CSA, 19% experienced emotional detachment, 44% reported mistrust/fear of men, 38% experienced decreased sexual pleasure, 25% reported having sexual relations motivated by a feeling of obligation to their partner, 19% reported feeling anger during sex, 25% reported orgasmic dysfunctions, 13% experienced anxiety around the sexual relationship, and 19% reported experiencing guilt. CSA survivors reported dysfunctions as severe or more severe than women in the two rape groups in terms of decreased sexual pleasure, obligatory sex, emotional detachment, anxiety, and fear of anticipated sexual intimacy. The CSA group was also the only group to report orgasmic dysfunction and guilt.

Westerlund (1992) provided one of the most comprehensive examinations of the nature of psychological components associated with sexual dysfunctions in her study of women's sexuality after childhood incest. Her research sample included 43 adult women recruited from a self-help support group for incest survivors who completed the Westerlund Incest Survivors Questionnaire and focused interviews. While 84% of the participants were involved in concurrent psychotherapy, only 5% had ever been in sex therapy and no one was at the time of the study. The illustrative examples provided by the women as they expressed their feelings and thoughts about sexuality and intimacy should prove particularly enlightening for clinicians and researchers alike.

Westerlund (1992) found that 53% of the women who participated in her study reported interference with the sexual desire phase of sexual functioning, and 14% reported an absence of sexual desire. Interference with the desire phase of functioning took several forms. Westerlund identified patterns of disinterest in and lack of desire for sexual activity or conflicts about feeling desire and attempts to deny the desire. Some of the women described their experiences associated with desire as including feeling guilt and shame (53%) about their desires; they feared that having sexual desire "proved" that they wanted the incest to occur and in some cases these feelings were accompanied by "self-loathing" or "self hatred" (p. 77). They also reported a negative view of sex and sexuality, confusion about the differences between affection and sexuality (i.e., "Can I have love, nurturance, and closeness without having to pay for it by sex?" (p. 78). For these women issues of power and control were associated with those of sexual desire.

Westerlund (1992) also found that 84% of the respondents reported interference with the sexual arousal phase of functioning. An absence of sexual arousal at the time of the survey was reported by 26% of the women. The dynamics of specific difficulties with sexual arousal, as reported by the respondents, were strikingly similar to those reported for sexual desire (e.g., feelings of guilt and shame and issues of control), as well as fears of vulnerability while aroused, fears of humiliation, and the ability to be physically but not emotionally aroused. Twenty-six percent of the sample reported interference in the

orgasmic phase of sex. Several women who were able to experience orgasm reported that they did not achieve pleasure from this experience. The respondents reported feelings of shame associated with perception of being viewed as sexual, fears of vulnerability, and loss of control, which affected their orgasmic abilities.

Sexual dissatisfaction is a factor that has been assessed in more studies, albeit to a limited extent, than any other psychological factor associated with sexual dysfunction. Unfortunately, most studies that have assessed survivors' sexual satisfaction have done so using a single question. Sexual dissatisfaction may result from one or more other sexual dysfunctions, or it may exist independently of dysfunction. It is possible for a woman to be aroused, want sexual activity, even experience orgasm, and still feel dissatisfied (Jehu, 1988). Many studies have reported the prevalence of different dysfunctions, but have not reported how dissatisfaction may be related to dysfunctions. Thus, in the following studies, it should be noted that reported dissatisfaction was not necessarily independent of other reported sexual dysfunctions.

In Jehu's (1988) clinical sample of abused women, 58% reported dissatisfaction in their sexual relations. Tsai et al. (1979) assessed sexual satisfaction in clinical abused, nonclinical abused, and nonclinical control groups with a single question. They found that the clinical group reported significantly less satisfaction than the nonclinical or control groups, and there was no difference between the latter two groups. Jackson et al. (1990) examined sexual functioning in a college community sample and found that sexually abused participants reported less satisfaction in their sexual functioning on the satisfaction scales of the Derogatis Sexual Functioning Inventory (Derogatis, 1975) than did the nonabused group. Westerlund (1992) found that 60% of her sexually active incest survivors reported more satisfaction than dissatisfaction, with 25% reporting total satisfaction at times, and 13% reporting total dissatisfaction at times. Respondents reported both satisfaction and dissatisfaction following sex. Dissatisfaction following sex was associated with feelings that they had been "used," which was a common response. Feelings of guilt, sadness, and shame after sex were associated with dissatisfaction. Alexander and Lupfer (1987) explored sexual functioning in a college sample of abused and nonabused participants. These investigators reported using a scale of sexual satisfaction, although they do not specify what scale was used or the item content. They did suggest, however that the instrument used may not have been sensitive enough to detect possible difficulties, given that no differences were found between the abused and nonabused groups. Indeed that may have been the case. An alternative explanation is that the college survivor sample was less affected in this area, as has proved to be the case with other outcome measures.

