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Relationship of Child Sexual Abuse Survivor Self-Perception of Consent to Current Functioning

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**Relationship of Child Sexual Abuse Survivor Self-Perception of Consent to Current
Functioning**

By

Nathan R. Daly M.S.

A Dissertation Presented to the College of Psychology
of Nova Southeastern University
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

NOVA SOUTHEASTERN UNIVERSITY

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DISSERTATION APPROVAL SHEET

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ABSTRACT

In 1998 Rind, Tromovitch and Bauserman conducted a meta-analysis using a college sample which challenged the prevailing belief that childhood sexual abuse (CSA) has inherent deleterious effects. Resultantly, the authors proposed alternative terminology (e.g., child-adult sex), without adequate investigation into what distinguishes child-adult sex from CSA. In response, the current study investigated the relationship between CSA, consent and adult functioning in a college sample. The sample consisted of 297 undergraduate college students, ranging in age from 18 to 63-years-old. Data was collected at a mid-sized university in the southeastern United States. The measures utilized in the study include the Symptom Checklist-90 Revised (SCL 90-R), Characteristics of First Sexual Experiences and Demographics Survey, Family Adaptability and Cohesion Evaluation Scale-Second Edition (FACES-II), and the Derogatis Interview for Sexual Functioning-Revised (DISF-R). Proposed questions were, 1) prevalence of CSA in the college sample 2) the effect of CSA status and consent on the outcome measures and 3) differences in consent between the CSA and non-CSA groups. The findings were that approximately 10% of the sample reported experiencing CSA, that sexual orientation (e.g., SCL 90-R) and perceived consent of the sexual experience (e.g., SCL 90-R and FACES-II) were the only variables that significantly impacted outcomes scores, and that participants in the CSA group were significantly more likely to report being victimized in their first sexual experiences. These results suggest that based on CSA status, a college sample does not exhibit significant deficits in psychological functioning or family environment and may not be comparable to samples of CSA survivors in the general population.

Statement of Original Work

I declare the following:

I have read the Code of Student Conduct and Academic Responsibility as described in the Student Handbook of Nova Southeastern University. This dissertation represents my original work, except where I have acknowledged the ideas, words, or material of other authors.

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CHAPTER 1: Review of the Literature and Problem

Rind, Tromovitch, and Bauserman (1998) conducted a meta-analysis in which they challenged the prevailing notion of sexual acts between children and adults as inherently abusive. A core component of their argument was the contention that such interactions can only be considered abusive to the extent that they can be demonstrated to cause lasting psychological harm. They further argued that a dysfunctional family environment confounded sexual abuse and that therefore it was likely that observed differences in psychological adjustment were attributable to family environment rather than sexual abuse. They therefore contended that it is “unscientific” to label these encounters abusive, and that a more accurate designation would be “child-adult sex.”

Following the publication of Rind et al.’s meta-analysis (1998), spurious debate ensued regarding the validity of the findings, and their application to legislation, mental health practice, and judicial ruling. The article was endorsed by the National Man/Boy Love Association (NAMBLA), an organization that advocates for adolescent and teenage males to engage in sexual interactions with adult males. The article was also cited in a legal case (*State v. Steward*, 1999) in which the defense used the findings to argue for a lesser sentence for an adult who had sex with a child. However, the United States House of Representatives and the United States Senate, for the first time in the history of the U.S., formally denounced the findings of Rind et al.’s (1998) meta-analysis (Dallam, Cepeda- Bennito, Kraemer, Gleaves, Silberg, & Spiegel, 2001; Ondersma, Berliner, Chaffin, Cordon, & Goodman, 2001). While popular media and the U.S. legislative branch responded with a resounding disapproval, there were mixed reviews in the scientific community. Some respondents viewed Rind et al.’s (1998) findings as grossly misrepresented and artfully crafted, while others found the results to provide sound scientific

inquiry, warranting further exploration (Dallam et al., 2001; Lilenfeld, 2002; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993; Oellerich, 1998; Ondersma et al., 2001; Whittenburg, Paradis Tice, Baker, & Lemmey, 2002, Rind et al., 2001).

Prior to their 1998 meta-analytic publication in *Psychological Bulletin*, Bauserman and Rind published an article review of nonclinical literature in the journal *Archives of Sexual Behavior* in 1997. The review intended to distinguish the impact of CSA sex relationships by comparing male children to female children, with the researchers hypothesizing that male children are more likely to experience sexual interactions with adults as neutral or positive. This hypothesis emerged from research that reported male participants expressing more “positive reactions” than females to their first experience of intercourse (Darling, Davidson, Passarello, 1992), with males being more likely to view their first sexual experience as “sexual initiation” while females were more likely to endorse that it constituted “sexual violation (Fritz, Stoll, & Wagner, 1981). The hypothesis proposed in Bauserman and Rind’s (1997) review of nonclinical literature introduced their contentions that would be more pointedly addressed in Rind, Bauserman, and Tromovitch’s (1998) “A Meta-Analytic Examination of Assumed Properties of Child Sexual Abuse Using College Samples.”

The meta-analysis consisted of 36 published studies, 21 unpublished dissertations, and 2 unpublished master’s theses, 59 studies in total. Studies included in the meta-analysis (a) contained a control group that included students reporting no CSA experiences; (b) used a distinct CSA group, rather than a general “abused” group that could include participants without a history of CSA; (c) reported on at least one of the 18 outcome symptoms identified by the authors (e.g., alcohol problems, anxiety, depression, dissociation, etc.); and (d) provided sufficient data to compute one or more effect sizes.

Support for Child-Adult Sex

Rind et al. (1998) concluded that college-enrolled women and men who were sexually abused in childhood reported different experiences of CSA. Specifically, men were more likely to view their CSA experiences as a positive event (i.e., an adventure or curiosity satisfying experience), whereas women construed CSA as invasive, fear inspiring, confusing, and embarrassing (Rind et al., 1998). Rind et al. posited that a contributing factor to gender differences in perceptions of child adult sex was that girls may have viewed their sexual experience as more damaging because girls were more likely to experience intrafamilial CSA and CSA at younger ages. Additionally, based on their operational definitions of consent Rind et al. (1998) reported male survivors to be more likely to view their CSA as “willing and unwanted sex” (e.g., termed consent) and women to view their CSA as “unwanted sex only” (e.g., termed non-consenting).

Their second primary conclusion was that wide-scale psychological harm was not prevalent in the meta-analytic sample. They reported that two-thirds of men sexually abused in childhood and one-fourth of women reported neutral or positive reactions. Their operational definitions of “neutral” or “positive” reactions differed depending on the study included in the meta-analysis. However, a comprehensive definition of “neutral” came from self-reports of survivors who viewed their current functioning to not be directly impacted by CSA, and “positive” came from self-reports of survivors who viewed CSA as having a positive outcome on their current functioning.

Finally, the meta-analytic findings suggested that family environment explained nine times the variance in adjustment compared to CSA alone, which Rind et al. (1998) interpreted as indicating that family environment was a key factor in predicting outcomes of CSA survivors.

They also reported that family problems preceded CSA rather than following it. Although survivors of incestuous CSA were removed from the sample, the authors noted that in cases of intrafamilial CSA, CSA may be more likely to cause family dysfunction and not be applicable to the current findings. The significant role of family environment, compared to solely CSA, highlighted the authors' hypothesis that CSA was not an accurate predictor of negative outcomes.

