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The Impact of the Characteristics of Childhood Sexual Abuse on Psychological Functioning in Adulthood in Women

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Abstract

Childhood Sexual Abuse (CSA) includes a wide range of sexual acts between a child and an adult. Some of these acts include: coercion, rape, harassment, touching or looking inappropriately at a child's genetalia, as well as other unstated sexual acts against a child (Freyd, Putnam, Lyon, Becker-Blease, Cheit, Siegel & Pezdek, 2005). When examining the differences between gender in CSA victims, females are more than twice as likely as males to become victims and revictimized in adulthood (Lopez, Faro, Lopetegui, Pujol-Ribera, Monteagudo, Avecilla-Palau & Fernandez, 2017). It has been shown that CSA can have adverse effects in adulthood such as: physical problems (e.g., obesity, gastrointestinal, and cardiopulmonary symptoms) and psychological problems (e.g., depression, anxiety, PTSD) (Irish, Kobayashi, & Delahanty, 2009). Further, it has been supported that the more severe the abuse was, the greater the symptomology that the individual will experience after the event (Yancey, Naufel, & Hansen, 2013). Therefore, the current study examined specific characteristics of CSA and their impact on depression and anxiety in adult women who were victims of CSA. Archival data from 217 adult women was taken from a larger online study (Hive, 2009). The participants completed a sexual abuse questionnaire, depression scale, and an anxiety scale. Data that were related to initial abuse, number of abusers, and degree of coercion were subjected to a multiple regression analyses and analyzed for the relationship between CSA and depression and anxiety. Further, six additional items were answered dichotomously "yes" or "no" regarding characteristics of the sexual abuse and were analyzed with t-tests. It was hypothesized that the regression analyses would reveal that more severe characteristics of the abuse would predict higher levels of depression and anxiety. It was also hypothesized

that “yes” responses to severity of the characteristics of CSA would reveal more depression and anxiety than “no” responses to severity of CSA. Most of the hypotheses were unsupported, but there was support that suggests there was a relationship between: a) the number of abusers and depression, and anxiety, b) a father or father figure as the abuser and anxiety, and c) women’s disclosure about CSA and increased level’s of anxiety. The lack of support for the other hypotheses was speculated as due to the sample used, and the way the questions were presented. Furthermore, future research should examine how abuse-specific characteristics influence a women’s ability to form positive relationships in adulthood.

The Impact of Childhood Sexual Abuse on the Psychological Functioning in Adulthood in Women

Childhood maltreatment is a worldwide problem and approximately one percent of all children are abused and neglected every year (Debowska, Willmott, Boduszek, & Jones, 2015). Child maltreatment refers to the physical and emotional mistreatment, sexual abuse, and/or neglect towards a child by an adult (Butchart et al., 2006). There are four types of child maltreatment: physical abuse, emotional and psychological abuse, neglect, and sexual abuse. Physical abuse refers to an intentional use of physical force against a child that has a high likelihood of resulting in harm to the child's health. Hitting, beating, kicking, shaking, and biting are types of physical abuse that are typically seen towards a child (Butchart et al., 2006). Emotional and psychological abuse refer to: patterns of belittling, restriction of movement, blaming, threatening, or discrimination towards a child. Emotional and physical abuse have a high probability of damaging a child's physical or mental health. Neglect refers to patterns of failure of care and isolated incidents that result in the child not receiving care from a parent or family member in one of the following areas: health, education, emotional development, nutrition, and/or shelter or a safe living condition. Sexual abuse refers to a child being involved in sexual activities that he or she does not: fully comprehend, unable to give informed consent to, or violates the laws of society. An adult or another child can be a perpetrator of sexual abuse (Butchart et al., 2006). Current research suggests that approximately 5-20% of all children that have reported Childhood Sexual Abuse (CSA), girls were three times more at risk than boys (Aydin, Akbas, Turla, & Dundar, 2016).

Childhood Sexual Abuse

CSA involves sexual contact between an adult (typically male) and any child who

is under the age of 18 years old (Freyd et al., 2005). Surveys and other reports typically underestimate the prevalence of CSA due to individuals underreporting or failure to recall the abuse. As much as 90% of sexual abuse cases are not reported to authority officials, which can subject these individuals to being victimized again. Coinciding with the abuse can be serious mental health disorders (substance abuses, mood disorders, depression, or PTSD) and physical health problems (gastrointestinal, gynecological or reproductive health issues) (Irish, Kobayashi, and Delahanty, 2010). Either a family member (father, mother, brother, uncle, grandfather) or an individual who is close to the child (friends of family, babysitter etc.) commits most CSA (Molnar, Buka, & Kessler, 2001) Furthermore, many victims report ambivalent feelings towards their perpetrator who in turn uses these feelings to strategize and keep their victim silent and submissive (Paine & Hansen, 2002). Being abused in childhood often leads to longstanding mental health problems in adulthood such as depression or anxiety.

Stoltenborgh, Kranenburg, Alink, & Ijzendoorn (2015) conducted a Meta-analysis with the goal of discovering how many children are truly affected by maltreatment every year. They combined and collected data from January 1980 through January 2008 to include in their meta-analysis study. A total of 244 publications in total were included in their meta-analysis study in which 217 included reports on sexual abuse. It was concluded that through studies that were informant categorized (medical professionals, child protection workers, or teachers reported the maltreatment experiences of the child) and studies that used self-report measures (the participants providing prevalence of abuse during childhood) approximately 7.6% of boys were sexually abused, and about 18% of

girls were sexually abused. Further, 22.6% of the children were physically abused, and 36.3% were emotionally abused (Stoltenborgh, Kranenburg, Alink, & IJzendoorn, 2015).