Many clinicians and researchers have assumed that sexual satisfaction can be accurately assessed by the reported frequency of sexual activity or orgasms. However, the suggestion has been made (Jayne, 1981; LoPiccolo, & Stock, 1986) that satisfaction of sexuality encompasses more than behavioral activity or responses. Jayne (1981) reviewed research on female sexuality and reported that women engaged in intercourse more often than masturbation. Jayne attributed this to the intimate component of coitus, in spite of the fact that orgasm was less likely to occur during coitus, and coital orgasms are typically less intense than those achieved through masturbation. Jayne concluded that ratings of satisfaction with sexual activity are not dependent on the amount or intensity of pleasure derived from orgasms. Instead, it appears that many women report greater sexual satisfaction through intimacy with partners (i.e., the emotional and interpersonal aspects of sexual activity), even when this does not include pleasure through achieving orgasms (see also LoPiccolo & Stock, 1986).

This pattern may be particularly characteristic of some survivors of CSA. While some survivors report that they experience satisfaction with their sexual activities, they also

report that they are anxious during sex, do not experience pleasure, and are relieved when sexual activity ends. Concomitant with these reports they indicate satisfaction in being able to engage in intercourse, pleasuring their partner, etc. This discrepancy between satisfaction and the experience of personal pleasure suggests that these women may interpret satisfaction not as a personal experience of physical pleasure but as an experience in which they provide pleasure to their intimate partner. In addition, women who report that they are celibate may also report satisfaction with their sexual lives. This may reflect their satisfaction with their choice not to desire sexual involvement (Jayne, 1981). Unless researchers inquire more deeply into the dynamics of sexual satisfaction, particularly as it applies to survivors of CSA, an accurate understanding of its dimensions will remain unknown.

Other psychological components of sexual problems that have been studied in CSA survivors include intrusions, sexual anxiety and guilt, and sexual self-esteem. First, certain activities within their adult sexual experiences may serve to trigger intrusive thoughts, feelings, or flashbacks associated with the abusive experience(s); these intrusions serve as constant reminders of the abuse. In one study (Laviola, 1992), 12 of 14 women reported intrusive thoughts or memories of their sibling incest experiences. Nine of these women reported that they felt that they were actually reliving the abuse experience. This reexperiencing of CSA trauma may have serious repercussions on the survivor's sexual relations. The flashbacks may be sufficiently disruptive to result in the avoidance of sexual relations altogether. Second, guilt may be experienced by survivors. Langmade (1983) studied the prevalence of sexual anxiety and sexual guilt in abused and nonabused women and found that abused women more often reported these problems. In a community sample of abused and nonabused women and men, Hunter (1991) found that female victims obtained higher scores on the symptomatology and fantasy scales and lower scores on the affect scale of the Deragotis Sexual Functioning Inventory (Deragotis, 1975) than did nonabused women. Finkelhor (1980) studied sexual self-esteem in a college sample of men and women who reported sibling sexual experiences and found that females who reported such experiences had higher levels of current sexual activity than those who did not report sibling experiences. Females who reported sexual experiences self-rated as positive that occurred after the age of 9 reported higher levels of sexual self-esteem. In contrast, those whose experiences occurred before the age of 9 and that involved much older siblings reported lower sexual self-esteem. The latter group also did not report higher levels of current sexual behavior. Finkelhor cautioned against interpreting these results to mean that sex between siblings is not harmful or that there is necessarily a causal association between the incest experience and these findings. He suggested several interpretations of the results. One interpretation was that the sample was biased, consisting of a more psychologically healthy group. A second interpretation was that people with higher sexual self-esteem would be more open to reporting a sibling sexual experience than those with lower sexual self-esteem. Fromuth (1986) also examined sexual self-esteem in a college sample using Finkelhor's scale and found no difference between abused and non-abused women.