Based on these findings, Rind et al. (1998) called for reconsideration of the use of the term *abuse* when studying CSA sexual interactions. The article stated that abuse implies causation of harm to an individual, and the conclusions of their meta-analysis contradict the implicit moral belief that CSA interactions are always harmful and therefore always abusive. Consequently, they advocate that the more neutral term "adult-child sex" be adopted as more scientific than the term CSA, which presumes that sex between adults and children is harmful. Rind et al. (1998) suggested that future research focus on the child's willingness to participate in the sexual interaction with an adult, and his or her reactions to the experience. CSA would then only be considered an accurate designation if a young person felt s/he did not freely participate in sex that occurred with an adult and if negative psychological consequences were experienced

Reactions in the Scientific Community

In response to Rind et al.'s (1998) meta-analytic review there were a handful of published rebuttals and commentaries whose contentions challenged the interpretations of Rind et al. (1998). For example, Whittenburg et al. (2002) viewed Rind et al.'s (1998) meta-analytic approach as deviating from typical scientific practice. Specifically, Rind et al. (1998) identified four common beliefs; CSA causes harm, this harm is pervasive in the population of persons with a history of CSA, this harm is likely to be intense, CSA is an equivalent experience for boys and

girls in terms of negative impact, and proceeded to dispute their significance, rather than stating a clear hypothesis, testing it, and specifying directions for future research.

Ondersma and colleagues (2001) stated “our deeper concerns-like those of many-lie less with the data than with their presentation” (p. 708). They went on to comment that Rind et al. (1998) made assertions that went well beyond their conclusions, that if CSA was not demonstrably “harmful” then there were instances in which it was appropriate for an adult to engage in sexual behavior with a child.

Magnitude of Effect Sizes

A primary source of contention was the small magnitude of gender-related effect sizes of CSA-outcomes reported by Rind et al. (1998). Dallam et al. (1998) referenced Rind et al.’s claim that there was gender-based differences in maladjustment. They pointed out, however, based on their own moderator analysis, that the effect sizes for gender-based maladjustment of .07 for men and .10 for women were non-significant, contradicting the alleged significant gender differences reported by Rind and colleagues. Furthermore, Dallam et al. identified that if Rind et al. had corrected for base rates they would increase the male effect size from .07 to .10, making it equivalent to the female effect size. Dallam et al. therefore concluded that Rind et al.’s (1998) claims regarding gender differences were not supported by the data.

Contrarily, Ondersma et al. (2001) cited Cohen (1988) to convey that small effect sizes (e.g., $r = .10$) can still have massive personal and societal costs when the phenomena are prevalent (e.g., CSA). They went on to reference a major study assessing the effects of aspirin in preventing heart attacks, which yielded a small effect size (e.g., $r = .03$) that resulted in half as many heart attacks in the experimental group as in the placebo group. In conclusion, Ondersma and colleagues (2001) reiterated that they did not take concern with the effect sizes reported by

Rind et al. (1998), but rather with the strategic interpretation of data-based research to advocate for a preconceived belief regarding the harmlessness of CSA.

Limitations of a College Sample

Rind et al. (1998) argued that college samples were “useful for addressing questions regarding the general population because about 50% of U.S. adults have some college exposure.” Despite this claim, rebuttal articles and commentaries took issue with the generalizability of a college sample to the general community. For example, Dallam et al. (1998) noted that the use of a college sample offers advantages in terms of accessibility but limited the generalizability of the study’s findings, as those who have attended college are a younger and more well-adjusted subset of the larger population of adult CSA survivors.

Whittenburg, et al. (2002) explained that those who endorsed CSA experiences were separated into mutually exclusive groups of negative or neutral and positive. Rind et al. (1998) excluded the most severe clinical and legal cases, because they considered them to be outliers unrepresentative of the general CSA population. However, Whittentburg et al. (2002) analyzed Rind et al.’s three national samples and the colleges samples using a nonparametric chi-squared test and found that there were sizable gender differences in the national sample in the type of CSA experienced. In the national sample, contact and penetrative forms of CSA were more common among men, while non-contact forms of CSA (e.g., fondling) were more common among women. Whittenburg et al.’s primary intention in presenting these results was to convey that college samples are not representative of the CSA population as a whole. Their analysis suggested that if anything the types of CSA reported by men were more rather than less invasive than those reported by women, the opposite pattern of that contended by Rind et al.

Additionally, Ondersma, et al. (2001) expressed concern with the broad conclusions drawn by Rind and colleagues (1998) using solely a college sample. Ondersma and colleagues posited that despite similarities in effect sizes between college samples and three meta analyses of broader samples, results yielded from a college sample may conceal risks for subgroups experiencing psychopathology. Ondersma et al. also stated that the global analyses utilized by Rind et al. (1998) could obscure the effects of CSA for subgroups that are more severely impacted (e.g., those experiencing psychopathology).

Measuring Psychological Adjustment

Another area of methodological criticism was Rind et al.'s (1998) definition and codification of "maladjustment." Rind et al. (1998) examined 18 symptoms to assess for "maladjustment" in their college sample of CSA survivors. The 18 symptoms were added and averaged to create a single maladjustment variable, and on this basis, they concluded that abused individuals did not have significantly worse outcomes as compared to non-abused individuals. However, Dallam et al. (1998) re-examined Rind et al.'s (1998) data set, and rather than looking at an average score of maladjustment, individually examined the 18 symptoms. They found that abused students were less well-adjusted than controls on 17 of the 18 symptoms. Dallam et al. (1998) viewed the original method of analysis as having resulted in an underestimation of the level of adjustment because the 18 symptoms did not perfectly overlap to create one unitary construct of "maladjustment." For this reason, Dallam et al. (1998) found Rind et al.'s (1998) averaging of symptoms to be an inappropriate means of statistical analysis.

Spiegel (2000) also criticized Rind et al.'s (1998) measurement of "maladjustment" by stating that CSA survivors have a tendency to show a subset of all possible symptoms, meaning that CSA survivors maladjustment may be characterized by subthreshold symptomatology across

diagnostic criteria as opposed to within a single category. Additionally, Spiegel noted that the abuse-specific outcome of posttraumatic stress disorder (PTSD) was not included in the list of dependent measures. Finally, Ondersma and colleagues (2001) declared that in solely using mental health symptoms (i.e. psychological adjustment) to operationally define “harm” Rind et al. (1998) did not adequately define or assess the “harm” of CSA, as harm could also be defined by social and economic variables.

Consent

An integral component of Rind et al.’s (1998) conclusion of gender differences in adjustment hinged upon the moderating impact of consent. Rind et al.’s findings aimed to show that males in a nonclinical population were more likely to view their CSA experiences as positive or neutral and were therefore less maladjusted due to their willingness to engage in sexual relations with adults.

Dallam et al. (1998) strongly advised caution in interpreting these findings, as the contention of Rind et al. regarding the role of consent represented an attempt to examine a variable that was not directly measured by most of the studies included in the meta-analysis. In order to conduct analyses Rind et al. assumed the variable termed *consent* was attributable in all studies that did not directly instruct participants to report only unwanted sex. Two groups were formed based on this assumption; “unwanted” and “all levels of consent.” Upon review, Dallam et al. (1998) were only able to locate one study that directly asked CSA survivors whether they participated willingly (i.e., directly inquired whether they “consented” to the sexual contact). Once again, Dallam et al. (1998) viewed the means of drawing these conclusions to be misleading and scientifically invalid.

