Abuse and Parental Characteristics, Attributions of Blame, and Psychological Adjustment in Adult Survivors of Child Sexual Abuse

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The purpose of this study was to examine the influence of abuse and parental characteristics on attributional content and determine the relative contribution of different attributions of blame in predicting psychological symptomatology among adult survivors of childhood sexual abuse. One hundred eighty-three female undergraduates with a history of childhood sexual abuse completed self-report questionnaires. Abuse characteristics were significantly related to attributions. Family- and perpetrator-blame accounted for significant variability in psychological symptomatology, beyond the contributions of abuse characteristics, family environment, and self-blame. Implications for research and treatment are discussed.

KEYWORDS childhood sexual abuse, internal attributions, external attributions, family, posttraumatic stress

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A history of childhood sexual abuse (CSA) has been consistently related to adult psychological symptomatology in women, including anxiety, depression, posttraumatic stress, interpersonal difficulties, sexual dysfunction, and somatization (see reviews by Beitchman et al., 1992; Briere & Runtz, 1993; Neumann, Houskamp, Pollock, & Briere, 1996). However, wide variability among the presence and severity of negative outcomes has been observed. Factors that have been found to account for some of this variation in adult adjustment include abuse characteristics (e.g., severity, number of incidents; Briere & Elliott, 2003; Steel, Sanna, Hammond, Whipple, & Cross, 2004) and family characteristics such as parenting style and parental psychopathology (Fossel, 1995; Whealin, Davies, Shaffer, Jackson, & Love, 2002). Furthermore, an emerging body of research has demonstrated a link between cognitive mechanisms, such as attributions for the abuse, and psychological outcomes in abuse survivors (see review by Valle & Silovsky, 2002). The majority of these studies has concentrated on internal attributions, or self-blame for the abuse. Some studies have also examined the relationship between external attributions, such as blaming the perpetrator or family members, and psychological symptomatology (e.g., Feiring, Taska, & Chen, 2002; McMillen & Zuravin, 1997). However, little is known about the influence of abuse and parental characteristics on attributional content. Moreover, the relative contribution of self-blame, family blame, and perpetrator blame to the sequelae of CSA is poorly understood.

CSA is known to occur within the context of parental dysfunction. The families of intrafamilial and extrafamilial abuse victims have been characterized by patriarchal and unavailable parenting styles, more parental rejection, and high levels of parental psychopathology (Fossel, 1995; Paradise, Rose, Sleeper, & Nathanson, 1994; Vogeltanz et al., 1999; Whealin et al., 2002; Williamson, Borduin, & Howe, 1991). CSA is often perpetrated by a known and trusted individual, and poor parenting may set the stage for such abuse to occur. For example, unavailable parents may not monitor their children or respond appropriately once sexual abuse has occurred (Vogeltanz et al., 1999). Furthermore, dysfunctional family experiences may function as stressors that impact the CSA victim's psychological adjustment well into adulthood (Brock, Mintz, & Good, 1997; Fassler, Amodeo, Griffin, Clay, & Ellis, 2005).

In addition to parental and abuse characteristics, attributions may account for individuals’ responses to CSA. Attribution theory posits that causal inferences about an event, or the perceived reason why an event has occurred, can be linked to resulting emotional experiences and actions. For example, an individual who attributes a negative event to internal causes tends to experience feelings of shame or guilt and to withdraw from others or attempt restitution for wrongdoing (Weiner & Graham, 1999). Feelings of guilt and shame have been associated with negative mental health outcomes, such as depression and post-traumatic stress disorder (PTSD), among survivors of CSA (e.g., Feiring et al., 2002).
Internal attributions, or self-blame, represent the primary focus of studies examining attributions for CSA. Internal attributions for CSA have been consistently associated with long-term maladjustment. A number of studies of adult survivors of CSA have documented significant associations between internal attributions and low self-esteem, interpersonal difficulties, posttraumatic stress symptoms, suicidality, and general symptomatology (Barker-Collo, 2001; Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; McMillen & Zuravin, 1998; Steel et al., 2004).