Psychological components of sexual functioning also include the CSA survivor's potential for intimacy. As Wincze and Carey (1991) have commented "Sexual health involves more than just intact physiology and typical 'functioning' (i.e., progression through desire, arousal, and orgasm phases) . . . sexual health is enhanced to the extent that it occurs in a rich interpersonal context that involves respect and trust, open lines of communication, and mutual commitment to all aspects of the relationship" (p. 7). However, few published empirical studies have concurrently examined the variables of intimacy and sexual functioning.

These findings demonstrate that there are detrimental long-term consequences for sexual functioning in survivors of childhood sexual victimization. The psychological components that have been explored were found to be significant in facilitating our understanding of sexual dysfunctions. Certainly specific behavioral and physiological outcomes associated with adult functioning in CSA survivors must continue to be assessed. However, the saliency of underlying cognitive and emotional aspects associated with sexuality for the improvement of survivor functioning cannot be underestimated. The above findings have important implications for both research and treatment.

Sexual Orientation

The authors are aware of no published empirical studies that have specifically examined difficulties with intimacy and sexuality experienced in adult gay, lesbian, or bisexual relationships as a function of CSA experiences. The authors contacted the staff of Division 44, The Society for the Psychological Study of Lesbian and Gay Issues, of the American Psychological Association, and they indicated that they were unaware of any such research studies (personal communication, January 4, 1996). In a recent review of the long-term effects of child sexual abuse, sexual orientation was not even mentioned (Polusny & Follette, 1995). One clinical study by Van Buskirk and Cole (1983) inquired about sexual orientation in their clinical sample of CSA survivors. They found that two thirds of their sample reported same-sex experiences, although only one third of these women considered themselves to be lesbian. They further reported that these women reported difficulties with sexual relations, as had the heterosexual women. "They report homosexual encounters as being less sexually threatening, yet apparently find the emotional component of intimacy affecting their ability to enjoy any sexual relationship" (p. 512).

Some studies have attempted to establish a connection between CSA and sexual orientation (i.e., lesbianism or celibacy). The underlying assumption is that these orientations result from failed heterosexuality, as opposed to being a choice or option independent of heterosexuality. Other authors, however, caution against this assumption (Meiselman, 1978; Westerlund, 1992). Blume (1990) has gone so far as to state that trying to find the cause (e.g., CSA) of homosexuality may communicate prejudice against it. As has been discussed in this article, the trauma of child sexual abuse exerts an influence on various aspects of the survivor's sexuality. Although CSA may also influence sexual orientation as well as behavior, most studies that have attempted to examine the association between CSA and subsequent sexual orientation have not identified or assessed sexual orientations or behaviors prior to abuse. Thus, it is not possible to make a causal connection between CSA and sexual orientation. Of course, because of negative attitudes that have prevailed toward homosexuality, it also is possible that even if survivors were asked about their sexual orientation, they may have been reluctant to report same-gender sexual feelings or experiences (Hyde, 1994; Westerlund, 1992).

Most of the studies that have examined the relationship between CSA and a lesbian sexual orientation have provided information about the CSA experiences reported by clinical samples of incest survivors. Thus, interpretations made from this group of survivors may not be generalizable to the broader population of lesbians with histories of extrafamilial CSA. Herman (1981) interviewed 40 outpatient clients who reported histories of incestuous experiences. A small number of these survivors reported a lesbian or bisexual orientation (i.e., 2 identified themselves as lesbian, 3 as bisexual). The 2 lesbian women reported that their sexual orientation was influenced by their abuse histories. "For these women, development of a lesbian identity seemed to be an adaptive and positive way of coming to terms with the incest trauma" (p. 105). The survivors explained that they had

difficulty being sexual with men and stated they were looking for “female nurturance” and sexual relations that “could be mutually satisfying rather than exploitative” (p. 104). However, it should be noted that the number of women reporting different sexual orientations in this sample are not substantially different from those numbers reported in non-abused populations (Hyde, 1994).