Ondersma et al. (2001), in addressing the issue of the moral standard regarding a child's ability to consent to sex with an adult, cited Finkelhor (1979), who identified two components that must be present in order for an act to be considered consented: "full knowledge of what is being consented to and absolute freedom to accept or decline" (p. 711). Finkelhor therefore stressed that from a moral perspective, regardless of the way in which consent is empirically assessed and coded, children are not mature, knowledgeable or experienced enough to provide informed consent to engage in a sexual act with an adult. The contentions outlined in Dallam et al. (1998) and Ondersma's (2001) rebuttals are valid in that they call into question Rind et al.'s (1998) interpretation of a variable (e.g., consent) that was directly assessed in a minority of studies included in the meta-analysis. However, the rebuttals do not build upon Rind et al.'s conclusions with proposed methodology for exploring the "consent" variable, which perpetuates the cycle of fruitless debate.

Family Environment

Dallam et al. (1998) commented on Rind et al.'s (1998) argument that the psychological difficulties exhibited by individuals with a history of CSA were more likely attributable to family environment than to CSA itself. Dallam et al. argued that CSA was measured as a dichotomous variable (e.g., participants were either sexually abused or they were not sexually abused) while family dysfunction was measured as a continuous variable by a validated measurement (e.g., Family Environment Scale; Moos & Moos, 1986). Dallam et al. asserted that the predictive validity of continuous variables (e.g., family environment) compared to a single dichotomous variable (e.g., CSA) could lead to an unfounded attribution of significance, in favor of the continuous variable. While Dallam and colleagues' assertions, about the methodology of the studies utilized by Rind et al., are accurate they fail to acknowledge that CSA is measured

incongruently across the literature and it is common to find CSA measured dichotomously in contemporary literature. The measurement of CSA severity has been a point of contention and Dallam et al. do not provide adequate evidence to support their critique of the methodology used by studies cited in the meta-analysis.

Ondersma et al. (2001) viewed the use of self-report and retrospective designs as hazardous, as family environment can be a risk factor, a correlate, and an outcome of CSA. Ondersma et al. pointed out that although the studies utilized in the meta-analysis measured family environment and applied covariance analysis, they neglected to address alternate interpretations on the role of family environment (e.g., CSA leading to more negative assessments of family environment). The implications and interpretations of family environment on symptom outcome are undoubtedly complex and receive additional attention in the Mediating Role of the Family Environment section of the current paper.

Additional Methodological Concern

Other areas of methodological concern existed in the means for assessing interrater reliability. The interrater reliability in Rind et al.'s (1998) study was 85% to 100%, but all disagreements were resolved by discussion. Whittenburg et al. (2002) expressed concern with this approach, as the two authors coding the cases likely shared similar attitudes towards CSA. For that reason, Whittenburg et al. did not view the interrater judgments to be truly independent. The coders also neglected to acknowledge the complex and diverse responses to CSA, by sorting participants into mutually exclusive groups (e.g. negative or neutral and positive). Finally, Whittenburg et al. felt it was dangerous to not consider those in the positive group to be displaying a coping strategy in response to CSA that could lead to failed interpersonal relationships. For example, a child who perceived CSA positively may be identifying with the

perpetrator or idealizing the perpetrators intentions in an attempt to integrate a developmentally inappropriate experience. In subsequent interpersonal experiences the child may utilize these perceptions to relate, which could lead to a repetition compulsion of abusive dynamics. The theory supporting repetition compulsion posits that children who experienced abuse develop into adults who seek to master the abusive experiences by reenacting them in interpersonal relationships. For an adult functioning under the influence of a repetition compulsion their ability to objectively reflect on childhood experiences would be compromised and therefore result in a positivistic belief about the experience.

Ondersma et al. (2001) highlighted that the way in which CSA was defined by Rind et al. (1998) may have had a major impact on their findings. Ondersma and colleagues (2001) provided the following as a commonly held operational definition of CSA: “an age differential (typically 5 years), the use of coercion, a negative reaction on the part of the child, abuse perpetrated by an authority figure, and abuse involving physical contact or penetration” (p. 710). They acknowledged that varying definitions exist across the literature, but that by including relatively low-intensity non-contact sexual experiences and not differentiating them from much more invasive experiences involving penetration, Rind et al. (1998) may have underestimated the degree of maladjustment found to be associated with a history of CSA.

Mediating Role of the Family Environment

Rind et al. (1998) reported that family environment was a more powerful predictor of psychological adjustment than CSA. Dallam et al. (1998) contested this finding by arguing that dichotomizing CSA as present versus absent and measuring family environment as a continuous variable led to an inaccurate portrayal of the role of family environment. The role of family environment in the psychological adjustment of CSA survivors is a question that has received

inquiry in psychological literature. Nash Hulseley, Sexton, Harralson, & Lambert (1993) and Fassler, Amodeo, Griffin, Clay, & Ellis (2005) have both explored the long-term sequelae of CSA and the mediating role of family environment.

Nash and colleagues (1993) tested the hypothesis that CSA was associated with a broad spectrum of impairment in psychological adjustment, independent of the effects of perceived family environment. Contrary to their hypothesis, the findings suggested that when family environment was included in analyses, CSA was not a significant predictor of psychological adjustment. The authors interpreted these results as an important reminder that when researching CSA, the potentially imbedded pathogenic factors (e.g., social, economic, familial) must be accounted for.

Fassler et al. (2005) investigated long-term outcomes of CSA and compared the contribution of abuse severity versus family environment. Exploration into the impact of family environment has yielded contradictory results in that some research points to no differences in psychological adjustment between CSA survivors and others when controlling for family environment (Higgins & McCabe, 1994), while other research yielded results suggesting that CSA contributes to psychological adjustment after adjusting for family environment (e.g., Merrill, Thomsen, Sinclair, Gold, & Milner, 2001).

The results of the study found that the family environment variables of conflict, expressiveness, and cohesion, as measured by the Family Environment Scale (FES; Moos & Moos, 1981), were incremental predictors of psychological adjustment in adulthood. The results supported an increased focus on CSA survivor's family environments to better understand psychological adjustment in adulthood.

Taken together the findings of Nash et al. (1993) and Fassler et al. (2005) provide support for Rind et al.'s (1998) finding that family environment was a more robust predictor of psychological adjustment than CSA. However, the impact of family environment cannot be so easily isolated, as a family environment characterized by dysfunction can leave a child vulnerable to abuse and childhood abuse can often result in family dysfunction. To exclusively focus on one without considering the impact of the other may result in unfounded conclusions.

Alternative Perspectives

As illustrated above, the scientific communities' response to Rind et al.'s (1998) meta-analysis varied greatly. The articles summarized above represented views of Rind et al.'s interpretations as flawed, and their overall conclusions as questionable. However, this was not the case across disciplines. Oellerich, a professor in the school of Social Work at Ohio University, expressed an alignment with Rind et al.'s (1998) findings and cautioned against the hastiness to assign pathologies to CSA survivors. Oellerich's (2000) article focused on the lack of evidence to support the contention that CSA inevitably results in harm to the child or adolescent, and the importance of distinguishing abusive and non-abusive "adult/non-adult" sexual behavior in both research and practice.

Oellerich (2000) posited that the clear majority of psychological damage resulting from CSA originates from the way in which parents, teachers, medical professionals, law enforcement, and mental health professionals handle the events. Finkelhor (1979) was cited throughout the article, and one time in particular was quoted saying "once the ideology is stripped away, we still remain ignorant about whether sexual abuse in childhood wreaks damage in adult life, and if so, how much" (p. 68)? Additionally, Oellerich cited a review of 25 studies conducted by Conte (1985) that led him to conclude that CSA affected some victims more than others. Oellerich et al.

cited additional studies, each with the purpose of highlighting the inconsistent nature of CSA responses, and the current lack of validity regarding the harmfulness of CSA (Browne & Finkelhor, 1986; Kendall Tackett et al., 1993; Levitt & Pinnell, 1995). Finally, the author called for advocates to discontinue their over exaggeration of the intensity or inevitability of CSA consequences, because their responses and beliefs may exacerbate the effects of CSA.