Barth, Bermetz, Heim, Trelle, and Tonia (2012) conducted a meta-analysis in order to determine the current prevalence of CSA worldwide. Published studies between 2002 and 2009 were included in their analysis. Majority of the studies were conducted in Asia or North America. Based on the findings from Barth, Bermetz, Heim, Trelle, & Tonia (2012) study, approximately 9% of girls reported forced intercourse, and 15% reported a mixed type of sexual abuse. For boys, approximately 3% reported forced intercourse, and approximately 8% reported a mixed type of sexual abuse. For non-contact abuse (inappropriate sexual solicitation or indecent exposure), approximately 17% of males experienced this type of abuse, and approximately 31% of females reported this form of abuse. The prevalence for contact abuse (touching, fondling, or kissing) was approximately 6% for males, and 13% for females. The highest rates of intercourse sexual abuse were reported in Africa for both girls and boys and the highest rates of mixed sexual abuse for girls were reported in Ethiopia, and for boys in Canada.

Lopez Faro, Lopetegui, Pujol-Ribera, Monteagudo, Avecilla-Palau, and Fernandez (2017) conducted a study with the objective of estimating the prevalence of CSA among women who sought out psychological treatment in the Programmes for Sexual and Reproductive Care of Catalonia (Spain). Additionally Lopez & colleagues (2017) analyzed the differences between sociodemographic characteristics of the sample according to exposure to abuse, characteristics of the abuse, revictimization, and the relationship between the victim's age, type of sexual abuse, and the relationship to the perpetrator.

A total of 917 women participated in Lopez & colleagues (2017) study. All women who met the inclusion criteria were invited to participate with the use of their own clinical psychologists. The researchers explained the aim and implications of the study and after signing a consent form, the participants responded to a questionnaire in front of their psychologists. Three hundred and forty five (37.6%) women reported exposure to CSA, 86% were born in Catalonia or other regions of Spain, 24.5% attended university, and 47.6% were married or widowed.

According to Lopez's and colleagues research findings, women who were unmarried or separated reported higher rates of CSA than married women. Additionally, women who were born in Central and South America reported higher rates of sexual abuse. No other significant differences regarding sociodemographic characteristics (age, education, or employment), were found.

Abuse was classified under four mutually exclusive categories; the victim being touched in a sexual way without consent, forced to touch an adult sexually and touched in a sexual way, attempted sexual intercourse without consent and other types of abuse (except for sexual intercourse), completed sexual intercourse without consent. Of all 325 victims, approximately 47% of women suffered one-victimization, while approximately 53% were abused on several occasions. Amongst the women who experienced CSA, 19.3% experienced victimization from more than one perpetrator. Furthermore, of all victims who experienced sexual abuse as a child, 16.5% of women experienced re-victimization in adulthood (Lopez et al., 2017).

Of all women who experienced CSA, 63% reported that they were less than 13 years old at the time of the abuse and approximately 37% were between 13 and 17 years

old. Girls under the age of 13 years old were more frequently touched in a sexual way while attempting and completion of sexual intercourse was more frequent in girls older than 13 years. For victims who were under the age of 13 years, the perpetrator 80% of the time was related to the victim in all four classifications of sexual abuse. For victims between the ages of 13 to 17 years, the perpetrator was more frequently a family friend or acquaintance.

The results of the Lopez study confirmed the reality and magnitude of CSA and how it can impact an individual's psychological functioning and well-being in adulthood. Lopez et al. (2017) further deepened the understanding that we have of CSA's, characteristics that are involved and the reoccurrence or revictimization that is a reality for females.

Gender Differences

There has been an ample amount of CSA research (Alaggia, 2005; Goodman-Brown et al., 2003; Lam 2015) that focused on gender differences and how that can be a predictor to the amount of disclosure, the impact of adult relationships, and how attitudes based on masculine and feminine stigma plays a vital role to seeking help or speaking out about their abuse. Victims of CSA were more frequently females than males (Stoltenborgh, Van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). According to a review of the literature that was conducted by Lopez et al., (2017) between 1970-1990, approximately 7% - 36% of women were victims of CSA compared 3%-29% of men that were affected by CSA. Additionally, a metaanalysis that consisted of 65 studies revealed that when looking at data from 22 different countries, 19.7% of women and 7.9% of men were victims of CSA (Lopez et al., 2017).

Alaggia (2005) suggested that boys are less likely to disclose CSA than girls. She proposes this for a number of reasons. One reason includes an increased risk of stigmatization that is attached to males that are victims of sexual abuse. Additionally, since adult males more often abuse boys, this raises an associated fear of being labeled as homosexual. A final reason as to why boys are less likely to disclose sexual abuse as a child is if an adult woman was the abuser. This is often mistakenly viewed as desirable and this diminishes the view of their victimization (Goodman-Brown et al., 2003)

In 2005, Alaggia conducted a study that focused on the trauma that is left after CSA and disclosure of one's experiences. After reviewing past literature, Alaggia (2005) came across the astonishing findings that between 30% and 80% of victims do not disclose their trauma from their CSA until after adulthood. These statistics have not changed in over a decade, which leaves these children without receiving proper interventions after being exposed to such a traumatic event in their young lives. There are a variable amount of reasons as to why many individuals do not disclose their experiences, one being the relationship to the perpetrator. Wyatt & Newcomb (1990) discovered that when the individual has a closer relationship to the perpetrator, they are less likely to disclose CSA. If a parent or caregiver abuses the individual, many attachment issues as well as a breach in the trust or bond can be something that traumatizes the individual throughout their lives.

The purpose of Alaggia's (2005) study was to explore the factors that impede disclosure by various factors including gender. Additionally Alaggia (2005) focused on disclosure of females and how they were contrasted to males. The study took place in a Canadian city and included 19 females and 11 males who are survivors of CSA. All

participants were interviewed about their experiences. The participants were between the age of 18 and 65 years. The average age of onset abuse was 5.3 years. Adult males abused all of the men in the current study. The majority of the male perpetrators were biological fathers, stepfathers, mothers' partners, or grandfathers.