Few studies have described the role of external attributions in psychological adjustment to CSA. External attributions can be defined both generally as “other blame” and specifically as family blame or perpetrator blame. Family blame can consist of blaming family members for allowing a situation in which abuse could occur, for not taking protective action after learning of the abuse, and for not believing or supporting the survivor. Family blame has been associated with relationship anxiety among female adult CSA survivors (McMillen & Zuravin, 1997) and posttraumatic symptoms among children and adolescents (Feiring et al., 2002). In reference to perpetrator blame, most studies involving child and adult survivors of CSA have found it to be associated with better adjustment (e.g., higher self-esteem, fewer depressive symptoms) in comparison to individuals making more internal attributions (Feiring et al., 2002; Hoagwood, 1990; Lev-Wiesel, 2000). Although perpetrator blame may be associated with better outcomes than self-blame, it remains unclear whether perpetrator blame is generally positively or negatively related to maladjustment among CSA survivors. For example, one study of sexually abused children and adolescents found a positive relationship between perpetrator blame and sexual anxiety (Feiring et al., 2002), while another study on adult CSA survivors failed to find a significant main effect for perpetrator blame on self-esteem and relationship styles (McMillen & Zuravin, 1997).

Relationships among Abuse Characteristics, Parental Characteristics, and Attributions

It seems likely that abuse and parental characteristics play a role in determining attributional content. The literature relating abuse characteristics to the tendency to make internal attributions has demonstrated mixed findings. Some studies have concluded that a close relationship with the perpetrator (e.g., a family member) predicts increased internal attributions for the abuse (Barker-Collo, 2001; Quas, Goodman, & Jones, 2003), while another study reported the opposite effect, in that closer child-perpetrator relationships were associated with lower self-blame (Wyatt & Newcomb, 1990).
abuse onset has also been associated with self-blame, with some studies finding earlier onset of the abuse to be positively related to self-blame (Barker-Collo, 2001; Quas et al., 2003) and others finding the reverse to be true (Steel et al., 2004). Perhaps the most consistent finding has been that severity and chronicity of CSA, including duration, type, and frequency of abuse, is related to a greater tendency to make internal attributions (Beitchman et al., 1992; Quas et al., 2003; Steel et al., 2004). Regarding external attributions, a consistent relationship has been established between greater use of physical force or coercion and external attributions (Chaffin, Wherry, & Dykman, 1997; Hunter, Goodwin, & Wilson, 1992; Wyatt & Newcomb, 1990). Further research is necessary to understand the relationships among abuse characteristics (e.g., duration, frequency, age of onset, relationship to perpetrator), external attributions, and psychological sequelae.

Prior studies suggest that family characteristics, such as parenting style and parental psychopathology, affect children's cognitive and attributional style (e.g., Bruce et al., 2006; Garber & Flynn, 2001; McGinn, Cukor, & Sanderson, 2005; Rodriguez, 2006). For example, parenting characterized by criticism, low caring, and harsh discipline has been linked to depressogenic cognitive and attributional styles among children (i.e., internal, stable, global attributions for negative events; Bruce et al., 2006; Garber & Flynn, 2001; McGinn et al., 2005; Rodriguez, 2006). However, little is known about the impact of parental characteristics on attributions among CSA survivors.

In addition to lack of knowledge about factors influencing specific forms of attributions for CSA, prior studies have been limited in their measurement of attributions. Many studies measure internal and external attributions on a bipolar continuum, although these two types of attributions have been shown to represent separate, coexisting constructs (Feiring et al., 2002). Furthermore, attributions are often measured with a single item. This form of measurement does not take into account the multiple forms that attributions may take (e.g., blaming oneself for causing the abuse, blaming oneself for not recognizing or disclosing the abuse). Similarly, few studies have assessed multiple forms of blame simultaneously (e.g., self-blame, family blame, perpetrator blame) or the factors that contribute to these different forms of blame. Finally, no known studies have assessed the relative contribution of abuse characteristics, parental characteristics, and various forms of attributions to psychological symptomatology in adult survivors of CSA. Therefore, the purpose of the current study was to expand on prior literature by examining the potential determinants of CSA survivors' attributions for the abuse as well as the relative contributions of parental factors, internal attributions, and external attributions in predicting long-term psychological sequelae.

Two sets of research questions were investigated in this study. First, the influence of abuse and parental characteristics on attributions for CSA was analyzed. Based on the literature relating abuse characteristics to attributions,
it was expected that both internal and external attributions would be positively associated with greater abuse severity and chronicity (i.e., duration, frequency, type). No predictions were made regarding the potential association between age of onset or type of perpetrator and attributions, as the literature has diverged on this point. It was expected that self-blame for the abuse would be predicted by higher parental impairment and authoritarian parenting styles, given evidence that depressogenic cognitive styles, or internal attributions for negative events, have been predicted by these familial characteristics.