Oellerich (2000) also echoed Rind et al.'s (1998) sentiment that wrongfulness and harmfulness need to stop being equated in sexual matters. The author expressed that the inappropriate trauma ideology existed with the professional and pitted them against the child or parent who may feel differently. For a childhood sexual experience to be abusive it must involve coercion, threat and/or demonstrable harm (Oellerich, 2000). Subsequently, treatment would only be prescribed for children who exhibit demonstrable harm. Oellerich (2000) acknowledged the political incorrectness of Rind et al.'s study but evaluated their findings as scientifically impactful. The author suggested that researchers and clinicians stop assuming CSA causes psychological harm and routinely recommending psychotherapy for survivors of CSA.

Another published piece in abutment of Rind et al.'s (1998) scientific efforts came from Lilienfeld (2002), who sought to address the social and political implications of Rind et al.'s (1998) seminal meta-analysis. Lilienfeld questioned to what extent scientists in general, and social scientists specifically, are responsible for censoring research findings based on the potential reaction from society as a whole. Additionally, the author applauded Rind et al.'s (1998) inclusiveness by delimiting "clear-cut CSA from consensual sexual events" (p. 182) and using the term child-adult sex.

The premise of Lilienfeld's (2002) position, that quelling scientific inquiry that may contradict cultural norms is counterproductive and potentially harmful to the populations in

question, is based upon the notion that psychologists ought to play a more active role in correcting the logical errors perpetuated by lay people interpreting the potentially misleading findings (e.g., CSA's deleterious impacts). Lilienfeld (2002) argued that psychologists need to take more of a philosopher-scientist approach to thoroughly evaluate the scientific theories that support the treatment hypothesis. He argued that properly explaining the peer review process to the public, through micro level advocacy and macro level explanations by organizations such as the APA, would likely diminish the backlash displayed by media, court-room proceedings and in political settings.

In support of the second premise, Lilienfeld (2002) addressed the criticisms (i.e. in favor and opposition) that Rind et al. (1998) distinguished CSA from their newly proposed term "child-adult sex." Lilienfeld proposed that Rind et al. (1998) introduced the new term, child-adult sex, to address the instances of CSA that are not viewed negatively or do not result in psychological maladjustment. More specifically, the author argued that the term CSA assumes a pathological or deleterious response, and that this assumption results in denial of the possibility that there are people who experienced "child-adult sex" and did not experience negative sequelae. Finally, Lilienfeld (2002) posited that researchers who found fault with Rind et al.'s (1998) terminology need to employ the peer review process and propose alternative terms and provide empirical evidence for the appropriateness of the proposed term.

Rind and Colleagues' Rebuttal (2001)

As controversy and disagreement ensued regarding Rind et al.'s (1998) meta-analysis, Rind and colleagues prepared a rebuttal article published in 2001 that addressed the critiques of Ondersma et al. (2001) and Dallam et al. (1998; Rind, Tromovitch, & Bauserman, 2001). Rind et al. (2001) placed victimology at the core of the argument of those who responded to their

original article (Dallam et al., 1998; Ondersma, 2001; Whittenburg et al., 2002). Rind et al. (2001) posited sexual victimology originated from the 1960's and 1970's feminist movement that sought social and legal reform and held that victimization produces lasting psychological damage (Rind et al., 2001). The victimization viewpoint led to medicalization and therapy for CSA survivors, and became an essential viewpoint of mental health professionals. Rind et al. (2001) opened their rebuttal by acknowledging that their findings were aimed not at refuting that CSA can be harmful, but rather (e.g. to what degree and under what circumstances it is harmful). Their rebuttal hinged on three major points; internal and external validity, the role of family environment, and consent.

The validity of Rind et al.'s (1998) meta-analysis sample was challenged in multiple articles (Dallam et al., 1998; Ondersma et al., 2001; Whittenburg et al., 2002), with specific mention of the generalizability of a college sample (i.e., threat to external validity), removal of the most severe CSA cases/CSA operational definition (i.e., threat to construct validity), and averaging 18 adjustment symptoms into one "maladjustment" construct (i.e. threat to construct validity).

Rind et al. (2001) argued that general conclusions about CSA had been drawn in previous reviews, in which the samples were of mostly clinical and legal survivors, possibly leading to more severe symptom outcomes compared to the general population. The authors also mentioned that they did not present their samples as representative of the general population, but rather that the college data was relevant to the general population based on similarities in prevalence, severity and correlates. To refute Dallam et al.'s (1998) claim, that a college sample of CSA survivors would likely have less severe symptom outcomes compared to the general population, Rind et al. (2001) considered a sample of junior high and high school students. Rind et al. (2001)

stated that if Dallam et al.'s assertions were accurate, then a younger sample (e.g. Junior High and High School Students) would be more reflective of the general population. The findings for emotional/ behavioral problems and prevalence of sexually abused Junior High and High School students were relatively similar to those for the college samples. The authors proposed that secondary analysis on a younger population supported the generalizability and relevance of using a college sample when analyzing prevalence and severity of CSA in a non-clinical population.

Dallam et al. (2001) and Whittenburg et al. (2002) highlighted their concern in removing the most severe cases of CSA and utilizing studies with such broad definitions of CSA (Landis, 1956; Schultz & Jones, 1983; Sedney & Brooks, 1984). In response Rind et al. (2001) stated that the most severe cases, referred to by Dallam et al., were removed solely because they were statistical outliers and that conducting analyses in this way is a common statistical practice (Neumann et al., 1996). Regarding the operational definition of CSA, Rind et al. retorted that CSA definitions vary widely across research literature and the three studies contested by Dallam et al. (e.g., Landis, 1956; Schultz & Jones, 1983; and Sedney & Brooks, 1984) were recognized by many researchers in the field to have assessed CSA appropriately (e.g., Finkelhor, 1979; Fromuth & Burkhart, 1989; Sarbo, 1985). Rind et al. (2001) stated further that while Dallam et al. (1998) called into question their use of studies that incorporated the experiences of 18- and 19-years olds (i.e., legal adults), Dallam et al. also included cases of participants that were ages 18 and 19 in results used to contest those of Rind et al. (1998).

Another area of concern was the findings on family environment and their role in psychological dysfunction. As highlighted above, Rind et al. (1998) treated family environment, statistically, as a continuous variable while treating CSA as a dichotomous variable (Dallam et al., 1998). They concluded that family environment was a primary cause of maladjustment, as

opposed to CSA. Rind et al. (2001) addressed the statistical analysis of family environment by stating that all CSA research statistically treats these variables in the same way and cannot be selectively applied to their study. Further Rind et al. (2001) cited Wisniewski (1990) who utilized a continuous measure of CSA and family environment and the results suggested that family environment was a more powerful predictor of adjustment. Rind et al. (2001) concluded that measuring CSA as a continuous variable did not improve prediction of psychological adjustment over measuring CSA as a dichotomous variable.

The final issue was one of consent, which was raised in multiple response articles (Dallam et al., 1998; Ondersma et al., 2001; Whittenburg et al., 2002). The response articles summarized that Rind et al. (1998) assessed for consent in studies that did not operationally define or specifically ask if the child consented to engage in sexual acts with the adult in question. Rind et al. (2001) addressed this issue by first citing Webster's Third New International Dictionary (1981), which defines consent as "compliance or approval, especially of what is done or proposed by another" (p. 752) This definition is referred to by Rind et al. (2001) as simple consent or willingness and assent, and simple consent does not always mean informed consent. Informed consent is defined as "capable, deliberate and voluntary agreement to or concurrence in some act or purpose implying physical and mental power and free action" (p.752).

