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Dianne Mary. Maing
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PATTERNS OF PSYCHOPATHOLOGY IN SEXUALLY ABUSED GIRLS

by

Dianne Mary Maing

B.A., Brock University, 1982
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A Dissertation Submitted to the Faculty of Graduate Studies through the Department of Psychology in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy at the University of Windsor, Windsor, Ontario, Canada 1991

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Abstract

Several domains of child functioning were examined in 20 sexually abused girls, aged 5-12 years, referred to a child protection agency. Twenty clinical and 20 non-clinical nonabused girls, group-matched on age, parents' marital and socioeconomic status, served as comparison groups. Standardized measures, such as the Child Behavior Checklist and Teacher Report Form, were used to assess, in the children, intelligence, academic achievement, behaviour problems, impulsivity, social competence, sexualized behaviour, gender identity disturbance, and activity level. Multiple informants were utilized for some measures. Multivariate and univariate analyses indicated that the sexually abused girls were more impaired in behavioural and cognitive/academic functioning than were the non-clinical girls, but closely resembled the clinical girls in these areas. The sexually abused girls, however, appeared less socially competent than both the clinical and non-clinical girls. In addition, younger (< 7 years) sexually abused girls demonstrated more sexualized behaviour than did older sexually abused girls and younger clinical and non-clinical girls. Maternal report on marital discord and maternal psychopathology did not evidence overall differences among the three groups, although a correlational analysis
suggested that greater maternal symptomatology was associated with more behavioural disturbance and sexualized behaviour. Correlational analysis of the abuse-specific variables and child functioning measures indicated that an earlier age of onset was associated with more frequent sexualized behaviour, while fewer behavioural problems were associated with more frequent abuse and with more acts of the most as well as the least invasive abuse. Age was positively associated with fewer behavioural problems and sexualized behaviour, and with more enticement and bribes by the perpetrator. Implications for future interpersonal relationships and the potential impact on functioning for younger versus older sexually abused girls are discussed. The need for further research to determine the developmental course of the symptomatology is noted.
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CHAPTER 1

INTRODUCTION

The sexual maltreatment of children has clearly captured the attention of many health professionals, who have come to recognize the problematic issues that may arise for the affected child. In the United States and Canada, community surveys of adults reporting sexual experiences in childhood provide prevalence estimates that range from 5.3% to 62% (Badgley, 1984; Finkelhor, 1984; Russell, 1986; Stein, Golding, Siegel, Burnam, & Sorenson, 1988; Wyatt, 1985). The consequences to this potentially large segment of the population have been the focus of much clinical and empirical study. Early researchers on incestuous abuse, whose premise was that incest should engender guilt and horror in the abused child, indicated from clinical observations that there seemed to be little psychological harm to the child (Bender & Blau, 1937; Sloane & Karpinski, 1942) and that there may be even positive effects (Racovský & Racovský, 1950). Findings by recent researchers, however, have reshaped our thinking about the initial sequelae. To
date, a broad range of behavioural difficulties has been claimed to characterize sexually abused children (Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986; Beitchman, Zucker, Hood, daCosta, & Akman, in press; Browne & Pinkelhor, 1986). These difficulties appear to span the entire gamut of childhood psychopathology, including academic impairment, anxiety, conduct disorder, depression, and inappropriate sexualized behaviour.

With an awareness of these diverse, putative effects, researchers have begun to address the question of specificity and determinants of the behavioural maladaptation. In spite of continuing efforts, however, the present literature remains too inconclusive to suggest unique sequelae to childhood sexual abuse, with the possible exception of sexualized behaviours. In addition, the literature has been unable to separate the effects that are due solely to the abusive experience from those that may be due to premorbid conditions, such as family dysfunction or preexisting psychopathology in the child, or to the stress from disclosure (Beitchman et al., in press; Conte & Schuerman, 1987; Friedrich, Beilke, & Urquiza, 1987). Further clarification is needed to determine also why only a percentage of sexually abused children are affected, and why, among that percent, there seem to be varying outcomes.
Methodological problems contribute to the tenuous nature of the research. Three areas are of major concern: (1) the relative absence of appropriate control groups; (2) the heterogeneity of sexual abuse samples, with regard to age, sex, source of referral, and type of abusive acts; and (3) measurement difficulties, such as the use of single and/or unstandardized measures. These methodological constraints limit both the validity of the findings and the ability to compare across studies.

The primary goal of the present study was to examine domains of psychopathology in a homogeneous sample of sexually abused girls, where age was restricted to between 5 and 12 years, the source of referral to a child protection agency, and the abusive incidents to only contact abuse (incidents of exhibitionism and pornography were excluded). Two comparison groups were employed: a nonabused, clinical group obtained from the same child protection agency as the sexually abused group and a nonabused, non-clinical group from the general population. Several standardized measures, utilizing child, mother, and teacher report, assessed such domains as academic performance, behavioural disturbance, social competence, and sexualized behaviour. The study also examined the contribution of familial variables, maternal psychopathology and marital discord, and abuse-related
variables to adaptive functioning in the sexually abused girls.

Scope of the Problem: Clinical and Empirical Issues

Prevalence and Abuse Characteristics

Estimates of childhood sexual abuse have ranged from Weinberg's (1955) early figure of one case of incestuous abuse per million per year in all English-speaking countries to the 1979-1980 National Incidence Study of Child Abuse and Neglect (Pinkelhor & Hotaling, 1984; Russell, 1983) estimate of 700 cases per million children per year of child sexual exploitation in the United States alone. In comparison, the National Incidence Study estimated 1,000 cases of emotional neglect, 1,700 cases of physical neglect, 2,200 cases of emotional abuse, 2,900 cases of educational neglect, and 3,400 cases of other physical assault per million children per year (Russell, 1983).

Adult retrospective surveys provide prevalence rates of both reported and unreported cases of childhood sexual abuse. Unfortunately, the variation among the studies in terms of definition of the abusive act, the age of the victim, populations, and survey techniques has led to a range of estimates from as low as 5.3% (Stein et al., 1988) to as high as 62% (Wyatt, 1985).
Badgley's (1984) national survey of 2008 Canadians, drawn from 210 communities across the country, found that about 28% of the sample had experienced some form of contact victimization in childhood before the age of 16. When acts of exposure/exhibitionism were included, about 42% of the sample was counted as sexually victimized (Painter, 1986). In the United States, Russell's (1983) random household sample of 930 female residents of San Francisco reported a 38% estimate for intrafamilial and extrafamilial contact victimization before the age of 18. This estimate rose to 54% when noncontact acts were included. Remarkably similar figures were found for the female portion of Badgley's (1984) survey: 33.8% and 53% for contact and combined acts of contact and noncontact abuse, respectively. Higher prevalence figures were reported in Wyatt's (1985) community sample of 248 Afro-American and white women in Los Angeles County. Prior to age 18, 45% experienced contact abuse, while 62% experienced both contact and noncontact abuse.

Finkelhor (1979, 1984) has reported substantially lower figures. Of 796 New England college students, there was a victimization rate of approximately 15.7% for all abusive acts experienced prior to age 17 (Finkelhor, 1979). The figures for women and men (contact abuse only) were 15.3% and 7%, respectively. In a sample of 521 Boston parents,
the prevalence rate for all acts was 12% (15% for females and 6% for males for contact abuse) (Finkelhor, 1984). The lowest prevalence figure of 5.3% for contact abuse before age 16 was reported by Stein et al. (1988), who surveyed 3,132 Hispanic and non-Hispanic white adults in two Los Angeles catchment areas. The prevalence rates for women and men were 6.8% and 3.8%, respectively.

Females are the most common victims among the cases that come to professional attention, the ratio of female to male victims being approximately 4:5:1. The National Incidence Study (Finkelhor & Hotaling, 1984) reported that 83% of the victims were female, while Badgley’s (1984) survey has a comparative figure of 71.8%. The offenders are typically male (Badgley provides a figure of 99.2%) and usually known to the child (Badgely, 1984; Finkelhor, 1979; Russell, 1983).

Retrospective studies have indicated that abuse by family members constitutes between 10%-32% of all abuse. Russell (1983) found that 16% of her sample reported at least one experience of intrafamilial abuse before age 18, while 12% reported such an experience before age 14. Among this category of perpetrators, fathers and father surrogates comprised the largest single group. Twenty-four percent of Russell’s (1983) sample reported an incestuous relationship
with their natural or surrogate fathers before age 18. Sexual abuse by uncles was only slightly higher (26% of the cases), while abuse by mothers, grandmothers and aunts totalled less than 1% of the cases. Abuse by nonfamily members (e.g., family friends, neighbours, and authority figures) constitutes an additional 35% to 60% of all abuse cases, while strangers make up the remaining percentage (Badgley, 1984; Pinkelhor, 1979, 1984; Russell, 1983). Similar findings have been reported in studies of child victims (Dubé & Hébert, 1988; Pierce & Pierce, 1985). Sixty-four percent of Pierce and Pierce's (1985) clinical sample of 180 sexually abused girls (mean age, 10.6 years) was abused by their biological fathers or stepfathers. Persons outside the family and siblings each accounted for 6%, while mothers accounted for the remaining 1%. In contrast, males appear to be abused more by strangers or acquaintances (De Jong, Hervada, & Emmett, 1983; Dubé & Hébert, 1988). For example, Dubé and Hébert (1988) found 32.5% of the male victims were assaulted by a stranger as compared to 20% of the female victims.

With regard to the type of abusive act, research has shown that sexual touching of the children's bodies is the largest category of abuse (between 20% to 36%). Genital touching and digital penetration are involved in 10% to 26%
of abusive acts, oral/anal intercourse in 3% to 8%, and completed/attempted intercourse in 10% to 19% (Badgley, 1984; Finkelhor, 1979, 1984). The victim's relationship to the offender has also been considered to affect the severity of the abuse. Russell's (1983) study found that 53% of the incidents of extrafamilial abuse were classified as very serious as compared to 23% of the intrafamilial abusive incidents. Sex differences have also been reported with regard to abuse severity (Dubé & Hébert, 1988; Pierce & Pierce, 1985). Pierce and Pierce (1985) reported that males were more likely to be subjected to more serious abuse (52%), such as oral intercourse, while females were more likely to experience masturbation (40%) and fondling (63%).

**Early Questions of Harmfulness**

In 1895 and 1896, Freud published *Studies on Hysteria* (1895/1955) and *The Aetiology of Hysteria* (1896/1962), respectively, in which he proposed that childhood molestation by the father was the cause of many, if not all, cases of female hysteria and neurosis. A year later, however, allegedly in response to societal pressure, Freud retracted his seduction theory and concluded that the reported experiences were memories of incestuous fantasies in his female patients, thereby replacing the notion of actual trauma with that of incestuous wishes (Rosenfeld,
1987). One of the consequences of this retraction was to place the onus of sexual responsibility on the child, and to disavow the sexual desires of the parents.

The focus and attribution of blame on the child and not on the adult were central to later investigations on the effects of childhood sexual abuse and the origins of the sequelae. Bender and Blau (1937), in their study of 16 children, aged 5 to 12, described the children as being unusually charming and attractive, and contended that they, the children, were not totally innocent but may have behaved seductively toward the adult. "Rarely [acting] as injured parties" (p. 514), the children's failure to show guilt, shame, or anxiety was regarded as an indication of the emotional satisfaction they obtained from the sexual relations.

Any effects observed were thus considered in the context of the child's gratification of his or her sexual drives and not in the context of a sexually abusive act by an adult. The consequences were therefore not regarded as being deleterious to the child. Sloane and Karpinski (1942), in their study of 5 adolescent females who had experienced incest, concluded that the tendency among the victims to indulge in later promiscuity was a means of substitute gratification. Bender and Blau (1937) noted that
the increased sex interests led to developmental delays in some of the children: prolonged infantile behaviour and interests in the infantile stage; educability and social problems in early latency; and adolescent adjustment problems in prepuberty. A follow-up study (Bender & Gruett, 1952) of the children in Bender and Blau's (1937) study, however, found that the majority of the children did not experience maladjustment problems in adult life. A similar conclusion was reached by Racovsky and Racovsky (1950), who asserted, based on their clinical observations, that the ego's capacity for sublimation was favoured by the real satisfaction afforded by incest, and that "the actual consummation of the incestuous relation [diminished] the subjects' chance of psychosis and [allowed] better adjustment to the external world" (p. 45). The Kinsey studies (1953, cited in Russell, 1986) also helped to maintain the disbelief in the seriousness of the consequences of childhood sexual abuse. While acknowledging that the majority of their female subjects reported being emotionally upset and frightened, Kinsey and his colleagues argued that adverse conditioning, and not abuse, was responsible for the victims' observed hysteria.

**Methodological Issues**

While there has been clinical investigation into the
effects of incestuous and childhood sexual abuse for nearly half a century, the theoretical perspectives of early researchers and their minimizing of the psychological impact on the child have affected empirical study. It is only within the last decade that researchers have begun to investigate the potentially serious effects of childhood sexual abuse. Consequently, methodological sophistication is still lacking in the field. The methodological problems which exist in the current literature limit both the validity of the findings and the comparisons between studies. The following review is intended not only as an introduction to the methodological issues, but also as a context in which to appreciate the subsequent literature review on the effects of childhood sexual abuse.

**Samples.** The sensitive nature of childhood sexual abuse and the consequent underreporting of cases make it extremely difficult to obtain an unbiased and random sample of child victims. The studies of these children have been usually based on those who have come to the attention of child protection agencies and mental health centres. Their selection may be nonrepresentative of the sexually abused population given that the children and their families who come to the agencies are often from a certain socioeconomic segment of the population. Also, it is likely that the
mental health centres see children with more impaired functioning who are being assessed and treated.

A second methodological concern is the use of heterogeneous samples, which include varying victim characteristics and types of abusive incidents. For example, the age of the victims may range (from preschool to adolescence), both females and males may be included, the victim's relationship to the offender may vary (from father to stranger), as well as the severity (from exhibitionism to genital intercourse), duration, and frequency of the abuse. The unique contribution of each factor on impact is therefore often obscured.

**Comparison groups.** Many of the empirical studies have lacked comparison groups, recognized as a necessity against which the target can be evaluated. Beitchman et al. (in press) reviewed 40 studies employing sexually abused children and adolescents and found 18 (45%) did not use a control group, 6 (15%) used only "normal" controls, 13 (32.5%) used only clinical (psychiatric) controls, and only 3 (7.5%) used both clinical and normal controls simultaneously.

Potential methodological pitfalls exist in the selection of these control groups. Careful consideration must be given to matching the normal group to the sexually
abused on several demographic variables, such as socioeconomic status and ethnicity, since most of the sexually abused children available to the researcher are from more disadvantaged segments of the population. In addition, given the prevalence rates of child sexual abuse, careful screening must attempt to ensure that children who have been sexually abused are excluded.

Psychiatric groups of nonsexually abused children provide an additional means of control in terms of treatment and patient status. The actual severity of psychopathology in sexually abused children, however, may be underestimated since they may share clinical problems with other psychiatric populations, thereby minimizing the distinct effects of childhood sexual abuse (Browne & Pinkelhor, 1986). Another issue regarding the use of psychiatric controls is whether they should be heterogeneous or homogeneous in nature. Of the studies with psychiatric controls, the majority have employed heterogeneous samples. It is possible that a homogeneous sample, such as physically abused children, may provide more appropriate comparisons especially if they share with the sexually abused familial stressors that may influence the behavioural sequelae.

Outcome Measures. The lack of theoretical and empirical understanding of the impact of childhood sexual
abuse has impeded the development of outcome measures that assess the diverse and specific sequelae. Researchers have relied on clinical observations, projective measures, and checklists with unknown psychometric properties. More recent studies have used standardized measures, such as the Child Behavior Checklist (Achenbach & Edelbrock, 1981) and the Louisville Behavior Checklist (Miller, 1981). These measures, however, are completed by parents and are subject to biased reporting. Further, sometimes only one source of information (e.g., the nonoffending parent, usually the mother) is relied upon.

**Definition of incest and child sexual abuse.** Although incestuous relationships are often empirically subsumed under child sexual abuse, incest and child sexual abuse are not synonymous. Incest, defined in anthropological and sociobiological terms, concerns the aversion towards and the taboo regarding sexual relations between people who are too closely related to marry (Bagley, 1986). By statute, the specific sexual acts prohibited usually involve some type of intercourse (Badgley, 1984). On the other hand, child sexual abuse is a sexual act imposed upon a child who is in a dependent and subordinate position, which is in contrast to the all-powerful and dominant position of the adult or older adolescent perpetrator (Sgroi, Blick, &
Many researchers, however, have defined incest and child sexual abuse in a variety of ways. For example, some have taken into account the familial and psychological relationship between the participants in incestuous abuse and have included surrogate parents, such as foster parent and common-law spouse, as perpetrators, the presence or absence of consanguinity being of less significance than the kinship roles the perpetrators occupy (Sgroi et al., 1982). The definition of abusive behaviours has also covered the spectrum of contact and noncontact acts, with some researchers including exhibitionism and observation of the child in their definition. This lack of consistency in the definition of incest and child sexual abuse increases the difficulty of comparing and assessing the findings on impact.

**Theoretical Perspective**

While various researchers continue to investigate the psychopathological patterns observed in sexually abused children, few have endeavoured to synthesize the findings into a model that would specify how and why child sexual abuse results in such symptomatology. The model proposed by Finkelhor and Browne (1985) is, at present, the most comprehensive framework that attempts to conceptualize the
impact of child sexual abuse.

The model analyzes the abusive experience in terms of four trauma-causing factors, or as Finkelhor and Browne (1985) call them, traumagenic dynamics: traumatic sexualization, betrayal, powerlessness, and stigmatization. These dynamics, while not necessarily unique to child sexual abuse, alter the "children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities" (Finkelhor & Browne, 1985, p. 531). Traumatic sexualization refers to the process in which the child's sexuality develops in an inappropriate and dysfunctional fashion. The process may occur in a variety of ways: through the exchange of gifts or attention by the offender in return for the child's sexual behaviour, through the eroticization of the child's sexual anatomy, or through the transmission by the offender of confusing sexual behaviour and sexual morality. According to Finkelhor and Browne, the effects most readily associated with this dynamic are sexual problems which, when noted among children, include sexual preoccupation, repetitive sexual behaviour, and inappropriate sexual knowledge and interests.

Betrayal refers to the children's discovery that someone on whom they were dependent and whom they trusted
has caused them harm. Betrayal can be experienced not only by the offender, but also by other nonabusing family members who are unable or unwilling to believe or protect the children after the disclosure of the abuse. While there is greater potential for betrayal when the offender is a family member or a trusted individual, betrayal by a stranger may also be felt depending on how the child was manipulated. The behavioural and emotional manifestations may include anger, aggressive behaviour, delinquency, depression, and the inability to judge the trustworthiness of others.

Powerlessness refers to the process in which the children's will, desires, and sense of efficacy are contravened. This sense of powerlessness may be heightened by whatever coercion and manipulation the offender may use. Finkelhor and Browne postulate a number of effects that may be related to this dynamic. One reaction involves internalizing symptomatology, such as fear, anxiety, nightmares, and hypervigilance. A second reaction concerns the child's sense of efficacy and coping skills, which may be reflected in learning problems, running away from home, and even suicidal behaviour. A third reaction involves the need to compensate for the powerlessness by being aggressive and delinquent.
Lastly, stigmatization refers to the negative connotations, e.g., shame, guilt, badness, that are attached to and communicated to the child. Such communications may come from the offender who may blame or demean the child, from other people in the family or community, or, if the child is old enough, from her knowledge or sense that the sexual activity is taboo or deviant. Isolation, lowered self-esteem, suicide or self-mutilation may be the noted effects.