Second, the additive value of self-blame, family blame, and perpetrator blame in predicting adult psychological symptomatology was examined. A wealth of literature has established the connections among CSA characteristics, or measures of abuse severity, and psychological adjustment. Therefore, these characteristics (type, duration, frequency, age of onset, type of perpetrator) were entered as control variables. Based on prior literature establishing a relationship among parental factors and psychological outcomes among CSA survivors, it was expected that parental factors would account for variance in psychological symptomatology, beyond the contribution of abuse characteristics. Because the relationship between self-blame and psychological symptomatology has been well established, it was expected that of the three forms of attributions measured in this study, internal attributions would predict the most variance in psychological outcomes, beyond the effects of abuse and familial characteristics. Family blame and perpetrator blame were expected to account for additional variance. Family blame was predicted to contribute to increased symptomatology. No predictions were made regarding perpetrator blame, as findings from previous studies have been equivocal.

METHOD

Participants and Procedure

Participants were female undergraduates enrolled in introductory psychology courses. They were recruited through the research participant pool and received course credit for their participation. The study was approved by the Institutional Review Board at the University of Georgia, and informed consent was obtained from all participants. A total of 1,406 individuals completed self-report questionnaires. Within the questionnaires, individuals who endorsed histories of CSA \( n = 183 \); 13\%) were asked follow-up questions regarding the nature of the CSA and attributions for the abuse. For the multiple regression and additive effects models, participants missing data on study variables were excluded, resulting in sample sizes of \( n = 155 \) and \( n = 157 \), respectively. Participants with missing data did not differ significantly on demographic variables from participants included in the study.
CSA was defined as sexual activities occurring before age 18 that were perceived as coercive, unwanted, or that involved an individual who was significantly older. Sexual activities included kissing, fondling, exhibitionism, voyeurism, oral intercourse, vaginal intercourse, and/or anal intercourse. For women reporting sexual experiences before the age of 13, a 5-year age difference was considered abusive. For women reporting sexual experiences between age 13 and 17, the experience was labeled as abusive if the perpetrator was at least 10 years older and/or if the experience was perceived to be unwanted or coercive (Finkelhor, 1979). Similar criteria have been used in prior studies (e.g., Russell, 1983; Vogeltanz et al., 1999; Wyatt, 1985).

Abuse survivors included as participants in this study ranged in age from 17 to 32 years ($M = 19.1, SD = 1.7$). Participants were predominantly Caucasian (73%), while 12% were Asian American, 10% were African American, and 5% identified as multiracial, Hawaiian or Pacific Islander, or Latino. The majority of participants had never been married (95%). Participants were predominantly upper-middle class, as indicated by their parents’ occupational status (72% of participants’ fathers and 51% of participants’ mothers held professional positions).

In terms of childhood abusive experiences, 59% endorsed childhood sexual experiences with someone at least 5 years older (adult-perpetrated abuse) and 58% endorsed experiencing unwanted and/or coercive sexual contact with someone less than 5 years older (peer-perpetrated abuse). The majority (77%) reported their abusive experiences to be perpetrated by a non-family member. Participants’ ages during their first abusive experiences ranged from 1 to 17 ($M = 12.1, SD = 4.5$). The most frequent form of abuse was fondling (31%), followed by vaginal intercourse (19%), oral sex (16%), forced fondling of the perpetrator (13%), exhibitionism (6%), anal intercourse (4%), voyeurism (3%), and kissing (3%). Of women who reported CSA, 17% indicated that they experienced at least two independent episodes of abuse (i.e., involving different perpetrators). The majority (79%) reported that the abuse involved pressure or coercion (e.g., threats of disclosure, threats of violence).

MEASURES

Life Experiences Questionnaire (LEQ)

The LEQ (Ray, 1993) is a self-report instrument that assesses demographic information, histories of childhood and adolescent sexual and physical abuse, and abuse characteristics. The items were adapted from structured interviews developed by Jackson, Calhoun, Amick, Maddever, and Habif (1990) and Resick, Calhoun, Atkeson, and Ellis (1981). This instrument has demonstrated significant test-retest reliability among victims’ reports across
a two-week period. Pearson product moment correlations for abuse characteristics assessed on continuous variables ranged from $r = .83$ to $.93$; Kappa coefficients for categorical abuse characteristics ranged from $.60$ to $.96$ (Ray, 1993).