In a clinical sample of 23 incest survivors, Meiselman (1978) found that 1 woman reported being a lesbian before she was abused by her stepfather, and one third (7) of the women “had become gay or had significant experiences or conflicts centered on homosexual feelings” (p. 245). While some women reported that they began experiencing homosexual feelings around the time that incest was occurring, others did not recognize them until much later. This number is larger than reported in other studies, and Meiselman cautions that this may have been a sampling issue. She also comments that clinical samples may yield higher numbers of women reporting a lesbian orientation because women are probably more likely to divulge this information to their clinician with whom they have established some sort of trusting relationship than to a researcher, about whom they know very little and with whom they have spent little time. Meiselman cautions that “It seems plausible that overt incest may sometimes cause female homosexuality, but this hypothesis should not be read as implying that overt incest is a *frequent* causal factor in female homosexuality” (p. 260). She further states that there are many dynamics in these women’s lives that may have influenced their sexual orientation.

Maltz and Holman (1987) found that half of the women in their study who reported their orientation as lesbianism stated that incest had no influence on their orientation, whereas the other half stated it did. Westerlund (1992) reported that of 43 participants with incest histories, 42% were heterosexual, 35% lesbian, 9% celibate, 9% undecided, and 5% bisexual. She cautions that these percentages should not be used to generalize about frequencies of sexual orientation among survivors because this sample was specifically chosen to represent women with orientations other than heterosexual. Sixteen percent of all respondents stated that the incestuous experience had influenced their choice of sexual orientation, with the majority of these women being celibate. Several participants reported being dissatisfied with or confused about their sexual orientation, all of whom reported a heterosexual orientation. Some reported that they would rather be celibate, while others reported a desire to be lesbian. Forty percent of the lesbian respondents reported difficulties when “coming out” because they felt stigmatized again, as they did from the incest. One third of the lesbian respondents reported having sexual experiences with men in an attempt to avoid the feeling of being stigmatized again. Women of all orientations feared that their choice would be viewed as being directly related to the incest experience.

Finkelhor (1980) reported on the frequency of homosexual activity in young adulthood in persons with sibling sexual experiences and those without this history. No significant group differences were found. However, he also found that of those individuals with homosexual sibling experiences, 23% reported homosexual activity within the past year. Again, this does not imply causation, but as Finkelhor suggests, persons with homosexual orientations may be more likely to have these experiences in childhood as well as adulthood. Finally, Fromuth (1986) inquired about sexual orientation in her college population study. She found a significant relationship between CSA experience and having a homosexual experience after the age of 12.

There have been a few studies conducted with individuals identified as lesbians or gay males that have inquired about CSA. For example, a study of 29 lesbians and 54 gay males inquired about the incidence and prevalence of incestuous experiences, as well as the aftereffects of such experiences (Simari & Baskin, 1982). The researchers found that

38% of the women and 46% of the men reported an incestuous experience. Ninety-six percent of the males (all of the male participants had experienced same gender incest) and 45% of the females (36% of the females had experienced same gender incest) reported that they were “homosexual” before the abuse occurred. The authors cite Yorukoglu and Kempf (1966) as stating that, after experiencing same heterosexual incest, individuals “often seek to escape into homosexuality” (Simari & Baskin, 1982). However, they also state that using sexual orientation as a coping mechanism may occur more frequently in individuals “whose own sexual orientation is not firmly integrated” (p. 339) at the time of the incestuous experience. Not all participants evaluated the experience as a negative one, but of those who did view this as negative (23% of the males and 64% of the females), most were either in therapy at the time of the study or had been in therapy in the past. The problems for which they sought treatment included interpersonal problems, sexual problems, depression, anger, and guilt. Although the researchers did not focus on these problem areas, the range of difficulties reported are the same as have been noted for heterosexual survivors of CSA (Simari & Baskin, 1982).

Most of the studies that assessed sexual orientation have reported similar incidence rates of CSA for lesbian and heterosexual women. However, several studies have reported higher percentages of CSA experiences for lesbian women in their samples. For example, a study by Gundlach and Riess (1967) found that 17% of the lesbian women and 7% of the heterosexual women reported a history of child sexual abuse. In a study of lesbian ($n = 225$) and heterosexual ($n = 233$) women, Gundlach (1977) found that 18 women were molested by a stranger or friend before the age of 16. Ten of the 18 molested women reported a lesbian sexual orientation and 8 reported a nonlesbian sexual orientation. Further, of the 17 women who reported molestation by a close family friend or relative, 16 identified themselves as lesbians. Also, Cameron, Proctor, Coburn, Forde, and Cameron (1986) found in a random sample in five U.S. cities, that 77% of lesbians/bisexuals claimed sexual activity with an adult as a child, compared to 15% of heterosexual women.