Short-Term Effects of Child Sexual Abuse

Despite the early controversy regarding the harmfulness of childhood sexual abuse, the recent literature indicates deleterious consequences for sexually abused children (Alter-Reid et al., 1986; Browne & Finkelhor, 1986). These behavioural and emotional symptoms appear to differentiate sexually abused children from nonabused children. The differences in symptomatology between the sexually abused and psychiatric children, however, are less clear. Three areas of research will be considered: the first deals with the initial effects, while the second and third examine the abuse-related and familial variables, respectively, that are associated with greater psychopathology.
Short-Term Effects

Several empirical studies have found that sexually abused children display more internalizing and externalizing behavioural difficulties than normal children (Pagot, Hagan, Youngblade, & Potter, 1989; Friedrich, Beilke, & Urquiza, 1987; Friedrich & Reams, 1987; Friedrich, Urquiza, & Beilke, 1986; Gomes-Schwartz, Horowitz, & Sauzier, 1985; Tong, Oates, & McDowell, 1987; White, Strom, Santilli, & Halpin, 1988). Einbender and Friedrich (1989) compared 46 sexually abused girls, between the ages of 6 and 14, with a sample of nonabused girls recruited from schools, matched on age, race, family income, and family constellation. The authors found that the sexually abused children had poorer social skills, lower cognitive abilities, and greater sexual preoccupation on several objective and projective measures, such as the Child Behavior Checklist (CBCL) and the Roberts Apperception Test, respectively. An earlier study by Friedrich et al. (1986) reported that on the CBCL 46% of their sexually abused sample had significantly elevated scores on the Internalizing scale (e.g., Depression, Somatic Complaints) and 39% had significantly elevated scores on the Externalizing scale (e.g., Aggression, Delinquency) as judged by mothers. In comparison, only 2% of the normative sample had scores in the clinical range. Tong et al. (1987)
reported similar findings on the Teacher Report Form (Edelbrock & Achenbach, 1984) version of the CBCL. Thirty-six percent of their sample of 28 sexually abused children (median age 11.5 years) seen over a 2 year period at a sexual assault centre had scores in the clinical range on such scales as anxious, self-destructive, and aggressive. In contrast, only 3% of the nonabused group, matched to the sexually abused group for age, sex, socioeconomic status, and race, had scores in the clinical range.

It is unclear, however, whether sexually abused children demonstrate more or less behavioural disturbance in comparison to other nonabused clinical controls (Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Friedrich et al., 1987; Goldston, Turnquist, & Knutson, 1989; Gomes-Schwartz et al., 1985; Kolko, Moser, & Weldy 1988; White et al., 1988). For example, in a chart review, Deblinger et al. (1989) found that sexually abused children could not be differentiated from physically abused inpatients on symptoms of avoidance/dissociative phenomena associated with a post-traumatic stress disorder. Friedrich et al. (1987) compared sexually abused children, aged 3-12, with nonsexually abused outpatients and normal children and found the sexually abused children were as depressed and anxious as the outpatients, but less aggressive and hyperactive. Gomes-
Schwartz et al. (1985) also reported that sexually abused children were more similar to clinical controls based on comparisons with published clinical norms on the Louisville Behavior Checklist.

None of the studies, however, controlled for elapsed time since last abusive incident. In the Friedrich et al. (1987) study, as much as four years had elapsed since the last occurrence of abuse. It is thus possible that the lower level of behavioural disturbance was mediated by between-groups differences in time since last abuse. This possibility is supported by an earlier finding that degree of internalizing difficulties was inversely related to time since the abuse had ended among the sexually abused group (Friedrich et al., 1986).

Contrasting findings have been found in studies which have either been entirely or substantially comprised of physically abused children as clinical controls (Pagot et al., 1989; Goldston et al., 1989; Kolko et al., 1988). These studies have found that sexually abused children were generally less aggressive than the physically abused children, but appeared to show more withdrawn behaviour. For example, Goldston et al. (1989), reviewing medical records, found that sexually abused girls were more likely to exhibit depressive symptoms than nonabused psychiatric
controls, but less likely to show physical or verbal aggression. Thirty-nine percent of the sexually abused girls, however, were also physically abused, which may have contributed to or attenuated the behavioural problems. Similarly, Kolko et al. (1988) found, through clinical interviews with parents, that hospitalized sexually abused children had more internalizing problems than physically abused patients. This finding, though, may have been affected by large differences in the sex composition of the two groups.

Two studies have reported preliminary findings on the adequacy of sexually abused girls' impulse control. Yates, Beutler, and Grago (1985) compared the human figure drawings of 18 incest victims, ranging in age from 3.5 to 17 years, with those of 17 nonabused psychiatric girls matched for age and social class. The drawings were rated on 15 domains of functioning by raters blind to group status. A significant deficiency in impulse control was observed among the incest victims. The authors, however, cautioned that this finding may be due in part to selection bias, in that the impulsive child may be more likely to reveal the abuse, and to measurement bias due to administration by a physician who was aware of the referral reason. Einbender and Friedrich (1989) also used a projective tool, the Rorschach, to
examine impulse control, but found no significant differences between the sexually abused girls and the nonabused controls.

Commonly reported symptoms of sexual abuse are cognitive difficulties and school-related problems (Adams-Tucker, 1981; Einbender & Friedrich, 1989; Elwell & Ephross, 1987; Friedrich & Luecke, 1988; Johnston, 1979). Tong et al. (1987) found that both parents and teachers reported poor academic performance on the Child Behavior Checklist and Teacher Report Form, respectively. Teachers rated the sexually abused children significantly lower than nonabused children in all areas of adaptive functioning, which included school performance, working hard, and learning. Similar findings were reported by Adams-Tucker (1981), who found that 55% of her sample were at least one grade behind at school. Einbender and Friedrich (1989) found lower academic achievement on the Wide Range Achievement Test-Revised and Child Behavior Checklist, and lower IQ scores on the Wechsler Intelligence Scale for Children-Revised for sexually abused girls in comparison to nonabused normal girls.

None of the studies reporting school problems included clinical control groups, making it difficult to determine to what extent these problems can be attributed solely to
sexual abuse. In Adams-Tucker's (1981) study, for example, many of the sexually abused children had a history of developmental or psychiatric difficulties. Gomes-Schwartz et al. (1985) reasoned that the developmental immaturity and cognitive deficits found in their sample of preschool sexually abused children probably predated the abuse. The researchers suggested further that these deficits may have put the sexually abused children at greater risk for sexual abuse and that this experience may have contributed to the deterioration of their academic performance.

Lower social competence has also been found in a few studies employing the Social Competence scale of the Child Behavior Checklist (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989; Tong et. al., 1987; Wolfe, Gentile, & Wolfe, 1989). These studies suggest that the sexually abused children have fewer hobbies and friends and interact less well with family and peers. Einbender and Friedrich (1989), employing the Activities and Social scales of the Child Behavior Checklist, found a significant difference between the sexually abused and nonabused girls, with the sexually abused girls demonstrating poorer social skills. Wolfe et al. (1989) found that 26% of their sample of sexually abused children obtained a T score ≤ 30 on the total Social Competence scale as judged by mother, whereas
2% of the general population would be expected to score at this level. This percentage may be inflated because of the inclusion of the School scale in the total Social Competence score. Neither of these studies, however, employed clinical controls. Where such a group was included, the outpatient group was found to score lower than the sexually abused group on the social scale of the Child Behavior Checklist (Friedrich et al., 1987). The nature of the presenting problems or of the diagnoses of these clinical groups were not indicated however.

Two studies have reported on the clinical diagnosis of sexually abused children referred to psychiatric clinics. Adams-Tucker (1981) noted that all but one of the 28 sexually abused children received a DSM-II diagnosis. Fifty-seven percent received a diagnosis of behaviour disorder (overanxious reaction, other reaction, withdrawal), while 25% received a diagnosis of adjustment reaction. Livingston (1987), using the Diagnostic Interview for Children and Adolescents—Child version, found that the sexually abused were more likely to receive diagnoses of major depressive disorder, psychosis and anxiety disorders, while the physically abused were commonly diagnosed as having a conduct disorder. Livingston (1987) pointed out, however, that the majority of the physically abused children
were boys, while girls dominated the sexually abused group, which could account for the difference in diagnostic status.

The effect of sex on diagnostic status, however, remains unclear. Kremer (1985) reported that adjustment disorder with mixed emotional features was the most common diagnosis of the 68% of the female sample who had received a DSM-III diagnosis. In contrast, Pomeroy, Behar, and Stewart (1981) reported that 70% of their female sample met the criteria for a DSM-III diagnosis of unsocialized aggressive conduct disorder, while the remaining 30% had undiagnosed conduct disorders.

Preliminary evidence has suggested that confusion over gender identity may also be a potential consequence of childhood sexual abuse (Kaufman, Peck, & Taguiri, 1954; Livingston, 1987; Sansonnet-Hayden, Haley, Marriage, & Fine, 1988; Zucker & Kuksis, 1990). The early work by Kaufman et al. (1954) found themes of gender identity disturbance on the projective testing of seven sexually abused girls. More recently, Livingston (1987) found 2 of 13 sexually abused children (mean age 9.7 years) met the diagnostic criteria for Gender Identity Disorder on the Diagnostic Interview for Children and Adolescents. In comparison, none of the 15 physically abused and 72 nonabused children met the criteria. Sansonnet-Hayden et al. (1988) noted that 5 of
the 6 sexually abused adolescent boys had a history of cross-dressing versus 1 of the 19 boys not reporting a sexually abusive experience. It is unclear at this point what role gender dysphoria plays in childhood sexual abuse: whether it is a specific outcome for some abused children or a manifestation of predisposing developmental factors that has been exacerbated by the abusive experience (Zucker & Kuksis, 1990).

An important clinical and research issue has been to determine the specificity of the symptoms observed in sexually abused children. A promising and fairly consistent candidate as a specific response to sexual abuse appears to be sexualized behaviour. An increasing number of empirical studies has lent support to clinical observations that sexually abused children show an increase in inappropriate sexualized behaviours (Deblinger et al., 1989; Einbender & Friedrich, 1989; Friedrich et al., 1987; Friedrich & Luecke, 1988; Gale, Thompson, Moran, & Sack, 1988; Jampole & Webber, 1987; Kolko et al., 1988; Livingston, 1987; White et al., 1988). Einbender and Friedrich (1989) found that sexually abused girls scored higher on a composite measure of sexual preoccupation than nonabused, non-clinical controls. Sexual preoccupation was defined by three variables: bodily preoccupation, impulse control (both measured by the
Rorschach), and sexualized behaviours (as reported on the Child Behavior Checklist). When these variables were analyzed separately, however, only the Child Behavior Checklist measure significantly differentiated the two groups. Deblinger et al. (1989) examined the charts of inpatient samples of sexually abused, physically abused, and nonabused children, and rated behaviours on a symptom checklist, developed by the authors, in accordance with three post-traumatic stress disorder categories. On the category labelled "re-experiencing phenomena", which included provocative behaviour, repetitive sexual talk, masturbation, and sexualized play, the sexually abused children exhibited more sexually abusive and inappropriate behaviours than both control groups. Livingston (1987), in his study of physically and sexually abused inpatients, found that nearly half of the sexually abused had a presenting complaint of sexual misbehaviour in comparison to none of the physically abused. Sexual misbehaviour, though, was neither defined nor further assessed.

The assessment of sexualized behaviours has employed diverse techniques, including parent-report, symptom checklists, observation of play with "anatomically-correct" dolls, and the use of projective techniques. Unfortunately, some of the studies have not used appropriate control
groups, while others have relied on measures that have unknown psychometric properties (e.g., Deblinger et al., 1989; Kolko et al., 1988). At present, Friedrich's parent-report inventory of sexualized behaviour (Friedrich, Grambsch, Broughton, & Beilke, 1988; Friedrich, Grambsch, Broughton, Kiuper, & Beilke, in press; Friedrich, Grambsch, Koverola, Hewitt, & Damon, 1989) appears to have the best psychometric properties and initial evidence of reliability and discriminant validity.

**Summary of short-term effects.** The majority of empirical research on the short-term effects of childhood sexual abuse notes that there are deleterious consequences to the child. Many of these symptoms, however, are present in other clinical samples and thus to date, with the exception perhaps of sexualized behaviour, there appear to be few unique indicators of childhood sexual abuse. The psychopathology associated with childhood sexual abuse does not seem monolithic, since not all sexually abused children display the same symptoms or the same degree of pathology. Preliminary evidence indicates that a portion of the sexually abused population shows more internalizing features, while another portion appears more externalizing. In addition, there is a percentage of the population who do not report or are not observed to be symptomatic.
Effects of Abuse-Specific Variables

Abuse-specific variables, such as severity of abuse, and victim's relationship to the offender, have been the focus of most of the research that has attempted to explain the heterogeneity of the observed symptomatology in sexually abused children and to assess those children who may be at greater risk for psychopathology. While many of the findings are inconclusive and inconsistent, some trends that would determine the contribution of each variable to outcome are evident.

Relationship to offender. Several studies indicate that sexual abuse by fathers or father figures appears to be associated with a greater traumatic effect on the child compared to abuse by other intrafamilial perpetrators (Adams-Tucker, 1982; Friedrich et al., 1986; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988; Russell, 1986). Adams-Tucker (1982) found that children who had been abused by father figures (50% of the sample) were the most disturbed, with depression and withdrawal being the most common diagnoses. In Russell's (1986) study, the highest percentage of incest victims who reported extreme or considerable trauma (defined as how upset the victim reported she was and the extent to which the abuse affected her) were victimized by biological fathers (81%) and step-
adoptive, and foster fathers (82%). In comparison, abuse by brothers and uncles was experienced by 50% and 60% of the women, respectively, as being extremely traumatic.

It is less clear whether differences in impact exist between intrafamilial and extrafamilial abuse. Studies by Friedrich et al. (1986) and Sedney and Brooks (1984) have found greater psychopathology to be associated with abuse by relatives than by nonrelatives. In a female college sample, Sedney and Brooks (1984) found significantly more problems, for example, depression, thoughts of hurting self, victim of further crime, and learning problems, among victims of intrafamilial abuse than among those of extrafamilial abuse. This finding, however, is not consistent across studies (Einbender & Friedrich, 1989; Pinkelhor, 1979; Johnston, 1979; Mian, Wehrspahn, Klajner-Diamond, LeBaron, & Winder, 1986; Russell, 1983).

The discrepancy in the findings may be due partly to the interaction between the child's age and sex and his or her relationship to the offender. Tong et al. (1987) found that girls were more likely to be abused by relatives or acquaintances (78%), while boys were more likely to be the victims of stranger abuse (58%). Scores on the Piers-Harris Self-Concept Scale analyzed by sex revealed that girls had a significantly lower self-concept in comparison to boys.
boys. With regard to age, Mian et al. (1986), in their chart review of 105 cases, found that 73% of preschool children (under 5 years) were victims of intrafamilial sexual abuse versus 42% of 5- and 6-year-olds. In addition, Dubé and Hébert (1988) found that abuse by a stranger was more likely to happen to school-age children (25.5%) than to preschoolers (14.1%).

Severity of abuse and use of force. Most of the studies of short-term effects have concluded that the more intrusive the abuse the greater the associated trauma (Adams-Tucker, 1982; Elwell & Ephross, 1987; Friedrich et al., 1986; Wolfe et al., 1989). Using a stepwise regression analysis on Child Behavior Checklist scores, Friedrich et al. (1986) found that greater internalizing behaviour was associated with severity of abuse, among other variables. Likewise, Wolfe et al. (1989) found that abuse severity significantly predicted negative feelings about sexualization as well as trait anxiety in their sample of 71 sexually abused children. Russell's (1986) long-term study also found that 63% of the adult incest survivors who experienced genital intercourse reported extreme or considerable trauma as opposed to 19% of those experiencing sexual kissing and touching. A multiple regression analysis revealed that severity of abuse was the most significant
predictor of trauma, followed by whether or not the perpetrator was a father or some other relative, use of physical force, age disparity between victim and offender, and duration of abuse. These variables accounted for 31% of the variance.

Use or threat of physical force and/or violence also appears to increase the risk of negative outcome (Elwell & Ephross, 1987; Finkelhor, 1979; Russell, 1986; Seidner, Calhoun, & Kilpatrick, 1985; Tsai, Feldman-Summers, & Edgar, 1979). Elwell and Ephross (1987) found that more severe symptomatology was associated with physical injury to the child and force applied by the offender. Finkelhor (1979), in his sample of 796 college students, reported that the use of force was the most powerful predictor of trauma, correlating .53 with his measure of trauma. Russell (1986) found that in all cases in which violence was used, extreme or considerable trauma was reported. In instances in which force was used, 74% were similarly traumatized compared with 46% experiencing nonforceful abuse.

**Age at onset.** Both retrospective and short-term studies have presented inconsistent findings regarding the relation between age of onset of the abuse and outcome. Several retrospective studies have found prepubertal experiences to be associated with greater behavioural
disturbance (Courtois, 1979; Meiselman, 1978; Russell, 1986). Meiselman (1978) found that 37% of her sample of women seeking psychotherapy, who had been incestuously abused prior to puberty, were seriously disturbed (psychoses, borderline conditions, serious suicidal attempts), compared with 17% of those who had been abused after puberty. Courtois (1979), assessing adult women's long-term sense of self and their relationships with men, also found more serious ratings among those who had prepubertal experiences.

Similar findings have been reported in studies of child victims (Gomes-Schwartz et al., 1985; Wolfe et al., 1989; Zivney, Nash, & Hulsey, 1988). Gomes-Schwartz et al. (1985) examined behaviour problems in three age groups of sexually abused children -- preschool, school-age, and adolescence -- and found that the preschoolers and adolescents displayed fewer signs of pathology than the school-age children. The researchers suggested that the adolescents first victimized in adolescence were better able to deal with the abusive experience cognitively, while the kindergarten children may not have been able to understand the nature of the abuse. Zivney et al. (1988) examined the Rorschach protocols of 3 groups of girls: 37 abused before their ninth birthday, 43 abused after their ninth birthday, and a control group of 72
patients with no history of sexual abuse. Over half of the early-abused group manifested a preoedipal form of pathology, characterized by disturbed cognition, a damaged self, and a preoccupation with themes of primitive supply. In contrast, only 12% of the later-abused girls displayed this pattern.

Other studies of children and adolescents have reported opposite findings (Adams-Tucker, 1982; Peters, 1976; Sedney and Brooks, 1984). Adams-Tucker (1982), for example, found that children first abused between the ages of 10 and 15 received more severe DSM-III diagnoses and were more likely to be referred for inpatient treatment than children first molested prior to age ten. Similarly, Peters (1976) reported that sexually assaulted children exhibited fewer changes in behaviour compared to adolescent and adult victims.

Beitchman et al. (in press) posit possible explanations for the inconsistent findings. They suggest that the discrepancy may reflect developmental differences in symptomatology and as children mature new symptoms will be associated with the abuse. They reason also that age of onset and duration may be related, since younger children would have recently disclosed the abuse and therefore would not have been abused for as long as older children. It is
also conceivable that age of onset interacts with other variables, such as abuse severity and perpetrator. For example, Dubé and Hébert (1988) found that 41% of school-age children were more frequently subjected to more serious abuse, such as digital penetration and attempted intercourse, in comparison to 29.1% of preschoolers. It may be that preschool children, whose offenders are more likely to be intrafamilial, may experience less serious abuse in comparison to older children, whose offenders may include less emotionally close assailants and the severity of the abuse may be more serious.

**Duration and frequency.** The data are conflicting also with regard to duration and frequency. Johnston (1979) found that depression was most severe among school-age sexually abused children who were abused longer than two years. Longer duration has also been found to be one of the significant predictors of externalizing and internalizing behaviour (Eimbender & Friedrich, 1989; Friedrich et al., 1986). On the other hand, studies of adult victims have reported a negative relationship between impact and duration (Courtois, 1979; Finkelhor, 1979). Courtois (1979), for example, found an inverse relationship between duration and outcome. In her sample of women, who had incest experiences in childhood or adolescence, the experiences of longer
duration were reported as causing less serious long- or short-term effects. The outcome effects observed in the child studies may be more of a reflection, however, of the child's age, which is necessarily correlated with duration.