Rind et al. stated that informed consent was not implied in their study and that simple consent has been commonly examined in nonclinical research (e.g., Condy et al., 1987; Coxell et al, 1999; Nelson & Oliver, 1998; Rind, 2001; Sandfort, 1992; West & Woodhouse, 1993). Rind et al. (2001) drew distinctions between these definitions stating that informed sexual consent was treated by researchers, specifically those who opposed their findings, as a construct that had been

empirically studied. However, Rind et al. posited that consent is more complex, and requires further research and clarification with regard to distinguishing child-adult sex from CSA.

To summarize, Rind et al. (1998) reported that male survivors of CSA were more likely to view these experiences as positive or neutral than female survivors. Additionally, wide-scale psychological harm was not prevalent in the meta-analytic sample. Finally, the meta-analytic findings suggested that family environment explained nine times the variance in adjustment compared to CSA alone, which Rind et al. interpreted as indicating that family environment was the key factor in predicting outcomes of CSA survivors. Taken together, Rind et al. called for reconsideration of the term *abuse* when studying CSA and utilization of the term child-adult sex in instances when the sexual experience was perceived neutrally or positively by the child.

Upon reflection it has become apparent, in both Rind et al. (1998) and the subsequent rebuttals, that very few questions raised in the meta-analysis have been empirically addressed using a contemporary college sample. Although twenty years have elapsed since, there has not been direct assessment on the role of psychological harm, consent in child-adult sexual interactions, or adequate inquiry into the mediating factors of Rind et al.'s findings on gender differences and family environment.

CHAPTER 2: Method

Procedure

The current study collected data at a mid-sized university in the southeastern United States. Participants were recruited from entry level psychology courses and participants were provided an option of taking part in the study or completing a reading assignment. Those who agreed to take part in the study were provided a consent form explaining that the study aimed to gather information on college students' beliefs about power dynamics in relation to previous sexual experiences, the students psychological and sexual functioning at the time of the survey, and the levels of adaptability and cohesion of their family of origin. Data were collected in the classroom setting.

The primary research questions were as follows: 1) What percentage of the college sample would endorse sexual experiences (e.g., oral, vaginal sex and anal sex) before the age of 18 with someone at least 5 years or more older, 2) Is there a significant difference in the psychological and sexual functioning and family environment of participants who endorsed a sexual experience before the age of 18 with a partner at least five years older compared to participants who either did not endorse a sexual experience before the age of 18 or whose partner was less than five years older, and finally 3) Did participants who endorsed a sexual experience before that age of 18 with a partner at least 5 years older view the sexual experience differently (e.g., then and now) than participants who experienced a sexual encounter with someone before the age of 18 who was not at least 5 years older?

To answer the research questions participants were asked to: (1) provide the age at which they first experienced oral sex, vaginal sex and anal sex; (2) the age of the person with whom the sex act occurred; and (3) whether they considered the sexual encounter consensual (a) at the time

it occurred (e.g., Then), and (b) currently (e.g., Now). These three variables constitute the standard operational definition of CSA. Additionally, these three questions were asked separately to determine which participants met this definition of being CSA survivors. Further, participants completed the Symptom Checklist 90-Revised (SCL 90-R; Derogatis & Unger, 2010) to assess their psychological functioning, the Derogatis Interview for Sexual Functioning-Revised (DISF-R; Derogatis & Melisaratos, 1979) to assess their total level of sexual dysfunction, and the Family Adaptability and Cohesion Evaluation Scale-Second Edition (FACES-II; Olson, Portner, & Bell, 1982) to assess the family environment.

Participants

The sample consisted of 297 undergraduate college students, 83.2% of which were Female ($n = 247$) and 15.8% were Male ($n = 47$). Participants ranged from 18 to 63 years of age ($M = 24.83$, $SD = 7.49$). A majority of the sample was Caucasian (49.5%), with the remainder of the sample identifying as Hispanic (20.9%), African American (13.8%), Other (9.8%), and Asian (4%). Regarding sexual orientation, a majority were Heterosexual (91.9%), with a minority being Bisexual (4%), Lesbian/Gay (1.3%) and Asexual (.3%). A majority of the sample reported the annual income of their family of origin as being between 61,000 and 100,000 (41.4%), while the remainder of the sample reported between 41,000 and 60,000 (22.6%), 21,000 and 40,000 (19.9%), 10,000 and 20,000 (9.4%) and less than 10,000 (3.7%).

Measures

Symptom Checklist 90-Revised (SCL-90-R; Derogatis & Unger, 2010). The SCL 90-R is a ninety-five item self-report instrument that is designed to screen for a vast array of psychological problems and psychopathological symptoms. The SCL 90-R contains nine primary symptom dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression,

anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism) and three global indices (global symptom severity index, positive symptom distress index, positive symptom total). Reported internal consistency and test-retest reliability range from .77 to .90. The internal consistency coefficient for the current sample was .98. The SCL 90-R takes twelve to fifteen minutes to complete. Participants were asked to what degree they were distressed by various symptoms (e.g., headaches, feeling outside of your body, hearing voices that other people do not hear). Items were answered based on a 5-point Likert scale (e.g., 0 = “Not at all” to 4 = “Extremely”).

Characteristics of First Sexual Experience Questionnaire and Demographics.

The characteristics of first sexual experiences questionnaire and demographics form is a twelve-item questionnaire with an attached demographics page (e.g. age, sex, race/ethnicity, socioeconomic status of family of origin, sexual orientation). Questions include, age of first sexual experience (oral sex, vaginal sex and anal sex) and perceptions of first sexual experience at that time (e.g., Then) and currently (e.g., Now). The response options for perception of first sexual experience were as follows: The other person and I freely chose to do it; I was not sure if I wanted to do it, but the other person convinced me to do it; The other person was not sure if he/she wanted to do it; I did not want to do it, but the other person forced me to do it; The other person did not want to do it but I forced her/him to do it; Not applicable. This measure takes approximately five minutes to complete.

Family Adaptability and Cohesion Evaluation Scale – Second Edition (FACES-II; Olson, Portner, & Bell, 1982). The FACES-II is a thirty-item self-report measure that looks at family adaptability and cohesion in one’s family of origin. It contains sixteen measures of cohesion and fourteen measures of adaptability. Reported internal reliability is .91 for cohesion

and .80 for adaptability. This measure takes approximately ten minutes to complete. Sample items: Family members are supportive of each other during difficult times; In solving problems the children's suggestions are followed. Items are answered using a 5-point Likert scale (e.g., 1= "Almost Never" to 5= "Almost Always")

Derogatis Interview for Sexual Functioning- Revised (DISF-R; Derogatis, 1997) The Derogatis measures components that are believed to be crucial to healthy sexual functioning (e.g., drive, body image, sexual satisfaction) as well as general well-being (affects balance and psychological distress). Studies published to date suggest that this measure is highly reliable regarding the construct of sexual functioning. Derogatis & Melisaratos (1997) report internal consistency reliability coefficients based on a sample of 325 between .60 and .97. While test-retest coefficients over a 14-day period ranging from .70 to .90. The majority of studies assessing medical treatment populations concluded that the DISF-R was highly sensitive to naturally occurring and disease-induced interference with sexual functioning. Participants were asked questions regarding sexual cognition/fantasy (e.g., number of times in the past 30 days you had thoughts, dreams or fantasies about a sexually attractive person), sexual arousal (e.g., number of times in the past 30 days did you feel aroused when you were alone), sexual behavior/experiences (e.g., number of times in the past 30 days when you read or viewed romantic or erotic books/stories), orgasm (e.g., number of times in the past 30 days that you were satisfied with your ability to orgasm) and drive/ relationship (e.g., with your partner of choice what would be your ideal frequency of sexual intercourse). Items were answered on an 9-point Likert scale (e.g., 0 = "Not at all" to 8 = "4 or more per day").