In conclusion, no causal connection has been established between a history of CSA and homosexuality in women. “[O]ne is not gay by default, that is, who one loves is not defined by who one hates. A woman who hates men because she was molested by a man does not gain the capacity to be aroused by women” (Blume, 1990, p. 228).

TREATMENT STUDIES³

Much of the literature that addresses issues of interpersonal functioning of CSA survivors consists of self-help books, clinical reports addressing observed effects, and articles that address broad treatment issues or strategies applicable to the treatment of survivors. However, there is a void in the empirical literature in terms of treatment outcome studies. Although much has been written about the issues, processes, and strategies for treatment with survivors, there have been decidedly few studies that have used control groups, assessment procedures, or outcome measures. As stated by Conte and Schuerman (1988) in regard to the literature on the effects of sexual abuse on children, “While such reports are useful in providing a context for discovery, without measurement or control procedures, they fail to demonstrate with any certainty what the actual functioning of children is

³This section not intended to be a comprehensive review of treatment literature concerning CSA survivors. The intent is to provide an overview of the sexual/intimacy issues that may be salient in survivor therapy.

and what may account for such functioning” (p. 158). The same may be stated for the interpersonal functioning of adult survivors of CSA.

There are several treatment modalities discussed in the clinical literature for use with survivors of CSA. These include: individual psychotherapy, group psychotherapy, sex therapy, individual psychotherapy with partner consultation, and couples therapy. There are different interventions and issues associated with each of these modalities, and without empirical support it is unclear which modality should be used with what clients and when.

There are currently many different general sex therapy programs available for sexual dysfunctions, but very few incorporate specific interventions that target issues unique to CSA survivors. The survivor treatment literature discusses many common issues as to sexual functioning that are often a focus of therapy with survivors of CSA within a broader treatment protocol. One of the sexual difficulties noted is that survivors may, in the midst of a sexual experience, confuse their partner with their perpetrator (Buttenheim & Levendosky, 1994). They may experience flashbacks to the abuse and reexperience the feelings of shame and disgust. “Feelings experienced at the time of the incest such as guilt, fear, shame, and helplessness have typically become conditioned with sexual arousal and stimulation” (Maltz, 1988, p. 147). Becker, Skinner, Abel, and Cichon (1984) “developed a time-limited, behaviorally-oriented sexual dysfunction treatment package” for sexual assault survivors based on the PLISSAT model (Annon, 1974, cited in Becker, Skinner, Abel, & Cichon, 1984). The focus of treatment was for the survivor to face her fears about her sexuality through exposure to sexual situations, behaviors, and interactions, thereby regaining control over her sexuality and increasing her assertiveness in sexual relationships (see also Maltz, 1988; Weiner, 1988). Becker, Skinner, Abel, and Cichon (1984) reported that treatment gains were greatest when the treatment package was used in a group as opposed to an individual treatment format. Gains were maintained at follow-up assessments, which occurred both 2 weeks and 3 months posttreatment. Unfortunately, gains in general nonsexual goal categories (e.g., trust, emotional, cognitive) were found immediately posttreatment but were not maintained. Since such goals were not a focus of treatment, the inability to maintain gains in these areas is not surprising.

Other treatment approaches address individual difficulties that may impact on the survivor’s interpersonal relationships. For example, Becker, Skinner, Abel, and Cichon (1984) included assessment of general nonsexual client goals within their treatment protocol although these goals were not addressed specifically within the treatment protocol. These eight categories of nonsexual goals clearly included interpersonal issues, such as increasing assertiveness, feeling more affectionate, reducing “numbing” or “shutting down” feelings, selecting more appropriate partners, reducing fear of and increasing trust of men, and feeling good about being with people as they (the survivors) were/that they (the survivors) were “worth the effort” (p. 108). Other clinical researchers have addressed interpersonal issues within the context of treatment, if only to some extent. Tsai and Wagner (1978) stated that survivors often “craved affection apart from sex, something which was denied them in their childhood” (p. 424). Unfortunately, interpersonal relationships were addressed as one of several issues, including sexual functioning, and the emotional and behavioral effects of their abuse were discussed in only two therapy sessions. It did appear, however, that women in the groups rated relationships with partners as more positive as a function of their participation in the group.