The results of a multiple regression in Friedrich et al.'s (1986) study revealed that greater internalizing behaviour and sexual problems were significantly predicted by greater frequency. Russell's (1986) study of incest survivors found that abuse which occurred more than 20 times was described by 78% of the respondents as extremely or considerably traumatic. In comparison, 61% of the women reported such trauma when the abuse occurred between 2 to 20 times, while 46% gave such descriptions when the abuse occurred only once. When finer distinctions were made, however, in the frequency count this linear association was not apparent. Abuse that occurred between 6 and 10 times and between 11 and 20 times was considered less traumatic than abuse that occurred between two and five times.

**Family Psychopathology**

The contribution of familial variables to the occurrence and sequelae of childhood sexual abuse has been largely ignored by researchers, whose focus has been mainly the sexual/abusive component. Where recognition has been given is in the mostly descriptive literature on incestuous
abuse, where parental characteristics and family dynamics have been regarded as the most prominent contextual factors. The limited empirical evidence, however, suggests that families, in which sexual abuse occurs, may possess characteristics of a chaotic, disorganized family life.

Several studies have found that the majority of sexually abused children seem to come from single or reconstituted families. Mian et al. (1986), for example, found that children of intrafamilial sexual abuse were significantly more likely to come from broken homes (67%), compared with children who had experienced extrafamilial abuse (27%). A disorganized family life is also a common finding. Krener (1985) found from chart data that 54% of 22 incest victims came from families with structural disorganization, such as a recent divorce, moving, incarceration, or commitment of a family member. These children presented with more symptomatic behaviours than those who came from more "organized" families.

In comparison to other treatment groups, however, these "disorganized" characteristics do not appear to differentiate the sexually abused. Livingston (1987) found that the families of both physically and sexually abused children shared similar psychosocial stressors, such as marital conflict, money problems, and separation or divorce.
Similarly, Emslie and Rosenfeld (1983) found that chaotic, single-parent families typified incest and non-incest groups.

Parental marital problems have also been observed. Gruber and Jones (1983), using a sample of delinquent adolescent females, found that the sexually abused victims were more likely to report marital conflict between their parents than the nonsexually abused girls (65% vs 19%). A stepwise discriminant analysis indicated that variables measuring marital conflict, poor relations with mother, and living with a step/foster parent correctly classified 80% of the victim sample. Poor sexual relations have also been a common finding in clinical studies of incestuous abuse (Herman, 1981; Maisch, 1972; Westermeyer, 1978). Westermeyer (1978), for example, found that in 5 of the 13 incest cases the mothers of the incest victims reported that they had refused to have sexual relations with their husbands before and during the time of the abuse.

Another finding has been the greater number of psychiatric problems, the most frequent being chemical dependency and depression (Adams-Tucker, 1981; Friedrich & Luecke, 1988; Herman, 1981; Smith & Israel, 1987). Seventy-nine percent of the families in Adams-Tucker's (1981) study had a history of psychiatric treatment, drug and alcohol
abuse, completed or attempted suicide, depression, and nervous breakdown. Herman (1981), in her sample of 40 adult female outpatients who were victims of incestuous abuse, found that 55% indicated that their mothers had suffered from a major illness, the most common being depression, alcoholism and psychosis, in comparison to only 15% of a nonabused therapy group. In a sample of female juvenile delinquents, Taylor (1984) found that 77% of the sexually abused victims versus 37% of a control group reported a significantly higher incidence of alcohol/drug abuse among their fathers.

Several researchers have reported on the occurrence of intergenerational sexual abuse (Friedrich & Reams, 1987; Goodwin, McCarthy, & DiVasto, 1981; Sansonnet-Hayden et al., 1987; Smith & Israel, 1987). In their sample of 100 mothers of incest victims, Goodwin et al. (1981) found that 24% had revealed they had been incest victims as children. In contrast, 3% of the 500 mothers, in the control sample of nonabused children, reported such victimization as children. Goodwin, Cormier, and Owen's (1983) subsequent study of grandfather-granddaughter sexual abuse found that 6 of the 10 mothers reported being sexually abused by the same perpetrator as their children. Similarly, Sansonnet-Hayden et al. (1987) found a significantly higher proportion of
maternal sexual abuse among sexually abused adolescents compared to psychiatric controls (67% vs 3%).

Attention has recently been paid to the contribution of familial variables to outcome. Research in the area of child abuse and neglect has noted that family functioning and interaction patterns may be more or as responsible for the social and developmental consequences reported in children than the abusive experiences (Toro, 1982; Wolfe & Mosk, 1983). Initial evidence in the child sexual abuse literature would appear to concur with this finding. Conte and Schuerman (1987), with a sample of 369 children seen at a sexual assault centre, found that variables indicating the absence of family psychopathology and the presence of supportive relationships explained the largest proportion of variance in parent and social worker measures of child functioning. Variables related to family stress (e.g., parents' tendency to have a negative outlook, number of stressful events child experiences) accounted for 22% of the variance in child behaviour ratings. Differences, though, between the abused and nonabused samples were still significant after the family and demographic variables were controlled for, with the sexual abuse explaining an additional 11% of the variance in behaviour scores. Friedrich et al. (1987) found that variables measuring
family conflict and family cohesion explained the greatest proportion of variance in the sexually abused children's internalizing and externalizing scores on the Child Behavior Checklist. Time elapsed since abuse and severity of abuse explained additional but smaller proportions of variance for the Child Behavior Checklist scores.

Significance and Purpose of Study

Several methodological constraints, among them the use of heterogeneous groups and inadequate or absent control groups, have contributed to the caution in accepting much of the child sexual abuse research. Accordingly, the design of the present study hoped to ameliorate some of the problems that have characterized the literature.

First, studies have typically employed heterogeneous samples of child subjects with respect to child characteristics (e.g., age, sex, source of referral) and to the nature of the sexual abuse experience itself (e.g., contact vs. noncontact abusive acts). The present study used a more homogeneous sample by restricting it to females in the age range of 5-12 years, studying only contact abuse, and sampling subjects from a child protection agency.

Second, the methodological issue of most concern to date has been the relative absence of control groups. The
use of a psychiatric or clinical group presents a problem with regard to the appropriateness of the sample. The most commonly utilized group has been a heterogeneous patient sample. It was hoped that the present study's use of control subjects from the same child protective agency would facilitate the matching procedure since it was expected that the two groups would share certain demographic characteristics, such as social class. It was also anticipated that the two groups would have common experiences with regard to agency intervention, which may have been stressful. In addition, the present study employed a second control group comprised of nonabused, non-clinical girls sampled from the general population.

Third, many studies have relied on single and/or unstandardized measures of dysfunction and also have made little attempt to provide evidence of cross-validation. For example, studies have employed the nonoffending parent, invariably mother, as the sole informant. Given the emotional nature of sexual abuse, it is important to consider whether over-reporting or under-reporting of symptoms is present (cf. Reid, Kavanagh, & Baldwin, 1987). The present study addressed some of these issues by using multiple measures that have shown good reliability and validity and multiple informants (i.e., child, mother,
Despite the burgeoning literature on child sexual abuse, significant gaps exist in our knowledge about the specific behavioural and emotional consequences to the child. While there is a percentage of children who seemingly are not negatively affected by the abusive experience, a substantial proportion display a number of psychopathological problems that are similar to other treatment groups. Further, there may be a differential impact on the child, depending on the abuse-specific correlates, the child's prior adjustment and development, and the family functioning and dynamics. At present, there is little conclusive evidence with regard to the significance of the familial and abuse-specific variables to the short-term effects.

The present study investigated different domains of adaptive functioning in a sample of sexually abused girls in comparison to those in nonabused clinical and non-clinical control groups. Based on the available literature the study examined the following hypotheses:

(1) Sexually abused girls would not perform as well cognitively and academically as the non-clinical girls, but would show commensurate levels of performance with clinical girls.
(2) Sexually abused girls would demonstrate more behavioural problems than non-clinical girls, but would be as disturbed behaviourally as clinical girls.

(3) Sexually abused girls would be less socially competent than non-clinical girls, but would be as socially skilled as clinical girls.

(4) Sexually abused girls would demonstrate more sexualized behaviours than clinical and non-clinical girls.

(5) Sexually abused girls would show more gender identity disturbance than clinical and non-clinical girls.

(6) There would be greater marital discord and maternal symptomatology among the mothers of the sexually abused girls than among those of the non-clinical girls. In comparison to the mothers of the clinical girls, it was expected that the mothers of the sexually abused girls would report similar levels of discord and distress.

One additional area of child functioning was explored, namely, activity level. It was anticipated that the sexually abused girls would show a higher activity level than both clinical and non-clinical groups.
CHAPTER 2

METHOD

Subjects

Three groups of 20 girls (age range, 5-12 years) and their mothers participated in the study. The first group consisted of confirmed cases of sexual abuse (SA) reported for the first time to the Children's Aid Society (CAS) of Metropolitan Toronto, a child protection agency which registers all disclosed incidents of sexual abuse. The cases were obtained from 4 of the 5 branches of the CAS over a period of 16 months (May 1989-September 1990). On average, the cases were opened or reopened (for reasons other than sexual abuse) at the agency 8.3 months (range, 0.33-20.43 months) prior to participation in the study. Fifty percent of the cases were previously opened for reasons other than sexual abuse. The average length of time between the last known incident of sexual abuse and participation in the study was 12.6 months (range, < 1-38 months).
The criteria for inclusion were: (a) at least one incident of intrafamilial or extrafamilial sexual abuse (defined here as contact abuse by Russell (1983), e.g., intercourse, touching of genitalia, kissing) of the child by a male (16 years and over) that was substantiated by two or more of the following—child report, admission by the offender, CAS report, medical/physical evidence; and (b) no severe developmental disability, such as mental retardation (Full Scale IQ ≤ 69). Cases that included incidents of physical abuse, as confirmed by maternal and CAS report, were excluded.

Two hundred and fifty-eight cases, coded as sexual abuse by the CAS, were screened for potential inclusion in the study. Of these, 52 (20.1%) did not meet the inclusion criteria, 25 (9.6%) were deemed "inappropriate" by social workers (e.g., family overwhelmed by crises, lack of favourable contact between worker and family, court appearance), 19 (7.3%) decided not to participate (2 of these decided after beginning the study), 27 (10.4%) were unsubstantiated cases of abuse, 21 (8.1%) were closed at intake or thereafter, and 34 (13.1%) were either refusing involvement with the CAS, had moved, were under investigation, had the child in care, or English was not the first language. Eighty-one (31.3%) remained as potential
cases, including the 20 cases used in the study. The remaining 61 potential cases were not utilized either because of the social worker's failure to contact the family, a decision to wait until a more appropriate time to contact the family, or the family not returning the call.

The second group consisted of clinical controls (CC), which were cases referred to the CAS for the following reasons: physical abuse of child (35%), physical neglect of child (5%), parental behaviour (e.g., drug or alcohol abuse, parenting skills) that may have endangered the child (45%), mental health of parent (10%), and request for support services (5%). On average, the cases were opened or re-opened 8.0 months (range, 0.43-15.37 months) prior to participation in the study. Fifty-five percent of the cases were newly opened. The inclusion criteria for the CC group were: (a) no suspected or reported occurrence of sexual abuse by parent or CAS; and (b) no severe developmental disability, such as mental retardation (Full Scale IQ ≤ 69).

Originally, the study was designed to use only physically abused girls as the CC group. There was much difficulty, however, in obtaining cases that met the study's inclusion criteria for physical abuse, in particular that the offender must be male, as well as the CAS' criteria, for example, many cases, though coded physical abuse at intake,
were considered upon investigation by the social workers to be instances of cultural differences where the offending parent was unaware of this society's disapproval of corporal punishment and/or were single incidents of a less serious nature, such as hair pulling. Consequently, the author decided to expand the CG group and include incidents of neglect and parental behaviour that may harm the child.

The third group consisted of non-clinical control (NC) girls, who were recruited through advertisements placed in local newspapers and community centres that reflected similar geographic and demographic characteristics of the SA sample. The girls in the NC group were screened through parent report to exclude those with a history of sexual abuse, developmental problems, mental retardation, involvement with mental health professionals and/or child protection agencies, and placement in a special class in the school setting.

The three groups were group-matched for age of child, parents' marital status, and social class of family, as judged by the Hollingshead (1975) four factor index of social status. The index is based on parent(s)' occupation, education, and marital status, with a higher aggregate score reflecting a higher social index. Five categories of social class are provided: (1) major business, professional (55-
(2) medium business, minor professional, technical (40-54); (3) skilled craftsmen, clerical, sales workers (30-39); (4) machine operators, semiskilled workers (20-29); (5) unskilled labourers, menial service workers (8-19).

A reimbursement of $80 for time and transportation costs was paid to each mother-daughter pair at the conclusion of their participation.

Measures

A questionnaire to quantify the parameters of the sexual abuse experience was completed by mothers and later verified by CAS social workers (see Appendix A). If discrepancies existed, the social workers' report was used.

The following measures were used to assess several domains of the child's functioning:

Wechsler Intelligence Scale for Children-Revised and Wechsler Preschool and Primary Scale of Intelligence

Intellectual functioning (IQ) was assessed either by the Wechsler Intelligence Scale for Children-Revised (WISC-R) (Wechsler, 1974) for children 6 years and older or by the Wechsler Preschool and Primary Scale of Intelligence (WPPSI) (Wechsler, 1967) for children under 6 years. Factor analyses (Cohen, 1959; Kaufman, 1975) of the WISC and WISC-R subtests have revealed three factors labeled Verbal
Comprehension (Information, Vocabulary, Comprehension, Similarities), Perceptual Organization (Picture Arrangement, Picture Completion, Block Design, Object Assembly) and Freedom from Distractibility (Arithmetic, Digit Span, Coding). Factor analysis of the WPPSI (Costes & Bromberg, 1973; Sattler, 1982) for children ages 5 to 6 have also yielded Verbal Comprehension (Information, Vocabulary, Comprehension, Arithmetic, Similarities) and Perceptual Organization (Block Design, Mazes, Geometric Design, Picture Completion, Animal House) factors, but not a Freedom from Distractibility factor. The present study employed the Verbal, Performance, and Full Scale IQs and Kaufman's three factor scores.

Wide Range Achievement Test-Revised

The Wide Range Achievement Test-Revised (WRAT-R) (Jastak & Wilkinson, 1964) is a standardized instrument of academic achievement. It is comprised of three subtests, Reading, Spelling, and Arithmetic, with two Levels for each subtest. Level 1 is designed for use with children between ages 5 and 12; Level 2 for individuals 12 and older. Standard scores, which are provided for each subtest, were used in the present analysis.
Child Behavior Checklist

The Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1981, 1983) is a standardized parent-report questionnaire of children's behavioural problems and social competencies (see Appendix B). Parents are asked to rate the child on a 0-2 point scale for each of 118 behaviour problem items and on 20 social competency items.

Factor analyses of CBCL ratings for clinically-referred girls and boys in three age categories, 4-5, 6-11, and 12-16, yielded either eight or nine behaviour problem narrow-band scales for each sex/age group. Further analyses on these narrow-band scales yielded two broad-band factors, labeled Internalizing and Externalizing. For girls aged 6-11, the Internalizing domain consists of four narrow-band scales: Depression, Somatic Complaints, Schizoid-Obsessive, and Social Withdrawal; while the Externalizing domain consists of five narrow-band scales: Hyperactivity, Aggression, Cruelty, Delinquency, and Sex Problems. Ratings are converted to T scores, where a score > 70 (98th percentile) is considered in the clinical range.

The CBCL also contains items related to three areas of social competence: Activities, Social, and School. The Activities score represents the amount and quality of participation in reported activities. The Social score
reflects the number and frequency of contact with friends, and how well the child gets along with family and peers. The School score reflects performance in academic subjects. Raw scores are also expressed as T scores, but are negatively skewed. A T score ≤ 30 (2nd percentile) is considered in the clinical range.

Considerable evidence has been garnered for the reliability and validity of the CBCL as an index of childhood behavioural psychopathology. An overall intraclass correlation of .95 for the behavioural items and .99 for the social competence items were found in a study of item one-week test-retest reliability (Achenbach & Edelbrock, 1983). The CBCL has also been found to discriminate between clinical and non-clinical samples on all social competence and behaviour problem scales (Achenbach, 1978; Achenbach & Edelbrock, 1979).

Various dependent variables are available for analysis. The present study employed the following: T scores for activities, social, school, the number of clinically-elevated narrow-band scales (T > 70), sum of behaviour problems rated as 1 or 2, and the T scores for Internalizing, Externalizing, and Total behaviour problems.
Teacher Report Form

The child's behaviour in the school environment was assessed by the Teacher Report Form (TRF) (Achenbach & Edelbrock, 1986; Edelbrock & Achenbach, 1984), completed by the child's main teacher. Similar in format to the CBCL, the TRF provides an index of the child's school performance, broad-band, and narrow-band dimensions of behavioural disturbance, and a total behaviour problem score (see Appendix C). A one-week test-retest reliability correlation of .90 has been found, while over a two-month interval a median test-retest correlation of .74 has been found (Achenbach & Edelbrock, 1986). The TRF has also been shown to discriminate between referred and nonreferred pupils on all the scales for all sex/age groups. Six measures of the TRF were used in the present study: T score for school, number of clinically-elevated narrow-band scales, sum of items of behavioural problems, T scores for Internalizing, Externalizing, and Total behaviour problems.

Matching Familiar Figures Test

The Matching Familiar Figures Test (MPFT) (Kagan, Day, Albert, & Phillips, 1964) is a visual-discrimination task that has been used as an index of impulsivity in children. The child is exposed to 12 different trials, each consisting of six arrays of similar-looking drawings. The task is to
identify from the array the drawing that matches exactly a standard. For each trial, a latency score (in seconds) and the number of errors before the correct response is given are obtained. The present study employed both measures, using total latency and response accuracy (i.e., total number of errors) as the dependent variables. Among school-age children test-retest reliabilities have ranged from .34 to .80 for response accuracy; corresponding reliabilities for latency have ranged from .58 to .96 (Messer, 1976).

There is also reasonable evidence for the construct validity of the task as the reflection-impulsivity construct remains fairly robust over changes in the MFPT, and in comparison to other tests such as the Raven's Coloured Progressive Matrices (Messer, 1976).

The MFPT was used to assess an additional aspect of behavioural disturbance. An association between impulsivity and externalizing behaviours has been noted in several studies of children with behavioural problems, including physically abused and hyperactive children (e.g., Green, 1978; Weintraub, 1973). In this study the assessment of impulsivity tests for the possibility that such a behaviour may be a factor in the sexual activities and externalizing behaviours of sexually abused girls, who may lack the necessary internal controls or take less time to think about
their actions.

Child Sexual Behavior Inventory

The Child Sexual Behavior Inventory (CSBI) (Friedrich et al., 1988; Friedrich et al., 1989; Friedrich et al., in press) is a parent-report questionnaire that assesses the frequency of a variety of putative sexual behaviours in children aged 2-12 (see Appendix D). The CSBI was developed by expanding the sexual behaviour items on the CBCL and by including additional items relating to sexual inhibition, sexual aggression, self-stimulation, and gender behaviour. The original version contained 48 items rated on a 0-3 point scale. Friedrich et al. (in press) reported that 13 of the original items were imprecisely worded or may have been interpreted differently by parents of normative versus clinical children (e.g., "sees nude adults", "watches parent(s) show sexual behavior such as necking, fondling") and consequently were removed from further analyses. The present study adopted a similar method and retained the remaining 35 items in its analyses (the appendix indicates these items by the use of an *).

Factor analysis has determined the utility of the total 35-item CSBI score as an index of sexualized behaviour. Inter-item correlations (alpha coefficient of .82 for the normative sample) and test-retest reliability after
approximately four weeks (correlation of .85) have indicated the reliability of the measure (Friedrich et al., in press). The CSBI has also shown initial discriminant validity between sexually abused and normal samples, and between sexually abused boys and sexually abused girls (Friedrich et al., 1989; Friedrich et al., in press). The CSBI, however, does not seem to be as sensitive in discriminating sexually abused girls from ages 10-12. In addition, normative studies of children between ages 2-12 indicate that sexualized behaviours appear to decline with age, with fewer behaviours persisting into the school-age years (Friedrich et al., in press).

