

# Childhood Sexual Abuse, Stigmatization, Internalizing Symptoms, and the Development of Sexual Difficulties and Dating Aggression

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Potential pathways from childhood sexual abuse (CSA) to subsequent romantic intimacy problems were examined in a prospective longitudinal study of 160 ethnically diverse youth with confirmed CSA histories. Participants were interviewed at the time of abuse discovery, when they were 8–15 years of age, and again 1–6 years later. Stigmatization (abuse-specific shame and self-blame) and internalizing symptoms (posttraumatic stress and depressive symptoms), more than abuse severity, explained which youth with CSA histories experienced more sexual difficulties and dating aggression. Stigmatization was found to operate as a predictive mechanism for subsequent sexual difficulties. Internalizing symptoms were not predictive of romantic intimacy problems, although they did show correlational relations with sexual difficulties and dating aggression. Early interventions such as trauma-focused cognitive-behavioral therapy that target stigmatization may be important for preventing the development of sexual difficulties in CSA youth.

*Keywords:* childhood sexual abuse, stigmatization, internalizing symptoms, sexual difficulties, dating aggression

Achieving healthy romantic intimacy is especially challenging for youth with childhood sexual abuse (CSA) histories. Healthy intimacy involves mutual social and sexual reciprocity between youth of similar age, as well as sensitivity to and concern for the partner's well-being (Collins & Sroufe, 1999). In contrast, CSA involves the unilateral imposition of adult sexual desire on children. For these children, intimacy becomes associated with shame and fear rather than warmth and caring and with concerns about dominance and submission rather than mutuality (Meston, Rellini, & Heiman, 2006; Wekerle et al., 2001).

Many studies on the connection between CSA and romantic intimacy problems have reported on CSA's association with dating aggression (DiLillo, Giuffre, Tremblay, & Peterson, 2001; White & Widom, 2003; D. A. Wolfe, Wekerle, Reitzel-Jaffe, & Lefebvre, 1998); sexual anxieties (Fleming, Mullen, Sibthorpe, & Bammer, 1999; Noll, Trickett, & Putnam, 2003); and dysfunctional and

risky sexual behaviors (Noll et al., 2003; Testa, VanZile-Tamsen, & Livingston, 2005; Vigil, Geary, & Byrd-Craven, 2005). Although the link between CSA and intimacy problems is empirically supported, the mechanisms to explain this link are not well understood. With few exceptions, such research is limited by the use of cross-sectional designs and adult retrospective reports of abuse. Longitudinal research is needed to understand which children with known histories of CSA develop intimacy problems in adolescence and early adulthood. Focusing on explanatory mechanisms that are potential targets for therapeutic change is essential for the design of more effective and timely interventions.

The purpose of this study was to examine how individual differences in abuse severity, abuse-specific reactions to CSA, and internalizing symptoms explain which youth with CSA histories develop romantic intimacy problems. To incorporate the sexual and social aspects of intimacy development and findings from previous literature, we examined two domains of intimacy problems: sexual difficulties and dating aggression. Sexual feelings and interactions are defining features of romantic intimacy (B. B. Brown, Feiring, & Furman, 1999). Youth with CSA histories are at risk for sexual difficulties because they experience violations of the typical sequence and context of sexual development (Bukowski, 1992). Constructive conflict resolution is a key intimacy skill for developing and maintaining satisfying relationships (Collins & Sroufe, 1999). Youth with CSA histories are likely to have problems regulating negative emotions such as hostility and helplessness, which put them at risk for dating aggression (D. A. Wolfe, Wekerle, Scott, Straatman, & Grasley, 2004).

Greater CSA trauma is believed to put youth at increased risk for intimacy problems (Wekerle & Wolfe, 1999). Indicators of

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abuse severity that suggest greater trauma, including penetration, use of physical force, and perpetration by a parent figure, are linked to a greater likelihood of intimacy problems (Arata, 2000; Fleming et al., 1999; Noll et al., 2003; West, Williams, & Siegel, 2000). Nevertheless, these links are weak and inconsistent. Abuse severity provides limited understanding of how CSA leads to romantic intimacy problems. Indicators of severity suggest but do not directly tap psychological processes that disrupt healthy intimacy development (e.g., a parent perpetrator suggests but does not index the level of shame associated with sexual abuse).

More than abuse severity, abuse-specific reactions related to stigmatization were expected to explain individual differences in intimacy problems. As originally conceptualized, stigmatization involves negative feelings and thoughts about the self as bad and blameworthy as a result of CSA (Finkelhor & Browne, 1985). More recently, *stigmatization* has been defined as shame and a self-blaming attributional style (Feiring, Taska, & Lewis, 1996). The phenomenological experience of shame is a desire to hide the damaged and degraded self from exposure to the censure of others. To the extent that CSA and its discovery are experienced as a social transgression in which the damaged self is exposed, shame is likely and can persist for several years following abuse (Feiring & Taska, 2005). Self-blame involves viewing characterological or behavioral aspects of the self as responsible for the abuse. The secretive context in which CSA takes place, the condemnation of the victim by the perpetrator, and the social taboos and legal sanctions against sexual acts of adults with children increase the likelihood that children will experience shame and self-blame for being involved in CSA. These negative emotions and cognitions may occur during the abuse and discovery processes and continue once the abuse and its discovery have ended. More severe CSA has been associated with higher levels of stigmatization (Feiring & Cleland, 2007; Kallstrom-Fuqua, Weston, & Marshall, 2004).

Stigmatization experienced during and in the aftermath of CSA may be carried forward to nonabusive relationships that involve sex and romantic intimacy. The emotional and cognitive processes that define stigmatization are related to intimacy problems. Shame disrupts the development of intimacy through fear of self-disclosure, anxiety about one's value as a partner, and expectations of reprobation from others (Tangney & Dearing, 2002). It is associated with being submissive, feeling devalued, and the desire to retaliate against a partner seen as the source of humiliation (Covert, Tangney, Maddux, & Heleno, 2003; Gilbert, Allan, & Goss, 1996). Individuals with a self-blaming attribution style are likely to believe they deserve hostile and aggressive acts from their partners. This style is related to dissatisfaction with close relationships, poor relationship quality, and risky relationship behavior (Feiring, Rosenthal, & Taska, 2000; Fletcher, Fitness, & Blampied, 1990; Liem & Boudewyn, 1999).

Internalizing symptoms of posttraumatic stress disorder (PTSD) and depression are common reactions to CSA (Gladstone et al., 2004; Widom, 1999) and are related to greater abuse severity (Feiring, Taska, & Lewis, 2002; Kallstrom-Fuqua et al., 2004). PTSD symptoms can contribute to intimacy problems by increasing the tendency to withdraw or feel anxious during intimate interactions and by increasing the intensity of negative reactions to ambiguous partner behavior (D. A. Wolfe, 1999). Research indicates that such symptoms in abused youth are related to fear of intimacy and being the perpetrator and victim of dating aggression

(Davis & Petretic-Jackson, 2001; Wekerle et al., 2001; D. A. Wolfe et al., 2004). PTSD symptoms among those with sexual abuse histories also contribute to a variety of sexual problems, including sexual concerns (Noll et al., 2003), sexual risk taking (L. K. Brown, Lourie, Zlotnick, & Cohn, 2000; Noll et al., 2003), heightened sexual activity (Browning & Laumann, 1997; Miller, Monson, & Norton, 1995), and sexual dysfunction (McClellan et al., 1996).

Symptoms of depression interfere with the development of intimacy because they are linked to viewing others as hostile and rejecting (Quiggle, Garber, Panak, & Dodge, 1992) and emotionally unresponsive and controlling (Rudolph, Hammen, & Burge, 1997; Shirk, 1998). Especially for women, depressive symptoms are predictive of subsequent dating aggression (Capaldi, Kim, & Shortt, 2005; Kim & Capaldi, 2004). Among adults, depression has been linked to the onset and maintenance of sexual concerns and dysfunction (Cyranowski, Frank, Cherry, Houck, & Kupfer, 2004) as well as risky sexual behavior (Morrill, Ickovics, Golubchikov, & Beren, 1996; Rohde, Noell, Ochs, & Seely, 2001).