Jehu et al. (1985) stated that common therapeutic targets for women survivors address general social relationship issues: limited social skills, feelings of difference from others, mistrust, insecurity in relationships, and isolation/alienation from others. Difficulties with men may involve fear of intimate relationships, fear of men, overvaluation of men, anger towards men, avoidance of long-term relations with men, dissonant relations with men,

oversexualized relations with men, and promiscuous relations. Difficulties in relationships with partner issues would include: partner discord, oppression, and physical abuse. Difficulties in relationships with women might address concerns with anger and disparagement.

In one of the few treatment outcome studies conducted with survivors, Jehu, Klassen, and Gazan (1986) focused their cognitively based treatment on the individual survivor. However, the problem areas they targeted may have had implications for the survivor's interpersonal relationships and appear to be amenable to implementation in either individual or couple therapy. In describing one component of their treatment program, Jehu et al. stated that survivors often hold distorted "beliefs associated with this [CSA] experience that appear to contribute to mood disturbances in adulthood, such as guilt, low self-esteem and sadness" (p. 49; e.g., all or nothing thinking, overgeneralization, mislabeling). Specific interventions aimed at correcting these distorted beliefs were suggested. For example, survivors might gain an awareness of their beliefs through roleplay, imagery, thought logs or diaries, and completion of self-report questionnaires (i.e., Belief Inventory, Jehu et al., 1986). They learn to identify possible cognitive distortions through exposure to education about common distortions. They subsequently assess their own beliefs to evaluate the presence of these and learn to substitute more accurate beliefs using a variety of cognitive techniques. For example, they might explore alternatives through Socratic questioning by the clinician, read information about CSA, logical analyses, decatastrophizing, distancing, reattribution, and testing hypotheses about the beliefs. The cognitive restructuring treatment program was conducted with 11 female survivors of CSA and evaluated by interviews, as well as responses to The Belief Inventory and the Beck Depression Inventory (Beck, 1978). All clients showed statistically significant gains from pre- to posttreatment as evidenced by decreased scores on both questionnaires. Thus, the cognitive restructuring intervention appears to have had a beneficial impact upon the mood disturbances of survivors of CSA. However, the authors cautioned that controlled research still needs to be conducted to be certain that components of this multicomponent treatment package were responsible for treatment gains. Another treatment option suggested for working with survivors is individual therapy accompanied by consultation with the survivor's partner. Courtois (1988) notes that frequently the stress associated with individual therapy puts such a strain on the primary relationship that the partners separate, which is why she recommends partner consultation to explain the course of therapy, specifically how symptoms may worsen before getting better. She also states her belief that separation "almost always causes an additional and overwhelming level of stress for the survivor" (p. 352). Another reason Courtois gives for involving the partner in therapy is that partners and other loved ones may themselves become traumatized by the abuse as they attempt to help the survivor cope, as well as feel the impact of the survivor's difficulties in their relationships with her. Courtois terms this "contact traumatization" (p. 348). In some instances, the survivor may be present for the consultation, and in other instances not. "As part of a consultation, the therapist can enlist the aid and support of the partner or loved one, can devise specific strategies for assistance, can offer the partner support, and can formulate plans if the survivors enters an acute state" (p. 352).

Whereas Courtois (1988) argues for inclusion of the partner in therapy on a consultative basis, Maltz (1988) argues strongly for selecting the modality of couples therapy in treating the interpersonal repercussions of incest. "Incest has serious negative consequences on adult intimate relationships, affecting trust development and sexual behavior" (p. 143). Maltz states that the focus of therapy is not the specific sexual dysfunctions, but rather the dynamics within the sexual relationship, and discusses specific issues perceived as particularly salient for survivors. One issue is that survivors experience anxiety and confusion about sex. For some survivors, sex is often a manipulative strategy employed to get other things. Consequently, for these individuals there may be difficulty combining af-

fection and sexuality with the same partner; sex may be viewed as something that is done for someone else or to them; or sex may be redefined as an obligation. "Incest repercussions limit their ability to establish and maintain satisfying long-term relationships. They are hindered by fear of physical intimacy, their own self-destructive tendencies, difficulty integrating sex and love responses, and problems with trusting a potential partner" (p. 148).