**Gender Identity Questionnaire**

Gender identity disturbance was assessed by a modified version of Elizabeth and Green's (1984) Gender Identity Questionnaire (Appendix E). The original parent-report questionnaire consisted of 12 items, which examined the child's degree of interest in a variety of stereotypical gender role behaviours. The modified questionnaire (Zucker, in press) added four items which focused on cross-sex wishes and feelings about sexual anatomy. All items are coded on a 1-5 scale such that the most sex-typical response is a 5 and the least sex-typical response is a 1. Factor analysis of the original version has produced one primary
factor, indicating the use of the total score, while inter-item consistency reliabilities of .93 for both sexes and .73 for within sexes have been found (Elizabeth & Green, 1984). The individual items and the total score have been found to discriminate strongly the behaviour of boys and girls (Elizabeth & Green, 1984; Zucker & Torkos, 1989) and gender-referred children from siblings (Zucker, in press).

Temperament Questionnaire

It has been argued that certain child characteristics may exacerbate or contribute to abuse situations (e.g., Parke & Collmer, 1975). Activity level may be considered a possibly relevant endogenous characteristic. The parent-completed Temperament Questionnaire (Zucker & Bradley, 1988) (see Appendix F) used in the present study was derived from previous studies of child temperament (Bates, Bentler, & Thompson, 1973; Rowe & Plomin, 1977; Thomas & Chess, 1977; Vroegh, Jenkins, Black, & Handrich, 1967). The 54 items that constituted the present questionnaire were factor analyzed, which yielded five factors: social responsive/competent (N=16 items); activity level/extraversion (N=17 items); reaction to food (N=5 items); sociability (N=6 items); and emotionality (N=10 items) (Zucker & Bradley, 1988). The Activity Level was employed as the dependent variable in this study. Zucker and Bradley (1988) have
found that Activity level discriminates between sexes, with cross-gender identified boys having the lowest mean compared to siblings and psychiatric control boys, whereas cross-gender identified girls had the highest mean compared to siblings and psychiatric control girls.

The following measures assessed maternal functioning:

**Dyadic Adjustment Scale**

Marital quality was measured by the Dyadic Adjustment Scale (DAS) (Spanier, 1976), a self-report questionnaire (see Appendix G) designed for use with married couples or couples in a committed relationship. The 32-item scale has a theoretical range from 0-151, with a higher score indicating better adjustment. Factor analysis of the 32 items found four interrelated components: dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression. The DAS has been found to correlate highly with the Locke Marital Adjustment Scale, a widely used and well validated instrument, and to discriminate between divorced and married individuals. The four component scales have reliability coefficients ranging from .73 to .94 (Spanier, 1976; Spanier & Thompson, 1982). The present study employed the four component scales.
Symptom Checklist-90-Revised

The Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1977) is a 90-item self-report symptom inventory (Appendix H) that yields nine primary symptom dimensions and three global indices of current distress. Questions are scored on a 0-4 point scale, where higher scores indicate greater levels of distress. T scores are provided for the symptom dimensions. Validation studies have shown that the SCL-90-R is comparable to similar questionnaires like the Minnesota Multiphasic Personality Inventory and very sensitive to change in a wide variety of medical and clinical contexts, while reliability studies have found satisfactory internal consistency and test-retest coefficients (Derogatis, 1977). The present study utilized the nine symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxious, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Procedure

A pool of potential subjects was obtained from the CAS via computer listings that identified the nature of the referral, the date of opening, and the number, sex, and date of birth of children. The SA and CC cases that met the criteria of age, sex, and reason for referral were discussed
with the appropriate CAS social worker. Based on the worker's assessment of the suitability of each case, the study initially was introduced to the family by the worker. Cases that were considered by the worker to be unsuitable commonly included families who were experiencing many life stressors or crises and/or were resistant or hostile to CAS intervention.

A suggested introduction to the study was offered to workers who used it at their discretion. The introduction stated that the study, conducted at the Clarke Institute of Psychiatry in Toronto, was investigating the behavioural characteristics of child abuse in young girls. The nature and duration of the participation as well as the reimbursement were explained. Families willing to participate were contacted by phone by the author. The above introduction was given or clarified, depending on the extent of information conveyed by the worker, and an appointment was made to meet with the mother.

The NC mothers and daughters were recruited in two time periods, the first in December 1989 and the second in June 1990. The advertisements, placed in a local newspaper and community centres, stated that the Clarke Institute of Psychiatry was seeking mothers with daughters, between the ages of 5 and 12, for a study of children's development.
The prerequisites were that the child must have had no contact with a child protection agency or a mental health professional and be in a regular class. Mothers responding to the advertisement were told further that the study wished to examine any potential differences between children who had been involved with a helping profession and those who had not. The mothers were not forewarned that the study concerned sexual abuse but were debriefed afterward. The remainder of the introduction was similar to that given to the SA and CC groups.

The girls in all the groups were introduced to the study with the explanation that the author required their assistance to help her better understand how girls of their age think and feel about various things. The girls were assured that they had not done anything wrong, informed of the nature of their participation, and encouraged to do their best.

Subjects were interviewed individually at one of three locations: a CAS branch office, the Clarke Institute of Psychiatry, or the family's home. The interviews and testing were conducted in one to three sessions, with the mothers being interviewed first. At the initial meeting with the mother, she was asked to read and sign an informed consent form (see Appendices I and J for the consent forms
for the CAS girls and the non-clinical girls, respectively) plus a Release of Information form necessary to obtain data from the child's school. The child was seen either the same day as the mother or at a later date. The sessions with the mother and child lasted an average of two to three hours each.

The SA mothers were asked to complete the sexual abuse questionnaire before beginning the written questionnaires. The child and maternal questionnaires were presented in the following order: CBCL, CSBI, Gender Identity Questionnaire, Temperament Questionnaire, DAS, and SCL-90-R. Single mothers were asked to complete the DAS by choosing either the child's father, if he maintained an active role in their lives, or the most recent relationship. The questionnaires were completed either while the daughter was being tested, or at home and returned to the author by mail in a stamped envelope.

Children were administered the measures in the following order: WISC-R, WRAT-R, MPFT. Breaks in the testing were allowed whenever necessary.

Teachers were requested by letter to complete the TRF about the child's behaviour and return it in a stamped, self-addressed envelope. The letter indicated that the student in question and her mother were participating in a
study, but it did not disclose the nature of the study.
CHAPTER 3

RESULTS

Two main statistical procedures were utilized to explore group differences. The first was a multivariate analysis of variance (MANOVA) on groups of theoretically-related variables. The use of the MANOVA was preferable to univariate analyses given the intercorrelations among the dependent variables and the consequent possibility of Type I error. Univariate tests ignore these interdependencies, while the MANOVA procedure adjusts for correlations and covariances among the variables.

The subgroups and their composition were:

1. cognitive/academic functioning, comprising (a) Full Scale IQ scores (b) WRAT-R Reading, Spelling, Arithmetic standard scores, and (c) CBCL and TRF school performance T scores;
2. behavioural disturbance, comprising (a) five measures each from the CBCL and TRF, and (b) MPFT latency and response accuracy scores;
3. social competence, comprising (a) CBCL activities and social competence scales; and
4. maternal functioning, comprising (a) four DAS
indices, and (b) nine SCL-90-R symptom dimensions.

One-way analyses of variance (ANOVA) were conducted on Verbal and Performance IQ, Kaufman's factor scores, sexualized behaviour, gender dysphoria, and activity level. Table 1 provides a list of child and mother dependent variables.

The second statistical procedure was a stepwise discriminant analysis that allowed for further study of the major dimensions along which the three groups might differ. The stepwise, as opposed to a hierarchical procedure, was utilized because of a lack of an a priori reason for the ordering entry of variables. Based on rational and empirical evidence, as provided by the alpha level and a principal components analysis, four composite variables, akin to the above subgroupings, were formed by standardizing (z-score transformations) and combining dependent variables.

The primary statistical consideration in the discriminant analysis was the appropriate alpha level for the predictor variables. Grove and Andreasen (1982) have noted that there are no firm rules by which to determine an alpha level. In the present study, each dependent variable was considered "significant" at the conventional .05 level. The reason for this is that since the study aims to explore patterns of behaviour any single measure is not of critical
Table 1

Child and Mother Dependent Variables

Cognitive functioning: WISC-R and WPPSI Verbal, Performance, and Full Scale IQ; Verbal Comprehension, Perceptual Organization, Freedom from Distractibility factor scores

Academic achievement: WRAT Reading, Spelling, Arithmetic standard scores; CBCL and TRF school T scores

Behavioural problems: Number of narrow-band scale elevations, sum of behavioural items, Internalizing T, Externalizing T, and Total T from the CBCL and TRF; MFFT total latency and total error scores

Social competence: CBCL activities and social competence T scores

Sexualized behaviour: CSBI total score

Gender dysphoria: GIQ total score

Temperament: Activity level score from the Temperament Questionnaire

Maternal functioning: DAS raw scores for dyadic consensus, dyadic satisfaction, affectional expression, dyadic cohesion; SCL-90-R T scores for somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxious, hostility, phobic anxiety, paranoid ideation, and psychoticism.
importance.

Pearson correlations were used to examine the relations among the composite measures of child and maternal functioning and demographic characteristics, as well as the relation between abuse characteristics and the composite measures of child functioning.

Demographic Analysis

Table 2 presents the means and standard deviations of the demographic characteristics of the three groups. One-way ANOVAS or chi-square tests revealed no differences among the three groups on the demographic variables (all Fs or χ² < 1.95) (see Appendix K).

Group Differences in Child Functioning

Cognitive/Academic Functioning

Group means and SDs for the 11 measures of cognitive/academic functioning are presented in Table 3. With the use of Wilks' criterion, a MANOVA conducted on six of these measures showed a significant multivariate effect, F(12,86) = 2.34, p < .01. Subsequent univariate ANOVAS (all df=2,48) were conducted on each measure to determine which variables contributed to the separation of the groups.
Table 2

Demographic Characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sexually abused</td>
</tr>
<tr>
<td>Age (in years)</td>
<td>M 8.82</td>
</tr>
<tr>
<td></td>
<td>SD 2.29</td>
</tr>
<tr>
<td>Social Class</td>
<td>M 26.15</td>
</tr>
<tr>
<td></td>
<td>SD 12.72</td>
</tr>
<tr>
<td>Range</td>
<td>11-53</td>
</tr>
</tbody>
</table>

Marital Status:
- Single/Never Married: N 6
- Married: N 3
- Divorced/Separated: N 11

Family Size:
- M 1.50
- SD 1.40
- Range 0-5

Ethnicity:
- White: N 15
- Black: N 1
- Native Indian: N 1
- Other: N 3

Child Residing With:
- Biological Parents: N 1
- Mother: N 18
- Relative: N 1

Note. The absolute range for the Hollingshead social class index is 8-66.
Table 3

Means and SDs on Cognitive/Academic Functioning

<table>
<thead>
<tr>
<th>Variables</th>
<th>Group</th>
<th>Sexually abused</th>
<th>Clinical controls</th>
<th>Non-clinical controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Verbal IQ</td>
<td>96.85</td>
<td>12.69</td>
<td>97.70</td>
<td>13.04</td>
</tr>
<tr>
<td>Performance IQ</td>
<td>98.95</td>
<td>13.11</td>
<td>104.90</td>
<td>15.03</td>
</tr>
<tr>
<td>Full Scale IQ</td>
<td>97.70</td>
<td>12.98</td>
<td>101.10</td>
<td>13.17</td>
</tr>
<tr>
<td>Verbal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehension</td>
<td>9.52_a</td>
<td>1.96</td>
<td>9.42_ac</td>
<td>2.21</td>
</tr>
<tr>
<td>Perceptual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>9.76</td>
<td>2.02</td>
<td>10.78</td>
<td>2.31</td>
</tr>
<tr>
<td>Freedom from</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distractibility^a</td>
<td>9.76</td>
<td>2.29</td>
<td>10.35</td>
<td>1.91</td>
</tr>
<tr>
<td>Reading</td>
<td>85.10_a</td>
<td>14.97</td>
<td>90.10_a</td>
<td>14.59</td>
</tr>
<tr>
<td>Spelling</td>
<td>83.10_a</td>
<td>12.64</td>
<td>89.05_a</td>
<td>12.78</td>
</tr>
<tr>
<td>Arithmetic</td>
<td>85.55_a</td>
<td>11.14</td>
<td>89.05_a</td>
<td>11.94</td>
</tr>
<tr>
<td>CBCL School^b</td>
<td>41.25_a</td>
<td>4.84</td>
<td>41.95_a</td>
<td>9.76</td>
</tr>
<tr>
<td>TRP School^c</td>
<td>45.76_a</td>
<td>7.88</td>
<td>44.57_a</td>
<td>9.09</td>
</tr>
</tbody>
</table>

Note. Higher scores reflect better functioning. F-ratios are from univariate
Table 3 continues

analyses. Means with the same subscript are not significantly different.

aN=53 because of the lack of an equivalent factor on the WPPSI.
bN=52 because subjects under 6 years lacked relevant school data.
cN=53 because one teacher did not return the questionnaire and 6 subjects under 6 years lacked relevant school data.

*P < .05. **P < .01.
Significant main effects ($p < .05$) were obtained for Reading, Spelling, Arithmetic, School CBCL, and School TRF (Table 3). Newman-Keuls tests (all $p < .05$) revealed that the sexually abused and clinical control girls had significantly lower standard scores on Reading, Spelling, and Arithmetic than the non-clinical girls. Duncan's multiple range test for unequal ns ($p < .05$) indicated that school performance, as rated by both mother and teacher, was significantly lower for the sexually abused and clinical groups than for the non-clinical group.

With the exception of the Verbal Comprehension factor, IQ did not significantly differentiate the groups. One-way ANOVAS were performed on Verbal IQ, Performance IQ, Verbal Comprehension, Perceptual Organization, and Freedom from Distractibility (all $df=2,57$, except for PD ($df=2,50$) (see Table 3). A Newman-Keuls test on the Verbal Comprehension factor indicated that the sexually abused group ($p < .05$) and the clinical group ($p < .06$) had lower scores than the non-clinical group.

A $2$ (informant: teacher vs. mother) x $3$ (group) ANOVA on school performance revealed significant main effects for group ($F(2,48) = 8.06$, $p < .001$) and informant ($F(1,48) = 8.23$, $p < .01$). The effect for informant indicated that the mothers perceived their children as performing more poorly
in school than did the teachers. The interaction effect was not significant, $F < 1$.

As hypothesized, the sexually abused girls performed less well on academic tests and on maternal and teacher reports of school performance than the non-clinical girls, but were comparable to the clinical girls. The three groups did not differ in overall cognitive functioning; however, on subtests of verbal ability, the sexually abused and clinical girls functioned more poorly than the non-clinical girls.

**Behavioural Disturbance**

Group means and SDs for the Child Behavior Checklist (CBCL), Teacher Report Form (TRF), and Matching Familiar Figures Test (MPFT) are presented in Table 4. With the use of Wilks criterion, a MANOVA revealed a significant multivariate effect, $F(24, 90) = 1.92, p < .05$. Univariate ANOVAS (all df=2,56) (see Table 4) yielded significant main effects for the following measures: number of narrow-band elevations, sum of items, Externalizing T, and total behaviour T as reported by mother; and sum of items, Internalizing T, Externalizing T, and total behaviour T as reported by teacher. Newman-Keuls or Duncan's multiple range test for unequal ns (all $p < .05$) indicated that the sexually abused and clinical groups displayed significantly more behavioural problems than the non-clinical group on:
Table 4

Means and SDs on Behavioural Disturbance

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sexually abused</th>
<th>Clinical controls</th>
<th>Non-clinical controls</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Child Behavior Checklist:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of elevations</td>
<td>2.25&lt;sub&gt;a&lt;/sub&gt;</td>
<td>2.75</td>
<td>2.60&lt;sub&gt;a&lt;/sub&gt;</td>
<td>2.87</td>
</tr>
<tr>
<td>Sum of items</td>
<td>41.70&lt;sub&gt;a&lt;/sub&gt;</td>
<td>25.27</td>
<td>46.05&lt;sub&gt;a&lt;/sub&gt;</td>
<td>33.18</td>
</tr>
<tr>
<td>Internalizing T</td>
<td>61.15</td>
<td>12.58</td>
<td>58.25</td>
<td>14.52</td>
</tr>
<tr>
<td>Externalizing T</td>
<td>61.20&lt;sub&gt;a&lt;/sub&gt;</td>
<td>10.51</td>
<td>62.30&lt;sub&gt;a&lt;/sub&gt;</td>
<td>14.14</td>
</tr>
<tr>
<td>Total T</td>
<td>62.25&lt;sub&gt;a&lt;/sub&gt;</td>
<td>12.16</td>
<td>62.10&lt;sub&gt;a&lt;/sub&gt;</td>
<td>15.38</td>
</tr>
<tr>
<td>Teacher Report Form:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of elevations</td>
<td>1.45</td>
<td>1.67</td>
<td>1.30</td>
<td>1.59</td>
</tr>
<tr>
<td>Sum of items</td>
<td>49.90&lt;sub&gt;a&lt;/sub&gt;</td>
<td>30.11</td>
<td>55.50&lt;sub&gt;a&lt;/sub&gt;</td>
<td>29.19</td>
</tr>
<tr>
<td>Internalizing T</td>
<td>60.00&lt;sub&gt;a&lt;/sub&gt;</td>
<td>8.93</td>
<td>60.55&lt;sub&gt;a&lt;/sub&gt;</td>
<td>8.15</td>
</tr>
<tr>
<td>Externalizing T</td>
<td>63.35&lt;sub&gt;a&lt;/sub&gt;</td>
<td>9.22</td>
<td>60.25&lt;sub&gt;a&lt;/sub&gt;</td>
<td>8.80</td>
</tr>
<tr>
<td>Total T</td>
<td>64.35&lt;sub&gt;a&lt;/sub&gt;</td>
<td>9.21</td>
<td>62.45&lt;sub&gt;a&lt;/sub&gt;</td>
<td>9.14</td>
</tr>
<tr>
<td>Matching Familiar Figures Test:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latency</td>
<td>108.00</td>
<td>102.27</td>
<td>142.85</td>
<td>181.88</td>
</tr>
<tr>
<td>Errors</td>
<td>28.30</td>
<td>9.07</td>
<td>24.20</td>
<td>6.42</td>
</tr>
</tbody>
</table>

Note. Higher scores reflect poorer functioning, the exception being the (table continues)
Table 4 continues

"Latency" variable where a higher score reflects better functioning. F-ratios are from univariate analyses. Means with the same subscript are not significantly different.

*P < .05. **P < .01.
number of narrow-band elevations, sum of items, externalizing behaviour, and total behaviour problems as reported by mother; and sum of items, internalizing behaviour, externalizing behaviour, and total behaviour problems as reported by teacher. Both mothers and teachers reported more maladaptive behaviours for the sexually abused and clinical groups than for the non-clinical group.

MPPT latency and error scores did not differentiate the groups. The means on the MPPT for the sexually abused girls indicated that they were more impulsive and produced more errors than either the clinical or non-clinical groups, but not significantly so.

A 2 (informant) x 3 (group) MANOVA on the 10 CBCL and TRF measures yielded a significant group x informant interaction, $F(10,104) = 2.68, p < .01$. None of the univariate ANOVAs, however, was statistically significant. There was also a multivariate main effect for informant, $F(5, 52) = 4.68, p < .001$. Inspection of the univariate ANOVAs showed that the number of narrow-band scale elevations was the only significant measure ($F(1, 56) = 4.02, p < .05$), with mothers reporting more elevations than teachers.

Concordant with the hypothesis, the sexually abused girls displayed more behavioural disturbance overall than
the non-clinical girls, but showed commensurate levels of symptomatology with the clinical girls. This finding was consistent between mothers and teachers.