The main objective of this study was to identify the influences that inhibit or promote children's disclosure of CSA and the participants were all asked the following questions: 1) From the perspective of the victims, what are the psychological tactics used by perpetrators of CSA to suppress disclosure? 2) In what specific ways do these tactics interact to have an impact on the victim's ability to disclose? 3) What individuals, familial, and environmental influences affect disclosure? (Alaggia, 2005).

Fifty-eight percent of the CSA sample did not disclose until adulthood. Some of the participants who attempted to disclose in childhood did so in nonverbal, indirect behavioral ways, although they were ultimately unsuccessful. One male participant stated "There were times when I tried to tell my mother or I did like leave her little hints...Um, I would say something like, oh 'can you come early tonight' or 'do you have to go to work?' Um, I couldn't come out and say it." Alaggia (2005) began to notice three themes emerge in relation to gender differences. For males: a fear of being viewed as a homosexual, feelings of stigmatization or isolation due to the ideation that boys are rarely victims of CSA, and the fear of becoming an abuser. In regards to the female participants, they experienced greater difficulties disclosing because they felt more conflicted about who was responsible for the abuse, and because they thought they would not be believed or even being blamed for it (Alaggia, 2005).

To summarize the findings from Alaggia's (2005) study, both males and females revealed similar dynamics in the process of disclosing their CSA. Delaying disclosure, attempting to reveal their secret in indirect ways, feelings of shame and blame, and the fear of a negative consequence due to disclosing all had a part in the 30 participants decision not to disclose until adulthood. For some of the participants, family dynamics shaped their decision not to disclose. For the 11 men in this study, being sexually abused by another male evoked internal conflict about their sexuality. Males tend to have attitudes regarding masculinity and what it means to be a man, so fear was evoked from possibly being identified as a homosexual by disclosing their abuse. The findings from Alaggia's (2005) study suggest that there are in fact differences between genders in regards to CSA.

Impact on Adulthood

Abuse in childhood can impact the development into adulthood. Research concludes that CSA is associated with an increased risk for a variety of adult medical problems (e.g., obesity, gastrointestinal, and cardiopulmonary symptoms) and psychological problems (e.g., depression, anxiety).

A meta-analysis was conducted by Irish, Kobayashi, & Delahanty (2009) to elucidate how children who have experienced sexual abuse may experience long-term physical and mental consequences. Additionally, individuals who have experienced CSA tend to use health care services more frequently than individuals who have not experienced CSA (Irish, Kobayashi & Delahanty, 2009). This meta-analysis of studies primary goal was to highlight the associations between CSA and various somatic complaints. The meta-analysis reviewed 31-studies comparing both individual's with and

without CSA and six health outcomes: general health, gastrointestinal (GI), gynecologic, pain, cardiopulmonary symptoms, and obesity. These six categories were selected because they had been well documented in a variety of studies that explored this correlation. Additionally, these six categories were chosen because in regard to each physical health outcome, there was plausible biological and behavioral evidence in which CSA has been proposed to influence physical health (Irish, Kobayashi, & Delahanty, 2009).

Individuals who have experienced CSA reported higher somatization symptoms and more negative overall physical health perceptions than individuals who had not experienced CSA. Irish, Kobayashi & Delahanty (2009) compared seven population-based samples that examined the association between CSA and health perceptions. The conclusion that was generated from the results of all seven studies suggested that participants who have experienced CSA had a more negative perception of their overall health than individuals who had no history of sexual abuse.

Based on research that has been conducted by Irish, Kobayashi & Delahanty (2009), it has been found that 53% of all patients with somaticized GI disorders have a history of CSA and 37% of those patients have an organic GI disorder. Additionally, another study that was conducted by Talley, Fett & Zinsmeister (1995) concluded that patients with a history of CSA were 1.7 times more likely to suffer from somaticized GI disorders than those who had not experienced CSA.

Research on CSA and woman's health has identified a strong correlation between CSA and chronic pelvic pain (Irish, Kobayashi & Delahanty, 2009). Harrop-Griffiths J, Katon W, Walker E, Holm L, Russo J, Hickok L (1988) suggested that woman who have

experienced CSA report more gynecologic symptoms more often than women who have not experienced CSA. These results have not been consistent throughout the literature and numerous well-designed studies found no significant differences in gynecologic health of woman with and without CSA (Sickel et al., 2002)

It has also been researched that pain and pain disorders are associated with CSA. Individuals who experience CSA are at a higher risk for musculoskeletal pain symptoms in adulthood such as headaches, backaches, muscle aches, or general pain symptoms (Walker, Gelfand, et al., 1999). Additionally, a number of studies (Chartier, Walker & Naimark, 2007; Runtz, 2002) have failed to find significant differences in pain measures between individuals with and without a history of CSA. Cardiopulmonary pain is pain relating to the heart and lungs. Research has suggested that individuals who have a history of CSA are more likely to report or experience chest pain, shortness of breath, or irregularity in their heartbeats (Goodwin & Stein, 2004) than individuals who have no history of CSA.

The final factor that was a focal point in Irish, Kobayashi, & Delahanty (2009) meta-analytic study was obesity. Although obesity can be associated with other factors, it has been reported that it can also be correlated to CSA as well. Research in a variety of community samples has suggested that individuals with a history of CSA are at an increased risk for obesity (Chartier, Walker & Naimark, 2009). Noll, Zeller, Trickett & Putnam (2007) conducted a longitudinal study that looked at girls from childhood to early adulthood that had and had not experienced CSA. The reason for their study was to evaluate the developmental changes in their Body Mass Index (BMI) through their lifespan. Results from this study revealed that abused girls had an increase in BMI

compared to non-abused girls, although their BMI did not significantly change until reaching early adulthood.