Past research on CSA and intimacy problems has typically failed to distinguish between mechanisms that have a correlational relation and those that have a predictive and potentially causal relation with such problems. In the current study, we addressed this weakness by considering longitudinal data from three time points: abuse discovery ( $T_1$ ), 1 year later ( $T_2$ ), and 6 years later ( $T_3$ ). We examined the extent to which earlier differences in reactions to CSA predicted subsequent sexual difficulties and dating aggression. The study focused on which individuals with CSA histories were more at risk for these intimacy problems rather than whether individuals with such histories were more at risk for relationship difficulties compared with those without such histories. Consistent with this focus, we employed a within-group design to examine potential pathways to sexual difficulties and dating aggression in a sample of confirmed CSA victims. Using structural equation modeling, we tested the conceptual model shown in Figure 1. We hypothesized that (a) abuse severity (e.g., penetration, the use of physical force, and abuse by a parent figure) would be related to higher levels of stigmatization and internalizing symptoms (mechanisms of distress) at  $T_1$  (Path A); (b) higher levels of stigmatization and internalizing symptoms at  $T_1$  would be related to higher levels of these mechanisms at  $T_2$  (Path B); (c) higher levels of stigmatization and internalizing symptoms at  $T_2$  would be related to higher levels of sexual difficulties and dating aggression at  $T_3$  (Path C); (d) the effects of abuse severity on subsequent intimacy problems would be indirect, working through stigmatization and internalizing symptoms (Paths A  $\times$  B  $\times$  C); and (e) the effects of stigmatization and internalizing symptoms at  $T_1$  on subsequent intimacy problems would be indirect, working through  $T_2$  stigmatization and internalizing symptoms (Paths B  $\times$  C). The proposed model focuses on predictive pathways from earlier to later time points. We considered, in addition to the predictive relations hypothesized in Figure 1, correlational relations between mechanisms measured concurrently with outcomes. We expected that there would be concurrent relations between mechanisms and outcomes such that greater stigmatization and internalizing symptoms at  $T_3$  would be related to more sexual difficulties and dating aggression. Whereas mechanisms measured concurrently were expected to explain additional variance in outcomes, they were not expected to eliminate the effects of the same

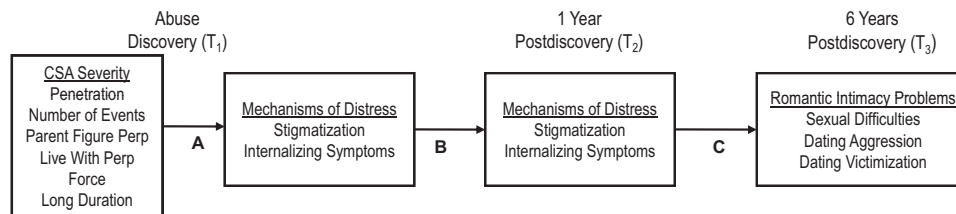


Figure 1. Conceptual model of predictive pathways through mechanisms of distress to romantic intimacy problems following childhood sexual abuse (CSA).  $T_{1-3}$  = Time 1–3; Penetration = penetration during abuse; Number of Events = number of abuse events; Perp = perpetrator; Force = threat of or use of force during abuse; Long Duration = duration of abuse was a year or more.

mechanisms measured earlier. Examination of the proposed model tested the assumption that abuse-related mechanisms compared with abuse severity would provide a better understanding of which youth with CSA histories were most at risk for subsequent intimacy problems. Finding that earlier mechanisms help explain risk for subsequent intimacy problems would provide meaningful evidence for targeting these mechanisms for early intervention.

## Method

### Participants

Participants were recruited from urban and suburban populations in southern, central, and northern New Jersey. The majority of the sample (95%) came directly from child protective services (CPS) offices or regional child abuse medical clinics working with CPS. Intake logs were reviewed by project staff to identify eligible cases. To be eligible, children had to be between 8 and 15 years of age, in the custody of a nonoffending parent or caregiver, and identified as a CSA case within 8 weeks from the date CPS opened the case (i.e., the time of abuse discovery). Caseworkers contacted families to obtain permission for project staff to contact them to discuss the study. *Sexual abuse* was defined as sexual involvement with a juvenile or an adult perpetrator by coercion. Although in this sample sexual involvement typically meant children experienced physical contact (e.g., fondling or oral, anal, or vaginal penetration), in a few cases they experienced nonphysical contact (e.g., forced to watch a parent masturbate). The final recruited sample was comprised of children whose sexual abuse was confirmed by at least one of the following criteria: specific medical findings, confession by the offender, abuse validated by an expert, or conviction of the offender in family or criminal court.

All but three of the 185 families approached by caseworkers agreed to be contacted by project staff. Of those contacted, 160 agreed to participate and completed the initial assessment at abuse discovery ( $T_1$ ), before any treatment was received. Of the original participants, 147 were seen approximately 1 year later ( $M = 1.2$  years,  $SD = 0.3$ ) at  $T_2$ . Between  $T_1$  and  $T_2$ , 68% of the sample had received some form of treatment, typically from community-based agencies (mean length of treatment = 5.4 months,  $SD = 4.7$ ). The third assessment ( $T_3$ ) was obtained approximately 6 years following abuse discovery ( $M = 6.2$  years,  $SD = 1.2$ ) on 121 of the participants seen at  $T_1$ ; 118 participants were seen for all three assessments. Between  $T_2$  and  $T_3$ , 39% received some form of treatment (mean length of treatment = 8 months,  $SD = 8.5$ ).

At  $T_1$ , 55% of the sample were children ages 8–11 years ( $M = 9.6$ ,  $SD = 1.1$ ), and 45% were adolescents ages 12–15 years ( $M = 13.5$ ,  $SD = 1.1$ ). Seventy-three percent of the sample were girls. The majority of the participants came from single-parent families (67%) and were poor (64%, with an income of \$25,000 or less). The ethnicity of the sample was self-reported as African American (41%), White (31%), Hispanic (20%), and other (8%, including Native American and Asian). Among the participants, 66% experienced genital penetration, the most serious form of contact abuse reported by this sample (31% experienced fondling or attempted penetration, and 3% had to watch the perpetrator masturbate). Almost all of the perpetrators were known to their victims, with 35% a parent figure, 26% a relative, 36% a familiar person who was not a relative, and 3% a stranger. Forty-three percent of the participants lived with the perpetrator at the time of the abuse. Frequency of the reported abusive events was once for 32% of the sample, 2–9 times for 38%, and 10 times or more for 30%. The abuse lasted for a year or longer in 39% of the sample. The use of physical force was reported in 25% of the sample, the threat of force in 20%, and in 55% of the cases no force or threat was reported.

### Procedure

All the procedures for this study were approved by the institutional review boards of the academic institutions where the research took place. A certificate of confidentiality protected the data that participants provided from being released without written consent. At each of the three assessment points, when the participant was a minor, written informed assent was obtained from the children and written informed consent was obtained from their parent or guardian. At  $T_3$ , those participants who were 18 or older provided written informed consent. At each time point, assessments were conducted by a trained clinician in a private office. Abuse-related information was obtained from CPS and law enforcement case records at  $T_1$  after the children were interviewed. Participants were reimbursed a total of \$250 for completion of the initial and the two follow-up assessments.

### Measures

**Abuse characteristics.** To obtain information on specific characteristics of the abuse incidents that qualified the participant for inclusion in the study, trained staff members copied information

from law enforcement agencies and CPS records to a checklist. The checklist provided space to record information on (a) the relationship of the perpetrator to the victim; (b) the frequency (number of events reported) and duration (dates began and ended) of the victimization; (c) how the abuse was discovered; (d) the types of abusive acts experienced (e.g., fondling, penetration); (e) the use of physical force; (f) medical findings; and (g) how the case was confirmed. To test the accuracy of filling out the checklist, we instructed two staff members to copy information from the same 20 participants' case files onto the checklist; 100% or nearly 100% accuracy was achieved for each category of information. Coding of abuse severity information from the checklist (e.g., identity of the perpetrator as a *stranger* = 1, *familiar person* = 2, *relative* = 3, *parent figure* = 4) was completed by trained project personnel, among whom acceptable interrater reliability was obtained ( $\kappa = .73$  to 1.0).