An additional descriptive examination of the CBCL and TRF data revealed the percentage of girls in each group who had scores in the clinical range on the Internalizing, Externalizing, and Total Behaviour Problem scales. Table L-2 in Appendix L presents the percentages. The table shows that 45% and 50% of the sexually abused girls were in the clinical range on the Internalizing and Externalizing scales, respectively, of the CBCL. In comparison, 45% of the clinical girls and 10% of the non-clinical girls were in the clinical range on both CBCL Broad-Band scales. On the TRF, 35% and 55% of the sexually abused girls were in the clinical range on the Internalizing and Externalizing scales; comparative figures for the clinical girls were 50% and 45%, respectively, and for the non-clinical girls 16% and 10.5%, respectively.

An investigation of the CBCL narrow-band scales (Depressed, Social Withdrawal, Somatic Complaints, Schizoid-Obsessive, Hyperactive, Sex Problems, Delinquent, Aggressive, and Cruel) was conducted as a final descriptive analysis of the CBCL data. Figure M-1 in Appendix M presents the means of the nine narrow-band scales for each
group, while Figure N-2 in Appendix N includes Achenbach and Edelbrock's (1983) standardized norms for girls 6-11 years in the clinical and non-clinical samples (lower SLS).

Social Competence

A MANOVA conducted on the CBCL activities and social scales yielded a significant effect for group, $F(4,112) = 6.04, p < .001$. Table 5 presents the means and SDs. Univariate ANOVAS revealed a significant main effect for group on the social score, $F(2,57) = 9.71, p < .001$. The activities variable was nonsignificant ($F(2,57) = 2.49$). Newman-Keuls tests ($p < .05$) showed that the sexually abused group was less socially competent than the clinical and non-clinical groups.

Descriptively, 20% of the sexually abused girls were in the clinical range ($T < 30$) on the social scale; in contrast, none of the scores of the clinical and non-clinical girls were in the clinical range.

The hypothesis that the sexually abused girls would be less socially competent than the non-clinical girls was supported. Contrary to the hypothesis, however, the sexually abused girls were also less socially competent than the clinical girls.
Table 5

Means and SDs on Social Competence

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sexually abused</th>
<th>Clinical controls</th>
<th>Non-clinical controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td>36.65 9.81</td>
<td>47.30&lt;sub&gt;a&lt;/sub&gt; 7.37</td>
<td>46.75&lt;sub&gt;a&lt;/sub&gt; 8.47</td>
</tr>
<tr>
<td>Activities</td>
<td>46.95 6.62</td>
<td>45.05 9.93</td>
<td>50.35 5.55</td>
</tr>
</tbody>
</table>

Note. Means with the same subscript are not significantly different.
**Sexualized Behaviour**

Table 6 presents the maternal ratings on the Child Sexual Behavior Inventory (CSBI) as a function of group. A one-way ANOVA for group was not significant, \( F(2,57) = 1.03 \); however, means were in the expected direction, with the sexually abused girls displaying more sexualized behaviours than the clinical and non-clinical girls.

Following the age groupings used by Friedrich et al. (in press), a 2 (age: < 7 vs. ≥ 7) x 3 (group) ANOVA revealed a group x age interaction, \( F(2,54) = 5.39, p < .01 \) (see Table 6). Simple effects analysis (Kirk, 1969) showed that the younger sexually abused girls displayed more sexualized behaviours than did the older sexually abused girls, and the younger clinical and non-clinical girls, \( p < .01 \). Figure 1 depicts the relation between sexualized behaviour and age.

Contrary to the hypothesis, sexualized behaviour did not significantly differentiate the sexually abused girls from the clinical and non-clinical girls. When age was considered, however, younger sexually abused girls were reported to display more sexualized behaviour than both younger clinical and non-clinical girls and older sexually abused girls.
Table 6  
Maternal Ratings on the Child Sexual Behavior Inventory

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>N</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group</strong></td>
<td></td>
<td></td>
<td></td>
<td>1.03</td>
</tr>
<tr>
<td>SA</td>
<td>5.85</td>
<td>6.20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>5.75</td>
<td>8.44</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>NC</td>
<td>3.15</td>
<td>4.49</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td>1.28</td>
</tr>
<tr>
<td>&lt; 7</td>
<td>6.44</td>
<td>4.39</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>≥ 7</td>
<td>7.02</td>
<td>6.41</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td><strong>Group x Age</strong></td>
<td></td>
<td></td>
<td></td>
<td>5.89*</td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 7</td>
<td>13.40</td>
<td>5.64</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>≥ 7</td>
<td>3.33</td>
<td>3.99</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 7</td>
<td>2.00</td>
<td>1.87</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>≥ 7</td>
<td>7.00</td>
<td>9.37</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>NC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 7</td>
<td>4.00</td>
<td>6.73</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>≥ 7</td>
<td>2.94</td>
<td>4.04</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

Note. Higher scores reflect more sexualized behaviours. SA = Sexually Abused; CC = Clinical Control; NC = Non-Clinical Control.  
*P < .01.
Figure 1
Mean Child Sexual Behavior Inventory Score by Age

Sexually Abused
Clinic Controls
Non-Clinic Controls

AGE
< 7 yrs
≥ 7 yrs

Mean CSBI Score

14 12 10 8 6 4 2 0
Gender Dysphoria

The hypothesis of greater gender identity disturbance among the sexually abused girls in comparison to the clinical and non-clinical girls was not supported. A one-way ANOVA for group on the total Gender Identity Questionnaire score was not significant, ($F(2,57) < 1$). The means and SDs were 3.93 (.29) for the sexually abused group, 3.87 (.23) for the clinical group, and 3.95 (.25) for the non-clinical group. In comparison to studies by Zucker (in press) and Zucker and Torkos (1989), the three groups in the present study scored within the conventionally feminine range on sex-typed play and behaviour.

Activity Level

The expectation that sexually abused girls would show a higher activity level than clinical and non-clinical girls was not supported. A one-way ANOVA did not reach statistical significance ($F(2,57) < 1$) on the Activity Level factor of the Temperament Questionnaire. The means and SDs were 3.14 (.78) for the sexually abused group, 3.10 (.70) for the clinical group, and 3.03 (.54) for the non-clinical group. These scores are similar to those found by Zucker and Bradley (1988) of sibling and psychiatric control girls, whose scores were significantly lower in comparison to gender-referred girls.
Group Differences on Maternal Functioning

A MANOVA on the 13 dependent variables from the Dyadic Adjustment Scale (DAS) and Symptom Checklist-90-Revised (SCL-90-R) did not reveal a significant multivariate effect using Wilks' criterion, approximate $F(26, 90) < 1$. The means and SDs are displayed in Table 7. Exploration of separate univariate ANOVAS (all df=2,57) indicated that five of the 13 variables were statistically significant at $p < .05$. The five variables, from the SCL-90-R, were somatization ($F = 3.71$), obsessive-compulsive ($F = 3.33$), hostility ($F = 3.20$), phobic anxiety ($F = 3.44$), and paranoid ideation ($F = 4.14$).

The following trends were noted using Newman-Keuls tests: somatization, obsessive-compulsive, and hostility differentiated the clinical mothers from non-clinical mothers; phobic anxiety differentiated sexual abuse mothers from non-clinical mothers; and paranoid ideation differentiated the two clinic groups from the non-clinical group. Given the insignificant multivariate effect, these results should be regarded cautiously.

The hypothesis of greater marital discord and maternal symptomatology among the mothers of the sexually abused girls in comparison with the mothers of non-clinical girls was not supported. Similarly, the hypothesis that the
Table 7

Means and SDs on Maternal Functioning

<table>
<thead>
<tr>
<th>Variables</th>
<th>Group</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sexually abused</td>
<td>Clinical controls</td>
<td>Non-clinical controls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyadic Adjustment Scale(^a):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyadic consensus</td>
<td>40.40</td>
<td>32.55</td>
<td>43.80</td>
<td>16.82</td>
<td>17.18</td>
</tr>
<tr>
<td>Dyadic satisfaction</td>
<td>26.40</td>
<td>22.30</td>
<td>28.85</td>
<td>11.57</td>
<td>12.77</td>
</tr>
<tr>
<td>Affective-expression</td>
<td>7.90</td>
<td>6.95</td>
<td>8.20</td>
<td>3.16</td>
<td>3.53</td>
</tr>
<tr>
<td>Dyadic cohesion</td>
<td>10.85</td>
<td>9.05</td>
<td>13.00</td>
<td>7.29</td>
<td>5.57</td>
</tr>
<tr>
<td>Symptom Checklist-90-R(^b):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatization</td>
<td>54.30(_{ac})</td>
<td>56.95(_{a})</td>
<td>47.10(_c)</td>
<td>11.36</td>
<td>13.77</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>54.45(_{ac})</td>
<td>58.65(_{a})</td>
<td>49.90(_c)</td>
<td>10.75</td>
<td>11.81</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>57.00</td>
<td>61.30</td>
<td>52.20</td>
<td>12.36</td>
<td>13.31</td>
</tr>
<tr>
<td>Depression</td>
<td>56.70</td>
<td>59.15</td>
<td>52.65</td>
<td>12.94</td>
<td>11.19</td>
</tr>
<tr>
<td>Anxious</td>
<td>51.80</td>
<td>56.95</td>
<td>48.75</td>
<td>13.00</td>
<td>12.94</td>
</tr>
<tr>
<td>Hostility</td>
<td>56.50(_{ac})</td>
<td>59.45(_{a})</td>
<td>51.60(_c)</td>
<td>10.25</td>
<td>10.65</td>
</tr>
<tr>
<td>Phobic anxiety</td>
<td>54.50(_a)</td>
<td>55.20(_{ac})</td>
<td>47.75(_c)</td>
<td>9.63</td>
<td>12.38</td>
</tr>
<tr>
<td>Paranoid ideation</td>
<td>59.15(_a)</td>
<td>61.15(_a)</td>
<td>51.30</td>
<td>11.61</td>
<td>13.35</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>53.50</td>
<td>58.55</td>
<td>53.65</td>
<td>12.30</td>
<td>11.41</td>
</tr>
</tbody>
</table>

(table continues)
Table 7 continues

**Note.** F-ratios are from univariate analyses. Means with the same subscripts are not significantly different.

*a*Higher scores reflect better functioning.  
*b*Higher scores reflect poorer functioning.

*p* < .05.
mothers of the sexually abused and clinical girls would report comparable levels of distress and marital discord was not supported.

**Discriminant Function Analysis**

**Development of Composite Variables**

Four composite variables were formed from 20 child and maternal measures that were statistically significant at the .05 alpha level in the univariate analyses. The variables comprising these composites are presented in Table 8. The composites were formed by standardizing the dependent variables by z-score transformations and computing a standardized mean for each of the composites.

A principal components analysis was performed on the 20 dependent variables to obtain empirical validity of their groupings. A varimax rotated factor matrix yielded six orthogonal factors, with eigenvalues greater than one. Variables with loadings greater than ±.30 (9% of the variance) were examined. Fifteen of the 20 variables (75%) were supported by the principal components analysis (see Appendix 0). The variables loading on the same factors are presented in Table 8.
Table 8

Composition of Composite Variables

(1) Cognitive/Academic functioning*: Kaufman's Verbal Comprehension factor, WRAT-R Reading\(^1\), Spelling\(^1\), Arithmetic \(^1\) standard scores, CBCL and TRF\(^1\) School T scores

(2) Behavioural disturbance: number of narrow-band elevations\(^2\), sum of items\(^2\), Externalizing \(^2\), and Total \(^2\) score from the CBCL; sum of items, Internalizing T, Externalizing T, and Total T from the TRF

(3) Social competence*: CBCL social \(^3\)

(4) Maternal functioning: SCL-90-R T scores on somatization\(^4\), obsessive-compulsive\(^4\), hostility\(^4\), phobic anxiety\(^4\), paranoid ideation\(^4\)

Note. Variables with the same superscripts load on the same factor.

*Higher scores reflect better functioning.
Discriminant Function Analysis

A stepwise discriminant function analysis was conducted on the composites and the sexualized behaviour score (standardized by z-score transformation) as predictor variables. Given that the number of subjects to number of variables ratio was not optimal (ideally 20:1) the findings should be interpreted with caution. All 60 cases were utilized in the analysis.

The overall percentage of cases classified correctly was 70%. The correct classification rates for the sexually abused, clinical, and non-clinical groups were 75%, 60%, and 75%, respectively. Fifteen percent and 10%, respectively, of the sexually abused group were misclassified in the clinical and non-clinical groups; 15% and 25%, respectively, of the clinical group were misclassified in the sexual abuse and non-clinical groups; and 10% and 15%, respectively, of the non-clinical group were misclassified in the sexual abuse and clinical groups.

Two discriminant functions were calculated, with a combined $X'(6) = 40.99, p < .0001$. After the first function was removed, statistically significant power remained, $X'(2) = 13.79, p < .001$. The two functions accounted for 70% and 30%, respectively, of the between-group variance.
The stepwise procedure selected three variables as optimally discriminating among the groups in the following order: behavioural disturbance ($F = 11.31, p < .0001$), cognitive/academic functioning ($F = 10.69, p < .0001$), and social competence ($F = 9.71, p < .001$). A loading matrix of correlations between predictor variables and functions, as seen in Table 9, suggested that behavioural disturbance and cognitive/academic functioning were the primary contributors to the separation among the three groups on the first function. The relative contribution of each variable to group differentiation was examined further by the standardized discriminant coefficients. The weights (shown in Table 9) revealed that cognitive/academic functioning was more heavily weighted than behavioural disturbance. The group centroids indicated that this behavioural/cognitive/academic dimension maximally separated the sexually abused group from the non-clinical group, with the clinical group falling closer to the sexually abused group.

These findings support the hypotheses that sexually abused girls would be more behaviourally disturbed and perform more poorly academically than non-clinical girls, while resembling the clinical girls on behavioural problems and academic functioning.
The second discriminant function appeared to be primarily defined by social competence (see Table 9) and, to a lesser extent, by behavioural disturbance. The standardized coefficients corroborated this. Group centroids indicated that this social competence dimension maximally separated the sexually abused group from the clinical group, with the non-clinical group falling closer to the sexually abused group. This finding confirms the hypothesis that the sexually abused girls would demonstrate fewer social skills than the non-clinical girls, but is contrary to the expectation that the sexually abused girls would be similar to the clinical girls.

In summary, the discriminant function analysis produced two functions that optimally separated the three groups. The first function was defined by behavioural/academic functioning that clearly distinguished the sexually abused girls from the non-clinical girls, with the former displaying more problems on this dimension. The clinical girls appeared to be as behaviourally disturbed as the sexually abused group, but evidenced fewer problems academically. The second dimension, defined by the social competence variable, distinguished the clinical and non-clinical girls from the sexually abused girls, who demonstrated fewer social skills.
Table 9

Results of Discriminant Function Analysis of Composite Measures

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Correlations of predictor variables with discriminant functions</th>
<th>Standardized coefficients</th>
<th>Group Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Behavioural disturbance</td>
<td>-.75</td>
<td>.38</td>
<td>-.41</td>
</tr>
<tr>
<td>Cognitive/academic</td>
<td>.76</td>
<td>-.22</td>
<td>.62</td>
</tr>
<tr>
<td>Social competence</td>
<td>.55</td>
<td>.74</td>
<td>.39</td>
</tr>
<tr>
<td>Maternal functioning</td>
<td>-.18</td>
<td>.28</td>
<td>.11</td>
</tr>
<tr>
<td>Sexualized behaviour</td>
<td>-.10</td>
<td>.01</td>
<td>.14</td>
</tr>
<tr>
<td>Canonical R</td>
<td>.62</td>
<td>.46</td>
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<tr>
<td>Eigenvalue</td>
<td>.627</td>
<td>.273</td>
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</tr>
</tbody>
</table>

Note. SA = Sexually Abused; CC = Clinical Control; NC = Non-Clinical Control.
Relation Between Child and Maternal Variables

As a final examination of the data, Pearson correlations were conducted between the four composites and sexualized behaviour. Table 10 presents the correlations. Six of the ten correlations (df=58) were significant. Greater behavioural disturbance was associated with lower social competence, poorer cognitive/academic functioning, and more frequent sexualized behaviour. More sexualized behaviour was associated with lower social competence. Greater maternal psychopathology was correlated with more behavioural disturbance and sexualized behaviour.

Demographic characteristics were also correlated with the child and maternal variables. The correlations are presented in Table 11. Four of the 20 correlations were significant at the .05 level (df=58). Higher socioeconomic status and a greater number of siblings were associated with poorer cognitive and academic functioning and less sexualize* behaviour. Among the demographic variables, higher socioeconomic status was associated with fewer siblings, while age and number of siblings were positively correlated.
Table 10

Correlations between Child and Maternal Variables

<table>
<thead>
<tr>
<th></th>
<th>Behavioural disturbance</th>
<th>Cognitive/ academic</th>
<th>Social competence</th>
<th>Maternal functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive/ academic</td>
<td>- .52**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social competence</td>
<td>- .38**</td>
<td>.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal functioning</td>
<td>.49**</td>
<td>-.21</td>
<td>-.04</td>
<td></td>
</tr>
<tr>
<td>Sexualized behaviour</td>
<td>.43**</td>
<td>.13</td>
<td>-.23*</td>
<td>.34*</td>
</tr>
</tbody>
</table>

*P < .05. **P < .01.
### Table 11

**Correlations between Demographic Characteristics, Child, and Maternal Variables**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Demographic Characteristics</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of siblings</td>
<td>Socioeconomic status</td>
<td>Marital status</td>
<td></td>
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<td></td>
<td>Age</td>
<td>siblings</td>
<td>status</td>
<td>status</td>
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<tr>
<td>Behavioural</td>
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<tr>
<td>disturbance</td>
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<td>-.09</td>
<td>-.04</td>
</tr>
<tr>
<td>Cognitive/Academic</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>functioning</td>
<td>-.12</td>
<td>-.33**</td>
<td>-.36**</td>
<td>.10</td>
</tr>
<tr>
<td>Social competence</td>
<td>.02</td>
<td>.23</td>
<td>-.21</td>
<td>.07</td>
</tr>
<tr>
<td>Sexualized behaviour</td>
<td>-.17</td>
<td>-.32**</td>
<td>-.36**</td>
<td>-.01</td>
</tr>
<tr>
<td>Maternal functioning</td>
<td>-.02</td>
<td>-.11</td>
<td>.03</td>
<td>-.06</td>
</tr>
<tr>
<td>Age</td>
<td>---</td>
<td>.28*</td>
<td>-.08</td>
<td>.09</td>
</tr>
<tr>
<td>Number of siblings</td>
<td>---</td>
<td>-.27*</td>
<td>.18</td>
<td></td>
</tr>
<tr>
<td>Socioeconomic status</td>
<td>---</td>
<td>.17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05. **p < .01.*
Characteristics of the Sexually Abused Group

The sexually abused girls experienced, on average, 3.15 abusive acts (range, 1-63). Russell's (1983) criteria for classifying the degree of seriousness of the sexual abuse acts were used. Twenty-seven percent of the acts were "least serious", i.e., inappropriate kissing, sexual touching when clothed, and/or sexual touching (nongenital) under clothes (M = 2.67, range, 2-8 acts); 49% were "serious", i.e., genital fondling, digital penetration of vagina or anus, and/or sexual touching of perpetrator (M = 5.43, range, 2-38 acts); 24% were "very serious", i.e., vaginal or attempted intercourse, oral intercourse, and/or fellatio (M = 5.67, range, 5-17 acts).

The most common means of manipulation was exploitation of adult authority, which was used with 45% of the girls. Forty percent of the girls received threats, while 15% were subjected to physical force. Enticement or bribes were used with 5%. (Percentages add to more than 100 because more than one form of manipulation was used with 5 girls). Data were unavailable for 5 girls.