Banyard, Williams & Siegel (2001), conducted a study to explore long-term mental health consequences of CSA. The researchers examined multiple traumas as a mediator of the relationship between CSA and negative adult mental health outcomes. Finkelhor & Browne (1985) developed a model that focuses on four components that CSA creates which are: betrayal, powerlessness, stigmatization, and sexualization. Each of these factors has a profound impact on a child's development, which lays the groundwork for both short-term and long-term consequences in functioning. Therefore, childhood trauma, particularly CSA, may have reactions that go well into adulthood. A study by Banyard, Williams & Siegel (2001) further examined exposure to multiple traumas across the lifecycle as a mediator between CSA and adult mental health.

The Banyard, Williams & Siegel (2001) study examined the differences between two samples of woman, one group had a history of CSA and the other group had no history. Other childhood traumas such as adult sexual assault, and other adult traumas were used as a mediator in the relationship between CSA and adult mental health consequences. This study had four main hypotheses. The first being that CSA would be associated with higher levels of symptoms of psychological distress that replicates other research findings on consequences of CSA. The second hypothesis was that sexual assault at various points in the life cycle would be associated with increased mental health symptoms in adulthood. The next hypothesis was that victims of CSA would report higher levels of exposure to other types of trauma at each stage of the lifecycle (childhood, adolescence, and early adulthood). The final hypothesis was that other forms

of trauma across the lifespan would mediate the relationship between CSA and adult psychological distress symptoms.

Participants in the Banyard, Williams & Siegel (2001) study were women who were interviewed in the third wave of a longitudinal study that focused on the consequences of CSA. Only 87 out of the original 206 participants who experienced CSA agreed to participate in the current study. There were additionally 87 participants who were used as a comparison sample. The mean age of the participants was 31.55 years. Fifty nine percent of the participants had never been married. Almost 89% of the total participants were African American, 47% graduated from high school, and approximately 15% received their GED. Although 87 of the participants were only recruited as a comparison sample, 41 of these women retrospectively discussed experiences of CSA during their interviews. A bivariate analysis was conducted and suggested that there was no statistical significance between the group that reported CSA and the group of participants who were not victims of CSA.

The interviews consisted of numerous questions that consisted of past and current mental health symptoms, relationships, and various questions that revolved around the theme of their victimization and the trauma that they experienced. Multiple measures were used to collect data for the Banyard, Williams & Siegel (2001) current study. Sexual abuse was measured from previously documented hospital records from the 1970's. Additionally, all participants were asked a series of questions about unwanted sexual experiences. They were additionally asked the age of any unwanted sexual occurrence that took place. The researchers counted the participant as experiencing CSA if both of the following occurred: 1) sexual abuse involving contact with genitals was documented

from their hospitalization records, and 2) if the participant reported any retrospective unwanted sexual experience prior to the age of 17 years. Self-reported incidents that did not involve physical contact were not counted as sexual abuse. Of the 128 women who reported CSA (reported and retrospective), 68% reported the use of force associated with the incident, and approximately 33% reported that the abuse was by an immediate family member (Banyard, Williams & Siegel, 2001).

The researches additionally asked the participants a sequence of questions that was associated with their abuse and with other forms of trauma that may have occurred in their lifecycle. General traumatic stress, child physical abuse, witnessing violence or harm, childhood neglect, and adult domestic violence were some themes the researchers focused their questioning around. Banyard et al. (2001) continued by asking a series of questions on childhood physical abuse assessed using a modified version of the *Conflict Tactics Scale* (CTS) (Straus, Hamby, Boney-McCoy & Sugarman, 1996). The CTS was scored as physical abuse if a caregiver: beat up, choked, burned on purpose, threatened with a weapon, or used a weapon on purpose to inflict pain on the victim. They followed by asking questions about childhood neglect, if the victim experienced domestic violence or physical assault as an adult and a series of questions about adult sexual assault. The researchers used the *Trauma Symptom Inventory* (Briere, Elliot, Harris & Cotman, 1995) and focused on the nine subscales, which were: anxious arousal, depression, anger/irritability, dissociation, sexual concerns, dysfunctional sexual behavior, intrusions, defense avoidance, and impaired self-reference.

The Banyard, Williams & Siegel (2001) study suggested consistent with previous work, that exposure to sexual abuse at multiple points in the lifecycle is associated with

higher levels of mental health symptoms in adulthood compared to abuse occurring at only one point. Moreover, when trauma is given a broader definition, where more events can be included, individuals who have a history of CSA have more mental health symptoms than individuals with no history of CSA and report additional exposure to other traumatic events. Furthermore, the link between CSA and adult mental health functioning is suggested to be mediated by a broad range of traumatic exposure across the lifecycle, specifically, other childhood trauma and adult sexual assault (Banyard, Williams & Siegel, 2001). The findings from Banyard, Williams, & Siegel's (2001) study support findings from previous research (Koss & Dinero, 1989; Sanders & Moore, 1999) which highlighted the importance of finding ways to discuss and comprehend revictimization and it's link between sexual abuse in childhood and adulthood. Findings from the Banyard, Williams & Siegel (2001) study suggested that sexual assault was associated with higher levels of mental health symptoms. Banyard, Williams & Siegel (2001) study further suggested that sexual abuse in childhood may be linked to a variety of traumatic exposures than just revictimization of sexual abuse in adulthood. The researchers suggested that further investigation is needed to clarify the link between CSA and mental health functioning in adulthood.