**Stigmatization.** Abuse-related shame was obtained at each assessment by using four items: (1) "I feel ashamed because I think that people can tell from looking at me what happened"; (2) "When I think about what happened I want to go away by myself and hide"; (3) "I am ashamed because I feel I am the only one in my school/work who this has happened to"; and (4) "What happened to me makes me feel dirty." The items were rated on a 3-point scale ranging from 1 (*not true*) to 3 (*very true*). Items were then summed, with a higher score indicating greater abuse-related shame. Abuse-specific self-blame attributions were measured at each assessment (where 2 = *very true*, 1 = *somewhat true*, 0 = *not true*) by having participants rate the extent to which the following eight causal statements were true for why the abuse happened: "This happened to me because:" (1) "I was to blame for what happened"; (2) "I was not smart enough to stop it from happening"; (3) "I was a bad person and needed to be punished"; (4) "of something I did"; (5) "I was not careful enough on those days"; (6) "I'm not a good person"; (7) "I am not a careful person"; and (8) "of the way I acted around 'perpetrator name.'" These items were then summed, with higher scores indicating more abuse-specific self-blame. Although the measures of abuse-specific shame and self-blame were developed for this study, they showed acceptable internal consistency at each assessment (shame  $\alpha = .85-.86$ ; self-blame  $\alpha = .75-.80$ ) and expected positive relations with depressive and PTSD symptoms within and over time (Feiring & Cleland 2007; Feiring & Taska, 2005; Feiring, Taska, & Chen, 2002; Feiring, Taska, & Lewis, 2002). A summary stigmatization score was created because these two indicators theoretically define this construct and because abuse-specific shame and self-blame were moderately related at each assessment ( $r = .36-.44$ ). Given the modest sample size, utilizing a summary score reduced the probability of Type I error and the number of predictors in the planned analyses. To create stigmatization scores at each assessment point, we scored the abuse-specific shame and self-blame measures each as a percentage of maximum possible (POMP; P. Cohen, Cohen, Aiken, & West, 1999), and the two scores were averaged. For each assessment point, this yielded a stigmatization score that could range from 0 to 100, with higher values indicating more stigmatization.

**Internalizing symptoms.** Measures of PTSD and depressive symptoms were available at each assessment point. The Children's Impact of Traumatic Events Scale-Revised (CITES-R; V. V. Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991), developed for

samples of children with CSA histories, was used to assess PTSD symptoms at  $T_1$  and  $T_2$ . Multitrait-multimethod matrix analyses provide evidence for good convergent and discriminant validity of this measure (V. V. Wolfe et al., 1991). Children respond on a 3-point scale ranging from 1 (*not true*) to 3 (*very true*), with each subscale score consisting of the mean of the items on that subscale. Scores for PTSD symptoms were computed at each age from the average of the Hyperarousal (six items, e.g., "I am easily startled or surprised"), Intrusive Thoughts (seven items, e.g., "Pictures of it [the CSA] pop into my mind"), and Avoidance (eight items, e.g., "I try not to think about what happened") subscale scores. The higher the average PTSD score, the more PTSD symptoms reported. The alpha coefficients for the PTSD scores were acceptable (.88 and .91 for  $T_1$  and  $T_2$ , respectively). At  $T_3$ , the Trauma Symptom Inventory (TSI; Briere, 1995; Briere, Elliott, Harris, & Cotman, 1995) was used to index PTSD symptoms (the TSI tests for the same types of PTSD symptoms as on the CITES-R but can be used with older participants). The switch to this measure also reduced the participants' burden, as it includes indexes of other behaviors, such as dissociation and self-injurious behavior, relevant for CSA samples. The TSI has shown acceptable convergent and discriminant validity for its PTSD subscales (Briere, 1995). Items on the TSI are rated on a 4-point Likert scale ranging from 0 (*Never*) to 3 (*Often*) and are summed to create a subscale score such that the more symptoms that are reported, the higher the score. The three subscales (eight items each) that were averaged to create a PTSD score were (1) Anxious Arousal (e.g., "being startled or frightened by sudden noises"); (2) Intrusive Experiences (e.g., "frightening or upsetting thought popping into your mind"); and (3) Defensive Avoidance (e.g., "trying to block out certain memories").<sup>1</sup> The internal consistency for the PTSD score at  $T_3$  was acceptable ( $\alpha = .88$ ).

At  $T_1$  and  $T_2$ , the Child Depression Inventory (CDI; Kovacs, 1985) was used to index depressive symptoms. The CDI, a 27-item forced choice questionnaire, quantifies a range of depressive symptoms such as disturbances of mood, hedonic capacity, vegetative functions, and interpersonal behaviors. At  $T_3$ , the CDI was used with participants 16 years old and under, and the parallel instrument for adults, the Beck Depression Inventory-II (BDI-II, Beck, Steer, & Brown, 1996), was used with participants 17 years old or more. Both the CDI and the BDI-II have shown acceptable convergent and discriminant validity (Beck et al., 1996; Saylor, Finch, Spirito, & Bennett, 1984). Scores for this sample showed good internal consistency (CDI  $\alpha$ :  $T_1 = .91$ ,  $T_2 = .90$ ,  $T_3 = .80$ ; BDI  $\alpha = .92$ ). Higher total scores indicated the more depressive symptoms.

A summary internalizing symptom score was created because depressive and PTSD symptoms were moderately related at each assessment point ( $r = .46-.71$ ). Internalizing symptom scores at each assessment point were created by using POMP index scores for PTSD and depression. For PTSD, each of the three PTSD subscale measures was scored using POMP, and the three scores

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were averaged to create a PTSD index that ranged from 0 to 100. For the depression measures, T scores were converted to POMP scores by dividing the difference between each individual's T score and the sample minimum by the sample range, resulting in a depression index that ranged from 0 to 100. The PTSD and depression POMP index scores were then averaged to create a single internalizing symptoms variable that ranged from 0 to 100, such that higher scores indicated more symptoms.

*Romantic intimacy problems.* The measures of dating aggression and sexual difficulties were obtained at T<sub>3</sub> but not at prior assessment points. Dating aggression was measured by the Conflict in Relationships Questionnaire (CIRQ; D. A. Wolfe et al., 2001). Developed for use with adolescents, this measure shows good test-retest reliability and structural and construct validity. This CIRQ was computer-administered, with responses entered directly into the computer. The interviewer was not present during this part of the assessment (although she was available in an adjacent room if questions arose). This method of administration emphasizes the anonymity of the assessment and has been shown to promote willingness to report sensitive information to a greater extent than have face-to-face interviews (Turner et al., 1998). Youth completed items on dating aggression in reference to the frequency of their own behavior and that of their current or most recent partner using a 4-point scale ranging from 0 (*Never*) to 3 (*Often*). Items used in this study indexed being the perpetrator and/or victim of (a) physical aggression (four items, e.g., "I pushed, shoved or shook my partner"); (b) threatening behavior (four items, e.g., "I threatened to hurt my partner"); (c) relational aggression (three items, e.g., "I spread rumors about my partner"); and (d) verbal emotional aggression (10 items, e.g., "I insulted my partner with put downs"). Items for each type of aggression were then summed, with higher scores indicating more frequent aggression. To reduce the probability of Type I error, we created summary perpetration and victimization scores by adding the scores for each type of dating aggression. The higher the summary scores, the more perpetration and victimization the participant reported. The rationale for these summary scores was based on the results of a principal components analysis done separately on perpetration and victimization subscale scores for the four types of aggression. All of the perpetration subscale scores loaded on one factor that accounted for 69% of the variance, and all the victimization subscale scores loaded on one factor that accounted for 73% of the variance. The alpha coefficients for these summary measures were acceptable (perpetration  $\alpha = .76$ ; victimization  $\alpha = .75$ ). Exploratory data analysis suggested both the perpetration and victimization measures were positively skewed. Each was transformed by taking the natural logarithm after adding a constant of one. The transformation reduced the skew of each measure, and the transformed variables were used in descriptive statistics and all analyses.