CHAPTER 3: Results

Descriptive Statistics

To assess characteristics of the sample, demographic variables were analyzed across the Case group (e.g., sexual experience before the age of 18 with a partner at least 5 years of age or more older) and the Non-Case group (e.g., participants who reported one of the three sexual experiences occurring after the age of 18, or if it did occur before the age of 18 their partner was not at least 5 years older), using a Pearson's Chi-Square test in the case of categorical variables, and independent samples T-test in the case of continuous variables. Differences between Case and Non-Case status were non-significant for the following demographic variables: Age, Sex at Birth and Socioeconomic Status. Significant differences did exist across Case and Non-Case groups in Sexual Orientation and Race. Regarding Sexual Orientation ($\chi^2 = 7.17, p = .07$), the odds of being in the Case group was 6.51 times higher for those who identified as Bisexual relative to Heterosexual participants. Regarding Race ($\chi^2 = 10.23, p < .05$), the odds of being in the case group was 2.3 times higher for African Americans relative to Caucasian participants.

The following figures are the percentages of the sample that indicated: That their first sexual encounter occurred before the age of 18 (Oral sex: 53.9%, $n = 160$; Vaginal sex: 51.9%, $n = 154$; Anal sex: 4.4%, $n = 13$) and those who endorsed that the other person in that encounter was at least five years older at the time (Oral sex: 6.1%, $n = 18$; Vaginal sex: 5.7%, $n = 17$; Anal sex: .3%, $n = 1$).

Table 1 displays the number of participants who reported engaging in sexual activity (e.g., Oral sex, Vaginal sex or Anal sex), whether they engaged in sexual activity before the age of 18 with a partner at least 5 or more years older (e.g., Case group) and those who did not (e.g.,

Non-Case group), and finally their belief about the power dynamics of the sexual act (e.g., Consenting, Victimized, Perpetrated). at the time of the event (e.g., Then) and Now.

Table 1

Type of sexual act, Case status, and perception of the power status of the sexual experience among participants acknowledging having been sexually active at the time of data collection (n = 264)

Sex Act	Consenting		Victimized		Perpetrated	
	Non-case	Case	Non-case	Case	Non-case	Case
<u>Oral Sex</u>						
Belief Then	183	15	43	11	0	1
Belief Now	172	15	52	12	1	0
<u>Vaginal Sex</u>						
Belief Then	183	14	44	12	2	0
Belief Now	175	13	48	13	2	0
<u>Anal Sex</u>						
Belief Then	48	3	30	5	3	0
Belief Now	49	3	30	4	2	1

To further assess the relationship between belief about the power dynamics of the sexual act and Case status, a Chi-Square test was utilized, in which the Perpetrated category was removed from analysis due to an insufficient sample size. The results revealed significant differences between Case group and Non-Case group status for the Oral Sex and Vaginal Sex categories. For participants who reported an Oral Sex experience, those in the Case group were significantly more likely to report being Victimized both Then ($\chi^2 = 6.50, p = .01, OR = 3.09$) and Now ($\chi^2 = 5.16, p = .02, OR = 2.63$) compared to Non-Case group counterparts. Similarly, for participants who reported a Vaginal Sex experience, those in the Case group were significantly more likely to report being Victimized both Then ($\chi^2 = 8.34, p < .01, OR = 3.63$)

and Now ($\chi^2 = 8.93$, $p < .01$, $OR = 3.55$) compared to Non-Case group counterparts. The results for the Anal Sex category could not be assessed due to an insufficient sample size.

Univariate Analyses

The ultimate model conducted was a full factorial Analysis of Variance (ANOVA) investigating the effects of Case group status, two levels (e.g., Case and Non-Case group), belief about the power dynamics of the sexual act, two levels (e.g., Consenting and Victimized) on the following outcome measures: Family Environment (e.g., FACES II), Sexual Dysfunction (e.g., DISF-R) and Global Symptom Severity (e.g., SCL 90-R).

The analyses were conducted in three phases, initial, preliminary-final and final. The variables entered into the initial phase included Case status (e.g., Case and Non-Case), belief about the power dynamics of the sexual act (e.g., Consenting and Victimized), an interaction between Case status and belief and covariates (Sexual Orientation and Race). Analyses were replicated in each phase for belief about the power dynamics of the sexual act Then and Now. The preliminary-final phase differed from the initial phase in that non-significant interactions (e.g. Case by belief) were pruned from analysis. Therefore, the final phase included Case status, belief about the power dynamics of the sexual act and covariates that remained significant in the preliminary-final phase for Global Symptom Severity and Family Environment (refer to Table 2).

Global Symptom Severity. There were two ANOVA models in the final phase of analyses that had a significant effect on Global Symptom Severity. The first included Case status, Belief Then and Sexual Orientation. Of these three variables only the covariate Sexual Orientation was significant. In the second Case status, Belief Now and Sexual Orientation were included. Both Belief Now and Sexual Orientation were significant. The participants who viewed

the sexual experience as Consensual Now ($M = 60.55$, $SD = 4.09$) had significantly lower Global Symptom Severity scores than participants who reported being Victimized ($M = 65.40$, $SD = 4.03$). The magnitude of effect for significant variables was assessed using R-Squared analyses (refer to Table 2). The magnitude of effect for both models was assessed as being small.

Family Environment. Two ANOVA models were produced that contained variables significantly related to Family Environment. The first consisted of the Case status variable and the Belief Then variable, of which only Belief Then was significant. Similarly, the second consisted of the Case status variable and the Belief Now variable, of which only Belief Now was significant. In the first model participants who viewed the sexual experience as Consensual Then ($M = 48.640$, $SD = 2.20$) had significantly higher scores on family adaptability and cohesion than participants who reported being Victimized ($M = 46.87$, $SD = 2.58$). In the second, participants who viewed the sexual experience as Consensual Now ($M = 49.06$, $SD = 2.19$) had significantly higher scores than participants who reported being Victimized ($M = 45.66$, $SD = 2.12$). The magnitude of effect (refer to Table 2) for both Belief Then in and Belief Now was assessed as being small.

Sexual Dysfunction. As reflected in Table 2, the Case Status variable and the consent variables (i.e., Belief Now and Belief Then) did not have a significant effect on sexual dysfunction in the sample.

Table 2

Final Phase: Full Factorial ANOVA with Covariates (n = 264)

Global Symptom Severity				
	DF	F	P	R Squared
Model 1				
Case	1,255	3.01	0.08	0.01
Belief Then	1,255	3.56	0.06	0.01
Sexual Orientation	2,255	6.26	0.00	0.05
Model 2				
Case	1,254	2.98	0.09	0.01
Belief Now	1,254	5.08	0.03	0.02
Sexual Orientation	2,254	6.32	0.00	0.02
Family Environment				
	DF	F	P	R Squared
Model 3				
Case	1,243	0.24	0.62	0.00
Belief Then	1,243	4.99	0.03	0.02
Model 4				
Case	1,242	0.13	0.72	0.00
Belief Now	1,242	8.72	0.00	0.04
Sexual Dysfunction				
	DF	F	P	R Squared
Case	1,241	0.027	0.871	0
Belief Then	1,241	0.028	0.868	0
Case	1,240	0.001	0.976	0
Belief Now	1,240	0.574	0.449	0

CHAPTER 4: Discussion

The current study set out to empirically assess Rind et al.'s (1998) contention that not all sex between children and adults can be presumed to constitute CSA. To assess this claim, the standard operational definition of CSA (i.e., being under the age of 18, a 5-year or more age difference, and perception of coercion) was used to examine whether the functioning of participants reporting having experienced a sexual encounter exhibited greater psychological impairment than those who did not. Current functioning was assessed using the Global Symptom Severity Index of the SCL 90-R. To investigate whether sexual adjustment was impacted, the Derogatis Interview for Sexual Functioning- Revised (DISF-R) was employed. Rind et al. also proposed that psychological difficulties exhibited by individuals with a history of sexual encounters with adults may be due to having been reared in a maladaptive family environment, rather than to CSA. This claim was assessed using the Family Adaptability and Cohesion Evaluation Scale-Second Edition (FACES-II). First a summary of the study's findings and interpretation will be presented. This will be followed by an in-depth exploration into the methodological and psychometric strengths as well as limitations of the study will be considered. Finally, strategies for improvement of the current methodology for future research will be explored.