Characteristics of Perpetrator and Abuse

It is more common than not that the perpetrator of a victim of CSA is either part of the victim's family, or a close friend to the family of the victim (father figure, relative, acquaintance) (Lopez, et al., 2017; Bulik, Prescott, & Kendler, 200; Roesler, & McKenzie 1994). Furthermore, many victims report ambivalent feelings towards their perpetrator. These feelings are used in turn to keep their victim silent and submissive

(Paine & Hansen, 2002). It has been suggested that frequent abuse that includes a form of penetration (oral, vaginal, or anal) be considered severe abuse, and abuse that does not involve direct contact (exposure or sexual talk) be considered less severe abuse. Some additional factors that could contribute to the severity of abuse are: force, weapons, or threats towards the victims and their family. Further it has been supported that the more severe the event was, the greater symptomology the individual experiences after the event (Yancey, Naufel & Hansen, 2013; Steel, Sanna, Hammond, Whipple & Cross, 2004; Briere & Elliott, 2003).

A study was conducted by Shevlin, Murphy, Elklit, Murphy & Hyland (2018) to examine and classify homogenous groups of adult CSA survivors. These groups were classified by similar typologies of sexual trauma, treatment seeking, and incest. The researchers additionally looked at the association between abuse-related variables: victim's age of initial abuse, gender, duration of abuse, and perpetrator of abuse. Shevlin, Murphy & Elklit, et al. (2018) hypothesized that multiple and distinct groups of abuse would be identified and these groups would further differentiated by gender and other abuse-related variables (age of onset, duration of abuse, perpetrator identity etc.)

All participants were attendees at the four Danish CSA treatment centers (N = 454). Clients who met the inclusion criteria were 85% female and had a mean age of 36.6 years. All participants presented as distressed and impaired due to their traumatic abuse history and received psychotherapy for their individualized needs. All participants were asked to provide information based on their demographics, relationship with their perpetrator, information regarding onset and duration of their abuse, and the various types of abuse that they experienced. There were 18 individual acts of abuse that were listed

and this list included the following categories: noncontact sexual abuse (verbally spoken to about sexual content), non-penetrative contact abuse (kissing, fondling in a sexual unwanted way), penetrative sexual abuse acts (attempt or completion of intercourse) (Shevlin, Murphy & Elklit, et al., 2018). Additionally, the participants were asked to identify who the perpetrator was and the frequency of the abuse.

The results of the Shevlin, Murphy & Elklit, et al, (2018) study suggested that the average age of initial abuse was 6.57 years (SD = 4.70) with there being no significant differences between males or females. The abuse lasted for an average of 6.88 years (SD = 6.39). Furthermore, 8.8% of participants reported experiencing one-victimization, 42.9% reported having fewer than 15 occurrences of abuse, and 48.3% reported more than 16 occurrences of abuse.

In regards to the perpetrators, 30.9% reported that their fathers did the abuse, 15.8% reported a sibling facilitating the abuse, 15.1% reported a stepparent, and 4.2% reported their mothers as the sole perpetrator. Approximately one third (32.7%) of the participants reported being sexually abused by a nonfamily member, and 13.6% reported being abused by more than one person. There were four classes that were identified which were: intercourse (highest probability of penetrative abuse experiences), verbal/low-contact class (high probability of being spoken to about sexual matters and higher probability of noncontact abuse), high sexual contact (high probability of having experienced sexual contact, specifically, genital contact), and sexual touch (lowest probability of experiencing most of the sexual acts discussed). The intercourse class comprised of approximately 17% of the participants, which left individuals in this class at a higher risk for revictimization in adulthood and additional negative outcomes such as

psychopathology or suicidal ideation. Two thirds of the sample fell into the sexual touch and high contact class. This finding would suggest that most sexual abuse experiences are nonpenetrative, with kissing, genital and nongenital fondling as more frequently reported (Shevlin, Murphy & Elklit, et al., 2018)

The second aim of the Shevlin et al. study was to investigate the association between the abuse-related variables and the four previously stated classes. Age of initial onset did not predict membership to a specific class, where the number and duration of abusive acts did predict class membership in the intercourse and high-contact class. Additionally, the data supported the notion that when the perpetrator was the victim's mother, he/she was more likely to be in the high-verbal/low-contact class. Furthermore, individuals in the intercourse class were more likely to report more than one perpetrator. Through Shevlin, Murphy, Elklit & Murphy et al.'s, (2018) classifying various components of CSA into four classes, it provided a useful and meaningful way to describe complex patterns of sexual abuse while facilitating CSA outcome and treatment needs.

Depression and Anxiety

CSA has a tremendous impact on mental functioning in childhood as well as in adulthood (Lopez, et al., 2017; Palo & Gilbert 2015; Jonzon & Lindblad, 2005). According to Gilbert and colleagues (2009), approximately 15-30% of women experience unwanted sexual abuse as a child. CSA is a well researched and known risk factor for mood and anxiety disorders such as generalized anxiety, Post Traumatic Stress Disorder (PTSD), and depression, as well as, chronic medical illnesses.

Molnar, Buka, & Kessler (2001) conducted a study from a national representation survey of individuals in the United States that focused on the relationship between CSA and the onset of psychological disorders, specifically mood disorders, anxiety, and substance disorders. The rationale for this study was that CSA can cause a disruption in a child's sense of self, the inability to appropriately deal with stressful situations or other emotional challenges that occur in life that that make psychiatric disorders more prevalent as well as difficulties bonding and understanding others.

Molnar, Buka & Kessler (2001) had three main objectives of their study: 1) to explore the relationship between CSA and psychopathology, 2) to examine other childhood adversities to examine CSA independently of other childhood trauma, 3) the type of sexual abuse, the relationship the victim has with the abuser, and if reoccurring incidents can put the victims at a higher risk for psychopathology.