Participants were asked “As a child or adolescent (under age 18), did anyone who was at least 5 years older than you involve you in any kind of sexual contact with him/her?” and “During your childhood or adolescence (under age 18), did anyone involve you in any unwanted and/or coercive sexual contact that was not covered in [prior section] (that is, anyone other than persons at least 5 years older than you, such as a peer/someone closer to your age)?” The items were followed by a list of activities that could be considered sexual contact, ranging from exhibitionism to intercourse. Participants were then asked to identify their relationship to the perpetrator (non–family member or family member). Examples of family members were provided, ranging from nuclear to extended family members. Participants were then asked to indicate age of abuse onset, age of perpetrator at abuse onset, abuse duration, abuse frequency, and abuse type. Duration of abuse was assessed on a scale ranging from 1 (one incident) to 8 (more than 10 years). Frequency of abuse was assessed on a scale ranging from 1 (one incident) to 8 (daily). The mode in the current sample was 1 for both variables. Participants checked each type of abuse that occurred from a list of activities, ranging from exposure to intercourse. Abuse type was coded into 3 categories according to a typology outlined by Russell (1983). Noncontact abuse, kissing, and sexual touching were coded as 1, genital fondling was coded as 2, and oral sex and intercourse were coded as 3. The highest code for any abusive experiences endorsed by the participants was used (mode = 3).

Parental Unavailability

Parental unavailability was assessed based on a scale developed by Whealin and colleagues (2002). Four items assessed whether the parent was depressed, anxious, substance abusing, and/or ill, using a 5-point scale ranging from 1 (never) to 5 (almost always). These items were summed, resulting in a range of 4 to 20. Among female undergraduates in a prior study, Cronbach’s alpha was .67 and the scale was positively correlated with intrafamilial unwanted sexual attention (Whealin et al., 2002). In the current study, means were 8.7 for mother unavailability ($SD = 3.4; \alpha = .71$) and 7.8 for father unavailability ($SD = 3.1; \alpha = .61$).

Parental Authority Questionnaire (PAQ)

Subscales from the PAQ (Buri, 1991) were used to assess authoritarian parenting style in mothers and fathers during the years the participant spent
in the family home. Examples of items from this scale include: “My mother/father has always felt that more force should be used by parents in order to get their children to behave in the way they are supposed to” and “My mother/father felt that wise parents should teach their children early just who is the boss in the family.” Respondents rated the items on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Scores ranged from 10 to 50, and participants completed a scale for both mothers (or stepmothers) and fathers (or stepfathers). Participants without a mother or father figure were instructed to skip the respective scale. In the current study, high Cronbach alpha values of .88 and .92 were obtained for mother and father authoritarianism subscales, respectively. The mean score on the mother authoritarianism scale was 30.4 (SD = 8.5) and on the father authoritarianism scale was 32.5 (SD = 10.2).

Attributions of Responsibility and Blame Scales (ARBS)
The ARBS (McMillen & Zuravin, 1997) measures the extent to which individuals attribute blame to the self or to others for experiences of CSA. Item analysis and multiple groups confirmatory factor analysis have revealed three subscales: self-blame, family blame, and perpetrator blame. Examples of items from these scales include: “I blame myself for allowing the sexual contact to occur,” “I blame my family for not doing more to protect me from the sexual contact,” and “I think the person who had the unwanted sexual contact with me intended to do these things.” Participants were asked to identify attributions made at the time that the abuse took place. This decision was based on evidence that adult CSA survivors’ retrospective reports of attributions made during childhood are more strongly related to symptoms than reports of attributions made during adulthood (Barker-Collo, 2001).

Respondents rated the items on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). In the current study, Cronbach alpha coefficients were .92 for self-blame (20 items), .88 for family blame (10 items), and .87 for perpetrator blame (10 items). The means for each subscale were 53.1 for self-blame (SD = 17.9; range = 20-90), 17.7 for family blame (SD = 8.6; range = 10–48), and 32.1 for perpetrator blame (SD = 9.8; range = 10–50). Mean item responses (ranging from 1 to 5) indicated that perpetrator blame was endorsed at the highest levels (M = 3.2, SD = .98), followed by self-blame (M= 2.6, SD = .90) and family blame (M = 1.8, SD = .86).

Symptom Checklist-90-Revised (SCL-90-R)
The SCL-90-R (Derogatis, 1983) is a self-report instrument designed as a screening tool for psychopathology among nonpatient, medical, and psychiatric populations. Participants rated items on a five point Likert-type scale indicating the extent that each problem caused distress during the past
seven days. For this study, the Global Severity Index (GSI) was used as a general measure of psychological distress. The GSI is obtained by calculating the mean response to the 90 items. Cronbach's alpha for the 90 items in the current study was .97. The mean GSI was .78 (SD = .58), which is indicative of significant symptoms in comparison to nonpatient adult female norms (mean = .24–.26).