Prevalence

Among the three sexual acts assessed (e.g., oral sex, vaginal sex and anal sex) approximately 10% of the sample (e.g., 27 out of 297 participants) reported experiencing at least one sexual act before the age of 18 with a partner 5-years or more older. This prevalence rate is comparable to other college samples, but generally lower than the general population (Peters & Range, 1995; Duane, 1997; Kenny & McEachern, 2001; Tang, 2002; Testa, VanZile-Tamsen, &

Livingston, 2005). Of the 27 participants 24 were female and 3 were male. This rate of CSA prevalence did not allow the current study to investigate Rind et al.'s (1998) findings that male participants were more likely to view CSA experiences as neutral or positive and exhibit significantly lower rates of psychological maladjustment.

Global Symptom Severity

One of Rind et al.'s primary interpretations, that psychological harm was not an assumed outcome of sex between adults and children, rather that psychological functioning was attributable to the adults view of the childhood sexual experience (i.e., belief). The results of the current study identified two variables that had a small but significant effect on psychological functioning (i.e., Global Symptom Severity). The first was the belief participants held about the power dynamics of the sexual experience (e.g., consenting or victimized). The second was the participants' sexual orientation.

The significance of participants beliefs about the power dynamics of the sexual experience is consistent with Rind et al.'s (1998) interpretations that irrespective of participants' CSA status, it was their belief about the power dynamics of the sexual experience that impacted current psychological functioning. The second variable that had a significant impact on Global Symptom Severity was the participants' reported sexual orientation. This finding is consistent with literature on Minority Stress Theory (Meyer, 2003) that the degrading nature of the social and interpersonal contexts that minorities, in this case sexual orientation minorities, are subjected to result in increased abuses, disenfranchisement and subsequently decreased psychological functioning (Frost, Lehavot, & Meyer, 2015; Herman, 1992).

Family Environment

The second outcome variable assessed was participants family of origin adaptability and cohesion (e.g., FACES-II) in relation to CSA status, beliefs about the power dynamics of the sexual experience and demographic variables entered as covariates. The only variable that had a significant impact on FACES-II scores was the participants' beliefs about the power dynamics of the sexual experience (e.g., consenting vs. victimized). These findings occurred in the expected direction, in that participants who reported victimization had significantly lower scores on the FACES-II than participants who viewed their sexual experiences as consensual. This finding suggests that participants who grew up in less adaptive and cohesive families were more likely to be coerced into sex or more likely to perceive the power dynamics of the sexual experience as coercive. These findings are consistent with the literature showing that people reporting a history of CSA describe having grown up in more maladaptive family environments than those who do not (Gold, 2000; Nash, Hulse, Sexton, Harralson, & Lambert, 1993). However, it is also a reasonable interpretation that causation occurs in the opposite direction, for example when a child has sex at an early age family functioning could be impacted. A bidirectional impact between family environment and sexual experiences is wholly possible and requires further investigation. Unexpectedly, participants' who reported CSA, compared to those who did not, did not have significantly different FACES-II scores. This could be the result of utilizing a college sample, who by virtue of matriculating to the undergraduate level exhibit more adaptive adjustment regardless of CSA status and family environment. This will be discussed in more depth in the Limitations section below.

Sexual Dysfunction

The final outcome variable assessed was participants' sexual functioning, and its relationship to CSA status, belief about the power dynamics of the sexual experience and demographic variables entered as covariates. The findings suggested that none of these variables had a significant impact on sexual functioning. These results can be interpreted in a handful of ways, the first being that while the CSA status, consent and demographic variables may adversely impact psychological functioning, they may not impair sexual adjustment. However, there are additional interpretations to consider, such as the samples maturity of sexual functioning. The mean age of the sample was approximately 25, an age at which development in sexuality and sexual expression are heavily impacted by emotional and cognitive maturity, peer relationships and the stigma surrounding sexual dysfunction. Due to assessment taking place in a group setting, respondents may have been hesitant to respond honestly to some of the sensitive variables measured. Finally, research validating the DISF-R was carried out with medical populations (Derogatis & Melisaratos, 1997), therefore it is possible that a relationship could be detected with an instrument validated on a population that more closely approximated the one in the current study. The DISF-R was selected for this study because it was the only available measurement tool of sexual functioning at the time of survey completion. In future research endeavors, the utilization of a measurement tool validated on a CSA sample will mitigate the potential impact of these factors and result in greater clarity around sexual functioning.

Strengths

The current study contained psychometric and methodological strengths that uniquely assess the proposed research question. One of the main arguments that Rind et al. (1998) made was that sex between adults and children is not harmful to the child if the child is consenting

(i.e., views the sexual experience as neutral or positive). Out of 59 studies in the meta-analysis only one directly assessed consent. The primary intention of the current study was to employ a design that directly assessed beliefs surrounding consent, and in order to avoid assuming that participants current perception of consent was consistent with their perception of consent at the time of the encounter, consent was assessed separately for perception at the time of occurrence (i.e., Then) and at the time of survey completion (i.e., Now).

To achieve this, the current study identified three sexual acts (e.g., oral sex, vaginal sex and anal sex) and requested that participants provide their age and the age of their partner when they first experienced the identified sexual acts. Additionally, participants were asked to report their perception of the sexual experience (e.g., consenting or victimized) at the time it occurred (e.g., Then) and at the time of the survey (e.g., Now). This allowed the current study to statistically analyze the relationship of participants beliefs about their first sexual experiences, without assuming harm, to variables that have been demonstrated in contemporary research to be related to CSA (e.g., psychological functioning, sexual functioning and family environment). This nuanced method of measuring consent has not been employed in existing research, and therefore represents a novel attempt to better understand the impact of beliefs about first sexual experiences.

In addition to a novel measurement of consent, the current study was influenced by a Contextual Trauma Theory (Gold, 2000) approach to assessment which accounts for the impact of both family environment and CSA. Rind et al. and other investigators (e.g., Nash et al., 1993) posit that those reporting sexual experiences with adults as children come from more maladaptive families than those who do not. That is, they suggest that the family environment is the sole cause of maladjustment in individuals with a history of sexual contact with adults when

they were children. Conversely, many clinical providers focus on CSA to the exclusion of social and familial factors effecting maladjustment in adulthood. That is, CSA is the sole cause of adjustment. Through the utilization of Contextual Trauma Theory, the current study assessed the relationship of CSA to both family environment as well as psychological adjustment. Therein, exploring the validity to both sides of the debate.

Finally, the current study replicated the methodology of Rind et al. (1998) by sampling exclusively from college participants. While the rebuttals highlight the limitations of utilizing a college sample when assessing CSA, and this will be discussed in the Limitation section below, the utilization of a college sample in the current study represents a contribution to the body of research aimed at understanding the unique impacts of CSA in a college sample.