Yet another modality employed with CSA survivors is group therapy. Courtois and Leehan (1982) discuss special issues involved with conducting group therapy with survivors. Many of the interpersonal problems that survivors experience can be observed in group dynamics. Survivors are often afraid to be critical of others (give critical feedback) and have difficulties taking criticism. Overall, survivors experience fear of closeness and difficulties in trusting others, along with a great need for love and attention. "What results in a group setting is a tug of war of sorts: members wanting closeness, understanding, and relief while running away from it and being too scared, insistent, or inexperienced to get their needs satisfied" (p. 566).

There are many issues about the therapeutic process that are unique to survivors of child sexual abuse. Many survivors present for treatment to mental health professionals with complaints revolving around interpersonal functioning; however, they may not disclose their history of abuse since they may not realize that current interpersonal difficulties are associated with their childhood abuse (Courtois, 1988). Mental health professionals have typically not asked about such histories on a routine basis. If survivors are not specifically asked about such histories, many will not offer the information. Courtois and Watts (1982) state that survivors may experience difficulties even when involved in very positive relationships because they believe they are not worthy of or do not deserve the relationship. Weiner (1988) states that the motivation for the survivor to seek treatment is often guilt that she is not satisfying her partner sexually, and subsequently, fear of divorce and/or emotional abandonment. "The concept of entitlement to sexual pleasure and satisfaction for the woman is often a totally alien concept" (Weiner, 1988, p. 256; see also Maltz, 1988). The therapist and survivor must deal with a range of partner reactions that may emerge during couples therapy, including anger and disbelief about the incestuous relationship itself, and frustration and guilt about the repercussions the incest has on the couple's intimate and sexual relationship.

Many authors have also noted that there are issues that will impact on the therapeutic relationship itself. Survivors very often have difficulties trusting others because of their abuse histories, the negative reactions of others regarding their histories, and possibly as a consequence of negative relationships with former therapists. This inability to trust may create difficulties in establishing rapport (Courtois, 1988; Courtois & Sprei, 1988; Courtois & Watts, 1982). Survivors may believe that the therapist will attempt to hurt them, blame them, reject them, and may have fears of abandonment by the therapist (Courtois, 1988). Because of some survivors' tendencies to oversexualize relationships, these women may also attempt to sexualize the therapeutic relationship (Blume, 1990; Courtois, 1988; Courtois & Watts, 1982). Briere (1992b) notes that the expression of intimacy difficulties within the therapeutic relationship may involve viewing the clinician "either as a potential enemy or as someone to be groomed, bribed, or manipulated into providing personal safety" (Briere, 1992b, p. 51). As such he believes that "debunking" the myth that intimate relationships always involve inevitable danger must be a goal of successful survivor therapy.

SUMMARY AND CONCLUSIONS

The empirical and clinical literature reviewed in this article identifies many substantive issues that must be considered in future research studies and clinical work with CSA

survivors. The long-term impact of CSA, particularly as relates to survivor interpersonal functioning, is much broader than originally conceptualized. As has been discussed, interpersonal functioning involves intimacy issues as well as sexuality. Further, researchers must go beyond the behavioral manifestations of the difficulties survivors report and explore the underlying psychological, cognitive, and affective components of those difficulties in order to gain a more comprehensive understanding of the complexities involved in survivors' interpersonal functioning. These psychological, cognitive and affective difficulties experienced by some survivors may not be immediately visible. Some survivors may present as the "walking wounded," appearing to function adequately in superficial social relationships, yet suffering personal and interpersonal difficulties associated with CSA that even they do not attribute to their earlier experiences.

Researchers and clinicians also must be aware of the long-term ripple effect that CSA has in terms of its impact on the loved ones in the survivor's life. Through reviewing the empirical and clinical literature, it appears obvious that CSA does not impact the survivor alone. As with the aftermath of other traumas and interpersonal violence experiences, the impact is broad. This review focused on intimate partner relationships, but it may be safe to assume that CSA may also impact other relationships, such as work relationships and friendships. For example, the very limited research and clinical literature on survivor's parent-child relationships has indicated that many survivors report fears about parenting.⁴ Many of these fears revolve around the possibility of the survivor repeating the abuse with her own children (Westerlund, 1992), being unable to protect her children from abuse at the hands of others (Herman, 1981; Westerlund, 1992), or overprotecting her children (Herman, 1981; Westerlund, 1992). Some women, however, have strong desires to have children so they can give to their children what they themselves did not get (Herman, 1981).