The sexual concerns and dysfunctional sexual behavior subscales of the TSI were used to index sexual difficulties (Briere et al., 1995). These subscales have shown adequate convergent and discriminant validity (Briere, 1995) and are higher in individuals who report CSA histories. The Sexual Concerns subscale measures perceptions of sexual problems in relationships, sexual dissatisfaction, and unwanted sexual thoughts and feelings (e.g., "bad thoughts or feelings during sex"). The Dysfunctional Sexual Behavior subscale measures sexual behavior that is indiscriminant

and the use of sex to achieve nonsexual goals (e.g., "using sex to get love or attention").<sup>2</sup> Participants rated their experiences in the past 6 months on a 4-point Likert scale ranging from 0 (*never*) to 3 (*often*). The nine items for each subscale are summed such that higher scores indicate more sexual problems. The internal consistency for these subscales was acceptable (Sexual Concerns  $\alpha = .82$ ; Dysfunctional Sexual Behavior  $\alpha = .78$ ). A sexual difficulties summary score was created because the two indicators were correlated ( $r = .63$ ). To create a summary score, we standardized both the Sexual Concerns and Dysfunctional Sexual Behavior subscale scores and then averaged the standard scores. Because this summary score was an average of standard scores, its mean was close to zero; higher scores indicated more problems.

### Missing Data

Missing data were handled by the full information maximum likelihood (FIML; Allison, 2002) method in Mplus (Muthén & Muthén, 1998–2006), which is more powerful and less biased than are ad hoc methods of handling missingness (e.g., listwise deletion). This method, also known as direct ML, works by finding model parameters that maximize the likelihood of each case's observed data. This approach assumes data are missing at random, that is, missing at random conditional upon values observed.

## Results

### Data Analyses

First, we provide descriptive information on the abuse characteristics of the sample and the study variables used in the proposed path models. Next, the results from SEM examining the path models of stigmatization and internalizing symptoms on sexual difficulties and dating aggression are reported. Direct and indirect effects on intimacy problems in the proposed conceptual model (see Figure 1) were estimated with SEM (Kline, 1998). Two separate models were fit for the stigmatization and internalizing symptom pathways. Although conceptually distinct, stigmatization and internalizing symptom variables assessed at the same time point were substantially correlated ( $r > .50$ ). Rather than having stigmatization and internalizing symptoms compete directly against each other, where the overlap might obscure each construct's effects, we chose to fit separate models. Each type of intimacy problem was included in the same model, with all correlations among endogenous variable residuals freely estimated. Since the literature shows that age and gender are related to romantic intimacy problems, these variables were used as covariates in the model (Coleman & Widom, 2004; Noll et al., 2003). The models were just-identified and recursive and included only observed variables. Since the models were not overidentified, the freely estimated model parameters (regression coefficients, covariances, and variances) were able to reproduce the observed covariance matrix exactly, and therefore no chi-square tests or fit indexes

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are reported. The Mplus modeling program (Muthén & Muthén, 1998–2006) was used because it handles missing data with the FIML approach and provides bootstrap confidence intervals for direct and indirect effects. Indirect effects were calculated and tested with the resampling method suggested by MacKinnon, Lockwood, and Williams (2004). This method constructs bootstrap confidence intervals for the indirect effects (indirect effect coefficients do not have *p* values because they are tested via bootstrapping and 95% confidence intervals). The data were resampled a total of 1,000 times.

*Descriptive Information*

Table 1 shows the descriptive statistics and correlations for the variables in the study. The continuous measures of stigmatization, internalizing symptoms, and intimacy outcomes showed good variability. As expected, similar types of variables were positively related. The abuse indicators of number of events, duration, having a parent figure perpetrator, and living with the perpetrator at the time of the abuse were positively related to each other, whereas penetration and force were not related to other abuse characteristics. Stigmatization and internalizing symptoms were positively related to each other within and over time. The intimacy problem outcomes were positively related to each other, with a particularly high correlation between being the perpetrator and being the victim of dating aggression (approaching Kline’s, 1998, definition of excessive correlation of  $r = .90$ ). However, we chose to consider each of these indicators of dating aggression separately to be consistent with previous literature and to examine whether there were different pathways to each indicator. No abuse characteristics were related to the  $T_1$  and  $T_2$  indicators of stigmatization or

internalizing symptoms or to subsequent intimacy problems.  $T_1$  and  $T_2$  stigmatization were not related to more of each type of intimacy problem, but  $T_3$  stigmatization was. More  $T_1$  and  $T_2$  internalizing symptoms were related to more sexual difficulties and perpetration of dating aggression. More  $T_3$  internalizing symptoms were related to more intimacy problems.

*Predicting Intimacy Problems From Stigmatization*

To examine the direct pathways from abuse severity to stigmatization to intimacy problems, we estimated the following pathways: (a) the covariates of age at discovery, gender, and six indicators of abuse severity to  $T_1$  stigmatization; (b) the covariates and  $T_1$  stigmatization predicting  $T_2$  stigmatization; (c) the covariates,  $T_1$  stigmatization, and  $T_2$  stigmatization predicting  $T_3$  sexual difficulties and dating victimization and perpetration. Table 2 shows all path coefficients ( $\beta$ ) for the direct effects leading to each endogenous variable, regardless of significance and unstandardized regression coefficients, standard errors, critical ratios, and bootstrap 95% confidence intervals to support inferences for each direct effect. Figure 2 shows the sequence that unfolds from abuse discovery to stigmatization and then to intimacy problems, with the significant direct effects and the variance accounted for in each endogenous variable. In the first step, penetration is the only abuse severity indicator that has a significant unique effect on  $T_1$  stigmatization, such that being penetrated during the abuse is related to higher stigmatization. Next,  $T_1$  stigmatization had a significant effect on  $T_2$  stigmatization, with higher levels at abuse discovery related to higher levels a year later. In the final step of the sequence, the direct effect of  $T_2$  stigmatization on sexual difficulties was significant, such that higher levels of stigmatization a year

Table 1  
*Descriptive Statistics and Correlations Among Study Variables*

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Female	—																
2. Age	0.07	—															
3. Penetration	0.17	0.03	—														
4. No. events	0.06	-0.18	0.04	—													
5. Parent	0.20	0.09	-0.01	0.23	—												
6. Live tog	0.13	0.08	0.06	0.29	0.60	—											
7. Force	0.02	0.13	0.05	-0.16	-0.11	0.00	—										
8. Long dur	0.08	0.03	0.05	0.53	0.22	0.27	-0.06	—									
9. Stigma 1	0.13	0.05	0.19	0.06	-0.08	-0.07	0.03	0.09	—								
10. Stigma 2	0.10	0.01	0.16	0.00	-0.02	0.11	0.05	-0.04	0.43	—							
11. Stigma 3	0.13	0.02	0.04	0.04	-0.01	0.07	0.03	0.16	0.22	0.45	—						
12. Internal 1	0.20	0.19	0.05	0.08	0.07	0.08	0.00	0.13	0.51	0.27	0.26	—					
13. Internal 2	0.21	0.16	0.10	-0.01	0.07	0.13	0.12	0.07	0.27	0.57	0.33	0.60	—				
14. Internal 3	0.28	0.01	0.07	0.01	0.07	0.00	0.22	0.18	0.08	0.25	0.61	0.25	0.32	—			
15. Sex prob	-0.06	0.13	0.05	-0.07	-0.07	-0.09	0.19	0.06	-0.02	0.17	0.49	0.20	0.24	0.59	—		
16. Vdate	-0.02	0.23	0.00	-0.16	-0.06	-0.08	0.14	-0.07	0.01	0.14	0.21	0.15	0.14	0.44	0.46	—	
17. Pdate	0.09	0.16	-0.07	-0.08	-0.04	-0.08	0.13	-0.05	0.03	0.15	0.20	0.25	0.22	0.44	0.41	0.88	—
<i>M</i>	0.73	11.35	0.66	0.68	0.36	0.42	0.45	0.42	32.08	20.11	20.65	19.44	15.16	35.03	0.01	2.08	2.14
<i>SD</i>	0.45	2.24	0.48	0.47	0.48	0.49	0.50	0.49	19.15	16.94	15.93	10.05	8.90	20.14	0.89	0.95	1.00