Limitations

While there are strengths to the current study, limitations existed that are imperative to consider in the interpretation of the findings and consideration for future research. The most glaring limitations to the current study was the lack of generalizability when comparing first sexual experiences between a college sample and the general population. Rind et al. (1998) contended that the use of a college sample, when assessing CSA, was relevant to the general population based on prevalence rates. However, the rates of CSA in the current study (e.g., approximately 1 in 10 participants of the sample), and rates reported using other college samples (e.g., Peters & Range, 1995; Duane, 1997; Kenny & McEachern, 2001; Tang, 2002; Testa, VanZile-Tamsen, & Livingston, 2005), are markedly lower than those reported in studies utilizing community samples. For example, studies utilizing community samples report rates of 1 in 6 males and 1 in 4 females (Lyons & Romano, 2019; Dube, Anda, Whitfield, Brown, Felitti, Dong, & Giles, 2005). These differing rates in prevalence may in-part explain the stark contrast

between the psychological functioning, sexual functioning and family environments of CSA survivors in a college sample compared to the outcomes reported by the general population.

Further, when comparing the findings of the current study to those of Rind et al. (1998), and more importantly to the body of existing CSA literature, conclusions can only be made if there is an adequate target sample size (e.g., college sample of CSA survivors). One of Rind et al.'s primary interpretations was that males were significantly more likely to perceive CSA experiences as neutral or positive compared to females. This question, as well as the others, could not be adequately explored due to a lack of male participants reporting CSA.

Additionally, a college sample of participants reporting CSA may also differ from the general population on variables such as their socioeconomic status, resulting in differing access to resources and interpersonal support in the face of abuses. This was illustrated by the majority of the current sample reporting an average household income of \$61,000 to \$100,000, compared to the U.S. average household income at the time the surveys were completed which was approximately \$44,000 (U.S. Census Bureau, 2005). Without samples that are comparable on variables shown to affect outcome scores, such as gender and SES, valid conclusions cannot be arrived at.

Another limitation of the current study comes from consideration of the reliability and validity of the measurement of consent. As stated above, the methods used to assess consent were unique to the current study and cannot be compared because there does not appear to be existing literature on the subject. In order to assess consent without assuming harm, specific sexual acts had to be identified (e.g., At what age was your first oral sex, vaginal sex and anal sex experience?). By preemptively identifying three specific sexual acts the current study was able to objectively assess the participants' age and beliefs of these sexual acts without assuming

harm. However, by using this method of measurement there was the possibility that some participants may select their first consensual sexual experience for a host of reasons, such as not viewing CSA as a sexual experience, fear of decompensation or not being believed. All resulting in an overrepresentation of consensual first sexual experiences.

Moreover, by naming three sexual acts the current study fails to take into account the occurrence of another possible sexual act. Participants may also have experienced non-consensual kissing, touching, coercive sexual language, frottage, or non-contact abuse. In addition, the established definition of CSA (e.g., before the age of 18 with a partner at least 5 years or more older) does not capture sexually abusive acts perpetrated by peers and siblings, which may result in higher CSA prevalence rates. Resultantly, the rates identified by the current study may not accurately reflect the prevalence of CSA in a college sample and the participants' beliefs about those experiences. In summation, the measurement of consent and CSA status remains in its adolescence, and more reliable and valid ways of assessing it must be explored before conclusions can be made regarding the power of its effect on human functioning.

Finally, there was an unexpectedly high number of participants who met criteria for the established definition of CSA (e.g., reporting a sexual act before the age of 18 with a partner at least 5 years or more older) but reported their sexual experiences as consensual (e.g., refer to Table 1). Exploration into the nature of the participants relationship with their partner, support systems at the time of the event, and participants intellectual functioning may better distinguish this sub-group of participants from college sample counter parts and the general population who reported being victimized. Before more clarity exists in distinguishing these CSA sub-groups the literature will be rife with endless debate based on theoretical assumption and conjecture.

Comparison to Rind et al.'s (1998) Findings

The current study set out to empirically assess Rind et al.'s claim that sex between adults and children is not inherently harmful. To achieve this, the three primary interpretations of Rind et al.'s meta-analysis (i.e., in a college sample males are significantly more likely to experience CSA as positive or neutral compared to females, wide-scale psychological maladjustment is not prevalent among CSA survivors, and family environment is a better predictor of functioning than CSA) required direct investigation.

In response to their first interpretation, that males in a college sample were significantly more likely to view CSA as positive or neutral compared to females. This conclusion could not be assessed due to an insufficient sample size of male participants in the case group ($n = 3$). The current study's findings regarding the relative absence of wide-scale psychological maladjustment among CSA survivors align with those of Rind et al., in that psychological adjustment in the college sample was not related to case group status (i.e., experiencing CSA) but rather to whether respondents viewed their first sexual experience as consensual or not. Finally, family environment was not analyzed as a mediator or predictor, as was the case in Rind et al.'s meta-analysis, but rather as an outcome variable. Due to this method of measurement one-to-one conclusions cannot be drawn; however, the current study's finding that CSA status did not have a significant effect on family environment scores while consent did bolsters Rind et al.'s position that CSA alone is not an adequate predictor of long-term functioning.

In addition to Rind et al.'s primary interpretations, a central tenant of the meta-analysis was the construct of consent. As mentioned in the Review of Literature and Problem section above, Rind et al.'s fundamental claim was that CSA did not result in dysfunction if it was not viewed as harmful (i.e., viewed positively or neutrally), which was the case for a significant

number of male college participants in the meta-analysis. Psychometrically; however, critics took issue with the indirect measurement of consent in the studies comprising the meta-analysis and the subsequent coding of consent (e.g., unwanted and all levels of consent) used in Rind and colleagues' analyses. In response the current study employed a direct method of measuring consent that allowed respondents to report specific sexual acts (e.g., oral sex, vaginal sex and anal sex) as consensual, victimizing or perpetrating. This methodology represents progress toward an objective measure of sexual events experienced in childhood. This measure yielded results that for college participants beliefs about sexual events experienced in childhood, operationalized consent, affect psychological functioning significantly more than CSA. This finding supports the interpretation of Rind and colleagues that perception of consent, not solely CSA, impacts future functioning. The limitations measuring consent and CSA in this way are outlined above and are essential to consider in future research attempting to better understand the relationship between CSA, consent and long-term functioning.

Future Directions

As continuing efforts are dedicated to research in the area of CSA it is imperative that the findings, strengths and limitations reported in the current study are considered. Firstly, future research must establish if CSA prevalence rates are comparable between a college sample and the general population. To achieve this, researchers should seek to replicate the prevalence rate of CSA reported by the current study and other contemporary research utilizing both college and general population samples. Once this is accomplished and agreed upon, the field can begin to create psychometrically valid ways to assess consent surrounding childhood sexual experiences. Any efforts to answer questions before this is established will be curtailed by scientific and political debate, similar to that initiated by Rind et al.'s (1998) initial publication.

What remains of primary interest is the spectrum of reactions to CSA and the factors that mediate long-term functioning. Existing literature is capable of agreeing on the fact that some survivors of CSA report more adaptive functioning than others. Which begs the question of what leads to more adaptive functioning? Is it an adaptive and cohesive family environment? Is it the family's SES and access to resources? Do minority stress factors predict functioning above and beyond CSA status and consent? The findings of the current study contribute to existing literature on the impacts of CSA in a college sample, but these questions cannot be definitively answered until the field stops declaring the 'right' answer and starts listening for universal solutions.

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