Purdue PTSD Scale–Revised (PPTSD-R)

The PPTSD-R (Lauterbach & Vrana, 1996) was used as a measure of PTSD symptoms among the sample population. The PPTSD-R is a self-report measure comprised of 17 items that assess reexperiencing, avoidance, and arousal symptoms in response to a specific traumatic event. Respondents rate the frequency of occurrence within the previous month of each item on a 5-point scale ranging from 1 (not at all) to 5 (often). Participants were asked to anchor their responses to their experiences of unwanted sexual contact. Continuous scores are obtained by summing the 17 items, for a total score ranging from 17 to 85. In the current sample, the mean score was 33.7 (SD = 14.4), which is consistent with the norm among nonclinical undergraduate populations.

The PPTSD-R has demonstrated excellent internal consistency overall among a sample of undergraduate students (α = .91; Lauterbach & Vrana, 1996). In the current sample, Cronbach’s alpha was .92. In terms of validity, the PPTSD-R has exhibited a stronger relationship with other measures of PTSD symptomatology (r = .50 to r = .66) than with measures of anxiety (r = .37) and depression (r = .39). Furthermore, students who experienced at least one traumatic event scored higher than those who did not report any traumatic events (Lauterbach & Vrana, 1996). In addition, individuals with a history of sexual abuse have scored significantly higher than nonvictims (Timmons-Mitchell, Chandler-Holtz, & Semple, 1996).

RESULTS

Factors Associated with Self-, Family, and Perpetrator Blame

To explore the relationships among abuse characteristics, familial factors, and attributions of blame, Pearson's correlations were examined. In addition, three multiple regression equations including abuse and family characteristics as predictors of each type of attribution were conducted (see Tables 1 and 2). Self-blame was positively correlated with abuse frequency, duration, type, and age of onset. Within the multiple regression equation, duration, type, age of onset, and peer-perpetrated abuse emerged as the strongest predictors of self-blame. Correlations revealed that family blame was positively related to abuse duration, intrafamilial abuse, and mother unavailability, and
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<sup>a</sup>Extrafamilial abuse was coded “0” and intrafamilial abuse was coded “1.”

<sup>*p < .05; **p < .01.</sup>
negatively related to age of onset. However, within the multiple regression equation, family blame was significantly predicted only by mother unavailability and peer-perpetrated abuse in the context of other abuse and family characteristics. Finally, perpetrator blame was positively correlated with abuse frequency and type and negatively correlated with age of onset. Within the multiple regression equation, only age of onset remained significant. Father unavailability, father authoritarian parenting style, and mother authoritarian parenting style were not significantly related to attributions.

Additive Effects of Self-, Family, and Perpetrator Blame

Hierarchical regression analyses were used to examine the potential additive effects of self-blame, family blame, and perpetrator blame in relation to psychological outcomes, beyond the contributions of abuse and family characteristics. Two types of psychological outcomes were examined: symptoms of PTSD and general symptomatology (SCL-90-R). In these analyses, abuse characteristics (abuse type, duration, frequency, intrafamilial abuse, and age of onset) were entered as control variables in the first step. Familial factors (mother unavailability, father unavailability, and father authoritarian parenting style) were entered in the second step. Mother authoritarian parenting style and adult-perpetrated abuse were not included due to lack of significant relation with attributions or psychopathology in this study (see Table 1). Of the attributions variables, self-blame was anticipated to account

### Table 2: Regression Results for Abuse and Family Characteristics Predicting Self-Blame, Family Blame, and Perpetrator Blame (N = 155)