All of the perpetrators were male and known to the child prior to the abuse; 95% were family members or individuals living in the home (40% were fathers or stepfathers, 25% were mothers' common-law partners, 20% were
grandfathers, 5% were uncles); only one case involved an
acquaintance. Each child was abused by one perpetrator.

The average age for the onset of abuse was 7.24 years
($SD = 2.16$, range, 4-12 years). In 35% of the cases, the
abuse occurred once; in another 35% of the cases the abuse
lasted between three to six months; in the remaining cases
the abuse lasted between one and two years. The average
length of abuse was 6.45 months ($SD = 7.59$, range, < 1-24
months).

Twenty-two percent of the girls were abused once, 61%
were abused between 2 and 10 times, and 17% were abused 30
or more times. For two cases frequency data were
unavailable.

The average time elapsed since the last known
occurrence of abuse and participation in the study was 12.55
months ($SD = 10.18$, range, < 1-38 months).

Relation between Demographic Variables, Abuse Variables, and
Child and Maternal Functioning

Table 12 presents the Pearson correlations between
demographic variables, abuse-related variables, sexualized
behaviour, and the composite measures of child and maternal
functioning. Twelve of the eighty correlations were
significant at or below the .05 level (df=18). Among the
demographic variables, younger sexually abused girls
Table 12

Correlations between Demographic Variables, Abuse Variables, and Child and Maternal Measures for Sexually Abused Girls

<table>
<thead>
<tr>
<th>Variables</th>
<th>Social competence</th>
<th>Behavioural problems</th>
<th>Sexualized behaviour</th>
<th>Academic functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.21</td>
<td>-.41*</td>
<td>-.57**</td>
<td>-.29</td>
</tr>
<tr>
<td>No. of siblings</td>
<td>.20</td>
<td>-.20</td>
<td>-.45*</td>
<td>-.40*</td>
</tr>
<tr>
<td>Socioeconomic status</td>
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<td>-.02</td>
<td>.63**</td>
<td>.40*</td>
</tr>
<tr>
<td>Marital status</td>
<td>-.03</td>
<td>.29</td>
<td>-.03</td>
<td>-.16</td>
</tr>
<tr>
<td>Age at onset</td>
<td>.17</td>
<td>-.29</td>
<td>-.53**</td>
<td>-.26</td>
</tr>
<tr>
<td>Perpetrator</td>
<td>-.33</td>
<td>.37</td>
<td>.01</td>
<td>-.21</td>
</tr>
<tr>
<td>Abuse severity:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least serious</td>
<td>.21</td>
<td>-.50*</td>
<td>-.15</td>
<td>-.10</td>
</tr>
<tr>
<td>Serious</td>
<td>-.03</td>
<td>-.17</td>
<td>.43*</td>
<td>.08</td>
</tr>
<tr>
<td>Very serious</td>
<td>.03</td>
<td>-.45*</td>
<td>-.09</td>
<td>.11</td>
</tr>
<tr>
<td>Duration</td>
<td>.24</td>
<td>-.40*</td>
<td>-.14</td>
<td>-.16</td>
</tr>
<tr>
<td>Frequency</td>
<td>.19</td>
<td>-.59**</td>
<td>-.20</td>
<td>.05</td>
</tr>
<tr>
<td>Physical force</td>
<td>.17</td>
<td>-.18</td>
<td>.26</td>
<td>-.12</td>
</tr>
<tr>
<td>Adult authority</td>
<td>-.03</td>
<td>-.27</td>
<td>.00</td>
<td>-.07</td>
</tr>
<tr>
<td>Enticement/bribes</td>
<td>-.08</td>
<td>-.06</td>
<td>-.18</td>
<td>-.11</td>
</tr>
<tr>
<td>Threats</td>
<td>-.15</td>
<td>.34</td>
<td>.31</td>
<td>-.22</td>
</tr>
<tr>
<td>Elapsed time</td>
<td>-.05</td>
<td>-.03</td>
<td>-.08</td>
<td>-.04</td>
</tr>
</tbody>
</table>

*P < .05. **P < .01.
Table 12 continues

<table>
<thead>
<tr>
<th>Variables</th>
<th>Maternal functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.14</td>
</tr>
<tr>
<td>No. of siblings</td>
<td>.06</td>
</tr>
<tr>
<td>Socioeconomic status</td>
<td>.11</td>
</tr>
<tr>
<td>Marital status</td>
<td>.30</td>
</tr>
<tr>
<td>Age at onset</td>
<td>-.18</td>
</tr>
<tr>
<td>Perpetrator</td>
<td>.00</td>
</tr>
<tr>
<td>Abuse severity:</td>
<td></td>
</tr>
<tr>
<td>Least serious</td>
<td>.08</td>
</tr>
<tr>
<td>Serious</td>
<td>.30</td>
</tr>
<tr>
<td>Very serious</td>
<td>-.18</td>
</tr>
<tr>
<td>Duration</td>
<td>.28</td>
</tr>
<tr>
<td>Frequency</td>
<td>-.35</td>
</tr>
<tr>
<td>Physical force</td>
<td>.18</td>
</tr>
<tr>
<td>Adult authority</td>
<td>-.08</td>
</tr>
<tr>
<td>Enticement/bribes</td>
<td>-.08</td>
</tr>
<tr>
<td>Threats</td>
<td>.15</td>
</tr>
<tr>
<td>Elapsed time</td>
<td>-.12</td>
</tr>
</tbody>
</table>
appeared to have more behavioural problems and sexualized behaviour. Higher socioeconomic (SES) and fewer siblings were associated with more frequent sexualized behaviour but better academic functioning. Age was correlated with a greater number of siblings \( r = .66, p < .01 \), and a lower SES \( r = -.48, p < .05 \). Higher SES was correlated with fewer siblings \( r = -.40, p < .05 \).

Among the abuse-related variables, fewer acts of "very serious" and "least serious" abuse were associated with more behavioural disturbance, while a greater number of "serious" acts was associated with more frequent sexualized behaviour. Shorter duration and less frequent abuse were associated with more behavioural problems, while an earlier age of onset was associated with more sexualized behaviour. Although the correlation between perpetrator's relationship to the child and child functioning did not reach statistical significance, the correlation was in the direction of increased behavioural problems when the perpetrator was a father figure. There were insignificant correlations between the various methods of manipulation (i.e., physical force, bribes, etc.) and child functioning. Also, time elapsed since last abusive incident was not significantly correlated with the child variables. Maternal functioning was not associated with any demographic or abuse variable.
Relation among Abuse Variables

Pearson correlations (df=18) indicated that as the number of "very serious" types of abuse increased so did the frequency (r = .58, p < .05); a greater number of "serious" acts was associated with longer duration (r = .55, p < .05) and greater frequency (r = .40, p < .05); while more "least serious" acts were associated with a later age of onset (r = .40, p < .05) and non-father figure perpetrators (r = -.53, p < .05). Longer duration and greater frequency were positively correlated (r = .54, p < .05). The use of force was associated with longer duration (r = .46, p < .05), while adult authority was positively correlated with duration (r = .40, p < .05) and frequency (r = .43, p < .05). The perpetrator's use of enticement or bribes was correlated with a later age of onset (r = .51, p < .01).
CHAPTER 4

DISCUSSION

The present study examined various domains of adaptive functioning in sexually abused girls between the ages of 5 and 12. Comparisons were made with groups of nonabused clinical and non-clinical girls, who were group-matched with the sexually abused girls on age, and parent's socioeconomic status and marital status. Child functioning was assessed by standardized measures and multiple informants (mother, teacher, and child) were utilized. Marital discord and maternal symptomatology were also evaluated.

As hypothesized, the current study corroborated previous research, which has shown that sexually abused girls display more behavioural problems, perform more poorly in school, and have lower social competence than nonabused non-clinical girls (Einbender & Friedrich, 1989). Consistent with earlier research, the sexually abused girls, however, appeared indistinguishable from the nonabused clinical girls with regard to behavioural disturbance and, to a lesser extent, academic achievement (Deblinger et al.,
1989; Friedrich et al., 1987). In the area of social competence, the sexually abused girls seemed more isolated, with fewer friends and hobbies than the clinical girls. As a group, degree of sexualized behaviour did not differentiate the sexually abused girls from the clinical and non-clinical girls; however, when age was examined, younger sexually abused girls displayed more frequent sexualized behaviour than younger clinical and non-clinical girls and older sexually abused girls. The expectation of greater gender identity disturbance and higher activity level among the sexually abused girls was not supported. Neither was there overall evidence for greater marital conflict and maternal psychopathology among mothers of sexually abused girls.

While previous studies have suggested comparable behavioural difficulties between sexually abused children and clinical controls (e.g., Deblinger et al., 1989; Friedrich et al., 1987; Comes-Schwartz et al., 1985), few have employed additional informants who would provide a measure of cross-validation of the findings. Consequently, the inclusion of teacher reports in the present study strengthens its conclusions. Mothers and teachers were generally consistent in their findings of more behavioural problems in both sexually abused and clinical girls. Both
informants reported more externalizing behaviours, more total behaviour problems, and endorsed a greater number of behavioural statements for the two groups of clinical girls in comparison to the non-clinical girls. Mothers of the sexually abused and clinical girls also reported more clinically-elevated narrow-band scales, while teachers reported more internalizing behaviours for these children. A degree of confidence can be placed in the objectivity of the teacher report since the teachers were neither apprised of the nature of the study nor of the composition of the groups. The study, however, did not investigate whether teachers of the sexually abused and clinical girls were aware of the girls' involvement with the child protection agency or the reason for the referral.

Maternal report of internalizing behaviour and the impulsivity dimension did not add to the distinctiveness among the three groups, although the trend was consistent with the expectation of greater internalizing behaviour and a lower level of impulse control for the sexually abused girls than for the non-clinical girls.

Poorer academic functioning appears to be a second area shared by sexually abused and clinical girls. Academic deficits characterized both groups of girls, who performed more poorly than the non-clinical girls on Reading,
Spelling, Arithmetic, and school-related problems. Cross-validation of poorer school performance was provided by teacher reports. Mothers, however, were more apt to perceive lower levels of academic performance than were teachers. Lower intellectual functioning per se (as measured by the WISC-R and WPPSI) did not appear to be a significant correlate of sexual abuse. Subtests of verbal ability, however, differentiated the sexually abused and clinical girls from the non-clinical girls. While this finding has not been previously documented in the child sexual abuse literature, similar results have been found in physically abused and in neglected children (Ammerman, Cassisi, Hersen, & van Hasselt, 1986).

The present study's finding of academic similarity between sexually abused and clinical girls expands previous research, which has been vague with regard to outcome since few comparisons to clinical controls have been made. Although differences have been suggested between sexually abused children and non-clinical children (Einbender & Friedrich, 1989; Tong et al., 1987), it has been more difficult to determine whether the abuse per se accounts for school-related problems. This study, however, did not ascertain the existence of academic problems prior to the onset of sexual abuse, which an examination of school
records would perhaps elucidate.

An unexpected finding was the unique social difficulties experienced by the sexually abused girls. Maternal report indicated that one-fifth of the sexually abused girls had fewer friends and interacted less well with family and peers in comparison to the non-clinical and clinical girls. This finding is consistent with research utilizing nonabused, non-clinical children (e.g., Einbender & Friedrich, 1989), but contradicts that employing clinical controls, who were found to be less socially competent than the sexually abused children (Friedrich et al., 1987). The discrepancy with the latter study may be explained by the inclusion by Friedrich et al. (1987) of both boys and girls in their sample, which may have obscured sex differences. Previous research has shown that male and female children differ in their experience of sexual abuse with regard to the severity and the perpetrator (e.g., Dubé & Hébert, 1988). Hence, it is possible that the short-term effects are different for sexually abused boys and girls. In addition, it is unclear whether Friedrich et al. (1987) controlled for the length of time elapsed between the date of the case opening and the date of the assessment for the psychiatric controls. The criteria for inclusion for the sexually abused required that at least one incident of
sexual abuse had occurred within 18 months of participation in the study. Such information was not presented for the psychiatric controls, and it is possible that they may have been assessed nearer to their date of referral than the sexually abused group.

Given that the majority of the abusive incidents in the present sexual abuse sample were incestuous in nature, the difficulty in interpersonal functioning may be related to the relationship with the perpetrator. The literature on incest victims speculates that parental social attachments, particularly that with the perpetrator, are dysfunctional (Gelinas, 1983). Support for this hypothesis comes from Einbender and Friedrich (1989), who found that a positive family environment characterized by good family relations was associated with better social functioning in sexually abused girls. Finkelhor and Browne (1985) theorized that the unique exploitative relationship between perpetrator and child breaches this sense of trust and oversteps role boundaries, and is experienced by the child as a lack of control, betrayal, and powerlessness. The child's social development may be disrupted, with the attendant loss of mastery of various developmental tasks, such as understanding social rules and roles. Inadequate social competencies might result in lowered self-esteem, social
withdrawal, or aggressive behaviour, and place additional stress on the sexually abused child's coping skills.

There are also implications for future adult friendships and interactions. Studies of adult female victims report difficulties in forming and sustaining relationships with males and females, and engaging in sexual intimacy (e.g., Harter, Alexander, & Neimeyer, 1988; Tsai et al., 1979). Future efforts to understand better the development of social competence in sexually abused children should include an investigation of the quality of parent-child interaction and the emotional support provided by parents. Alternatively or concurrently, the sexually abused child's interpersonal difficulties may be a reflection of her family's social isolation. While the literature has suggested the presence of such isolation (e.g., Vander Mey & Neff, 1982), empirical research has not yet documented it.

Contrary to prior research (e.g., Deblinger et al., 1989; Einbender & Friedrich, 1989; Friedrich et al., 1987; Goldston et al., 1989; Kolko et al., 1988), sexualized behaviour problems did not significantly differentiate the sexually abused girls from the two groups of control girls. The discrepancy in the present findings, however, can be explained by the finding of increased sexualized behaviour among younger (5-7 years) sexually abused girls in contrast
to younger clinical and non-clinical girls and older sexually abused girls. This outcome would have been cancelled out, due to the small sample size of the younger sexually abused group, when the scores for the two sexually abused age groups were combined. Previous studies of child victims have neither anlayzed the effects of age on sexualized behaviour nor reported on the number of children in this 5-7 age range in their samples, who may have accounted for much of the higher incidence of sexualized behaviour.

Biases in data collection (e.g., chart notes) or differences in the instruments used to measure sexualized behaviours may also account for the discrepancy between studies. Prior research attempting to determine the presence of sexualized behaviours has relied on chart reviews (e.g., Goldston et al., 1989; Kolko et al., 1988) and symptom checklists with unknown psychometric properties (Deblinger et al., 1989). As such, the accuracy and validity of these findings may be questionable.

The current finding of increased sexualized behaviour in younger sexually abused girls, which should be considered preliminary because of the small sample sizes, is consistent with the Friedrich et al. (1990) normative study of sexualized behaviours, utilizing the Child Sexual Behavior
Inventory. These authors found that as age increased, sexualized behaviour problems in non-clinical and sexually abused samples decreased. Friedrich et al. (1990) posited that the reason for this difference between older and younger sexually abused girls may be that the older girls may be more inhibited in their overt sexual behaviours. Gomes-Schwartz et al. (1985) have argued also that older children may possess the cognitive ability to process the sexually abusive experience and are thus less likely to demonstrate sexualized behaviours. There are several additional explanations for the decrease in sexualized behaviour. It is possible that older children are more aware of societal and cultural norms and hence, display such behaviour less readily in observable situations. In addition, the preschool years are commonly ones of exploration, where there are reportedly frequent self-stimulatory and exhibitionistic behaviours (e.g., Rutter, 1971), and it may be that these behaviours are heightened by the sexual abuse.

An alternative hypothesis concerns socioeconomic status (SES). From the correlational analysis, the mothers of the younger sexually abused girls were of a higher socioeconomic status. One of the correlates of such status may be being more well-informed, particularly given the media's attention
to the problem of child sexual abuse. Therefore, these mothers might have been more knowledgeable of the possible effects of child sexual abuse and/or reacted more strongly to its disclosure. A related variable is the sexual behaviour in the family. Friedrich et al. (in press) have noted that family nudity is related to greater sexual behaviour in the child. The authors did not indicate, however, whether SES was related to family nudity. It is possible that higher SES families may have more liberal attitudes and tolerate more sexual curiosity and behaviour in their children. The consequences for higher-SES sexually abused girls may thus be different from those for lower-SES sexually abused girls.

While there has been preliminary evidence suggesting potential gender identity problems for some sexually abused children (e.g., Kaufman et al., 1954; Livingston, 1987), the present study did not find support for this hypothesis. Comparisons with data of female siblings of gender-referred children (Zucker, in press) indicated that the three groups in the current study were very similar to the sibling controls. It is possible that the development of gender identity disturbance may occur as the children form sexual relationships.
Research on other forms of child abuse has suggested that endogenous characteristics of the child may influence the precipitation of the abuse as well as the environment in which the abuse occurs (Toro, 1982). The exploration of activity level, however, did not differentiate the three groups in the present study. Additional characteristics of the child, such as physical attractiveness and attributional style, may help clarify the predisposing variables that contribute to the child’s vulnerability to sexual abuse.

Several researchers have suggested that sexually abused children come from homes with a higher incidence of family psychopathology (Adams-Tucker, 1981; Einbender & Friedrich, 1989; Friedrich et al., 1987; Gruber & Jones, 1983; Krener, 1985). In the present study, the multivariate analysis indicated equal marital satisfaction and current symptomatology among the mothers of the three groups. Subsequent individual analyses, however, noted certain trends, which should be viewed cautiously. The mothers of sexually abused girls tended to experience more phobic anxiety than the control mothers, while the clinical mothers appeared to have more somatic complaints, be more obsessive-compulsive, and more hostile than the sexual abuse and non-clinical mothers; both groups of clinical mothers reported more paranoid ideation than the non-clinical mothers.
Measurement issues may account for the lack of differences among the three groups on maternal functioning. The most problematic issue concerned the choice of partner for single mothers on the Dyadic Adjustment Scale. In several cases, these mothers lacked a current partner and therefore completed the questionnaire with regard to a relationship that may have occurred some time ago. Consequently, there were difficulties in controlling for the length of time elapsed since the last meaningful relationship, which may have varied from months to years. Thus, the information provided may have been inaccurate.

It has been noted that familial variables may account for a significant proportion of the psychological symptomatology observed in sexually abused children (e.g., Conte & Schuerman, 1987; Einbender & Friedrich, 1989; Friedrich et al., 1987). In light of the absence of maternal differences on marital discord and current psychological distress, while controlling for the confounding effects of family disruption caused by changes in parents' marital status and agency involvement, the differences observed in social competence between the sexually abused girls and the clinical girls appear more convincing. While not denying the impact of family functioning on the child's social and behavioural
development, the current findings suggest that sexual abuse in itself accounts for some of the psychopathological behaviours.

Nevertheless, the importance of assessing familial variables was indicated by the correlational analysis between child and maternal variables for the three groups. Greater maternal psychopathology was associated with increased behavioural disturbance and sexualized behaviour in the children. While causality cannot be ascertained by correlational analyses, it is likely that interactive processes within the family occur, where both mother and child are affected by the other's functioning.

Before discussing the relations between the abuse variables and outcome within the sexually abused group, the exploratory nature of this analysis should be emphasized, given the small sample size. In general, the relationships were negligible or contrary to expectation, and those that were found require further corroboration from a larger sample. Nevertheless, the correlational analysis supported the earlier current finding of the importance of the child's age on the type of sexual abuse experienced and the psychopathology displayed. As age increased, behavioural disturbance and sexualized behaviour decreased, which is consistent with research with adult victims (e.g., Courtois,
1979; Russell, 1986) and with children (Wolfe et al., 1989; Zivney et al., 1988) that indicates that younger sexually abused children appear to demonstrate more psychopathology than older sexually abused children. Some researchers have posited that the younger child may lack the appropriate cognitive skills with which to comprehend their abusive experience, and thus may be more traumatized (Gomes-Schwartz et al., 1985). Rather than construing this finding as an absence of symptoms in older sexually abused children, it is more likely that as they mature they exhibit a different pattern of symptoms that is associated with particular developmental concerns. For example, the preschool child may show higher incidents of nightmares and enuresis (White et al., 1988), while adolescents may show more "acting out" behaviours, such as self-mutilation, suicide attempts, and running away (Brooks, 1985; Goldston et al., 1989; Gomes-Schwartz et al., 1985). For the school-age child, social acceptance and academic achievement may be the specific areas that may be affected by the abusive experience.