*Note.* All correlations, means, and standard deviations were estimated by maximum likelihood to take missing data into account. Conservatively (on the basis of the listwise deletion sample size of  $n = 91$ ), correlations with an absolute value  $> .20$  are significant at  $p < .05$ . Age = age at abuse discovery; Penetration = penetration during abuse; No. events = number of abuse events (value shows percentage with two or more events); Parent = parent figure perpetrator; Live tog = living with perpetrator at time of abuse; Force = threat of or use of force during abuse (value as a percentage); Long dur = duration of abuse was a year or more; Stigmas 1, 2, and 3 = stigmatization at Times 1, 2, and 3, respectively; Internals 1, 2, and 3 = internalizing symptoms at Times 1, 2, and 3, respectively; Sex prob = Time 3 sexual problems; Vdate = Time 3 victim of dating aggression; Pdate = Time 3 perpetrator of dating aggression.

Table 2  
Structural Equation Model Results for Pathways to Intimacy Problems Through Stigmatization

Variable	Est	SE	Est/SE	$\beta$	95% CIL	95% CIU
Stigma 1 on						
Female	4.690	4.007	1.170	0.109	-3.368	11.824
Age	0.507	0.795	0.638	0.059	-1.195	1.788
Penetration	6.819	3.196	2.134*	0.169	0.997	14.174
No. events	2.336	3.793	0.616	0.057	-5.535	10.287
Parent	-3.312	3.781	-0.876	-0.083	-10.822	5.302
Live tog	-3.314	3.582	-0.925	-0.086	-10.561	3.498
Force	0.741	3.309	0.224	0.019	-6.183	7.570
Long dur	3.213	4.087	0.786	0.083	-5.376	10.966
Stigma 2 on						
Female	1.197	3.000	0.399	0.032	-4.820	7.184
Age	-0.235	0.588	-0.400	-0.031	-1.506	0.952
Penetration	2.113	2.636	0.801	0.059	-3.252	6.911
No. events	-0.440	3.615	-0.122	-0.012	-6.988	7.545
Parent	-3.047	4.461	-0.683	-0.086	-12.934	4.756
Live tog	7.424	4.132	1.797	0.216	-0.197	16.174
Force	0.551	2.706	0.204	0.016	-4.917	5.731
Long dur	-3.900	3.328	-1.172	-0.113	-11.060	4.078
Stigma 1	0.388	0.080	4.823**	0.437	0.213	0.549
Pdate on						
Female	0.237	0.279	0.850	0.106	-0.213	0.672
Age	0.067	0.043	1.544	0.150	-0.027	0.161
Penetration	-0.211	0.219	-0.964	-0.100	-0.670	0.244
No. events	-0.028	0.263	-0.106	-0.013	-0.583	0.493
Parent	0.021	0.295	0.071	0.010	-0.616	0.658
Live tog	-0.261	0.306	-0.853	-0.129	-0.881	0.390
Force	0.201	0.195	1.033	0.100	-0.216	0.615
Long dur	0.025	0.238	0.106	0.012	-0.427	0.529
Stigma 1	-0.004	0.007	-0.515	-0.069	-0.018	0.012
Stigma 2	0.011	0.006	1.837	0.191	-0.002	0.024
Vdate on						
Female	-0.051	0.256	-0.201	-0.024	-0.490	0.445
Age	0.089	0.041	2.201*	0.210	0.006	0.185
Penetration	-0.010	0.199	-0.052	-0.005	-0.449	0.419
No. events	-0.168	0.222	-0.757	-0.082	-0.727	0.266
Parent	0.039	0.279	0.141	0.020	-0.552	0.630
Live tog	-0.209	0.274	-0.765	-0.109	-0.773	0.371
Force	0.175	0.178	0.982	0.091	-0.188	0.534
Long dur	0.030	0.215	0.141	0.016	-0.417	0.468
Stigma 1	-0.004	0.006	-0.646	-0.082	-0.017	0.011
Stigma 2	0.011	0.006	1.876	0.188	-0.002	0.022
Sexual diff on						
Female	-0.145	0.181	-0.801	-0.072	-0.563	0.240
Age	0.049	0.041	1.182	0.122	-0.026	0.128
Penetration	0.081	0.177	0.458	0.043	-0.262	0.433
No. events	-0.113	0.173	-0.655	-0.059	-0.546	0.279
Parent	0.051	0.229	0.222	0.027	-0.450	0.500
Live tog	-0.302	0.248	-1.217	-0.167	-0.746	0.247
Force	0.295	0.169	1.744	0.164	-0.046	0.584
Long dur	0.294	0.197	1.495	0.162	-0.088	0.655
Stigma 1	-0.007	0.005	-1.556	-0.156	-0.017	0.003
Stigma 2	0.013	0.006	2.349*	0.254	0.002	0.024

Note. Est = estimate; CIL and CIU = lower and upper limits of the bootstrap confidence intervals, respectively; Stigmas 1 and 2 = stigmatization at Times 1 and 2, respectively; Age = age at abuse discovery; Penetration = penetration during abuse; No. events = number of abuse events (value shows percentage with two or more events); Parent = parent figure perpetrator; Live tog = living with perpetrator at time of abuse; Force = threat of or use of force during abuse (value as a percentage); Long dur = duration of abuse was a year or more; Pdate = Time 3 perpetrator of dating aggression; Vdate = Time 3 victim of dating aggression; Sexual diff = sexual difficulties.

\*  $p < .05$ . \*\*  $p < .01$ .

after abuse discovery predicted subsequent sexual concerns and dysfunction. We were interested in whether, in addition to these direct effects, earlier abuse and stigmatization had indirect effects on subsequent sexual difficulties. The indirect path from penetra-

tion to  $T_1$  stigmatization, then to  $T_2$  stigmatization, and then directly to sexual difficulties was significant ( $B = 0.035$ , 95% confidence interval [CI] = 0.005–0.121;  $\beta = .019$ ). The indirect path from  $T_1$  stigmatization to  $T_2$  stigmatization and then directly

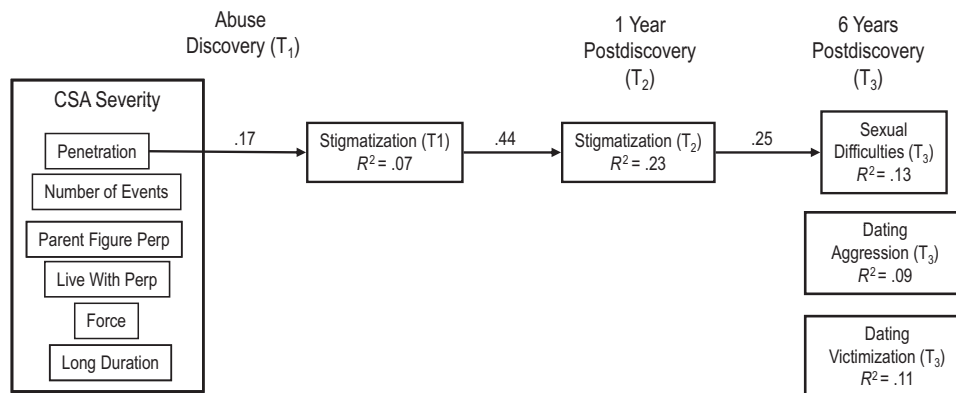


Figure 2. Structural equation model results for predictive pathways to intimacy problems through stigmatization. The figure shows significant pathways with standardized path coefficients.  $T_{1-3}$  = Time 1–3; CSA = childhood sexual abuse; Penetration = penetration during abuse; Number of Events = number of abuse events; Perp = perpetrator; Force = threat of or use of force during abuse; Long Duration = duration of abuse was a year or more.

to sexual difficulties was significant ( $B = 0.005$ , 95% CI = 0.001–0.011;  $\beta = .111$ ). As shown in Figure 2 and Table 2, there were no significant direct effects of  $T_1$  and  $T_2$  stigmatization on being the perpetrator or victim of dating aggression. Indirect effects from earlier stigmatization to dating aggression outcomes also were not significant.