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Self-Blame</th>
<th></th>
<th>Family blame</th>
<th></th>
<th>Perpetrator blame</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>R² adj</td>
<td>β</td>
<td>R² adj</td>
<td>β</td>
<td>R² adj</td>
</tr>
<tr>
<td>Abuse type</td>
<td>.15*</td>
<td>.20***</td>
<td>.03</td>
<td>.09**</td>
<td>−.06</td>
<td>.02</td>
</tr>
<tr>
<td>Abuse frequency</td>
<td>.16</td>
<td></td>
<td>.03</td>
<td></td>
<td>.17</td>
<td></td>
</tr>
<tr>
<td>Abuse duration</td>
<td>.21*</td>
<td></td>
<td>.13</td>
<td></td>
<td>−.07</td>
<td></td>
</tr>
<tr>
<td>Age of onset</td>
<td>.18*</td>
<td></td>
<td>−.11</td>
<td></td>
<td>−.26**</td>
<td></td>
</tr>
<tr>
<td>Intrafamilial abuse</td>
<td>−.08</td>
<td></td>
<td>−.01</td>
<td></td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>Peer perpetrated</td>
<td>.24*</td>
<td></td>
<td>−.29*</td>
<td></td>
<td>.08</td>
<td></td>
</tr>
<tr>
<td>Adult perpetrated</td>
<td>.06</td>
<td></td>
<td>−.14</td>
<td></td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>Mother unavailability</td>
<td>.09</td>
<td></td>
<td>.25**</td>
<td></td>
<td>.06</td>
<td></td>
</tr>
<tr>
<td>Father unavailability</td>
<td>.03</td>
<td></td>
<td>−.07</td>
<td></td>
<td>−.06</td>
<td></td>
</tr>
<tr>
<td>Mother authoritarian parenting style</td>
<td>.13</td>
<td></td>
<td>.12</td>
<td></td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>Father authoritarian parenting style</td>
<td>.08</td>
<td></td>
<td>−.10</td>
<td></td>
<td>.01</td>
<td></td>
</tr>
</tbody>
</table>

*aExtrafamilial abuse was coded “0” and intrafamilial abuse was coded “1.”

*p < .05; **p < .01; ***p < .001.
for the most variance and therefore entered in the third step. Because prior empirical support was stronger for family blame, it was entered in the step prior to perpetrator blame.

PTSD Symptoms

Table 3 presents the hierarchical regression results for the outcome of PTSD symptoms. Abuse characteristics and familial factors did not account for a significant portion of the variance in PTSD symptoms. Additive effects were found for self-blame, family blame, and perpetrator blame. In the final step, when perpetrator blame was added to the model, the standardized beta coefficients for self- and family blame were no longer significant. All three forms of blame exhibited a positive relationship with PTSD symptomatology.

SCL-90-R

Table 3 presents the hierarchical regression results for the outcome of SCL-90-R. Additive effects were found for familial factors, self-blame, and perpetrator blame, but not for family blame. However, when perpetrator blame

| TABLE 3 Hierarchical Regression Analyses for Abuse Characteristics, Parental Factors, and Attributions Predicting Psychological Symptomatology (N = 157) |
|-------------------------------+------------+---------+---------+-----------+------------+---------+---------+-----------+-----------|
| Independent variables          | PTSD Symptoms |         |         |          | SCL-90-R   |         |         |          |           |
|                               | β           | Δ R²    | R² adj  | F        | β         | Δ R²    | R² adj  | F        |           |
| **Step 1**                    |             |         |         |          |           |         |         |          |           |
| Abuse type                    | .16         | .00     | 1.04    |          | .07       | .00     | .90     |          |           |
| Abuse frequency               | −.11        | .07     | −.15    |          | −.10      | .06     | .09***  | 2.34     |           |
| Abuse duration                | .15         |         | .04     |          | -.05      | .09***  | .07*    | 2.34     |           |
| Age of onset                  | .03         | .13     | .21**   |          | .10**     | .13**   | .290**  |          |           |
| Intrafamilial abusea          | −.03        | .10     | −.06    |          | .09***    | .07*    | 2.34    |          |           |
| Peer abuse                    | −.05        | .09***  | .07*    | 2.34     | .10**     | .13***  | .290**  |          |           |
| **Step 2**                    | .04         | .02     | 1.34    | .09***   | .07*      | .07*    | .234    |          |           |
| Mother unavailability         | .08         | .19*    | .13     |          | .10**     | .13***  | .290**  |          |           |
| Father unavailability         | .00         | .06     | .06     |          | .10**     | .13***  | .290**  |          |           |
| Father authoritarian parenting style | .18*       | .21**   |         |          | .10**     | .13***  | .290**  |          |           |
| **Step 3**                    | .04*        | .05     | 1.82    | .03*     | .10**     | .13***  | .290**  |          |           |
| Self-blame                    | .21*        |         |         | .19*     | .10**     | .13***  | .290**  |          |           |
| **Step 4**                    |             | .03*    | .07*    | 2.13*    | .01       | .10**   | .265**  |          |           |
| Family blame                  | .19*        |         |         | .13       |           | .10**   | .265**  |          |           |
| **Step 5**                    | .03*        | .10**   | 2.51**  | .03*     | .10**     | .13***  | .290**  |          |           |
| Perpetrator blame             | .21*        |         |         | −.19*    |           | .10**   | .265**  |          |           |

*aExtrafamilial abuse was coded “0” and intrafamilial abuse was coded “1.”