Data in Molnar, Buka & Kessler's (2001) study was collected between 1990-1992 by the National Comorbidity Survey. There were 8098 participants with a total response rate of 82.40%. All participants were administered the *Composite International Diagnostic Interview* (Kessler, Calabrese, Farley, Gruber, Jewell & Katon, et al., 2012), which is a structured interview that are administered by non-clinician interviewers. The diagnoses were considered valid and were tested for interrater and test-retest-reliability. From all the data that was collected from the 8098 participants, 14 diagnoses were found and information about the disorder was collected such as age of first occurrence of associated symptoms that was then used to calculate the age of onset for each diagnosis. The second part of the survey consisted of questions that were associated with risk factors. Only individuals who had a positive diagnosis from part 1 were questioned (n =

5877, females (n = 2921), males (n= 2945)). These participants were used in the remainder of the study and were between the ages of 15 years to 24 years (Molnar, Buka, & Kessler, 2001). Questions specifically on sexual abuse were in this section to measure if there was any PTSD present. There was additionally a preliminary study to improve participant's memory on sexual trauma that has occurred to them. They were shown a list of 12 traumas and were asked if any of them had ever happened to them. If they responded with a response of yes, this happened to them, they were asked further questions about the sexual abuse they had experienced. Specifically, they were asked how old they were when the event first took place, if it was an isolated event or if it happened chronically, and if the person was a relative, step-relative, family friend or a stranger. If they were under the age of 18 years, they were classified as experienced sexual abuse as a child. Finally, Molnar, Buka & Kessler (2001) measured parental psychopathology from the *Family History Research Diagnostic Criteria Interview* (Andreasen, Endicot, Spitzer, & Winokur (1977).

Overall, prevalence rates for CSA were higher for females (13.5%) than for males (2.5%). Majority of the participants knew the perpetrator: relative (females = 5.8%, males =0.6%), step-relative (females = 1.8%, males = 0.2%), acquaintance (females = 5.1%, males = 1.4%), and stranger (females = 1.8%, males = 0.5%). Individuals who suffered from CSA had a higher prevalence of lifetime psychiatric disorders than those who did not report sexual abuse. Females displayed significant associations between CSA and 14 out of the 17 subsequent lifetime mood, anxiety, and substance disorders. Males displayed only 5 out of the 17 subsequent disorders when associated with CSA (Molnar, Buka & Kessler, 2001). In all of the subsequent disorders for both males and females,

most commonly the mother's psychopathology displayed the most adversity between the variables. Additionally, physical and verbal abuse between parents and the father's psychopathology was significant in 11 out of 34 of the subsequent disorders for both males and females. Parental substance abuse and antisocial behavior was only significant in the substance related disorders. PTSD was the only psychological disorder that presented an interaction with CSA. Based on all other disorders that were tested, PTSD was suggested to be eight times higher for sexually abused respondents than for nonsexual abused respondents.

Results from Molnar, Buka & Kessler's (2001) study support previous findings that there is a strong relationship between CSA and psychopathology. Additionally, many child adversities are associated with poor mental health outcomes. Additionally, the effects of CSA may be most profound when the individual has experienced an unexpected betrayal of trust from abuser.

A study conducted by Ramirez & Milan (2016) aimed to test whether a history of CSA magnifies the association between obesity and mental health symptoms such as anxiety and depression in an ethically diverse sample of low-income women. This study included 186 women who were from low-income communities. Approximately 58% were Latina, 22% were African American, and 20% were non-Hispanic White. The participants completed a survey that was computer administered. All participants were compensated with $40 for their time.

The participants were given three measures. The first was to check their Body Mass Index (BMI) (Ramirez & Milan, 2016). The second measure was to assess the participant's mental health. The participant was given a 9-item Patient Health

Questionnaire (Spitzer, 1999) that was used to assess depressive symptoms. Following the participant was given a 7-item *Generalized Anxiety Domain of Brief Symptom Inventory* (Spitzer, Kroenke, Williams, & Löwe (2006) to assess their level of anxiety. And concludingly, the participants were given a 17-item *Posttraumatic Checklist-Civilian Measure* (Weathers, Litz, Huska & Keane, 1994) to assess for PTSD symptoms. The final measure that the participants were asked to complete was a computer-based survey that examined the occurrence of several sexual events that occurred prior to the age of 18 years (Ramirez & Milan, 2016).

According to the results of the BMI, 27% of participants were overweight and 56% were obese. Approximately 36% reported a history of CSA, 22% reported experiencing depressive symptoms, 25% reported experiencing symptoms of anxiety, and 26% reported PTSD symptoms. Women who reported CSA did not show higher BMI than women who did not report CSA. Additionally, women who reported CSA history did not display significance in regards to other weight categories (healthy weight, overweight, or obese). In regards to mental health, women who reported CSA and were obese reported more severe symptoms compared to all other women in this study. Approximately 50% of women who reported a history of CSA and a BMI that revealed they were in the obese category reported an elevation in depressive symptoms compared to the other 15% of women who fell in the obese category who reported no CSA history Ramirez & Milan, 2016). A similar pattern was observed for women who reported elevated anxiety and PTSD symptoms.

Results from the Ramirez & Milan (2016) study indicated that there was a relationship between obesity, CSA, mood/anxiety related disorders in women who came

from low-income communities. The researchers suggested that the relationship between obesity and poor mental health could be magnified by CSA due to reasons such as stigmatization.

Summary

The literature provides support that CSA can have adverse effects in both childhood and adult functioning. CSA involves sexual contact that is unsolicited between an adult and a child who is under the age of 18 years (Freyd et al., 2005). Furthermore, there has been ample research that focuses on gender differences and how masculine and feminine stigma plays a role in help seeking behaviors. Research conducted by Lopez et al., (2017) suggests that up to approximately 20% of women are victims of CSA compared to only approximately 8% of men. Moreover, approximately 17% of women in Lopez et al., (2017) study were revictimized in adulthood. This thesis examined the degree of coercion and various characteristics of sexual abuse.