To examine the concurrent effects of  $T_3$  stigmatization on intimacy problems, we expanded the SEM model in the following ways: (a)  $T_3$  stigmatization was included as an additional endogenous variable, and it received direct effects from all variables that had direct effects on  $T_2$  stigmatization as well as received a direct effect from  $T_2$  stigmatization, and (b) for each intimacy problem outcome,  $T_3$  stigmatization was added as an additional direct effect. The direct effect of  $T_3$  stigmatization (concurrent with intimacy problems)—controlling for past stigmatization, age, gender, and abuse characteristics—was significant for the sexual difficulties outcome ( $B = 0.030$ , 95% CI = 0.016–0.041;  $\beta = .53$ ,  $p < .01$ ) and increased the variance accounted for from 13% to 33%. As would be expected, the significant direct effect of  $T_2$  stigmatization on sexual difficulties disappears when  $T_3$  stigmatization is added to the model. However, the persistent effect of earlier stigmatization over time is indicated by the significant indirect effect from  $T_1$  to  $T_2$  to  $T_3$  stigmatization and then to  $T_3$  sexual difficulties ( $B = 0.005$ , 95% CI = 0.002–0.010;  $\beta = .10$ ,  $p < .05$ ). In other words, even when concurrent relations between stigmatization and sexual difficulties are considered, it is clear that there is a predictive pathway from earlier abuse-specific mechanisms to later functioning. There were no significant direct or indirect effects for  $T_3$  stigmatization on dating aggression outcomes.

SEM analyses parallel to those done for stigmatization were conducted to examine internalizing symptom pathways to intimacy problems. There were no significant direct effects from  $T_1$  and  $T_2$  internalizing symptoms to any of the intimacy problem outcomes and no significant indirect pathways. However, the expanded SEM model that included concurrent internalizing symptoms showed that the direct effect of  $T_3$  symptoms was significant for each of the intimacy problem outcomes (after controlling for past internal-

izing symptoms, age, gender, and abuse characteristics). More  $T_3$  internalizing symptoms were associated with the following: more sexual difficulties ( $B = 0.028$ , 95% CI = 0.019 to 0.035;  $\beta = .63$ ,  $p < .01$ ,  $R^2 = .43$ ); more perpetration of dating aggression ( $B = 0.022$ , 95% CI = 0.012–0.032;  $\beta = .44$ ,  $p < .01$ ,  $R^2 = .26$ ); and more victimization ( $B = 0.024$ , 95% CI = 0.016–0.034;  $\beta = .51$ ,  $p < .01$ ,  $R^2 = .29$ ). None of the indirect effects of earlier internalizing symptoms through  $T_3$  symptoms on intimacy problem outcomes were significant. Thus, internalizing symptoms showed correlational relations with intimacy problems, but no predictive pathways from earlier symptoms to later intimacy outcomes were observed.

## Discussion

Using three assessments over 6 years from childhood to early adulthood, we focused this longitudinal study on mechanisms that explain how youth with CSA histories become at risk for sexual difficulties and dating aggression. Unlike much of the previous literature, the SEM analyses used to examine our conceptual model distinguished between mechanisms that showed predictive (direct and indirect effects from earlier to later time points) and correlational (concurrent associations within time) relations with intimacy problems. Stigmatization was found to operate as a predictive mechanism for subsequent sexual difficulties. Internalizing symptoms were not predictive of romantic intimacy problems, although they did show correlational relations with sexual difficulties and dating aggression.

This study provides support for conceptualizations that propose that the effects of CSA on romantic intimacy problems are a function of stigmatization (Feiring, Taska, & Lewis, 1996; Finkelhor & Browne, 1985; Kallstrom-Fuqua et al., 2004). Abuse-specific stigmatization, more than abuse severity, explained which youth were at risk for sexual difficulties. Our findings extend previous work by demonstrating long-term effects of self-related processes specific to sexual abuse on later sexual anxieties and risk behavior. In contrast to sexual problems, dating aggression was not predicted by earlier stigmatization. While more power may have

detected significant associations, our findings suggest the operation of domain-specific effects in which early disruptions of the self related to sexuality put individuals at risk for the development of problems within this domain. Even after controlling for the effect of  $T_3$  stigmatization on sexual difficulties, there was a persistent indirect effect of earlier stigmatization on subsequent problems. Although the amount of variance accounted for by predictive variables was moderate (J. A. Cohen, 1988), the demonstration of distal effects over several years' time on sexual difficulties suggests the potentially important role of shame and self-blame for the development of distorted sexual views and behaviors.

Abuse-specific stigmatization and distorted feelings and beliefs about the self during nonconsensual sex may carry over to negative self-views about sexual feelings and behaviors during consensual sex. Sexual development is challenging even without the experience of CSA (Bukowski, 1992; Simon & Feiring, 2008). It requires the synthesis of many aspects of the self and interpersonal relationships, such as changing views about the body and the experience of erotic feelings; learning about intimacy through interaction with peers; and sorting through conflicting messages from family, peers, and the media about the risks and benefits of sexual engagement (Tolman, 2002). Self-blame and shame reflect ways in which the experience of CSA can disrupt the development of a positive sexual self-schema (Meston et al., 2006). For individuals with such abuse-specific distortions of the self-schema, the development of coherent sexuality becomes substantially more difficult.

Internalizing symptoms did not operate as a predictive mechanism of intimacy outcomes; however, consistent with previous literature, concurrent relations were observed (Messman-Moore & Long, 2000; Meston et al., 2006; Noll et al., 2003; Wekerle et al., 2001; D. A. Wolfe et al., 2004). Although most of the existing literature is cross-sectional, one longitudinal study on a community sample of maltreated adolescents found a 1-year cross-time effect for internalizing symptoms on predicting perpetration of dating aggression (D. A. Wolfe et al., 2004). It is possible that the 5-year interval between the  $T_2$  and  $T_3$  assessments in this study was not optimal for detecting such predictive effects. Internalizing symptoms may show more fluctuation over this time interval compared with aspects of the self directly related to CSA, such as stigmatization. During middle adolescence there are significant changes in internalizing symptoms (Garber, Keiley, & Martin, 2002), and the majority of our sample was moving through this developmental period between  $T_2$  and  $T_3$ . We found that, consistent with the idea that the instability of internalizing symptoms over a long time span in adolescence may have diminished the likelihood of finding predictive relations, such symptoms were less stable from the second to the third assessment than was stigmatization (symptoms  $\beta = .21$ , stigmatization  $\beta = .45$ ; estimates obtained by expanding the SEMs to include  $T_3$  stigmatization and internalizing symptoms as endogenous variables).

Failure to find predictive results for internalizing symptoms does not imply they are unimportant for understanding intimacy problems in CSA youth. We can only suggest that they are less likely to be salient for early intervention to address sexual difficulties and dating aggression several years following abuse discovery. Strong concurrent associations between internalizing symptoms and intimacy problems suggest that such symptoms are related to worrying about and being dissatisfied with sexual inti-

macy and negative responses during conflicts including dating aggression. From a social-cognitive perspective, CSA youth with PTSD and depressive symptoms should approach romantic interactions with a heightened tendency to interpret their partners' ambiguous behavior as threatening and belligerent (Bugental & Shenum, 2002; Kim & Capaldi, 2004). This should be particularly true in relationships that are similar to past abusive experiences in their intensity of emotion and sexual involvement. Nevertheless, it must be acknowledged that, in the absence of predictive relations, internalizing symptoms may be caused by or at least exacerbated by intimacy problems.