*p ≤ .05; **p ≤ .01; ***p ≤ .001.
was added to the model in the final step, the standardized beta coefficient for family blame achieved significance ($\beta = .21, p < .05$). Both self- and family blame exhibited a positive relationship with general symptomotology, whereas perpetrator blame was associated with lower symptomotology on this measure.

**DISCUSSION**

Relationships among Abuse Characteristics, Family Characteristics, and Attributions

As expected, self-blame was positively associated with measures of abuse severity (duration and type). While external attributions were correlated with measures of abuse severity, these measures did not emerge as significant predictors within multiple regression analyses. Peer-perpetrated sexual abuse was positively associated with self-blame and negatively associated with family blame. It is possible that victims perceived themselves as having more control over or inviting the abusive experiences when the perpetrator was closer to their age. The relationship to family blame may be partially explained by the fact that, among CSA survivors endorsing peer-abuse, the relationship to the perpetrator was most likely to be a non–family member (86%). Previous research has indicated that when children disclosed abuse by a non–family member they were less likely to receive an unsupportive reaction from their parents than when they disclosed abuse by a family member (Hershkowitz, Lanes, & Lamb, 2007). Victims of peer-perpetrated abuse may be less likely to attribute blame to their family due to the support they receive and due to their greater likelihood of attributing responsibility to themselves.

Self-blame was predicted by older age of abuse onset, while external blame was associated with younger age of onset. These findings support the notion that survivors assume more responsibility for sexually abusive encounters as they age. It has been well-established in the literature that older CSA survivors are attributed more blame than younger ones (e.g., Back & Lips, 1998; Maynard & Wiederman, 1997). Studies suggest that older CSA survivors are perceived as being less sexually naive and more able to use physical force to defend themselves (Back & Lips, 1998; Maynard & Wiederman, 1997). As a result, older CSA survivors may begin to engage in self-blame due to others’ perceptions and reactions toward them.

Contrary to predictions, parental characteristics were not related to internal attributions. The only significant relationship between parental variables and attributions was the finding that mother unavailability predicted greater family blame. Maternal disability or illness has emerged as a risk factor for CSA in prior studies (Finkelhor, 1984). It is possible that CSA survivors discern a connection between mother unavailability and increased risk of victimization, thereby leading to increased mother blame for the abuse.
when they perceive their mothers to be impaired. At least one prior study has also noted that adult survivors of CSA are more likely to blame the female parent in comparison to male family figures (Croghan & Miell, 1995). Taken together, these findings suggest that family blame often takes the form of attributing responsibility to the mother and that this form of blame may be increased when mothers are psychologically or physically unavailable.

Additive Value of Self-, Family, and Perpetrator Blame in Predicting Psychological Distress

Consistent with hypotheses, family and perpetrator blame accounted for additional variability in PTSD symptoms, beyond the anticipated contribution of self-blame, abuse characteristics, and parental characteristics. Only perpetrator blame accounted for significant change in variance when added to the model predicting general symptoms. However, family blame attained significance upon the addition of perpetrator blame to the model. An intriguing finding emerged upon examining the relationships between perpetrator blame and symptom outcome measures. While increased perpetrator blame was associated with higher PTSD symptoms, the opposite was true for general symptomatology (as measured by the SCL-90-R). It is possible that specific features inherent to posttraumatic stress account for its divergence from general symptomatology in this case. For example, PTSD has been associated with hostility and anger (e.g., Orth & Wieland, 2006; Riggs, Dancu, Gershuny, Greenberg, & Foa, 1992). The fact that external attributions for negative events have generally been related to expressions of aggression and anger (e.g., Carmony & DiGiuseppe, 2003; Neumann, 2000; Petrocelli & Smith, 2005) may help explain the specific positive association between perpetrator blame and PTSD symptoms. On the other hand, hostility attributions have been associated with fewer internalizing symptoms among physical child abuse survivors (Lansford et al., 2006). Since the SCL-90-R includes an assessment of multiple internalizing symptoms, this effect could help explain the negative relationship between perpetrator blame and general psychological symptomatology. These results, in addition to contradictory findings in the literature, suggest that the relationship between perpetrator blame and symptom outcome is complex.