Recently, empirical investigations have begun examining the parent-child relationships of child sexual abuse survivors. For example, Cole, Woolger, Power, and Smith (1992) examined parental experiences and practices in women with histories of incest and alcoholic fathers, women with alcoholic fathers, and women with no such childhood experiences. They found that incest survivors reported feeling less adequate, less confident and possessing less control emotionally as parents. They felt less organized and consistent with their children and were less demanding of their children's maturity than the other groups. The investigators suggest that because of the other difficulties that these women reported with parenting issues, they are unable to provide an environment that was conducive to the development of autonomy in their children. Cole et al. also investigated partner relationships and family of origin relationships for these women and found that a dysfunctional family of origin was less predictive of parental difficulties than of reported partner relationship satisfaction. The quality of partner relationship, however, predicted the mother's feelings of control and confidence in parenting. The investigators suggest that positive partner relationships may encourage more positive feelings about one's parenting abilities. However, they also note that incest survivors often report difficulties in the area of partner relationships as well.

Thus, it appears that the trauma of child sexual abuse has implications for interpersonal functioning beyond that of the intimacy and sexual functioning of partner relationships. More research is needed in the area of the parenting skills of CSA survivors, as well as survivors of other types of childhood abuse. As has been noted, research has documented

⁴A comprehensive review of the issues regarding the parent-child relationships of survivors is beyond the scope of this article. The reader is referred to other sources for more information (Cohen, 1995; Cole & Woolger, 1989; Goodwin, McCarthy, & DiVasto, 1981; Westerlund, 1992).

parallels in the impacts of different types of interpersonal traumas. All forms of child abuse and adult victimization need to be explored more comprehensively, and concurrently, in order to gain a more comprehensive understanding of the interpersonal functioning of survivors of all interpersonal traumas.

Another issue that has come to light in the process of this review is the lack of research in this area which is grounded in theory. Although there are several different models that conceptualize the long-term impact of CSA, very little research has been done to test the adequacy of these models. It appears that many studies are being conducted that count and categorize symptomatology, which is an essential first step in the identification of CSA as a legitimate problem. However, the time has come to better explain why particular results are obtained in both victim functioning and treatment outcome. Although it has been well-documented that survivors report a variety of symptoms and symptom severity, we are unaware of why this variability exists. Further, we lack the knowledge of what treatment modality might best address specific symptom patterns.

Two questions have been raised as to issues for child survivors of CSA (Kendall-Tackett et al., 1993) that are also applicable to the adult population of CSA survivors: What is the course of interpersonal symptomatology over time? What contributes to recovery? Although we do not yet have the answers to these questions, we hope that the information in this review stimulates clinicians and researchers alike to respond to these most important issues. As has been suggested in this review, there appear to be three patterns of intimacy functioning in which survivors may engage. It is unknown at this point whether the patterns are exclusive or if they change over time, although there is some evidence that suggests survivors may manifest different patterns of interpersonal functioning across time. We are also unaware of the mechanisms responsible for the differing reported symptomatology of survivors. There are numerous survivors of CSA who evidence few negative aftereffects. Researchers have been very involved in the documentation of the type and magnitude of difficulties, yet we know very little about survivors who are functioning at higher levels. Although the study of the negative aftereffects of CSA is very important, it is equally important to know what may counter the negative effects. This area of research would have great implications for clinicians in terms of planning interventions that may assist survivors in coping better with the impacts of CSA. Treatment of relationship issues experienced by survivors requires further empirical study. Although many clinicians have discussed interventions and issues in the treatment of survivors, we are as yet unable to identify specific interventions that are most effective for specific interpersonal difficulties experienced by CSA survivors. Treatment programs must provide empirical validation of their effectiveness. Gaining such information will enable clinicians to provide the most effective therapy to survivors, increasing the opportunity for survivors to lead more healthy, productive lives.

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