The correlational analysis also suggested that the older the child when the abuse begins, the more likely she is bribed or given some form of enticement to comply. She is also likely to be subjected to more unintrusive acts, such as being kissed and touched on her breasts.
Perpetrators of these types of acts are more likely to be non-father figures. These acts are also associated with fewer behavioural problems. In comparison, the younger the child at age of onset, the more likely is the presence of sexualized behaviour. Greater sexualized behaviour is also associated with more genital fondling, which tends to last longer and is more frequent.

Shorter duration and infrequent abuse were associated with greater behavioural disturbance, while more invasive acts, such as vaginal intercourse, were associated with fewer behavioural problems. These findings contradict those of prior studies of child victims (e.g., Conte & Schuerman, 1987; Einbender & Friedrich, 1989; Friedrich et al., 1986; Johnston, 1979), but are consistent with those reported in adult research (e.g., Courtois, 1979; Finkelhor, 1979). The current findings may reflect the influence of age on outcome. Because of their age, younger girls are subject to abuse that is shorter and infrequent, and hence, as previously noted, the greater behavioural disturbance. Similarly, the association between less behavioural disturbance and more invasive acts may be explained by the correlations between abuse severity, duration, and frequency. Invasive acts tended to be more frequent and of longer duration. Therefore, as the child matures she may
acquire the coping skills to deal with the abusive situation and, consequently, may display less overt behavioural symptomatology.

The analyses also indicated, while not statistically significant, that abuse by father figures was associated with more behavioural problems and lower social competence, which is consistent with earlier research (Adams-Tucker, 1982; McLeer et al., 1988). Father figures were also more likely to use their adult authority to gain the child's compliance. The time interval between the last known occurrence of abuse and participation in the study did not have an effect on outcome.

The present findings on the abuse variables indicate the complexity of the abusive situation and its potential impact on the child. Given the possible interrelationships between various components of the abusive experience, a better assessment of these abuse variables is needed which incorporates a combination of the variables, perhaps in a weighted form. Such an approach would avoid treating the variables as isolated factors. In addition, clearer and more consistent operational definitions, particularly of the severity of the abuse, are also required. A more qualitative assessment of the abusive experience, such as the emotional relationship between the child and perpetrator
as Einbender and Friedrich (1989) suggest, may clarify this issue and provide convergent findings.

Although the sexually abused and clinical girls were indistinguishable when behavioural and academic functioning were examined separately, the discriminant analysis showed that the pattern of psychopathology involving lower social competence, poorer academic achievement, and greater behavioural dysfunction displayed by the sexually abused girls reasonably differentiated them from the clinical girls. The analysis indicated that an increase in learning difficulties may be associated with a concurrent increase in behavioural dysfunction. It is possible that academic difficulties may heighten behavioural problems, which may consequently lead to further frustration in the classroom and maladaptive behaviours. Further, the correlational analysis suggested that an increased difficulty in interpersonal relationships and more frequent sexualized behaviours were also associated with an increase in behavioural problems. The utility of assessing the relationships between various areas of functioning seems apparent, and would effect a clearer understanding of the sexual abuse sequelae.

While this pattern of symptomatology observed in the sexually abused girls appears indicative of a constellation
of pervasive effects, there was also evidence of a range of functioning from a relative absence of problems to more pathological and extreme symptoms. On internalizing and/or externalizing behaviours 50% of the sexually abused group were reported by mothers to be in the clinical range (T > 63), using Achenbach's cutoff scores for the CBCL. In comparison, 45% of the clinical girls and 10% of the non-clinical girls were rated as being deviant. The percentage of teacher judgements of deviant behaviour in sexually abused girls approximated the mothers' ratings.

Severe behavioural disturbance may thus be only one of the diverse outcomes for the sexually abused child. Longitudinal research would clarify the severity and the course of the symptomatology in the percentage of the sexually abused population who has been severely traumatized by the abusive experience. Additional efforts at distinguishing profile patterns, for example, grouping sexually abused children according to correlates of internalizing and externalizing behaviour with poorer social competencies, might further enhance our understanding of the outcome effects.

Certain limitations of the study need to be addressed. As opposed to sampling sexually abused subjects from only therapist referrals or hospitalized patients, where children
with more behavioural sequelae may be the norm, a child protective agency hypothetically sees abused girls who range in their level of functioning. The current study's reliance, however, on social worker referrals to obtain samples of sexually abused and clinical girls may have resulted in more highly functioning families, who were more co-operative and not as stressed psychosocially. The group of sexually abused girls, though small and hence limited in its generalizability, may be representative, however, of the potential population of protective agency cases that is available to the researcher.

Although already controlling for demographic variables and source referral, the potentially biased selection, on the part of the social workers, may also have given rise to more similar, than dissimilar, sexual abuse and clinical groups. Consequently, the differences in social competence can be more confidently related to the effect of sexual abuse.

The utility of multiple informants in assessing psychopathology was evident in the present study. The inclusion of teachers as another source of information provides a measure of cross-validation, particularly since some researchers have shown that maternal states affect mothers' reporting of child behaviour (Moretti, Fine, Haley,
& Marriage, 1985). Additional informants may include nonabused siblings and peers. The latter, in particular, may provide more reliable ratings than mothers in certain areas of functioning, such as social competence and sexualized behaviour, especially of the school-age child for whom peer interactions become increasingly more important and where sexualized behaviours may become less observable by parents.

In conclusion, as far as this author can document the present study is the first comprehensive one to incorporate several methodological features absent in prior research. The current study assessed sexually abused girls in the 5-12 year-old age range, examined multiple domains of child functioning with standardized measures, utilized multiple informants, and included both clinical and non-clinical nonabused comparison groups. The three prior studies that have employed similar comparison groups have either included males and females in their sample (Friedrich et al., 1987), which consequently makes the short-term outcome for sexually abused girls unclear, have used non-standardized measures developed by the authors (White et al., 1988), the psychometric properties of which are not reported, or have observed sexually abused children in a different age range (Pagot et al., 1989).
An important task for future researchers on child sexual abuse is to elucidate the developmental course of the psychopathology. Are there age-specific behaviours, in particular sexualized behaviour, or as Friedrich and Reams (1987) have noted, do symptoms subside and reappear over time, or perhaps are replaced by more age-appropriate symptomatology? Future studies can restrict age to correspond with a particular developmental stage, for example, 6 and under, or 7 to 12 years, and employ cross-sectional or longitudinal designs.

In addition, moderator variables that may contribute to the sustaining of behaviours also need to be examined more closely. Post-disclosure variables, such as support received from the non-offending parent upon disclosure, and subsequent interventions by social, legal, or medical agencies, may adversely affect the child and attenuate existing difficulties.
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APPENDIX A

SEXUAL ABUSE QUESTIONNAIRE
Name: ___________________________  Informant: ___________________

1. Nature of sexual contacts:
   a. ______ vaginal intercourse
   b. ______ attempted intercourse
   c. ______ anal intercourse
   d. ______ oral-genital
   e. ______ use of foreign objects (vaginal)
   f. ______ manual penetration (vaginal)
   g. ______ use of foreign objects (anal)
   h. ______ manual penetration (anal)
   i. ______ touching of genitalia
   j. ______ touching of breasts
   k. ______ kissing
   l. ______ child touches offender's sexual body parts
   m. ______ child touched over clothing
   n. ______ other ___________________________
   o. ______ not known

2. Offender's relationship to child ___________________

3. If more than one offender, offender by type of abuse ______

4. Duration of sexual contacts:

   ______ once only
   ______ 3 months - 6 months
   ______ 6 months - 9 months
   ______ 9 months - 12 months
   ______ 1 year
   ______ 2 years
   ______ 3 years
   ______ longer than 3 years

5. Frequency (#) of sexual contacts:

   ______ once
   ______ 2 - 5 times
   ______ 5 - 10 times
   ______ 10 - 15 times
   ______ 15 - 20 times
   ______ 20 - 30 times
   ______ 30 and more times
6. Age of child when sexual contacts began ________

7. Date of last known sexual contact ________________

8. How did child comply:

    ______ physical force
    ______ threat of punishment/physical force
    ______ threat of consequence to family
        (e.g., parent will be jailed)
    ______ adult authority
    ______ enticement, bribes
    ______ not known

9. To whom did child disclose abuse __________________

10. Is there physical/medical evidence of abuse:
    ______ yes ______ no ______ not known

11. Has offender been charged by police:
    ______ yes ______ no ______ not known
APPENDIX B

CHILD BEHAVIOR CHECKLIST
# Child Behavior Checklist for Ages 4-16

**Child's Name**

**Sex**
- [ ] Boy
- [ ] Girl

**Age**

**Ethnic Group or Race**

**Today's Date**

**Child's Birthday**

**Grade in School**

**Not Attending School**

Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the space provided on page 2.

## I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skateboarding, bike riding, fishing, etc.

<table>
<thead>
<tr>
<th>Compared to other children of the same age, about how much time does he/she spend in each?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
</tbody>
</table>

## II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include listening to radio or TV.)

<table>
<thead>
<tr>
<th>Compared to other children of the same age, about how much time does he/she spend in each?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
</tbody>
</table>

## III. Please list any organizations, clubs, teams, or groups your child belongs to.

<table>
<thead>
<tr>
<th>Compared to other children of the same age, how active is he/she in each?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
</tbody>
</table>

## IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc. (Include both paid and unpaid jobs and chores.)

<table>
<thead>
<tr>
<th>Compared to other children of the same age, how well does he/she carry them out?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>□</td>
</tr>
</tbody>
</table>
V. 1. About how many close friends does your child have?  □ None  □ 1  □ 2 or 3  □ 4 or more
(Do not include brothers & sisters)

2. About how many times a week does your child do things with friends outside of regular school hours?
(Do not include brothers & sisters)  □ Less than 1  □ 1 or 2  □ 3 or more

VI. Compared to other children of his/her age, how well does your child:

| a. Get along with his/her brothers & sisters? | Worse | About Average | Better | □ Has no brothers or sisters |
| b. Get along with other children? | □ | □ | □ |
| c. Behave with his/her parents? | □ | □ | □ |
| d. Play and work by himself/herself? | □ | □ | □ |

VII. 1. For ages 6 and older—performance in academic subjects: (If child is not being taught, please give reason)

| a. Reading, English, or Language Arts | Falling | Below average | Average | Above average |
| b. History or Social Studies | □ | □ | □ | □ |
| c. Arithmetic or Math | □ | □ | □ | □ |
| d. Science | □ | □ | □ | □ |
| e. Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., etc. | □ | □ | □ | □ |

2. Is your child in a special class or special school?  □ No  □ Yes—what kind of class or school?

3. Has your child repeated a grade?  □ No  □ Yes—grade and reason

4. Has your child had any academic or other problems in school?  □ No  □ Yes—please describe

When did these problems start?

Have these problems ended?  □ No  □ Yes—when?

Does your child have any illness, physical disability, or mental handicap?  □ No  □ Yes—please describe

What concerns you most about your child?

Please describe the best things about your child:
Below is a list of items that describe children. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

<table>
<thead>
<tr>
<th>0 = Not True (as far as you know)</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 1. Acts too young for his/her age</td>
<td>0 1 2 31. Fears he/she might think or do something bad</td>
<td></td>
</tr>
<tr>
<td>0 1 2 2. Allergy (describe: )</td>
<td>0 1 2 32. Feels he/she has to be perfect</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3. Argues a lot</td>
<td>0 1 2 33. Feels or complains that no one loves him/her</td>
<td></td>
</tr>
<tr>
<td>0 1 2 4. Asthma</td>
<td>0 1 2 34. Feels others are out to get him/her</td>
<td></td>
</tr>
<tr>
<td>0 1 2 5. Behaves like opposite sex</td>
<td>0 1 2 35. Feels worthless or inferior</td>
<td></td>
</tr>
<tr>
<td>0 1 2 6. Bowel movements outside toilet</td>
<td>0 1 2 36. Gets hurt a lot, accident-prone</td>
<td></td>
</tr>
<tr>
<td>0 1 2 7. Bragging, boasting</td>
<td>0 1 2 37. Gets in many fights</td>
<td></td>
</tr>
<tr>
<td>0 1 2 8. Can't concentrate, can't pay attention for long</td>
<td>0 1 2 38. Gets teased a lot</td>
<td></td>
</tr>
<tr>
<td>0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe: )</td>
<td>0 1 2 39. Hangs around with children who get in trouble</td>
<td></td>
</tr>
<tr>
<td>0 1 2 10. Can't sit still, restless, or hyperactive</td>
<td>0 1 2 40. Hears sounds or voices that aren't there (describe: )</td>
<td></td>
</tr>
<tr>
<td>0 1 2 11. Clings to adults or too dependent</td>
<td>0 1 2 41. Impulsive or acts without thinking</td>
<td></td>
</tr>
<tr>
<td>0 1 2 12. Complains of loneliness</td>
<td>0 1 2 42. Likes to be alone</td>
<td></td>
</tr>
<tr>
<td>0 1 2 13. Confused or seems to be in a fog</td>
<td>0 1 2 43. Lying or cheating</td>
<td></td>
</tr>
<tr>
<td>0 1 2 14. Cries a lot</td>
<td>0 1 2 44. Bites fingernails</td>
<td></td>
</tr>
<tr>
<td>0 1 2 15. Cruel to animals</td>
<td>0 1 2 45. Nervous, highstrung, or tense</td>
<td></td>
</tr>
<tr>
<td>0 1 2 16. Cruelty, bullying, or meanness to others</td>
<td>0 1 2 46. Nervous movements or twitching (describe: )</td>
<td></td>
</tr>
<tr>
<td>0 1 2 17. Day-dreams or gets lost in his/her thoughts</td>
<td>0 1 2 47. Nightmares</td>
<td></td>
</tr>
<tr>
<td>0 1 2 18. Deliberately harms self or attempts suicide</td>
<td>0 1 2 48. Not liked by other children</td>
<td></td>
</tr>
<tr>
<td>0 1 2 19. Demands a lot of attention</td>
<td>0 1 2 49. Constipated, doesn't move bowels</td>
<td></td>
</tr>
<tr>
<td>0 1 2 20. Destroys his/her own things</td>
<td>0 1 2 50. Too fearful or anxious</td>
<td></td>
</tr>
<tr>
<td>0 1 2 21. Destroys things belonging to his/her family or other children</td>
<td>0 1 2 51. Feels dizzy</td>
<td></td>
</tr>
<tr>
<td>0 1 2 22. Disobedient at home</td>
<td>0 1 2 52. Feels too guilty</td>
<td></td>
</tr>
<tr>
<td>0 1 2 23. Disobedient at school</td>
<td>0 1 2 53. Overeating</td>
<td></td>
</tr>
<tr>
<td>0 1 2 24. Doesn't eat well</td>
<td>0 1 2 54. Overtired</td>
<td></td>
</tr>
<tr>
<td>0 1 2 25. Doesn't get along with other children</td>
<td>0 1 2 55. Overweight</td>
<td></td>
</tr>
<tr>
<td>0 1 2 26. Doesn't seem to feel guilty after misbehaving</td>
<td>56. Physical problems without known medic cause:</td>
<td></td>
</tr>
<tr>
<td>0 1 2 27. Easily jealous</td>
<td>a. Aches or pains</td>
<td></td>
</tr>
<tr>
<td>0 1 2 28. Eats or drinks things that are not food—don't include sweets (describe: )</td>
<td>b. Headaches</td>
<td></td>
</tr>
<tr>
<td>0 1 2 29. Fears certain animals, situations, or places, other than school (describe: )</td>
<td>c. Nausea, feels sick</td>
<td></td>
</tr>
<tr>
<td>0 1 2 30. Fears going to school</td>
<td>d. Problems with eyes (describe: )</td>
<td></td>
</tr>
<tr>
<td>0 1 2 31. Fears he/she might think or do something bad</td>
<td>e. Rashes or other skin problems</td>
<td></td>
</tr>
<tr>
<td>0 1 2 32. Feels he/she has to be perfect</td>
<td>f. Stomachaches or cramps</td>
<td></td>
</tr>
<tr>
<td>0 1 2 33. Feels or complains that no one loves him/her</td>
<td>g. Vomiting, throwing up</td>
<td></td>
</tr>
<tr>
<td>0 1 2 34. Feels others are out to get him/her</td>
<td>h. Other (describe: )</td>
<td></td>
</tr>
<tr>
<td>0 = Not True (as far as you know)</td>
<td>1 = Somewhat or Sometimes True</td>
<td>2 = Very True or Often True</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>57. Physically attacks people</td>
<td>84. Strange behavior (describe):</td>
<td></td>
</tr>
<tr>
<td>58. Picks nose, skin, or other</td>
<td>85. Strange ideas (describe):</td>
<td></td>
</tr>
<tr>
<td>parts of body (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59. Sleeps in class</td>
<td>86. Stubborn, sullen, or</td>
<td></td>
</tr>
<tr>
<td>60. Apathetic or unmotivated</td>
<td>irritable</td>
<td></td>
</tr>
<tr>
<td>61. Poor school work</td>
<td>87. Sudden changes in mood</td>
<td></td>
</tr>
<tr>
<td>62. Poorly coordinated or clumsy</td>
<td>or feelings</td>
<td></td>
</tr>
<tr>
<td>63. Prefers being with older</td>
<td>88. Sulks a lot</td>
<td></td>
</tr>
<tr>
<td>children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64. Prefers being with younger</td>
<td>89. Suspicious</td>
<td></td>
</tr>
<tr>
<td>children</td>
<td>90. Swearing or obscene</td>
<td></td>
</tr>
<tr>
<td>65. Refuses to talk</td>
<td>language</td>
<td></td>
</tr>
<tr>
<td>66. Repeats certain acts over</td>
<td>91. Talks about killing</td>
<td></td>
</tr>
<tr>
<td>and over; compulsions (describe):</td>
<td>self</td>
<td></td>
</tr>
<tr>
<td>67. Disrupts class discipline</td>
<td>92. Underachieving, not</td>
<td></td>
</tr>
<tr>
<td>68. Screams a lot</td>
<td>working up to potential</td>
<td></td>
</tr>
<tr>
<td>69. Secretive, keeps things to</td>
<td>93. Talks too much</td>
<td></td>
</tr>
<tr>
<td>self</td>
<td>94. Teases a lot</td>
<td></td>
</tr>
<tr>
<td>70. Sees things that aren't</td>
<td>95. Temper tantrums or hot</td>
<td></td>
</tr>
<tr>
<td>there (describe):</td>
<td>temper</td>
<td></td>
</tr>
<tr>
<td>71. Self-conscious or easily</td>
<td>96. Seems preoccupied with</td>
<td></td>
</tr>
<tr>
<td>embarrassed</td>
<td>sex</td>
<td></td>
</tr>
<tr>
<td>72. Messy work</td>
<td>97. Threatens people</td>
<td></td>
</tr>
<tr>
<td>73. Behaves irresponsibly</td>
<td>98. Tardy to school or class</td>
<td></td>
</tr>
<tr>
<td>74. Showing off or clowning</td>
<td>113. Please write in any</td>
<td></td>
</tr>
<tr>
<td></td>
<td>problems the pupil has that</td>
<td></td>
</tr>
<tr>
<td></td>
<td>were not listed above:</td>
<td></td>
</tr>
<tr>
<td>75. Shy or timid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>76. Explosive and unpredictable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77. Demands must be met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>immediately, easily frustrated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78. Inattentive, easily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>distracted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>79. Speech problem (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80. Stares blankly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>81. Feels hurt when criticized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82. Steals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>83. Stores up things he/she</td>
<td></td>
<td></td>
</tr>
<tr>
<td>doesn't need (describe):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C

TEACHER REPORT FORM
UNABLE TO FILM MATERIAL ACCOMPANYING THIS THESIS (I.E. DISKETTE(S), SLIDES, MICROFICHE, ETC...).