Rationale

The purpose of the study was to examine the specific characteristics of CSA, age of initial onset, the degree of force, and disclosure about their abuse, and how these characteristics are related to depression and anxiety in adult women.

Method

Participants

This was an archival study. The participants were part of another online study that examined the relationship between CSA, sexual self-schemas, and adult sexual functioning (Hive, 2009). The current study included 222 women with a history of CSA. Three cases were excluded due to the participants being under the age of 18 years, and

two others were excluded because they did not respond to the anxiety questionnaire. The participant's ages ranged from 18-64 years (M= 32.15, SD= 10.43). Furthermore, 149 identified as White/non-Hispanic (69%), 13 identified as Black or African American (6%), 26 identified as Hispanic (12%), 13 identified as Native American (6%), and 16 identified as other (7%).

Measures

Abuse History Questionnaire. Several items were taken from Hive's (2009) abuse history questionnaire. These items assessed a variety of characteristics associated with the sexual abuse itself. Participants indicated the age of initial sexual abuse and the number of abusers they had. Participants answered the question "How much intimidation, coercion or force was involved during your childhood sexual abuse?". This question was answered on a 6-point Likert scale ranging from 0 (*none*) to 6 (*extreme*). Six additional questions were answered with a dichotomous format being answered yes or no and the questions were as follows: 1) "Did the abuse involve attempted or completed penetration?" 2) "Were you abused by a father, step-father, or father figure?" 3) "Were you abused by a family member?" 4) "Were you abused by a close family friend?" 5) "Were you abused by an acquaintance?" and 6) "Have you told anyone about your childhood sexual abuse?"

Depression Scale. The depression scale included one item "How depressed have you felt over the last two weeks?" This was scored on a 7-point Likert scale ranging from 0 (*not at all*) to 6 (*extremely*).

Anxiety Scale. The anxiety scale included one item "How anxious, nervous, tense, or worried have you felt over the last six months?" This was scored on a 7-point Likert scale ranging from 0 (*not at all*) to 6 (*extremely*).

Hypotheses

It was hypothesized that individuals who experienced sexual abuse in childhood will have symptoms of anxiety and depression. Specifically, it was hypothesized that more severe characteristics of sexual abuse will predict high levels of depression and anxiety.

Hypothesis 1:

It was hypothesized that the age at initial abuse would predict the level of depression and anxiety such that the lower the age the higher the depression and anxiety.

Hypothesis 2:

It was hypothesized that the number of abusers would predict the level of depression and anxiety such that the higher number of abusers the higher the depression and anxiety.

Hypothesis 3:

It was hypothesized that the degree of coercion would predict the level of depression and anxiety such that the higher the coercion the higher the depression and anxiety.

Hypothesis 4:

For the question "Did the abuse involve attempted or completed penetration?" it was hypothesized that depression and anxiety would be significantly higher for "yes" responses than for "no" responses.

Hypothesis 5:

For the question "Were you abused by a father, step-father, or father figure?" it was hypothesized that depression and anxiety would be significantly higher for "yes" responses than for "no" responses.

Hypothesis 6:

For the question "Were you abused by a family member?" it was hypothesized that depression and anxiety would be significantly higher for "yes" responses than for "no" responses.

Hypothesis 7:

For the question "Were you abused by a close family friend?" it was hypothesized that depression and anxiety would be significantly higher for "yes" responses than for "no" responses.

Hypothesis 8:

For the question "Were you abused by an acquaintance?" it was hypothesized that depression and anxiety would be significantly higher for "yes" responses than for "no" responses.

Hypothesis 9:

For the question "Have you told anyone about your childhood sexual abuse?" it was hypothesized that depression and anxiety would be significantly higher for "no" responses than for "yes" responses.

Results

Regressions

Linear regressions were performed on age of initial abuse, depression, and anxiety. Neither the regression for depression, F (1) = .06, p = .81, nor anxiety F (1) = .02, p = .88 was significant.

Linear regressions were performed on the number of abusers, depression, and anxiety. The regression for depression, F (1) = 7.3, p = .007, was significant and the regression for anxiety, F (1) = 7.5, p = .007 was significant.

Linear regressions were performed on the degree of coercion, depression, and anxiety. The regression for depression, F (1) = .00, p = .99, was not significant and the regression for anxiety, F (1) = .00, p = .99, was not significant.

T-tests

A t-test for independent samples was performed on the item "Did the abuse involve attempted or completed penetration?" (yes vs. no) for depression and for anxiety. The t-test for depression was not significant, t (210) = -.17, p =.89. The mean depression score for "yes" was 4.19 (SD = 1.98), and the mean depression score for "no" was 4.24 (SD = 1.96). The t-test for anxiety was not significant, t (210) = 0.23, p = .622. The mean anxiety score for "yes" was 4.51 (SD = 1.89) and the mean anxiety score for "no" was 4.44 (SD = 1.97).

A t-test for independent samples was performed on the item "Were you abused by a father, step-father, or father figure?" (yes vs. no) for depression and for anxiety. The t-test for depression was not significant t (209) = 2.36, p =.23. The mean depression score for "yes" was 4.61 (SD = 1.87), and the mean depression score for "no" was 4.22 (SD =

1.96). The t-test for anxiety was significant t (209) = 2.70, p = .02. The mean anxiety score for “yes” was 4.94 (SD = 1.73) and the mean anxiety score for “no” was 4.22 (SD = 1.96).

A t-test for independent samples was performed on the item “Were you abused by a family member?” (yes vs. no) for depression and anxiety. The t-test for depression was not significant t (210) = -0.77, p = 2.97. The mean depression score for “yes” was 4.06 (SD = 2.03), and the mean depression score for “no” was 4.27 (SD = 1.92). The t-test for anxiety was not significant t (210) = -.85, p = .83. The mean anxiety score for “yes” was 4.35 (SD = 2.03) and the mean anxiety score for “no” was 4.57 (SD = 1.90).