Limitations

There are several methodological limitations of the current study that should be noted. First, the data were obtained through retrospective reporting. It may have been difficult for participants to report accurately on prior attributions and childhood abuse experiences. A related limitation is that potentially distal relationships between variables were examined. As a result, multiple
intervening variables may have exerted an effect on outcome variables, thus reducing the ability to detect relationships among study variables. In addition, the time elapsed since the abusive incident(s) and the administration of the survey may differ among participants, thus adding to variability in the potential influence of intervening factors and to the error variance.

Due to the correlational nature of the study, causal linkages between variables cannot be established. Furthermore, the influence of confounding variables (e.g., social support, socioeconomic status) is difficult to anticipate or control. It is likely that the model proposed in this study was not fully specified and that inclusion of other variables may have allowed for a clearer understanding of relationships among the variables of interest.

Further limitations to this study involve the nature of the current sample. Since the sample consists of a convenience population of undergraduate students, the participants are likely more homogeneous and asymptomatic than a community population of CSA survivors. The prevalence of CSA (13%) was also low in comparison to the average prevalence among college women (27%; Rind, Tromovitch, & Bauserman, 1998). In addition, the majority of participants reported abusive experiences that were infrequent. As a result, relationships between variables of interest may have been attenuated, as suggested by the small effect sizes obtained in this study. Furthermore, the ability to generalize the results to the larger population of female trauma survivors is limited.

Implications

The findings from this study have several implications for research and practice with adult survivors of CSA. Empirical studies have already demonstrated the effectiveness of techniques that restructure distorted trauma-related beliefs (e.g., Resick & Schnicke, 1992). It is possible that such interventions could be improved by including components geared toward restructuring specific maladaptive attributions. The unique contributions of self-, family, and perpetrator blame in predicting psychological symptoms in this study suggest that interventions could benefit from focusing on each of these forms of attributions.

These findings also indicate that interventions may need to be tailored based on the types of symptoms exhibited among adult survivors of CSA. In the case of survivors who present with symptoms of PTSD, it may be most efficacious to focus on decreasing all three forms of blame. For survivors exhibiting other types of symptoms, treatment may be enhanced by decreasing self-blame and increasing the client’s recognition of perpetrator responsibility. Results from the current study additionally suggest that clinicians may wish to explore the role that abuse severity, age of onset, and maternal characteristics play in the development of maladaptive attributions. For example, survivors who exhibit high family blame in connection with
perceived maternal unavailability could be encouraged to reevaluate their understanding of maternal responsibility. Finally, assessing for maternal unavailability and paternal authoritarian parenting style among abuse survivors could help determine which individuals may be most at risk for mental health problems. Assessing for abuse characteristics (i.e., severity, type of perpetrator, and duration) could add to clinicians’ understanding of who may be predisposed to make maladaptive attributions and would therefore benefit from psychoeducational and cognitive interventions. Addressing these factors during adulthood would be of particular value not only because of the documented persistence of CSA-related sequelae but also because adults have developed a more sophisticated conceptualization of their trauma. Adults may therefore possess a greater ability than children to manipulate their cognitions about the abuse.

Several avenues for further research are suggested by this study. While the current study prompted participants to describe attributions at the time of abuse (preceding recent symptoms), longitudinal research is necessary to support the causal relations between attributions and symptoms. This research, in addition to treatment outcome studies, is essential to determining the utility of restructuring specific attributions for CSA. In addition, our findings should be replicated within a more representative population of adult CSA survivors. In particular, the contradictory relationship between perpetrator blame and symptom outcome deserves further investigation and confirmation within other samples. Future studies may wish to evaluate the influence of potential mediators or moderators of this relationship, such as hostility and relationship to the perpetrator. Furthermore, research could extend on present findings by investigating the influence of other aspects of family environment, such as cohesion, child physical abuse, and neglect.

In conclusion, the current study underscores the unique contributions of family and perpetrator blame, above and beyond the influence of abuse features, family characteristics, and self-blame, in predicting posttraumatic stress and general psychological adjustment in adult survivors of CSA. Abuse characteristics were significantly related to attributional content, whereas parental features seemed to play a lesser role. These findings imply that both family and perpetrator blame may represent important targets for treatment and future research. Furthermore, an understanding of abuse and familial factors could help inform both assessment and interventions that concentrate on maladaptive attributional processes.

REFERENCES


AUTHOR NOTE

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