PLEASE CONTACT THE UNIVERSITY LIBRARY.

INCAPABLE DE MICROFILMER LE MATERIEL QUI ACCOMPAGNE CETTE THESE (EX. DISQUETTES, DIAPOSITIVES, MICROFICHE (S), ETC...).

VEUILLEZ CONTACTER LA BIBLIOTHEQUE DE L'UNIVERSITE.

NATIONAL LIBRARY OF CANADA CANADIAN THESSES SERVICE

BIBLIOTHEQUE NATIONALE DU CANADA LE SERVICE DES THESI'S CANADIENNES
APPENDIX D

CHILD SEXUAL BEHAVIOR INVENTORY
Name of child: ______________________
Completed by: ______________________
Date: ______________________

Please circle the number that tells how often your child has shown the following behavior recently or in the last 6 months:

<table>
<thead>
<tr>
<th>Never</th>
<th>Less than 1 per month</th>
<th>1-3 times per month</th>
<th>At least 1 per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1. 0 1 2 3 Plays with dolls with adult sex parts
2. 0 1 2 3 Sees nude adults
3. 0 1 2 3 Showers or bathes with an adult
*4. 0 1 2 3 Dresses like the opposite sex
*5. 0 1 2 3 Talks about wanting to be the opposite sex
*6. 0 1 2 3 Touches sex (private) parts in public places
*7. 0 1 2 3 Masturbates with hand
8. 0 1 2 3 Does not want to undress in front of others
*9. 0 1 2 3 Scratches anal/crotch area
*10. 0 1 2 3 Touches or tries to touch mother's or other women's breasts
*11. 0 1 2 3 Masturbates with object
*12. 0 1 2 3 Touches other people's sex (private) parts
*13. 0 1 2 3 Imitates the act of sexual intercourse
14. 0 1 2 3 Asks parent(s) to stop showing sexually related activity (necking, fondling, etc.)
*15. 0 1 2 3 Puts mouth on another child/adult's sex parts
*16. 0 1 2 3 Touches sex (private) parts when at home
*17. 0 1 2 3 Uses words that describe sex acts
*18. 0 1 2 3 Pretends to be the opposite sex when playing
19. 0 1 2 3 Watches parent(s) show sexual behavior such as necking, fondling
*20. 0 1 2 3 Makes sexual sounds (sighing, moaning, heavy breathing, etc.)
21. 0 1 2 3 Asks parent(s) to stop showing affectionate behavior such as hugging or kissing
*22. 0 1 2 3 Asks others to engage in sexual acts with him or her
*23. 0 1 2 3 Rubs body against people and/or furniture
*24. 0 1 2 3 Inserts or tries to insert objects in vagina/anus
*25. 0 1 2 3 Tries to look at people when they are nude or undressing
*26. 0 1 2 3 Imitates sexual behavior with dolls or stuffed animals
27. 0 1 2 3 Watches parent(s) show affectionate behavior (hugging, kissing, etc.)
28. 0 1 2 3 Constipated
*29. 0 1 2 3 Shows sex (private) parts to adults
*30. 0 1 2 3 Tries to view nude or partially dressed people (may include catalogs)
*31. 0 1 2 3 Talks about sexual acts
32. 0 1 2 3 Urinates outside of the toilet
33. 0 1 2 3 Delays bowel movements as long as possible
34. 0 1 2 3 Delays urinating
*35. 0 1 2 3 Kisses adults not in the family
*36. 0 1 2 3 Undresses self in front of others
*37. 0 1 2 3 Sits with crotch or underwear exposed
*38. 0 1 2 3 Kisses other children not in the family
*39. 0 1 2 3 Talks in a flirtatious manner
*40. 0 1 2 3 Tries to undress other children or adults against their will (opening pants, shirt, etc.)
*41. 0 1 2 3 Asks to view nude or sexually explicit TV shows (may include video movies or HBO type shows)
*42. 0 1 2 3 When kissing, tries to put tongue in other person's mouth
*43. 0 1 2 3 Hugs adults he or she does not know well
*44. 0 1 2 3 Shows sex (private) parts to children
*45. 0 1 2 3 If a girl, overly aggressive; if a boy, overly passive
*46. 0 1 2 3 Seems very interested in the opposite sex
*47. 0 1 2 3 Will get physically sick when upset or sad
*48. 0 1 2 3 If a boy, plays with girl's toys; if a girl, plays with boy's toys
49. 0 1 2 3 Other sexual behaviors (please describe)

A. ____________________________________________

B. ____________________________________________
Name of Child: ___________________  Mother: ______

Date: ________________  Father: ______

Instructions

Please answer the following behavioral statements as they currently characterize your child's behavior. For each question, circle the response which most accurately describes your child.

01. Her favorite playmates are:

   a. always girls
   b. usually girls
   c. boys and girls equally
   d. usually boys
   e. always boys
   f. does not play with other children

02. She plays with girl-type dolls, such as "Barbie"

   a. as a favorite toy
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

03. She plays with boy-type dolls, such as "G.I. Joe" or "Ken"

   a. as a favorite toy
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

04. She experiments with cosmetics (make-up) and jewelry

   a. as a favorite activity
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

05. She imitates female characters seen on TV or in the movies

   a. as a favorite activity
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never
06. She imitates male characters seen on TV or in the movies
   a. as a favorite activity
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

07. She plays sports with boys (but not girls)
   a. as a favorite activity
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

08. She plays sports with girls (but not boys)
   a. as a favorite activity
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

09. In playing "mother/father", "house", or "school" games, she takes the role of
   a. a girl or woman at all times
   b. usually a girl or woman
   c. half the time a girl or woman and half the time a boy or man
   d. usually a boy or man
   e. a boy or man at all times
   f. does not play these games

10. She plays "girl-type" games (as compared to "boy-type" games)
   a. as a favorite activity
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

11. She plays "boy-type" games (as compared to "girl-type" games)
   a. as a favorite activity
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never
12. In dress-up games, she likes to dress-up
   a. in girls' or women's clothes all the time
   b. usually in girls' or women's clothes
   c. half the time in girls' or women's clothes and half the
      time in boys' or men's clothes
   d. usually in boys' or men's clothes
   e. in boys' or men's clothes all the time
   f. doesn't dress up

13. She states the wish to be a boy or a man
   a. every day
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

14. She states that she is a boy or a man
   a. every day
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

15. She talks about not liking her sexual anatomy (private parts)
   a. every day
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

   If you circled a, b, c, or d, please describe what she says:

16. She talks about liking her sexual anatomy (private parts)
   a. every day
   b. frequently
   c. once-in-a-while
   d. very rarely
   e. never

   If you circled a, b, c, or d, please describe what she says:
APPENDIX F

TEMPERAMENT QUESTIONNAIRE
Name of Child:_________________________  Mother:_______
Date:_________________________  Father:_______

Instructions

In this questionnaire, there are a total of 54 behavioural statements. Items 1-31 constitute the first of two item sets. For the first set, each behavioural statement is to be rated on a 5-point scale as shown below.

not at all like my daughter
1 2 3 4 5

alot like my daughter

Read each item and then circle the number which most appropriately characterizes your daughter's behaviour. For example, if the behaviour described is not at all like (your) daughter, you would circle the number 1; conversely, if the behaviour described is alot like (your) daughter, you would circle the number 5. The number 2, 3, and 4 are reserved for variations between these two extremes.
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Whenever she starts crying she can be easily distracted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02. She is very energetic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03. She gets upset easily</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>04. She is very sociable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05. She consistently dislikes many kinds of food</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06. If talked to, she stops crying</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>07. She is off and running as soon as she wakes up in the morning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08. She cries easily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>09. She makes friends easily</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10. She has strong likes and dislikes in food</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. When mother is busy and cannot do what child wants, she goes away and does something else instead of keeping after mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. She is always on the go</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. She often fusses and cries</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>14. She takes a long time to warm up to strangers</td>
<td></td>
<td></td>
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<tr>
<td>15. She makes faces at new foods</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. When upset by an unexpected situation, she quickly calms down</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>17. When she moves about, she usually moves slowly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>not at all like my daughter</td>
<td>alot like my daughter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>She tends to be somewhat emotional</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>She is very friendly with strangers</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>She rarely takes a new food without fussing</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>She stops fussing whenever someone talks to her or picks her up</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>In the playground, she runs, climbs, swings, and is constantly on the go</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>She reacts intensely when upset</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>She tends to be shy</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Once she decides she doesn't like something, there is no getting her to like it</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>When she moves about in the house, she runs rather than walks</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>She splashes hard in the bath and plays actively</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>When outdoors, in a playground or park, she plays quietly with toys or dolls</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>With a difficult toy, she gives up quite easily</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>She persists at a task until successful</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>She gives up easily when difficulties are encountered</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Note. The remaining items are also on a 5-point scale, but we are now changing the label attached to each number:

<table>
<thead>
<tr>
<th>never</th>
<th>seldom</th>
<th>frequently</th>
<th>very often</th>
<th>always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

32. She obeys parental instructions
33. She is physically aggressive
34. She is confident in her abilities
35. She likes people
36. She obeys her mother
37. She performs strenuous activity for long periods of time
38. She acts defiant when given orders
39. She is bold and adventurous
40. She is patient
41. She is noisy
42. She wakes up in the morning in a good mood
43. She is physically aggressive with her peers
44. She is cuddly with her father
45. She is curious and explores things
46. She plays cooperatively, shares toys
47. She likes rough-and-tumble play
48. She is cuddly with her mother
49. She fights
50. She must get her own way in games
<table>
<thead>
<tr>
<th></th>
<th>never</th>
<th>seldom</th>
<th>frequently</th>
<th>very often</th>
<th>always</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>She gets into fights with other children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>She has temper tantrums</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>She obeys her father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>She whines and whimpers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Name: ___________________________   Sex: Male  Female

INSTRUCTIONS

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

<table>
<thead>
<tr>
<th>Always Agree</th>
<th>Almost Agree</th>
<th>Occasionally Disagree</th>
<th>Frequently Disagree</th>
<th>Almost Disagree</th>
<th>Always Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

1. Handling family finances ................  5 4 3 2 1 0
2. Matters of recreation ....................  5 4 3 2 1 0
3. Religious matters .......................  5 4 3 2 1 0
4. Demonstrations of affection ..............  5 4 3 2 1 0
5. Friends ..................................  5 4 3 2 1 0
6. Sex relations ............................  5 4 3 2 1 0
7. Conventionality (correct or proper behavior)  ..................  5 4 3 2 1 0
8. Philosophy of life ........................  5 4 3 2 1 0
9. Ways of dealing with parents or in-laws  ..................  5 4 3 2 1 0
10. Aims, goals, and things believed important  ..................  5 4 3 2 1 0
11. Amount of time spent together ..............  5 4 3 2 1 0
12. Making major decisions ...................  5 4 3 2 1 0
13. Household tasks ..........................  5 4 3 2 1 0
14. Leisure time interests and activities .......  5 4 3 2 1 0
15. Career decisions ..........................  5 4 3 2 1 0
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship? .......... 0 1 2 3 4 5

17. How often do you or your mate leave the house after a fight? ...................... 0 1 2 3 4 5

18. In general, how often do you think that things between you and your partner are going well? ................. 0 1 2 3 4 5

19. Do you confide in your mate? ................. 0 1 2 3 4 5

20. Do you ever regret that you married (or lived together)? ................. 0 1 2 3 4 5

21. How often do you and your partner quarrel? ...................... 0 1 2 3 4 5

22. How often do you and your mate "get on each other's nerves"? .......... 0 1 2 3 4 5

<table>
<thead>
<tr>
<th></th>
<th>Every Day</th>
<th>Almost Every Day</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

23. Do you kiss your mate? ...................... 4 3 2 1 0

<table>
<thead>
<tr>
<th></th>
<th>All of them</th>
<th>Most of them</th>
<th>Some of them</th>
<th>Very few of them</th>
<th>None of them</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

24. Do you and your mate engage in outside interests together? ...................... 4 3 2 1 0

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

<table>
<thead>
<tr>
<th></th>
<th>Less than once a month</th>
<th>Once or twice a month</th>
<th>Once or twice a week</th>
<th>Once a day</th>
<th>More often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

25. Have a stimulating exchange of ideas ...... 0 1 2 3 4 5
<table>
<thead>
<tr>
<th>Never</th>
<th>Less than once a month</th>
<th>Once or twice a month</th>
<th>Once or twice a week</th>
<th>Once a day</th>
<th>More often</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

26. Laugh together .............................. 0 1 2 3 4 5
27. Calmly discuss something ..................... 0 1 2 3 4 5
28. Work together on a project ..................... 0 1 2 3 4 5

There are some things which couples sometimes agree and sometime disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no)

Yes  No
29. 0 1  Being too tired for sex
30. 0 1  Not showing love

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy", represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely Unhappy</td>
<td>Fairly Unhappy</td>
<td>A little Happy</td>
<td>Very Happy</td>
<td>Extremely Happy</td>
<td>Perfect Happy</td>
<td></td>
</tr>
</tbody>
</table>

32. Which of the following statements best describes how you feel about the future of your relationship?

5  I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

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

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

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

1  It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

0  My relationship can never succeed, and there is no more that I can do to keep the relationship going.
UNABLE TO FILM MATERIAL ACCOMPANYING THIS THESIS (I.E. DISKETTE(S), SLIDES, MICROFICHE, ETC...).

PLEASE CONTACT THE UNIVERSITY LIBRARY.

INCAPABLE DE MICROFILMER LE MATERIEL QUI ACCOMPAGNE CETTE THESE (EX. DISQUETTES, DIAPPOSITIVES, MICROFICHE(S), ETC...).

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NATIONAL LIBRARY OF CANADA CANADIAN THESSES SERVICE

BIBLIOTHEQUE NATIONALE DU CANADA LE SERVICE DES THESSES CANADIENNES
APPENDIX I

CONSENT FORM FOR CLINICAL GROUPS
CONSENT FORM

My Children's Aid Society social worker has explained to me that a team of researchers (Dr. Granville daCosta, Dr. Kenneth Zucker, and Dianne Maing, M.A.) from the Clarke Institute of Psychiatry is conducting a study on the effects of child abuse on behaviour. My child's participation will involve completing psychological tests and posing for a facial photograph. My participation will involve being interviewed and completing several questionnaires about my child's behaviour. I understand that the time involved to complete the testing will be approximately four (4) for my child, and approximately four (4) hours for me. I also give permission for my child's school grades to be released to the researchers, and for my child's school teacher to fill out a questionnaire about my child's behaviour in the school setting.

I understand that there will be no direct benefit to my child as a result of her participation in the study. However, I also understand that, at my request and with my written permission, any information about my child gained from this study may be sent to an appropriate agency or professional. I understand that I may withdraw my child's participation at any time, even after beginning the tests. I also understand that my child may choose not to participate even though I have given my permission for her to do so. I understand that my child's privacy will be protected in any scientific publication or presentation resulting from this study. I understand that my child and I will be paid for our time and for our transportation costs.

I acknowledge that I have been given a copy of this consent form.

Dated at ____________ this ___ day of __________, 19__

Witness                                    Parent or Legal Guardian
APPENDIX J

CONSENT FORM FOR NON-CLINICAL GIRLS
CONSENT FORM

Dr. Kenneth Zucker or Dianne Maing, from the Clarke Institute of Psychiatry, has explained to me that they are conducting a study on children's development. My child's participation will involve completing psychological tests and posing for a facial photograph. My participation will involve being interviewed and completing several questionnaires about my child's behaviour. I understand that the time involved to complete the testing will be approximately four (4) for my child, and approximately four (4) hours for me. I also give permission for my child's school grades to be released to the researchers, and for my child's school teacher to fill out a questionnaire about my child's behaviour in the school setting.

I understand that I may withdraw my child's participation at any time, even after beginning the tests. I also understand that my child may choose not to participate even though I have given my permission for her to do so. I understand that my child's privacy will be protected in any scientific publication or presentation resulting from this study. I understand that my child and I will be paid for our time and for our transportation costs.

I acknowledge that I have been given a copy of this consent form.

Dated at ______________ this ____ day of ________, 19__

Witness ____________________________________________________________________________

Parent or Legal Guardian ____________________________________________________________________________
APPENDIX K

ANO"V"AS OF DEMOGRAPHIC CHARACTERISTICS
Table K-1

**ANOVA of Demographic Characteristics**

<table>
<thead>
<tr>
<th>Variable</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between-Groups</td>
<td>2</td>
<td>0.25</td>
<td>0.12</td>
<td>0.02</td>
<td>.977</td>
</tr>
<tr>
<td>Within-Groups</td>
<td>57</td>
<td>305.14</td>
<td>5.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>305.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between-Groups</td>
<td>2</td>
<td>279.23</td>
<td>139.62</td>
<td>1.02</td>
<td>.365</td>
</tr>
<tr>
<td>Within-Groups</td>
<td>57</td>
<td>7769.70</td>
<td>136.31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>8048.93</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX L

PERCENT OF CHILDREN FROM THE CLINICAL AND NON-CLINICAL GROUPS SCORING IN THE CLINICAL RANGE ON THE CBCL AND TRF BROAD-BAND SCALES AND TOTAL BEHAVIOUR PROBLEM
Table L-2

Percent of Children from the Clinical and Non-Clinical Groups Scoring in the Clinical Range on the CBCL and TRP Broad-Band Scales and Total Behavior Problem

<table>
<thead>
<tr>
<th>Group</th>
<th>Internalizing T</th>
<th>Externalizing T</th>
<th>Total T</th>
</tr>
</thead>
<tbody>
<tr>
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Note. SA = Sexually abused; CC = Clinical control; NC = Non-clinical control.

Clinical Range: Internalizing and Externalizing T > 63; Total Behavior Problem T > 90th percentile.
Clinical Range: Internalizing, Externalizing, and Total Behavior Problem T > 89th percentile.
APPENDIX M

MEAN CBCL NARROW-BAND SCALES BY GROUP
Figure M-1

Mean CBCL Narrow-Band Scales by Group

- Sexually Abused
- Clinical Controls
- Non-clinical Controls

T SCORE

CBCL Narrow-Band Scales

(Figure continues)
Figure M-1 continues

Note. DEP = Depressed; SW = Social Withdrawal; SOM = Somatic Complaints; 
SO = Schizoid-Obsessive; HYP = Hyperactive; SEX = Sex Problems; DEL = 
Delinquent; AGG = Aggressive; CR = Cruel.
APPENDIX N

MEAN CBCL NARROW-BAND SCALES BY PRESENT GROUPS AND STANDARDIZED SAMPLES
Figure N-2

Mean CBCL Narrow-Band Scales
by Present Groups and Standardized Samples

T SCORE

Sexually Abused
Clinical Control
Non-Clinical Control
Non-clinical Norms
Clinical Norms

CBCL Narrow-Band Scales

(Figure continues)
Figure N-2 continues

**Note.** DEP = Depressed; SW = Social Withdrawal; SOM = Somatic Complaints; SO = Schizoid-Obsessive; HYP = Hyperactive; SEX = Sex Problems; DEL = Delinquent; AGG = Aggressive; CR = Cruel.
APPENDIX G

FACTOR MATRIX FROM PRINCIPAL COMPONENTS ANALYSIS
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VITA AUCTORIS

Dianne Mary Maing was born in Port-of-Spain, Trinidad. She attained her Advanced Level Certificate from St. Joseph's Convent, Port-of-Spain. She graduated from Brock University, St. Catharines, in June, 1982 with a Bachelor of Arts (First Class Honours) Degree in Psychology. In September, 1982, she enrolled in the Doctoral programme in Clinical (Adult) Psychology at the University of Windsor, where she obtained her Master of Arts Degree in June, 1985. The Doctor of Philosophy Degree was completed in May, 1991.