Although the findings from this study address long-term prediction of intimacy problems, limits to the results are acknowledged. Given the nonexperimental nature of the data, the findings are not conclusive concerning causal direction and rely exclusively on self-report methodology. As suggested previously, the opportunity to observe patterns of prediction from stigmatization and internalizing symptoms to intimacy problems was restricted by the considerable time gap between the second and third assessments. Determination of whether the predictors of interest would contribute to change in intimacy problems over time was precluded by not having earlier indicators of such problems. The measures of intimacy did not include more positive indicators of relationship skills and satisfaction. A more complete assessment of intimacy problems should include both positive and negative aspects of close relationships as well as reports from intimate partners. The external validity of the study is limited to individuals for whom the abuse was reported to the appropriate authorities. Nevertheless, this study is among the few to examine and find long-term effects of abuse-specific processes on intimacy problems by using data from multiple time points on confirmed cases of abuse.

The current findings highlight the clinical significance of longitudinal research that identifies mechanisms by which sexually abused youth become vulnerable to later intimacy problems. Whereas linking abuse characteristics to risk helps identify vulnerable youth, identifying risk mechanisms highlights psychological processes that may be amenable to clinical intervention. Our results indicate that sexually abused youth who experience persistent abuse-specific shame and self-blame may later encounter difficulties in sexual functioning. Such findings are promising because they suggest that early interventions that target youths' cognitive and emotional processing of the abuse may not only alleviate concurrent distress but also prevent subsequent sexual problems. Trauma-focused cognitive-behavioral therapy is more effective than other forms of child-centered therapy in reducing self-blame attributions, shame, and symptoms such as PTSD and depression (J. A. Cohen, Mannarino, & Deblinger, 2006).

A longitudinal approach to identifying risk mechanisms can also discriminate between mechanisms that predict and those that co-occur with intimacy problems and hence inform the timing and content of intervention strategies. For example, both internalizing symptoms and stigmatization warrant early clinical attention, as their associated distress can persist for years following abuse discovery. However, our results suggest that interventions focused on the reduction of internalizing symptoms, at least early on, may be insufficient for treating or preventing sexual difficulties or dating aggression. In contrast, the persistent effects of abuse-specific stigmatization on later sexual functioning suggest that trauma-focused therapies may be important in the prevention of

later intimacy problems. Useful strategies include those that promote adaptive skills for processing and coping with the abuse, address concerns about body function and integrity, and provide age-appropriate education about sexual thoughts and feelings (J. A. Cohen et al., 2006). To the extent that sexual problems are linked to sexual risk behavior, early intervention efforts that target stigmatization may help reduce subsequent risk for HIV and sexually transmitted infections among adolescents and adults with sexual abuse histories (Cunningham, Stiffman, Dore, & Earls, 1994). Sexual problems speak not only to poor sexual health but also to relationship difficulties, which themselves can be a significant source of distress. Reducing abuse-specific stigmatization may help youth develop healthier sexuality that not only mitigates the risk of infection and sexual dysfunction but also promotes more satisfying and intimate romantic relationships.

### References

- Allison, P. D. (2002). *Missing data* (Sage University Papers Series on Quantitative Applications in the Social Sciences, No. 07-136). Thousand Oaks, CA: Sage.
- Arata, C. M. (2000). From child victim to adult victim: A model for predicting sexual revictimization. *Child Maltreatment, 5*, 28-38.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.
- Briere, J. (1995). *Trauma Symptom Inventory: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Briere, J., Elliott, D. M., Harris, K., & Cotman, A. (1995). Trauma Symptom Inventory: Psychometrics and association with childhood and adult victimization in clinical samples. *Journal of Interpersonal Violence, 10*, 387-401.
- Brown, B. B., Feiring, C., & Furman, W. (1999). Missing the love boat: Why researchers have shied away from adolescent romance. In W. Furman, B. B. Brown, & C. Feiring (Eds.), *The development of romantic relationships in adolescence* (pp. 1-16). Cambridge, England: Cambridge University Press.
- Brown, L. K., Lourie, K. J., Zlotnick, C., & Cohn, J. (2000). Impact of sexual abuse on the HIV-risk-related behavior of adolescents in intensive psychiatric treatment. *American Journal of Psychiatry, 157*, 1413-1415.
- Browning, C. R., & Laumann, E. O. (1997). Sexual contact between children and adults: A life course perspective. *American Sociological Review, 62*, 540-560.
- Bugental, D. B., & Shennum, W. (2002). Gender, power, and violence in the family. *Child Maltreatment, 7*, 56-64.
- Bukowski, W. M. (1992). Sexual abuse and adjustment considered from the perspective of normal developmental processes. In W. O'Donohue & J. H. Geer (Eds.), *The sexual abuse of children: Theory and research* (Vol. 1, pp. 261-282). Hillsdale, NJ: Erlbaum.
- Capaldi, D. M., Kim, H., & Shortt, J. (2005). Women's involvement in aggression in young adult romantic relationships: A developmental systems model. In K. L. Bierman & M. Putallaz (Eds.), *Aggression, antisocial behavior, and violence among girls: A developmental perspective* (pp. 223-241). New York: Guilford.
- Cohen, J. A. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.
- Cohen, P., Cohen, J., Aiken, L., & West, S. (1999). The problem of units and the circumstance for POMP. *Multivariate Behavioral Research, 34*, 315-346.
- Coleman, R., & Widom, C. S. (2004). Childhood abuse and neglect and adult intimate relationships: A prospective study. *Child Abuse & Neglect, 28*, 1133-1151.
- Collins, W. A., & Sroufe, L. A. (1999). Capacity for intimate relationships: A developmental construction. In W. Furman, B. B. Brown, & C. Feiring (Eds.), *The development of romantic relationships in adolescence* (pp. 125-147). New York: Cambridge University Press.
- Covert, M., Tangney, J., Maddux, J., & Heleno, N. (2003). Shame-proneness, guilt-proneness, and interpersonal problem solving: A social cognitive analysis. *Journal of Social and Clinical Psychology, 22*, 1-12.
- Cunningham, R. M., Stiffman, A. R., Dore, P., & Earls, F. (1994). The association of physical and sexual abuse with HIV risk behaviors in adolescence and young adulthood: Implications for public health. *Child Abuse & Neglect, 18*, 233-245.
- Cyranowski, J. M., Frank, E., Cherry, C., Houck, P., & Kupfer, D. J. (2004). Prospective assessment of sexual function in women treated for recurrent major depression. *Journal of Psychiatric Research, 38*, 267-273.
- Davis, J. L., & Petretic-Jackson, P. A. (2001). Intimacy dysfunction and trauma symptomatology: Long-term correlates of different types of child abuse. *Journal of Traumatic Stress, 14*, 63-79.
- DiLillo, D., Giuffre, D., Tremblay, G. C., & Peterson, L. (2001). A closer look at the nature of intimate partner violence reported by women with a history of child sexual abuse. *Journal of Interpersonal Violence, 16*, 116-132.
- Feiring, C., & Cleland, C. (2007). Childhood sexual abuse and abuse-specific attributions of blame over six years following discovery. *Child Abuse & Neglect, 31*, 1169-1186.
- Feiring, C., Rosenthal, S., & Taska, L. (2000). Stigmatization and the development of friendship and romantic relationships in adolescent victims of sexual abuse. *Child Maltreatment, 5*, 311-322.
- Feiring, C., & Taska, L. (2005). The persistence of shame following childhood sexual abuse: A longitudinal look at risk and recovery. *Child Maltreatment, 10*, 337-349.
- Feiring, C., Taska, L. S., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame and symptom development following sexual abuse. *Child Maltreatment, 7*, 26-41.
- Feiring, C., Taska, L. S., & Lewis, M. (1996). A process model for understanding adaptation to sexual abuse: The role of shame in defining stigmatization. *Child Abuse & Neglect, 20*, 767-782.
- Feiring, C., Taska, L. S., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attributional style. *Developmental Psychology, 38*, 79-92.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530-541.
- Fleming, J., Mullen, P. E., Sibthorpe, B., & Bammer, G. (1999). The long-term impact of childhood sexual abuse in Australian women. *Child Abuse & Neglect, 23*, 145-159.
- Fletcher, G. J. O., Fitness, J., & Blampied, N. M. (1990). The link between attributions and happiness in close relationships: The role of depression and explanatory style. *Journal of Social and Clinical Psychology, 9*, 243-255.
- Garber, J., Keiley, M., & Martin, N. (2002). Developmental trajectories of adolescents' depressive symptoms: Predictors of change. *Journal of Consulting and Clinical Psychology, 70*, 79-95.
- Gilbert, P., Allan, S., & Goss, K. (1996). Parental representations, shame, interpersonal problems, and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy, 3*, 23-34.
- Gladstone, L., Parker, G., Mitchell, P., Malhi, G., Wilhelm, K., & Austin, M. (2004). Implications of childhood trauma for depressed women: An analysis of pathways from childhood sexual abuse to deliberate self-harm and revictimization. *American Journal of Psychiatry, 161*, 1417-1425.
- Kallstrom-Fuqua, A. C., Weston, R., & Marshall, L. L. (2004). Childhood