A t-test for independent samples was performed on the item “Were you abused by a close family friend?” (yes vs. no) for depression and anxiety. The t-test for depression was not significant t (207) = -.73, p = .521. The mean depression score for “yes” was 4.06 (SD = 2.04), and the mean depression score for “no” was 4.27 (SD = 1.93). The t-test for anxiety was not significant t (207) = -.82, p = .22. The mean anxiety score for “yes” was 4.34 (SD = 1.99) and the mean anxiety score for “no” was 4.57 (SD = 1.86).

A t-test for independent samples was performed on the item “Were you abused by an acquaintance?” (yes vs. no) for depression and anxiety. The t-test for depression was not significant t (207) = 1.77, p = .31. The mean depression score for “yes” was 4.51 (SD = 1.89) and the mean depression score for “no” was 4.01 (SD = 2.04). The t-test for anxiety was not significant t (207) = 1.47, p = .87. The mean anxiety score for “yes” was 4.74 (SD = 1.922) and the mean anxiety score for “no” was 4.34 (SD = 1.89).

A t-test for independent samples was performed on the item "Have you told anyone about your childhood sexual abuse?" (yes vs. no) for depression and anxiety. The t-test for depression was not significant t (209) = 4.19, p = .44. The mean depression score for "yes" was 4.45 (SD = 1.87) and the mean depression score for "no" was 2.97 (SD = 2.07). The t-test for anxiety was significant t (209) = 4.81, p = .006. The mean anxiety score for "yes" was 4.76 (SD = 1.74) and the mean anxiety score for "no" was 3.14 (SD = 2.17).

Discussion

The purpose of this study was to examine the specific characteristics of CSA and how they are related to depression and anxiety in adult women. Although most of the hypotheses were not supported, there were several hypotheses that were supported.

The first three hypotheses examined certain characteristics of abuse and predicted that there would be a significant effect on the levels of depression and anxiety in the sample of adult women. However, this was not true for the age of initial onset and the degree of coercion. However, the number of abusers did significantly predict both depression and anxiety. A review of the frequency data showed that 47% of the women had one abuser, and 90% of the sample had between one and four abusers. This suggests that abuse by more than one perpetrator was particularly traumatic and may have had lasting impact on psychological functioning. This finding regarding the number of perpetrators is consistent with the research (Shevlin et al., 2018; Steel, et al., 2004; Briere & Elliott, 2003). The lack of significance regarding age of initial onset, degree of coercion, depression, and anxiety are inconsistent with previous findings (Bulk, Prescott & Kendler, 2001). However, findings from Bulk, Prescott & Kendler (2001) study

suggest that there is a correlation between psychopathology, such as depression and anxiety in women and the amount of force that was used during their abuse. Their findings further suggest that psychopathology in women can be related to other characteristics of the abuse such as: attempted or completed intercourse, the perpetrators relationship to the victim, and whether the victim disclosed about their abuse.

A review of the frequency data suggested that there was enough variability in all of the scores to show differences that may have existed although none were found. Results may be due to some unique aspect of the sample, for example; the original study was soliciting women that were interested in responding to sexual self-schemas and these individuals may not reflect the typical women who have experienced CSA and this may explain the inconsistent results.

Twelve t-tests were conducted to examine the presence versus absence of specific characteristics of CSA and if they supported that there would be depression or anxiety in women. Only two out of the 12 t-tests were supported and this was for anxiety only. In summary, women who were abused by a father, stepfather, or father figure and women who disclosed about their CSA had higher levels of anxiety and this was consistent with previous research (Molnar, et a., 2001; Bulk et al., 2001; Roesler & McKenzie, 1994). Molnar et al. (2001) study suggests that women who experience CSA by a close relative has more severe long-term mental health consequences than individuals who have isolated incidents by strangers or acquaintances. This was consistent with the results of the current study, which suggested that there are higher levels of anxiety when a close family member such as a father or father figure perpetrated the abuse.

The t-test analysis suggested that disclosure about CSA increases the participant's level of anxiety. This is consistent with some research (Palo & Gilbert, 2015; Jonzon & Lindblad, 2005) and is inconsistent with other research (Lam, 2015; Campbell et al., 2001). Palo & Gilbert's (2015) study suggested that individuals who disclose about their CSA and receive negative and insensitive feedback experience negative psychological outcomes and had more anxiety symptoms than those who did not receive negative social reactions to their disclose of their CSA. Lam's (2015) study suggested that the individual's negative feelings towards disclosure rather than the severity of their abuse experience predicted anxiety and related symptoms. Therefore, this suggests that the disclosure itself did not have an impact on the individual, however, the social support or potential victim blaming predicted anxiety related symptoms.

The lack of significance for greater depression and anxiety in the presence of the other characteristics is unclear and inconsistent with the literature (Molnar, Buka, & Kessler, 2001; Bulk, Prescott & Kendler, 2001). It is possible that it is a unique aspect of the sample or was measured inaccurately. Further, the phrasing of certain questions could have additionally caused misunderstanding to the participants as some were confounding specific characteristics "attempted v. completed penetration".

In view of the limitations that have been seen, future research should look at more diverse samples. For example, in the current study, almost 70% of the sample identified as White/non-Hispanic and women who identified as Hispanic were the second largest ethnic group in this sample, contributing to only 12% of the sample size. In addition, the participant's in this sample were solicited to participate in a study that focused on self-schema and may not represent the average women who

has experienced CSA. Furthermore, future researchers should examine how abuse-specific characteristics influence the women's ability to form positive relationships in adulthood such as with their father or father figure, sexual relationships, or friendships.

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