- and adolescent sexual abuse of community women: Mediated effects on psychological distress and social relationships. *Journal of Consulting and Clinical Psychology*, *72*, 980–992.
- Kim, H., & Capaldi, D. M. (2004). The association of antisocial behavior and depressive symptoms between partners and risk for aggression in romantic relationships. *Journal of Family Psychology*, *18*, 82–96.
- Kline, R. B. (1998). *Principles and practice of structural equation modeling*. New York: Guilford Press.
- Kovacs, M. (1985). The Children's Depression Inventory (CDI). *Psychopharmacology Bulletin*, *21*, 995–998.
- Liem, J., & Boudewyn, A. (1999). Contextualizing the effects of childhood sexual abuse on adult self and social functioning: An attachment theory perspective. *Child Abuse & Neglect*, *23*, 1141–1157.
- MacKinnon, D. P., Lockwood, C. M., & Williams, J. (2004). Confidence limits for the indirect effect: Distribution of the product and resampling methods. *Multivariate Behavioral Research*, *39*, 99–128.
- McClellan, J., McCurry, C., Ronnei, M., Adams, J., Eisner, A., & Storck, M. (1996). Age of onset of sexual abuse: Relationship to sexually inappropriate behaviors. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*, 1375–1383.
- Messman-Moore, T. L., & Long, P. J. (2000). Child sexual abuse and revictimization in the form of adult sexual abuse, adult physical abuse, and adult psychological maltreatment. *Journal of Interpersonal Violence*, *15*, 489–502.
- Meston, C., Rellini, A. H., & Heiman, J. R. (2006). Women's history of sexual abuse, their sexuality, and self-schemas. *Journal of Consulting and Clinical Psychology*, *74*, 229–236.
- Miller, B. C., Monson, B. H., & Norton, M. C. (1995). The effects of forced sexual intercourse on white female adolescents. *Child Abuse & Neglect*, *19*, 1289–1301.
- Morrill, A. C., Ickovics, J. R., Golubchikov, V. V., & Beren, S. E. (1996). Safer sex: Social and psychological predictors of behavioral maintenance and change among heterosexual women. *Journal of Consulting and Clinical Psychology*, *64*, 819–828.
- Muthén, L. K., & Muthén, B. O. (1998–2006). *Mplus user's guide*. Los Angeles: Muthén & Muthén.
- Noll, J. G., Trickett, P. K., & Putnam, F. W. (2003). A prospective investigation of the impact of childhood sexual abuse on the development of sexuality. *Journal of Consulting and Clinical Psychology*, *71*, 575–586.
- Quiggle, N., Garber, J., Panak, W., & Dodge, K. A. (1992). Social information processing in aggressive and depressed children. *Child Development*, *63*, 1305–1320.
- Rohde, P., Noell, J., Ochs, L., & Seely, J. (2001). Depression, suicidal ideation and STD-related risk in homeless older adolescents. *Journal of Adolescence*, *24*, 447–460.
- Rudolph, K., Hammen, C., & Burge, D. (1997). A cognitive-interpersonal approach to depressive symptoms in preadolescent children. *Journal of Abnormal Child Psychology*, *25*, 33–45.
- Saylor, C. F., Finch, A. J., Spirito, A., & Bennett, B. (1984). The Children's Depression Inventory: A systematic evaluation of psychometric properties. *Journal of Consulting and Clinical Psychology*, *52*, 955–967.
- Shirk, S. (1998). Interpersonal schemata in child psychotherapy: A cognitive-interpersonal perspective. *Journal of Clinical Child Psychology*, *27*, 4–16.
- Simon, V. A., & Feiring, C. (2008). Sexual anxiety and eroticism predict the development of sexual problems in youth with a history of sexual abuse. *Child Maltreatment*, *13*, 167–181.
- Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford Press.
- Testa, M., VanZile-Tamsen, C., & Livingston, J. (2005). Childhood sexual abuse, relationship satisfaction, and sexual risk taking in a community sample of women. *Journal of Consulting and Clinical Psychology*, *73*, 1116–1124.
- Tolman, D. L. (2002). *Dilemmas of desire: Teenage girls talk about sexuality*. Cambridge, MA: Harvard University Press.
- Turner, C. F., Ku, L., Rogers, S. M., Lindberg, L. D., Pleck, J. H., & Sonenstein, F. L. (1998, May 8). Adolescent sexual behavior, drug use, and violence: Increased reporting with computer survey technology. *Science*, *280*, 867–873.
- Vigil, J., Geary, D., & Byrd-Craven, J. (2005). A life history assessment of early childhood sexual abuse in women. *Developmental Psychology*, *41*, 553–561.
- Wekerle, C., & Wolfe, D. (1999). Dating violence in mid-adolescence: Theory, significance, and emerging prevention initiatives. *Clinical Psychology Review*, *19*, 435–456.
- Wekerle, C., Wolfe, D. A., Hawkins, D. L., Pittman, A.-L., Glickman, A., & Lovald, B. E. (2001). Childhood maltreatment, posttraumatic stress symptomatology, and adolescent dating violence: Considering the value of adolescent perceptions of abuse and a trauma mediational model. *Development and Psychopathology*, *13*, 847–871.
- West, C. M., Williams, L. M., & Siegel, J. A. (2000). Adult sexual revictimization among black women sexually abused in childhood: A prospective examination of serious consequences of abuse. *Child Maltreatment*, *5*, 49–57.
- White, H., & Widom, C. (2003). Intimate partner violence among abused and neglected children in young adulthood: The mediating effects of early aggression, anti-social personality, hostility, and alcohol problems. *Aggressive Behavior*, *29*, 332–345.
- Widom, C. S. (1999). Posttraumatic stress disorder in abused and neglected children grown up. *American Journal of Psychiatry*, *156*, 1223–1229.
- Wolfe, D. A. (1999). *Child abuse: Implications for child development and psychopathology* (2nd ed.). Thousand Oaks, CA: Sage.
- Wolfe, D. A., Scott, K. S., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., & Straatman, A.-L. (2001). Development and validation of the Conflict in Adolescent Dating Relationships Inventory. *Psychological Assessment*, *13*, 277–293.
- Wolfe, D. A., Wekerle, C., Reitzel-Jaffe, D., & Lefebvre, L. (1998). Factors associated with abusive relationships among maltreated and non-maltreated youth. *Development and Psychopathology*, *10*, 61–85.
- Wolfe, D. A., Wekerle, C., Scott, K., Straatman, A., & Grasley, C. (2004). Predicting abuse in adolescent dating relationships over 1 year: The role of child maltreatment and trauma. *Journal of Abnormal Psychology*, *113*, 406–415.
- Wolfe, V. V., Gentile, C., Michienzi, T., Sas, L., & Wolfe, D. A. (1991). The Children's Impact of Traumatic Events Scale: A measure of post-sexual abuse PTSD symptoms. *Behavioral Assessment*, *13*, 359–383.

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